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On Behalf of the

American Psychiatric Association

Given On

April 5, 2022

Submitted to the

U.S. House of Representatives Energy and Commerce Committee

HEALTH SUBCOMMITTEE HEARING:

Communities in Need:

Legislation to Support Mental Health and Well-Being

Chair Eshoo and Ranking Member Guthrie, on behalf of the American Psychiatric Association (APA), the national medical specialty association representing over 37,000 psychiatric physicians, I want to thank you for conducting the hearing today entitled, *"Communities in Need: Legislation to Support Mental Health and Well-Being."* The APA appreciates the Committee's continued work on mental health and substance use disorder legislation that will ultimately help save lives. I would also like to thank you for the opportunity to testify on behalf of the APA. My name is Rebecca W. Brendel, MD, JD, and I am the APA's President-Elect and the director of the Master's Degree Program at the Harvard Medical School Center for Bioethics, where I am also an associate director. 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. Sadly, it is a crisis that shows no signs of abating. As the pandemic continues to exacerbate mental health conditions, including substance use disorders (MH/SUD), the consequences are plain to see: rising rates of suicide, record overdose deaths, and increased depression and anxiety across nearly all ages and demographics. Even beyond these sobering statistics, COVID-19 has impacted almost every single aspect of our lives, from job security to health equity, health outcomes, and beyond. Indeed, this is a crisis which has impacted not just individuals, or families, but entire communities.

Fortunately, there are many policies which Congress can promote to strengthen communities in need, both now, and into the future. These policies include but are not limited to incentivizing the integration of behavioral healthcare into primary care, bolstering the MH/SUD workforce, promoting stronger enforcement and better implementation of the parity law, addressing health equity, increasing access to telehealth, expanding crisis care services, and improving psychiatric bed supply. Championing evidence-based policies that ensure that every American and every community receive the MH/SUD care that they need will save lives, improve overall health outcomes, and reduce overall health costs. I will detail these policy proposals throughout my testimony below.

Reauthorization of Mental Health and SUD Programs

The APA is encouraged by this Committee's focus on reauthorizations for MH/SUD programs that currently fall under the Public Health Service Act. It is important that most of these reauthorizations occur at a level that addresses the years of neglect in funding for public mental health programs. Sustained increases across the board for MH/SUD programs, especially given the significant MH/SUD challenges communities and patients are experiencing across the country, is the only way that we will reach every patient who needs help. The APA is grateful for recent Congressional efforts to boost funding for many of these programs, however, funding levels have not having kept pace with the need.

For example, the APA supports reauthorizing the **Community Mental Health Services Block Grant (MHBG) (42 U.S.C. §300x-9)**, funding that is distributed by formula to help states establish new or supplement existing state-based MH service activities. H.R. 7241, the **Community Mental Health Services Block Grant Reauthorization Act** introduced by Reps Crenshaw (R-TX), Butterfield (D-NC), Garcia (R-CA) and Luria (D-VA), proposes a 5-year reauthorization that would fund the block grant at FY22 enacted levels. However, it is important to note that last year appropriators proposed doubling that amount to correspond to the need, but ultimately took only a step in that direction with a \$78 million increase. The Biden Administration's recently proposed budget also proposed a substantial funding increase for the block grant, but ultimately took only a step in that direction with a \$78 million increase. As Congress considers the long-term reauthorization of the MHBG, the APA recommends that the program authorization be significantly increased and that the authorization for the crisis services set-aside be increased from 5% to 10%. The APA also supports a more significant increase in the authorization for the **Substance Use Prevention, Treatment, and Recovery Services Block Grant** than what has been proposed in H.R. 7235.

Similarly, the APA supports increasing the reauthorizations for the **Encouraging Innovation and Evidence-Based Programs within the National Mental Health and Substance Use Policy Laboratory (42 U.S.C. §290aa-0)**, which is the focus of H.R. 7237 and the **Reauthorizing Evidence-based and Crisis Help Initiatives Needed to Generate Improved Mental Health Outcomes for Patients Act of 2022**, otherwise called the **REACHING Improved Mental Health Outcomes for Patients Act of 2022**, introduced by Reps Griffith (R-VA), Tenney (R-NY), Davids (D-KS) and Craig (D-MN). The policy laboratory at the Substance Use Disorder and Mental Health Services Administration (SAMHSA) ensures that providers, administrators and others implementing mental health and substance use disorder programs have access to best practices that have been rigorously evaluated and proven in real-world settings to improve patient outcomes across the prevention, treatment and recovery continuum.

The **Priority Mental Health Needs of Regional and National Significance (42 U.S.C. §290bb32)** program reauthorized by the bill allows SAMHSA flexibility to address emerging needs and changing trends related to mental health and is vital to addressing mental illness across a patient's lifespan. The **Assisted Outpatient Treatment (42 U.S.C. §290aa)** program has been shown effective in ensuring that patients get care in states that have Assisted Outpatient Treatment laws. However, as Congress considers the AOT reauthorization proposed in H.R. 7237, the APA recommends examining outcomes with regard to implementation, utilization and equity, and that this program be coordinated with SAMHSA's Center of Excellence for SMI – SMI Advisor.

In addition to the programs H.R. 7237 proposes to reauthorize, the APA supports the reauthorization of the **Grants for Jail Diversion Programs (42 U.S.C. §290bb-38)** as this program promotes and educates drug courts through SAMHSA to ensure that patients receive resources on all FDA-approved medications for opioid use disorders and other treatments available for their individual SUD needs. Furthermore, as Congress works on reauthorizing **Development and Dissemination of Model Training Programs under the Health Insurance Portability and**

Accountability Act (42 U.S.C §1320d-2), the APA recommends that the Department of Health and Human Services continue to educate clinicians about changes to privacy laws, and also to consider how they interact with regulatory changes to improve interoperability and prevent information blocking.

The APA also supports the reauthorization of the **Promoting Integration of Primary Care and Behavioral Health (42 U.S.C. §290bb-42)** program. Though the APA supports this program, we encourage Congress to strengthen it by pushing awardees of these grants to move towards models of integration that are population-focused, evidence-based, and measurement-based to show improvement in patients' medical and behavioral health incomes. The APA is also pleased to support **H.R. 7076, the Supporting Children's Mental Health Care Access Act**, introduced by Reps. Schrier (D-WA) and Miller-Meeks (R-IA), which reauthorizes both the Pediatric Mental Health Care Access Grant and the Infant and Early Childhood Mental Health Promotion, Intervention and Training Grant. These grant programs support the integration of behavioral health into pediatric primary care and support human services agency and nonprofit infant and early childhood mental health promotion, intervention and treatment programs, all of which are essential to the health of our nation's children.

Finally, the APA supports H.R. 7249, the **Anna Westin Legacy Act of 2022**, as introduced by Reps. Matsui (D-CA), McKinley (R-WV), Deutch (D-FL) and Van Drew (R-NJ) and H.R. 7255, **the Garrett Lee Smith Memorial Reauthorization Act**, as introduced by Reps. McMorris Rodgers (R-WA), Trahan (D-MA), Axne (D-IA) and Kim (R-CA). H.R. 7249 would reauthorize the Center of Excellence for Eating Disorders through 2027. The Center of Excellence for Eating Disorders is vital to the proliferation of training and education of clinicians in how to appropriately recognize, screen, diagnose and treat eating disorders. H.R. 7255 would reauthorize the Suicide Prevention Resource Center, the Garrett Lee Smith State and Tribal Youth Suicide Prevention and Early Intervention Grant Program, the Garrett Lee Smith Campus Suicide Prevention Program and authorize funding for suicide prevention through mental and behavioral health outreach and education programs.

Integrating Behavioral Health & Primary Care

Long term investments in our behavioral health care workforce are much needed and overdue, but as we continue to grapple with the dual epidemics of mental health and substance use disorder, action is also needed to ensure access for those currently in need. One of the more promising near-term solutions can be found in the promotion of population-focused, and evidence-based, integrated care models. The Collaborative Care Model (CoCM) in particular, has proven adept in providing prevention, early intervention, and timely treatment of mental illness and SUDs. Many individuals first display symptoms of a MH/SUD in the primary care setting but do not receive the necessary follow-up treatment. Often, they have difficulty finding a mental health clinician or avoid seeking treatment due to the stigma that still exists around MH/SUDs. CoCM provides a strong building block to address these problems by ensuring that patients can receive timely behavioral health treatment within the office of their primary care physician.

The CoCM integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and a care manager working together in a coordinated fashion. Importantly, the team members use measurement-based care to ensure that patients are improving, and treatment is adjusted when they are not. The CoCM is supported by more than 90 statistically validated studies to show its effectiveness, but has demonstrated a particular and significant utility in treating depression, where patients have seen a fifty percent decline in symptoms. In addition to demonstrated clinical efficacy, the CoCM's population-based approach helps to alleviate the psychiatric workforce shortage by leveraging the expertise of the psychiatric consultant to provide treatment recommendations for a panel of 50-60 patients in as little as 1-2 hours per week. All of these features function to prevent downstream emergency room visits or hospitalizations, and ultimately, reduce costs to our healthcare system.

The CoCM is currently being implemented in many large health care systems and practices, and is also reimbursed by Medicare, most private insurers, and numerous state Medicaid programs. Despite its strong evidence base and availability of reimbursement, uptake of the Collaborative Care Model by primary care physicians and practices remains low due to the up-front costs associated with implementing the model. As a result, the APA strongly encourages the Committee to support ***H.R. 5218, the Collaborate in a Cohesive and Orderly Manner Act***. This important legislation, introduced by Reps. Fletcher (D-TX) and Herrera Beutler (R-WA), would expand access to high-quality behavioral health care by providing grants to primary care practices to cover start-up costs and by establishing technical assistance centers to provide support as practices implement the model. Additionally, the bill authorizes funding for research grants to identify additional evidence-based models of integrated care. H.R. 5218 is supported by a diverse group of 42 national stakeholders including members of the mental health community, every major primary care physician association, patient advocates, employers and payors.

In addition to adopting proven models like CoCM, which seek to leverage existing resources, the APA likewise supports additional evidence-based care that aims to improve outcomes and reduce strain on our stressed behavioral health workforce. In particular, research has shown that evidence-based peer support services reduce recurrent psychiatric hospitalization for patients at risk of readmission, and that these services also improve individuals' relationship with their health care providers, therefore reducing outpatient visits. The APA is thus supportive of ***H.R. 2929 the Virtual Peer Support Act of 2021***, introduced by Reps. Lee (D-NV) and Upton (R-MI), which would boost the capacity and accessibility of behavioral health support programs by creating a grant program to support and enable eligible local, tribal, and national organizations who currently offer behavioral health support services to transition to online platforms or to build out their current online capacity to meet increased need due to the COVID-19 pandemic.

Finally, a robust and diverse mental health workforce is essential to ensure that children have timely access to high-quality, developmentally- and culturally-appropriate care. Shortages in the mental health workforce are especially acute within pediatric specialties, and are projected

to increase over time. A 2018 report from the U.S. Health Resources and Services Administration called “Behavioral Health Workforce Projections, 2016-2030” used a mathematical model to find that there was a 20 percent greater demand for pediatric psychiatry services than the current supply. To address barriers to entry into these critical professions and to recruit a more diverse workforce, the APA supports workforce development in a wide array of pediatric mental health fields where shortages persist, and accordingly supports **H.R. 4944, the Helping Kids Cope Act**. Introduced by Reps. Blunt Rochester (D-DE) and Fitzpatrick (R-PA), this much needed legislation would provide grant funding in support of pediatric behavioral health care integration and coordination. The legislation also supports recruitment and retention of community health workers and expands evidence-based and integrated models of care for pediatric, mental, emotional and behavioral health care services. Finally, the legislation supports pediatric behavioral health workforce training for child and adolescent psychiatrists, psychiatric nurses, psychologists, APRNs, family therapists, social workers, and other practitioners.

Reducing Health Disparities and Improving Health Equity

The APA is encouraged by the Committee’s ongoing efforts to address social determinants of health and to reduce health disparities by prioritizing policies and funding programs to advance access to evidence based and culturally-competent care. The APA supports the reauthorization and increased authorization of appropriations to \$25 million per year for SAMHSA’s **Minority Fellowship Program (42 U.S.C. §290II)**. This program improves behavioral health care outcomes for racial and ethnic minority populations by growing the number of racial and ethnic minorities in the nation’s behavioral health workforce. The APA is honored to be a part of this program and each year we, along with our MH/SUD clinician colleagues take part in the program train hundreds of psychiatrists and non-physician MH/SUD workers through this program.

In addition to the Minority Fellowship Program, the APA is pleased to support the ***Into the Light for Maternal Mental Health Substance Use Disorders Act of 2022, H.R. 7073***, introduced by Reps. Clark (D-MA), Herrera Beutler (R-WA), Burgess (R-TX), Clarke (D-NY), Matsui (D-CA) and Kim (R-CA). This bill reauthorizes and expands the U.S. Health Resources and Services Administration’s Screening and Treatment for Maternal Mental Health program and authorizes the recently created maternal mental health hotline. H.R. 7073 is vital in ensuring that pregnant and post-partum individuals, especially those who come from communities with high maternal mortality and maternal morbidity, are screened early and treated appropriately for MH/SUD conditions during and after pregnancy. Further, the APA supports **H.R. 4251, the Native Behavioral Health Access Improvement Act of 2021**, as introduced by Chairman Pallone (D-NJ) and Rep. Ruiz (D-CA). This legislation provides funds through the Indian Health Service to tribal health programs for the prevention and treatment of MH/SUD conditions, which is vital given the high prevalence of MH/SUD conditions amongst tribal members when compared to the general population.

Though reauthorization of these health equity-related programs is encouraging, the APA continues to be concerned about social determinants of health as they are among the most significant contributors to negative health outcomes and overall health inequity. As such, the

APA is pleased to support ***HR 2376 – Excellence in Recovery Housing Act*** as introduced by Reps. Trone (D-MD), Chu (D-CA), Levin (D-CA) and McKinley (R-WV) which would require SAMHSA to promote high quality recovery housing for individuals with SUDs. Although legislation noticed for today’s hearing is a good start, the APA encourages the Committee to continue to focus further on policies that **(1) increase the culturally competent workforce of mental health and substance use disorder practitioners, (2) increase the availability of culturally competent resources for practitioners and states to help them meet unmet mental health and substance use disorder screening and treatment needs in hard to reach populations, (3) work to reduce discrimination and bias in the screening and treatment of minority patients, (4) increase access to culturally competent and inclusive maternal prenatal, delivery and post-partum care to help reduce maternal mortality and severe maternal morbidity, and (5) increase resources for public health campaigns that use evidence-based practices to reduce mental health and substance use disorder stigma, encourage community support such as housing assistance, and dispel population distrust in the medical profession, specifically mental health professionals.**

Implementing, Strengthening and Enforcing MH/SUD Parity

Passed by Congress in 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires that insurance coverage for MH/SUD services be no more restrictive than coverage for other medical care. We thank the committee for playing a central role in the important changes to the law that were included in the December 2020 Consolidated Appropriations Act. These changes strengthened MHPAEA by requiring insurance plans and insurers to demonstrate their compliance with the parity law, including codifying key guidance developed by the Department of Labor (DOL).

However, the report issued on January 25, 2022 by DOL, Health and Human Services and Treasury, found numerous parity violations potentially affecting millions of beneficiaries. In addition, a report issued last week by the Government Accountability Office found that consumers experience myriad challenges in accessing mental health services because their insurance coverage is not in compliance with parity law. Both of these reports validate concerns that insurance plans and insurers are still not compliant with the federal parity law and that more transparency and accountability are needed. In addition, I would like to stress that insurers were given thorough and detailed guidance about how to demonstrate compliance with the law beginning in 2018 and continuing through 2021, yet according to both reports, they still failed to produce adequate compliance materials to federal regulators and failed to provide coverage for essential MH/SUD services that patients so desperately need. **The APA encourages the Committee and Congress to support policies that would bring insurers into compliance with MHPAEA immediately.** It is also crucial that federal and state agencies receive the resources necessary to enforce the law and hold insurance plans and issuers accountable when they are not in compliance. The recent Biden Administration FY2023 Budget Request echoes the need for resources by requesting funding for both the federal government and states to enforce mental health parity requirements. As such, the APA encourages this Committee to support legislation such as ***H.R. 7232, the 9-8-8 and Parity Assistance Act of 2022*** introduced by Reps. Cardenas (D-CA) and Fitzpatrick (R-PA) which would authorize grant funding to state insurance departments to help them implement and enforce the parity

law. Additionally, Congress needs to close the loophole that allows non-federal governmental health plans to opt-out of MHPAEA. To this end, the APA encourages the Committee to support legislation that prohibits these non-federal governmental health plans from opting out of coverage requirements, as H.R. 7254, the ***Mental Health Justice and Parity Act of 2022***, introduced by Reps. Porter (D-CA) and Dingell (D-MI).

Further, in light of the recent reversal by the Ninth Circuit of the February 2019 decision of the U.S District Court for the Northern District of California in *Wit v. United Behavioral Health*, **Congress should take actions like those taken by the states of California, Oregon and Illinois, to prevent insurers from adopting restrictive internal guidelines for making medical necessity determinations and level of care placements that are contrary to generally accepted standards of care.** *Wit*, while not technically a parity decision, is certainly related. Congress should enact legislation for ERISA plans as well as for Medicare and Medicaid, that is analogous to what these states have done. While states such as Oregon, California, and Illinois have codified important medical necessity standards, most Americans are covered by ERISA plans that operate beyond state jurisdiction. Only an act of Congress can ensure that all patients with MH/SUD are guaranteed fair and equitable coverage for MH/SUD services and that federally regulated plans are held accountable to parity law.

Finally, it is important to note that Medicare beneficiaries are not protected by MHPAEA. That means that many of those with the most severe mental illnesses do not receive the MH/SUD care that they need. **The APA, along with our colleagues at the National Council for Mental Wellbeing, the National Association for Behavioral Healthcare and the American Society of Addiction have developed a legislative proposal to apply parity requirements to Medicare.**

Last week, the Biden Administration also stressed that parity protections should be applied to Medicare through its FY2023 Budget Request. Not only is the lack of Medicare parity protections a major shortcoming that harms those 65 and older, but it is also a serious barrier for the nine million Americans who have Medicare coverage because of their disability status. Also in the Biden budget request, the Administration also revised Medicare criteria for psychiatric hospital terminations by eliminating the 190 day lifetime limit on these services.

Maintaining Access to MH/SUD Services via Telehealth

Though not an explicit focus for this hearing, I want to express our thanks to Congress and this Committee for the recent passage of legislation through the 2022 Omnibus that extended telehealth flexibilities allowed under the COVID-19 public health emergency (PHE) five months beyond the PHE's expiration. This included audio-only services and a delay in the six-month in-person requirement for mental health services. Prior to COVID-19, substance use disorders and co-occurring mental health services were exempt from geographic and site of service restrictions under Medicare, but mental health treatment services alone were not. At the end of 2020, Congress took an important step forward by permanently waiving these restrictions for mental health. However, Congress also included a 6-month, in-person requirement for mental health services via telehealth, which is not required for other services. This requirement is discriminatory as there are no other services that have such a requirement, and it also doesn't

align with current requirements for substance use disorders and co-occurring telemental health services. The APA strongly supports permanently removing the six-month, in-person requirement, which is unnecessary and is a barrier to a clinician's clinical judgment of when to treat a patient in-person.

988 Implementation, Crisis Services and Psychiatric Beds

I would also like to thank the Committee for its past support of the *National Suicide Hotline Designation Act of 2019*, the passage of which enabled the forthcoming launch of the new three-digit number (988) for suicide prevention. The July launch of 988 represents an important first step in reimagining crisis response, but significant unfinished work remains to ensure that those calling 988 receive the response they need and deserve. Unfortunately, most communities presently have limited or no options when it comes to services that support someone in a behavioral health crisis. Law enforcement and hospital emergency departments often function as the de-facto response, placing a strain on these systems and delaying mental health treatment for those in need. Too often, there is a lack of a continuum of care and patients with mental illnesses often end up boarding in emergency departments (ERs). Due to a lack of crisis beds, these patients are typically discharged from the ER prematurely, without receiving the care they need, resulting in readmissions at best and further crisis and even completed suicide at worst. To fully support the mission of 988, critical investments are needed in our national crisis support infrastructure. APA thus encourages the Committee to support **H.R. 7232, the 9-8-8 and Parity Assistance Act of 2022** introduced by **Reps. Cardenas (D-CA) and Fitzpatrick (R-PA)**. With the new crisis line set to go live in a few short months, this legislation would authorize \$1 billion for Health Resources and Services Administration Capital Development Grants. This legislation includes specific language broadening eligible uses to include crisis receiving and stabilization programs as well as call centers. Importantly, recipients of these grants would be required to demonstrate working relationships with local Certified Community Behavioral Health Clinic (CCBHCs) and other local mental health and substance use care providers.

In closing, I thank you for your attention to the mental health needs of our patients across the country. I am encouraged by the bipartisan, bicameral support we're seeing from Congress and in particular this Committee with regards to addressing our most pressing mental health and substance use disorder needs. Finally, I thank you for extending me the opportunity to testify on behalf of the American Psychiatric Association before you here today and look forward to both hearing my colleagues on the panel testify and to answering each of your questions.

American Academy of Pediatrics

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Testimony of Sandy Chung, MD, FAAP

President-Elect, American Academy of Pediatrics

On Behalf of the American Academy of Pediatrics

Before the U.S. House of Representatives

Committee on Energy and Commerce

“Communities in Need: Legislation to Support Mental Health and Well-Being”

April 5, 2022

Chairwoman Eshoo and Ranking Member Guthrie, thank you for the opportunity to testify here today. I am Dr Sandy Chung, President-Elect of the American Academy of Pediatrics. I am President of Fairfax Pediatric Associates, and the CEO of Trusted Doctors, a pediatric group with over 120 clinicians in 22 locations in northern Virginia and Maryland. I am the founder and medical director of the Virginia Mental Health Access Program and serve as medical director of informatics for the Pediatric Health Network at Children's National Hospital in Washington, D.C. I also serve as a clinical assistant professor at Georgetown University School of Medicine and associate professor at Virginia Commonwealth University School of Medicine and University of Virginia. On behalf of the AAP, a non-profit professional organization of 67,000 primary care and subspecialty pediatricians, thank you for inviting me to be here today.

The COVID-19 pandemic has had a profound effect on the emotional and behavioral health needs of children, adolescents, and families. There are many factors unique to this pandemic (e.g., duration of the crisis, rapidly changing and conflicting messages, need for quarantine and physical isolation, and uncertainty about the future) that have increased its effects on emotional and behavioral health. Groups with a higher baseline risk, such as populations of color, communities and families living in poverty, historically under resourced communities, children who are refugees or seeking asylum, children and youth with special health care needs, and children involved with the child welfare and juvenile justice systems, may be especially vulnerable to these effects. The impact of the pandemic is also compounded by the interruption in vital supports and services including school, health care services, and other community supports.

Emotional and behavioral health challenges were at a crisis point before the COVID-19 pandemic, and the public health emergency has acutely exacerbated these challenges. The pandemic highlights preexisting disparities in morbidity and mortality, access to health care, quality education, affordable housing, adequate nutrition, and safe environments, which create more challenges and stressors for many families and communities. Already high rates of anxiety, depression, and post-traumatic symptoms among children grew even faster during the pandemic, especially among young people of color.

Suicide is the second leading cause of death of youth ages 10-24 in the U.S. and rates have been rising for decades.ⁱⁱⁱ Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24% for children ages 5-11 and 31% for children ages 12-17.ⁱⁱⁱ The CDC also found a more than 50% increase in suspected suicide attempt Emergency Department (ED) visits among girls ages 12-17 in early 2021 as compared to the same period in 2019.^{iv} Among female adolescents, ED visits for eating disorders doubled during the pandemic, while visits for tic disorders (ie, sudden twitches or repeated movements) tripled.^v Stressors such as social isolation, loss and grief, academic and extracurricular disengagement, interruptions in social/health services, and financial hardships have impacted mental health. At least 10 million youth in the US experienced economic instability during the pandemic, with 14% of families with children reporting food insecurity.^{vi}

More than 140,000 US children and adolescents lost a primary or secondary caregiver to COVID-19, with youth of color disproportionately impacted.^{vii} Loss of a parent or caregiver is a significant trauma and adverse childhood event that can lead to poor long-term health outcomes into adulthood. Special attention must be paid to support these children who face higher risks to their health, safety, and well-being.

Compounding these challenges is our nation's ongoing reckoning with systemic racism and related violence, which disproportionately impacts the mental health, physical well-being, and trajectory of educational

achievement for children and adolescents from Black, Latinx, American Indian/Alaska Native, and Asian American/Pacific Islander communities.^{viii} These ongoing stressors have the potential to impact children's development and resilience for years to come.

In light of the mental health crisis, the AAP, along with the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association, declared a [National State of Emergency in Children's Mental Health](#) last fall. The challenges facing children and adolescents are so widespread that we are naming the situation exactly what it is, a national emergency for children and adolescents. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment.

Most recently, the AAP and the American Foundation for Suicide Prevention, in collaboration with experts from the National Institute of Mental Health, released the [Blueprint for Youth Suicide Prevention](#)—an educational resource to support clinicians in identifying strategies to support youth at risk for suicide. The blueprint represents the first major interdisciplinary effort to infuse suicide risk reducing strategies into pediatric care and youth community settings.^{ix}

Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services, including trauma-informed care, to appropriately address their mental and behavioral health needs. Tackling the pediatric mental health crisis requires a comprehensive approach that addresses the full continuum of healthy mental development and includes promotion and prevention, early intervention and treatment, as well as crisis response. To do this, we must ensure that children are able to access care in the settings where they are: schools and early childcare settings, their pediatrician's office, community settings, and emergency departments. This is especially important given the serious shortages of pediatric mental health professionals, which is impeding access to care for children.

Unique Needs of Children and Adolescents

From prevention to early identification to treatment to crisis intervention, our mental health care system must address the full continuum of children's needs. Children are not little adults, and the behavioral health care needs of children differ from those of adults.

For example, when a young child experiences anxiety, they are more likely to show symptoms such as disrupted sleep, toileting issues, feeding refusal, regression in skills, or being more irritable. Young children may not be able to verbally express what they are feeling. Older children and adolescents may first show symptoms of anxiety or depression at the doctor's office with chronic stomachaches or recurrent headaches. Since children and adolescents are still developing skills, and treatments need to be appropriate for age, they may feel shame or be afraid to share what they are thinking since they may feel that they must meet expectations of their caregivers or shoulder the responsibility of solving their own problems. Because adolescents do not yet have as full functioning of an executive part of their brain as an adult does, they are less able to control impulses compared to adults, sometimes with disastrous consequences.

Solutions for adults are not the same as solutions for children. Half of the adults in the United States with a mental health disorder had symptoms by the age of 14 years.^x And, 75% of mental health disorders occur before age 24.^{xi} Children whose mental health needs go unaddressed grow into adults whose needs are also likely to be unaddressed and more severe.

Additionally, children's emotional and behavioral health is greatly impacted by that of their parents and caregivers. Parents and caregivers experiencing their own mental health problems, health issues, substance use disorder, or increased stress due to loss of income, housing, and access to nutrition and other supports during the pandemic may impact the emotional health of children and adolescents. The mental health system must be prepared to meet the needs of whole families, not just individuals. Oftentimes it is impossible to treat a child's mental health issues without involving the family, especially if a parent or family member has their own mental health or substance use challenges. Dyadic/family-focused therapies (e.g., treatment for maternal depression or parental substance use) can be effective in treating the mental health needs of families. Parenting education is often the preferred first line of treatment for many pediatric behavioral concerns, especially for younger children, as the presence of a safe, stable, and nurturing adult in a child's life can buffer adversity and build capacity for resilience, potentially changing the trajectory of a child's outcome. Embedding multigenerational integrated behavioral health services in primary care settings, such as parenting/development/behavior specialists, could help to identify and address child, family, and community needs.

Role of the Pediatrician

Pediatric primary care clinicians have unique opportunities to improve the mental health of children and adolescents: preventing mental health problems by guiding parents in safe, stable and responsive caregiving that nurtures child resilience and appropriate responses to behavioral issues; identifying mental health symptoms as they emerge; intervening early, before symptoms have evolved into disorders; managing more common conditions themselves; facilitating referral of children, adolescents, and their family members when mental health or substance use specialty services are needed; collaborating with child and adolescent psychiatrists, developmental and behavioral pediatricians and other mental health professionals in caring for children with severely impairing mental health and substance use disorders; and coordinating the primary and specialty care of children with mental health conditions and substance use disorders, as they do for children with other special health care needs.

Primary care clinicians see children and their caregivers 15 times between birth and 5 years of age for well visits and at least annually thereafter. Because primary care clinicians are familiar with developmentally appropriate behavior, they are able to distinguish between typical behaviors and concerning behaviors as children grow and age and intervene to prevent disorders. Behavioral health screening should be a required standard of care, independent of provider, patient, or parent biases.

Given the workforce shortage and increased number of children and adolescents presenting in primary care offices with mental health symptoms, pediatricians have had to take on a larger role in the assessment and management of mental and behavioral health issues. However, pediatricians routinely report that their training programs did not adequately train them to provide this care, and they may lack the confidence to do so. For example, when I was completing my training in pediatrics, I was taught to refer any patients with mental health conditions, as pediatricians did not treat conditions like anxiety or depression in their patients.

However, with the shortage of pediatric mental health providers, it often takes 4-6 months on average for my patients to be connected with a mental health specialist who can treat their issues. This is true in my urban practice area, however, patients in rural areas face even longer wait times for specialized care.

AACAP estimates that we need nearly four times the number of child psychiatrists as we have today to meet the demand for these services.²⁰ Wait times for pediatric mental health services are increasing across the country, pushing many families to sign up for multiple wait lists, to pay in cash instead of waiting for care that would take insurance, and ultimately to seek help at the emergency department.²¹ This trend is increasing the strain on overtaxed emergency departments, which have seen significant increases in wait-times for pediatric mental health emergencies, with children and adolescents waiting hours—and often days—for treatment.^{22,23} For many families, the barriers to pediatric mental health care are insurmountable: an estimated 50-75% of youth with mental health conditions receive no treatment at all.^{24,25}

In this midst of this crisis, pediatricians are increasingly taking on the management of mental health symptoms and conditions in primary and subspecialty care practice. A study in *Pediatrics* found that primary care pediatricians are the sole physician care-managers for approximately one-third of US children with mental health disorders.²⁶ During the COVID-19 pandemic, pediatric practices reported a decrease in visits for acute physical illnesses, but an increase in visits focused on mental health concerns.²⁷ However, 2019 data from the [AAP Periodic Survey of Fellows](#) found that only 22% of primary care pediatricians have an on-site mental health provider in their practice.

Pediatric Mental Health Care Access Program

Several years ago, I had a 14-year-old patient who suffered from bipolar disease. His child psychiatrist had just retired and his family called our practice to see if we could refill his medications while they waited several months for the next available appointment with another child psychiatrist. He was on five very complex psychiatric medications which pediatricians do not typically prescribe or manage. So, instead of refilling medications that we did not know how to use, our staff called multiple places and helped the family find an earlier appointment in four weeks. Unfortunately, during that time, he ran out of his medications, and he had an exacerbation of his disease. In a parking lot near my office, he got into a fight with a man and, unfortunately, had a gun. He shot and killed the man. Now this adolescent is in jail. I believed this tragedy could have been prevented and I started to search for solutions.

This led me to work with stakeholders across our state to found the Virginia Mental Health Access Program (VMAP), which is a statewide initiative that helps health care providers take better care of children and adolescents with mental health conditions through provider education and increasing access to child psychiatrists, psychologists, social workers, and care navigators. VMAP gives primary care providers the training and tools they need to serve children and young adults with mental health needs. This includes year-round education opportunities and access to on-call child and adolescent psychiatrists 40 hours a week. Now, if a primary care provider encounters a patient with depression or anxiety and has a question about how to manage care, they can be connected with a child and adolescent psychiatrist who can answer their question within 30 minutes and enable the primary care provider to manage care for the patient nearly immediately without a referral.

How Does VMAP Work?



In 2018, Virginia received a HRSA grant to support VMAP. Virginia is just one of the 45 states, D.C., tribal organizations, and territories that have received a grant from HRSA to create or expand this type of program through the Pediatric Mental Health Care Access (PMHCA) program. The Pediatric Mental Health Care Access Program supports pediatric primary care practices with telehealth consultation by child mental health teams, thereby increasing access to mental health services for children and enhancing the capacity of pediatric primary care to screen, treat, and refer children with mental health concerns. Integrating mental health and primary care has been shown to substantially expand access to mental health care, improve health and functional outcomes, increase satisfaction with care, and achieve cost savings. Expanding the capacity of pediatric primary care providers to deliver behavioral health through mental and behavioral health consultation programs is one way to maximize a limited subspecialty workforce and to help ensure more children with emerging or diagnosed mental health disorders receive early and continuous treatment.

Congress's investment in the HRSA Pediatric Mental Health Care Access Program is paying off. A recent RAND study found that 12.3% of children in states with programs such as the ones funded under this HRSA program had received behavioral health services while only 9.5% of children in states without such programs received these services.^{xii} The study's authors concluded that federal investments to substantially expand child psychiatric telephone consultation programs could significantly increase the number of children receiving mental health services. Programs funded by HRSA have increased pediatric provider capacity to screen, refer, or treat children's mental health, increased screening, incorporated health equity, and supported quality improvement.

Our state of Virginia has many examples of how programs funded by the HRSA Pediatric Mental Health Care Access Program are an effective investment in enhancing mental health care for children. A mother in Virginia came up to me to tell me how she has seen this impact firsthand. Several years ago, she went to her

pediatrician with her older child who was having mental health issues. At that time, the pediatrician did not know how to treat the child and referred them to a mental health specialist. We did not have VMAP. The parent had to do most of the work herself to find someone who would accept her child's insurance and it took almost a year for her child to receive treatment. This year, this same mother brought her younger child to the same pediatrician because the child was also showing signs of mental health issues. This time her child's pediatrician was able to connect with VMAP for a consult and treated her child right there in the office without a wait or need for referral to a psychiatrist.

AAP is a strong supporter of the *Supporting Children's Mental Health Care Access Act of 2022 (H.R. 7076)*, as it will reauthorize the HRSA Pediatric Mental Health Care Access Program for another five years at a level that allows HRSA to maintain all existing grantees and allows programs to expand the services they offer to additional settings, including schools and emergency departments. These are critically important sites for enhancing the availability of pediatric mental health team consultations because they are sites where children may present with mental health needs but there may not always be a pediatric mental health provider on site.

Prevention and Early Identification

We recommend Congress focus on comprehensive approaches to getting children, adolescents, and their families the supports they need to maintain emotional and behavioral health including trauma-informed care and community supports and services. By some estimates, as many as 19% of children have mental health symptoms that impair their functioning without meeting criteria for a disorder. Programs and funding that are limited to children with serious emotional disturbance miss a key opportunity to support early prevention and early intervention. For young people who have experienced significant or complex trauma, such as those in foster care, our current system makes it difficult to access services without applying diagnoses that do not fully capture their needs and can lead to fragmented and unnecessary care that does not address the root need they have. Similarly, lack of insurance payment for services for children and adolescents whose needs do not yet rise to the level of a diagnosis is a major barrier and contributes to the mental health crisis we are confronting. While some symptoms my patients have may ultimately become a diagnosable condition, the rigidity of federal funding and lack of insurance payment prevents support for those children and adolescents with emerging problems. As a pediatrician, I see this in my practice every day.

For example, nearly every day, I see children and adolescents who do not score high enough on our screening and diagnostic tools to warrant a formal diagnosis for anxiety, depression, or ADHD. However, they are clearly struggling at home, at school, with social interactions, or dealing with stress. Because they do not yet have a diagnosis, they do not qualify for programs at school where accommodations could be made to reduce triggers, or for therapy where insurers require a diagnosis of a disorder before treatment can begin. So, instead, these children and their families are left to struggle alone instead of receiving professional help and services.

AAP urges Congress to revisit funding restrictions such as those in the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grant that prevent federal funding from being able to support prevention and early identification. The current statute constrains federal funding of services for children to children with serious emotional disturbance. We would recommend expanding that definition to children with, *or at risk of*, serious emotional disturbance. We would also urge Congress to support major new investments in mental health promotion, prevention, early intervention and treatment for children and adolescents.

The Infant and Early Childhood Mental Health (IECMH) Grant Program administered by SAMHSA, improves outcomes for children aged zero to twelve by developing, maintaining, or enhancing evidence-informed, culturally appropriate IECMH services. The goal of the program is to ensure that children and families have access to a continuum of services, including prevention, early identification, early intervention, and treatment activities. **AAP strongly supports the *Supporting Children's Mental Health Care Access Act (H.R. 7076)* which reauthorizes the SAMHSA program for five years at a level that would allow for additional grantees.**

Increasing Integration, Coordination, and Access to Care

Important research shows that the integration of mental health and primary care makes a difference for infants, children, and adolescents in terms of expanded access to mental health care, improved health and functional outcomes, increased satisfaction with care, cost savings, and improved coordination among primary care clinicians and behavioral providers in clinics and school-based and community settings. Integration also allows for the primary care clinician to receive training that enables them to practice more advanced mental health care. Most integrated care efforts are funded through a patchwork of short-term public and private grants, limiting their reach and sustainability.

Best practices for integrating behavioral health with pediatric primary care recognize the medical home as a critical component of mental and behavioral health in a whole-person care approach. Mental health professionals should be included as members of the medical home team with participation in preventive, acute, and chronic care visits. Working in partnership with mental health practitioners to practice integrated care can improve care, enhance preventive services, lower costs, and strengthen the medical home. Incentives to integrate behavioral health with primary care should be created and funded, such as providing enhanced payment for services housed within a primary care setting. Co-location of mental health providers in primary care offices and schools is the gold standard of care and allows for warm handoffs and brief interventions at visits and effective referrals to psychiatric care when needed.

Pediatric primary care clinicians have a longitudinal, trusting relationship with patients and their parents. Given this special relationship, parents often seek joint visits with their trusted primary care physician and a mental health specialist. However, there is currently no payment model to support this type of visit. Allowing a specialist to provide a brief intervention with a pediatrician will increase access, allow intervention before symptoms reach the level of a disorder, and train pediatricians to better provide mental health care. Payment should be provided for behavioral health services embedded within primary care, on the same day as other primary care services. **AAP supports provisions of the *Strengthen Kids' Mental Health Now Act (H.R. 7236)* and the *Helping Kids Cope Act (H.R. 4944)* that would create grant programs to support pediatric behavioral health care integration and coordination.**

Barriers to the provision of integrated care should be eliminated. For example, in many clinical settings, co-located behavioral health providers cannot bill for a patient on the same day that the primary care clinician sees that patient (at least for the same mental health problem), making warm hand-offs extremely difficult. Different kinds of providers need to be able to bill for the same patient for the same diagnosis on the same day in order to promote integrated care.

Payment mechanisms that minimize fee-for-service/volume-based payment and encourage value-based, high-quality care, such as bundled or capitated payments or meaningful per member per month (PMPM) models, could encourage integration of behavioral health with primary care. It is critical that pediatric alternative payment models are designed to appropriately measure quality of care, long-term health outcomes, and the value of prevention to ensure that financial incentives support primary care practices investing in preventative care, early intervention, and behavioral health services.

Collaborative Care

The Collaborative Care Model integrates behavioral health care within the primary care setting and features a primary care physician, a psychiatric consultant, and care manager working together in a coordinated fashion. It is one of several models of integrated care that need a greater federal investment. Policies and models that expand the capacity of front-line pediatric and family medicine clinicians to respond to the mental health needs of children and adolescents, such as the HRSA Pediatric Mental Health Care Access Program and models that integrate a mental health or developmental specialist within a primary care practice, such as the Primary Care Behavioral Health Consultation model (PCBH), should also be supported. Unfortunately, billing for these models of integrated care often trigger a co-pay, co-insurance, or deductible for families. That should be eliminated as it serves as a barrier to access for families.

Care Coordination

Significant barriers exist to care coordination between mental health professionals and primary care clinicians. While coordination and communication take a lot of time, time spent coordinating care is often not paid for. Non-physicians are rarely able to be paid for care coordination and physicians are only able to bill for coordination with a specialist if the conversation with the specialist occurs on the same day as the patient's visit—which often proves to be impossible to schedule. Payment, without co-pays, co-insurance or deductibles for families, should be provided for care coordination activities such as time spent by pediatricians discussing a child's mental health with a behavioral health specialist, school staff, or family member whenever the consultation occurs.

Further, administrative barriers frequently prevent standardized communication between mental health professionals and primary care clinicians. Pediatricians report difficulty in care coordination in the school setting due to real or perceived barriers under Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA). Behavioral health specialists are often reluctant to share information with primary care clinicians, believing HIPAA proscribes such communication. Because mental health information is considered to be more protected than information about physical health, the rules for sharing information are perceived to be stricter. If a patient consents to having their provider or care team speak to other health professionals about their care, mental and behavioral health information should be included—separate consent should not be required for behavioral health information.

Navigators

Funding should also be available for primary care practices to hire care coordinators or navigators who help families navigate the often-complex mental health care system. Systems for care linkages and follow-ups, including referral to outpatient and community behavioral health centers should be created. Payment should also be provided for time spent addressing social drivers of health, such as nutrition, safety, transportation, and housing, which often impact mental health.

Family navigators and family support providers are key partners in addressing the spectrum of mental health needs in children and adolescents. Navigating the landscape of behavioral health care can often be difficult for families: dealing with limited provider networks, insurance, calling offices, finding appointment times are all time-consuming tasks. Family navigators, partnering with primary care and mental health, assist families in understanding and keeping up with their array of services, identifying community resources, and following up with recommendations. Home visitors similarly help with screenings, referral to other services, and coordination, and also support implementing strategies in the home environment. These providers should collaborate and communicate with both the medical home and the family and should not serve as a substitute for high quality behavioral health intervention.

Workforce

Across the United States, there is a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults. Prior to the pandemic, in 2020, SAMHSA estimated that 4.5 million additional behavioral health practitioners are needed to address the needs of children with serious emotional disturbances and adults with serious mental illness, including an additional 49,000 child and adolescent psychiatrists.^{xiii} The gap between currently available child and adolescent providers including developmental-behavioral pediatricians and what is needed to provide evidence-based mental and behavioral health care for this population is stark. New incentives and opportunities are needed to quickly expand a diverse child and adolescent mental and behavioral health workforce. The shortage of providers with specialized training to treat mental health conditions in infants and toddlers is even more extreme. When working with children and families, it is very important for the provider to be trained in child development—children are not little adults.

The lack of sufficient providers, including child and adolescent psychiatrists, developmental-behavioral pediatricians, psychologists, and social workers, prevents patients from accessing needed behavioral health care services. Today, 50% of children with mental health conditions receive no treatment at all.^{xiv} Pediatric patients trying to access services often face long wait times for a behavioral health appointment, long travel times to providers, or are unable to find a provider who accepts insurance. **AAP supports provisions of the *Strengthen Kids' Mental Health Now Act (H.R. 7236)* and the *Helping Kids Cope Act (H.R. 4944)* that would create pediatric behavioral health workforce training programs that would accelerate the time to licensure or enhance capabilities of the existing workforce for practitioners. Given the demand for such training by pediatricians, as well as the financial and other barriers to being able to receive it, we urge Congress to ensure that pediatricians are listed as eligible providers for behavioral health workforce training programs.**

Low payment rates for the provision of behavioral health services heavily contributes to the workforce shortage. For example, the fields of developmental and behavioral pediatrics and psychiatry have become more popular but the interest in these fields has not grown in part because of the length of training without the subsequent increase in salary. Trainees report economic disincentives to entering pediatric subspecialties because of the debt they will accrue. Providers must be adequately paid for the care they provide. Feedback from providers reflects that payment for mental and behavioral health services does not reflect the difficulty of the work performed by these providers. For example, I am paid better for treating a wart that takes 5 minutes than I am for spending an hour helping a child who is thinking about suicide.

Better utilizing pediatricians to provide care for behavioral health issues would also help to reduce the negative impacts of the behavioral health workforce shortage. Training programs should be established for general pediatricians and those going into subspecialty care to gain additional expertise in mental health promotion, prevention, diagnosis, and treatment so that pediatricians are competent to assess and manage mild to moderate mental and behavioral health conditions. Training in trauma-informed responses is critical for pediatricians, health systems and school personnel. The educational curriculum for pre-hospital personnel, emergency department physicians, staff, nurses, and trainees, including emergency medicine residents and pediatric emergency medicine fellows should include training to provide patient/family-centered, trauma-informed, and culturally appropriate mental and behavioral health care.

Access Considerations

Children and adolescents with behavioral health needs often face waiting times of several months to get an appointment (even in large cities with more developmental and behavioral pediatricians or child psychiatrists than most parts of the country), and this wait time often extends to many more months for children whose preferred language is not English. While more providers are needed to address the mental health needs of the pediatric population, payment rates for these services are a key barrier to both building the workforce and building practices. Many providers choose to work in cash-only practices that do not accept insurance because payment rates for mental health services are so low, especially for patients on Medicaid and CHIP. **AAP is strongly supportive of provisions in the *Strengthen Kids' Mental Health Now Act (H.R. 7236)* that would ensure payment parity for health care providers by matching Medicaid and Medicare payment rates for pediatric behavioral health services.**

Medicaid is designed to meet children's unique needs, particularly through its Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT). Together, the Medicaid equal access provision and the EPSDT benefit should ensure that children enrolled in this essential program have timely access to needed care, including mental health services. However, state Medicaid programs implement EPSDT and medical necessity determinations differently, a challenge exacerbated by the proliferation of Medicaid managed care plans with varied benefit designs and coverage limitations. In addition, previous rulemaking has failed to include guidelines for or assessment of mental health network adequacy and access to services for children. **AAP also strongly supports provisions of the *Strengthen Kids' Mental Health Now Act (H.R. 7236)* that would require HHS to issue guidance to states on how to support the provision of mental, emotional, and behavioral health services covered by state plans.**

In addition, to address the real and perceived barriers to payment for mental health care for children by Medicaid, **Congress should require CMS to provide guidance to states on Medicaid payment for evidence-based mental health services for children including those that promote integrated care.** The medical and behavioral health screenings provided to Medicaid-eligible children and adolescents under EPSDT are of particular importance for those being released from incarceration in the juvenile justice system. **AAP supports provisions of the *Keeping Incarceration Discharges Streamlined for Children and Accommodating Resources in Education Act (H.R. 7233)* that would help increase the timely provision of screening and needed referrals to these children to ensure continuity of care during the crucial community reentry period.**

Additionally, despite enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its subsequent expansions to Medicaid managed care, CHIP, and the health

insurance marketplaces, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. Further, MHPAEA still needs to be expanded to children and adolescents enrolled in Medicaid fee-for-service arrangements. While new compliance measures included in recently passed legislation are promising, many children and adolescents still face barriers in accessing mental health and substance use disorder treatment due to insurance discrimination that singles out these services. Increased oversight is needed to ensure that insurers are complying with mental health parity laws to promote broader mental health insurance networks.

Children and Adolescents in Crisis

Clinicians are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm. From April to October 2020, hospitals across the U.S. saw a 24% increase in the proportion of mental health emergency department visits for children ages 5 to 11, and a 31% increase for children and adolescents ages 12 to 17. Behavioral health clinicians have reported over the last several years that children and adolescents are increasingly “boarding” in emergency departments for days because they do not have sufficient supports and services including inpatient hospital beds in psychiatry. In addition, research shows significant disparities in suicide rates, risk, and care for youth across cultures and communities; support is needed to enhance suicide prevention efforts for youth of color, youth who identify as LGBTQ, and youth from communities that have been marginalized or medically underserved.

AAP was pleased to support legislation expanding the Suicide Prevention Lifeline and is eager to see a successful, nationwide rollout of 988. To be successful, 988 should have 24/7 availability and be a crisis response system that is prepared and staffed to meet the needs of children in crisis. It needs to be able to connect children and adolescents to urgent mental and behavioral health services within a day if they are not emergent enough to go to the emergency department. It should account for how crisis symptoms present in children and adolescents across cultures and communities, must have specific pediatric and family-based training for crisis intervention teams, engage peer support, be able to refer children and adolescents to pediatric-specific care, and coordinate with the pediatric medical home.

Pediatric crisis intervention should be accessible for children, families, and pediatricians and be designed to meet the needs of particularly vulnerable populations such as LGBTQ youth, children with disabilities, children in foster care, and children of color including children and families with limited English proficiency. Access to professional interpreter services and/or interpreters trained in crisis management should be made available for patients and families with limited English proficiency. It is also important to recognize that pediatricians' offices are likely to utilize 988 as we frequently encounter children in crisis in our offices. **The 9-8-8 and Parity Assistance Act of 2022 (H.R. 7232) takes important steps towards ensuring that crisis response standards and capacity will address the needs of children and adolescents. We look forward to working with Congress to ensure we have the right system in place for children and adolescents.** In addition, funding for crisis services for children should not be limited to children with serious emotional disturbance (SED). The SAMHSA definition for children with SED requires that a child or adolescent has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria. Children or adolescents in crisis deserve appropriate crisis intervention services to meet their needs regardless of whether they have a prior diagnosis that results in functional impairment.

Trained crisis response teams should be used as an alternative to having law enforcement respond to a mental or behavioral health emergency in the community. **Services like those that would be supported by the *Mental Health Justice and Parity Act of 2022 (H.R. 7254)* more appropriately address the needs of people in crisis and prevents injury and death.** These models, by having staff who are knowledgeable about and connected to community resources can facilitate warm handoffs. Universal implementation of such models should be a goal. Mobile health crisis teams should be available to respond to schools, physician offices, homes, or wherever children are. These interventions can also support placement stability for young people in foster care who are experiencing crisis, so they can receive needed supports while remaining with the family caring for them. Given the current workforce shortage and that crisis intervention services tend to be underpaid positions, professionals who do this work should be given a competitive wage to ensure a high-quality workforce and improve retention.

Because of the lack of available pediatric behavioral health services, children and adolescents experiencing suicidal ideation or other mental health crises often end up in the emergency department seeking care. Prehospital personnel should be trained in acute management of pediatric behavioral health emergencies. Emergency department staff should be supported and trained in recognizing and providing initial care to youth with potentially increased risks of behavioral health concerns, including LGBTQ youth, victims of maltreatment, abuse, or violence, including physical trauma, mass casualty incidents, and disasters; and those with substance use-related problems (e.g., acute intoxication, overdose), pre-existing conditions (e.g., autism spectrum disorder, developmental delay, intellectual disability), post-traumatic stress, depression, and suicidality.

Prompt consultation with a well-trained mental health professional and interpreter services should be available in the emergency department. Standards should be established for documentation, communication, and appropriate billing and payment for inpatient and outpatient psychiatric care by mental health specialists consulting on emergency department patients (including telemedicine consults), as well as for emergency and prolonged emergency department care for children boarding in the ED. Interfacility transfer agreements should be created to refer children to care, including simplification of psychiatric bed search for patients requiring inpatient care or community mental health centers where available, to help limit ED boarding. Currently, patients face delays to get into outpatient care. The increased availability of “step down” services such as partial hospitalization and intensive outpatient programs would promote effective care transitions. Upon discharge from hospitals or emergency departments, navigators should help families connect to community services including family supports.

Community services should be expanded to include mobile crisis intervention, intensive case management, respite services, bridge programs upon discharge from an ED or psychiatric hospital, and emergency department diversion programs such as psychiatric urgent care centers. Outpatient care services should be designed to serve children and adolescents with unique needs, such as those with autism spectrum disorder, substance use disorders, and eating disorders. Schools also play a critically important role in supporting the mental health of children and adolescents. Although not the subject of today’s hearing, AAP **supports the *Youth Mental Health and Suicide Prevention Act (H.R. 1803)***, which provides direct funding to schools for a variety of mental health promotion and suicide prevention purposes, such as educational seminars, awareness campaign materials, peer-to-peer program support, telehealth, and training programs.

AAP supports the *Garrett Lee Smith Memorial Reauthorization Act (H.R. 7255)* which would reauthorize programs established under the *Garrett Lee Smith Memorial Act* that support community-based youth and young adult suicide prevention efforts and make treatment options for opioid use disorder more accessible. States, Tribal communities, and college campuses have used funds from this program to support education and mental health awareness programs, screening activities, gatekeeper training events, improved community partnerships and linkages to service, programs for suicide survivors, and crisis hotlines. A study found counties implementing Garrett Lee Smith programs had significantly lower suicide rates for youth and young adults following implementation, which was estimated to have averted 79,000 suicide attempts.

School-Based Mental Health Care

Children must be able to access care in the settings where they are, particularly in schools. Lack of mental health professionals in schools is another significant barrier to children's access to needed services. Comprehensive school mental health systems provide an array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness.^{xv} By having mental health services available in schools, children can have access to the care they need with minimal disruption to their school day, and in the case of acute behavioral health crises in school, they could receive urgently needed services and de-escalation on site.

At the very least, every school should have a staff member with mental health training, including trauma-informed responses, who can recognize behavioral health issues and is able to facilitate connection to appropriate resources. Ideally, schools should have an on-site therapist who can provide trauma-informed psychotherapy to children free of charge and education to teachers, staff, parents, and students about mental wellness, stress management, basic Cognitive Behavioral Therapy principles to cope with anxiety/depression, and Mental Health First Aid. Increased funding is needed to support multi-tiered systems that promote mental health and help reduce the prevalence and severity of mental health disorders in schools. There is a large need for school-based mental health professionals to serve the needs of children and adolescents; providers must be adequately trained and supported. Consideration should be given to payment for support groups for children and adolescents living with chronic illnesses such as cancer and children and adolescents dealing with the loss of a parent or caregiver.

The AAP supports provisions of the *Keeping Incarceration Discharges Streamlined for Children and Accommodating Resources in Education Act (H.R. 7233)* that would help reduce administrative barriers to Medicaid and CHIP reimbursement for school-based health and mental health services.

Maternal Depression

Maternal mental health conditions -- including depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, and substance use disorder -- are serious illnesses that begin during pregnancy or the year following pregnancy and affect 1 in 5 pregnant and postpartum people.^{xvi,xvii,xviii} These illnesses are the most common pregnancy complication, adversely impacting 800,000 families each year in the United States.^{xix} Unfortunately, as many as 75% of those affected never receive treatment,^{xx} resulting in potential long-term negative consequences for the health and well-being of parents, infants, and families. Moreover, the cost of untreated maternal mental health conditions is \$14.2 billion each year (or \$32,000 per mother-infant pair) in health costs as well as lost wages and productivity of affected parents.^{xxi} The COVID-19 pandemic has pushed

an existing maternal mental health and substance use crisis to catastrophic levels, with pregnant and postpartum patients reporting a threefold increase in symptoms of anxiety and depression.^{xxii,xxiii}

The well-documented racial inequities in maternal health outcomes also extend to maternal mental health. Individuals facing racial or economic inequities are more likely to be affected by these conditions but have less access to screening or treatment.^{xxiv} In the United States, more than half of infants in low-income families are being cared for by a mother with some level of depressive symptoms.^{xxv} These same infants are also likely to suffer intergenerational effects: maternal mental health disorders increase the likelihood of preterm birth, low birthweight delivery, and infant mortality; impair parent-infant bonding; and can lead to behavioral, cognitive, and emotional impacts on the child.^{xxvi,xxvii}

Maternal depression affects the whole family and can lead to increased costs of medical care, inappropriate medical treatment of the infant, discontinuation of breastfeeding, family dysfunction, and an increased risk of abuse and neglect. AAP supports the HRSA Screening and Treatment for Maternal Depression program that helps address mental health conditions that arise during and after pregnancy. For example, this program funds Maternal Mental Health Psychiatric Access Lines, which allow providers, including pediatricians, real-time psychiatric consultation in which a specialist guides screening, brief intervention, and referral for maternal mental health conditions.

AAP supports the *Into the Light for Maternal Mental Health Act of 2022* which would reauthorize and expand the HRSA program and so that more individuals would be able to access care. Currently, HRSA funds seven state programs, however this legislation would expand the reach of the program to 30 states, enabling more pregnant and postpartum individuals to receive the care they need. The legislation would also authorize trainings for providers in providing culturally appropriate care and enhance technical assistance from HRSA to help state grantees with implementation. Further, the legislation would authorize the maternal mental health hotline, allowing for a nationally operated 24/7 real-time voice and text access resource for emotional support, information, and brief intervention for individuals and families affected by maternal mental health conditions.

Eating Disorders

Interruptions in regular access to healthy, nutritious foods and the impact of isolation and increased screen time have impacted children's health and wellbeing on both extremes. Recent CDC data show a rise in childhood obesity during the pandemic – about 22% of children and teens with obesity last August, up from 19% a year ago. Relatedly, we are also seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. Eating disorder diagnoses have also increased 25% overall for youth ages 12 to 15 since the onset of the pandemic.^{xxviii} Adolescent medicine and child psychiatry clinicians are seeing many more cases of eating disorders that are more severe and are starting at even younger ages, even down to the age of 8 or 9. Because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients. Despite increasing prevalence rates, most pediatric and adult primary care physicians lack training in eating disorders, with only 20% of medical schools offering any elective trainings in the subject.^{xxix}

There is a need for more services, and the training of more providers, to treat children and adolescents with eating disorders, as well as outpatient care services designed to meet the needs of this population. **AAP supports the *Anna Westin Legacy Act* which would authorize the SAMHSA Center of Excellence for Eating**

Disorders that trains providers in screening, intervention, and referral for eating disorders, and has trained over 7,000 primary care providers since 2019. This legislation aims to give the Center of Excellence a more permanent home and expand its funding so it can create the nation's first pediatric protocol for eating disorders in a primary care setting and establish protocols for vulnerable populations at higher risk for eating disorders.

Substance Use Disorder

Adolescence is a critical period in the prevention of substance use disorder (SUD). Adolescents are the age group at greatest risk of experiencing substance-use related acute and chronic health consequences, making a targeted approach to SUD prevention and treatment for adolescents imperative. The neurodevelopmental changes during adolescence confer particular vulnerability to addictions. Of particular concern, the age at first substance use is inversely correlated with the lifetime incidence of developing a substance use disorder.^{xxx xxi} In other words, adolescents face increased risk of opioid dependence and SUD due to their unique developmental and physiological characteristics, posing a threat to lifelong health and well-being for adolescents who develop SUD prior to entering adulthood. Policies to expand access to SUD treatment options are therefore essential to mitigate the impact of SUD on young people. Research demonstrates that youth who reach adulthood without ever using substances are unlikely to develop a substance use disorder in their lifetime. Programs that can help identify youth at risk of SUD and intervene upstream before a problem occurs as well as programs that provide treatment to those who need it are smart approaches to improving the health and well-being of adolescents now and in the future.

The AAP supports provisions of the *Continuing Systems and Care for Children Act (H.R. 7248)* that reauthorizes a program for substance use disorder treatment and early intervention services for children and adolescents. The AAP also strongly supports the *Sober Truth on Preventing (STOP) Underage Drinking Act* which is reauthorized in the *Summer Barrow Prevention, Treatment and Recovery Act (H.R. 7234)*. The STOP Act would reauthorize an important program that would provide grants to train pediatric providers in alcohol use screening, brief intervention, and referral to treatment for children and adolescents.

It is also important to note that the majority of youth with substance use disorder have one or more co-occurring mental health condition. Substance use disorder and mental health conditions can also exacerbate one another. Recognition of this interplay is essential in understanding how to build systems of care for children and adolescents with or at risk of substance use disorder. In addition, providers of care to adolescents with substance use disorder are also in short supply, resulting in adolescents being much less likely than adults to receive the most effective evidence-based care, such as medication for opioid use disorder.

Thank you for the opportunity to testify before you today. AAP looks forward to working with the committee to improve mental health care for children and adolescents.

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"
COMMUNITIES IN NEED: LEGISLATION TO SUPPORT MENTAL HEALTH AND
WELL-BEING"

Testimony before House Energy & Commerce Health Subcommittee

April 5, 2022

Debra A. 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

Testimony of Debra A. Pinals, M.D.

On behalf of the

National Association of State Mental Health Program Directors (NASMHPD)

Before the Subcommittee on Health of the Committee on Energy and Commerce

April 5, 2022

Introduction/Background

Good morning, Subcommittee Chairwoman Eshoo, Subcommittee Ranking Member Guthrie, Chairman Pallone, and Chairwoman McMorris Rodgers and members of the subcommittee. Thank for you for the opportunity to appear before this subcommittee today to discuss policy solutions to the overlapping opioid overdose and mental health crises impacting the United States. 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 serving millions of people annually in all 50 states, 6 territories and pacific jurisdictions, and the District of Columbia. NASMHPD works with states, federal partners, and stakeholders to promote wellness, recovery, and resiliency for individuals with mental health conditions or co-occurring mental health and substance related disorders. I serve as the Chair of the Medical Director's Division of that Association and separately I provide technical assistance to them.

I am also the Medical Director of Behavioral Health and Forensic Programs at the State of Michigan Department of Health and Human Services (MDHHS) and a Clinical Professor of Psychiatry at the University of Michigan Medical School and Clinical Adjunct Professor at the University of Michigan Law School. I am a psychiatrist, board certified in psychiatry, forensic psychiatry and addiction medicine. I have worked throughout my career in a variety of capacities including as a treating psychiatrist across many settings, an expert witness in litigation, a researcher, an academic instructor, a government official, a consultant, and a policy adviser often related to the legal regulation and of psychiatric practice and access to care.

Like in most states, the coronavirus pandemic has exacerbated pre-existing behavioral health challenges in Michigan. In my role within the Michigan Department of Health and Human Services working to support our Disaster Behavioral Health response, I have been tracking data from the CDC household pulse survey, and that has consistently shown that about 30% of people in Michigan and around the United States report significant symptoms of depression and anxiety. We have all been faced with extraordinary challenges, and we are so appreciative of the federal support that has come to us to help address these challenges brought on by the pandemic. I'm especially grateful for the leadership on these important issues by members of the Michigan delegation, especially Senators Stabenow and Peters in the Senate, and Representatives Dingell and Upton of this subcommittee. With regard to the emotional toll of the pandemic, we have worked with funding from SAMHSA and FEMA to lift up our Crisis Counseling Program, which allowed us to deliver a new

“Michigan.gov/Staywell” program (www.michigan.gov/staywell), offering a variety of types of support for individuals who have had difficulty emotionally coping with all that has come our way in the face of the pandemic. This work has included a number to call attached to our COVID-19 information line, virtual support groups, information dissemination about our supports and a wealth of resources on our website such as videos that can be helpful in fostering emotional resilience during these difficult times. I urge you to look at this website yourselves.

Despite these efforts, we are acutely aware of ongoing demands for mental health and substance use services. Even before the pandemic, needs for persons with mental illness, substance use disorders, and co-occurring intellectual and developmental disabilities were great. I am here today to speak to my experience working with these individuals and in developing services for them as you deliberate on the many bills before you. My message is clear. Funding for mental health services is necessary and should be a national priority. In making this statement, let me begin by recounting some of the pressing issues we are facing in Michigan.

Since 2000, drug overdose deaths have grown five-fold in our state with just over 2,700 drug overdose deaths in 2020 alone. Opioid overdose deaths increased by 23% percent from 1,768 in 2019 to 2,171 deaths in 2020. The percentage of opioid overdose deaths that involved fentanyl in 2020 was 86%, an increase from 80% in 2019. And these drug overdose death rates are impacting our communities disproportionately, with Black and Hispanic residents having higher age-adjusted all drug overdose death rates than White

residents in 2020. Even with these grim statistics, we are proud of the progress we have made in reducing overall opioid prescriptions and significantly increasing the number of pharmacists and physicians enrolled in our prescription drug monitoring program. Yet, there is so much more needed to help us turn these numbers around in these challenging times as we pivot through this pandemic.

In addition to the opioid overdose rates, our mental health challenges, like in many states, are highlighted by the number of state residents we lose to suicide. Suicide rates have increased across the United States and Michigan over the past decade. In 2020, Michigan saw 1,431 total suicides including deaths occurring out-of-state. Suicide was the third leading cause of death for Michigan residents from ages 15 to 34 in 2020. And while we do not yet know the full impact of the pandemic on future suicide rates, there are many things that give us cause for alarm that has inspired further focus by our Suicide Prevention Commission on preventing suicide especially among high-risk populations. Having access to immediate supports can be one way of reducing these tragic and untimely deaths, along with reducing misuse of drugs and alcohol.

State of Michigan Mental Health Reform

To deal with these challenges, my department has initiated broad reform efforts, only some of which I will highlight today, including those that leverage two key federal initiatives. First, across Michigan there are currently 36 Certified Community Behavioral Health Clinic (CCBHC) sites, with 34 of them funded through the SAMHSA CCBHC

Expansion Grants and 13 receiving funds as CMS CCBHC demonstration sites. These span 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 to mobile crisis response, jail diversion, and medication for addiction treatment (MAT) for all, regardless of ability to pay, just to name a few of the service models. An estimated 367,000 Michiganders might be eligible to participate based on mental health and substance use disorder disorder diagnoses. We are grateful to have been selected to be able to expand our CCBHC portfolio.

Second, MDHHS is also expanding the Michigan Crisis and Access Line (MiCAL), a service that launched first on April 19, 2021 in two very distinct regions-- Oakland County and in our more rural Upper Peninsula. This work was initiated seamlessly with amazing partnerships despite the complexity of the endeavor. This service provides support for people in distress and information and referral for people who do not know where to go for help. MiCAL aims to provide a single number access point for immediate crisis response, with the goals of reducing suicide, getting people to the right level of care, minimizing unnecessary wait times, and tracking information to coordinate follow-up services.

Since its initiation, MiCAL has expanded to five (5) of our ten (10) Pre-paid Inpatient Health Plan (PIHP) regions, with planned expansion to the other five (5) over the course of this calendar year. To date, there have been 25,416 calls to MiCAL/National Suicide Prevention Lifeline (NSPL)/Community Mental Health Services Program (CMHSP) after

hours and 28,751 calls to the affiliated Peer Warmline. Approximately 60% of the calls are for general support, and 23% are addressing some type of crisis need. Our team is working diligently to expand these activities to link to other crisis services that we are establishing in concert with many stakeholders and with legislative support.

Presently, Michigan is also working to codify all of the MiCAL services under one structure and coordinate with the new National Suicide Prevention Lifeline 988 number scheduled for implementation in July 2022 nationwide. We plan to add a bed board, which will provide real time information on in-patient and residential bed occupancy which will simplify transferring patients and streamline the referral process.

Mental Health Block Grant – Crisis Care Set-aside.

The bipartisan legislative agenda that NASMHPD has presented to the committee dovetails with Michigan's strategic direction while helping us to address our immediate crises. In preparation for implementation of the new nationwide 9-8-8 National Suicide Prevention Lifeline (NSPL), the state mental health directors are seeking a Mental Health Block Grant set-aside of 10% to help finance the crisis care continuum in every state. Flexible block grant dollars will assist with the three (3) legs of the crisis care stool: funding local and regional call centers, organizing mobile crisis teams to respond to individuals in immediate mental or substance use crisis, and financing crisis receiving and crisis stabilization beds for persons in need of short-term acute psychiatric services in non-hospital community-based settings.

But make no mistake. With 9-8-8 going live in less than four (4) months, standing up a crisis care system is an enormous undertaking that will require financing well beyond the capacity of existing federal discretionary programs.

Mental Health Block Grant --- Early Intervention & Prevention Set-aside

At the same time, as the medical director who advises our leadership overseeing state mental health and addiction services in order to achieve the best clinical outcomes for our residents, and as a psychiatrist who has spent her career working in settings ranging from emergency rooms to prisons, I see the importance of funding for preventative programs that head off crises and avert long waits in emergency departments, child removals into foster care due to substance use disorders in the parents, arrest and incarceration in county jails and homeless shelter placements. NASMHPD and citizens advocacy organizations like Mental Health America have come together and supported the creation of a new 10% early intervention and prevention set-aside within the mental health block grant. Many of the major neuropsychiatric illnesses have a typical age of onset in late adolescence, and experience and data showing early intervention points ever more directly to the need for prevention efforts. Studies also demonstrate that half of those who will develop mental health disorders show symptoms by age 14. Effective early intervention and prevention programs will reduce suicide prevalence rates, school dropout, homelessness, child removals, and involvement in the criminal justice system. Similar to the successful prevention set-aside program in the Substance Use and

Prevention Block Grant, this initiative will involve constructive public-private partnerships with school systems, primary care associations, and local businesses.

In closing, I should note that statutory modifications will be needed to permanently waive the application of certain Mental Health Block Grant statutory requirements drafted in the early 1990s to facilitate the implementation of both new set-aside programs. A significant upward adjustment in the block grant authorization ceiling will also 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 to help Americans experiencing an acute mental health or substance use crisis while, at the same time, engaging in public mental health initiatives to prevent those crises from emerging in the first place.

Again, thank you for the opportunity to testify. I am happy to answer any question you may have.

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***“Communities in Need: Legislation to Support
Mental Health and Well-Being”***

Written Testimony Submitted to:

The House Energy and Commerce Committee

Subcommittee on Health

The Honorable Anna Eshoo, Chairwoman

The Honorable Brett Guthrie, Ranking Member

Hybrid Hearing in the John D. Dingell Room

2123 of the Rayburn House Office Building

and Cisco Webex

Submitted By: Cassandra Price

Director, Office of Addictive Diseases within Georgia’s Department
of Behavioral Health and Developmental Disabilities

Past President, National Association of State Alcohol and Drug
Abuse Directors (NASADAD)

Tuesday, April 5, 2022

Chair Eshoo, Ranking Member Guthrie, and members of the Committee, my name is Cassandra Price and I serve as the Director of the Office of Addictive Diseases within Georgia's Department of Behavioral Health and Developmental Disabilities.

I also serve as the Past President and a member of the Board of Directors of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). NASADAD represents State agency directors across the country that manage their respective State alcohol and drug prevention, treatment, and recovery systems.

About NASADAD: NASADAD is a private, not-for-profit educational, scientific, and informational organization originally incorporated in 1971 and located in Washington, D.C. NASADAD's mission is to promote effective and efficient State substance use disorder prevention, treatment, and recovery systems.

NASADAD seeks to:

- Serve as the national voice of State alcohol and drug agencies,
- Foster partnerships among States, Federal agencies and other key national organizations,
- Develop and disseminate knowledge of innovative substance use disorder programs policies and practices,
- Promote key competencies of effective State alcohol and drug agencies,
- Support a "States-helping-States" approach to program, policy and service improvement,
- Promote increased public understanding of substance use disorder prevention, treatment and recovery processes and services.

The President of NASADAD's Board of Directors is Sara Goldsby (South Carolina). The rest of the Board includes Trina Ita (Texas), Jennifer Smith (Pennsylvania), Lori Criss (Ohio), Michael Langer (Washington State), Valerie Mielke (New Jersey), Sheri Dawson (Nebraska) Cynthia Seivwright (Vermont), Kirk Lane (Arkansas), Jared Yurow (Hawaii), and Sarah Mariani (Washington State).

NASADAD works closely with the National Governors Association (NGA). Governors across the country have been providing critical leadership regarding the opioid crisis in particular, and substance use disorders in general. We very much appreciate and value NGA's work and partnership.

Further, we are pleased to coordinate with other State-based groups, such as the Association of State and Territorial Health Officials (ASTHO), National Association of Medicaid Directors (NAMD), Safe States Alliance, the National Association of State Mental Health Program Directors (NASMHPD), National Criminal Justice Association (NCJA) and many others.

It is an honor to testify before you today regarding legislation designed to help improve our nation's substance use disorder service delivery system. We appreciate the Subcommittee's commitment and dedication to these issues.

Continued challenges related to overdose: We continue to see the devastating impact of substance use disorders across the country. The number of overdose deaths is staggering. From April 2020-April 2021, 100,306 individuals died from drug overdoses in the United States, the highest number ever recorded in a 12-month period and a 28.5% increase from the previous year. Approximately 75% of overdose deaths involved synthetic opioids and illegally manufactured fentanyl (Centers for Disease Control and Prevention (CDC), 2021).

The Georgia Department of Public Health (DPH) Drug Surveillance Unit has received increased reports of overdoses due to drugs mixed with fentanyl, particularly cocaine, methamphetamine, and counterfeit pills. Overdoses have been reported in several areas of the State over the past month. Between early February and mid-March, at least 66 emergency department visits involved the use of cocaine, methamphetamine, heroin, pain killers, and cannabis products that were likely laced with fentanyl. Patients described extreme reactions to drugs – one patient reported taking a Percocet and went unresponsive – or patients were seen for a stimulant overdose but had a positive response to naloxone. Naloxone is administered to reverse the effects of opioid overdoses. Fentanyl is a deadly substance that can be made illegally and is found in all types of street drugs, not just opioids. It is important to know that it is possible to have an opioid overdose from a stimulant (e.g., cocaine) that is laced with fentanyl.

Fentanyl-related overdose deaths have been increasing in Georgia since the start of the COVID-19 pandemic. Between May 1, 2020, and April 30, 2021, fentanyl-involved overdose deaths increased 106.2% compared to the same time period the previous year. In addition, alcohol related deaths have increased from 1,699 in FY 2019 to 2,202 in FY 2020.

Impact of COVID-19 in Georgia: The COVID-19 pandemic has a significant impact on the lives of all Georgians. Of the over 30 million reported COVID-19 cases in the U.S., Georgia currently ranks 10th in the country in number of reported cases. According to Georgia Department of Public Health data, as of October 8, 2021, there have been 23,342 confirmed deaths and 2,415 probable deaths, 82,566 hospitalizations, and 9,537 ICU admissions.

There is no doubt that the COVID-19 pandemic contributed to increases in problems related to substance use disorders. People with substance use and mental health disorders are particularly vulnerable during these difficult times. Fears of contracting the disease or having a family member or close relationship contract it, social isolation, financial concerns, and other impacts of the pandemic can trigger anxiety, loneliness, traumatic stress, obsessions, and other mental health symptoms. In addition, these conditions may trigger increased or re-initiated substance use for individuals with substance use disorders. Research suggests people with opioid use disorder and methamphetamine use disorder may be at increased risk of COVID-19 because their respiratory systems may have been impacted by their substance use. Individuals who vape or smoke tobacco or marijuana may also be at increased risk because of respiratory issues related to their substance use (<https://mhanational.org/research-reports/2021-state-mental-health-america>)

While the pandemic presented challenges to service delivery, we all worked together to adjust. States and providers developed innovative approaches to prevention, treatment, and recovery programming. Federal agencies and Congress worked to provide States and providers important flexibilities through program guidance and communication. In addition, Congress and the Administration worked to provide critical funding for prevention, treatment, and recovery along with life-saving overdose reversal medication. While we still face challenges, please know that the support from this Subcommittee, the full House, the Senate, and the Administration has been vital. We can not thank you enough.

Critical Role of the State Alcohol and Drug Agency: I would like to step back and describe the role of each State's alcohol and drug agency. These agencies oversee and implement the publicly funded prevention, treatment, and recovery service system.

Planning, oversight, and accountability: To begin, State alcohol and drug agency directors work to craft and implement annual plans for Statewide program and service delivery. In the process, our members capture data and information describing top challenges, populations served, and the types of services provided. State alcohol and drug agencies use such tools as performance management and reporting, contract monitoring, corrective action planning, on-site technical reviews, and technical assistance.

In Georgia, our Office of Addictive Diseases (OAD) provides leadership for adult and adolescent substance use disorder treatment services. Community based services are delivered by a network of over 600 private and public providers, including 24 Community Service Boards that serve as the public safety net, with whom DBHDD contracts or has letters of agreement. The Department's Division of Behavioral Health (DBH) funds and regulates the programs and services that are delivered.

Promoting and ensuring quality: NASADAD members are dedicated to continuous quality improvement. In particular, State agencies work to ensure quality services through State established standards of care. In addition, NASADAD members participate in initiatives to promote innovative practices and programs. For example, State Directors use data described above to help advance these practices and drive management decisions. State directors also work to translate cutting edge discoveries from the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol and Alcohol Abuse (NIAAA) and implement these practices into the publicly funded system. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Addiction Technology Transfer Centers (ATTCs) and the Prevention Technology Transfer Centers (PTTC) are key partners in helping to develop and strengthen our nation's workforce focused on prevention, treatment, and recovery.

In Georgia, quality reviews are conducted with substance use disorder and mental health providers by the Georgia Collaborative Administrative Services Organization (ASO) on behalf of DBHDD. The goals of these quality reviews are to identify strengths and concerns and provide technical assistance to help providers improve the quality of the services offered to the people we serve. These quality reviews are comprehensive and include evaluation of the following items:

1. A review of a sample of employee records to evaluate provider staff qualifications and training
2. A review of a sample of patient records, to include the following:
 - a. Provider performance in correctly assessing patient needs and planning their treatment
 - b. Provider performance on several focused outcome areas
 - i. Whole Health
 - ii. Safety
 - iii. Person Centered Practices
 - iv. Rights
 - v. Choice
 - vi. Community
 - c. Provider performance on required billing practices and supporting documentation
3. During and after the review, technical assistance is provided by the ASO for any areas of concern.

In general, each substance use and mental health service provider receives at least one quality review annually. Those with scores below certain thresholds receive two, which provides an additional opportunity for feedback and technical assistance to the provider.

DBHDD requires all providers to obtain appropriate credentialing provided by entities such as the Commission on Accreditation of Rehabilitation Facilities (CARF) to become and remain a provider within our network. A Drug Abuse Treatment and Education (DATEP) license is required of any provider offering substance use disorder treatment.

Management of the Substance Abuse Prevention and Treatment (SAPT) Block Grant: An important role played by NASADAD members is the management and oversight of the SAPT Block Grant – a \$1.9 billion federal formula grant that is allotted to NASADAD members. By statute, at least twenty percent of the SAPT Block Grant must be dedicated to critical primary substance use prevention programming. Georgia received \$57,157,652 million in SAPT Block grant funding in fiscal year 2021.

Managing the State Opioid Response (SOR) Grant: State alcohol and drug agencies manage funds from the State Opioid Response (SOR) Grant housed at SAMHSA. SOR seeks to address the opioid crisis by increasing access to treatment and reducing opioid overdose deaths through prevention, treatment, and recovery activities. These funds supplement existing opioid-related services led by the State alcohol and drug agency. SOR funds may now be expended to address issues related to stimulant use disorders. Georgia received \$29,263,842 million in SOR grant funding in fiscal year 2022.

Promoting coordination across State government: NASADAD members promote cross-agency collaboration given the impact of alcohol and other drug use has on other sectors. For example, State directors engage with criminal justice entities on issues like individuals reentering back into the community, drug court programs, and deflection initiatives. State alcohol and drug agencies also coordinate with sectors related to child welfare, transportation, employment, education, and others.

In carrying out this work in Georgia, our agency takes a proactive approach of working across all offices and other divisions within the department as well as with other State agencies (e.g., Department of Public Health) to identify needs across the State's substance use disorder service system and implement services that address those needs. The Department is involved in many initiatives that coordinate substance use disorder services within a broader system. The Department has developed memoranda of understanding and other types of partnerships with organizations including The Division of Aging Services, the Department of Human Services, the Department of Community Health, the Department of Community Affairs, the Department of Public Health, the Georgia Vocational Rehabilitation Agency, the Department of Corrections, the Department of Community Supervision, and other governmental agencies. In addition, our division works to coordinate services for veterans through relationships with the State Department of Veterans Services, the Department of Veteran Affairs, and Veterans Administration Medical Centers.

Supporting the provider community: State alcohol and drug agencies have a very unique and important relationship with the service provider community. State agencies observe that this connection is critical given the increased pressures on those delivering prevention, treatment, and recovery services. NASADAD members assist providers by offering training, continuing education, oversight, and other support.

DBHDD Office of Provider Relationships strives to equip DBHDD's network of providers with the right tools, services, resources, and information to enable them to deliver high-quality services to the substance use and mental health and intellectual and developmental disabilities populations.

The Office of Provider Relations helps capture, track, and resolve issues submitted by the Department's network of providers in a timely manner. This office also offers Community Provider Manuals; provider toolkits; provider frequently asked questions; video toolkits; monthly newsletters; and Special Bulletins to ensure vital information is disseminated immediately as appropriate.

The Office of Provider Relations also communicates DBHDD's training resources. These resources include trainings about intellectual/developmental disabilities; coordination of care; cultural and linguistic competency; core standards of care; disaster preparedness, response, and recovery requirements for providers; opioid crisis training for the faith-based community; opioid crisis training for first responders; and evidence-based practices.

The Office of Recovery Transformation (ORT) has its roots in the former Office of Consumer Relations which was formed in 2000. Under the leadership of its Director (a Certified Peer Specialist) and through the work of an Assistant Director, and in collaboration with staff from other offices, ORT brings the voice

of lived experience from adults and youth in recovery from mental and/or substance use disorders, to inform, guide and support DBHDD's transformation to a Recovery Oriented System of Care (ROSC). ORT partners with an internal steering committee of DBHDD leadership as well as the Georgia Recovery Initiative, a group of community advocates, providers, and people in recovery, to exchange information, vet ideas and inform their work.

Annual Conferences: The annual Georgia School of Addiction Studies Prevention, Treatment, and Recovery Training (<https://www.thegeorgiaschool.org/>), held each August, offers a unique opportunity for professional development, information exchange, and networking. It is designed to address the need for knowledge and skill development through advanced training. The Georgia School grew from many years of experience with and support of the Southeastern School of Alcohol and Drug Studies, which was among the oldest existing regional training events of its kind.

Both the DBHDD Office of Addictive Diseases and Office of Behavioral Health Prevention have representation on the Georgia School of Addiction Studies Board. Other agencies and organizations serving on the Board include the Alcohol and Drug Certification Board of GA, Athens Technical College – Social Work Assistant Program, Council of Accountability Court Judges, Criminal Justice Coordinating Council, Georgia Addiction Counselors Association, Georgia Association of Community Service Boards, Georgia Association of Recovery Residences, Georgia Council on Substance Abuse, Georgia Department of Community Supervision, Georgia Department of Corrections, Georgia Department of Education, Georgia Department of Human Services – Division of Family and Children Services, Georgia Department of Juvenile Justice, Georgia Department of Public Health, Heritage Foundation, Licensed Professional Counselors Association of Georgia, Mercy Care, National Association of Social Workers – GA, Penfield Addiction Ministries, Prevention Credentialing Consortium of Georgia, Recovery Place, and the Southeast Addiction Technology Transfer Center.

Culturally competent prevention services: To support the delivery of culturally competent prevention services, the Office of Behavioral Health Prevention & Federal Grants (OBHPFG) provides training and workshops for providers on working with different special populations. Some have been delivered through DBHDD's contract with Prospectus Group, Inc. which provided Cultural Competency webinars and trainings as well as SAMHSA's 4-day Substance Abuse Prevention Training Skills (SAPTS) for prevention providers. Also, the Georgia School of Addiction Studies (GSAS) offers a unique opportunity for professional development, information exchange, and networking.

DBHDD training collaborations with other entities: DBHDD acknowledges the gravity of the work to reduce the number of overdose deaths, provide access to those needing treatment, and increase the availability of recovery support in communities throughout Georgia and recognizes that this cannot be accomplished by one agency. The Department has partnered with the following organizations in order to address OUD and overdose in a collaborative way:

- Georgia Public Safety Training Center (GPSTC) – OBHPFG has partnered with GPSTC to develop a new training that focuses on opioid overdose response, crowd control/safety for responding officers, accidental overdose from first responders responding to an overdose, etc. This training is being offered to all public safety personnel statewide.

- Department of Corrections/Community Supervision – Teaching addiction as a brain disease, promoting ways to provide support to those with OUD returning to communities, and to promote empowerment by sharing information and resources to assist those in their program
- Accountability Court Judges – Teaching addiction as a brain disease, why treatment cannot be limited to one medication, and the challenges and triumphs of having a MAT program within an accountability court
- Department of Family and Children Services – Teaching addiction as a brain disease, the challenges of providing support to a parent with OUD, and the resources available to assist individuals that may need treatment or connection to a recovery support center
- Department of Public Health (DPH) – Providing strong support in the development of a State strategic plan on the opioid epidemic, sharing information regarding trainings throughout the State and gaps in coverage, and education on ways to collaborate to reduce overdose deaths and provide greater recovery support. OBHPFG is also working with Georgia DPH to embed overdose information into HIDTA’s ODMAP. This enables OBHPFG’s SOR Prevention Team to find suspected overdose clusters to coordinate naloxone trainings and to retarget ads/PSAs to these suspected overdose cluster areas.
- Physicians at various hospitals – Provide the required three continuing medical education (CMEs) credits through education on the risks and known benefits of treating pain with opioids, addiction as a brain disease, and identifying and educating patients at greater risk for addiction
- Provider network – Provide training on improved communication around substance use disorder to increase appropriate language awareness and reduce stigma
- Partnered with Georgia Council on Substance Abuse to launch a Statewide project titled “Georgia Recovers”. This project consists of billboards and videos of people that have recovered from substance use disorder sharing their story.
- Department of Education (DOE) – OBHPFG is working with the Georgia DOE in order implement the Sources of Strength evidence-based program for school-age youth in 60 middle and high schools and is also piloting it in five elementary schools. This program aims to build resiliency and coping skills to reduce opioid and prescription drug use among those youth.
- Technical College System of Georgia, Other Colleges/Universities – OBHPFG is working with local colleges and universities in an Adopt-A-School program where college students teach an “adopted” high school the SAMHSA Strategic Prevention Framework to conduct an opioid prevention campaign.

State alcohol and drug agencies appreciate action taken by Congress to address substance use

disorders: NASADAD is appreciative of this Committee, along with Congress and the Administration in general, for the work done to address substance use disorders. We appreciate, for example, passage of the Comprehensive Addiction and Recovery Act (CARA), 21st Century Cures Act, and the SUPPORT Act. These important programs include but are not limited to:

- Substance Abuse Prevention and Treatment (SAPT) Block Grant (21st Century Cures, Section 8002)
- State Response to the Opioid Crisis (21st Century Cures, Section 1003): We sincerely appreciate the creation of an account for the State opioid response to the opioid crisis (Section 1003).
- Priority substance abuse treatment needs of regional and national significance within SAMHSA’s Center for Substance Abuse Treatment (CSAT) (21st Century Cures, Section 7004)

- Priority substance abuse prevention needs of regional and national significance within SAMHSA's Center for Substance Abuse Prevention (CSAP) (21st Century Cures, Section 7005)
- Improving Treatment for Pregnant and Postpartum Women (CARA, Section 501 and SUPPORT Act, Section 7062)
- Medicare Coverage of Certain Services Furnished by Opioid Treatment Programs (Section 2005, SUPPORT Act)

I will now offer overarching recommendations for the Subcommittee's consideration. I will then offer more specific observations regarding certain legislative proposals before the Subcommittee.

NASADAD's overarching recommendations for consideration

Promote and ensure a strong SAMHSA that serves as the lead federal agency across the federal government on substance use disorder service delivery: We support maintaining investments in SAMHSA as the lead agency within the Department of Health and Human Services (HHS) focused on substance use disorders. The nation benefits from a strong SAMHSA given the agency's longstanding leadership in the field. A strong SAMHSA includes a vibrant role for each of its distinct centers – the Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), Center for Mental Health Services (CMHS), and Center for Behavioral Health Statistics and Quality (CBHSQ).

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

Ensure that federal policy and resources related to substance use disorders are routed through the State alcohol and drug agency: State alcohol and drug agencies play a critical role in overseeing and implementing a coordinated prevention, treatment, and recovery service-delivery system. These agencies develop annual Statewide plans to ensure an efficient and comprehensive system across the continuum. Further, State alcohol and drug agencies promote effective systems through oversight and accountability. Finally, NASADAD members promote and ensure quality through standards of care, technical assistance to providers, and other tools. As a result, NASADAD prefers federal funding, programs, and policies designed to address substance use prevention, treatment, and recovery flow through the State alcohol and drug agency. This approach allows federal initiatives to enhance and improve State systems and promotes an effective and efficient approach to service delivery. Federal policies and programs that do not flow through or at least coordinate with the State agency run the risk of creating parallel or even duplicative publicly funded systems and approaches.

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

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

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

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

We also believe federal funding provided to States specifically designed to address the workforce crisis is important. As a result, we recommend action to give SAMHSA the full general statutory authority to help address our challenges related to the substance use disorder workforce. This includes action clarifying that SAPT Block Grant funds may be used to help States address workforce needs. Further, we support a specific proposal in CARA 3.0 – Section 211 – that would authorize a grant in SAMHSA's CSAP to State alcohol and drug agencies in order to bolster our nation's substance use prevention workforce needs as we are not aware of any federal programs that currently address this.

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

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

Maintain Recent Flexibilities to Ensure Access to Substance Use Disorder Services: The regulatory changes seeking to ensure continued substance use disorder service delivery during the COVID-19 pandemic should be maintained at least one year after the federal government determines the United States is no longer operating under a public health emergency. At this point, these policies should be further evaluated. These actions include the flexibilities regarding take-home doses of methadone for certain patients; the ability to initiate buprenorphine treatment for opioid use disorders without a face-to-face appointment; reasonable flexibilities related to HIPAA rules in order to allow service providers to utilize a variety of communication tools for service delivery; and others.

NASADAD's observations on certain proposals before the Subcommittee:

I will now offer some observations on selected initiatives before the Subcommittee.

Substance Use Prevention, Treatment, and Recovery Services (SAPT) Block Grant Act of 2022 (H.R. 7235): The Substance Use Prevention, Treatment, and Recovery Services Block Grant Act would reauthorize the SAPT Block Grant from 2023 through 2027. The bill would adjust certain allowable use of funds, remove stigmatizing terms such as "abuse" and add more specific language related to recovery support services.

NASADAD observations: The SAPT Block Grant, NASADAD's top programmatic priority, represents the backbone of our nation's substance use disorder prevention, treatment, and recovery system. The SAPT Block Grant is the cornerstone of States' substance use disorder prevention, treatment, and recovery systems. The SAPT Block Grant serves approximately 2 million people annually.

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

We sincerely appreciate recent action by Congress to allocate historic investments in the SAPT Block Grant. These investments were made in the FY 2021 omnibus appropriations bill (P.L. 116-260) and subsequently in the American Rescue Plan (P.L. 117-2). In addition, Congress allocated an increase of \$50 million for the SAPT Block Grant in the final FY 2022 omnibus appropriations package (P.L. 117-103). Prior to these significant investments, the SAPT Block Grant remained essentially level-funded for a number of years. In particular, from 2011 to 2021, SAPT Block Grant funding did not keep up with health care inflation, resulting in a 24% decrease in purchasing power.

As a result, we appreciate the work of Representatives Tonko (D-NY), Guthrie (R-KY), Wild (D-PA) and McKinley (R-WV) to draft and introduce this important piece of legislation. NASADAD supports the

bill's efforts to remove stigmatizing language by renaming the program to the Substance Use Prevention, Treatment, and Recovery Services Block Grant. In addition, NASADAD supports proposed language designed to increase screening and referral for viral hepatitis for those receiving substance use disorder treatment services. Further, NASADAD supports the provision in H.R. 7235 that would require State alcohol and drug agencies to describe their respective Statewide recovery support service activities, people served, priority needs, information on funds spent on recovery, and other data points. Finally, we appreciate the provision that would help develop a model needs assessment process for States to consider as they consider SAPT Block Grant spending across prevention, treatment, and recovery.

Excellence in Recovery Housing Act (H.R. 2376): The Excellence in Recovery Housing Act would promote the availability of recovery housing for people with substance use disorders. In particular, the bill authorizes a study describing the current availability of high-quality recovery housing. In addition, the bill requires SAMHSA to develop and release guidelines to States to help increase access to high-quality recovery housing. Further, the bill authorizes a grant program within SAMHSA to help States promote the availability of recovery housing and help States secure technical assistance related to recovery housing.

NASADAD Observations: NASADAD applauds Representatives Trone (D-MD), Chu (D-CA), Levin (D-CA), and McKinley (R-WV) for drafting and introducing this legislation. NASADAD has been engaging in a dialogue about this important issue with our members and other important groups such as the National Association of Recovery Residences (NARR). NARR's mission is to support persons in recovery from substance use disorders by improving their access to quality recovery residences. In 2011, NARR released national standards for recovery residences. These standards define the spectrum of recovery-oriented housing and services and distinguishes different types and levels of support. We hope the Committee considers NARR as a valuable partner in this effort. We would hope further deliberations related to H.R. 2376 include action that would ensure State alcohol and drug agencies are specifically referenced as eligible applicants for the newly authorized grant to implement recovery housing best practices.

The 9-8-8- and Parity Assistance Act of 2022 (H.R. 7232): This legislation authorizes resources for a Crisis Coordination Office within SAMHSA; creates a grant program for regional and local lifeline and call centers; establishes a crisis response partnership pilot program; authorizes a national suicide prevention media campaign; and other provisions.

NASADAD Observations: We applaud Representative Cardenas (D-CA) and seven other original co-sponsors for their efforts on 988 implementation in particular, and crisis services in general. NASADAD recommends specifically referencing substance use disorders in all areas of the legislation in order to acknowledge and elevate substance use disorder considerations as a core pillar of any work related to crisis response. We believe the use of precise terminology in statute and regulation is needed given the many distinct and unique considerations that accompany service delivery for people with substance use disorders. We appreciate efforts by Representative Cardenas and others to increase references to substance use disorders in a number of provisions. We look forward to working with the sponsors and the Subcommittee as the legislation moves through the consideration and approval process.

The Summer Barrow Prevention, Treatment, and Recovery Act (H.R. 7234): This legislation reauthorizes 11 important programs within SAMHSA.

NASADAD Observations: NASADAD wishes to recognize Representatives Spanberger (D-VA), O'Halleran (D-AZ), Salazar (R-FL), and Armstrong (R-ND) for their work on this bill. Although there are

a number of important provisions in the bill, we will highlight two authorizations that have a large impact on State prevention, treatment and recovery systems across the country:

- Priority substance abuse treatment needs of regional and national significance within SAMHSA's Center for Substance Abuse Treatment (CSAT): CSAT works closely with State alcohol and drug agencies to help expand access to treatment for and recovery from substance use disorders. CSAT focuses on work to improve the quality of substance use treatment services through its Addiction Technology Transfer Center (ATTC). NASADAD recognizes Dr. Ingvild Olsen, Acting Director of CSAT, for her leadership of the Center. Further, we wish to recognize the Division of State and Community Assistance (DSCA) for their support of NASADAD's members in working to implement State-based awards including the Substance Abuse Prevention and Treatment (SAPT) Block Grant. In addition, the Division of Pharmacologic Therapies (DPT) is a key component of SAMHSA that works with State Opioid Treatment Authorities (SOTAs) and State agency directors to ensure effective programming related to medications for substance use disorders, including those moving forward within our nation's opioid treatment programs (OTPs).
- Priority substance abuse prevention needs of regional and national significance within SAMHSA's Center for Substance Abuse Prevention (CSAP): As noted by SAMHSA, CSAP provides national leadership in the development of programs, policies, and services to prevent the onset of illegal drug use, prescription drug misuse, and underage alcohol use and tobacco use. CSAP also works to help promote evidence-based practices through structures like the Prevention Technology Transfer Centers (PTTC). We applaud Dr. Jeff Coady, Acting Director of CSAP, for his direction. In addition, we recognize CSAP's Division of Primary Prevention (DPP) for their work with States. A NASADAD priority program within CSAP is the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) initiative. This program allows State alcohol and drug agencies to utilize cross-agency collaboration to address prevention priorities through a data-driven process. State alcohol and drug agencies partner with anti-drug coalitions to implement this important work at the local level. At the national level, NASADAD partners with the Community Anti-Drug Coalitions of America (CADCA) to help foster these relationships and promote best practices in prevention.

Timely Treatment for Opioid Use Disorder Act of 2022 (H.R. 7238): The Timely Treatment for Opioid Use Disorder Act of 2022 would eliminate the requirement that an individual must be addicted to opioids for at least one year before being admitted for treatment by an opioid treatment program (OTP).

NASADAD Observations: NASADAD wishes to recognize Representatives Bucshon (R-IN), Axne (D-IA), Miller-Meeks (R-IA), and Pappas (D-N.H.) for their work on this bill. The Association, which houses the State Opioid Treatment Authorities (SOTAs) referenced above, supports this bill. NASADAD recognizes the benefits of promoting increased access to services provided by OTPs. We also appreciate placing more decision-making authority into the hands of States and qualified providers in order to promote clinically appropriate substance use disorder service delivery.

Conclusion

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

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

**Prepared Written Testimony of Vail W. Smith U.S.M.C.
House of Representatives Energy and Commerce
Health Subcommittee Hearing
Communities in Need: Legislation to Support Mental Health and Well-Being
Tuesday April 5, 2022**

Subcommittee Chair Eshoo, Subcommittee Ranking Member Guthrie, Chair Pallone, Ranking Member McMorris Rodgers, and Members of the Committee:

Thank you 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. I will address issues that have not only affected me, but so many others as well.

As a participant of the Depression and 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 will reauthorize this year. As an instructor for the DBSA peer specialist course, I have been able to share with my students my own journey, which is one of turning confusion, despair, and grief to one of hope, understanding, and promise for the future.

After years in and out of psychiatric wards, institutions, treatment, or being a lost soul on the streets, I began a comeback 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 along side of me as I fought this war within me. I was shown skills and tools she had learned from DBSA to help me cope with my 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, and I was not just some broken thing to be thrown away callously by society.

I am grateful to now be a Peer Specialist Instructor, helping individuals learn how to use their own lived experience to help others in their recovery journey. However, we definitely need more Peer Support Specialists in America. The SAMHSA Behavioral Health Workforce report states that to fully support those receiving behavioral health care services, the country needs over 700,000 Peer Specialists, yet we only have 23,000 trained. Our position is spread so thin that even with maximum effort, we are only able to reach a portion of those who could greatly benefit from our services, which I believe would decrease the suicide rate and other related problematic mood disorder issues, as well as to help inspire those afflicted to become a more productive citizen of our great country. I encourage Congress to provide much needed funding to allow for the training of peer specialists by working with and supporting organizations, like DBSA, that have a long history in peer specialist training.

I also serve as a mentor for peers participating in the DBSA peer apprentice program. This program is a SAMHSA Project of Regional and National Significance and is funding a pilot to create a program providing individuals with a pathway to becoming a state certified peer specialist. Peer apprentices who participate in the program attend and facilitate DBSA virtual support group meetings for members of the Black Community. In these virtual support groups, I am able to share my own lived experiences in a therapeutic manner with others who also struggle with mood disorders. The ability to reach out for help from the comfort of my own surroundings increases my desire to seek help as well as give my support. These meetings comfort me immensely in various ways and also let me know that I am not alone. It is programs like this that are going to expand the number of peer specialists and ensure that there are well-qualified to provide support. However, for all Americans to have access to this type of assistance when they are in need, Congress must create and fund a program that focuses on making peer specialist apprentice programs a reality.

Like many things, COVID brought to light both the value and the barriers that exist to receiving care. Limited access to virtual meetings was a significant barrier for peers and individuals seeking support during the lockdowns and even now as we are trying to return to a sense of normalcy. Since the start of the pandemic, DBSA has seen participation in their virtual online support group meetings grow by 137% and there are wait lists for every single meeting. As someone who uses these virtual support groups to reinforce my recovery, I wish to tell you that it is extremely discouraging when I am unable to attend because of limited capacity. That is why I was so pleased to see that there is bipartisan support for H.R. 2929, the Virtual Peer Support Act. If it becomes law, this bill will provide funding to expand access to virtual peer support services. I hope Congress can pass it very soon to eliminate the wait list to join support groups.

Additionally, as we look toward full implementation of the 988 program, it is reassuring to know that certified peer specialists are recognized under the law and will play an important role to support increased capacity by staffing the phone lines and providing support and services to people in need. I have an intimate personal experience with the VA crisis line, which is similar to the new 988 program. Years ago, I was distraught, alone, and in abject dysfunctional misery. My spirit was weary of trying to deal with my mood disorder. The only person I was able to reach that day as the reality of suicide hovered nearby was a patient, understanding individual that picked up the phone. She talked to me for the better part of three hours and her selfless support persuaded me to give it one more try. So, gratefully, here I am today.

I also serve on the board of the Lake County Coalition for the Homeless. As a person who has experienced homelessness, I understand the unique challenges faced by people who are experiencing them and appreciate how to connect them with programs that can provide safe and supportive housing. I know that in trying to navigate my dual diagnosis successfully, housing gave me a safe refuge, a home base where I was able to plan the goals of my recovery. It also provided a case manager to assist me in reintegrating as I dealt with my mental health issues. The case manager was an individual I could turn to when things didn't go as expected instead of letting my depression drag me into a dark place where there was no hope and only suffering.

Another area where I fervently hope Congress could provide more support is enhanced funding for programs associated with law enforcement education and training programs. In 2014, during a particularly impairing episode of PTSD, I was shot multiple times by the Chicago Police resulting in multiple ostomy's simply because the officers had a lack of understanding concerning mental health issues. I believe a program such as the Crisis Outreach and Support Team (COAST) in my area, where police pair with a Peer Support Specialist and or mental health professional, would have prevented this from happening to me. As a reminder of these catastrophic events, I have a bullet lodged in my sternum, centimeters above my heart as well as one in my lower spine, which confined me to a wheelchair for months. The irony of this is that I made it through a war serving my country without being shot, only to be shot in my home country, stemming from mental health conditions originating from that war.

I also think highly of jail diversion programs, such as mental health court and Veterans court, which I have participated in, and gives the participants a chance to turn their lives around. The partnership between the legal system along with supportive services for mood disorders and/or substance issues help reintegrate participants back into society instead of just giving up on them and throwing away the key.

In closing, I would like to say, by no means am I a finished product. But, because of many of the 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, for the help you have implemented thus far, and for taking this time to contemplate how to improve our Country and its citizens rather than give up on those of us who suffer from within.