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COMMUNITIES IN NEED:

LEGISLATION TO SUPPORT MENTAL HEALTH AND WELL-BEING

TUESDAY, APRIL 5, 2022

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:18 a.m. in the John D. Dingell Room, 2123 of the Rayburn House Office Building, Hon. Anna Eshoo [chairwoman of the subcommittee], presiding.

Present: Representatives Eshoo, Matsui, Castor, Sarbanes, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Kelly, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Staff Present: Shana Beavin, Professional Staff Member; Jacquelyn Bolen, Health Counsel; Jesseca Boyer, Professional Staff Member; Tania Calle, Fellow; Hilary Carruthers, Fellow;

Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Perry Hamilton, Clerk; Stephen Holland, Senior Health Counsel; Zach Kahan, Deputy Director Outreach and Member Service; Saha Khaterzal, Professional Staff Member; Mackenzie Kuhl, Press Assistant; Una Lee, Chief Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Policy Analyst; Kaitlyn Peel, Digital Director; Kylea Rogers, Staff Assistant; Andrew Souvall, Director of Communications, Outreach, and Member Services; Rick Van Buren, Health Counsel; Charlton Wilson, Fellow; C.J. Young, Deputy Communications Director; Alec Aramanda, Minority Professional Staff Member, Health; Sarah Burke, Minority Deputy Staff Director; Seth Gold, Minority Professional Staff Member, Health; Grace Graham, Minority Chief Counsel, Health; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Cole McMorris Rodgers, Minority Special Counsel; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Olivia Shields, Minority Communications Director, and Michael Taggart, Minority Policy Director.

*Ms. Eshoo. The Subcommittee on Health will now come to order.

Due to COVID-19, today's hearing is being held remotely, as well as in-person.

For members and witnesses taking part remotely, microphones will be set on mute to eliminate background noise. Members and witnesses, you will need to unmute your microphone when you wish to speak.

Since members are participating from different locations at today's hearing, our recognition of members for questions will be in the order of subcommittee seniority.

And documents for the record should be sent to Meghan Mullon at the email address we have provided to your staff. All documents will be entered into the record at the conclusion of the hearing.

We have a lot of work to do today, colleagues, and I know that everyone is eager to participate, whether here or remotely. And so I welcome each member and all of our witnesses.

The chair now recognizes herself for five minutes for her -- my opening statement.

The children in our country, I believe, are in crisis, and Congress must act. And that is why today is a very big day for this subcommittee.

Last October, the American Academy of Pediatrics, the

American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in youth mental health. Emergency department visits for children's mental health more than doubled between 2016 and 2020. According to a new CDC report released just last week, one in five teens, 20 percent of the teens in our country, have contemplated suicide during the COVID-19 pandemic, and 44 percent of students said they felt sad or hopeless.

Despite the frequency of mental illness, too many suffer in silence. Mental health is a neglected part of our national health care system. Less than 40 percent of people with mental illness receive treatment, and children fare even worse. Prior to the pandemic, approximately half of children with mental disorders did not receive care. This is inadequate -- this inadequate mental health system is due to insufficient insurance coverage, limited options due to poor provider reimbursement, and an aging system that too often relies on jails and shelters.

The good news is there are many strong bills to address these issues, and today we are considering 19 with two expert panels of witnesses, including the administrators of the Substance Abuse and Mental Health Services Administration and the Health Resources and Service Administration.

I am proud to sponsor, with Representatives Blunt Rochester and Fitzpatrick, H.R. 7236, the Strengthen Kids'

Mental Health Now Act. This bill is comprehensive. It supports the entire continuum of mental health care for children by increasing reimbursement for pediatric mental health services through Medicaid, and by creating new grant programs to expand our national capacity to deliver appropriate care for our nation's children.

Eleven other bills also address pediatric mental care by addressing the recent increase in youth suicides, racial disparities in mental health outcomes, telehealth, and access to mental health service in the families community.

Several bills also address other gaps in mental health care, including the creation of housing for individuals with substance use disorder, improving vital peer support, and establishing the special behavioral health program for Indians. This slate of bills meet the bipartisan demand to address the mental health crisis in both the pediatric and adult populations in our country.

Our country, our nation, faces large and difficult challenges. But these challenges are not insurmountable. In fact, I believe every challenge that we have, there -- represents an opportunity for us to act. We can provide the mental health care and support our fellow Americans need to live and to thrive. So today's hearing is the first step in moving a comprehensive legislative package to address our nation's ongoing mental health crisis.

[The prepared statement of Ms. Eshoo follows:]

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

*Ms. Eshoo. The chair now recognizes and is pleased to recognize the ranking member of our subcommittee, Mr. Guthrie, for his five minutes for an opening statement.

*Mr. Guthrie. Thank you, Madam Chair. I appreciate that, and appreciate our witnesses for being here today.

Substance use disorder and the growing mental health needs are two things that I frequently hear about when I am home in Kentucky. The Commonwealth has been battling the drug epidemic and its associated consequences for far too long.

The COVID-19 pandemic only made substance use disorder and mental health issues across Kentucky and the nation worse. Onerous lockdowns, which recent reports show were ineffective at slowing the rate of transmission of COVID-19, caused some of the most vulnerable populations to live in social isolation for months, with little to no connection to critical, community-based support services. These measures, unsurprisingly, coincided with drastic increases in overdoses throughout the pandemic.

In a 12-month period ending in April 2020, the reported number of drug overdoses across the country was 77,000 and, sadly, jumped to 101,000 in a 12-month period between October 2021 -- ending 2021. Overdoses from synthetic opioids also rose significantly during the pandemic, with the Centers for Disease Control and Prevention data showing that illicit

fentanyl and its analogs were the leading cause of death for individuals ages of 18 to 45 between 2020 and 2021. In Kentucky, elicit fentanyl accounted for over 70 percent of these drug overdoses in 2020 alone, up from 58 percent in 2019.

Despite all of this, the Biden Administration has doubled down on these questionably effective public health measures. The Administration's response to these alarming overdose rates was to keep our schools closed, to turn to masking mandates, and police -- and policies grounded in politics -- even propose a grant program that could have potentially provided Federal funding to purchase crack pipes for users, if not for significant bipartisan pushback. And I note bipartisan pushback.

Worse, the Administration and congressional Democrats have rejected calls by House Republicans to permanently schedule fentanyl-related substances as Schedule 1 drugs. These poisons are largely flooding into our country through the southern border at a rate at which we have never seen. Between fiscal year 2020 and 2021, illicit fentanyl seizures at the southwest borders has increased by more than 130 percent.

My colleagues and I on this committee wrote directly to President Biden asking for his plan to fight illicit fentanyl trafficking. We have yet to hear back.

My Republican colleagues and I on this committee will continue to push the HALT Fentanyl Act, which will permanently schedule fentanyl-related substances as Schedule 1 drugs under the Controlled Substances Act. This will give our law enforcement officials the tools they need to effectively crack down against a list of fentanyl tracking -- trafficking. This will serve as a deterrent for drug cartels that develop variations of these poisons, which we know works, and will, most importantly, save American lives.

To effectively curb the growing drug overdose epidemic, we need to focus an equal amount of attention on providing access to recovery and treatment resources for those seeking help. I am proud of this bipartisan track record this committee has in advancing legislation designed to bolster resources for those with substance use disorder.

My bipartisan, comprehensive Opioid Recovery Centers Act was signed into law by President Trump in 2018 as part of the overwhelmingly-passed SUPPORT Act for patients and communities. This law established programs designed to provide funding to local organizations delivering a full range of recovery and treatment services in communities with high drug overdose mortality rates. This program, importantly, recognizes there is no one-size-fits-all solution to combating addiction. Funds can be used for withdrawal, management services, community-based peer

recovery support services, and job training for those looking to reintegrate into the workforce.

I am especially grateful and proud to have the support of two of my colleagues on this committee, Representatives Bucshon and Schrader, and I look forward to continuing to find opportunities to promote access to recovery and addiction treatment services. That is why I am proud to co-lead on the bipartisan Substance Use Prevention Treatment and Recovery Services Block Services Grant, which was introduced by Representative Tonko and being heard before the committee today.

This legislation would reauthorize the Substance Abuse Prevention and Treatment Block Grant program that provides funding to states to deliver coordinated substance use disorder, prevention, and treatment services. This legislation would also now make clear that the block grant funds can also be used to provide recovery support services.

Above all, it is incredibly important, now more than ever, for Congress to be working on bipartisan solutions to address and close the gaps for those seeking help. I look forward to advancing many of these critical proposals that we have before us today, and I thank my colleagues for their hard work on these issues.

[The prepared statement of Mr. Guthrie follows:]

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

*Mr. Guthrie. And I yield back.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the chairman of the full committee, Mr. Pallone, for his five minutes for an opening statement.

*The Chairman. Thank you, Chairwoman Eshoo. Today the committee continues its critical work to support the mental health and well-being of all Americans.

Over the past year, this committee has considered multiple mental health bills, several of which have already passed the House, such as legislation supporting the National Suicide Prevention Lifeline and the Minority Fellowship Program. And today we will consider 19 bills that collectively provide resources for mental health and substance use prevention, care, and coverage, treatment, and recovery support services.

The need for mental health care is greater than ever. One in five American adults report that the COVID-19 pandemic has had a significant negative impact on their mental health. The pandemic has been particularly disruptive to young people. Children are experiencing increasing rates of mental health conditions. Last week, the Centers for Disease Control and Prevention released a report finding that four in ten high school students in the U.S. said they felt persistently sad or hopeless during the pandemic.

Unfortunately, while the need for mental health services

is greater than ever, Americans of all ages face a range of barriers to the care they need. These barriers include stigma and discrimination, provider workforce shortages, and concerns over the cost and coverage of care. The bills we are considering today will address all of these barriers as we continue to work to ensure people have access to the critical care that they need.

And two of the bills we will consider come from Representatives Cardenas and Porter, and they will help strengthen mental health parity, which is so critical to ensuring that people have access to care. The bills do this by applying mental health parity laws to self-funded state and local health plans, and by providing critical funding to states to implement and enforce parity. And I believe it is critically important that we achieve comprehensive parity, and these bills are another major step to meet that goal.

We will also discuss bills from Chairwoman Eshoo and Representative Fletcher that will strengthen the behavioral health workforce and promote integration of physical and mental health care. Chairwoman Eshoo's bills supports pediatricians, children's hospitals, and other providers to recruit and retain community health navigators, incorporate behavioral health services and pediatric practices, and expand telehealth services. Representative Fletcher's bill provides resources for primary care physicians and practices

to implement and evaluate models of care that integrate behavioral health in primary care services.

There are also several bills that support linkages to care and services for those in times of crisis or recovery, including recovery housing support and peer support services through virtual platforms.

We will also consider legislation from Representatives Hudson and Kuster that will ensure that Medicaid screens incarcerated children for medical and behavioral health issues when they are released, and to help states provide Medicaid-covered services in schools.

And we have my bill to address the behavioral health needs of tribal populations through the creation of a special behavioral health program for Indians modeled after the special diabetes program for Indians.

And while the growing mental health needs require innovative approaches to addressing the nation's crisis, there are existing programs that need our continued support and future investments. So today's slate of bills also includes eight bipartisan bills that will together reauthorize more than 30 Substance Abuse and Mental Health Service Administration, or SAMHSA, programs and 2 Health Resources and Service Administrators, or HRSA, programs that expire this September.

These programs support mental health awareness,

education, and prevention initiatives, care and crisis services, and workforce training. And the programs target those in greatest need, with interventions for children and young adults, those living in rural areas, and individuals experiencing housing insecurity. So these reauthorization bills present an essential starting point for future discussions as they move through the committee. I hope we will have bipartisan support for increased funding for these existing programs to respond to the urgent and pressing needs of our constituents.

I also hope we will be able to come to an agreement on the block grant reauthorizations and how to best provide states with the resources and flexibility to expand prevention and early intervention efforts, as well as recovery support services. So I want to thank the SAMHSA Assistant Secretary Delphin-Rittmon, and HRSA Administrator Johnson, and our stakeholder witnesses for joining us today.

I look forward to the discussions as we work to provide the critical investments necessary to support the mental well-being of all Americans.

[The prepared statement of The Chairman follows:]

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

*The Chairman. And I yield back the balance of my time, Madam Chair.

*Ms. Eshoo. The gentleman yields back.

Now, before I recognize his mother, I want to welcome -- where is Cole? Did he take -- oh, there you are, Cole.

*Mrs. Rodgers. Special counsel.

*Ms. Eshoo. Welcome, welcome. Yes, our special counsel, Cole.

[Applause.]

*Ms. Eshoo. Is it -- we are thrilled that you are here, Cole. And we have been hearing about you for a long time, for a long time.

*Mrs. Rodgers. Yes.

*Ms. Eshoo. So that -- you are here in person, and you are making us all very happy today. We have a lot of work to do, but we are happier because you are here.

*Mr. Guthrie. And he will provide counsel if you need it.

*Ms. Eshoo. Absolutely, absolutely.

So the chair now recognizes your mother, who is the ranking member of our full committee.

This sounds like gobbledygook to him, right?

[Laughter.]

*Mrs. Rodgers. Yes.

*Ms. Eshoo. For your five minutes --

*Mrs. Rodgers. Thank you.

*Ms. Eshoo. -- now for an opening statement.

*Mrs. Rodgers. Thank you, Madam Chair.

*Ms. Eshoo. Certainly.

*Mrs. Rodgers. Thank you. I am thrilled to have Cole McMorris Rodgers here today as special counsel. It is fun for a mom.

I also wanted to recognize that Amy Upton is in the room, and the distinguished gentleman from Michigan, Fred Upton, just recently announced his retirement. And it is a big loss for this committee. He has led with integrity. He -- and as chairman of this committee, he led us to focus on solving problems. I will always remember -- and I think everyone on this committee appreciates -- that the bipartisan bills were always the priority because he knew that those were the best solutions. So we will be honoring him, and appreciate both of you so much.

*Voice. [Inaudible.]

*Mrs. Rodgers. Yes, yes, for sure.

Our children are in crisis. More high schoolers are unhappy and depressed. Mental health emergencies are increasing. Last year there was a two-and-a-half-fold increase in emergency department visits for suicidal ideation and self-harm among children under the age of 18.

It is hard to know where to begin, but I can't help but

think that society is leading with too much fear. Fear has been dominating our lives, especially during the pandemic. Fear shuts us down. And I believe we have seen too much fear forced on our children. Fear and government arrogance kept schools closed, and made the crisis worse. This is what we are seeing in schools in my community, and we are not alone.

More screen time during isolation made children more vulnerable to the dangers of Big Tech and social media, leading to more stress, anxiety, and depression. We have seen significant declines in math and reading, more school violence, increases in obesity. Children have lost motivation because they were shut out of their extracurricular activities and sports. Many are so lost and feeling alone that they are turning to the internet to self-medicate. We hear the stories nearly every day of young people that are taking their lives or purchasing pills online, not knowing that they are laced with fentanyl.

Fentanyl seizures are up 1,100 percent in Spokane County. Spokane County's overdose deaths have nearly tripled. Every parent I know is warning their child, you know, don't take any pill that you don't know where it came from. It could be laced in Xanax, and will kill you instantly.

We should all be asking why. What is making our children and our young adults feel so broken and alone? How

can hope be restored? And how do we stop the -- this -- the fear? How do we stop fear from dominating?

So, Madam Chair, I thank you for bringing us together today to focus on solutions. I want to learn what the existing programs are, and how they are working. I want to -- I think we need to focus there.

I am proud to be leading with Congresswomen Lori Trahan, Young Kim, and Cindy Axne to reauthorize the Garrett Lee Smith Memorial Act. It will help bring additional mental health services to places like WSU to support students' mental health and suicide prevention. But there is a lot more that needs to be -- get done.

We need to address the duplicate programs. I am concerned about new duplicate programs that are going to compete with existing and effective programs, such as H.R. 4944, 5218, 7232 running this risk. I am especially concerned with H.R. 7254, and I am concerned that it will restrict access to care to patients with serious mental health illness, undermine law enforcement, and ultimately hurt local communities. We should support, not undermine the residential and inpatient treatment options that will be the most appropriate place for certain patients to get help, and I look forward to discussing this more, as well as the bipartisan solutions before us.

Finally, I want to speak specific on a problem of

Medicaid IMD exclusion. Right now, Medicaid cannot pay for inpatient or residential care and facilities with more than 16 beds. As a result, more people are either incarcerated or homeless when they should be receiving mental health care. More than a third of the homeless population are untreated with severe mental illness. We simply don't have enough care settings for these patients.

There is also cases of children being kept in emergency rooms for days because they have no place else to go. Foster care can't access short-term residential treatment. These problems with Medicaid access for vulnerable groups must be addressed, especially before the 988 suicide pipeline -- hotline is implemented.

We need to find solutions, and I do thank my colleagues for their work in a bipartisan way. My hope is that we will build on this hearing that -- and we will bring hope and healing to the next generation. We need -- there is one message we need to send them today, and that is -- it is you matter. You are not alone. You have huge potential, and a life worth living.

So I look forward to working together for a more secure future for our young generation.

[The prepared statement of Mrs. Rodgers follows:]

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

*Mrs. Rodgers. And I yield back. Thank you, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back.

All members' written opening statements, every last magnificent one, shall be made part of the record.

Now I would like to introduce the witnesses on our first panel, two important -- very important women, both superb leaders, superb professionals.

Dr. Miriam Delphin-Rittmon is the assistant secretary for mental health and substance use at the Substance Abuse and Mental Health Services Administration. We always shorthand it by saying, SAMHSA. Welcome to you. We are -- it is an honor to have you here today with us.

And Ms. Carole Johnson, she is the administrator of the Health Resources and Services Administration, HRSA.

Welcome to you, and thank you. We look forward to your testimony.

I think the lights were explained to you, just like the traffic signals out there, green, yellow, and red. But we are going to concentrate on the green.

So we will -- after you complete your testimony, we will go to members' questions. But first we will go to Dr. Miriam Delphin-Rittmon for your five minutes of testimony. Welcome again, and thank you.

STATEMENT OF MIRIAM E. DELPHIN-RITTMON, PH.D., ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION; AND CAROLE JOHNSON, M.A., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION

STATEMENT OF MIRIAM E. DELPHIN-RITTMON

*Dr. Delphin-Rittmon. Good morning, and thank you, Chair Eshoo, Chair Pallone, Ranking Member Guthrie, Ranking Member McMorris Rodgers, and members of the Committee for inviting me to be here today.

I am the assistant secretary of mental health and substance use at SAMHSA, an agency that leads the public health efforts to advance the behavioral health of the nation, and improve lives of individuals living with mental and substance use disorders, as well as their families. It is an honor to lead this agency. In fact, I am a proud product of one of its programs, the Minority Fellowship Program. I am pleased to be here with the HRSA administrator, Carole Johnson, to discuss the growing mental health and substance use crisis.

As President Biden has noted, our country faces an unprecedented mental health crisis among people of all ages and all backgrounds. Even before the pandemic, rates of

depression and anxiety were inching higher. But the grief, trauma, physical isolation of the last two years have driven Americans to a breaking point.

In addition, drug overdose deaths have reached a historic high, devastating families and communities. More than 104,000 Americans died due to drug overdose in the 12-month period ending September 2021. For these reasons, President Biden has included addressing mental health and addiction as two of the four pillars of the unity agenda he outlined in the State of the Union address.

SAMHSA is actively working to advance the unity agenda, including helping to implement the national mental health strategy. This strategy includes strengthening system capacity, connecting more Americans to care, and creating a continuum of support that aims to transform our health infrastructure to address mental health holistically and equitably. To help advance SAMHSA's mission, I have identified five core, near-term priorities for the agency.

The first is preventing overdose. Given the escalating overdose crisis and the negative impact of the COVID-19 pandemic, HHS created a new, comprehensive overdose prevention strategy meant to strengthen our primary prevention efforts, increase access to a full continuum of care and services for individuals with substance use disorder and their families.

The second is enhancing access to suicide prevention and crisis care. Preparing the National Suicide Lifeline for full 988 operational readiness requires a bold vision for a system that provides direct, lifesaving services to all in need, and links them to community-based providers uniquely positioned to deliver a full range of crisis services. SAMHSA sees 988 as a linchpin and catalyst for a transformed behavioral health system of care.

The third is promoting children and youth behavioral health. To focus our efforts on improving behavioral wellness for our nation's youth, SAMHSA has developed the Health, Opportunity, Potential, and Equity, or HOPE, framework for children, youth, and families.

The fourth is integrating primary care and behavioral health care. We know that an individual's first interaction with a health system is typically through a primary care or emergency room. During the COVID-19 pandemic, while providers initially focused on acute medical concerns, we heard that many were not adequately resourced to consider the behavioral health effects of the pandemic.

Finally, the fifth is using performance measures, data, and evaluation. For example, SAMHSA recently released the Behavioral Health Equity Report 2021, drawing on data from the National Survey on Drug Use and Health.

My written testimony outlines four additional critical

cross-cutting principles and several SAMHSA programs that will bolster our work to improve these -- to move forward these important priorities. These cross-cutting principles are greater equity within the behavioral health system, enhancing the behavioral health workforce, promoting and supporting recovery practices, and working to ensure financing of a robust array of behavioral health services.

SAMHSA maintains a strong commitment to these priorities and principles in our fiscal year 2023 budget request by enhancing the delivery of clinically-sound, evidence-based, and effective services. The fiscal year 2023 budget request aligns with the Administration's priorities to address mental health and substance use disorders in children, adults, families, and communities.

I will close by echoing President Biden's call in his State of the Union address to support the millions of Americans who are in recovery. Early on and throughout my career, I have been inspired, both personally and professionally, by family members, friends, colleagues, acquaintances who, with courage and resilience, have striven for wellness and recovery.

On behalf of my colleagues at SAMHSA, thank you for your interest in our programs and support for our work, and for supporting the nation's behavioral health. I look forward to answering any questions that you have. Thank you.

[The prepared statement of Dr. Delphin-Rittmon follows:]

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

*Ms. Eshoo. Thank you, Doctor.

Now, Ms. Carole Johnson, for your five minutes of testimony. And again, a warm welcome to you, and we all thank you for being here in person with us.

STATEMENT OF CAROLE JOHNSON

*Ms. Johnson. Good morning. Thank you, Chair Eshoo, Chair Pallone, Ranking Member Guthrie, and Ranking Member Rodgers, and members of the subcommittee.

*Ms. Eshoo. Can you pull your microphone a little closer? We don't have to miss a word.

*Ms. Johnson. Is this better?

*Ms. Eshoo. Great.

*Ms. Johnson. Is that better? Okay.

*Ms. Eshoo. Yes, much better.

*Ms. Johnson. Thank you. I am Carole Johnson, administrator of the Health Resources and Services Administration. I appreciate the opportunity to speak with you today about HRSA's programs that support the mental health and well-being of our nation.

As you know, HRSA supports health care services in communities across the country, including, for example, for the nearly 29 million people who receive care through HRSA-funded community health centers; the more than half-a-million people diagnosed with HIV who receive care through the HRSA-funded Ryan White HIV AIDS program; about 60 million pregnant women and children who benefit from our infant screening, preventive care visits, and other funded services; and individuals in more than 1,500 rural counties across the

country who receive HRSA-supported substance use disorder services.

HRSA also plays an important role in supporting the health care workforce. We provide scholarship and loan repayment assistance to thousands of clinicians in return for them practicing in under-served communities. This year marks our largest scholarship and loan repayment cohort yet, with more than 22,000 clinicians in these programs.

We also invest in recruiting, training, and retaining health professionals, from community health workers to mental health professionals to advance practice nurses.

The President's fiscal year 2023 budget for HRSA includes a nearly $500 million increase to support our strategic investments in delivering mental health care and substance use disorder services, and in growing the behavioral health workforce, including new funding to train more mental health and substance use disorder providers, new resources to support the mental health of the current health care workforce, and additional dollars for delivering behavioral health services in under-served and rural communities.

Like you, we recognize that mental health is essential to overall health for people of all ages, including parents and children who have been affected by the pandemic. So today I would like to highlight two HRSA maternal and child

mental health programs that are currently up for reauthorization: the Screening and Treatment for Maternal Depression Program and the Pediatric Mental Health Care Access Program.

The Screening and Treatment for Maternal Depression Program supports states in integrating mental health care into maternal health care. There is tremendous demand for this program, but to date we have only been able to fund about a quarter of the applicants. Grantees provide training to help mental -- maternal health care providers screen and treat their patients' mental health conditions. And in a critical part of the program design, grantees give maternal health care providers the opportunity to connect with mental health clinical experts through teleconsultation to help them treat their individual patient's mental health conditions.

As a result, more pregnant and postpartum women are being screened for depression, and maternal health care providers are growing their capacity to support the mental health needs of their patients. Of note, where those needs are more complex, maternal care providers have the benefit of an expert teleconsult to support them. For example, through our program, a midwife in Montana and her pregnant patient with emergent mental health needs got real-time mental health help from a perinatal psychiatrist through teleconsultation. In the normal course of business, the midwife would have had

to refer the patient to a provider hours away, who likely would have not been able to easily fit her in to their schedule.

Similarly, our Pediatric Mental Health Care Access Program promotes mental health care integration in pediatric primary care. These grants provide teleconsultation, training, and care coordination to help local pediatric primary care providers diagnose, treat, and refer children for mental health care. Similar to the maternal care program, our Pediatric Mental Health Care Access Program both provides training that builds the capacity of pediatric primary care providers to respond to children's immediate mental health needs, while also giving them the additional support of teleconsultation with a mental health expert to ensure they have the backup and the resources they need to best serve their patients.

Funding from the American Rescue Plan allowed us to broaden the program's reach from 21 to 45 states, territories, and tribal areas, and we are currently taking additional applications, as well. There is considerable interest in demand for these programs, and we look forward to working with the subcommittee on their reauthorization.

In addition to our programs that support mental health services, HRSA's workforce programs are training the behavioral health workforce and creating incentives to

encourage them to practice in the communities where they are needed most. Our Behavioral Health, Workforce, Education, and Training Program supports the training of psychologists, school and clinical counselors, marriage and family therapists, community health workers, peers, and others. And our scholarship and loan repayment programs are increasingly supporting behavioral health care providers, as well.

We also launched a new program with American Rescue Plan funding --

*Ms. Eshoo. You need to summarize.

*Ms. Johnson. -- to help support health care workers' mental health resilience and reduce provider burnout.

In closing, I want to thank the Committee for your ongoing support for HRSA's programs, and your commitment to the mental health and well-being of America's families.

[The prepared statement of Ms. Johnson follows:]

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

*Ms. Eshoo. Thank you very much, Ms. Johnson.

Now that you have both offered your testimony, we will go to members' questions. And I recognize myself for five minutes to do so.

Let me just start with you, Ms. Johnson, and pick up on some of the things that you just mentioned in your testimony. You say that the President's budget would -- is projected to bring in an additional $500 million. How many more would that add to the workforce that is needed, relative to those that you -- you know, that you fund --

*Ms. Johnson. So, thank you for the --

*Ms. Eshoo. -- out of your agency?

*Ms. Johnson. Thank you for the question, Madam Chairwoman. The 500 million is actually across a range of programs and services --

*Ms. Eshoo. I understand that. But what is it going to get us?

*Ms. Johnson. We actually --

*Ms. Eshoo. Particularly in terms of the workforce. This is a big issue.

*Ms. Johnson. Yes. So you -- I will need to get back to you with the specific numbers. But we -- in the current program we trained 6,000 providers in the last year, and over the history of the program we have trained 18,000 providers.

*Ms. Eshoo. And what do you project to add to that? Do

you have -- I mean, if you don't have that yet, you can say so. I am just -- I would like to know what it is, if you have it.

*Ms. Johnson. I will have to get back to you with the numbers --

*Ms. Eshoo. Okay.

*Ms. Johnson. -- Madam Chairwoman.

*Ms. Eshoo. How should HRSA's various grant and training programs adapt to really better address this crisis?

We all know what it is. The members have spoken to it on each side of the aisle. Both of you have in your testimony. What is your top line? Are you changing something in the agency, enlargement of -- an enhancement of the programs that are -- that exist?

Give us a brief overview, and then I want to go to Dr. Delphin-Rittmon.

*Ms. Johnson. Thank you for the question, Madam Chairwoman. We are increasingly focused on ensuring that our primary care workforce -- so through our community health centers -- that we are continuing to focus on mental health and substance use disorder treatment in those settings, and that we are also building out our capacity to train more mental health and substance use providers through our workforce programs, not only directly training them, but we also run the National Health Service Corps program, which is

our program that places individuals in communities that are high need in return for loan repayment and scholarship. And that program has about 20,000 clinicians in it now, and about half of them are behavioral health providers. And of the behavioral health providers, about a third of them are in rural areas.

So we are continuing to focus on how we can use the leverage we have --

*Ms. Eshoo. Yes, if you could get back to us to share information about what you anticipate the enhancement of these programs to be -- they are important, but we need so much more. If you could get that back to us, it would be terrific.

To Dr. Delphin-Rittmon, thank you again for your testimony. In three short months, July 16th, there is going to be a new famous number that is launched, 988, in our country. It will become the nation's new three-digit national suicide prevention and mental health crisis number.

Number one, are we ready?

*Dr. Delphin-Rittmon. So thank you for that question, and I do have to say we are excited about this critical transformation in how we approach suicide prevention and crisis care. We are in the -- we are getting very close.

We are working closely with states. We invested 282 million to be able to continue to staff up and shore up

crisis centers, crisis call centers. We are already seeing rates increase there, and improve there. And so we are excited. We are working closely with states and crisis call centers.

*Ms. Eshoo. Are the -- is there good coordination between the PSAPs and those that are launching this?

*Dr. Delphin-Rittmon. Yes. So there is quite a bit of coordination and collaboration going on across a broad range of stakeholders. So we are having meetings with state commissioners and state teams, with crisis teams, with a number of national groups that are working with us around operational readiness and helping to develop messaging, and playbooks to ensure readiness across the crisis -- you know, across the country, in terms of the crisis call centers.

We are also standing up backup centers. And so that will help us in terms of readiness --

*Ms. Eshoo. What is the backup center, 911?

*Dr. Delphin-Rittmon. Yes. Well, so the backup centers know -- so they are -- if an individual calls 988, and the local crisis center is not able to pick up the call, either because they are on another call or, you know, they may be on several other calls, we have national backup centers that the calls will then be routed to, to ensure that an individual's needs are met. So --

*Ms. Eshoo. So you are saying we are ready?

*Dr. Delphin-Rittmon. We will be ready. We will be ready. I mean, it is a major system transformation. So in terms of today, we anticipate that, even moving forward from today, we will continue to see answer rates and call rates improve, and we will continue to see the staffing up of the various crisis centers, as well as the backup centers, to ensure that we are able to meet the calls that come in -- calls, texts, and chats.

*Ms. Eshoo. Well, you are -- what you are saying is really reassuring. And given that reassurance, I feel better.

So let's just hope it works, it meets the need, because the need is so great across the country. The last thing we need is to be bragging about 988, and have people call, and either because of a lack of, you know, the technology not working or connections being dropped, in a crisis that is -- we can't have that. So thank you.

Okay. The chair now recognizes Mr. Guthrie for his five minutes of questions.

*Mr. Guthrie. Thank you, and thank you both for being here.

Dr. Delphin-Rittmon, I -- so I am a co-leader of the bill before us, the Substance Abuse Prevention, Treatment, and Recovery Support Services Act, the reauthorization of that, with Representatives Tonko, McKinley, and Wild from

Pennsylvania.

And if -- the way that is funded is that 20 percent of it goes to -- 20 percent of it is for prevention services and 80 percent is flexible for the grantee. And there are a lot of needs. And we see the needs, and we have seen this -- we want to kind of prescribe sometimes how that is spent, and we were discussing that amongst ourselves. So it would be helpful to what your view is, how flexible that other 80 percent needs to be. I am one that thinks it should be 80 percent for the local, as much as I see needs here, and valid needs. But the locals may have a different view and use of that.

Would you talk about how important it is for at least that additional 80 percent to be flexible at the local level, if you believe that, I mean, that is what -- yes. I am sorry, yes.

*Dr. Delphin-Rittmon. Excuse me, Ranking Member. So are you speaking about the -- what grant was that, was that the mental health block grant, or the --

*Mr. Guthrie. Yes, that is the Substance Abuse Prevention, Treatment, and Recovery Support Services block grant, yes.

*Dr. Delphin-Rittmon. Yes.

*Mr. Guthrie. Yes, it is the block grant.

*Dr. Delphin-Rittmon. Yes. So, yes, you know, the

flexible funding -- and I can say this as a state -- former state commissioner, as well -- the flexible funding helps. It does help to be able to address and identify specific needs or gaps that may be present within the state system, and to be able to address community needs, whether it be prevention, treatment, recovery, harm reduction services and supports. So the flexible funds do help with being able to implement needed services at the community level.

*Mr. Guthrie. Okay, thanks. And also, again, so I was a main sponsor, I worked with colleagues for the Comprehensive Opioid Recovery Centers to make sure we have just a full range of services for somebody that is suffering from opioid use disorder -- substance use disorder. So we are looking at how we measure that, how successful they are with that.

And aside from reduced overdose rates, which is obviously the top measure, we want to keep people alive and hopefully we can get them into recovery if we can do that, but that is the number-one thing. But besides from that, how do you measure when you have these comprehensive Federal programs -- these are all Federal programs that are designed to promote -- how do you measure access to treatment and recovery services?

*Dr. Delphin-Rittmon. Yes. Yes. You know, first, Ranking Member, I would like to thank you for your leadership

around that important area of work.

So we know that, you know, ultimately, the goal is to increase access to services. And so certainly that is one important measure, and we do track that across our grantees, what is the penetration rate -- that is, the -- what is the rate at which community members are accessing services and supports. And we do collect that based on -- disaggregated by demographics, different demographics, as well. So that is certainly one measure.

But then there are a range of other measures that we look at, as well, depending upon how the program is formed and what some of the particular areas of implementation are within the particular program.

But grantees submit GPRAs, they submit NOMs, national outcome measures. And so we do have quite a bit of data on our various grant programs.

*Mr. Guthrie. Thanks. And then CORCs and specific -- so Federal programs in general, as we were talking in broad -- broadly, and then CORCs, specifically. In your estimation, has it been successful in getting people into these comprehensive services?

I mean, we want to get them to treatment. That is the number one, and reduce overdose, get them into treatment, and then get them into the services that prevent them from relapsing -- that was the idea -- and the treatment that is

appropriate for them.

What is the kind of estimation -- it is relatively new, but it has been out there a little bit. Do you have any view of the success of CORC, specifically?

*Dr. Delphin-Rittmon. You know, I would have to follow up on specific data related to those programs. But what I can say is that the programs are very helpful in terms of diverting people from further penetration into the criminal justice system.

What the programs often do is help to connect people to medication-assisted treatment, other prevention, treatment, recovery services and supports, as needed. We also, though, fund re-entry programs. So for individuals that are connected to criminal justice systems, prior to re-entry we begin work with connecting them with community providers, in some instances starting them on medication-assisted treatment, individuals that have that need, to be able to reduce the possibility or likelihood of overdose upon re-entry. So the CORC programs are important, but also the re-entry programs are really critical, as well.

*Mr. Guthrie. Okay, and I just have a couple of seconds.

Your agency said that state opioid response funding is not being spent. And given the issues that we are having now, would you like to comment on that?

I mean, we have such an uptick in overdoses, would you like to comment on the data from your agency shows that state opioid response funding is not being spent? Can you just kind of share a view of that?

*Dr. Delphin-Rittmon. So what we find is that there is a little bit of a lag in terms of when the states receive resources and when the spending begins. In part, it is based on sort of when they receive the money, and then their own internal grant-making processes, and then, you know, implementation of any particular program. So there does tend to be a bit of a lag.

We do track the spending rates. And what we find is that they are spending the resources, but there is sometimes a 12-month lag or so, give or take.

*Mr. Guthrie. Okay, thank you.

My time has expired, and I yield back.

*Ms. Eshoo. The gentleman yields back. The chair recognizes the chairman of the full committee, Mr. Pallone, for your five minutes of questions.

*The Chairman. Thank you, Chairwoman. Let me ask Dr. Delphin-Rittmon.

SAMHSA has been leading the way in the efforts to address the concurrent mental health crisis. And I know that your testimony highlighted a range of alarming mental health trends in the United States, but what are you most concerned

about? What has your most concern at this point amongst these various concerns?

*Dr. Delphin-Rittmon. You know, I mean, so there are a number of areas that we are prioritizing to really work to mitigate some of the trends that we are seeing. I mean, certainly it is concerning when we look at the level of crisis and individuals that are experiencing suicidal ideation, young people as well as across the board.

As I mentioned earlier, our transformation of the national suicide lifeline to a three-digit number, 988, that is one strategy to help to ensure that people have access to services when they need it and where they need it. That work is initially focused on the call line, but ultimately we are looking at the full crisis continuum to ensure that people have a place to call, someone to go and meet with them if necessary, and a place to go.

You know, the other area where we are concerned is when we look at the continued rates of overdose that we are seeing. When we look at data, fentanyl is implicated in many of those overdose deaths. HHS implemented an overdose prevention strategy. That is a cross-department strategy. SAMHSA was involved, many other HHS agencies. There are four pillars to that strategy: preventing overdose, evidence-based treatment, harm reduction, looking at -- so those are at least three critical pillars of that.

That work is important. We are focused on working to bring and address the overdose rates that we are seeing through comprehensive, evidence-based services and supports and practices.

*The Chairman. Well, thank you. And I know no community is immune from mental health challenges, but we know that some communities bear disproportionate burden, such as tribal communities. And I have a bill, which I mentioned, H.R. 4251, that establishes a special behavioral health program for Indians within the Indian Health Service, which is modeled after the special diabetes program for Indians.

So I wanted to ask you what mental health trends are you seeing amongst American Indians and Alaska Natives?

Do you believe that it is important to have funding dedicated to tribal communities for prevention, treatment, and recovery of mental health and substance use disorders, specifically?

*Dr. Delphin-Rittmon. Yes. You know, thank you so much for your leadership and work in this area. This is a -- we are seeing troubling trends that we are working to address, and working closely with tribal leaders and tribal communities in terms of identifying needs, and then having discussions related to what will help there.

I mean, some of the trends we see, unfortunately, are, you know, increased rates of overdose, you know, among tribal

communities. We also see increased suicidal thoughts and suicidal ideation among tribal individuals within the 18 to 25 age range.

Where we have seen decreases -- that is encouraging -- is in terms of all three of those. So ideation, attempts is individuals 26 to 49 years old within tribal communities. We have we have seen rates of opioid misuse, as well as suicidal ideation and attempts decrease.

This is an -- it is an important area. For SAMHSA, equity is one of our priority areas. We have a number of tribal-specific grants to include our TOR grant, so tribal opioid response grant, similar to SOAR, where we fund a range of prevention, treatment, recovery, harm reduction services and supports. Also Native Connections. Native Connections is a mental health-related tribal-only grant that focuses on addressing suicide and other mental health challenges, as well. So those are just two examples of tribal-only grants.

*The Chairman. Thank you. I just have less than a minute, but I wanted to ask Administrator Johnson.

I appreciate your leadership at HRSA, and appreciated the opportunity to speak to you recently about the Teaching Health Center Graduate Medical Education Program. But there is a lot of these workforce programs at HRSA that are really important as the country grapples with primary care physician shortages.

Just -- you have 30 seconds -- some ways that HRSA is meeting this challenge in growing and training our mental health workforce.

*Ms. Johnson. Thank you so much for the question, Mr. Chairman. And we are actually, in our primary care program, in our primary care training programs, working to integrate mental health and substance use training in that setting so that more primary care providers in the community have some -- the knowledge they need to identify issues early, and help get people connected to services.

*The Chairman. All right. Thank you so much.

I yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentleman from Texas, Dr. Burgess, for your five minutes of questions.

*Mr. Burgess. Thank you.

Dr. Delphin-Rittmon, several people on this committee are interested in what is called the IMD exclusion, the Institute for Mental Disease exclusion. In your time at SAMHSA, have you encountered that as being a barrier to patients getting the care that they need?

*Dr. Delphin-Rittmon. Thank you for that question, Congressman.

So certainly, we have heard some, you know, advocacy related to IMD. My colleagues at CMS, you know, often, that

is work that they are steeped in and sort of working through, in terms of their -- you know, their work. But certainly, we have heard that there are some challenges there at times.

*Mr. Burgess. We did -- in -- when Chairman Upton was chairman, we did a bill called Cures for the 21st Century. It had a mental health title. And that was one of the big debates that we had here in this very committee, was the IMD exclusion, and would it be important to lift that. Cost was seen to be a barrier, because there is no question that the Congressional Budget Office will return that as a cost.

But the more I have studied it, it seems that if you are -- either you pay me now or pay me later. And the problems we see throughout the country with the increase in homeless populations, and the increase in overdose deaths, some of those problems could be mitigated, solved, or avoided by having the availability of an inpatient facility or a longer stay at an inpatient facility. Would that be a fair assessment?

*Dr. Delphin-Rittmon. You know, it often depends on what the individual's sort of clinical picture is looking like. For some individuals and inpatients, they could actually be disruptive to their daily life rhythms, and they could perhaps more appropriately be treated on an outpatient basis with wraparound services and supports to include recovery services and supports.

But certainly, for many individuals, inpatient care is warranted. And often that -- it is, again, just based on how an individual is presenting, and what their needs are at the moment.

*Mr. Burgess. So let me ask you this. Do you have -- does the agency have data on that?

I mean, just the casual observer would say that the homeless problem seems to have gotten more pronounced with the closure of all mental health facilities across the country. Not funding those facilities, obviously, has had a -- has played a role. And then again, it seems to me that the exclusion that exists in Medicaid from paying for inpatient care, or the -- limiting the length of stay, it is -- do you have data on that that says it is better not to have people in hospital?

*Dr. Delphin-Rittmon. I mean, we -- certainly, we could look into that. I mean, I think my primary point was it really depends on what an individual's clinical picture is. For some individuals a hospital may be appropriate, whereas others, being treated at a community level with wraparound services and supports --

*Mr. Burgess. So, you know, we are the committee that is supposed to authorize the expenditures in these things. So you will help us come to the right conclusions and decisions if you will share with us the data that you are

collecting. And yes, we need to query CMS as well, because, clearly, they will have some of that data.

But this committee did the SUPPORT Act in 2018, which was a pretty significant bit of work. And, at least arguably, for a brief period of time overdose deaths actually declined -- a small amount, but they did decline for the first time after going inexorably up and up and up. Pandemic intervened, and now the numbers are so significantly worse.

But again, it seems like we should extrapolate from the benefit that we got from instituting the SUPPORT Act to be able to get those -- get the trend line going in the right direction.

*Dr. Delphin-Rittmon. Yes. And we are -- you know, we are happy to follow up and have any additional follow-up conversations and share any data that we do have there. It sounds like we are talking about a couple of different potential data points, and we are definitely interested in sharing whatever we have that would be useful.

*Mr. Burgess. Well, I don't think there is any question the amount of fentanyl coming over the southern border is contributing to that. And unfortunately, it is fixing to get a lot worse with the expiration of Title 42. But that is another discussion, and I will yield back.

*Ms. Eshoo. The gentleman's time is expired. The chair now recognizes the gentlewoman from California, Ms. Matsui,

for your five minutes of questions.

*Ms. Matsui. Thank you very much, Madam Chair, for holding this hearing, and I want to thank the witnesses for being here today. I want to talk about eating disorders.

It is very disturbing [inaudible] serious mental illness will impact nearly 30 million Americans across their lifetime. However, because of stigma, lack of identification, and limited access to care, only one in three individuals with an eating disorder will ever receive treatment.

For kids and teenagers in particular, early detection and intervention by a primary care provider can be absolutely lifesaving. And that is why I introduced the bipartisan, bicameral Anna Westin Legacy Act with my E&C colleague, Representative McKinley. This legislation would continue and strengthen the work of the National Center of Excellence for Eating Disorders.

Congress first gave HHS the authority to train providers on eating disorders in 2016, and in 2018 SAMHSA used that authority to establish a grant program to support a center of excellence. Dr. Delphin-Rittmon, can you -- why did you believe that this should be a priority for SAMHSA, to implement training on eating disorders for health professionals?

*Dr. Delphin-Rittmon. Thank you for that question,

Chairwoman.

So, you know, training, I think, is so important to be able to ensure that providers are equipped to be able to meet -- work with individuals, and meet the needs of individuals struggling with eating disorders. And so the National Center for Excellence on Eating Disorders provides a broad range of training, resources, technical assistance for providers across the country that need assistance in terms of their work in working with individuals with eating disorders.

Those centers also provide resources --

*Ms. Matsui. Great.

*Dr. Delphin-Rittmon. -- as well.

*Ms. Matsui. Good.

*Dr. Delphin-Rittmon. Yes.

*Ms. Matsui. Now, the pandemic is driving unprecedented demand for mental health care [inaudible]. We all know that. This is especially true for youth who struggle with eating disorders.

Now, Dr. Delphin-Rittmon, do you agree that greater support for existing professionals, including the centers [inaudible] resources to integrated primary care practices is an integrated, active way to meet demand for eating disorder screening and intervention services?

*Dr. Delphin-Rittmon. Yes. Yes, thank you for that, for that question. So, you know, health care integration

that is integrating primary care and behavioral health services, that is certainly a priority area for SAMHSA, also across the Administration.

I am one of the co-chairs of the Behavioral Health Coordinating Council --

*Ms. Matsui. Right.

*Dr. Delphin-Rittmon. -- with Admiral Levine, and that is one of the areas we are focusing on.

But absolutely, I think integrating behavioral health into primary care services can help with the identification -- and vice versa, really, but can help with the identification of individuals that are struggling with eating disorders.

*Ms. Matsui. Okay.

*Dr. Delphin-Rittmon. And to the extent that providers are trained, that is helpful, as well.

*Ms. Matsui. Madam Chair, I would like to submit to the record a letter of support for the Anna Westin Legacy Act, signed by both of the nation's leading mental health, addiction, and well-being advocacy groups.

*Ms. Eshoo. So ordered.

[The information follows:]

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

*Ms. Matsui. I want to quickly touch on the need to expand the number of certified community behavioral clinics in the United States.

With the support of the Expansion Grant Program administrated by SAMHSA, today there are over 400 CCBHCs in 42 states. However, the [inaudible] payment demonstration that helps increase caseload capacity is still limited to only a handful of states.

Dr. Delphin-Rittmon, I have heard reports that CCBHC utilization has increased during the pandemic and, at the same time, these clinics are seeing more adults needing higher acuity care. Is that correct?

*Dr. Delphin-Rittmon. You know, we are hearing that from some states and from some community providers, that they are seeing a greater acuity of care, requiring significant coordination of services and support to be able to meet the needs of the individuals they are servicing.

*Ms. Matsui. Okay. I brought that up only because it is -- it really is specially designed to meet elevated needs and levels of need in critical [inaudible] care for individuals in crisis.

And I also brought this up, too, because that is a way to really integrate primary care and behavioral health care also at the same time. So I urge this committee to consider [inaudible] expand this program further.

And with that, I yield back. Thank you very much.

*Ms. Eshoo. The gentlewoman yields back. It is more than a pleasure to recognize the gentleman from Michigan who has served as the chairman of the full Energy and Commerce Committee, a member that is respected, beloved on both sides of the aisle, who has been a leader on so many issues here, and has delivered a body of exceptional work during his tenure in the Congress.

This is a -- it is a sad day, with your announcement that you plan to retire, Fred. We will have other events and gatherings to honor you and your service, but, you know, we who work with you day in and day out, we love you, we respect you, and I am sure that this was a difficult decision for you and your family. I can't think of anyone that is ever going to fill your shoes, Fred. But here we are together. We love you.

You are recognized for your five minutes of questions.

*Mr. Upton. Well, thanks. Thanks, Madam Chair. It is a delight to be here. I am sorry that I missed some of the opening testimony. It has been a pretty busy day, starting early. But I just -- a couple of things I would just like to pass along.

First of all, this committee, every member, we have had just tremendous representation on both sides of the aisle. I look at our former chairs, people that I knew: John Dingell

and, obviously, Henry. But I look over here at Joe, and Billy Tauzin, and Bliley, who was my tennis partner. I look at who is going to take my place a little bit later this week, when we put Greg Walden's portrait up -- and that is going to be on Wednesday this week.

But this committee has always been known for bipartisanship, big time, and that is what makes it so strong. And as I look at this hearing -- I know we are going to do a couple of panels, we have got a bunch of different votes today -- but I look at the legislation that you have called up for a legislative hearing today, some -- almost 20 bills. And every one of them is bipartisan. And that is because we need to deal with this issue of mental health in a bipartisan way.

When we did 21st Century Cures, something that everyone on this committee worked on, had mighty important elements, we included mental health. We included $1,000,000,000. And back then $1,000,000,000 was a lot more -- and remember, we started that bill in about 2014, 2015. It was signed into law by President Obama in 2016. But that was a very important element, that we included mental health as a part of the funding for that. And, of course, we paid for it. We did offsets to make sure that it didn't increase the deficit. You know, that is one of the things that Speaker Ryan insisted on. We actually did two pay-fors, because they got

stolen once by the Senate, but we got it done.

And as you think about mental health, it impacts every community in a huge way. You talk to our law enforcement. You talk to our caretakers. You see the people on the streets. You know that mental health needs are there, are critical, are underfunded at all levels. And that is why we really need to push legislation that you have organized here. So I am so glad -- because we all believe in regular order -- that now we can say we have had some legislative hearings and, hopefully, move them.

I have been fortunate, was named by our side, Kevin McCarthy, to be the lead Republican from the House on opioids. And I got to say David Trone, who is the leader on it, appointee by the Speaker, and Tom Cotton over there in the Senate, we have had meetings literally every week for the last two years. And the issues of fentanyl and, you know, all these different issues are really important. And together we have now done a pretty lengthy report of pieces of legislation that we think can be used as arrows in the quiver to really deal with this mess, because not only is every community impacted, but most families are, too, including mine.

So here is an area where, once again, our committee can work together in a bipartisan way to really make a difference for folks. And I would just -- I would like to think that

our chair now, Frank Pallone -- his portrait will hang here someday, too -- will also be one of the champions that we will look to in years to come for saying we tried to do our best to really handle some of these situations that need help.

There is a lot of good ideas on both sides, and this is where we need to come together and really use that bipartisan stick to get her done. So Madam Chair, I just want to thank you for your -- obviously, for your kind words, your friendship over many, many years, but your leadership on this issue, in this very important role as chair of the Health Subcommittee, as we move forward together to help families that need it.

With that, I yield back.

*Ms. Eshoo. Thank you, dear Congressman Upton. Thank you.

Did you want to ask any questions? I will give you the time.

*Mr. Upton. Sadly, I missed the fine presentations, so I will yield back. And knowing that we have two panels and votes coming up, I will yield back. Thank you.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for your five minutes of questions.

*Ms. Castor. Well, thank you, Madam Chair, but let me

also thank our former chairman, Fred Upton, for his service on this committee, his legislative legacy, his service to our country. We are all grateful.

And thank you to our witnesses for being here today. You have both rightfully focused on the workforce shortage in behavioral and substance use. It is not a new problem, but it has certainly been eliminated during the COVID-19 pandemic.

And in my district in the Tampa Bay area, I hear frequently from providers and from neighbors in need that it is very difficult to find routine care from a qualified mental health professional, especially for kids. For example, the leading community health center network, Tampa Family Health Centers, they are -- they have only been able to find one psychiatrist for their nearly 115,000 patients, many of whom have behavioral health needs, including the many children that they serve.

Another major health system, BayCare, they have experienced a doubling of adolescent mental health hospitalizations during the pandemic. And the Hillsborough County Public Schools, a -- probably the eighth largest school district in the country, they have reported the shortages of certified personnel within the school district and licensed providers in the community has led to longer wait times, less access for face-to-face services, and fewer

wraparound services for students, especially with intensive needs.

So it is clear, and you all testified to this, we need urgent action to expand capacity to deliver appropriate care to meet children's mental health and behavioral needs. And you have highlighted a number of strategies. I want to ask you about another.

Despite being the largest insurer for children, Medicaid pays significantly lower rates for mental health services compared to commercial rates. And this is a barrier for many providers who want to care for children in schools or in the community, but the low rates just make it unsustainable.

Dr. Delphin-Rittmon, why don't you start? Talk to us about the relationship between Medicaid reimbursement rates and the access to care, in particular, for pediatric behavioral health services.

*Dr. Delphin-Rittmon. So certainly, the -- and thank you for that question and for your leadership and work in this area. And I certainly agree that there are -- we are just seeing significant challenges for young people across the country, and the pandemic certainly has exacerbated that. So increasing access to care is so critical for children and families.

Again, my colleagues at CMS could probably speak more directly and accurately to the Medicaid rates. I am not

steeped in that work. And so it is probably best to follow up with CMS related to that.

What I can say is SAMHSA and some of our programs really are focused around finding ways to help ensure access to services for kids. So for example, Project Aware is a school-based program. In fact, we were able to expand it recently through American Rescue Plan resources. And Project Aware provides training for school personnel, as well as ultimately screening and referral of individuals, children to services and supports within the community who are identified with mental health challenges. So that is one area where we focus to work to increase access to services for children and families.

*Ms. Castor. Okay. Administrator Johnson?

*Ms. Johnson. Thank you for the question, Congresswoman.

I tend to think about children's access to mental health services, which is such a priority for us, as a bit of a three-legged stool. There is the workforce. We have to have a robust and highly-skilled, high-quality workforce. There is the access points that Miriam talked about, which incorporates the coverage and payment issues that you spoke of. And then there is the early intervention getting -- going as far upstream as we can to identify children who are at risk as soon as possible.

And so I think of those three stools as part of our problem set here, and how we need to work together to address this issue, which is why the Secretary has put SAMHSA, HRSA, CMS, CDC around the table in our Behavioral Health Coordinating Council at HHS to try to identify and work together to solve for the whole equation.

*Ms. Castor. And what else needs to happen in our loan repayment programs to encourage young people to go into these careers?

*Ms. Johnson. I so appreciate you asking that question, because it is critical for us to be able to recruit into the pipeline.

One of the things that is also challenging for us is that mental health providers are so overworked as it is, and we need them to be preceptors for students who are coming through who have clinical hours. So we need to work both on recruiting people into behavioral health jobs, as well as supporting the current behavioral health workforce, so that they have the time and capacity to help train the next generation.

*Ms. Castor. Thank you very much.

I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the ranking member of our full committee, Congresswoman McMorris Rodgers, Cole's mommy.

*Mrs. Rodgers. Yes, thank you. Thank you, Madam Chair.

*Ms. Eshoo. Did he [inaudible]?

*Mrs. Rodgers. Yes, he did. Yes. He is a good sport, yes.

Dr. Delphin-Rittmon, I have said many times before that I really believe that the COVID-19 policies, the lockdowns, driven by too much fear, have created a mental health emergency for our children. I wanted to ask, are you a member of the White House COVID-19 response team?

*Dr. Delphin-Rittmon. No, not of the team specifically, no.

*Mrs. Rodgers. As the Assistant Secretary for Mental Health and Substance Abuse -- Use, do you feel you should have been asked to be a part of this team?

*Dr. Delphin-Rittmon. So, I mean, certainly, the -- you know, the team started its work before my tenure, and I have participated in several White House-related events related to mental health and COVID, so have done some site visits in Atlanta and -- or excuse me, in Alabama, in other states related to what we are seeing associated with mental health ripple effects of COVID.

*Mrs. Rodgers. Yes.

*Dr. Delphin-Rittmon. At the community level.

*Mrs. Rodgers. Well, and I hope that, in the future, that the person in this position, whether it is Republican or

Democrat administration, include this important voice representing mental health at the table in situations such as a pandemic. Because what we saw was that, when there is no public health -- when the public health experts with no background in mental health or substance abuse are recommending long periods of social isolation and closure, that needs to be taken into effect, or into consideration when we are making these decisions.

I have another question. Do you know the number of children that have died by suicide or overdose, compared to the number of children who have died from COVID?

*Dr. Delphin-Rittmon. I don't have that data with me, no.

*Mrs. Rodgers. Okay. Well, the data suggests that far more children have died from behavioral health issues, compared to those who died from COVID in the same time period. Given these realities, I believe we have a very important lesson to learn here in following the science, and protecting children from the risks most likely to negatively impact them, rather than imposing restrictions that have significantly harmed our children.

SAMHSA recently released funding to support crisis in care communities. The intention behind this was to support the implementation of 988, the new suicide hotline number that was established in a bipartisan -- with bipartisan

support, with the goal of making it easier for those in crisis to know how to access help. Rather than to allow for funding to be used for multiple purposes, such as technology, training, and crisis stabilization services, SAMHSA has prescribed that 85 percent of the funding had to be used for one specific purpose, and that is the call center funding.

Given that states have different needs, and SAMHSA appears to have trouble ensuring how the funding is actually spent, do you believe that we should -- that this restrictive approach should be continued with the crisis funding?

*Dr. Delphin-Rittmon. I mean, ultimately, we are -- and thank you for that question.

You know, our approach is a two-phased approach. So the first phase is around shoring up the crisis call centers to ensure that they are able to accommodate the calls, texts, and chats that we know that will be coming in. The President's fiscal year 2023 budget includes a proposed 700 million additional resources to both shore up the crisis call centers, and then, of course, if there are additional needs within the crisis infrastructure, you know, there are opportunities there, as well.

*Mrs. Rodgers. I would like to ask if you would assure this committee that future funding will come with more flexibility for the states, so that the states and the communities can really address the needs of the residents in

crisis, while providing appropriate oversight on the back end to ensure these funds.

So do you believe that we can do a better job, as far as providing that kind of flexibility at the state and local level, to really ensure that the money is going to those who need it the most?

*Dr. Delphin-Rittmon. So -- and I appreciate that question. So some of our approach has been to work very closely with states. There is a weekly call. It is called the Crisis Jam. All states are on that call. We have also held two national convenings, one with CMS around funding the full crisis care continuum, above and beyond the call center.

So there is quite a bit of work currently underway related to, you know, thinking about how we can fund different components of the full crisis continuum, but certainly interested in having follow up conversations, and it would be interesting to hear your thoughts on the approaches that we are discussing.

*Mrs. Rodgers. Okay. Well, I look forward to working with you. Thank you.

*Dr. Delphin-Rittmon. Thank you.

*Mrs. Rodgers. I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair now is pleased to recognize the gentleman from Maryland, Mr. Sarbanes, for his five minutes of questions.

*Mr. Sarbanes. Well, Madam Chair, thanks very much. I want to join you in saluting Fred Upton for his service to this committee and to our Congress.

I want to thank the Administration witnesses [inaudible] here today to discuss [inaudible] important bills and, obviously, the mental health needs across our nation.

We have already heard this morning that we are facing a continuing mental health and substance use crisis that has been exacerbated by COVID-19, and it has affected millions of people across the country, including children and adolescents. That is why my colleagues and I recently introduced H.R. 7248, the Continuing Systems of Care for Children Act. And I want to thank Representatives Joyce, Underwood, and Gimenez for joining in this bipartisan proposal for reauthorization.

It would reauthorize two grant programs through fiscal year 2027, the comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances program, as well as the enhancement and expansion of treatment and recovery services for Adolescents, Transitional Aged Youth, and their Families grant program, known as the Youth and Family Tree Program.

Secretary Delphin-Rittmon, could you explain the importance of these two programs to children with mental health needs and substance use disorders and their families?

*Dr. Delphin-Rittmon. Thank you for that question and for your work in this area.

You know, so system of care approaches for children are so critical in that they incorporate many of the systems and services that touch children and children's needs. So whether it be health care systems, school systems, other community-based systems -- and so these programs are so critical in terms of being able to ensure that kids get connected to the services and supports that they need.

*Mr. Sarbanes. The President's fiscal year [inaudible] budget requests more than $1,000,000 increase for the Youth and Family Tree program. Could you explain briefly why there is a need for increased resources for this program?

[Inaudible] respects it would be obvious, based on the conversation we are having, but if you could talk about it in terms of what extra resources could mean, in terms of [inaudible] impacts that the programs can [inaudible].

*Dr. Delphin-Rittmon. Yes, yes. So programs like this, again, in taking a system approach, in taking a family-based approach are critical for being able to meet the broad range of needs that children have.

Children often touch multiple systems within, you know, any given week, for example. So whether it be the school system, again, the health care system, and being able to identify any other needs within the family system are

critical, as well.

*Mr. Sarbanes. I mean, the key here, I think, is the holistic approach, the wraparound, essentially wrapping our arms [inaudible] society around children that are facing [inaudible] challenges and bringing all of the resources, attention, focus to bear [inaudible] to make a difference, and not just a momentary difference, but sustained positive impact in their lives.

Administrator Johnson, let me talk -- quickly turn to you. In your testimony you discuss [inaudible] important mental health is to children's overall health. And I was also pleased to see that Secretary Becerra announced a joint initiative with HHS and the Department of Education and school-based health services for kids, with a focus on mental health assistance, which is something I focused a great deal of attention on in my time in Congress.

Could you discuss the importance of school-based health centers in delivering health care services, including mental behavioral health services to children, and what HRSA is doing to support those services?

*Ms. Johnson. Thank you, Congressman, and thank you for your leadership on this issue. As you note, Secretary Becerra and Secretary Cardona did a recent letter to educators about the importance of working across the health and education system to support children and children's

mental health.

And at HRSA, in September of last year, we did $5 million awards to 27 health centers for the -- to support school-based health centers. As you note, what we want to do is meet children where they are, and so we want to make sure that we have primary care services, including mental health services, in those accessible locations.

We are -- we intend to do, this spring, another $25 million in grants for school-based health centers to do another 125 awards.

*Mr. Sarbanes. That is terrific. I mean, one can make the argument, I think, pretty easily, based on all the stresses coming at young [inaudible] today, that every school in America should be equipped with a qualified, licensed health care worker, and many should have a full suite of school-based health services. So we would love to continue to work with you and follow up with you on this topic in the future.

With that, let me yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back. The chair is more than pleased to recognize the gentleman from Virginia, Mr. Griffith.

*Mr. Griffith. Thank you very much, Madam Chair.

We heard comments from McMorris Rodgers and then Mr. Sarbanes both dealing with mental health and children. Mrs.

McMorris Rodgers asked about suicide during COVID, and versus COVID deaths for children. Mr. Sarbanes talked about the importance of school-based health care, particularly focusing on the fact that the schools provide some mental health services to students. And I am just wondering if either one of you have any plans, or if there is anything already in the works to do a long-term study of the mental health impacts of us shutting down society.

And while children clearly -- I think the evidence is there already, or at least it appears to be, that there were more suicides because of the isolation because they were removed from friends and so forth than probably there were deaths from COVID, and Mrs. McMorris Rodgers pointed to some data.

But even for other classifications there were suicides that were brought on by this isolation, and significant mental health problems that were increased as a result of that. In fact, one of my colleagues who was a year or two older than me in competitive swimming back home, and who consistently was two to three body lengths in front of me had some mental health issues. And when all of a sudden everything was closed down -- and there was no science to believe that, if you are swimming in a vat of chlorine, COVID can survive -- we shut them all down. And during that shutdown period he committed suicide, because his whole world

at this point in his life had become his swimming and coaching young swimmers to be the best that they could be.

I am just wondering if either one of you has plans in your agencies to do a study on how severe the mental health impacts were as a result of us shutting down society in COVID.

*Dr. Delphin-Rittmon. I mean, so within our NSDUH -- and, you know, I first want to say my condolences to your friend. With our NSDUH, the National Survey on Drug Use and Health, we did include some questions related to the mental health and substance use-related impacts of the pandemic. So, for example, young people did report that the pandemic negatively impacted their mental health. We also had reports of individuals reporting that they used substances more to cope with the pandemic. We also see the repressions also related to suicidal ideation. And so we did see increases in suicidal ideation.

*Mr. Griffith. Can you get that data to us, and then -- and maybe consider other ways to look at the impacts that that had? Because I don't think COVID is going to be the last virus we have to deal with. And let's make sure we do a better job in the future.

Ms. Johnson, do you have anything to add to that?

*Ms. Johnson. I would just add I would share the condolences that Miriam referenced for your friend, and also

just say, as a services agency, so much of what we do is make sure that services are available to folks. And so we sort of defer to our colleagues across the agency on the research component of it.

But we know that what has been critical has been able to deliver services and have a robust workforce to help meet the mental health needs of children pre-pandemic and, increasingly, during the pandemic.

*Mr. Griffith. All right. Back to you, Ms. Delphin-Rittmon. The CARES Act directed SAMHSA to revise 42 CFR Part 2, which, for folks at home, deals with the confidentiality of substance use disorder, SUD, patient records. The goal is to better align this section with HIPAA regulations to improve the ability of individuals with substance use disorders to get safe and effective treatment. Updated regulations were required to be released in March of 2021.

What is the status of these regulations?

Why has there been a major delay? I mean, and I will tell you the reason we put that in there was we had heard testimony from -- and I remember one family in particular, where the brother had been a substance user, particularly opioids, and then was injured in an automobile accident, was unconscious, got to the hospital. Because they had no records on his substance use disorder, they pumped him full of opioids. And it wasn't the accident that killed him. It

was the overuse of opioids about three months after the accident.

So where do we stand on these regs, and why haven't we gotten it done?

*Dr. Delphin-Rittmon. So that work is currently underway. It is currently underway, and can certainly have a follow-up.

*Mr. Griffith. When do we expect it? Because it was supposed to be out last year.

*Dr. Delphin-Rittmon. Yes, yes. I don't have an exact date, but I can --

*Mr. Griffith. Can you get me some --

*Dr. Delphin-Rittmon. -- certainly follow up, yes, with --

*Mr. Griffith. -- info on that, please? Because we can't be this late on these important issues.

Last, but not least -- I see I got a whole seven seconds -- I will just tell you that I have a bill, H.R. 7237, which I think is going to be coming up later this year, Reaching Improved Mental Health Outcomes for Patients Act. And it reauthorizes a lot of things that I think we can all agree on.

And I yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the gentleman from Oregon, Mr. Schneider --

Schrader -- for your five minutes of questions.

*Mr. Schrader. Thank you very much, Madam Chair. I appreciate it very much.

The mental health workforce, it has been alluded to, and even before the pandemic we were seeing crisis levels of need in my home state of Oregon, and just a lack of providers out there across the spectrum of mental health care. I was looking at a recent data report. By 2030 there is expected to be a 20 percent decrease in psychiatrists, and yet the need is going up, you know, three, four, five percent a year, as we speak. So there is a real mismatch in what is going on in our country and -- with adults, as well as children.

I mean, the pandemic particularly hit our kids extremely hard. I talked to the teachers in my community back in my district and, you know, the behavioral health issues coming out of COVID and back into school, just trying to interact with people, I mean, those skills are lost. They are -- there are perishable skills, apparently, and we need people to help counsel these young people to get to be where they need to be.

So Administrator Johnson, I want to thank you and -- both for being here, and highlighting the importance of the agency providing some of the supports for communities, particularly rural communities. I got a big swath of rural Oregon in my district, the Willamette Valley, and potentially

going over the mountains to central Oregon. And just programs like the National Health Service Corps are just critical to, hopefully, building a workforce element out there. You know, programs like the Pediatric Mental Health Care Access Grants are very important for small communities that just don't have an infrastructure, can't afford, you know, with their limited tax base, to staff up in those mental health areas.

So can you talk a little bit more about success and opportunities that you see in our rural communities?

*Ms. Johnson. Thank you so much, Congressman, for the question, and for your leadership on delivering health care, critical healthcare services in rural areas. It is such an important need. And we are -- just to circle back to the chair's question earlier -- we expect our budget to train another 7,500 mental health professionals, and we expect a specific increase in our budget to help us grow the National Health Service Corps for mental health providers.

We also have a new initiative in our budget to try to put mental health providers in sort of non-traditional settings, so in school, in libraries, and in other community settings, to try to make sure people have a touchpoint. Because part of what we want to do, again, is sort of meet people where they are. And it -- unfortunately, there is far too much stigma that is still associated with these services,

and we want to make sure that we are making mental health part of the usual source of care. And to do that we need a robust workforce. And so that is what we are committed to doing.

*Mr. Schrader. Very good. Very good. Any -- the way you talk about it, is not just psychiatrists or psychologists. We are talking about nurses, counselors, all sorts of other folks. Will they get that same training to be able to deal with our children, and --

*Ms. Johnson. That is correct. Our -- we have -- our training program invests both in sort of the graduate-level psychiatrists, psychologists, social -- licensed clinical social workers and the like, but also in community health workers, mental health assistants and aides, peer supports, people with lived experience who can be so critical in connecting people to care. And so we train across the continuum.

*Mr. Schrader. Well, it is great to see the agency become a true mental health agency, not just substance abuse, but look at the whole person and some of the root causes of why these things develop, and it gives me a little optimism, despite our workforce needs, that we will be able to take care of some of those and a lot of people going forward.

So thank you both for being here.

*Ms. Johnson. Thank you, sir.

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

*Ms. Eshoo. The gentleman yields back. The chair is now pleased to recognize the gentleman from Florida, Mr. Bilirakis, for your five minutes of questions.

*Mr. Bilirakis. Thank you, Madam Chair. I appreciate it very much. Thanks for holding this very important hearing.

Dr. Delphin-Rittmon, emergency department boarding and wait times for placement for children with serious emotional disturbance and other mental health conditions are higher than ever before across the country -- I think you know that, and we see this in our communities. What is SAMHSA doing to provide resources to states and communities to address this issue, please?

*Dr. Delphin-Rittmon. Thank you for that question. And so, you know, there are several programs that SAMHSA -- that we implement, ultimately with the goal of helping to address children's mental health needs so that they don't get to a point of a crisis and end up in an emergency department. And so I will name just a few.

So one, I mentioned this earlier, Project Aware. Project Aware, again, is a program to be able to identify children that are struggling within school settings, and ultimately connect them to services and supports. We also do mental health awareness training, and that is within school

settings, a broad range of community settings, with first responders, with law enforcement. Those trainings are really important as well, because they can help to identify children that are struggling and, again, connect them to services and supports before they get to the point where they are in a crisis and end up in an emergency department.

We also find early intervention programs for individuals that are experiencing prodromal, for example, initial symptoms of psychosis. Those early intervention programs also, again, help to connect people. That is part of the mental health block grant. It will help to identify young folks that are struggling, and get them connected to services and supports to ultimately help to improve their treatment trajectory and reduce the likelihood, again, of emergency department need.

*Mr. Bilirakis. How successful have those programs been so far, particularly during the pandemic?

*Dr. Delphin-Rittmon. Yes. So the -- you know, I would have to look at specific data related to that, you know, looking specifically at the pandemic period of time.

What we find, though, in general, is that those programs are successful, especially the first episode psychosis-related programs. It is funded through the block grant. It does help to identify children early that are struggling.

Also training school personnel to be able to identify

signs and symptoms of a child who is experiencing anxiety or depression or other behavioral health challenges, they are very --

*Mr. Bilirakis. Thank you.

*Dr. Delphin-Rittmon. -- successful, as well.

*Mr. Bilirakis. Thank you. And I believe we must be doing more on every level in the continuum of care, for example, from the emergency department. And you stated -- which I am grateful we recognized earlier this Congress when we passed the Effective Suicide Screening and Assessment in the Emergency Department Act to award grants -- very important -- to award grants to hospitals to improve their capacity to identify those at risk of suicide, and connect them with mental health resources.

I am hopeful that that bill can get across to the Senate, because we need this as soon as possible, Madam Chair.

It also can mean at the residential level, where there are programs with trauma-informed treatment models that address the needs of foster youth with serious mental health issues, like the qualified residential treatment programs, but who can't always -- they -- these kids can't always get the full access to Medicaid, due to the IMD exclusion. We need to pass that bill to make an exception. We must get that fixed, as far as I am concerned. And I want to work

with the Administration, of course, with the other side of the aisle. I have a bill with Congresswoman Castor to do just that.

Another level where this should be addressed is at the school level, as you mentioned. And I am not going to take too much time, Madam Chair. This committee was proud to have passed our bipartisan bill, the STANDUP Act, which I led with Congressman Peters, and it was signed into law by President Biden just recently. The STANDUP Act increases suicide prevention education for adolescents, and provides for best practices and guidance for schools and early student suicide intervention strategies.

Dr. Delphin-Rittmon, what is SAMHSA's Suicide Prevention Resource Center, funded under the Garrett Lee Smith Memorial Act, doing to help middle schools and high schools -- as you said, we got to get them early, identify early. So middle schools and high schools, what are we doing here to prevent and intervene in adolescent potential suicide, please?

*Dr. Delphin-Rittmon. Yes. So the resource center is available to provide training, technical assistance, resources as needed and as requested by schools and communities across the country.

But we also have the Garrett Lee Smith Campus Suicide Prevention Program. And so that program, they provide, you know, suicide awareness training, not only on campus, but in

communities, as well. So the middle schools that you mentioned could be impacted here, as well, from the training that happens within those community settings around a college area. So the Garrett Lee Smith Award, we have seen significant impacts there, in terms of just the numbers of students, as well as school personnel that are trained through that, as well as students and individuals connected to services and supports, as well.

*Mr. Bilirakis. I yield back.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the gentleman from Vermont, Mr. Welch, for five minutes of questions.

*Mr. Welch. Thank you very much, Madam Chair.

First of all, I just want to thank everyone, including my colleagues, including our chairman, Mr. Pallone, and [inaudible] you have been a champion on this.

And I also want to acknowledge the Ranking Member McMorris Rodgers for her tremendous work on this, and has often described many of the opioid deaths as deaths of despair, which I think is true.

I want to focus on two things: the importance of housing and the importance of peer support. All of you have given many of the really sad, hard statistics about how tough it is, especially aggravated by COVID in the sense of isolation and loneliness. But recovery housing and peer

support are two essential items for a person to have a real shot at getting -- of recovering.

And I want to ask Dr. Delphin-Rittmon, can you share the impact of housing stability for individuals in recovery?

And how can housing security be a catalyst for recovery from substance use disorder?

*Dr. Delphin-Rittmon. Yes, thank you for that. Thank you for that question.

So we know that housing can form and can help to provide an initial sort of place of stability for individuals, particularly if the housing is a site that also offers wraparound services and supports. So some recovery housing will offer peer support services. So individuals in recovery that work with the individuals who are there to help connect them to other services -- for example, employment services, or education services, or even treatment services. So recovery housing --

*Mr. Welch. Let me direct your attention -- well, sorry to interrupt, but one of our bills is H.R. 2376, the Excellence in Recovery Housing Act, and it directs SAMHSA to develop national recovery housing best practices, and provides grants to help implement those standards.

Can you just comment on your view of the importance of what is offered, if my bill is passed?

*Dr. Delphin-Rittmon. Yes. I mean, again, I think, to

the extent that, you know, we know housing can be so vital for individuals in recovery, and to the extent that wraparound services and supports are offered, as well, can absolutely help in terms of an individual's recovery trajectory.

So again, thank you for your work there, and I am happy to have further conversations around what those models -- and what we see with some of those approaches.

*Mr. Welch. And talk a little bit about the importance of virtual peer support here, behavioral support services. You know, it has always been my observation that folks who have a significant issue, you know, or a significant, intense experience, the interaction with folks who have shared that experience is, really, much more powerful than with folks who haven't. Can you comment on that?

*Dr. Delphin-Rittmon. Yes. You know, so we have learned so much through the course of the pandemic. And so one of the things that we have seen is that, for services that have been offered virtually, that that makes an impact. People feel connected to services and supports. They feel connected, if it is a peer group, to other peers that are participating in that group. So there is real value there.

We have seen, again, people in recovery offer hope for the individuals that they are working with. So the peer support workforce is a real vital part of the workforce, in

terms of ensuring and helping to, again, promote hope and working and walking alongside individuals that are in recovery.

*Mr. Welch. Okay, thank you.

And Ms. Price, from your leadership in Georgia to your engagement in conversations with your own peers through the National Association of State and Alcohol Drug Abuse Directors, how critical is the block grant funding to maintain prevention, treatment, and recovery services?

*Ms. Price. Well, thanks for your question. I am not sure I am on the panel yet, but I would be happy to answer that, sir.

The block grant is critical in Georgia and to all of our states, and Georgia in particular. It is a little bit over 50 percent of our funding for prevention, treatment, and recovery. {Inaudible] specifically for our prevention set-aside, it is almost 100 percent of our funding. And so that block grant and its abilities are just critical in nature to supporting our entire infrastructure --

*Mr. Welch. Okay, thank you.

*Ms. Price. But thank you for your question --

*Mr. Welch. Thank you very much. Thank you.

Madam Chair, I yield back. I want to thank the panel.

*Ms. Eshoo. I don't know if you heard that comment, Peter. Anyway, it kind of threw us off, because you went to

someone on the next panel. But you are a member, and you can do just about anything you want.

*Mr. Welch. Oops.

[Laughter.]

*Ms. Eshoo. The gentleman yields back. Good to see you.

*Mr. Welch. Good to see --

*Ms. Eshoo. The chair is pleased to recognize the gentleman from Missouri, Mr. --

*Mr. Welch. I didn't realize that the question I was asking -- it is a good question [inaudible]. It was to a person [inaudible].

*Ms. Eshoo. The gentleman yields back. Thank you very much.

The gentleman from --

*Mr. Welch. All right --

*Ms. Eshoo. -- Missouri, Mr. Long, you are recognized for five minutes.

*Mr. Long. Thank you, Madam Chair. I appreciate that.

Ms. Johnson, the health care workforce has suffered major losses in staffing over the course of the pandemic. For behavioral health care, this has been especially acute, as you know. Prior to the pandemic, lack of access to behavioral health care was a major problem nationally, which has been substantially worsened by attrition related to

COVID.

What is your agency doing to address the critical loss of behavioral health providers?

*Ms. Johnson. Thank you for that question, Congressman. It is certainly a critical issue and a critical need.

I would say our work falls into two buckets. One is supporting the mental health of the current workforce. And so we were able to do some recent grants. We did 45 grants across the country to help support the resilience and mental health needs, and creating healthy work environments for the current health workforce. And then we are investing in training the new workforce, and that is training new social workers and psychologists, as well as community health workers and peer supports, as the Congresswoman referenced, and providing loan repayment and scholarships to encourage those new mental health providers to practice in the communities where we have identified there is the highest need.

So we are continuing to support the current workforce, while we work to train and bring on additional new mental health workers.

*Mr. Long. Okay, thank you.

And moving over to Dr. Delphin-Rittmon, Certified Community Behavioral Health Centers have an important role in providing major comprehensive community-based mental health

services. Missouri was one of the eight states to participate in the initial demonstration program, and we have seen really good results in improving outcomes and access to care.

What is the data showing on the effectiveness of the CCBHC's model nationally, and what is SAMHSA doing to address the coordination and integration of behavioral health and primary care services?

*Dr. Delphin-Rittmon. Thank you for that question. And it is wonderful to hear that you are seeing positive outcomes with the Missouri CCBHC.

So, you know, we are real pleased with this model. What we are finding across the country is that it is helping to increase access to a broad range of services and supports for individuals that need not only mental health services, but also linkages to primary care and substance use services. So that is one thing that we have been pleased to see, just the level of increased access.

Many of the CCBHCs also offer crisis services. So if an individual is in crisis, that is part of the offering, as well. And then many also offer recovery, peer recovery support services. So for individuals who are accessing the care related to either mental health or substance use services, they are often connected or can be connected with an individual in recovery who works with them on their

recovery journey.

So in terms of specific data, I can follow up with you and get you some of that data, as well. But we have been pleased to continue to expand and increase the CCBHCs, because the outcomes, from an integrated care perspective, have been really, really positive.

*Mr. Long. Thank you. And I will stick with you for the next question, if I can.

With this being my last term in Congress, I -- one of the things I am very proud about is that we got telehealth going and moving before COVID hit, in the previous Congress. And I know telehealth has helped expand access to behavioral health care, but what are SAMHSA and HRSA doing, and what should Congress be looking to to address access to behavioral health care in our rural areas, of which I represent a lot of?

*Dr. Delphin-Rittmon. Yes, thank you for that question and for your service in Congress, as well.

So, you know, telehealth, again, we have learned so much through the pandemic. And one thing that we have seen is that telehealth makes a difference. It has helped to keep people connected to care when -- particularly individuals who are in rural areas.

One of the things that we put in place is allowing individuals to receive treatment for buprenorphine through

telehealth. And so that is something that we are looking to extend beyond the public health emergency. We have received -- we see positive data there, again, in terms of ensuring that people are being connected to the services and supports that they need to include in rural areas.

*Mr. Long. Okay, thank you.

And Ms. Johnson, I will ask you the same question as far as what SAMHSA and HRS are doing, and what should Congress be looking at to address access to behavioral health care in our rural areas.

*Ms. Johnson. Yes, thank you for the question. And just briefly, we, as an agency that serves under-served communities in rural areas, we have seen telehealth, particularly when it comes to substance use disorder treatment, help solve for some longstanding problems like transportation and other issues that have made it hard for people to access services in the past. So we want to continue to do this, but do it well, and do it in partnership with you and Congress.

*Mr. Long. Thank you.

And, Madam Chair, I have a question for the next panel. But as a point of personal privilege, I am going to wait until they are here. I yield back.

*Ms. Eshoo. Thank you, Mr. Long. The gentleman yields back.

The chair is pleased to recognize the gentleman from California, Mr. Cardenas, for your five minutes of questions.

*Mr. Cardenas. Thank you very much, Madam Chairwoman and Ranking Member Guthrie, for holding this important hearing, and for having all these witnesses. And I will wait for my second questions to the second panel for the second panel.

As you are all aware, we are just months away from implementing 988 across the country. That will be in July of this year. This three-digit code will be instrumental in responding to anyone experiencing mental health-related distress, whether it is thoughts of suicide, mental health, or substance use crisis, or any other kind of emotional suffering. This transformation will take -- make it easier for Americans in crisis to reach help when they need it, just like we are used to calling 911 for other crises, and it will save lives.

I am proud to have introduced the bipartisan 988 Implementation Act and the 988 and Parity Assistance Act with several of my colleagues, including my fellow Energy and Commerce colleagues Doris Matsui and Lisa Blunt Rochester, and many others. These bills take a comprehensive approach that make available the full continuum of care for those in crisis, including mobile crisis response and community-based crisis receiving/stabilization centers.

I have a question for Dr. Delphin-Rittmon. It is good to see you again, and I really do appreciate the work that SAMHSA is doing to enact 988 across the country for this year. In 2020, SAMHSA released its national guidelines for behavioral health crisis care, which outlined the continuum of care needed for effectively responding to crises. Can you explain what this crisis continuum of care is, and why it is important [inaudible] is sustainably funded?

*Dr. Delphin-Rittmon. Yes. Yes, thank you so much, Congressman Cardenas, and I so appreciated the conversation that we had a few weeks back. So, you know -- and I also want to thank you for your leadership in this area, because we know 988 is such an important transformation for the country.

So, you know, a robust crisis care continuum, we really see it as having three components. You know, one initial critical component is the call center. So it is important to have a call center that is staffed up with individuals to be able to receive calls that come in from a diverse array of community members. Another important point is crisis teams. So crisis teams that are ready to be deployed to meet with individuals in the community if they need some additional assistance at the community level. But then also crisis receiving or stabilization centers, so places for individuals to go if they need additional crisis support.

So those are the three components, really, that make up a robust crisis care continuum: again, a call center; crisis teams; and stabilization or receiving centers for individuals.

*Mr. Cardenas. Thank you, Doctor. It is clear that having someone to call, someone to come, and somewhere to go are all necessary to have success in effective and compassionate crisis services for everyone across the country. We have that now in 911, and 988 is going to be the future and -- to make the agencies respond properly [inaudible].

I also wanted to ask you about something that is always of bipartisan interest: cost savings. Multiple studies [inaudible] report, including those done by McKinsey [inaudible] Institute and the National Association of State Mental Health Program Directors have found that implementing the continuum of crisis services results in a substantial cost savings. In fact, McKinsey predicts that the roughly 73 billion -- that is with a B -- in health care expenditures that we currently spend on crisis care would be cut in half to below $34 billion. That is a lot of money.

Can you talk about why providing specific services for crisis care [inaudible] so much money, and how it is important to implement the entire continuum [inaudible] care in order to attain these types of cost savings?

*Dr. Delphin-Rittmon. Yes, thank you for that question. And so what we anticipate is -- as a function of implementing 988, what we anticipate is that there will be a reduced need for 911 calls for individuals that are experiencing a behavioral health crisis. So that can reduce costs in terms of fewer law enforcement being deployed to meet with individuals who may be in crisis. I mean, there is certainly cost savings there.

Also, individuals who are brought to crisis receiving centers, there are cost savings there, as opposed to the individual being brought to emergency department. We know emergency department costs can be significant, whereas a crisis stabilization center, where a person is actually having their behavioral health needs met, you know, that certainly could be cost saving.

Those are just two areas where we anticipate that there -- where we will see cost savings as a function of the implementation of 988 and having a robust crisis system.

*Mr. Cardenas. Thank you. It is clear that fully funding and operationalizing 988 will save lives and save money, too.

With that, Madam Chair, I yield back.

*Ms. Eshoo. The gentleman's time has expired, he yields back. The chair is pleased to recognize Dr. Bucshon from Indiana for your five minutes of questions.

*Mr. Bucshon. Thank you, Madam Chairwoman. First I want to thank you and the ranking member for including the Timely Treatment of Opioid Use Disorder Act, a bill that I have helped author, in today's hearing. Thank you. This bill would revise opioid treatment program criteria to remove the requirement that patients must have been addicted for at least one year before being admitted for treatment.

With nearly one in every 12 Hoosiers meeting the criteria for having a substance use disorder, Hoosiers are now more likely to die from a drug overdose than a car crash. It is tragic. We need to continue to make sure Americans have access to treatment early, and this bill is a great stride in that effort. I look forward to working with my colleagues to advance the legislation through the committee.

Substance use disorder can often times be a coping mechanism for mental health. And as we know, resources for mental health programs in the Federal Government can be scarce. We at this committee have been working together to make sure that we -- what we spend on mental health is being used in programs, therapy, and medications that are evidence-based. As a doctor I want to be certain that the scarce resources we have are truly going towards mental health services and resources that are proven to help patients battling mental health challenges.

Ms. Delphin-Rittmon -- did I pronounce that right? Yes

or no, as we consider reauthorizations for the programs before us today, are grantees able to use funds provided by SAMHSA programs to provide surgeries or other medical intervention procedures?

*Dr. Delphin-Rittmon. No.

*Mr. Bucshon. Okay. Thank you for that. Another issue that is troubling people in Indiana is maternal mortality. Sadly, Indiana has the third highest maternal mortality rate in the country: the statistic I am dedicated to change.

As you both know, the leading cause of our nation's high maternal mortality rate is actually suicide and overdose caused by maternal health -- maternal mental health conditions. I recently joined Congresswoman Barragan in introducing the Triumph for New Moms Act to help coordinate Federal and state strategies and dollars to improve maternal mental health.

My first question for both of you is, what are the agencies throughout HHS, the Department of Defense, and the VA doing to coordinate a singular national strategy for maternal mental health, and ensure maternal mental health is integrated into existing programing that reaches new mothers?

I guess I can start with you, Doctor.

*Dr. Delphin-Rittmon. Yes. Yes, and thank you for that question. So, yes, you know, there is work across the Department and discussions related to, you know, looking at

maternal mental health.

You know, one program that SAMHSA funds is the PPW, so the Pregnant and Postpartum Women program, and that addresses some of the mental health and substance use challenges that individuals who are, you know, postpartum may be experiencing.

Also as part of the BHCC -- so the Behavioral Health Coordinating Council -- that is a cross-departmental group, and so there are discussions and work looking at sort of maternal mental health, you know, there, as well.

*Mr. Bucshon. Great. Ms. Johnson?

*Ms. Johnson. Thank you so much for the question, Congressman. It is a critical issue, and one that we are all working on across the Department.

In our agency we are focused on one -- the program that I mentioned earlier, our maternal depression program that is training maternal care providers in mental health services, so that they get more confidence and ability to identify these conditions early, as well as providing expert mental health teleconsults to maternal care providers so that they can help address issues in real time, as opposed to having to refer patients out for services.

At the same time, We are also implementing language that was in last year's appropriation bill to create a maternal mental health hotline, so that pregnant women have access to

those kind of services by phone, without having to make appointments and the like, can actually consult with someone when they are having issues and concerns.

But this is all part of a larger Administration effort that is being coordinated across agencies to make sure that we are focused on this critical issue that is of great concern to us.

*Mr. Bucshon. Yes. And also there are regional, racial, and ethnic disparities. What are we doing about that, Doctor?

I mean, I -- we have heard testimony about maternal mortality in different locations in the country. You know, we have to recognize that that is factual, right? And we have to address it. Are we doing anything specific to address that?

*Dr. Delphin-Rittmon. Yes. And so within the work that, you know, I mentioned within the Department, equity is one of the critical areas that is being considered there, as well, in terms of our -- you know, particular patterns and trends as it relates to diverse communities. So yes, that is part of that work, as well.

*Mr. Bucshon. Ms. Johnson, briefly, because I am out of time.

*Ms. Johnson. That is a critical issue because it is not an economic variation. It is often racially based. And

we are seeing Black women die at too high a rate relative to others. And it is a priority for us to address.

*Mr. Bucshon. Well, it should be. I am aware of that data, and we need to fix it.

So I yield back.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the gentleman from California, Mr. Ruiz.

*Mr. Ruiz. Thank you. I would like to thank our witnesses for joining us today.

Your combined experience in the mental and behavioral health space is critical to informing the important policies being discussed at this hearing.

You know, there is so much to cover: access, affordability: and, like, the health insurance companies added barriers to reimbursing providers; the stigma over seeking care; shortages of mental health professionals. And the list goes on and on and on and on. As we all know, some of these barriers have only worsened throughout the COVID pandemic. So I am glad that this committee is addressing ways in which Congress can tackle the problem.

I saw some of these issues firsthand in the emergency department. My patients would come to address an immediate emergency need, but I often saw additional layers of longer-term issues that needed to be managed, as well. And unfortunately, my patients often didn't have access to

longer-term mental and behavioral health care that they needed. So these barriers exist in my district, parts of which are critically under-served, as they do in communities throughout our great nation.

We know that -- and even more pronounced, these issues are in tribal communities, which have historically been under-served and under-represented. We know that tribal communities have the lowest life expectancy of any racial category, the highest rates of substance use disorders, and native youth suicide rates at 3.5 times higher than the national average. These statistics have only been exacerbated by the pandemic.

And as a long-time advocate of tribal issues dating back to my advocacy as a college and a medical student, I have always fought to reduce these health disparities. And I appreciate Chairman Pallone's partnership on tribal issues throughout the years, and for including our bill, the H.R. 4251, the Native Behavioral Health Access Improvement Act, in this hearing today. This resulted out of a roundtable we held years ago to discuss the Affordable Care Act, and we had over 20 tribal communities represented, and they mostly talked about the opioid epidemic and other mental health needs that they had.

So this bill seeks to address mental health access by establishing the Special Behavioral Health Program for

Indians within the Indian Health Service, which is modeled after the Special Diabetes Program for Indians. Specifically, the bill provides IHS with grants for the prevention and treatment of mental health and substance use disorders.

Dr. Delphin-Rittmon, can you outline some of the factors that contribute to high incidences of mental and behavioral health disparities in tribal communities, and how this bill can address those disparities?

*Dr. Delphin-Rittmon. Yes, thank you for that question and for your leadership and work in this area.

So certainly, we know and the literature across the board shows that often -- you know, social determinants of health. So various inequities and social determinants of health can help to impact and create some of the disparities and patterns and trends that we see within tribal communities, as well as other communities.

So, for example, access to education or healthy food or health care services or school settings, so just a range of community factors that ultimately impact health outcomes. And so ultimately, I mean, any -- we are in support of, you know, programs or initiatives that help to reduce those disparities and that help to increase access to services and support for tribal communities.

We have participated in a number of tribal

consultations, and have had discussions related to what some of the current needs are of tribal communities. And so I am happy to have follow-up conversations and --

*Mr. Ruiz. Wonderful.

*Dr. Delphin-Rittmon. -- share some of that, as well.

*Mr. Ruiz. And how can we ensure -- how can Congress ensure that funds dedicated or set aside for tribal programs appropriately serve tribal members in all geographic areas of the United States?

*Dr. Delphin-Rittmon. Yes, again, you know, I am happy to have ongoing and follow-up conversations. I think, through some of our work with the Indian Health Service and --

*Mr. Ruiz. So let's go ahead and schedule some of these conversations to continue working on this issue.

One of the things that is seldom talked about is the mental health consequence of historical trauma. Historical trauma has been studied primarily in the Jewish communities as a result of World War II and the attempted genocide, and how that can -- how that -- mental health effects is intergenerational. And so too, these mental health aspects is a result of the historical trauma that tribes have faced in the United States.

And so the -- it is -- let's talk about ways to address that, as well, in the future.

*Ms. Eshoo. Yes, the gentleman's --

*Mr. Ruiz. And with that, I yield back my time.

*Ms. Eshoo. -- time has expired. The gentleman's time has expired.

The chair is pleased to recognize the gentleman from Utah, Mr. Curtis, for your five minutes of questions.

*Mr. Curtis. Thank you, Madam Chair, Mr. Ranking Member, witnesses. This is so timely, and I think you have realized from all the questions on both sides here just how interested Congress is in this, and how supportive we are, particularly in light -- as we try to grasp the full extent of the impact of COVID, as my colleagues, particularly right behind me, have spoken so articulately about this impact.

I have spoken in previous hearings about the many ways that COVID-19 has exasperated existing health care problems. Many in Utah and across the United States are experiencing isolation. And particularly, children's mental health is in a crisis. Ensuring that Utahns and all Americans have access to mental health behavioral sciences is very vital, and I think we all agree on that.

I want to use my time to divide this into two sections. First is mental health parity, and then look at the role of law enforcement in responding to those suffering from acute mental health episodes.

There continues to be significant focus on coverage

parity. By my count, there have been ten hearings in five bicameral committees over the last three months, just on this issue alone. And yes, we have come a long way. I think it is important to acknowledge that, particularly in destigmatizing mental health. But we all acknowledge that we have a long ways to go.

And it is true that the parity report found widespread gaps in coverage, and that is a topic for later today. And today we are talking about it more from your perspective. And I want to make sure that we address the regulatory side of this, rather than just being -- this having to be a demerit on industry. The report itself discovered where additional guidance is necessary throughout the process. And when coverage parity was raised at the previous ten hearings, almost always the lawmakers agreed more guidance, not more laws, is needed. And to be clear, that is largely the bipartisan consensus.

So my question is, we seem to agree on parity policy. We seem to agree on party politics and the importance of this, and we agree on the process. That is the need for more guidance. To both of you, just quickly, do you agree that Labor Department could do a better job with clearer guidance?

And should we be concerned about passing additional laws permanently before we have this guidance?

And Doctor, if you would start.

*Dr. Delphin-Rittmon. Yes, thank you for that question. So parity is such an important issue for the American people. We know that it is critical that behavioral health services are covered at a rate equal to primary care services.

At SAMHSA we don't have a regulatory role here, but we do see our role as important in terms of, you know, in our collaborations with Department of Labor, Department of Justice, or even, you know, CMS, you know, reflecting the needs of the individuals that we serve.

We have convened a number of --

*Mr. Curtis. And, you know, I would love to hear from you all afternoon, but we are going to move on.

*Dr. Delphin-Rittmon. Yes.

*Mr. Curtis. Just quickly. Yes, thank you.

*Ms. Johnson. Thank you so much for the question. I defer to our regulatory colleagues on the particulars.

I will say that, you know, parity and coverage writ large are critically important to making sure that our programs are maximized, and we are reaching the people who are under-served. And so the more that parity works for people, the less they will need all of our social safety net supports.

*Mr. Curtis. Thank you. And this may also not be your area of expertise, but I would like to bring it up. We are facing this -- these high rates of acute mental health

instability, which has led to an uptick in episodes for mental health crisis that require responses from the community. And we all agree it is vital to be mindful of the individual safety, who they are responding to, when this happens. But we are considering legislation today that would send mental health professionals, rather than law enforcement officials, to respond to this.

Dr. Johnson, I quoted -- I wrote down your quote earlier, "Mental health workers are overworked.'' Perhaps law enforcement is, as well. But as I look with several hats on, one as a former mayor, where I was responsible for law enforcement; as a former employer, where we trained law enforcement; and as a father who has a son who is a psychiatrist, a practicing psychiatrist, trying to balance who responds to these, I think, is a very important thing.

But to me, overwhelmingly, our law enforcement are trained in many, many ways. They are on the road every day in a city. They know the quickest way to get to homes. They are on call 24/7. They carry with them appropriate equipment for these responses.

And I took an opportunity to inquire of some folks in law enforcement, and they were very clear that their training has improved on mental health response, particularly on stabilizing and de-escalating situations. It seems to me, although both elements are important as we respond, the

ability to train law enforcement on how to respond versus training mental health experts on how to respond if it escalates, we know that most law enforcement incidents happen in -- I am out of time, so I am sorry you can't respond. But I would just like to point out that we don't --

*Ms. Eshoo. I would have the witness respond to your question.

*Mr. Curtis. Thank you. Yes, please, Doctor.

*Dr. Delphin-Rittmon. So I am -- I think you were maybe leading up to the question.

But, you know, I mean, I think it is important, the training of officers in mental health techniques, that is something that we have done in the past. And then we also, you know, work with crisis teams that are deployed to instances where individuals need mental health support.

*Mr. Curtis. Thank you.

If the chair will allow, Ms. Johnson, just briefly, please.

*Ms. Johnson. I would just echo that training is so critical, and that we are ensuring that whoever is responding has the appropriate training and the connections and the resources to be able to get people to the appropriate source of care.

*Mr. Curtis. Thank you, Madam Chair, for indulging me. I yield my time.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentlewoman from Michigan, Mrs. Dingell, for your five minutes of questions.

*Mrs. Dingell. Thank you, Chairwoman Eshoo and Ranking Member Guthrie, for convening this hearing on a variety of important mental health bills, because we really do know it is a crisis in this country, and it continues to have significant public health impacts in Michigan and across the country.

Madam Chair, before I get to the questions, I would like to make sure that the record reflects that there are serious concerns that opening up the IMD exclusion, as our colleagues have suggested, could lead to greater institutionalization and less use of home and community-based services.

I ask that the following letters be entered into the record. They are from organizations that represent individuals with disabilities and substance abuse disorder, including the National Health Law Program, the [inaudible] Center, Autistic Self-Advocacy Network, the Center for Public Representation, and the National Disability Rights Networks. These letters express these organizations' concerns about the proposals discussed about the [inaudible] to enter into the record, Madam Chair.

*Ms. Eshoo. So ordered.

[The information follows:]

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

*Mrs. Dingell. Thank you.

And it is great to have a witness from the State of Michigan, Dr. Debra Pinals with the Michigan Department of Public Health -- Human Services joining us for panel two today.

Michigan has had to contend with a substantial increase in substance abuse issues as a result of the opioid crisis. In fact, in 2020 nearly 2,200 Michigan residents lost their lives as a result of opioid overdoses, an almost 25 percent increase over 2019. And as all of you know, I lost my sister earlier to an opioid overdose. So I understand how serious these issues are.

Let me first ask Dr. Delphin-Rittmon, you highlight the importance of harm reduction in your testimony, including measures like facilitating increased access to fentanyl test strips to detect synthetic opioids. But I would like to ask you about co-prescribing, when a doctor pairs an opioid prescription with a prescription of an opioid overdose reversal drug like naloxone.

Co-prescribing drugs have been implemented in states across the country. Can you describe the evidence supporting these interventions in response to the opioid crisis?

*Dr. Delphin-Rittmon. Now, in terms of specific studies, I would have to follow up in terms of what specifically the data is saying.

But one thing we do know is that co-prescribing can be valuable in terms of ensuring that people have, if there is an instance where it is needed, naloxone or overdose-reversing medication is present, and the individual or family members have that on hand.

*Mrs. Dingell. Thank you. And I --

*Dr. Delphin-Rittmon. I also just want to say my condolences to your family member who passed from an overdose, as well.

*Mrs. Dingell. We just -- my family knows the impact of this more than many. Thank you for that.

Congressman French Hill and I are leading legislation, the Preventing Overdoses and Saving Lives Act to encourage the uptake of co-prescribing. And it is my hope that we are able to expand access to these lifesaving programs.

It is also important that we look at ways to strengthen the mental health workforce. In my home state of Michigan, approximately half of the 83 counties in the state either have no psychiatrists or only one practicing psychiatrist.

Administrator Johnson, you discussed the importance of addressing these sorts of workforce shortages in your testimony. How will the Administration's proposed national strategy to tackle the nation's national mental health crisis address these issues?

What additional actions should Congress be looking at to

address workforce shortages of psychiatrists and other mental health providers in under-served areas?

*Ms. Johnson. Thank you, Congresswoman, for the question, and for highlighting this critical issue. We think there are four steps that really are where we need to invest in workforce; one is training new behavioral health providers; two is incentivizing more providers to practice in under-served communities through our loan repayment and scholarship programs; three is training primary care providers in behavioral health issues, so that primary care providers are better able to identify issues early and manage what they can in primary care practice, and refer people to specialists; and four is -- are the -- some of the programs that this committee has created that we are implementing that are creatively using teleconsults to get mental health experts to maximize mental health expertise by getting direct, real-time connections to primary care providers to meet their patients' needs where they are, when they are in a primary care practice.

So our strategy invests across those continuums. We also are investing in ways to put providers in non-traditional settings, as I mentioned before. So training mental health providers, and then encouraging them to be in places like libraries and other settings, where there are community-based access to mental health providers. So we are

thinking both about the -- in the clinic setting, as well as in the community.

*Mrs. Dingell. Thank you. My time is up. We have a very tragic situation in Michigan, where [inaudible] school sought attention. There was no doctor. His parents were called. He took his father's gun and shot and killed his parents. We have got a real crisis, and I look forward to working with all of you on this. And I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair now recognizes the gentleman from Texas, Mr. Crenshaw, for your five minutes of questions.

*Mr. Crenshaw. Thank you, Madam Chair. Thank you -- and thank you to the ranking member for holding this extremely important hearing. Thank you to our witnesses for being here.

I am thankful to lead the Community Mental health Services Block Grant reauthorization. This bill provides block grant funding to the states to pursue innovative solutions for each state's mental health needs without the typical one-size-fits-all approach. In Texas, we use this block grant funding in a variety of innovative ways. One of those ways is the Texas Child Mental Health Care Consortium. It coordinates efforts between primary care, schools, and hospitals to make sure that children and teens get the mental health care that they need. And I am thankful to my friends,

Representatives Butterfield, Luria, and Garcia for introducing this bill with me.

I have a few questions today. Dr. Delphin-Rittmon, why is the -- just to speak broadly, why is the Mental Health Services Block Grant reauthorization so important when we talk about supporting states' efforts to support mental health?

*Dr. Delphin-Rittmon. Yes, so reauthorization of the block grant is so important because it helps to provide flexible funds for states to be able to implement evidence-based mental health services and supports at the community level. As -- and as a former commissioner, I can say that it is just valuable resources to look at gaps, and to be able to ensure that services are available for people that need them.

*Mr. Crenshaw. I fully agree. Look, we are happy to reauthorize this in a bipartisan way.

And I also hope that this committee acknowledges mistakes made at a policy level throughout the pandemic. I echo many of the comments already made that I think school lockdowns exacerbated and worsened mental health issues for our youth in an exorbitant way. The cost benefit of such lockdowns was enormously skewed in the wrong direction.

Doctor, do you agree that lockdowns exacerbated the youth mental health crisis?

*Dr. Delphin-Rittmon. Thank you for that question. And

so, you know, when the -- certainly, NIH -- so National Institute of Health, my colleagues there are engaged in research to get a better understanding of mitigation strategies.

One thing the data does show, though, is that it is important, incredibly important, for social, emotional, and cognitive development and well-being for children to be in school. And so the range of layered mitigation strategies allowed that to be possible for children to be able to be in school. And for that reason, that was a priority, and has been a priority of the Administration.

*Mr. Crenshaw. And how might we better evaluate whether or not we shut down schools when we consider future pandemics, future bills? Is there better standards that we should be looking at?

*Dr. Delphin-Rittmon. I mean, I think continuing to look at the data -- I mean, as I mentioned, my colleagues at NIH are engaged in research here. So I would defer to them in terms of research. SAMHSA is primarily a grant-making service agency in terms of the -- you know, in terms of the work that we do related to providing grants nationwide.

But the data has shown that -- or some data has shown that it is important for social, emotional, and cognitive well-being for children to be in schools.

*Mr. Crenshaw. Sure. I engage in a lot -- I do a lot

of events with high school and college-aged kids. And I want to know what to tell them if they are struggling with their mental health. Can you give us any advice to share with kids who might be struggling with their mental health?

*Dr. Delphin-Rittmon. Yes. So -- and there is a number of campaigns that we have here. So for example, "Talk. They Hear You.'' is one of the campaigns that we have for adults to speak with kids about their mental health. But sometimes it is just asking questions about, you know, how are you doing? Or, you know, "I see that, you know, it looks like you are struggling. Is there is there anything that I can help with,'' or letting them know that they are not alone, that there is help available if they are struggling -- can help to open up conversations for young folks.

I think what we hear and what we have found is that young folks are often poised and ready to speak about what they are experiencing and feeling when the question is asked.

*Mr. Crenshaw. Yes. And in my remaining time, I will say it is hard enough to be a young person, a young teenager with social media the way it is. It is not what a lot of us grew up with. I don't think any of us -- I don't think anybody is younger than me here. So I know I didn't grow up with social media. It makes it rough. And it is horrifying to learn that one in five adolescents have contemplated suicide, and four in ten teens feel persistently --

"persistently sad and hopeless,'' because it has long been a problem. It is exacerbated by, again, poor policy decisions like locking down schools, where all they see is the online world. And that is a hell, that is an absolute hell for some teenagers.

And I just hope we never make that mistake again. And I hope we are all united in that.

Madam Chair, I yield back.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the gentlewoman from New Hampshire, Ms. Kuster, for your five minutes of questions.

*Ms. Kuster. Thanks --

*Ms. Eshoo. And I would say we don't have -- just a moment. Any other Republicans?

Okay, I was going to say followed by Ms. Kelly, and Mr. Tonko is on board and waiting, as a -- to waive on.

So Ms. Kuster, it is your time for five questions.

*Ms. Kuster. Great, thank you so much, Madam Chair. This is a very important hearing. And I think, as we put COVID in the rearview mirror, we are certainly hoping we pivot to the mental health and addiction issues that have arisen coming out of COVID.

In New Hampshire we saw very early on the devastation of the mental health and addiction epidemic, even pre-COVID. But while the COVID pandemic has certainly exacerbated the

mental health and substance use disorder crisis, it did not originally create it. Our friends, families, and communities were struggling long before the global pandemic. And that is why, way back in 2015, I founded the bipartisan Heroin Task Force -- today it has evolved into the bipartisan Addiction and Mental Health Task Force -- to better reflect the scope of the epidemic and the co-occurring illness.

The Task Force is now comprised of 145 members from both sides of the aisle, many of whom are on this committee, working to bring an end to this crisis. And I want to thank you for your leadership, as well.

The most recent data shows that over 100,000 Americans lost their lives to overdose just in the past year, the highest number ever recorded over 12 months. And that number does not capture non-fatal overdoses, those who survive and continue to struggle with co-occurring mental health and substance use disorders. We must do better for our communities, for our friends, and I can say, like Mrs. Dingell, for our families. We must do better for the children and young people across this country.

This legislative hearing is a critical step to ensure that they get the support they need. I want to express my gratitude to the chair for including so many bills from our bipartisan Addiction and Mental Health Task Force legislative agenda in today's hearing, and we appreciate working with

committee staff, as well.

Our 2021 legislative agenda includes 67 bills, all bipartisan, Republicans and Democrats, bringing together good ideas to help people across this country. Over 40 of these bills fall within this committee's jurisdiction, and we look forward to continuing to build on the long history of bipartisanship in this committee in addressing the addiction crisis.

Just before the onset of COVID-19, I visited our women's prison in Concord, New Hampshire, where I learned that fully 100 percent of the women in the women's prison were survivors of either sexual assault and trauma -- that was 75 percent -- the remaining 25 percent from abuse and neglect in their childhood. The majority of the women also struggled with substance use disorder and needed medication-assisted treatment. And that is why I have introduced legislation called the Humane Correctional Health Care Act to repeal the Medicaid inmate exclusion, and allow justice-involved individuals to access mental health care and medication-assisted treatment for addiction during their incarceration.

It is also why I enjoined my colleague, Congressman Hudson, to introduce the Kids Cares Act (sic) included in today's hearing to improve children's mental health in the justice system by ensuring that children will receive a mental health screening prior to release.

Before I get to my questions, I want to clarify a colloquy that Representative Burgess had earlier. Dr. Delphin-Rittmon, it is my understanding that it is the Centers for Medicare and Medicaid Services that is responsible for overseeing the AMD exclusion. Isn't that correct?

*Dr. Delphin-Rittmon. Yes, Congresswoman. That is correct.

*Ms. Kuster. And so it is fair to say that questions about the IMD's exclusion would be better directed to CMS, and not SAMHSA.

*Dr. Delphin-Rittmon. Yes, that is correct.

*Ms. Kuster. Great. And just to be clear, you were not expressing an official Administration position on the IMD exclusion earlier in this hearing?

*Dr. Delphin-Rittmon. No, that is correct. So because the IMD does not fall under the purview of SAMHSA's work, that --

*Ms. Kuster. Right.

*Dr. Delphin-Rittmon. -- that is really more -- yes.

*Ms. Kuster. So turning to -- it would be helpful to discuss how these high-risk [inaudible], such as the re-entry period for those released from the criminal justice system, can be particularly important in providing appropriate mental health and addiction care, how critical is the continuity of

care for adolescents with mental health diagnoses?

*Dr. Delphin-Rittmon. Yes. Thank you for that question and for your leadership and support of behavioral health issues.

So continuity of care, we know, is important in terms of helping people to be able to have an ongoing trajectory of care, and be connected as needed.

*Ms. Kuster. Great.

*Ms. Eshoo. The gentlewoman's --

*Ms. Kuster. My time is up, but --

*Ms. Eshoo. -- time has expired.

*Ms. Kuster. Thank you. I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair recognizes Dr. Joyce from Pennsylvania for your five minutes of questions.

*Mr. Joyce. Thank you for yielding, Chair Eshoo and Ranking Member Guthrie, for convening a hearing on such a critical issue at an important time.

We have seen a tragic increase in mental health issues and substance use issues across the nation, and my home state of Pennsylvania is no exception. Exacerbated by lockdowns and school closures, these problems have been particularly acute among pediatric and teenage populations. My office has heard from Children's Hospital of Philadelphia in the east, and from UPMC Children's Hospital in Pittsburgh in the west,

and this covers east, west, and central, and it exists statewide, and it is not going to go away as we continue to feel the secondary impacts of the COVID-19 pandemic.

As policy-makers, we can't turn away from this crisis, and we must work together to make sure that physicians and mental health professionals are able to face these issues in every state. And to that end, I would like to thank Representative Sarbanes for working with me to introduce the Continuing Systems of Care for Children Act.

This bill will reauthorize two important programs at SAMHSA which will focus on comprehensive community health-based mental health services, as well as early intervention, treatment, and recovery services for children and young adults who struggle with substance use disorder.

My first question is for Dr. Delphin-Rittmon.

You have mentioned that SAMHSA supports the entire continuum of care and systems of care, and that, for some patients, inpatient care is necessary. Does SAMHSA provide support for these inpatient services?

*Dr. Delphin-Rittmon. So inpatient services are not are not supported with the Community Mental Health Block Grant. And so I would have to check back through all of our programs, but I don't believe we support inpatient services.

*Mr. Joyce. Does SAMHSA allow states to spend grant funding on inpatient treatment?

*Dr. Delphin-Rittmon. Again, the Community Mental Health Block Grant is primarily for outpatient community services, and I do not believe that we have grant programs that fund inpatient services. But I will go back and check that for sure.

*Mr. Joyce. And I would appreciate that. If that is in the purview of SAMHSA, could you please provide us -- and if the law is a barrier, is that something that we should look at when reauthorizing these programs? Specifically, not limiting bed numbers for inpatient hospitalization and treatment, which we have seen during COVID is so important?

And as I mentioned, I hear from the hospitals throughout the Commonwealth of Pennsylvania how important these inpatient services are.

*Dr. Delphin-Rittmon. Can you repeat that question?

*Mr. Joyce. Absolutely.

*Dr. Delphin-Rittmon. Yes.

*Mr. Joyce. If the law is the barrier, is this something we should look at when reauthorizing these programs?

*Dr. Delphin-Rittmon. We are open to, you know, ultimately services and supports that help people get, you know, connected to the care that they need. And so I am certainly happy to have follow-up conversations about what you have mentioned.

*Mr. Joyce. And thank you. I think that is so important for this dialogue, that the care that they need, Dr. Delphin-Rittmon, includes inpatient care. And your ability to address that and dialogue with us is so important.

I think that the mental health crisis that we have seen throughout this COVID-19 pandemic has only accentuated the need for programs that do include inpatient beds. So if you could please follow up with us, and let us know how we can better equip the facilities throughout America to provide those necessary inpatient programs --

*Dr. Delphin-Rittmon. Yes, we will absolutely do that.

*Mr. Joyce. Thank you very much.

*Dr. Delphin-Rittmon. Thank you.

*Mr. Joyce. Thank you, Madam Chair, and I yield.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the gentlewoman from Illinois, Ms. Kelly, for your five minutes of questions.

*Ms. Kelly. As a former mental health counselor, I am concerned about the state of mental health in this country. And I want to thank you, Madam Chair and Ranking Member Guthrie, for holding this important hearing.

The integration of mental health and substance use services into primary care has been shown to improve mental health and physical health outcomes for patients across racial and ethnic backgrounds. That is why I support the

Collaborate in an Orderly and Cohesive Manner Act, which would improve uptake of the collaborative care model, a highly effective integrated care model.

Dr. Delphin-Rittmon, it is great to see you again. This bill would also support research from promising behavioral health integration models. Can you shed some light on why it is important to study integrated care models that incorporate a diverse range of mental health providers such as psychologists, social workers, and mental health counselors?

*Dr. Delphin-Rittmon. Yes. Thank you for that question, and it is good to see you again, as well.

You know, so integrated care, this is definitely a priority area for SAMHSA, and also a priority across the Department. It is one of the areas that the Behavioral Health Coordinating Council is looking at. We know that integrated care helps to ultimately create multiple entryways into behavioral health services.

Data shows that many individuals will ultimately connect with mental health, either services or support, sometimes first through a primary care provider. So to the extent that services are integrated, for one, it means taking a whole health approach. We know mental health is a critical part of health, and so that integration with primary care services certainly is important.

And then the research there. Again, my colleagues

within other departments are engaged in research there, but it is important to look at what models make a difference. You know, what models and different constellations of integrated care, whether it is co-location or referral models of integrated care, and what makes a difference in terms of outcomes.

*Ms. Kelly. Thank you. Other than the policies that have been discussed today, how can Congress better incentivize integrated care delivery models within existing payment structures in the Medicaid and Medicare program?

*Dr. Delphin-Rittmon. Again, and I would defer that to my colleagues at CMS in terms of payment models.

*Ms. Kelly. Okay. Ms. Johnson, in your testimony you discuss the importance of protecting the mental health of our health care workforce. Research shows that the stress of working as a public safety telecommunicator answering 911 calls can have severe mental impacts, with one in seven of these professionals reporting recent thoughts of suicide. And I actually have a bill dealing with 911 operators.

Does HRSA administrator any grant programs -- or administrate any grant programs to support wellness for public safety telecommunications folks?

*Ms. Johnson. Thank you, Congresswoman, for the question, and thank you for your work in the mental health field. Having your expertise in Congress is really important

for the larger effort.

I -- we were able, with American Rescue Plan funds, to be able to fund mental health supports for the existing workforce. Much of that was focused on health care providers, but several of our grantees are actually public safety awardees. And so, in several instances, we are supporting EMS providers and other public safety providers with resilience awards.

We also proposed in our budget for fiscal year 2023 to grow this program and put additional resources to this. So we hope to be able to continue to work on this issue going forward, and would welcome the opportunity to work with you on that.

*Ms. Kelly. I would absolutely love that, because there is a significant need to provide these professionals with the support they deserve. They are like the first responders of the first responders. And I know during COVID, what they had to deal with almost immediately with the onset, you know, was really, I don't know, earth shattering in some ways for them, and listening to more domestic violence, and gun violence, and, you know, on and on and on, [inaudible] wanting to take their lives.

So thank you both so much for the work you do, and thank you for being with us [inaudible] and I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair now

recognizes the gentlewoman from Massachusetts, Congresswoman Trahan, for your five minutes of questions.

*Mrs. Trahan. Well, thank you, Madam Chair. And first I want to congratulate Mr. Upton, and thank him for his long career of public service and dedication to this committee. And thank you to both Administration leaders for joining the committee today.

We have covered quite a bit of ground on the essential programs that SAMHSA and HRSA support in the ongoing efforts to protect the well-being of Americans. Likewise, we have heard about the particular challenges facing our nation's children and our young people. They are inundated with daily stressors and anxieties. Yet, unfortunately, if they turn to online content for help, they may face additional harms and threats to their mental health.

While there is much more we can do and must do to support beneficial online content and reduce online harms, we must also continue to invest in early intervention strategies and youth suicide prevention efforts that meet young people where they are. It is precisely for this reason that I was pleased to join Ranking Member Rodgers and my colleagues, Representatives Axne and Kim, in introducing H.R. 7255, the Garrett Lee Smith Memorial Reauthorization Act, last week.

This legislation extends the authorization for four key prevention programs through youth-serving institutions

through fiscal year 2027. So Assistant Director Delphin-Rittmon, I would appreciate your insight into the need for and value of these programs. If you could, just speak to the particular mental health challenges our older adolescents face, and what trends we are seeing among these older youth.

*Dr. Delphin-Rittmon. Yes, thank you for that question.

I mean, some of our data is showing us that, you know, in terms of older adolescents -- and I mentioned some of the NSDUH data, so our National Survey on Drug Use and Health, that survey did show that, for 2020, individuals in the 18 to 25-year-old range reported that, for example, increased suicidal ideation, increased suicidal attempts, that the pandemic negatively impacted their mental health.

So we do see challenges related to, you know, adolescents, and particularly older adolescents and young adults in the ages 18 to 25.

*Mrs. Trahan. And could you speak to the awareness-building activities such as those supported through SAMHSA's Suicide Prevention Resource Center, as well as the public outreach and education on college campuses, how they help prevent youth suicides?

*Dr. Delphin-Rittmon. Yes. So each of those -- so, you know, through our Garrett Lee Smith Award, there are a range of public awareness activities, training, resources that are disseminated both on college campuses, as well as community-

wide around identifying and being able to recognize young people that are struggling, connecting people to services and supports. And so each of those awards are geared towards early intervention and helping to address the needs of individuals that may be experiencing mental health challenges, to include experiencing feelings of and thoughts of suicide.

*Mrs. Trahan. Vital, vital in this moment. And finally, my last question. If you could, comment on the impact that these youth suicide prevention programs have had on college-aged youth, why it is critical that we continue to invest in them.

*Dr. Delphin-Rittmon. Yes. So we have actually found data and have data that communities and campuses that implement these suicide prevention programs and initiatives, that they have sustained reduced rates of suicide, as compared to communities that have not implemented those. So we see that the programs do make a difference. They help to raise awareness, also help to connect individuals that are struggling to services and supports. And so the Garrett Lee Smith and other awareness raising initiatives do make a difference.

*Mrs. Trahan. Thank you for that.

Thank you, Madam Chair. I yield back.

*Ms. Eshoo. The gentlewoman yields back almost a

minute. My goodness.

All right, we don't see anyone on the Republican side, and I think all the members of our subcommittee have questioned. So now we will go to the gentleman -- and that is exactly what he is, a gentleman -- from New York, Mr. Tonko.

Thank you for waiving on. Thank you for being with us all morning, and now part of this afternoon. You have five minutes for your questions.

*Mr. Tonko. Well, thank you, Madam Chair, and thank you for allowing me to waive on. And let me join in your sentiments exchanged to Representative Upton. I appreciate the opportunity to work with him, and his decision is a loss for this committee.

So thank you, Fred.

Last week I was proud to introduce the bipartisan Substance Abuse Prevention, Treatment, and Recovery Services Block Grant with my colleagues and friends, Representatives Guthrie, Wild, and McKinley.

Thank you to Chair Eshoo and Ranking Member Guthrie, Chair Pallone, and Ranking Member Rodgers, as well as their staff, for the focus on this legislation.

Across our nation, millions of Americans are struggling with the disease of addiction, a crisis that has become even more dire during this pandemic. During my time in Congress I

have fought hard to support programs that address this worsening crisis and deliver critical resources to our communities.

Last year I fought successfully to deliver funding to the block grant program through our American Rescue Plan. Yet a staggering 101,306 people died of drug overdoses in the past year. There is no corner of the country that has escaped the effects of this crisis.

One of the best ways we can lessen the impacts of this epidemic is by strengthening and supporting state substance use prevention, treatment, and recovery efforts through the reauthorization of the Substance Use Prevention, Treatment, and Recovery Services Block Grant. This funding stream serves as the cornerstone of state substance use treatment, prevention, and recovery systems. Block grant funds, which are distributed by formula to all states and territories, provide lifesaving treatment services to approximately 1.4 million individuals per year. In some states, the block grant investment accounts for 100 percent of substance use prevention dollars.

My legislation will reauthorize the crucial block grant for another five years, ensuring sustained investment in evidence-based programs that support states, communities, and families battling the disease of addiction.

While I am proud and committed to this bipartisan

process, I am not yet satisfied with the text as it is today. I want to see several changes before markup, particularly an increase in authorized funding levels.

I also am supportive of a recovery set-aside in conjunction with an equal increase in authorization. With that in mind, I would like to enter a letter from over 500 state, local, and national organizations in support of the set-aside for the record.

*Ms. Eshoo. So ordered.

[The information follows:]

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

*Mr. Tonko. Thank you, Madam Chair.

And when we are losing over 100,000 of our loved ones annually due to this epidemic, we can't continue with the status quo. We need to be strategic, and make investments over the next five years so that thousands of American families don't have to keep paying the price of lost loved ones.

Flat funding does not meet the needs of the movement. I hope that all members here will continue to work with me to find an acceptable authorization level that addresses the needs of our constituents and our communities and demonstrates that, regardless of party, we stand together, ready to properly invest in the substance use prevention and treatment block grant program.

So with that, Assistant Secretary Delphin-Rittmon, thank you for joining us today. And I turn to you to help us better understand the importance of addressing substance use disorders through this block grant reauthorization. Can you share the impact this block grant has had over the years?

And what sort of evidence do we have as to its effectiveness in strengthening communities, keeping families together, and saving lives?

*Dr. Delphin-Rittmon. Yes. Congressman Tonko, I would like to thank you for your leadership and work around the block grant, for your support of the recovery set-aside.

We know that the substance abuse block grant has been -- is just vital funding for states in terms of being able to fund prevention, treatment, recovery, harm reduction strategies. These resources, again, help communities to be able to -- and states -- be able to identify gaps that they may have in terms of their treatment systems.

As you have mentioned, for some states this is, by and large, a significant part of their funding. It helps to -- the resources help to be able to support services and treatment for individuals struggling with substance use.

And so the -- you also mentioned the recovery set-aside. We are very much in support of the recovery set-aside. What we see is that recovery services make a difference. And so this set-aside will be able to help states fund recovery community centers, individuals in recovery.

So the peer workforce -- we have seen peer workforce connected to a range of substance use services and programs at the community level.

*Mr. Tonko. Thank you so much.

And with that I yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back. You all settled there, Mr. Carter?

The chair recognizes the gentleman from Georgia, Mr. Carter, for five minutes of questions.

*Mr. Carter. Thank you, Madam Chair, and thank both of

you for being here, and thank you for your indulgence.

You know, this is extremely important. We all understand that. And no one understands it and appreciates it more than you do. And I just want you to know we are very thankful for your service.

We all know -- I am a health care professional myself, I am a pharmacist. So we all know that the health care workforce has suffered major losses as a result of staffing over the course of this pandemic. And we all know that they have done yeoman's work. They have truly been our heroes, and we appreciate them very much. But the situation has affected every state, and every corner of the nation. No one has been immune from this. And it has challenged health providers' ability to care for their patients in dire need of lifesaving health care treatment.

Ms. Johnson, in your written testimony you highlighted over 12 workforce development programs that are focused on increasing the number of health care professionals trained in behavioral health, mental health, and substance use dependance. Describe what measures, if you will, are used to determine the effectiveness of these programs, and provide your overall assessment of it, and if these programs are meeting their mission.

*Ms. Johnson. Thank you, Congressman, for the question, and for your attention to the critical workforce needs.

We assess the number of individuals trained, and then we track over time to see that those individuals -- our goal is often to ensure, for many of our programs, by statute, to ensure that individuals practice in under-served communities, that we identify by assessing what capacity looks like on the ground in communities across the country, and so we also measure practice over time, where individuals who we train are practicing.

And so what we see -- in particular, a program like the National Health Service Corps, which is our loan repayment and scholarship program, where individuals -- we offer loan repayment and scholarship in return for individuals practicing in high-need communities. Our data continuously suggests that people tend to stay in those communities even beyond their service commitment. So we have seen real success with programs like that.

I think that one of our challenges is just ensuring that we have the resources to continue to recruit people into the mental health and substance use disorder pipeline, and that we have the mental health and substance use disorder workforce that can be preceptors that can help make sure that people can do their clinical practice as part of the training.

*Mr. Carter. Understood. But let me ask you -- because we know that nothing is perfect -- if the programs are not

effective, or they are not sufficient, how do you -- what other measures does HRSA implement, or would you implement to address the extreme lack of behavioral health providers in particular?

*Ms. Johnson. Well, so one of the things that we have done is really look at all of our programs to figure out where there are opportunities to address mental health and behavioral -- sorry, mental health and substance use disorder needs.

And so, you know, over the years, programs have been expanded to allow for mental health and substance use disorder providers to be part of them. Or we have taken programs like some of our primary care training programs and added mental health and substance use disorder to the curricula, so that we can expand access to these services and capacity.

*Mr. Carter. Good. Thank you very much for those responses.

Dr. Delphin-Rittmon, let me ask you. I want to touch on the impact that the pandemic has had on the mental well-being of our kids. I am a grandfather. I have got six grandchildren. And it is very important to me. Three of them are school-aged, and I know it has had a mental impact on them.

You know, it has been two years since we came to a halt

due to COVID-19. But there is a lot that we know about the pandemic now that we didn't know before. In fact, the surgeon general has stated that the effect of lockdowns is devastating on young people's mental health. What is being done? What is being done to ensure that we address the mental health issues and substance abuse disorders that resulted from mandated school closures?

*Dr. Delphin-Rittmon. So in terms of the services and programs that are in place to address the mental health challenges that we are seeing, you know, among students, you know, there are programs like Project Aware. So Project Aware, again, is a school-based program that helps to identify children that may be struggling, and connect them with services and supports.

We know that, even before the pandemic, research and data showed that there -- that children were struggling. Certainly we saw an increase during the pandemic. During the pandemic we did increase and expand the Project Aware programing. Also programs like mental health awareness training, to be able to train individuals to be able to identify students that are struggling or community members that are struggling, and ultimately connect them to services and supports.

*Mr. Carter. Good. Well, thank you both again for your work. This is extremely important. And we appreciate all

your efforts.

Thank you, Madam Chair, and I will yield back.

*Ms. Eshoo. The chair now has the pleasure of recognizing another one of our doctors that is a member of our committee, Dr. Schrier of Washington State, for your five minutes of questions.

*Ms. Schrier. Thank you, Madam Chair, and thank you to our witnesses today. It is great to see you both.

One of the bills that we are discussing today is mine, the Supporting Children's Mental Health Care Access Act. And Madam Chair, 47 organizations have signed a letter of support for this bill, and I would like to request that the letter be submitted for the record.

*Ms. Eshoo. So ordered.

[The information follows:]

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

*Ms. Schrier. Thank you. Now, one of the programs that this bill authorizes is the Pediatric Mental Health Care Access Program. And these programs give pediatricians quick access to mental and behavioral health specialists for quick consultation and guidance in the middle of their day. One on-call psychiatrist can advise hundreds of pediatricians.

In fact, we have the PAL program in Washington State, the Partnership Access Line. Yesterday I spoke with Dr. Hilt, who established this program back in 2008, and I thanked him for the program, which was so useful to me. I asked him, and he kindly sent me reports from consults that I had received over the years, and there were 15 of them. Reading through them reminded me just how critical the PAL program has been for me, as a general pediatrician, and for so many of my colleagues facing really challenging situations.

Examples: a child victim of abuse now threatening his siblings, seven of them; a teen saying she is doing fine now on a screening for depression, but then noting that she made a serious suicide attempt the week prior; a four-year-old exposed to drugs in utero who was diagnosed by another doctor with ADHD, young age, and oppositional defiant disorder, brought in to see me by foster parents asking to refill a medication that is not typically prescribed for such young children.

And this is why the PAL program is such a lifesaver and child saver in the pediatric world. Well, PAL is funded by HRSA, partly funded by a HRSA Pediatric Mental Health Care Access Grant, one authorized in this bill.

Ms. Johnson, you have already touched on how important this program is, PAL is, in rural areas. I was wondering if you could expand a little bit on ways that we can continue to meet patients where they are in rural and under-served areas, and also what a program like PAL means for our workforce shortages in mental health.

*Ms. Johnson. Thank you so much, Congresswoman, for raising that, and for your leadership on this issue, and for sharing your personal experience with the program.

We are -- we hear so much enthusiasm from pediatricians about having access to these services, because, as we have all talked about here, you know, there is so much pressure on the system for pediatricians to be able to respond to children's mental health needs, and this gives them ready access to the expertise to allow them to get expert consult, or just to reassure them of the path that they are taking going forward. And what -- we have wonderful testimonials from pediatricians from across the country about the value of the program.

We also have some anecdotal data that suggest that calls to the consult line from certain pediatricians get more

complex over time, suggesting that there is more confidence and ability among pediatricians to handle other mental health conditions, once they have had some experience and exposure to the line.

And so, particularly in rural areas where access to mental health services is such a challenge, and where we are working hard across all our programs to expand access, being able to use our -- and maximize primary care providers, pediatricians who want to be able to meet their patients' needs by giving them access to this resource, is so critical.

*Ms. Schrier. Thank you. I can attest to exactly that case, that over time I was able to take care of more and more complex patients.

I will also note that the -- that PAL allowed -- also had flow charts. It had weekend courses that were almost like a miniature residency program that could catch pediatricians up on how to handle more and more complex mental health cases because that is not something that, at least when I trained, was something that we delved deeply into. So I want to thank you for that answer.

And I will yield back, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back. The chair now recognizes the gentlewoman from Illinois, Ms. Schakowsky, who is waiving onto our subcommittee, and is always welcome here, for your five minutes of questions.

*Ms. Schakowsky. Thank you so much, Madam Chairwoman, for letting me waive on.

And also, you know, you and I have been in the Congress for more than two decades, and I don't think for any minute of those we haven't talked about the need for better mental health services. And so hopefully, this Congress we are going to make some considerable progress.

I wanted to lift up the issue of older Americans and mental health. I know there has been a lot of talk about the need for children, especially during the pandemic. But let's remember who suffered the most during the pandemic and before, as well. But over 200,000 nursing home residents and staff have died during the pandemic, more than any other sector. Others died and suffered from the consequences of isolation, depression, and neglect.

And so I just wanted to talk about a woman that called me who said she used to visit her mother, who has some dementia, every single day at the nursing home. But what happened during the pandemic? The families could not go in, and so they were completely isolated. She would go to the window every day, and her mother was totally confused by her being outside the window. And people were often not allowed even outside enough in -- when they were confined in their nursing homes.

So I wanted -- I think we have sort of a cultural

dilemma that means that we don't -- I think we don't pay enough attention to the mental, the psychological needs of older Americans.

So, Dr. Delphin-Rittmon, I wanted to ask you, in your testimony you said, "unprecedented mental health crisis among people of all ages and backgrounds.'' But I wondered if you could expand on the state of mental health among American -- America's elderly.

And I know that there actually is a geropsychology, you know, professional, and I am wondering [inaudible].

*Dr. Delphin-Rittmon. Yes, yes, thank you for that question. And so one resource that SAMHSA does provide -- because, as you mentioned, you know, this is an area of need across the country -- as a function of the pandemic we saw many communities and families grappling with ways to keep connected to elders that may have been in nursing homes and other settings.

We do have a technology transfer center that provides training and other resources across the country related to the mental health needs of older adults. And so that is a resource that is available.

In terms of specific data, I would have to follow up in terms of what some of our specific NSDUH -- so National Survey on Drug Use and Health -- what some of our specific NSDUH data identified in terms of older adults. But I would

be happy to follow up, and have additional conversations with you related to that.

*Ms. Schakowsky. I was just the co-chair of the Democratic Caucus on Aging and Families.

You know, if you think about the challenges of getting old in America -- and more and more of us are -- it is really a difficult, you know -- you are often in retirement. What does that mean? How am I going to live?

The stresses on older Americans, especially, I think, on women, who tend to live longer and poorer, that -- and I think that we need to make available and make it okay for people to seek the kind of help [inaudible] very stressful time. You know, adolescence is a difficult time in life, but so is growing older. And so, you know, the more that we can do, the better. I look forward to having a further conversation, because I do feel like the focus on kids is great, but I think that we need to have a special focus and have the staff and providers on hand to deal with our aging society right now.

So [inaudible] and I yield back.

*Ms. Eshoo. The gentlewoman yields back. I don't see anyone from either side of the aisle that is seeking time.

So at this juncture I would like to thank you, Ms. Johnson, for your excellent testimony and addressing the questions that came to you from the members, and likewise to

Dr. Delphin-Rittmon. Thank you very, very much. And we will take a few minutes to get the next panel set up. All right?

[Pause.]

*Ms. Eshoo. Okay, all right. Our first panel has concluded, and I want to welcome each one of the witnesses that are here with us today, not only in person, but virtually. We very, very much appreciate it.

We have 19 bills that we are having hearings on today, and we look forward to your testimony, to your expertise, and then, of course, answering the questions of members. So we will straight away get to our witnesses.

The first, Dr. Rebecca Brendel, who is the director of the master's degree program at the Harvard Medical School Center for Bioethics, and is the president-elect of the American Psychiatric Association.

Thank you for being with us.

The second witness is Dr. Sandy Lee Chung, and is the president of Fairfax Pediatric Associates, and the president-elect of the American Academy of Pediatrics. Well, we have got two madam presidents coming on board. I like the sound of that.

Dr. -- just a minute, I want to make sure it is in the correct order -- Dr. Steven Adelsheim is the director of the Center for Youth Mental Health and Well-being, as well as clinical professor of psychiatry and behavioral services at

Stanford University School of Medicine and Stanford Children's Health.

I am very proud to have you as my constituent, as our witness today, and to represent the Stanford University School of Medicine and Children's Health. Let's see. This is -- see, they are not in order in my book, so bear with me.

Dr. Deborah Pinals is the medical director of behavioral health and forensic programs at the Michigan Department of Health and Human Services, and she is testifying on behalf of the National Association of State Mental Health Program Directors, an important, very important group in our country.

And just a minute. Ms. Cassandra Price is the director of the office of addictive diseases at the Georgia Department of Behavioral Health and Developmental Disabilities, and she is testifying on behalf of the National Association of State Alcohol and Drug Abuse Directors.

And last, but not least, Mr. LeVail Smith is a peer support specialist, instructor, and mentor.

So thank you to each one of you. Hearings are, I think, very rich, rich in content and in stories and in professionalism, highly instructive to each member here. And you help us shape the policies. And again, we thank you.

So why don't we begin now with Dr. Rebecca Brendel?

And thank you again for being with us.

STATEMENT OF REBECCA W. BRENDEL, M.D., J.D., PRESIDENT-ELECT AMERICAN PSYCHIATRIC ASSOCIATION; SANDY L. CHUNG, M.D., F.A.A.P., F.A.C.H.E., PRESIDENT-ELECT, AMERICAN ACADEMY OF PEDIATRICS; STEVEN ADELSHEIM, M.D., CLINICAL PROFESSOR OF PSYCHIATRY AND DIRECTOR, STANFORD CENTER FOR YOUTH MENTAL HEALTH AND WELL-BEING, STANFORD UNIVERSITY SCHOOL OF MEDICINE, STANFORD CHILDREN'S HEALTH; DEBRA PINALS, M.D., MEDICAL DIRECTOR, BEHAVIORAL HEALTH AND FORENSIC PROGRAMS, MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; CASSANDRA PRICE, M.B.A., DIRECTOR, OFFICE OF ADDICTIVE DISEASES, GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES, ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS; AND LEVAIL W. SMITH, C.P.S.S., PEER SUPPORT SPECIALIST INSTRUCTOR AND MENTOR

STATEMENT OF REBECCA W. BRENDEL

*Dr. Brendel. Chair Eshoo and Ranking Member Guthrie, on behalf of the American Psychiatric Association, the National Medical Specialty Association, representing more than 37,000 psychiatric physicians, I want to thank you for conducting today's hearing.

My name is Rebecca Brendel, and I am the American

Psychiatric Association's president-elect. I base my clinical work in psychiatry at Massachusetts General Hospital, where I am the director of law and ethics at the Center for Law, Brain, and Behavior. I am also assistant professor of psychiatry at Harvard Medical School. Thank you for having me here today to address the status of our nation's mental health.

I sit here before you today because the United States is experiencing a profound crisis of mental health and well-being, one compounded by the disruption, isolation, and loss experienced during the COVID-19 pandemic.

As the pandemic continues to exacerbate mental health conditions, including substance use disorders, the consequences are plain to see: high rates of suicide, unprecedented overdose rates, and increased depression and anxiety nationwide. With these realities in mind, I would like to start by thanking the Committee for its continued work on mental health and substance use disorder legislation that will improve access to care, reduce costs to our health care system, and, most importantly, help save lives.

This committee's focus today on reauthorizations for several mental health and substance use disorder programs that currently fall under the Public Health Service Act is especially encouraging. It is critically important, however, that these programs are not only reauthorized, but that

Congress do so at levels that better address the years of under-funding of public mental health programs.

To adequately address the mental health and substance use disorder crisis facing our nation, it is imperative that the Committee continue to support implementation and enforcement of the Mental Health Parity and Addiction Equity Act enacted 14 years ago to require that insurance coverage for mental health and substance use disorders services be no more restrictive than coverage for other medical care. This committee played a central role in amending the law by requiring insurers to demonstrate their compliance via provisions in the 2021 Consolidated Appropriations Act.

Unfortunately, recent reports from the DoL and GAO demonstrate that many insurers are still not compliant, leaving millions of beneficiaries struggling to obtain care, even though insurers received detailed guidance about how to demonstrate compliance with the law over the past five years. Further congressional action is clearly needed to bring insurers into compliance with parity law, beginning with providing Federal and state agencies the resources necessary to enforce the law and hold plans accountable, something that H.R. 7232, the 988 and Parity Assistance Act of 2022, would do.

Congress should also stop allowing non-Federal governmental health plans to opt out of parity law coverage

requirements, and support H.R. 7254, the Mental Health Justice and Parity Act of 2022.

The integration of behavioral health and primary care is also vitally important. Population and evidence-based integrated care models hold great promise to enhance access for the millions of Americans who struggle with undiagnosed and untreated mental health and substance use disorders. To that end, the APA is pleased to see this committee considering H.R. 5218 on collaborative care. This important legislation, introduced by Representatives Fletcher and Herrera Beutler, would expand access to high-quality behavioral health care by providing grants to primary care practices to cover startup costs, and establishing technical assistance centers to implement the collaborative care model.

The collaborative care model has proven effective in providing prevention, early intervention, and timely treatment of mental illness by ensuring that patients can receive prompt and evidence-based behavioral health treatment within the office of their primary care physician. This model is supported by more than 90 high-quality studies, and its population-based approach helps to alleviate workforce shortages by leveraging the expertise of a consulting psychiatrist to provide treatment recommendations for a panel of 50 to 60 patients in as little as one to two hours per week. Collaborative care also works to prevent emergency

room visits and hospitalizations, and reduces costs to our health care system.

I appreciate the opportunity to testify on behalf of the American Psychiatric Association. APA looks forward to working with you to improve the availability, accessibility, and affordability of quality mental health care across our country.

Thank you.

[The prepared statement of Dr. Brendel follows:]

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

*Ms. Eshoo. Thank you, Doctor.

Now to Dr. Sandy Lee Chung.

Welcome and thank you.

STATEMENT OF SANDY L. CHUNG

*Dr. Chung. Thank you. Chairwoman Eshoo, Ranking Member Guthrie, thank you for the opportunity to testify. I am Dr. Sandy Chung, president-elect of the American Academy of Pediatrics, a non-profit professional organization of 67,000 pediatricians.

The mental health challenges facing youth today are alarming and widespread, which is why AAP and the American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association came together to declare a national emergency in children's mental health. Rates of suicide, anxiety, and depression have all been exacerbated by the COVID-19 pandemic, especially among young people of color.

Tackling this crisis requires a comprehensive approach that addresses the full continuum of children's needs, from promotion and prevention to early intervention to treatment to crisis response. Children must be able to access care in the settings where they are, such as schools, their pediatrician's office, or, if in crisis, the emergency room or hospital.

Pediatricians are taking on a much larger role in the assessment and management of mental health issues. In fact, one-third of children with mental health disorders have their pediatrician as their sole mental health care provider.

Several years ago, I had a 14-year-old patient with bipolar disorder. His child psychiatrist had retired, and the family reached out to our practice to get a refill of his medications. He was on five complex medications that pediatricians don't typically prescribe or manage. So instead, my staff helped him to find an earlier appointment within four weeks. Unfortunately, during that time he ran out of medications. And when he ran out of medications, his bipolar disease had an exacerbation. He got into a fight in a parking lot near my office, and, unfortunately, he had a gun. During that fight he shot and he killed another man. That 14-year-old now is in jail, and that other man lost his life. And I believe that tragedy could have been prevented.

That led me to work with stakeholders across our state to found the Virginia Mental Health Access Program, or VMHAP. VMHAP provides telehealth consultation to primary care providers with pediatric child psychiatrists and mental health providers, and gives primary care providers the training and tools that they need to screen, diagnose, and manage children with mental health needs. Virginia is one of the 45 states and tribal organizations and territories that have received a grant from HRSA through the Pediatric Mental Health Care Access Grant program.

The AAP is grateful to this committee and to the leadership of Representatives Schrier and Miller-Meeks for

the introduction of H.R. 7076, which would continue this program for another five years, allowing states to expand their services to schools and emergency departments, which we are doing in Virginia.

Nearly every day I see children who do not yet warrant a diagnosis of anxiety, depression, or ADHD. But clearly, they are struggling at home and in schools. However, because they do not yet have a diagnosis, they don't qualify as having a serious emotional disturbance, and face barriers accessing services that would be helpful to them. This must change. We need to fund mental health promotion, prevention, and early intervention, including for children who are at risk for serious emotional disturbance.

Integration of mental health with primary care improves health outcomes, saves costs, increases family and patient satisfaction. But under our current payment system, it is not financially sustainable for many practices, and is costly for families. AAP has urged CMS to provide guidance about how Medicaid and its EPSDT benefit can ensure adequate payment for and integration of mental health services in pediatric primary care settings.

And we support provisions of H.R. 7236 that would ensure payment parity by matching Medicaid and Medicare payment rates for pediatric behavioral health services. Provisions of this bill in H.R. 4944 would provide much-needed grants to

support pediatric behavioral health integration and coordination, as well as pediatric mental health and substance use disorder workforce training.

Suicide is complex, but often preventable. The AAP recently released the Blueprint for Youth Suicide Prevention, which includes recommendations for the effective implementation of 988 nationwide. To be successful, 988 should be staffed to meet the needs of children in crisis. H.R. 7232 takes important steps towards ensuring that crisis response standards and capacity will address the needs of children.

Substance use disorder and mental health conditions can exacerbate one another. That is why the AAP strongly supports the Stop Underage Drinking Act, which is reauthorized in H.R. 7234.

We may not all know how it feels to have a child who is suffering from a mental health condition, but we all know how it feels to help. These bills today would do just that.

Thank you for the opportunity to testify, and I look forward to your questions.

[The prepared statement of Dr. Chung follows:]

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

*Ms. Eshoo. Thank you very much, Doctor.

Next, Dr. Adelsheim.

It is wonderful to see you here, and thank you for traveling across the country. You have five minutes for your testimony, and welcome to the great --

*Dr. Adelsheim. The great cherry --

*Ms. Eshoo. Yes.

*Dr. Adelsheim. Right?

*Ms. Eshoo. All things children's health care, yes.

STATEMENT OF STEVEN ADELSHEIM

*Dr. Adelsheim. Chairman Eshoo, Ranking Member Guthrie, and members of the subcommittee, my name is Dr. Steve Adelsheim. I am a child and adolescent psychiatrist at Stanford, where I direct the Center for Youth Mental Health and Well-being.

My career has focused on creating access to early mental health care through expanding early intervention programs for young people, through schools, early psychosis programs, and now allcove, community-based early intervention centers started in California by and for youth. Prior to Stanford I worked in New Mexico on rural mental health, telehealth, youth suicide, and American-Indian and Alaska Native tribal partnerships. In addiction, I worked in adolescent inpatient units.

I am honored to be here before you and this subcommittee representing the entire continuum of youth mental health, especially pediatric mental health professionals and the critical role children's hospitals have. Thank you for holding this important hearing, and especially Chairwoman Eshoo, for your continued commitment to children's health through the Strengthening Kids Mental Health Now Act with Representative Fitzpatrick and Representative Blunt Rochester, who is also leading through the Helping Kids Cope

Act.

Given our limited time, I want to just acknowledge the pediatric mental health crisis we faced prior to the pandemic. Since the pandemic, we have only seen higher rates of anxiety, depression, and suicide attempts by our pediatric population. It is clear why several of our leading children's organizations, including the Children's Hospital Association, felt the need to declare a national emergency in child and adolescent mental health.

While we have long known that half of all lifetime cases of mental illness start by the age of 14, our country has not yet created the public mental health infrastructure or workforce our children have sorely needed and deserve. Thankfully, many of the bills under consideration today reflect this recognition and prioritization.

Putting Medicaid reimbursement rates on par with Medicare rates, as seen in the Strengthening Kids Mental Health Now Act is critical. The current low Medicaid reimbursements seem to imply we don't value our pediatric population's well-being to the same degree we value our older adults.

Furthermore, the current low rates disincentive the provision of pediatric early mental health care and keep the workforce numbers low, since agencies could not afford to hire enough child mental health providers even if they were

available, which sadly is not the case.

Several of these bills expand the continuum of care for pediatric mental health services, including urgently-needed reimbursement for mental health checkups and visits prior to diagnosis. We need to expand funds and programs that support both prevention and early detection of mental health challenges, in addition to prioritizing crisis services.

An additional challenge is the siloed nature of Federal funding for our mental health services continuum. We separate funding streams for school mental health from clinical high risk for psychosis to early psychosis to systems of care for children with serious emotional disturbance. Few community mental health programs can utilize each of these separate funding streams to thus provide the entire continuum of support. Perhaps we need to consider and reconsider the structure of our block grant funding to make this entire public mental health continuum more easily available.

Importantly, many of these bills support integrated models with primary care through mental health consultation and integrated clinical service delivery. My work in school based and allcove centers reflect that our children and youth are more likely to connect to mental health supports when linked to primary care.

The workforce priorities in these bills provide for the

urgent development of the entire continuum of the pediatric mental health workforce. We must incentivize opportunities for education that prioritizes development of a diverse workforce that reflects and supports our under-served communities.

The stigma surrounding mental health keeps us from openly acknowledging that we all live in families facing mental health challenges every single day. The stigma also prevents us from creating the pediatric public mental health system with the enforcement of parity that would allow for screening early for pediatric mental health issues, just like we do for cancer. A well-functioning mental health system would enable us to treat childhood depression as quickly and urgently as childhood asthma.

Our pediatric communities need us to create the pediatric mental health continuum of care now, which includes a robust workforce and primary care collaboration. We are grateful for your leadership in recognizing these needs, and appreciate the opportunity to successfully address them with you.

[The prepared statement of Dr. Adelsheim follows:]

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

*Ms. Eshoo. Thank you very, very much, Doctor. Next we have Dr. Deborah Pinals.

You have five minutes for your testimony, and welcome, and thank you for being with us.

STATEMENT OF DEBRA PINALS

*Dr. Pinals. Thank you. Good morning, Subcommittee Chairman Eshoo, Subcommittee Ranking Member Guthrie, Chairman Pallone, and Chairwoman McMorris Rodgers, and members of the subcommittee. Thank you for the opportunity to appear before you to discuss policy solutions to the opioid and mental health crises impacting our country.

My name is Dr. Debra Pinals, and today I am testifying on behalf of the National Association of State Mental Health Program Directors, or NASMHPD, which represents state executives responsible for the public mental health service delivery system in all 50 states, six territories and Pacific jurisdictions, and the District of Columbia. I am a psychiatrist and the medical director of behavioral health and forensic programs at the Michigan Department of Health and Human Services, and a clinical professor of psychiatry at the University of Michigan Medical School, and clinical adjunct professor at the university's law school.

Data from the CDC has been showing that about 30 percent of U.S. adults are reporting significant symptoms of depression and anxiety. And the emotional toll of the pandemic on youth has sounded alarms. To lift up Michigan's Stay Well crisis counseling program as part of our disaster behavioral health response, we relied heavily upon Federal

funding. We so appreciate support for this work by members of the Michigan delegation, especially Senators Stabenow and Peters in the Senate, and Representatives Dingell and Upton of this subcommittee.

Even before COVID-19, however, needs for persons with mental illness, substance use disorders, and co-occurring intellectual and developmental disabilities were great. As you deliberate on the many bills before you, my message is clear: funding for mental health services should be a national priority.

In Michigan, drug overdose deaths have grown fivefold in our state from 2000. In 2020 there were just over 2,700 drug overdose deaths, and a 23 percent increase in opioid overdose deaths from 2019. And Black and Hispanic residents are disproportionately impacted. Michigan also saw over 1,400 total suicides in 2020, with suicide the third leading cause of death for our residents ages 15 to 34.

Even with our efforts on the opioid crisis and with the State Suicide Prevention Commission, more Federal supports are needed to turn these grim numbers around. Our work in Michigan to address these challenges includes many things, including establishing our 36 Certified Community Behavioral Health Clinic, or CCBHC, sites, spanning the state, stretching from Kalamazoo through Washtenaw to Wayne County, serving greater Detroit and beyond, and up north to Mason

County. This program increases access for all to a variety of mental health and substance use services, including mobile crisis services and jail diversion, with an estimated 367,000 Michiganders eligible to participate. We are grateful to our Federal partners for selecting Michigan to expand our CCBHC access.

We are also expanding the Michigan Crisis and Access Line, or MCAL, statewide this year, a service that launched in April 2021 in Oakland County and in our more rural upper peninsula. MCAL supports people in distress through a single number access point and an associated peer warmline. To date, over 50,000 calls have been handled. We are also coordinating MCAL with the National Suicide Prevention Lifeline 988 number scheduled for implementation in July 2022 nationwide.

NASMHP's bipartisan legislative agenda dovetails with Michigan's strategic direction. In preparation for the 988 rollout, the state mental health directors are seeking a mental health block grant set-aside of ten percent to help finance the crisis care continuum. Flexible block grant dollars will assist funding call centers, organizing mobile crisis response teams, and financing crisis receiving and crisis stabilization beds in non-hospital community-based settings.

With 988 going live in less than four months, standing

up a crisis care system is an enormous undertaking and, make no mistake, will require financing beyond existing discretionary programs.

In addition, NASMHP and other organizations, such as the Mental Health America, support the creation of a new ten percent early intervention and prevention set-aside within the mental health block grant.

Having treated patients in settings from emergency rooms to prisons, I see the need for upstream prevention. Many of the major mental illnesses have a typical age of onset in late adolescence. Similar to the prevention set-aside in the substance use and prevention block grant, this new set-aside could avert negative downstream outcomes, such as long waits in emergency departments, arrest and incarceration, homeless shelter placements, and even foster care placements. It will enhance constructive public-private partnerships with school systems, primary care associations, and local businesses. To realize these goals, statutory modifications and a significant upward adjustment in the block grant authorization ceiling will be required.

State mental health agencies have a responsibility to attend to the mental health needs of some of the most vulnerable residents, yet they need the flexibility for -- to help Americans facing a mental health or substance use crisis, while engaging in initiatives to prevent those crises

from emerging in the first place.

*Ms. Eshoo. You need to summarize.

*Dr. Pinals. Again, thank you for the opportunity to testify. I am happy to answer any questions you may have.

[The prepared statement of Dr. Pinals follows:]

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

*Ms. Eshoo. Wonderful, thank you.

We will now go to -- let's see -- Dr. -- Ms. Cassandra Price.

Welcome, and thank you. You have five minutes for your testimony.

STATEMENT OF CASSANDRA PRICE

*Ms. Price. Thank you. Chair Eshoo, Ranking Member Guthrie, and members of the subcommittee, my name is Cassandra Price, and I serve as the director of the office of addictive diseases within the Georgia Department of Behavioral Health and Developmental Disabilities. I also serve as past president of the National Association of State Alcohol and Drug Abuse Directors, also known as NASADAD. It is a privilege to join you today.

We are very grateful for the programs authorized by this very subcommittee in CARA, the 21st Century Cures Act, and the SUPPORT Act. We are particularly grateful for your work to provide critical resources through the Substance Abuse Prevention and Treatment Block Grant, NASADAD's number-one programmatic priority.

I would like to offer a core principle for the subcommittee's consideration as you examine legislation before you today.

First, we recommend Federal funding programs and policies designed to address substance use disorders flow through the state alcohol and drug agencies. This approach allows Federal initiatives to enhance and improve state systems and promote effectiveness and efficiency.

Second, please work to ensure consistent, predictable,

and sustained Federal resources in order to avoid a large fiscal cliff. We recommend extending the duration of Federal grant programs beyond the typical one to two-year funding cycle by utilizing a three or even five-year grant cycle.

Third, we hope Congress continues to work to address the opioid crisis, but we also recommend work to elevate efforts to address all substance use disorders, including those linked to alcohol. In Georgia, for example, alcohol use-related deaths increase from 1,699 in fiscal year 2019 to 2,202 in fiscal year 2020, a significant concern.

Fourth, promote and ensure a strong SAMHSA that serves as the default home for all Federal substance use service delivery programing. I would like to express my strong support for and appreciation of Dr. Miriam Delphin-Rittmon, assistant secretary for mental health and substance use, and leader of SAMHSA.

Fifth, we hope for continued support for and investments in the SAPT Block Grant.

Now I would like to offer more specific comments on a few proposals highlighted at this hearing.

First, thank you for your initial work to reauthorize the SAPT Block Grant. NASADAD prefers to maintain as much flexibility as possible in the use of SAPT Block Grant funds. NASADAD supports the bill's efforts to remove stigmatizing language, increase screening or referral for viral hepatitis,

increase reporting on how states allocate funds for recovery support services, and the development of needs assessment processes for states to consider. We thank Representatives Tonko, Guthrie, Wild, and McKinley.

Second, we appreciate your work reflected in the Summer Barrow Prevention, Treatment, and Recovery Act led by Representative Spanberger and others. The proposal would reauthorize a number of important programs within SAMHSA, including the Center for Substance Abuse Treatment and Center for Substance Abuse Prevention.

Third, we appreciate efforts related to 988 and crisis services. We hope Congress elevates and specifically references substance use disorders as a core and distinct component of work related to crisis response. And we thank Congressman Cardenas and other cosponsors for movement in this direction.

Fourth, thank you for the Excellence in Recovery Housing Act. We support this proposal, and recognize the work of Representatives Trone, Chu, Levin, and McKinley.

Finally, we hope work is done to address the nation's substance use disorder workforce crisis. While we appreciate moving towards -- moving forward at HRSA, we need an all-above strategy. Therefore, NASADAD recommends strongly providing SAMHSA general statutory authority to address substance use workforce issues. NASADAD also recommends

[inaudible] clarifying the SAPT Block Grant funds may be used by states on workforce needs.

Further, NASADAD recommends the development of a grant program within SAMHSA to states to address the workforce crisis. One approach is included in section 11 in CARA 3.0 that would authorize a grant in SAMHSA to state and alcohol drug agencies to bolster our substance use prevention workforce.

Thank you for all of your leadership on all of these critical issues. I look forward to answering any questions you may have.

[The prepared statement of Ms. Price follows:]

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

*Ms. Eshoo. And we thank you.

Let's see, are we -- we have Mr. Smith.

Thank you for your patience. Mr. LeVail Smith, you are now recognized for your five minutes of testimony.

STATEMENT OF LEVAIL W. SMITH

*Mr. Smith. Thank you, Chair Eshoo, Ranking Member Guthrie, and members of the committee, for the opportunity to participate in today's hearing to share my experience of recovery and wellness living with a mental health issue and substance use condition. I am honored to share how SAMHSA and other government-funded programs can make a difference in the lives of people living with behavioral health conditions, and will address issues that have not only affected me, but so many others, as well.

In 2014, during a particularly impairing episode of service-related PTSD, I was shot several times by the Chicago Police, resulting in multiple ostomies and left with bullets in my sternum centimeters above my heart and lodged in my lower spine, simply because the officers had a lack of understanding concerning mental health issues. This episode and others led me to a time when I was distraught, alone, in abject dysfunction and misery. My spirit was weary of trying to deal with my mood disorder.

The only person I was able to reach that dismal day as relative suicide hovered nearby was a patient, understanding individual that picked up the phone when I called the Veteran's Crisis Line. He talked me for the better part of three hours [inaudible] persuaded me to give it one more try.

After years in and out of psychiatric wards, institutions, treatment, or being a lost soul in the streets, I [inaudible] come back that DBSA played an integral part of. I met a DBSA-trained peer support specialist, an Army veteran that showed patience, compassion, and empathy for me that created a bond that made me realize there were others out there who understood what was going on inside of me, and who were willing to walk alongside of me as I fought the war inside of me.

I was shown skills and tools he had learned from DBSA to help me cope with my service-related PTSD and depression. She, along with some outstanding mental health professionals and my faith in God, became the cornerstones of my supportive foundation. With their help, I began to believe I could overcome and there was a use for me in life, that I had a purpose, that I was not just some broken thing to be thrown away callously by society.

As a participant of the Depression Bipolar Support Alliance known as DBSA, the leading national organization for people living with mood disorders, I have been directly impacted by many of the programs that Congress reauthorized this year. As an instructor for DBSA's peer specialist course, I have been able to share with my students my own journey, which is why I am turning confusion, despair, and grief to one of hope, understanding, and promise for the

future.

I sit before you today a man of recovery, living a life that I am proud of. I am a United States Marine Corps veteran who honorably and proudly served my country. I am also someone giving back to his community by volunteering on the board of the Lake County Coalition for the Homeless, striving to end chronic homelessness, as well as [inaudible] organization that works to prevent substance misuse disorder and reduce the stigma associated with it.

As a recovering individual, I have now served as a peer specialist trainer, helping DBSA implement a new and innovative pilot program, training and supporting peer apprentices, many of whom are veterans, on their way to becoming certified peer specialists. I implore you to consider, based on my many experiences, the following recommendations as you reconsider reauthorization of the SAMHSA programs.

The creation of a program that provides funding along non-profit organizations to identify candidates and train and certify them as peer specialists. This is definitely needed to increase the number of existing certified peer specialists.

Expand existing peer specialist apprentice pilots to allow for the creation of programs and communities located across the country.

Pass H.R. 2929, the Virtual Peer Support Act. This will increase funding for virtual peer support, and eliminate waiting lists by preventing people in need from accessing these vital support services.

Pass H.R. 7116, the 988 Implementation Act. This will ensure that needed resources are available to successfully implement this important new program.

Expand training programs for law enforcement officers that focus on de-escalation and engaging with an individual experiencing a behavioral health crisis, and expand opportunities for partnerships between law enforcement and behavioral health professionals to eliminate tragedies like the one I experienced.

Expand access to supportive housing and outreach into the homeless community, many of whom are veterans who experienced serious service-related PTSD.

In closing, I would like to say by no means am I a finished product. But because of the many programs I spoke of today, I am able to give back to society by sharing my lived experiences, instead of being just a misunderstood burden to the country I love.

Thank you for listening to me, what help you have implemented thus far, for taking this time to contemplate how to improve our country and its citizens, rather than give up on those who suffer from within. Semper Fi.

[The prepared statement of Mr. Smith follows:]

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

*Ms. Eshoo. Thank you very, very much, Mr. Smith, and to each of our witnesses. You have given us very important testimony today. Thank you for your patience, as well.

So now the chair is -- we are going to move to our questions now, and I recognize myself for five minutes to do so. Let me start with Dr. Adelsheim and Dr. Chung.

I am -- you know, in listening to the testimony from the heads of the agencies part of the Administration, and then all the questions that members asked, my takeaway is this. We have a lot of good things in place. And there is testimony for that. And many of the witnesses have referenced different grant programs, what their goals are.

Some programs have been around much longer than others. You always look to refine them. We need to reauthorize some of the legislation that we have that we are considering that is before us today are up for reauthorization.

But all each one of us has to do is listen to our constituents. And whatever we have in place is nowhere near what we need. I mean, this is -- there is just this overwhelming need. And as someone that has represented my district for more than two decades, I have never, never before heard so many people asking, inquiring about mental health services. So we know the need is there.

My legislation, I am excited about it because it is comprehensive. And I think unless and until we go the

comprehensive route, that we are still -- that we are going to just have hits and misses in our system. And I think, in -- that is the least thing we can afford at this particular moment in our country. Because when you have the misses, people fall through the cracks. And the need is so great, there are a lot of people that will fall through those cracks.

So to each one of the witnesses, is there anyone that doesn't support H.R. 7236?

It is a wonderful way to ask a question, because when you hear silence you want to applaud. So I will take that as support.

In looking at the legislation, are we missing anything? Are we missing anything? And maybe you want to speak, Dr. Adelsheim, to how insurance reimbursement rates affect the availability of mental health services.

I mean, if we don't have the money in the public system, and then, in terms of providers -- fill in the blank for us.

*Dr. Adelsheim. Madam Chair, I mean, your comments, I can't agree with you more.

My concern is really that we don't have anywhere near the basic capacity that we need for children's mental health service, compared to any other health condition that we have.

*Ms. Eshoo. And the rest of it is not so great.

*Dr. Adelsheim. Well, that is right, okay. But --

*Ms. Eshoo. I mean, it is as if we have a sterling part of it over here, and the other one is just lagging. This is the stepchild of the American health care system. And really, most people never even thought that little kids could have a mental health issue. Honestly, that was not in our thinking.

*Dr. Adelsheim. Well, but, you know, we have known -- the papers that said that half of all mental health conditions start by the age of 14, those papers are almost 20 years old. We have known this for a long time. And even, you know, going back to -- I was a member of -- you know, when President Bush convened the Commission, you know, on Mental Health back in -- 20 years ago this month, these same issues were raised, and the same concerns about disparities in terms of access to care, the need for early detection for young people. And to your point, we have been talking about these issues for a very long time.

*Ms. Eshoo. When we take -- or parents take their children into a pediatrician today, is there any kind of just built-in mental health screening at all?

*Dr. Chung. Thank you, Chairwoman Eshoo, that is an important question. And yes, in many practices in our adolescent population, we will do screening for depression, anxiety.

The challenge is, though, if you are doing a screening,

then you need to know what to do with the answer.

*Ms. Eshoo. Yes.

*Dr. Chung. And having that wraparound service, having that ability and resources in the community for the pediatrician, so that when you diagnose a child with anxiety to depression is incredibly important.

*Ms. Eshoo. Thank you. Just -- you can finish answering my question.

*Dr. Adelsheim. Right. So could I -- the comment I would make is that, you know, the idea that we wouldn't screen for certain things because we don't have enough of a workforce is not really something we can deal with at this point. We would not choose not to screen for cancer because we don't have the providers to take care of people with a cancer diagnosis. And the idea that we would hold up on screening for youth for mental health conditions because we haven't developed the workforce really just reflects maybe how we view, you know, the importance of early access for our kids.

And we really need, you know, through your legislation and others, the workforce to be able to provide this --

*Ms. Eshoo. Well, thank you. I thank you very much. My time has run out, and -- but each one of us can submit questions, written questions, to you. So I will have more. Thank you again.

The chair is now very pleased to recognize the ranking member of this important subcommittee for your five minutes of questions.

*Mr. Guthrie. Thank you, Madam Chair.

Ms. Price, I want to go to the subject of substance misuse disorder, substance use disorders, and ask you. You mentioned that Georgia had -- or overdose deaths rose by 106 percent in April 2020 to April 2021. In Kentucky, fentanyl-related overdose deaths were responsible for over 70 percent of all drug overdose in 2020. And we still haven't been able to get a bill to permanently schedule fentanyl-related substances as Schedule 1 drugs. And so my question, Ms. Price, how important would it be for Congress to schedule fentanyl-related substances as a Schedule 1?

*Ms. Price. I can only speak from a Georgia perspective, as I am not sure NASADAD has discussed that issue. But I will say, for Georgia, I think it would be very important because we have seen that increase, and it has been related to the introduction of fentanyl into the products that are hitting the street. So I would say that it was important from a Georgia perspective. Thank you.

*Mr. Guthrie. Do you think we are getting the most out of our Federal substance use programs -- use disorder programs without it being scheduled?

*Ms. Price. You know, I think that, when you talk about

supply and demand and enforcement, they are very hard to parse out. I do think that it could be -- I wouldn't say it is a losing battle, but I think it can make it an uphill battle when you have the fentanyl that is out there, and it is just really hard on the demand side to work within the treatment and recovery community when we can't reach people because of the lethality of fentanyl. So I think that is an important factor that would probably help us.

*Mr. Guthrie. Okay, thank you. And also staying with you, Ms. -- staying with you, I would -- so you mentioned in Georgia you received over 57 million in substance abuse prevention treatment block grant funding in 2021.

As I mentioned myself, my friend Mr. Tonko, colleagues McKinley and Wild are working to reauthorize that program. And we just want to ensure that it works for local organizations, and 80 percent of the funding is flexible. And I just want to have you talk about how important it is that the 80 percent of the grant funding is flexible.

*Ms. Price. Yes. Flexibility is key for us. In Georgia, the majority of our funding is braided with our state allocation to fund the entire infrastructure of the system. So from detox, residential, outpatient, peer support, recovery services, women's treatment -- and so that flexibility allows us to fill gaps and support the infrastructure where it is needed. And so we appreciate

everything that you are doing to ensure that flexibility in that block grant. We really -- that is really critical for us and for other states to have that flexibility.

*Mr. Guthrie. Well, thank you. And I know in my community -- and I have a brother that lives in Georgia and a son who went to college there, so I know there is a big difference when -- in different parts of Georgia, as it is in -- whether you live in Louisville or you live in rural Kentucky. And so I know that the communities we serve share similar sets of needs, and I know their needs vary.

Can you talk about the different needs that you could see the flexibility is important with between areas and communities in Georgia, as a --

*Ms. Price. Yes.

*Mr. Guthrie. And we can extrapolate that across the country, I guess, is what I am saying.

*Ms. Price. Yes, absolutely. That is a really great question because, in Georgia, we have 159 counties. And so we are stretched all over. And we have, of course, the population masses in metro Atlanta. And so we have a lot of resources there.

But we also know that we have plenty of folks out in rural Georgia that need services and supports. And you can't put -- we don't have enough infrastructure to put a treatment center on every corner. But what we do have is the ability

to put addiction recovery support centers -- which is something that Georgia created, we have 26 of those -- and I see Mr. Smith nodding, and thank you for your story -- 26 addiction recovery support centers across the state.

And so what we do is we fill those in communities that may not have treatment centers. So if someone receives treatment somewhere, then there is addiction recovery support centers to go back to in their community in rural areas to support their recovery. So it is all about using the entire infrastructure between prevention, treatment, and recovery to try to cover as much ground as possible, and support people in getting to what we expect in Georgia, which is recovery.

So thank you for your questions.

*Mr. Guthrie. Thank you. I think those support centers was -- one of the leaders is a former member here, Ernie Fletcher, former governor of Kentucky, I believe, has kind of really worked hard in those areas. So some of you who have been here for a few years may remember when Ernie Fletcher was a member of the committee.

So thanks, and I -- that completes my time, and I yield back.

*Ms. Eshoo. The gentleman yields back. The chair is pleased to recognize the gentlewoman from California, Ms. Matsui, for your five minutes questions.

*Ms. Matsui. Thank you very much, Madam Chair.

Before I get into my questions I would like to briefly touch on the importance of tele-mental health by sharing a quote included in a recent letter sent to my office by a constituent. She says, "Telehealth is the only way I could access medical care, due to my disabilities. And the prospect of losing that is, quite frankly, terrifying to me.'' On behalf of the millions of Americans including my constituent relying on these services, I ask this committee to support my bill to permanently remove Medicare's in-person requirement for tele-mental health visits.

I want to go on to maternal mental health now. Maternal mental health and substance use disorder can -- really contribute to the highest rate of maternity -- maternal mortality in the United States. And that is why I joined with Congresswoman Katherine Clark to introduce the bipartisan Into the Light for Maternal Mental Health and Substance Use Disorders Act, legislation that reauthorizes a crucial program at HRSA for screening and treating maternal mental health conditions.

Dr. Brendel, why is care coordination critical to addressing perinatal mental health problems?

What role do perinatal psychiatrists play in these coordinated care models?

*Dr. Brendel. Thank you for your question, and thank you for bringing forward this legislation. You know there

are not enough psychiatrists to be able to treat all the people who need mental health care, and we know that the perinatal period during pregnancy and after pregnancy for a year are high-risk times for the development of not only postpartum depression, but other mental health conditions, as well.

And so, in order -- and these mental health conditions also have significant effects on the health of the pregnancy and the bonding and early infant experience of children. And so it is absolutely critical to make sure that we are both screening and making care accessible through psychiatric consultation for new pregnant women and new mothers, and also ensuring that we can have the wraparound services that are needed through care coordination to make sure that other needs are met, as well.

*Ms. Matsui. Certainly, and thank you for that.

Several of you have spoken about the impact that Mental Health First Aid continues to have in early intervention and suicide prevention. Mental Health First Aid is an incredible tool, and I am very proud to see how this program has grown to train youth, teens, and adults about mental health and substance use issues in schools, workplaces, and communities nationwide.

As children return to classrooms, schools are playing a big role in addressing the toll the pandemic has taken on

youth mental health. Dr. Chung, do you agree that skills taught in mental health first aid training will help create greater opportunities for teachers and other school workers to engage with kids facing emotional challenges?

*Dr. Chung. Thank you for this question, a very important one. The awareness of mental health conditions is incredibly critical. We know that children are in various places. They are in schools, in pediatrician offices, at homes, in organizations and clubs. So wherever they are, it is so important that those around them are able to recognize when a child is in distress.

And so Mental Health First Aid is one of the such programs. And I think that it is really important that we continue to look at creative solutions to increase awareness and reduce the stigma of mental health.

*Ms. Matsui. Thank you.

The uncertainty and instability brought on by COVID pandemic has negative effects on many people's mental health, and created new barriers for people already suffering from mental illness and substance use disorders. Dr. Adelsheim, can you expand on some of the challenges that come with identifying -- in this particular case I am talking about eating disorders. What resources provided by the National Center of Excellence for Eating Disorders help to address these issues?

*Dr. Adelsheim. Ms. Matsui, first let me just thank you for your long-term commitment to addressing these issues.

I would quickly say that, as we have been working to be developing early intervention models, one of the things we are finding is increasing numbers of young people and families that are coming in to get support for their children's eating disorders. And we see a huge need to expand the prioritization and support for these critical programs.

*Ms. Matsui. Right, thank you very much. I know it is important that we advance the Anna Westin Legacy Act to support the center's essential work to promote screening and intervention and treatment.

So I thank you very much, and I yield back.

*Ms. Eshoo. So lovely. The gentlewoman yields back. Let's see, who do we have next?

The gentleman from Maryland, Mr. Sarbanes, is recognized for five minutes for questions.

*Mr. Sarbanes. Thank you very much, Madam Chair. I want to thank our panelists here today.

And Dr. Chung, let me go straight to you. You noted in your testimony that you and the American Academy of Pediatrics support the legislation my colleagues and I have introduced, H.R. 7248, which extends the authorization for two SAMHSA programs, one supporting early intervention

services for children, and the other addressing substance use disorder treatment needs for youth.

Could you speak specifically of the needs the [inaudible] community mental health services for children with serious emotional disturbances program seeks to meet [inaudible] perspective, and what types of needs are we talking about for children with serious emotional disturbances?

*Dr. Chung. Thank you for that question. We know that, with children, that they present on a continuum, that mental health illnesses start mostly -- half before the age of 14. And when they present, they do not always present yet with a diagnosis. And so, as they progress along that continuum perhaps, it is important that, with early intervention and promotion and prevention services that we intervene early. We know with children that, when we do something early in their lives, that we can have a lifetime of impact for them. And so it is so critical that we do work early.

And we thank you for all the work that you are doing in this space. We appreciate it.

*Mr. Sarbanes. Thank you. Shifting briefly to the other program, which would be reauthorized by H.R. [inaudible] Youth and Family Tree program, are there particular needs there of children and adolescents when it comes to treating substance use disorders and offering

support not only for the children, but for their families as well?

*Dr. Chung. Yes, thank you for that question. And adolescents especially are particularly vulnerable to substance use disorder. And so having programs like that are incredibly important in order to intervene early, before they become further along the substance use disorder spectrum and get to the point of crisis.

So absolutely, we continue to need more services in our communities.

*Mr. Sarbanes. I appreciate that. I would like to shift topics a little bit to the question of mental health parity.

Dr. Brendel, you described in your testimony the Department's recently [inaudible] found insurance companies are falling short of providing [inaudible] mental health and substance use disorder benefits. And the Department's report documented numerous parity violations. A recent report by the GAO also found that insurance companies have more restrictive coverage limitations on mental health services than they do for medical services.

It is really unacceptable, after all the work that has been done and all the focus that has been brought to bear, that even today mental health services are being covered at far lower levels than general medical care, and insurance

companies continue to limit consumers' access to mental health services.

It is also unacceptable that, for too long, frontline workers, including our teachers, police officers, firefighters, and others, have lacked access to coverage for the treatment they need for mental health services due to loopholes in current law that allows self-funded state and local plans to opt out of mental health parity.

Dr. Brendel, can you briefly discuss why mental health parity is so essential for frontline workers, particularly in light of COVID-19 and what we have seen?

*Dr. Brendel. Thank you for your question. The -- as you know, the APA supports both closing loopholes for self-funded local governmental programs, as well as full parity enforcement, and thanks this committee for its work in -- to that end.

Frontline workers were really affected at every stage of this pandemic, both in terms of responding to public need, being at risk themselves, and then often times being funded by these plans with loopholes that do not allow them to seek mental health care and receive coverage for the conditions that they are -- they have as a result of their work, due to these exclusions.

There is no health without mental health. We know that individuals -- there are high rates of depression and anxiety

in this country that exceed levels pre-pandemic. We also know that individuals who have pre-existing health conditions fare worse, both in terms of medical outcomes and mental health outcomes, when there is no parity. Parity is something that we need to effect, and effect immediately.

*Mr. Sarbanes. Thank you very much. And I will just note that the Mental Health Justice and Parity Act of 2022 would ensure that our nation's frontline workers have comprehensive access to mental health services. And we absolutely have to close this longstanding loophole.

With that, Madam Chair, I yield back.

*Ms. Eshoo. The gentleman yields back. You know, one of the great sources of frustration to me is -- now this was, what, a decade, decade-and-a-half ago when we passed mental health parity? I mean, what a celebration. It was Patrick Kennedy in the House, Senator Domenici, I believe, in the Senate. We were going to address this unfair, dark system, and once and for all. Except it didn't happen. So I think that, you know, that we do have some legislation here that can help address why that hasn't worked.

And the gentleman from California, Mr. Cardenas, you are recognized for five minutes. I think you have legislation that addresses this.

*Mr. Cardenas. Yes, thank you.

*Ms. Eshoo. How is that for a setup? How is that for a

setup?

*Mr. Cardenas. Yes, thank you, Madam Chairwoman. I have been elected at the local level, as well. And there is plenty of reasons why mental health parity hasn't come about in America.

And one of the issues is the lack of commitment at every level. There needs to be buy-in at the local level, at the state level, at the Federal level, with private insurers, et cetera. And then we need to fortify that with the personnel to support them to know that they can have a career in mental health.

So my first question is, Dr. Pinals, thank you for being here today to represent the priorities of the state mental health program directors. I have heard from mental health directors all over the country who anticipate that 988 is not adequately resourced for the expected need when it goes live just this July, and it is coming up fast.

In addition to funding for regional call centers, a specific issue that has been raised in the need for a full continuum of crisis services -- it is not enough to have a phone line to call. Someone also needs to respond and provide a safe place to go. Without this investment, I fear that calls to 988 could lead to increased interaction with police, which sometimes ends up deadly, and higher wait times for already impacted services such as an emergency room.

Would you agree that this is a concern? And how might extending congressional investments of increased Federal assistance for crisis services help alleviate this?

*Dr. Pinals. Yes, thank you for that great question. I would say that it is more than just a phone number to call. We need an entire crisis care continuum of services, as you said, somebody to answer the call, somebody to go and see what is going on with that person when necessary, and then also place for people to go for more intensive services when they need it in community-based settings.

And so that is why NASMHP has and other organizations have been proposing, in part, you know, the mental health block grant set-aside for crisis, for -- you know, to support the crisis continuum, more prevention-based services, and anything, really, that can be lifted up to expand mental health resources for that entire continuum to promote community-based services.

*Mr. Cardenas. Thank you. And I think it is really important that we all understand that what we are talking about when it comes to mental health is public safety, safety for the person in crisis, safety for the agony of the family members watching their family member in crisis, and a community that deserves to have the proper response and the proper services when that occurs.

Another thing we have seen is -- in states across the

country -- is that funding for crisis services is disproportionately funded by Medicaid or general state funding. Provisions in our 998 Implementation Act, led by Ms. Blunt Rochester, would require all insurers, public and private, to cover crisis services.

Do you see this as a parity issue? And how might this requirement benefit residents in Michigan and across the country, Ms. Pinals, Dr. Pinals?

*Dr. Pinals. Yes. Again, thank you for that great question.

You know, I think we need to have all payers on board, because we know that people will access a crisis service, regardless of insurance. And that is the design of those crisis services, just like we have with 911. And so we really do need to think about how to make sure that we have equal access to responses for behavioral health crises, as we do for medical emergencies.

*Mr. Cardenas. Yes, thank you.

And I just want to complement what the chairwoman just said. We are talking about well over a decade, beyond a decade in the United States of America we expected us to have mental health parity. And rationing of services, avoiding care affects mostly low-income families and all peoples of all colors. And that is something that we need to understand, and we need to do a better job of, not just when

it comes to providing funding, but also when it comes to services, and also when it comes to providing the laws with teeth in them to make sure that it plays out on the streets of America, as it should.

Dr. Rebecca Brendel, thanks for being here today. I also want to get your input on parity for mental health and substance use disorders, which translates to so many Americans having severely long wait times or no access at all. Can you comment on why parity enforcement, especially at the state level, is such a pressing issue, and what kind of support might states need in order to actually implement parity sufficiently?

*Dr. Brendel. Right, thank you for highlighting the critical importance of mental health parity. We know there is no health without mental health, and we know that across this country Americans are struggling to get access to mental health care, as well as affordable mental health care.

And so, when benefit administrators are using opaque formulas essentially to make it harder for Americans to access mental health care, that really goes not only against parity, but against the very fundamental nature of what health insurance is supposed to provide to our overall health.

*Mr. Cardenas. Thank you very much. My time has expired.

I yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back. The chair recognizes the gentleman from Florida, Mr. Bilirakis, for your five minutes of questions.

*Mr. Bilirakis. Thank you, Madam Chair. I appreciate it so much.

Dr. Pinals, earlier in the first panel I mentioned how Qualified Residential Treatment Programs, or QRTPs, can play an important role in the continuum of care, but that Medicaid's IMD -- I know you are familiar with the exclusion -- can limit the provision of services, particularly for foster care youth in crisis who may need access.

My bipartisan bill, H.R. 5414, the Ensuring Medicaid Continuity for Children in Foster Care Act, which I lead with Representative Castor -- and I understand it is a bipartisan bill in the Senate, as well, the companion -- it would fix this barrier to care by ensuring QRTPs don't fall under the IMD exclusion, ensuring that foster kids under Medicaid don't get crowded out from certain facilities as a result.

I am disappointed that, despite our requests, this bill was not included in today's hearing. Madam Chair, I hope that we can work that out, and fix the issue for maybe future hearings.

Dr. Pinals, can you talk about the need to support access to all parts of the continuum of care?

And in particular, can you speak to how these types of residential treatment programs can play a role in our mental health system and the need for ensuring there are no arbitrary barriers to care, particularly for our children, please? Thank you.

*Dr. Pinals. Yes. So first of all, thank you for your question and for your interest in children's well-being. You know, these are all very complicated issues, you know, with a lot of fiscal implications.

What I can say, as a clinician, is that what we really have to understand is that children who are removed from homes and are in the child welfare system are at increased risk of trauma, and emotional disturbances, and really need appropriate mental health supports, as do, potentially, the parents from whom the children were removed so that there could potentially be reunification to safe haven and harbors in the natural family setting when that is feasible. And so an entire continuum of care for children and their families is going to be critical in meeting behavioral health needs.

*Mr. Bilirakis. I appreciate it. This question is for Dr. Adelsheim.

A recent CDC survey for almost 8,000 teenagers showed that four out of ten were feeling persistently sad or hopeless. From 2009 to 2021, the rates of teens with poor mental health rose from 26 percent to 44 percent. Sadness

and hopelessness is a significant risk factor, as you know, a risk factor for suicide -- already being the second leading cause of death for youth.

I am concerned that, along with the rising youth mental health concerns, that we will continue to see -- I am concerned that the suicide rate will go up, unfortunately. This is an issue we must address immediately.

I am also incredibly concerned that social media is playing a significant factor to this rise in depression amongst teens, particularly teens -- teen girls in this case. Since 2004, Congress has dedicated significant funds for the Garrett Lee Smith Memorial Act, including funding to states, tribes, and campuses for youth suicide prevention and intervention strategies.

Can you discuss some of the successes of the Garrett Lee Smith programs, and how reauthorizing and expanding -- funding this law can help in the fight? We would appreciate that, thank you.

*Dr. Adelsheim. Thank you, sir, for your question.

So the Garrett Lee Smith programs have been incredibly important in the communities I have worked in, in both New Mexico and California, in terms of being able to reach successfully to rural partners, in terms of building early access to care through linking schools, through linking child psychiatry, back up through building prevention programs for

young people to access early support so that we have early recognition for kids at risk for depression and suicide, and can link them to evidence-based supports in very critical ways. And I am seeing that in multiple rural communities and with Native American-partnered communities, really, throughout the country, as well.

So, I -- you know, we have been grateful to have those programs available, and they continue to be incredibly important. And as you mentioned, with the increasing suicide rates over the previous years, and now increasing suicide risk and attempts, they are more important than ever.

*Mr. Bilirakis. I will yield back.

*Ms. Eshoo. The gentleman's -- the gentleman yields back. The chair is pleased to recognize the gentlewoman from Florida, Ms. Castor, for her five minutes of questions.

Then we will go to -- let me just say this. I would like to complete the questions from both sides with our panelists, and not return after the series of votes. So I am always generous with extra time and that because everything that everyone says, their questions are important. But I don't want to keep the witnesses, okay?

So with that, the gentlewoman from Florida, you have five minutes for your questions, followed by the ranking member of the full committee, followed by Mr. O'Halleran, who is here, and the gentleman from Utah. And then that will be

it. Okay, let's roll.

*Ms. Castor. Great, and thank you, Madam Chair.

*Ms. Eshoo. Yes.

*Ms. Castor. And I will be direct. And thanks to the witnesses for being here.

It has just become more and more apparent that Big Tech platforms and social media is harming our children's health. I have been following very closely the growing body of research that correlates children's social media usage with higher levels of anxiety and depression, self-injury, suicidal ideation, body dissatisfaction, eating disorders, et cetera.

And these platforms are not innocent bystanders. They -- what we have learned in this committee and just looking at what is going on in the world, having two young daughters grow up in this age, it -- you know, they really work to get kids addicted and keep them addicted. And during the COVID, it has become even worse. So I have introduced two pieces of legislation, the Kids Privacy Act and the KIDS Act that will outlaw behavioral advertising directed at children, protect them online, and then the KIDS Act to change the way social media platforms are allowed to interact with kids -- design code, if you will, such as they are working on in the UK and the EU.

So Dr. Chung, for the record today, tell us what role

you think that social media has played in exacerbating children's mental health problems.

*Dr. Chung. Thank you for that question, Representative Castor, and thank you so much for your leadership and work in this space. It is so important.

And so we do know that, with social media, that there are designs in place that are designed for children to continue to use their products. And we do need additional guardrails and restrictions and rules in place to make sure that we are not doing things to further implement things in -- for kids where it may be damaging to a young child in their developmental stages. So thank you so much for your work.

We do know that social media has its roles in certain places, and where they may be able to reach out to their peers, or reach out to groups where they may otherwise be isolated. So it is really important that we advocate for responsible social media, and we really appreciate your leadership in this work.

*Ms. Castor. Good. And I will just ask any of the witnesses on the panel today, until we pass these laws to better protect kids online and have a new design code for children's social media use, what is the best advice that you all have for parents to ensure that their children have a healthy relationship with technology?

*Dr. Chung. So I can start with that. And really, what

the American Academy of Pediatrics, we recommend, is that parents, as much as they are able to, and caregivers, to sit with their child, and to sit with them as they interact with social media so that they can see what is happening and how their child is using social media, and helping them to understand how to do that in a responsible way, and in a healthy way, and using resources like Common Sense Media to really help to determine, you know, as they are interacting with all types of media, how to do that in a way that is appropriate for their child's age.

*Ms. Castor. Thank you, Madam Chair. I will yield back.

*Ms. Eshoo. The gentlewoman yields back. The gentlewoman from Washington State is recognized for five minutes for her questions.

*Mrs. Rodgers. Thank you, Madam Chair.

Dr. Adelsheim, suicide is the second leading cause of death for youth. In the first six months of 2021, children's hospitals nationwide reported a shocking 45 percent increase in the number of youth self-injury and suicide cases compared with the same period in 2019. What are some of the best practices and processes for health professionals and parents when an adolescent is experiencing suicidal ideation?

*Dr. Adelsheim. Thank you for your important question. So what has been very important, I think, first of all, is

for people to learn the warning signs, for families to be having regular conversations at home with their young person to be made aware of risks around depression, around understanding when their child might be struggling with a different issue. So having those conversations is important.

In many of our families it gets difficult sometimes, and young people are often fearful of having those conversations with their parents. So, even as a parent, being able to share your own struggles at different times around mental health with your child makes it not as scary to then have those conversations, as well.

I think, when you are looking at a young person who might be at risk, being able to do important safety and treatment plans is important.

In addition, though, what is also critical is creating the upstream types of support so that young people have comfortable settings where they can raise these issues early, before they have reached the point of a crisis. And so the school health programs, the integrated youth health models that are driven by and for young people that are comfortable and friendly places to get that early help are also urgently needed.

*Mrs. Rodgers. So what is driving it right now? What is driving it in the last two years? What have we missed that is driving these numbers to this shocking level?

*Dr. Adelsheim. I would suggest, you know, we have been having these increases, really, for the last ten or 15 years in terms of youth suicide rates. They have been going up for quite some time. I think, over the last several years, as our families have all faced increasing stress and trauma, as families have suffered losses due to COVID, the grief, the challenges that family are facing personally, economically as well, where young people are also coping with the stress within all of our homes together, have all -- lead to increases in terms of these struggles that our young people, frankly, and our whole families are facing.

*Mrs. Rodgers. Thank you, and I -- it was, it was bad before COVID. The numbers were really shocking then. And it has only been made worse.

Dr. Pinals, I would like to raise an issue with a persistent barrier to care and Medicaid program: the IMD exclusion. I am a mom who has a son with that extra 21st chromosome, and it absolutely has made me more sensitive to the needs of people with disabilities.

The exclusion was created at a time when we didn't have laws like the ADA or the Olmstead U.S. Supreme Court decision to protect the rights of people with disabilities. Today, however, the IMD exclusion is limiting access to care to those who need it most. And so I would like to ask how can we pursue targeted means to lift the IMD exclusion so that we

can protect people with disabilities and other vulnerable communities, while also expanding care, lifesaving care at times, to individuals who need it?

*Dr. Pinals. Yes. So I think the IMD exclusion, as you well said, has such a long and complex history. And I think, given where we are at today with some of our, you know, like you said, the Americans with Disabilities Act and other things, there are, you know, lots of complexities around that question.

I think, again, for me, what I would say is the real importance is to really make sure that we continue to pursue community-based services so that we have an entire continuum of care, so that options are not just, you know, hospitalization or nothing, that we have the continuum of care that will address needs of people, and so that when people need a hospital bed they can access it, but also that they have alternative services that they can go to, and that whatever we do with regard to any of those policy decisions, you know, we don't compromise quality in any way in any setting where people are receiving services.

*Mrs. Rodgers. Well, I greatly appreciate those insights, because I think this is -- I appreciate the sensitivities that people bring to this question. But we also have individuals who need care that aren't getting it. And I appreciate your focus on the community-based care, and

continuing to ensure the quality.

I look forward to having more conversations about this question before the committee, and I yield back, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back. Dr. Schrier of Washington State, you are recognized for five minutes for your questions. And if you can do it in a shorter period of time, so we can end our hearing, we would appreciate it.

*Ms. Schrier. You got it. Thank you. Thank you, Madam Chair. And thank you to the witnesses today.

I am so glad to hear your testimonies today, and would like to specifically thank Dr. Brendel of the American Psychiatric Association; Dr. Chung, the president-elect of my dear American Academy of Pediatrics, for your support of my bill, the Supporting Children's Mental Health Care Access Act.

One of the programs reauthorized in the Supporting Children's Mental Health Care Access Act is the Pediatric Mental Health Care Access Program. And these programs, as I mentioned earlier, give pediatricians quick access to mental and behavioral health specialists for consultation and guidance. And one on-call psychiatrist can advise hundreds of pediatricians. Earlier today I spoke about some of the times I reached out to the PAL, Washington's version of this, for consultation as a community pediatrician, and how incredibly helpful that program has been.

Dr. Chung, it is nice to see you again. In your testimony you discuss this heartbreaking case where a lack of access to mental health care, to a mental health care provider, resulted in a lapse of a teen's medication with deadly results. And in response you set up a pediatric mental health care access program in Virginia called VMAP. And I was wondering if you could talk a little bit about how a pediatrician in Virginia would access a specialist through the Virginia Mental Health Access Program, or VMAP.

*Dr. Chung. Great, thank you so much for that question, Representative Schrier, and thank you so much for your leadership and support of these programs.

And so within VMAP, for example, as a pediatrician, when I am seeing a child I can reach out to a specialist for other systems of care. So if I was worried about the child's heart, for example, I could reach out and speak to a cardiologist right away. However, that does not exist for mental health care.

And so, with these programs, what we have been able to do is set up a statewide phone number so that a pediatrician, family physician, nurse practitioner, PA, anyone in our state who is seeing a child can reach out and call and speak to a child psychiatrist right away. With that support, we can take care of children right in front of us.

We have pediatricians who have told us that otherwise

they would have referred the child to the emergency room, but instead, with VMAP, they don't need to do that. So --

*Ms. Schrier. It has been a really incredible resource. And without the Washington version of that program, kids would have to wait months to see a therapist, a psychiatrist in Washington State, child psychiatrist. They just don't take insurance any more, because there is too much bureaucracy, and because there is such a demand that they don't have to. I mean, it -- mental health care has become inaccessible.

I was wondering if you have any stats to show kind of what patient outcomes have been like. You know, [inaudible] how many kids have seen, or you -- fewer emergency room visits, whatever metrics you use.

*Dr. Chung. Yes, thank you for that great question. And really, what we have seen is that, with this program, we have been able to help families immediately, right when they are at the pediatrician's office, and so that they don't need to necessarily go to a specialist or the emergency room.

What we -- in Virginia, for example, we have trained hundreds of pediatricians. We have reached over a million children in our state. We did an informal survey of our pediatricians who use the line, and over half said that, again, they would referred the child to the emergency room.

We do know that, nationally, over 60 percent of

pediatricians report now that they do screening, and that they also treat behavioral issues in their practices, when, before these programs, they would not have done that.

*Ms. Schrier. It has certainly made us all more comfortable with it. I have very -- just a very short amount of time left, but I just had a curiosity question for you, which was we have talked a lot about the impact of the pandemic on kids. People attribute it to various things, everything from, you know, masks to being out of school to anxiety, uncertainty, different messages coming from different places, and just kind of feeling of lack of control.

I was wondering if you, if anybody has looked at the impact of just [inaudible] anger in our society over the past couple of years has had on kids, because it seems like, with all of the other emotions, that one has just been front and center. And I think parents see that, and kids see that in their parents [inaudible] may be having a profound effect on their behavior and mental health.

*Dr. Chung. Yes, thank you for that question. And absolutely, in our pediatric practice we have seen this.

We know that parents have undergone stressors, and pediatricians absolutely work with [inaudible] --

*Ms. Eshoo. The gentlewoman's time has expired. The chair now recognizes the gentleman from Utah, Mr. Curtis,

followed by Mrs. Fletcher, followed by Mr. O'Halleran. And that is going to be it.

*Mr. Curtis. Thank you, Madam Chair. I will be quick. And you and I often find ourselves in this position. It seems to be our lot.

The SAMHSA reauthorization is very important, and it has been delightful today to begin this conversation in the morning and continue it this afternoon.

I would like to preface my comments with this note: Utah has the highest birth rate of -- by percentage of any state. As a matter of fact, in my district I have the highest per capita birth rate hospital in the United States.

We are all very aware that children are experiencing high levels of mental health distress, and we have an adolescent mental health crisis, I think, on our hands. I believe it is important to recognize that -- the maternal connection to all of this. There are many mothers suffering themselves with mental and behavioral health concerns. My district in Utah has the highest percentage of expectant mothers suffering from substance abuse disorder.

Dr. Adelsheim, increasingly, researchers define maternal depression or substance use as an infant's first adverse childhood experience. According to the CDC, adverse childhood experiences can have a tremendous impact on a child's future behavioral health.

In addition, experiencing one or more of these as a child is significantly associated with substance use during pregnancy, demonstrating the intergenerational impacts of maternal mental health conditions.

Given the long-term impacts of maternal mental health and substance use disorders on children, how can our health care system better recognize and act on a maternal mental health as a factor in infant and child health?

*Dr. Adelsheim. Thank you for that important question. You know, as has been discussed today, the importance of screening both prenatally and post-natally with mothers is very important. Building out these integrated care models of support and collaborative care ways is also very critical.

In addition, the family visiting programs that have been developed and been implemented over time that allow for support for both pregnant and new moms in terms of building on attachment capacity with their child and the ability to have that early support as needed from outside to ensure that close connection and recognition of needs for additional support are quite critical.

*Mr. Curtis. Thank you.

Dr. Chung, I would like to tee off on the screening topic that he brought up. We know new mothers spend far more time in a newborn's pediatric office than their own physician's office. We know that screening plays such a

vital role in identifying those in need of treatment for mental health concerns.

What role do pediatricians play in screening and referring mothers for maternal mental health?

And what approaches can be taken to be mindful of family dynamics when addressing mental health conditions and substance use disorder?

*Dr. Chung. Great, thank you so much for that important question. And pediatricians absolutely are responsible for screening often for the maternal depression because, as you mentioned, after the baby is born, more often they are in our offices.

And so, when we identify that a mother needs services, we absolutely want to be a part of that process. And we need to be able to have the resources so that we can refer. And so reauthorizing this grant program will be an incredibly important part of that.

*Mr. Curtis. Thank you.

Madam Chair, being aware of the time, I will yield.

*Ms. Eshoo. I thank the gentleman, he yields back. The chair recognizes the gentlewoman from Texas, Mrs. Fletcher, for your questions, followed by Mr. O'Halleran, and then the gavel is coming down. Thank you.

*Mrs. Fletcher. Thank you, Chairwoman Eshoo, and thank you to our witnesses for coming to testify on this important

topic and sharing your personal observations and stories.

Mr. Smith, your story in particular is so important for the Congress and the country, so thank you for your service to us once again.

There is agreement across this committee and this Congress that the United States has a mental health crisis, which, as we have heard throughout today, the pandemic exacerbated. Through the pandemic Americans experienced increased rates of anxiety, depression, and trauma, with approximately four in ten adults reporting symptoms of anxiety or depressive disorder. Recent census data shows, however, that the number of Americans expressing the need for mental health assistance, but who did not receive it, jumped by more than 33 percent over the past year.

So we can and must do more to ensure that Americans can access critical mental health care. That is why I am glad that my legislation, H.R. 5218 the Collaborate in an Orderly and Cohesive Manner, or COCM Act, a bipartisan bill that I introduced with Congresswoman Herrera Beutler, is being considered today.

As a few of our witnesses have discussed today, the collaborative care model is an evidence-based, proven, and effective care delivery model that integrates behavioral health care within the primary care setting. More than 90 published trials in many different settings for both adults

and children have studied the model, and have shown that it improves patient outcomes, lowers total costs of care, reduces stigma related to mental health, and improves health equity.

There is also strong support from dozens of health stakeholders, including the American Psychiatric Association and the American Academy of Pediatrics, both of whom have testified today on this model's merits.

Madam Chair, I request unanimous consent to enter a coalition letter from many of these groups in support of H.R. 5218 into the record.

*Ms. Eshoo. So ordered.

[The information follows:]

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

*Mrs. Fletcher. And just last week, during a Senate Finance Committee hearing, almost all the witnesses discussed the value and effectiveness of the collaborative care model. And Dr. Chung, your discussion with Dr. Schrier, Representative Schrier, just now was so useful in illuminating what these statistics mean to doctors and to patients. So I am going to ask a quick couple of questions.

Dr. Brendel, thank you for your testimony today, as well, for the American Psychiatric Association and its support for this bill. I wanted to have you expand on some of the issues that you raised today in the limited time that we have. You talked about how this model is a population-based and measurement-based approach that helps alleviate the behavioral health workforce shortage.

Can you talk just a little bit about what you mean by population-based and measurement-based, and what makes the collaborative care model different from other integrated behavioral health models?

*Dr. Brendel. Thank you so much for your question, and for your advocacy on behalf of Americans with mental illness.

The difference between the collaborative care model and the way we traditionally see care is that it enables, as others have so clearly spoken about, a single psychiatrist to work alongside a care manager and a primary care doctor to provide consultation that can allow a psychiatrist, rather

than just seeing maybe four or six patients in one or two hours, to be able to provide consultation around as many as 50 or 70 patients in that same amount of time by creating capacity and working within primary care practices.

This is so important, and we know it works. There are more than 90 high-quality, evidence-based studies of the collaborative care model. It expands capacity, and it is measurement-based. We know it is working. And it also elevates the level of screening and prevention, because it is teaching all of us how to use validated measures to assess for mental health symptoms at the point of care that people go into, reduce the stigma of having to make a separate mental health appointment. It happens at the point of service with primary care physicians, with pediatricians, with obstetrician gynecologists. And then it also allows cost savings.

So it is really a model that has all -- that has everything, and can be implemented very quickly with the existing workforce.

*Mrs. Fletcher. Well, thank you so much, Dr. Brendel.

And in the interest of time, Madam Chair, I will submit the remainder of my questions for the record.

[The information follows:]

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

*Mrs. Fletcher. And I yield [inaudible].

*Ms. Eshoo. Music to my ears, the gentlewoman yields back. And last, but not least, the gentleman from Arizona who is waiving on to our subcommittee today, Mr. O'Halleran, you have five minutes. Lovely to have you with us.

*Mr. O'Halleran. Thank you, Madam Chair, and I appreciate your allowing me to waive on. This is a critical issue for our country.

I would also like to thank the witnesses for their testimony today, and participation.

SAMHSA and HRSA have provided critical support to our frontline health providers who are working with those struggling with substance abuse and mental health disorder. The overdose deaths in Arizona continue to -- on record highs in 2020. Arizona saw 2,550 overdose deaths, a 28.5 percent increase compared to the previous year. This continues to have real-world impacts on children and families, as we have seen a similar increase in domestic violence incidents, particularly in rural and tribal communities. These communities need our support.

I am going to a real-life issue right now, because I have seen it. As a police officer in major -- and a homicide detective in a major metropolitan area in America, I have been there as I have watched, sadly, people pass away from suicide and overdose time and time again -- in most

instances, with friends and family by their sides. And the trauma and what it does in tearing apart families throughout America as this occurs, this is something that just has to be addressed. It is just tearing our families apart, and it shatters the whole process. And we get further involvement in mental health issues from that, and substance abuse issues from that.

And I have also been there as my fellow police officers have committed suicide, and dealt with those cases, and our veterans, and the trauma that we are seeing veterans' families go through. And yet we still are sending people back into the environments where they came from to try to deal with their issues without the support base that they need today to be able to address those issues.

This is why I, and along with my friend, Congresswoman Spanberger, Congresswoman Salazar, and Congressman Armstrong included the Summer Barrow Prevention, Treatment, and Recovery Act. This bipartisan legislation authorizes -- or reauthorizes and improves upon the number of critical programs funded, supports for doctors, support for residential services, support for pharmacies' access to overdose medication.

And I think, after having seen what I have seen, I have seen way too much death in my life. And what I have seen -- you have seen the aftereffects, probably, of those families

that have been traumatized. But when you are there and see this firsthand, day after day, time after time, decade after decade that is occurring in our country, you understand why the chairwoman wants to address things in a comprehensive way. Let's move to get this resolved in a collaborative process here in this committee. I appreciate the hearing, and I look forward to working with the chairwoman and the ranking member on that comprehensive approach.

Dr. Price, thank you for your testimony and participation in today's hearing. Rural and tribal communities have some of the highest level of opiate, drug, and alcohol dependency in the nation. When working with community leaders, can you explain -- expand upon what programs have you found to be the most successful in supporting rural and tribal communities?

And what must Congress do to improve these programs to ensure that they have as broad of a reach as possible?

And I know funding is going to be one of those issues. Thank you.

*Ms. Price. And just to clarify, sir, are you speaking around opiates or all substance use disorders?

*Mr. O'Halleran. All of the above. They are all --

*Ms. Price. All of the above. Well, I mean, there are many evidence-based practices, medication-assisted treatment related to alcohol use disorder, as well as opioid use

disorder.

You have mentioned a lot about suicide and trauma. We have trauma informed care. That is very critical.

We also have, at least in Georgia, we have Apex, which is 700 schools we are involved in, to help do that screening and treatment of children who have mental health issues.

We have 15 clubhouse programs for youth and nine clubhouse programs related to recovery support for addiction.

And then we have 26 addiction recovery support centers.

So I think, you know, those are Georgia-specific. But I think, as far as NASADAD, [inaudible] best practices to show the best outcomes to treat individuals, family members, and we also really support certified --

*Mr. O'Halleran. Doctor --

*Ms. Price. -- [inaudible] specialists --

*Mr. O'Halleran. -- [inaudible] here, thank you very much. I appreciate it.

[Laughter.]

*Ms. Price. Okay, thank you.

*Ms. Eshoo. Thank you. It kind of kills me to do that, but we need to get over to the Capitol to vote. None of us want to miss the vote. I -- we thank the gentleman for being here, and for your magnificent expression and commitment on this issue.

I want to thank each one of the witnesses on behalf of

all of the members of the subcommittee, and all of the staff of the subcommittee, as well. You are so highly instructive to us, and this is the largest number of witnesses, I think, that we have had so far. And thank you, thank you for those that are here in person, but to each one of you.

I want to say to Mr. Smith -- and I didn't earlier -- in the last sentence of your written testimony you said in closing, "I would like to say by no means am I a finished product.'' Well, Mr. Smith, none of us are. But I think, together, given the testimony, given the legislative ideas that have been put forward on a bipartisan basis here, that this is about improving and thriving, a better life for all Americans.

We realize the fullness of this -- of these legislative efforts. I have no doubt that there will be a very, very grateful nation, and a healthier one. So all of not only my thanks, but on behalf of the subcommittee, our fullest gratitude to you.

Now I have a unanimous consent request for the 27 documents.

*Mr. Guthrie. No objection.

*Ms. Eshoo. Without objection, we will enter these into the record.

[The information follows:]

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

*Ms. Eshoo. I had them review them before I asked --

*Mr. Guthrie. Okay.

*Ms. Eshoo. -- so we could do this.

So with that, my thanks to the subcommittee staff, to the able Aisling McDonough.

The subcommittee is adjourned.

[Whereupon, at 3:06 p.m., the subcommittee was adjourned.]