S. HRG. 117–775

PROTECTING YOUTH MENTAL HEALTH: PART II—IDENTIFYING AND ADDRESSING BARRIERS TO CARE

HEARING

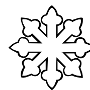
BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

FEBRUARY 15, 2022



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PROTECTING YOUTH MENTAL HEALTH: PART II—IDENTIFYING AND ADDRESSING BARRIERS TO CARE

TUESDAY, FEBRUARY 15, 2022

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., via Webex, in the Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Casey, Whitehouse, Hassan, Cortez Masto, Crapo, Grassley, Thune, Portman, Cassidy, Lankford, Young, and Barrasso.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Elizabeth Dervan, Health Counsel; and Michael Evans, Deputy Staff Director and Chief Counsel. Republican staff: Kellie McConnell, Health Policy Director; and Gregg Richard, Staff Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Senate Finance Committee will come to order. And, during this morning's hearing on the youth mental health epidemic, we are going to have an opportunity to build on last week's superb discussion with the Surgeon General, Dr. Murthy.

Last Tuesday, Dr. Murthy told us that mental health problems often show up first when we have people who are very young, but the average delay between the onset of mental health symptoms and the beginning of treatment is actually 11 years. Those are, in the Surgeon General's words, "11 long, confusing, isolating, and painful years."

This obviously is a number worth a thousand words, and more than anything it says that America's approach to mental health care is way out of whack, and it starts failing America's young people early on. So, there are several priorities for today.

Let's focus on how mental health care for young people starts much earlier—earlier screenings, earlier interventions, earlier discussions with primary care doctors. There is also a need to step up mental health efforts in schools and in our communities.

Those are also places where trained professionals can get the symptoms right from the outset and refer young people to skilled

practitioners when necessary. At present, we get told again and again that school counselors are overwhelmed, community-based programs are too few, and referrals are inconsistent. Mental health care simply does not start early enough, and it's not reaching young people where they are, especially kids in rural areas.

Second, our country must have better crisis care. The 11-year treatment gap is a sign that young people are struggling, going without the treatment they need, and heading on a path to crisis. In addition, America's mental health system too often fails the young when they are in crisis as well.

The evidence shows that the pandemic has driven a shocking increase in self-harm among young people. Suicide attempts among young teen girls resulting in hospitalizations recently jumped more than 50 percent. Far too many of these young people in distress are spending days or even weeks boarded in emergency departments. For the bulk of the time, they are probably alone. Imagine, colleagues, feeling a sense of extreme isolation clashing with the chaos and commotion of the emergency department buzzing outside your door.

Just yesterday I spoke with a group of Oregon health-care practitioners and physicians who told me they were concerned that in many of these crisis situations, young people who end up in the hospital emergency rooms are not even seeing practitioners who have training in mental health. The emergency room is no place for a child in crisis to spend day after day, but it is all too common. Young people simply deserve better.

Third and finally, solving these problems is going to require creativity from the public and the private sector. The Children's Health Insurance Program and Medicaid, which is the largest single payer of mental health care for young people, can play a key role in sparking new solutions. These efforts will be essential to make sure mental health is treated with the same consistency and focus given to physical health.

The bottom line is, no more mental health business as usual, because business as usual is failing too many young people at every single point, from the first sign of symptoms to the most critical moments of crisis.

There is a lot for the committee to discuss today on these key issues. We are going to have a great panel whom I am going to introduce shortly. I want to thank Senators Carper and Cassidy for heading up our efforts on youth mental health care. And I also want to commend Senator Stabenow for her years and years of work on behavioral health issues that are so important, and that we will build on.

[The prepared statement of Chairman Wyden appears in the appendix.]

The CHAIRMAN. Now we will turn to Senator Crapo for his opening remarks. And then we will have introductions—and where is my friend, Senator Crapo?

There he is. Senator Crapo?

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Mr. Chairman, and thank you to our witnesses for joining us today as we discuss ways to respond to mental health challenges impacting children and adolescents across the country.

According to recent reports from the CDC, the number of young people dealing with depression, anxiety, and suicidal thoughts has unfortunately risen during the pandemic, as social isolation has taken its toll on far too many children and adolescents. Although it appears the pandemic is subsiding and our return to normalcy may be imminent, we cannot ignore the lasting effects of the past 2 years on the social and emotional well-being of children.

We should do all that we can, within our jurisdiction, to increase access to high-quality mental health services and reduce the causes of delayed and forgone treatment. While mental health issues affect people of all ages, children's needs are often different from those of adults, necessitating carefully tailored solutions.

As this committee works in a bipartisan way to advance the conversation on mental health, we must not only identify the complexity and scope of the problems at hand, but also explore innovative, sustainable, and concrete policy solutions. I look forward to working with my colleagues on both sides of the aisle to develop meaningful measures to meet some of the Nation's mental health challenges, including by expanding access to telehealth services, supporting our mental health workforce, and better integrating physical and mental health-care services.

Children can and often do benefit from services delivered via telehealth. While we often focus our telehealth discussions on Medicare, where key access gaps and barriers remain, this committee should also prioritize clarifying and expanding care delivery options for children covered by Medicaid, regardless of geographic location.

Additionally, we should work to maintain a strong mental health workforce with the capacity to care for all who need services. These efforts will prove particularly crucial as health-care professionals burn out, steep regulatory demands continue, and other strains jeopardize long-term provider retention and capacity.

We have clear opportunities for improvement at every level. I regularly hear from front-line providers, as well as State policymakers, seeking the flexibility to innovate and craft targeted, local solutions to the challenges facing their communities.

Their ideas and input will play a critical role in this process, especially as we look to bridge gaps in care, better integrate physical and behavioral health services, and promote value-based payment models that put patients first. If structured effectively, these reforms could prove game-changing for populations of all ages, including young people.

Finally, no conversation on mental health-care reforms for children and young adults would be complete without input from those whom the policies intend to empower and support. To that end, Trace, thank you for your willingness to join us today to share your perspective.

We have the opportunity to better support children, their families, and their providers, by enhancing mental health outcomes across the United States. Moreover, we can and must do so while honoring this committee's strong tradition of member-driven, bipartisan, and fiscally responsible legislative solutions.

Thank you to our witnesses for agreeing to share their expertise from across the continuum of care. They have provided invaluable service during these unprecedented times, and I look forward to hearing their testimony.

Thank you.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. Senator Crapo, thank you for a very helpful opening statement. As you noted, we are going to do this in a bipartisan way. There is an awful lot of common ground here, and I am especially appreciative that you zeroed in on telehealth, because the Finance Committee is especially proud of the telehealth contribution we made at the beginning of the pandemic, during those early days when the Centers for Medicare and Medicaid Services, headed by Seema Verma, were trying to figure out how to proceed. And to a great extent, they took the telehealth provisions of the CHRONIC Care law that was written in a bipartisan way in our committee.

So I appreciate your zeroing in on telehealth issues, and we are certainly going to build on them in our work this year. And also, thank you for giving a little bit of a send-off, as we move to introductions, to Trace Terrell, because he is one of our own, a student from La Pine, OR, a mental health leader, and an advocate in his community. He has volunteered with YouthLine, a peer-to-peer youth crisis service based in our State that receives 27,000 contacts each year from young people across the country. YouthLine is provided by Lines for Life, a nonprofit dedicated to suicide prevention and mental health support, and Oregon's home for the National Suicide Prevention Lifeline.

Beyond YouthLine, Mr. Terrell has advocated for youth mental health through a number of other organizations, including the National Mental Health Advisory Board supported by Well Being Trust, Young Invincibles, and Active Minds.

A high school senior—because I am on the Intelligence Committee, people sometimes tell me important little items about our guests, and I recently learned that Mr. Terrell has been accepted to Johns Hopkins University, and we all want to extend congratulations for that great achievement.

With that, I am going to turn it over now to my colleagues to introduce witnesses that they have worked with and are very proud of. Senator Casey will introduce Dr. Tami Benton from the Children's Hospital of Philadelphia. Senator Hassan will then introduce Jodie Lubarsky from Seacoast Mental Health Center in New Hampshire. And then Senator Cardin will introduce Dr. Sharon Hoover from the University of Maryland School of Medicine's National Center for School Mental Health. And then we will hear their testimony.

Senator Casey?

OPENING STATEMENT OF HON. ROBERT P. CASEY, JR., A U.S. SENATOR FROM PENNSYLVANIA

Senator CASEY. Mr. Chairman, thanks very much for this opportunity. I am pleased to introduce Dr. Tami Benton. And I appreciate Dr. Benton's expertise at this hearing today, in addition to her lifelong commitment to serving both children and families.

Dr. Benton is psychiatrist-in-chief, executive director, and chair of the Department of Child and Adolescent Psychiatry and Behavioral Sciences. She is clinical director of child and adolescent psychiatry, and a psychiatrist in the 22q and You Center at the Children's Hospital of Philadelphia, which we often refer to by the acronym CHOP. She also serves as president of the American Academy of Child and Adolescent Psychiatry and as an associate professor of psychiatry at the Perelman School of Medicine at the University of Pennsylvania. Dr. Benton also serves on the board of the Juvenile Law Center, which advocates for children and child welfare in the juvenile justice system.

Her expertise spans pediatric depression, suicide, and anxiety, particularly for minority youth and those with chronic diseases, as well as our mental health workforce shortage.

So, Dr. Benton, thank you for being with us today. And thank you for all you have done to support families long before and throughout this pandemic. I look forward to your insights today.

The CHAIRMAN. Thank you, Senator Casey, and we look forward to hearing from Dr. Benton.

Senator Hassan is here to introduce Ms. Lubarsky.

OPENING STATEMENT OF HON. MAGGIE HASSAN, A U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Well, thank you so much, Chairman Wyden and Ranking Member Crapo, for holding today's hearing on protecting youth mental health. It is essential that we get our children the mental health support and resources that they need. And I would like to welcome a Granite Stater who is with us today to serve as an expert for today's hearing.

Jodi Lubarsky is the vice president for clinical operations, Youth and Family Services, at the Seacoast Mental Health Center in Portsmouth, NH. She has a master of arts in mental health counseling and is a licensed clinical mental health counselor.

At the community mental health center where Ms. Lubarsky works, she oversees the evaluation and treatment services for children, adolescents, and their families. These services include psychotherapy, psychiatry, community-based behavioral supports, targeted case management, substance use disorder treatment, 24/7 crisis intervention, and post-intervention services to schools and communities affected by suicide and loss.

To say she is at the front lines of some of the toughest battles our children face would be an understatement. In her role as vice president and as mental health counselor, Ms. Lubarsky provides support to young people who are experiencing mental health challenges, and she has seen firsthand how the pandemic and the shortage of mental health services has increased the number of patients in her center.

In fiscal year 2020, the Youth and Family Services team at Seacoast Mental Health Center provided more than 33,000 services. In fiscal year 2021 alone, it provided more than 41,000 services to children and families, a 25-percent increase. The number of patients seen in fiscal year 2021 was almost 13 percent higher than in the previous year.

In response to the wave of children and young adults requiring services, Ms. Lubarsky has worked on innovative programs in New Hampshire that have been integrated into places like our schools and our summer camps.

Given her extensive experience and expertise, she will be able to speak today about the challenges facing our children, the critical programs that she has helped to develop, and the persistent barriers that limit access to mental health care.

Jodi, thank you for being here and for your work on behalf of New Hampshire's children and families. I look forward to hearing from you today.

Thank you, Mr. Chairman.

The CHAIRMAN. And thank you for all your help for this hearing, and for making sure we could have Ms. Lubarsky. And we are looking forward to working closely with you every step of the way as we tackle this issue.

Senator Cardin is here to introduce Dr. Sharon Hoover.

OPENING STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. SENATOR FROM MARYLAND

Senator CARDIN. Well, thank you, Mr. Chairman. Let me thank Senator Wyden and Senator Crapo for their leadership on this issue, and on so many others, bringing us together to deal with the critical problems.

I first want to acknowledge Trace, and congratulations on your acceptance to Johns Hopkins, located in Baltimore, MD. We are proud to have you in our State.

I am proud to introduce a fellow Marylander, Dr. Sharon Hoover. She is a licensed clinical psychologist and professor at the University of Maryland School of Medicine, Division of Child and Adolescent Psychiatry. She is also co-director of the National Center for School Mental Health, and director of the National Center for Safe Supportive Schools within the National Child Traumatic Stress Network.

Dr. Hoover has led and collaborated on multiple Federal-State grants, and is currently co-leading two large randomized trials of school mental health efforts. Since 2004 she has worked with the National Child Traumatic Stress Network's Treatment Services Adaptation Center for Resiliency, Hope, and Wellness in Schools to train school districts and school leaders, educators, and support staff in a multiple-tiered system of support for psychological trauma.

Dr. Hoover is a certified national trainer for the Cognitive Behavioral Intervention for Trauma in Schools program, and the Support for Students Exposed to Trauma program.

Last year she was kind enough to join the constituent event I hosted concerning youth and COVID–19, and I know that Dr. Hoo-

ver's input was extremely helpful to my constituents, and I know she will add greatly to our discussion today.

Welcome, Dr. Hoover. It is a pleasure to see you.

The CHAIRMAN. Thank you, Senator Cardin, and for your years of advocacy in the health-care area for vulnerable folks in Maryland and our country.

So thank you all, colleagues.

And, Mr. Terrell, we are glad to have your voice coming from La Pine, and please proceed.

STATEMENT OF TRACE TERRELL, LEAD INTERVENTION AND OUTREACH SPECIALIST, YOUTHLINE, LA PINE, OR

Mr. TERRELL. Thank you. Thank you Chairman Wyden, Ranking Member Crapo, and the other members of the committee, for the opportunity to represent the youth perspective as it pertains to mental health.

My name is Trace Terrell, I use he/him pronouns, and I am a 17-year-old from La Pine, OR. Before I share more about myself, I would first like to tell you some things I have heard from teens across the country.

4:07 p.m.: I just need someone to talk to; 4:37 p.m.: my dad hit me, but you can't call the cops; 5:23 p.m.: I need therapy, but my family can't afford it; 8:07 p.m.: I just lost my dad, and I can't stop crying; 6:42 p.m.: I want to kill myself.

These are just some examples of the many conversations that I respond to as a volunteer with YouthLine, a free, confidential, teen-to-teen crisis help support hotline located in Oregon. Whether helping someone navigate complicated feelings about their sexuality or working with others to develop comprehensive safety plans, I spend 3½ hours every week responding to a variety of mental health challenges experienced by teens across the country, with an emphasis on the fact that no problem is ever too big or too small.

I became involved with YouthLine during my freshman year of high school. As someone who struggled with depression, suicidal ideation, eating disorder behavior, and anxiety throughout middle and early high school, I, for the longest time, believed that no one could relate to my experiences.

However, as I became more involved, I realized that my challenges were a microcosm of public health issues that affected hundreds of thousands of teens across the country.

As more and more teens start to have conversations about mental health and engage in help-seeking behaviors, the need for expansive and intersectional mental health efforts has never been so great.

So, what can we do to address the youth mental health crisis?

One, we must centralize our efforts in schools. From my experience and many of my peers, mental health efforts in schools are lacking. Day after day, I hear my friends and those on the line talk about how inaccessible school counselors are due to being overworked and overloaded. This has been an especially difficult challenge for the many teens who rely on school mental health professionals for crisis care. We have to address this staffing crisis.

We must also create a streamlined approach to free mental health screenings and referrals. At my school, four of every five re-

ferrals to external resources are not carried out. Let that sink in: 80 percent of referrals go nowhere. Someone who needs help, should receive help.

Last, we need a comprehensive and standardized mental health curriculum. All students should learn about engaging in real-world help-seeking behavior, developing systems of self-care, and supporting our friends with mental health struggles, because statistics show that we turn to each other before anyone else.

Two, we need to address the pressing challenges that young people continue to face in accessing mental health care. While I am no expert in policy solutions, I am someone with lived experience. I know what it is like to be a teen today struggling with mental health. And I know what it is like to offer support to teens in crisis.

On and off the lines, the most common struggles I see expressed by my peers in regard to accessing mental health care are financial, transportation, and broadband barriers; the urban/rural divide in mental health care; the lack of mental health professionals and adequate follow-through care; and the stigma around mental health.

These issues are incredibly real. My friends have struggled to receive professional mental health services because it is too expensive for their families, too far away, or inaccessible because of unreliable Internet access. We need to bring care to where people are. And for teens, that is in schools or at home.

In addition, we know that the lack of mental health professionals in the United States prevents teens from receiving the help they need. One of the ways we can approach this issue is by funding a national YouthLine. We know that peer-to-peer support works, and that there is a substantial need for it.

What youth need is to be able to call on the new 988 and have the opportunity to be connected with another trained teen.

Three, we must invite youth to the table and value their insights as natural partners in this work. I am just one of 165 YouthLine volunteers. What does that tell you? Youth are not afraid to talk about mental health. If anything, adults are. Across the country, young people are mobilizing and advocating for mental health like never before.

Beyond YouthLine, I have been involved with organizations like Active Minds, for whom I and millions of my peers helped to change the narrative for how we talk about value and seek care for our mental health.

My peers and I believe that we deserve a seat at the table. While there are many ways we can do this, it starts by ensuring that young people can meaningfully contribute to and be involved with legislative work on the local, State, and Federal levels.

If there is anything I want to leave you with today, it is this. Teens are talking, and we need you to listen. At YouthLine, we know that the work we do makes a difference in the lives of young people across the country, and we know that because of what we hear from teens after we have connected them to help, after we have talked about self-care, and after we have helped them find a path forward.

6:26 p.m.: I feel so much better talking; 8:34 p.m.: if it weren't for this conversation, I would not be here today.

Thank you.

The CHAIRMAN. Trace, thank you for getting us off to such a powerful start, and what I want you to know—you said that young people were mobilizing. Those are very welcome words, and I think you are going to see today the Democrats and Republicans in the U.S. Senate, the Finance Committee, are going to start mobilizing to move real reform. And make no mistake about it, you and young people are going to have a seat at that table when we are working on these reforms.

So, thanks for getting us off to such a strong and powerful start.

[The prepared statement of Mr. Terrell appears in the appendix.]

Dr. Benton, let's see where you are. Dr. Benton from Children's Hospital of Philadelphia, you have the honor of trying to keep up with Trace. It is a big challenge, and you do wonderful work, as Senator Casey said.

STATEMENT OF TAMI D. BENTON, M.D., PSYCHIATRIST-IN-CHIEF, EXECUTIVE DIRECTOR, AND CHAIR, DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY AND BEHAVIORAL SCIENCES, CHILDREN'S HOSPITAL OF PHILADELPHIA, PHILADELPHIA, PA

Dr. BENTON. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for this opportunity to testify.

I wish there were no need for me to appear today, but children and adolescents are experiencing mental distress at higher rates and with more dire consequences than ever before.

In the first half of 2021 alone, we reported cases of self-injurious behavior and suicide in children ages 5 to 17 at a 45-percent higher rate than during the same period in 2019. And for children under 13, the suicide rates for Black children have increased at twice the rate for White children.

The pandemic has both highlighted and worsened disparities in pediatric mental health care. There are barriers to access, under-recognition, and under-treatment of mental health disorders. The burden of illness is worsened for children of color, who often have greater exposure to environmental traumas.

It is also true that children with mental health challenges are overrepresented in the juvenile justice and child welfare systems, where higher rates of mental health disorders are often unrecognized and untreated.

You have heard many of these statistics before, but I would like to share with you how these situations show up in my day-to-day life as a physician.

A 5-year-old in the emergency department who discloses suicidal feelings and plans to run into traffic in reaction to her parents' job loss, financial stresses, and her mother's depression.

A 6-year-old boy suspended from first grade for kicking a desk after witnessing a shooting 20 feet away from him while walking home from school, too terrified to disclose the experience for fear that he would be the next victim.

A 16-year-old honor student becoming depressed after a romantic breakup, eventually making a serious suicide attempt while waiting 6 weeks for treatment, and then hospitalized for 2 weeks in a

medical facility where he waited for in-patient psychiatric care. And then when it was available, financial barriers interfered with the smooth transition.

It is situations like these that led the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the Children's Hospital Association to sound the alarm for kids, and to declare a national emergency in children's mental health. But there are things that we know.

Children and adolescents recover best when care is targeted to their needs, evidence-based, no more restrictive than it must be for safety, and close to home. And, while I can speak more directly to the shortage of child and adolescent psychiatrists, there are also severe shortages of other pediatric mental health providers, which all must be addressed.

These shortages lead to increased emergency visits for things that are preventable. In my home institution at Children's Hospital Philadelphia, we have 20 to 30 patients boarding, awaiting acute psychiatric care. And this is true on any given day.

We typically operate at full capacity, so occupied beds prevent children with complex medical needs from receiving care. But despite the things I have just shared, I remain optimistic. Effective strategies exist for preventing and treating pediatric mental and behavioral conditions while supporting the natural resilience of children and families.

But success requires responses to two urgent tasks before us: first, addressing the immediate crisis that we are facing right now; and second, reframing our pediatric mental health system with the goal of preventing disrupted development and facilitating a successful transition to adulthood. Expansion of the workforce will take time, even if we start today. So I will focus more on immediate options to address the crisis.

One of the best things that we can do is to support those on the front lines now by providing them with effective training. This should also extend beyond primary care pediatricians. Caregivers and educators can be empowered through training to better manage the situations they face. And we must act now to pivot mental health services from crisis-driven care to prevention, and make sure that needed treatments are available where families are likely to be, such as pediatricians' offices, daycare, after-school programs, and schools.

The pandemic has also taught us important lessons. Telehealth has been an important tool for providing care across State lines, in underserved areas, rural areas, local and distant communities, and for working families. It has had surprising therapeutic advantages such as seeing the whole family, and seeing them in their natural environment.

This tool must continue as an adjunct to our current continuum of treatment. And I cannot conclude my remarks without noting that both coverage of the range of services kids need, and the appropriate reimbursement for these services are essential. The continuum of services needed for children for mental health are absent at every level. Children need to get the right treatment at the right time at the right place.

And finally, I want to end by sharing an experience that reflects my hope for the future.

Just last week I interviewed two fifth graders, Daniel and Kaitlin. They asked me, "When can normal feelings like depression, anxiety, become bad for you?" These are questions that all Americans should be asking at this time—and should be able to answer.

I want to thank you again for allowing me to provide this testimony. I am confident that you will take this opportunity to secure our Nation's future by supporting our children through the crisis.

Thank you.

[The prepared statement of Dr. Benton appears in the appendix.]

The CHAIRMAN. Dr. Benton, thank you very much for your helpful testimony. And I noted you talked about access to coverage and reimbursement. We think that is very much intertwined with some of these big insurance companies not following through on parity, which is so essential for mental health patients. So you gave us a lot of very valuable input, and we look forward to working with you.

Now we will go to Ms. Jodie Lubarsky.

STATEMENT OF JODIE L. LUBARSKY, M.A., LCMHC, VICE PRESIDENT OF CLINICAL OPERATIONS, YOUTH AND FAMILY SERVICES, SEACOAST MENTAL HEALTH CENTER, INC., PORTSMOUTH, NH

Ms. LUBARSKY. Good morning, Chairman Wyden, Ranking Member Crapo, Senator Hassan, and members of the U.S. Senate Committee on Finance. I want to thank you for the opportunity to testify today as a witness regarding pediatric mental health. I am both humbled and grateful for this opportunity.

I currently serve as the vice president of clinical operations for Youth and Family Services at Seacoast Mental Health Center. We are one of 10 community mental health centers in the State of New Hampshire. I am also a Licensed Clinical Mental Health Counselor still actively seeing pediatric patients, a youth swim coach, and a parent.

In March of 2020, life as we once knew it changed for all of us. As adults, we made many quick pivots to respond and adapt to the COVID–19 pandemic. As we made many adaptations in both our personal and professional lives, we had our past experiences to reflect upon. When faced with the new and often unpredictable challenges the pandemic created, we pulled from our toolbox of coping strategies. We knew who we could turn to for the extra support we might have needed as we navigated those challenges.

But for most of the youth in our country, they were left feeling paralyzed, stymied, hopeless, and scared. For many youth, this was their first experience with grief, trauma, depression, or anxiety. Life for them had completely changed, and their worlds were turned upside down. The uncertainty, social isolation, and stressors related to the pandemic have left many kids unable to cope or understand the breadth and depth of this experience. And for some, there was no trusted adult to support them during this critical developmental period and their only means of symptom relief was contemplating death.

We are learning that teenage girls have begun to demonstrate an increase in the acuity of their symptom presentation. Data from the Centers for Disease Control and Prevention indicates a 51-percent increase in suicide attempts by teenage girls ages 12 to 17. LGBTQ+ youth continue to have higher rates of suicide than their heterosexual peers. Data from 2020 demonstrated that the percentage of emergency department visits for mental health emergencies rose by 24 percent for children between the ages of 5 and 11 and 31 percent for those ages 12 to 17, compared with 2019.

Youth mental health has become the secondary pandemic to COVID. As mental health needs rise for pediatric patients, the availability of services continues to become more scarce. Youth are presenting to hospital emergency rooms in a state of psychiatric crisis. Many who are assessed and meet the criteria for psychiatric inpatient level of care will be faced with boarding in an emergency room for days, weeks, and sometimes months before a bed becomes available.

Emergency room boarding often creates more distress, decompensation in psychiatric symptoms, and increased traumatic exposure, while receiving no mental health care until the inpatient bed becomes available. Staffing shortages in both outpatient and inpatient settings due to an exhausted, depleted, and underpaid mental health workforce have only prolonged access to care for pediatric patients.

Without adequate funding and reimbursement structures from both Medicaid and private payers, mental health providers are left with the difficult decision to leave the nonprofit world and enter a for-profit world in order to make a livable wage. During the pandemic, there were two 3-percent increases to Medicaid rates. And while that is appreciated, prior to those two increases there had not been meaningful increases in Medicaid rates in over 20 years. Without a realistic reimbursement structure based on the current cost of living, centers are losing staff who can no longer afford to work in mental health settings.

Some mental health centers are reporting a 40-percent rolling 12-month turnover rate in staffing during the pandemic, leaving no workforce available to attend to the critical and fragile needs of pediatric patients. And for the mental health workforce that remains, they are often left supporting higher caseloads than their private-practice peers, with limited time while attending to significant administrative tasks that private mental health providers are not expected to complete.

The community mental health workforce treats some of the most complex cases. The complexity of cases, the severity of need, and demand placed upon this workforce during the pandemic have left many professionals questioning their longevity in the mental health field. I feel many mental health professionals entered with an altruistic spirit and are now left feeling broken and tired.

While we can discuss an ideal service array, evidence-based practices, and the ideal care setting, none of this can be provided without a robust, well-trained, adequately compensated, and sustainable mental health workforce from all professional disciplines and degree levels. Simply put, we need to be able to adequately reimburse mental health providers in order to compensate the mental

health workforce. Adequate reimbursement will help to sustain a robust mental health workforce to provide high-quality, timely, adequate care to our pediatric population.

I thank you for your time today.

[The prepared statement of Ms. Lubarsky appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Lubarsky. You finished so powerfully with the workforce, I just wanted to come back for a moment and say "thank you" for mentioning at the outset, that in those first days of the pandemic, you reached for your mental health toolbox, because that is really what this is all about: making sure that practitioners, not somebody micro-managing in Washington, DC, can have an adequate array of tools.

And as you know so well from your outstanding work, too often the toolbox is pretty barren in much of the country. And that is what Dr. Murthy told us last week. So, thank you. I know you are going to get some questions in a moment.

Dr. Sharon Hoover is next, please.

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

Dr. HOOVER. Thank you. I want to express my thanks to you, Chairman Wyden, for the invitation to speak with the committee today, and for your leadership on the issue of mental health in our Nation, including the impacts on youth. I thank also Ranking Member Senator Crapo, and all of the committee members for your vision to improve the mental health and well-being of our young people, and for the opportunity to be here with you today to talk about these important issues.

I am speaking to you from my perspective as co-director of the National Center for School Mental Health, which is funded by the U.S. Department of Health and Human Services, and as a professor of child and adolescent psychiatry. But I also speak to you through my lens as a parent to three teenagers, all of whom had their learning landscape significantly altered during COVID, with almost a year of virtual education.

They, along with most children across the globe, had significant disruption to their learning and to their well-being, though I am fortunate that my kids are now going to school, and they are doing well. But we know that many are suffering. Even before the pandemic, youth mental health challenges were rising, with suicide being the second leading cause of death for young people ages 10 to 24.

As noted by Surgeon General Murthy during last week's hearing, one of the most central tenets in creating accessible and equitable systems of care is to meet people where they are. And for most young people, this is in schools.

I often think back to a story that my dad, who is now 85 years old, told me about his first day of school. He grew up in a small town in rural West Texas called Spur. They didn't have pre-K or Kindergarten, so it was first grade, and on that first day he recalled that his peers and he received toothbrushes from his first

grade teacher. It was the first toothbrush that he had ever owned. And I remember asking him, “You didn’t have toothbrushes?”, to which he replied, “No; my family wouldn’t have spent the money on toothbrushes back then.” Mind you, my dad went on to a long career in computer science, and he helped create coding to put our astronauts on the moon. But he often credits those teachers in his early years who cared about him with setting him on that path.

And when I consider that moment when he received his toothbrush on the first day of school, I think of it really as a classic example of how our schools are a vital place to promote our children’s health and well-being. We simply cannot rely on our health-care system alone to support the mental health and well-being of our young people.

We know on average, as Senator Wyden noted in the beginning, that people do not get into care for over a decade after the initial onset of symptoms, and half of mental illnesses begin in the school-age years.

Our traditional approach to mental health care has not leveraged the natural venues where our young people access support. It is really akin to waiting for toothaches, cavities, and abscesses until a child gets proper dental care. Instead, we should do the equivalent of passing out toothbrushes and providing preventive and early dental care, by offering every child in every school the social, emotional, behavioral, and mental health supports that they need to be successful.

Increasingly, schools have comprehensive school mental health systems, which reflect partnerships between the education and behavioral health sectors to support a full continuum of mental health and substance use services and supports, from promotion to treatment. And when treatment is delivered in a school setting, youth are far more likely to be identified early and to initiate and complete care.

Schools that have these systems in place recognize that poor mental health leads to poor learning, and positive mental health promotes academic and life success.

There are many policy and funding opportunities, including strengthening full Medicaid programs that can help advance a continuum of mental health supports and services in schools. And Congress has the opportunity to support investment and technical assistance to ensure that young people can get the mental health support that they need.

In my written testimony, I do provide detail on several steps that Federal and State leaders can take to advance comprehensive school mental health systems. And we have witnessed many States adopt new policies to advance school mental health.

Tomorrow, the Hopeful Futures Campaign, a coalition of national organizations committed to ensuring that every student has access to effective and supportive school mental health care, is releasing the first ever “America’s School Mental Health Report Card and Action Center,” with individual report cards for all 50 States and DC. And these school mental health report cards highlight accomplishments and provide important action steps to help address the children’s mental health crisis in every State. They can serve as a great starting point for policymakers who want to strengthen

school mental health supports and policies in their communities. You can find the report cards at *hopefulfutures.us* starting tomorrow morning.

Today, Americans across the country are united in our concern about the mental health of our young people and the impact it has throughout their lives. I want to express my gratitude to you all for opening up this important discussion on youth mental health, for recognizing schools as an essential place to strengthen our children's well-being, and for committing to investing now to create hopeful futures for our Nation's youth.

[The prepared statement of Dr. Hoover appears in the appendix.]

The CHAIRMAN. Thank you very much, Dr. Hoover, and we are going to get you into this discussion in just a minute.

Trace, you really make all of us in Oregon so proud, and you said it so well. And I want to get into an area that I really had not heard about from you. And that is, how serious this problem is with young people getting lost in the system, where they just do not get connected. And the figure you used is 80 percent of referrals from schools for mental health support just go nowhere—just get lost.

How does this make students and young people feel when they just get lost in all of this red tape and bureaucracy?

Mr. TERRELL. That is a great question, Senator Wyden. And I want to clarify that that statistic was for my school. So, I do not actually know the national figure, but I imagine there are similar trends across the country.

The CHAIRMAN. That was for your school, right, Trace?

Mr. TERRELL. Yes.

The CHAIRMAN. Good. Please, go ahead.

Mr. TERRELL. But I think, when we talk about access to care, there has to be a conversation about what happens next, right? What happens next? Who is going to provide the follow-through care? And I think for a lot of teens who get to this point and initially have that first conversation, not being able to get those accesses afterwards is incredibly isolating and incredibly defeating. And I think it really highlights some of the failures of our mental health-care system and things that need to be addressed. Because teens who need help should receive help, and that help should be meaningful and sustainable for as long as they may need it.

The CHAIRMAN. Okay. Sit tight, Trace.

Dr. Hoover, that 80-percent figure is really show-stopping. And my sense is, whether it is 80, or 60, or something, we are just losing a lot of young people at a really crucial time. What ought to be done about that?

Dr. HOOVER. I totally agree, and I would agree with Trace that it is probably not just in his school. We are seeing these figures across the Nation.

So, the bottom line is that getting care to kids in some of our traditional outpatient settings really is a challenge. So, as you heard earlier, one of the first lines of action really is to bring services to where young people are in their schools. We know that every State, and many districts within each State, have examples of really effective school-based mental health care, right? So this includes expanding our school-employed workforce, including our school psy-

chologists, school social workers, and counselors, but also helping facilitate partnerships with community behavioral health provider organizations to bring their services into schools. School-based health centers are also an ideal model of providing this type of on-site care. So, increasing support for school-based health centers is one avenue.

We mentioned telehealth already. We know the expansion of telehealth offers incredible opportunity to expand the reach of specialists, not just in rural settings, although that is critical, but also into our urban settings. We have been providing telehealth from our hospitals into Baltimore City schools for a number of years now.

We heard from Ms. Lubarsky about reasonable reimbursements. That is a critical way of getting services to schools and into outpatient care, and having providers there to receive students when they are referred.

So those are some of the avenues.

The CHAIRMAN. Well, thank you both.

And, Trace, if ever there was an area, as you said, for the committee to work with young people, it is mobilizing, in your words, to make sure that we do not see as many of these referrals get lost in the system. It is just too important, because those are young people who are getting lost.

I want to ask you one other question, Trace. And that is, you and I talked about barriers to care. And clearly, stigma associated with mental health challenges is a big part of this. I saw this with my brother who struggled with schizophrenia for years—and as I went off and played basketball and all kinds of things like that. And my concern is, I keep hearing from people in the schools, and students like yourself, that the stigma has clearly gotten worse as a result of the pandemic, causing more young people to be isolated from each other; that there is not enough peer-to-peer contact and the like.

Can you give us your thoughts on that?

Mr. TERRELL. Of course; yes. I mean, I think we definitely saw how the pandemic increased rates of loneliness, isolation, and other high-acuity mental health struggles. But I think really the most important takeaway from the pandemic, and our response to the mental health-care crisis, is the fact that COVID–19 exacerbated disparities that were already there, right? We know that access to care was limited before COVID–19, and the pandemic only amplified those barriers.

So, if a teen's only way of receiving mental health support was with a school counselor, that relationship was no longer there and they could no longer have that conversation about mental health. And that in and of itself is destigmatizing the stigma around mental health. And I just want to bring up, if a teen feels like the only way they can express their emotions is through the barrel of a gun, what have we become as a society in our perception of mental health for young people?

And we really need to talk about mental health, and I think that first starts with having this conversation and recognizing how COVID exacerbated already existing disparities.

The CHAIRMAN. Trace, we had high expectations for you this morning, and you went way over the bar. So, thank you so much. And you are going to have a seat at the table as we go forward on these big issues, and thank you.

Senator Crapo is next.

Senator CRAPO. Thank you very much, Senator Wyden.

And I agree, Trace, with Senator Wyden's comments. I am going to let you off the hot seat for a minute, though, and go back to Dr. Hoover, and then to some of our other witnesses.

Dr. Hoover, for Idaho and other States with large rural communities, the mental health-care delivery system looks substantially different from other urban or suburban populations. Even though the need for mental health services is similar between rural and urban areas, it is harder for children in rural areas to access those same mental health services.

In your work with the States, can you elaborate on some of the specific risks and challenges that younger Americans living in rural areas might confront with regard to mental health?

And I ask this question in the context of, already you have indicated that our schools, many of them, have good programs in place, and that they are working well and need to be strengthened and enhanced and given more tools.

But focus a little bit on rural areas. How are we doing there? And what role do schools play in providing mental health services to our youth?

Dr. HOOVER. Thank you, Senator Crapo, for the question. And frankly, school mental health is perhaps even more relevant and important in our more rural communities, just because of the workforce shortage, and also some of the stigma issues that Trace just spoke to.

We know that, in rural communities, our young people and families often have a harder time accessing services, as you mentioned. And there often is more of a stigma associated with seeking out mental health supports. We hear often—I was just working with some rural counties in Maryland, and we often hear "everybody knows each other," right? So seeking mental health supports can be even more risky from a student perspective, or even from a family perspective.

That being said, we know that schools can be a place where mental health can be destigmatized. So it is one step, I would say, that is critical in rural communities, and in all communities, to really make mental health part of the education that our young people experience.

So, we can establish mental health as part of the K through 12 curricula, and a number of States are doing that. I know New York, Florida, Virginia, have led the way to infuse mental health as part of what young people learn about. They learn about how to achieve positive mental health, how to recognize if there are some problems, and how to seek support when they actually need support for themselves or for a family member or a peer. So part of it, again, is reducing stigma, and that is particularly critical in our rural settings.

I would say, in terms of the workforce, we know we have to get workforce into our rural communities. And some of that will re-

quire kind of reaching down into our high school, and certainly our undergraduate training environments. I worked with some groups in Nebraska that have done an excellent job of really fostering the high school interest in mental health specialties as they come into undergraduate and then graduate training, but also really working with other providers in schools, including our school nurses and other health providers, and even our front-line educators, to do some task shifting, to adopt some of the skills that they can equip young people with.

We do not have to—we really simply cannot rely exclusively on our specialty mental health providers, especially when we do not have enough.

So those are some of the solutions that I look forward to working with you on.

Senator CRAPO. Well, thank you very much.

Let me move next to Ms. Lubarsky. I am not going to have time to get to all the witnesses. I apologize. But we have lots of questions, and we will give you some even after the hearing.

Ms. Lubarsky, your experiences can provide a deeper understanding of the range of services provided across the continuum of mental health care. One of the most common concepts discussed in the stakeholder responses we have received is the need for increased coordination and case management to lead to better outcomes.

In your role as a community mental health leader, can you explain exactly what "targeted case management" means in practice when you are caring for the kids and their families?

Ms. LUBARSKY. Yes. Thank you, Senator Crapo, for your question. Targeted case management I really view as a fundamental important service for every youth who is receiving clinical services at a mental health center.

When we think about Maslow's hierarchy of needs and that ability to meet your most basic needs in life, that is why we utilize case management with our pediatric patients and their families. If you cannot feel food secure, housing stable, able to access your education in a meaningful way, and really be able to be socially connected to your community in a manner so that, when you are done with your mental health care, you are moving to your supports in your community, then you are not going to be able to reach that final goal, which may be your therapeutic goal when you are coming in for mental health care.

So providers here at the center—for every youth who is eligible for mental health services, they have the ability to receive targeted case management as well. So we are doing that very nice balance between providing the clinical mental health care, while also looking at their needs outside of mental health to make sure we are bringing those worlds together.

Senator CRAPO. Well, thank you. And I will submit my questions for the record to the other witnesses I did not get to. Thank you to all of you for your testimonies.

[The questions appear in the appendix.]

The CHAIRMAN. Thank you, Senator Crapo. And as we said at the outset, we are going to make this a bipartisan effort. This is one

of the most important undertakings the Finance Committee has been part of, and we thank you for your leadership.

And also, to focus on bipartisanship, Senator Stabenow—who for years has worked relentlessly to improve behavioral health with our colleague, Senator Blunt of Missouri—is with us.

Senator Stabenow, your questions.

Senator STABENOW. Well, thank you, Mr. Chairman. I just want to say "thank you" to you and "thank you" to Senator Crapo. This is so important. Spending not one hearing but multiple hearings on mental health is absolutely critical and has not been done since I have been in the Senate, and I am very grateful for all of your leadership.

And yes, this is an area of bipartisanship where we have begun a process of changing to address health care above the neck the same way we address health care below the neck—in the funding and so on. We have models that work now, and we've just got to move forward and get it done. And there is a lot more to do.

And I want to also just give a shout-out to Trace. Thank you so much. Thank you for coming forward and sharing your experience, and for now being a part of really making a difference in young people's lives. And part of overcoming the stigma is all of us just telling our own story, the story of someone in our own family, so that we are treating anxiety, or mental illness, the same way we would if somebody was a diabetic, or had a broken leg, a broken arm, that it is just part of health care. And I hope we are going to work together and we are all going to get there.

So let me—and by the way, I also wanted to say, Trace, in your written testimony, I appreciate your mentioning both our school-based health clinics, which I think are the model for us in the school setting, and our Certified Community Behavioral Health Clinics, which really are the model for quality, comprehensive care in the community now that are fully funded, where professionals are fully funded, so that we can move forward.

So, Dr. Benton, I wanted to ask you particularly about that point, because I appreciate all of our witnesses and their wonderful testimony, but our Certified Community Behavioral Health Clinics, which we now have demonstrated in 10 States, are fully funded. What can happen—if we are funding behavioral health like our FQHCs, our community health centers, with high standards, full funding—is health care where we are seeing now the difference that that can make. And we are working hard to have this be the structure across the country really, which I believe can really transform the services we are talking about.

But the CCBHCs, as we call them, really make help available where children are. And we nearly have about 25 percent so far of the community services being given to children. And there is a lot more that we can do.

So I wonder if you might speak a little bit more—I know you discussed this in your testimony, but highlight the importance of these comprehensive community clinics, particularly on under-served communities.

Dr. BENTON. Thank you so much, Senator Stabenow, for that question. The Certified Community Behavioral Health Clinics are key components of the mental health continuum. And a significant

component of the problems we faced this year related to those services being overwhelmed by the number of patients and limited numbers of providers.

It is vitally important to address equity for all children to have care in their communities where they are everyday that is accessible to their families, that is culturally competent, and integrates principles of cultural humility. And in academic centers like the children's hospitals, we partner very strongly with the community centers to expand access. And so we should be able to provide and fill in the gaps where they exist in those clinics.

So, for example, because the reimbursement is not always what it should be, they tend to run with a lower number of providers. And it is our responsibility in centers where there are more resources to be able to provide that support to the communities.

But without a strong partnership, we will never be able to successfully address the concerns of young people in our country.

Senator STABENOW. Absolutely. I totally agree. And we can do this. We have done this on physical health, and so we absolutely can do this.

I know my time is running out. The time is too short. I have many questions I will submit. I did want to also just indicate that I am excited to be leading the committee's working group on workforce issues, which each of you have raised and are so critically important. And I am working with Senator Daines, my colleague, on this, and we will be reaching out to each of you to ask for your further input.

So, thank you, Mr. Chairman.

[The questions appear in the appendix.]

The CHAIRMAN. Thank you, Senator Stabenow. I was about to mention the good work that we know you are already beginning with Senator Daines.

So our guests have an understanding of how we are going to work, we have a Democrat and a Republican serving on each of the key areas that we have to tackle. And because Senator Stabenow's expertise in this area and her advocacy is so important, I think we are especially lucky to have her handling the workforce issue, which I think we have all heard people mention repeatedly.

So, Senator Stabenow and Senator Daines are going to be playing a key role, and we thank her for all of her leadership.

Senator Grassley is next. And we welcome him.

Senator GRASSLEY. Thank you, Mr. Chairman.

I am going to lead into a question for Dr. Benton. In September, the DEA issued its first Public Safety Alert since 2015. It warned of a significant nationwide surge in counterfeit pills that are mass-produced by criminals in labs, deceptively marketed as legitimate prescription drugs. These counterfeit pills are killing unsuspecting Americans, particularly young people, and at an unprecedented rate. Many youth are getting illicit pills knowingly or unknowingly through Snapchat or TikTok. This use of illicit drugs is driven by mental health challenges, anxiety, suicidal thoughts, and is resulting in accidental overdose deaths.

So, do you believe that kids dying of suicide or accidental drug overdose is driven by mental health challenges?

Dr. BENTON. Well, thank you for that question, Senator Grassley. It is a complicated one. And so, definitely there are increases in rates of mental health conditions that contribute to suicide. But mental health conditions are not the only factors that contribute to completed suicide, which is one of the reasons it has been so difficult to prevent.

So, environmental factors, other things that you just identified, exposure on the Internet, all kinds of unregulated advertisements for young people, all contribute to those challenges.

I also want to call out something else that you were highlighting with your question, which is that the focus on medications and the focus on pill treatments for young people with mental health conditions discounts the fact that most young people actually need psychosocial intervention.

So there are multiple environmental factors, psychosocial factors, and other treatment factors that we need to consider when thinking about treatment—not just emphasizing pharmacologic treatments that are available, which I think would diminish some of the focus on young people obtaining medications.

Senator GRASSLEY. I am going to go on to another subject, Dr. Benton. In your written testimony you mentioned the importance of patient-centered medical homes for kids to improve access. In 2019 we passed the bipartisan ACE Kids Act establishing pediatric home health for kids with complex medical conditions.

Last fall, the Centers for Medicare and Medicaid Services issued guidance for ACE kids and is working with Medicaid programs in the same way.

For you, Dr. Benton: is access to out-of-State providers a challenge for kids with complex medical needs? And let me follow it up with what might be my last question. For kids with these needs, what does coordinated mental and physical health care look like? And describe medical home.

Dr. BENTON. Thank you, Senator Grassley, for your leadership in this area. So for patients, the medical home has provided significant support for young people with complex medical conditions. But we still have work to do in the area of integrating the medical and mental health benefits and treatments.

And so, for the patients in our medical home, we do better at providing mental health support for young people, but we still face challenges around parity for mental health and medical services.

So, within our own institutions, when young people come to us locally or from out of State, frequently the medical benefit is accepted and easily accessible, but when those same youngsters need mental health treatment, they frequently find themselves in a situation where they are being billed for a service that is out of network, or they are not paid at all. And it poses significant challenges for families who deserve the care that their child needs, but the parity issues remain barriers.

We have made significant progress, and I look forward to your continued work in this area in leading us through these complex co-morbid conditions. We have made progress, but we still have more work to do.

Senator GRASSLEY. For Mr. Terrell, you will have to give a short answer to this because my time is up, but what efforts should be taken to address unique rural mental health needs?

Mr. TERRELL. Like I said, access to care is super important. And I really appreciate this question, just because I think that you have had so much stewardship and insight about this issue. So I think if we can really bring—personally, I live in a rural community, and what I think would be really helpful would be to bring care to where people are. And that means funding school-based health centers, CCBHCs, and other community-based mental health supports that really help teens to just get the support that they need.

It is easier to be on a school campus and get medical services than it is to be at home, have to coordinate transportation, and get there, which is a barrier that so many teens in rural communities face.

Senator GRASSLEY. Thank you.

Thank you, Mr. Chairman. I will submit questions in writing.

[The questions appear in the appendix.]

The CHAIRMAN. Very good.

Senator Cantwell is next, our Northwest partner.

[No response.]

The CHAIRMAN. Senator Cantwell, are you on line?

[No response.]

The CHAIRMAN. I will give this just a quick moment, because I think she is.

[Pause.]

The CHAIRMAN. Senator Thune would be after Senator Cantwell.

[No response.]

The CHAIRMAN. Senator Menendez?

[No response.]

The CHAIRMAN. Senator Portman?

[No response.]

The CHAIRMAN. Senator Carper?

[No response.]

The CHAIRMAN. And for our guests, you should know that this is a particularly hectic day in the Senate, so members are going to be coming in and out.

Senator Carper?

[No response.]

The CHAIRMAN. Senator Cassidy is here. Senator Cassidy is a very valued member, with his expertise on health care as a physician. Senator Cassidy?

Senator CASSIDY. Thank you very much for that. By the way, I thought I had 15 or 20 more minutes to listen, and everybody else is out. So, anyway, thanks for doing that.

Dr. Hoover, I used to work with a school-based clinic to do hepatitis B immunization, and I am very aware of how well they can function bringing care.

Now first, I think we have to acknowledge that if the child is not in school, it is difficult for the child to be evaluated. But that said, now kids are back in school, so there is some progress there. But let me ask—and you may have covered this while I was in another committee hearing.

Now my understanding is that the schools and the school systems would benefit when CMS gives them updated guidance as to the possibility of providing these services in that venue. Any comments on that, Dr. Hoover?

Dr. HOOVER. That is exactly right, Senator Cassidy. And I appreciate the question. And you are correct that it is easier to get the school-based care to young people when they are actually in schools.

And one of the things that we are hoping Congress can support is really urging CMS to modernize the existing school guidance for Medicaid in schools. This guidance has not been updated since 2003, and it is critical for State education and State Medicaid agencies to work together to actually be able to support and resource mental health providers.

Senator CASSIDY. Let me ask you—I have limited time—what is the problem with the current guidance, or lack thereof, that limits the ability to expand mental health services through the school-based clinics?

Dr. HOOVER. So just quickly, a lot of States do not want to move forward with implementing the current Medicaid-supported mental health services in schools. They are worried. They are hesitant that expanding their programs may put them at audit risk. The guidance really is not updated to reflect improvements in telehealth. It is not updated to reflect the free care policy reversal in 2014. So there are a number of updates to Medicaid that would need to be reflected in this guidance for States to feel comfortable moving forward.

Senator CASSIDY. And specifically, you mentioned tele-mental health. I am really struck. If you look at adolescent psychiatrists in my State, they are in the cities. They are not in the rural areas.

So one, the infrastructure bill expands Internet services throughout the State. That will be huge. But secondly, you have to get the adolescent psych who is in Shreveport to be able to communicate to the child who might be in Winn Parish. You do not know the geography of my State, but it is urban to rural. What impediments right now does the rule give as regards the utilization of that telemental health?

Dr. HOOVER. So as you know, during COVID we saw a huge expansion of telehealth. And we know that providers and families need guidance and technical support to actually use the telehealth equipment. But more important than that, we need to see the continued expansion of reimbursement and policies that support teleproviders to be able to not only provide services within their communities, but even across State lines as necessary, to address some of the workforce shortages.

Senator CASSIDY. Now, if you gave advice to this committee—because we have jurisdiction over Medicare, Medicaid, CMS—one thing is to urge CMS to update this guidance. And again, is there any single point—you are talking to Senators Wyden and Crapo right now [laughter]. They are the straws that stir the drinks of Medicaid, Medicare, and CMS. So, if you had to kind of just sit down and pound your hand on the table, what would you say to our chair and ranking member that we have to get done before we move on?

Dr. HOOVER. Absolutely I would say that Congress should encourage all States to cover all medically necessary mental health services, including prevention services for all Medicaid-enrolled students, and simultaneously ensure that school Medicaid programs have the updated guidance, best practices, and technical assistance that they need.

Senator CASSIDY. Mr. Terrell, can you just put the dot on the "I" as regards the importance of school-based clinics with regard to the provision of mental health?

Mr. TERRELL. Of course; yes. Like I said, this is a great question, because I think it is so relevant. And when the teens are able to get care where they are, it just encourages health-seeking behaviors. It promotes developing systems of self-care. And it really promotes general health and well-being outcomes.

I think the fact that teens are sometimes able to just walk over to a medical clinic and get the help that they need is so essential, especially if they are not able to at home and they do not have reliable Internet access. So when we concentrate our efforts on schools, it is really important to make sure that we build these natural partnerships and kind of leverage the power within those.

Senator CASSIDY. I would just add to that, from my experience working with school-based clinics, sometimes there are issues which should not be—for example, abuse by a parent, which can be discussed in the safe setting of a school-based clinic with a licensed health-care provider. And so it also, frankly, helps the business model of the school-based clinic. In some States they have a very difficult time keeping their doors open, so that they cannot provide a needed service that actually benefits.

With that, I yield back, Mr. Chair.

The CHAIRMAN. Thank you, Senator Cassidy.

And for our guests, Senator Cassidy and Senator Carper are going to be leading the task force on young people, so they are going to be invaluable on the issue we are dealing with.

We now have an order of Senator Cantwell, Senator Thune, and Senator Menendez. And members have been coming in and out. Senator Cantwell is next in the order.

Senator CANTWELL. Thank you, Mr. Chairman.

And continuing on that same theme of young people, Ms. Lubarsky, the Surgeon General's December advisory on mental health stated that one in three high school students and half of the female students reported persistent feelings of sadness and hopelessness during the COVID pandemic.

So we already know what our challenges are. The Washington Hospital Association reported that, during the past 2 years, major depression disorders are leading youth inpatient diagnoses in my State. So, when it comes to seeking treatment, not everybody gets a fair shot at that. The number on individuals with lower incomes is that they are nearly 20 percent higher than the rate for those people with higher incomes. So affordability is a factor.

I know my colleague, Senator Stabenow, had a chance to ask questions earlier, but I am very supportive of her Certified Community Behavioral Health Clinics. These have been great programs.

There are five community clinics in my State that serve low-income populations. And this grant over the past 2 years has been used to enhance the care of those experiencing mental illness. So we really are building capacity. Clinics like Comprehensive Health Care in Yakima were used for innovative purposes, creating a program to offer mental health first aid training, critical incident stress debriefings, and helping to receive support.

So do you think that these programs such as the Certified Community Behavioral Health Clinics and their grants have been helpful in reducing the barriers for treatment of youth and families, particularly in some of our less accessible areas in more rural parts of the United States? And should Congress consider expanding these programs to address disparity in access? And what would you prioritize within that system?

Ms. LUBARSKY. Senator, thank you very much for your question. I am so pleased that you mentioned mental health first aid. As a youth mental health first aid instructor, I think it is also a vital component of our prevention efforts in youth mental health.

In regards to the CCBHCs and other health-care facilities, I think they are one of many ways that we reduce the barriers to accessing mental health care for our pediatric population.

There really is no one-size-fits-all for the right delivery model. And so, where some youth and their families are comfortable coming into an outpatient clinic, because of the stigma that is often attached with mental health services, I think having the ability to access your mental health care at a community health center, at a pediatric office, at your school setting, or through a telehealth device, is crucial to make sure that we have mental health care accessible to everybody.

In our community, it may be hard for some of our families who lack adequate transportation to get to our offices. Yet one of our federally funded health-care facilities is on the bus line. And so, we worked in partnership with the health-care facility to have mental health staff there so if that is the only means of using public transportation to get to the appointment, families can still access their health care. So I think it is critical.

Senator CANTWELL. And what about this issue that you bring up of integrated health care—so, you know, treating mental health and other physical health in the same location? Because most times people come with both issues, or things that exacerbate one or the other, like you said. So there is less stigmatization in treating the whole person.

Ms. LUBARSKY. Absolutely. It is critical, because I really do think physical health and mental health occur together. And when our mental health is not doing well, we will see a decompensation in our physical health system, whether that is poor sleep, poor diet, isolating from others, not engaging in physical activities that can promote good mental wellness. So we really do have to bring the physical and mental health worlds together for the whole self.

Senator CANTWELL. Well, thank you. Is there anything you would prioritize in the improvement of that program if we had more dollars for the certified program?

Ms. LUBARSKY. I think, as I spoke to in my verbal statement, it is really around those reimbursement rates, and making sure that

we are reimbursing centers, individuals, organizations in a meaningful way to sustain the workforce in order to deliver the crucial care.

Senator CANTWELL. Okay; great.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cantwell. The Northwest is going to be very united in this effort, and I look forward to working with you.

I believe Senator Menendez will be next. Senator Menendez, are you out there online?

[No response.]

The CHAIRMAN. We may have lost Senator Menendez. Senator Menendez?

[No response.]

The CHAIRMAN. Senator Portman is next then.

Senator PORTMAN. Thank you, Mr. Chairman.

I appreciate the testimony and the fact that you all are in the trenches every day doing great work with our young people.

Dr. Hoover, you talked about telehealth, and I just want to be sure that we are also focused on the broader behavioral health, and specifically substance abuse. It seems to me that telehealth is one of the few silver linings in an otherwise dark cloud of COVID, and with regard to substance abuse treatment, that there has been some real improvements. Would you agree with that?

Dr. HOOVER. I would agree with that. I mean, certainly the opioid crisis has brought attention to that, and it has been exacerbated during COVID. So the funding provided by the Federal Government to States and communities to support the opioid crisis has been tremendous, and certainly there has been an improvement in care. Tele-mental health has improved that as well.

Senator PORTMAN. This is why we have to continue the reimbursement under Medicare and Medicaid—and Medicaid particularly—for substance abuse, at a time when we had 100,000 drug overdose deaths in the period from April of last year to April of this year; so, during 1 year, a record level. That was a 28½-percent increase in overdose deaths. That is really heartbreaking, because we had made great progress in 2018 and 2019.

Now we are, unfortunately, seeing more and more people dying of overdose deaths. The report we have about young people—because that is the topic today—shows that we have seen an increase of anywhere from three times higher number of overdose deaths to thirteen times higher in 2021 compared to the numbers we had from 2019—and by the way, dramatic increases among Black youth in terms of overdoses that are particularly concerning.

Our State has done a report. It recently looked at it from a different perspective. They said how many years have been lost. So their analysis is that, beyond the numbers we already know, the loss of years lived for more than 21,000 young people who died from overdoses show that adolescents and teenagers 10 to 19 lost, cumulatively, 200,000 years of life. And when they expanded the study to include 10- to 24-year-olds, it grew to more than 1 million years lost.

So it is a shocking way to look at it, but think of all that lost potential, and all that God-given potential being ruined. So this is

a huge reason why we need to figure out, as a Congress, how to get back on this issue. And deadly fentanyl is killing, we think, about two-thirds of these kids. So this is synthetic opioids streaming across the border.

We have done a lot more in terms of the prevention side and the treatment and recovery side, but obviously not enough. And what we see in Ohio is that this deadly fentanyl is often masked as other substances. So it looks like a pain medication, or an anti-anxiety medication, or an ADHD medication, and we have had parents approach me in Ohio and talk to me about this issue because they believe that their son or daughter died of an unintentional overdose by being deceived about what was in a pill.

So, Dr. Hoover, talk to us a little about that. And anybody else can jump in. What do you think the reasons are for this big jump in overdose deaths? And how much of it do you think is attributable to these cartels putting fentanyl into other medications?

Dr. HOOVER. Well, to jump in quickly and defer to Dr. Benton on the impact of drugs and the medical side of that, certainly in terms of the co-morbid mental health issues, we know that the substance abuse issues we are seeing increasing in young people are likely very related to their increase in depression, anxiety, and post-traumatic stress.

Not only were we seeing increases in that pre-pandemic, but we are seeing real exponential growth in that in the context of COVID. So we know when that happens, we see increases in substance use, and so it is not surprising when you get those really tragic numbers.

I will defer my time over to Dr. Benton with respect——

Senator PORTMAN. You are talking about self-medication because of other behavioral health and mental health challenges?

Dr. HOOVER. That is a piece of it, absolutely, that self-medication to address anxiety, depression, trauma, and just to really cope with the isolation and loneliness that our children have experienced over the last couple of years.

Senator PORTMAN. Dr. Benton, can you talk a little about the synthetic opioid issue of the fentanyl getting into other medications?

Dr. BENTON. So what I can say is that we are seeing increases in utilization across the country. And unfortunately, I have to say that in many mental health programs, there is not the robust substance use and addiction treatments that we would like to see. And a major focus of expansion of resources in treatment for young people needs to focus on increasing the integration of substance use and mental health treatment services.

We know that for young people with any mental health condition, the co-morbid use of substances only makes the outcomes worse. And the substance use is associated with worse outcomes, including suicide and other impulsive behaviors that land young people in bad situations.

And so, that has to be a focus. Right now, they run almost as two separate systems in some ways. And that really needs to be a focus of our efforts going forward if we are going to address the substance-related morbidities that we are seeing right now.

Senator PORTMAN. Okay.

I think my time has expired, but, Trace, I would love to hear from you on this, if we can have a minute, Mr. Chairman, if Trace has any thoughts.

Mr. TERRELL. Yes, I would love to. Thank you, Senator. I think when we talk about all these statistics, it is really alarming. But I also think that there is a beacon of hope. Since YouthLine's inception, we have experienced an annual increase in contact volume of about 15 percent annually, with an additional increase of 3 to 5 percent since the COVID–19 pandemic.

And obviously, while that proves that there is a need for mental health care, there are also so many teens reaching out for help. And I think that that is really inspiring, and I think it shows the resilience of teens in regard to mental health challenges and substance use challenges. And so I think, if we can really ensure that the people reaching out for help are able to receive help, we will get really far on this issue.

Senator PORTMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Trace.

Next is Senator Menendez.

Senator MENENDEZ. Well, thank you, Mr. Chairman.

Across the Congress, we all talk about the provider shortages the Nation is facing, especially mental health providers who are available for Black and Latino communities. And the pandemic has taken a disproportionate toll on minority communities, and the provider shortage has only grown more dire.

More dedicated support for a larger and more diverse pediatric workforce is critical, I believe, to address children's mental health needs now and into the future.

So, Dr. Benton, what are three things this committee can do to address the recruitment, training, retention, and professional development of a diverse clinical and nonclinical pediatric mental health workforce?

Dr. BENTON. Thank you for that question, Senator.

It is one of the issues that I struggle with every day as a training director and as a physician. One of the things that we could do now is developing pipelines at a much younger age.

So, in my testimony I mention the 5th graders interviewing me. They were interviewing me about why did I become a child psychiatrist? And I was really pleased that they were asking these kind of questions in 5th grade. So starting a pipeline where we are present and we are reaching out to communities of color is really important.

Education and destigmatizing mental health conditions in the Black community, and the Latino community, by partnering with trusted community organizations—loan repayment is an incredible issue. Many of my physicians say, "I cannot afford to work for you because I have loans to repay, and you don't pay enough."

And so loan repayment for all the mental health professionals, I think is important. And incentives for people to choose mental health could be part of loan repayment—or some other payment measure would be really helpful. And then reaching into the communities where minority populations are would be extremely important.

So we tend to recruit from communities that are affiliated with academic centers, and we do not reach into the communities where patients are actually receiving services.

Those are some of the things that we could do now to support diversification of our workforce.

Senator MENENDEZ. Well, I appreciate those insights. And we may reach out to you to build upon them as we explore the initiatives here.

And part of the reason I raise this—I look at the first half of 2021 alone. Children's hospitals reported cases of self-injury and suicide in ages 5 to 17 at a 45-percent higher rate than during the same time frame in 2019. And for children under 13, the suicide rate is twice that for Black children than for White children.

So what can we do to reduce the likelihood of suicide in children and adolescents, particularly minorities? And how do we better target our resources?

Dr. BENTON. Senator Menendez, this is one of my areas of passion. So among minoritized youths across ethnic groups, the rates of suicide attempts are higher than they are among non-minority groups. And one of the challenges has been identification among minoritized youth and access to services that are culturally competent and/or a demonstration of cultural humility.

The data demonstrates pretty strongly that culturally concordant therapists and patients have better retention and treatment, and better outcomes in treatment over time. And certainly it will never be the case that we will have one-to-one matching for patients by ethnic group, nor am I sure that is the goal, but the goal is, for groups where there is not concordance between the patient and the therapist, that there be cultural humility, that we train individuals to learn to inquire and understand the cultural experiences of others when we are engaged in treatment.

And so the training opportunity is there. But it is essential because we are seeing, for youth across each ethnic group, increasing rates of suicide, while they are declining for non-minoritized populations. So it is vitally important.

Senator MENENDEZ. And finally, about roughly 17,000 3- and 4-year-olds are expelled from their preschools each year. And despite Black children making up only about 18 percent of the school population, they make up 40 percent of all expelled children. And even more troubling is that, within the high rate of expulsion for Black toddlers, how often Black boys are expelled.

So how can we better support training for pre-K teachers and child-care providers in basic behavioral health techniques to combat bias and give these important social and emotional regulation tools to children from their earliest ages? And I am happy to entertain anybody who can answer that.

Dr. BENTON. Well, thank you. Thank you, Senator Menendez. I would hope that Dr. Hoover would respond as well.

Prevention and education are key. Addressing bias among school personnel is essential to address this—and providing more resource supports in centers where children appear every day in day care, and in primary care, with some preventive education around what is normal and abnormal development.

I am sorry, Dr. Hoover; I wanted to give you an opportunity to comment.

Dr. HOOVER. Not at all. I know the time is short, and I will just quickly add that investment in early childhood mental health consultation programs across States is critical—and as you alluded to, culturally responsive teaching practices. There is a lot of evidence to suggest that those can help in reducing discipline referrals and expulsions.

Senator MENENDEZ. Thank you all.

The CHAIRMAN. Thank you, Senator Menendez.

Senator Cardin is next.

Senator CARDIN. Thank you, Mr. Chairman. And let me thank all of our witnesses. I think this panel has been extremely helpful. This is an area, as you can tell by the questions, where you do not know who the Democrats or the Republicans are on the committee. We have a mutual desire to try to get this right, and we recognize we have a real challenge in mental health in this country, but particularly with our youth with the experiences of COVID–19. We know that we have a greater challenge than ever before.

So I want to talk about the school setting for one moment, what we can do. I am responsible—as one of the co-chairs of the groups that Senator Wyden has been talking about—to deal with telehealth, and I am curious.

You have all talked about the importance of expanding telehealth, but what are the challenges within the school setting of expanding telehealth services? Where do we need to try to put our attention, either change in policy or resources, in order to expand the productive use of telehealth in the school setting?

Either Dr. Hoover, or whoever would like to respond to that. Perhaps start with Dr. Hoover.

Dr. HOOVER. I am happy to jump in. Thank you, Senator Cardin, for your leadership on this issue of mental health across the Nation, and specifically in the area of parity and tele-mental health.

We know tele-mental health has actually been in the schools for years. Our child psychiatrists were delivering tele-mental health across schools in Maryland and in Baltimore City back when I was delivering services in the early 2000s.

We know that there are continued infrastructure improvements that are necessary to improve tele-mental health services in schools, and that would include enhanced broadband systems, up-to-date telehealth delivery equipment, Internet connectivity services, especially to some of our rural communities. We know that policy expansion is important, including reimbursement parity for tele-mental health and expanded access to Medicaid and children's health insurance telehealth programs.

So there are a number of areas that we have seen improvements in during COVID that we need to continue and to expand. And that applies to physical health as well.

Senator CARDIN. If I could get either your view or Dr. Benton's view, we have made a lot of resources available to our school systems in response to COVID. Have they been used to expand the connectivity that you are talking about for mental health services?

Dr. HOOVER. Some have, and again I am happy to defer to Dr. Benton here as well, but some have. One of the things we know,

though, is that some of the COVID-related funding, for example, is creating kind of a one-and-done, or some hiring—you know, short-term hiring fixes. But we know that it is critical to make some of these Medicaid policy adjustments so that we can allow for sustainable funding for telehealth and other mental health services.

Dr. Benton?

Dr. BENTON. Yes, I would concur with Dr. Hoover. I think many of the systems have used the resources well, but many of them were under-staffed before the pandemic and did not have access to adequate resources.

They have reached out for telehealth, but there are a variety of factors that impact their ability to optimize its use. One of them is the privacy standard. So communications between mental health providers and schools, through HIPAA and FERPA, are issues that really need to be addressed in communicating about mental health concerns.

Some schools may have one or two school counselors, but not necessarily access to a provider team of psychiatrists that can partner with the schools, as Dr. Hoover described, to provide that additional level of care that is not necessarily available in the schools.

And then in addition to that, you know, we do need to think about our care models very differently. So, for example, there are services that are cheaper to set up that are available right now, such as school-based crisis services, so when a school is under-resourced and there is a crisis, it is very possible to send someone to that school to see that youngster on site with the family, or urgent cares that are on-site at schools.

So there are some other things that we could do to support our schools. So I thank you for your leadership in supporting the schools through the pandemic. We should retain those things, and there are other things that we could do to expand them.

Senator CARDIN. So, Dr. Benton, you talked about the need to have improved screening in regards to mental health for our students. Can telehealth be helpful in dealing with screening, recognizing that you need personnel in the school itself? But can that be better utilized than we are using it today for screening?

Dr. BENTON. Yes, Senator. That is an excellent recommendation. And yes, it would be very helpful. One of the challenges for schools is they screen, and then they cannot respond. And so, having telehealth allows them to screen youngsters for problems or challenges before they become major problems. And telehealth can be used to address some of the more acute things on site.

Currently, screening is not viewed enthusiastically because, if you find something, you cannot do anything about it. The utilization of telehealth to connect with a crisis provider would allow the school to be able to respond in a safe and effective way.

Senator CARDIN. Thank you, Mr. Chairman. I appreciate it.

The CHAIRMAN. Thank you, Senator Cardin, and we appreciate your leadership on these issues as well.

Next I believe—Senator Lankford, are you out there?

[No response.]

The CHAIRMAN. Senator Brown?

[No response.]

The CHAIRMAN. Senator Barrasso, and then Senator Bennet.

Senator BARRASSO. Well, thanks, Mr. Chairman.

First I want to congratulate and compliment you on your opening statement. I thought you really hit the point on the head in terms of how long this is often brewing before we know of the problems. I am an orthopedic surgeon, and I have worked with many people as president of the Wyoming State Medical Society. I think you were absolutely right in the comments that you made.

But being from Wyoming, rural health is a big issue for us. And Senator Crapo started by talking about that. And then telehealth is something we have used from a mental health standpoint long before the pandemic. I think the pandemic has brought mental health, as well as other kinds of health care, to the fore in terms of the ability to try to use telehealth much more productively. I think we are, hopefully, fast-forwarding, as Senator Cardin was just saying, the acceptance of telehealth.

My question is about trying to just get enough providers on site in rural America, which is what Senator Crapo talked about. So, for Dr. Benton and Dr. Hoover and Ms. Lubarsky—you know, when I was in the State Senate in Wyoming, we were very blessed with additional revenue that we were not expecting, but we had it. And the commitment we made was to mental health.

So we put in a lot of financial resources and made a deliberate effort to train, to recruit, and to attract more mental health providers to Wyoming. But in spite of our best efforts, Wyoming and other rural States that have tried to make those similar commitments continue to face huge shortages of all types of mental health providers.

So the money was there, and we still had the challenge. So, can you discuss some solutions related specifically to workforce development that you believe may help improve our ability to attract and maintain staff into rural and sometimes remote areas?

Ms. LUBARSKY. If I may—and I think it is a great question, Senator. I think one of the challenges that occurs within our State of New Hampshire is some of the licensure requirements for professionals.

We have a lot of silos with our Board of Mental Health Practice about who is allowed to provide licensure supervision for an individual who comes from their master's degree program. And that at times creates the barriers to who we are able to hire. Because, if we have to have a specific credentialed professional to provide supervision to that same category of professionals, and we do not have them employed at our center, then that candidate no longer looks at us as a place that they want to be employed at.

I have talked to colleagues across our State who have lost employees who went to other States because, not only could they make a higher income, but they needed to get the licensure supervision from a particular person. So I think we need to make licensure requirements create more flexibility on who can provide that supervision in order to attract the staff that are needed to provide the care.

Senator BARRASSO. Anyone else?

Dr. BENTON. I was——

Senator BARRASSO. Yes, go right ahead. No, please.

Dr. BENTON. I was going to say, I would echo your comments. Telehealth also adds another opportunity, and it is for training remotely. And so, for areas where there is a shortage of providers, we have been able to partner using telehealth to expand skills and to train people.

You know, thinking about Ms. Lubarsky's comments about task shifting, it is an excellent opportunity for us to provide skills for master's-level clinicians, clinicians who need supervision and may be in another State, for backup consultation across counties. But also, by allowing us to continue with licensure across State lines, we can actually also provide support for clinicians in those areas.

I also just want to mention, a quick win is really educating the people that we already have. So the pediatricians, the nurse practitioners, other mental health clinicians, master's-level people, peer navigators like Trace—all of those resources in communities can be utilized to support individuals.

We have programs where we are teaching grandmothers to do cognitive behavioral therapy for their anxious grandchildren. And so I think, thinking about how we provide care differently could provide us more opportunities for mental health support.

Senator BARRASSO. Well, thank you, Dr. Benton.

And to Ms. Lubarsky, to your point of the—actually, I am working with Senator Smith; it is a bipartisan bill on marriage counselors who do some mental health work as well. And they are not able to be reimbursed through Medicare, and different Federal issues too where they provide health care but—so it is the siloing by State, but also the Federal Government sometimes gets in the way as well.

And then—I know I am running out of time. You know, we have a commitment in my family to working with families who have lost someone to suicide, what we can do along those lines. We are continuing to look, not just to raise awareness, but for best practices.

And, Dr. Benton, I see you are shaking your head "yes" on this. It is a big issue for all of us. So I do not know if you have some final thoughts on that.

Dr. BENTON. Yes, thank you, Senator, for that question. So, in addition to the suicides, you know that over 160,000 young people have lost parents to COVID. And of course, the threat is always not just grief, but traumatic grief. And we are not ready for it.

Fortunately, there are quite a few support services available to families who have lost family members to suicide, and for those who are suicide survivors. So the American Foundation for Suicide Prevention is a resource for all families that provides a lot of support and information nationally for families who have experienced that loss.

But we have to pay particular attention to those populations who have experienced traumatic grief, because traumatic grief is more closely associated with the onset of depression. And in order to be preventive, we need to develop early interventions and support for youngsters who have lost their parents during COVID, and for individuals who have lost their families to events like suicide and homicide.

So, thank you for that.

Senator BARRASSO. Thank you for that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Barrasso. And we are very much going to focus on the best practices that you mentioned. It is a very solid way forward.

We are having colleagues come and go. So we are going to have Senator Thune, Senator Bennet, and Senator Lankford, and we are going to lock in those three, okay?

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman and Senator Crapo, and I appreciate your continued focus on youth mental health, and I appreciate the panel for joining us today.

As I discussed last week, when I talk to parents, teachers, and school administrators across South Dakota, addressing the behavioral health needs of students is a big priority.

Dr. Hoover, in your testimony you mentioned that we need to be looking for more formal partnerships with community behavioral health providers. We have multiple cooperatives in place in my State where schools are in close enough proximity to share a provider, but in some circumstances distance is a barrier.

Do you know of instances where the partnerships you referred to have been formed using telehealth, or a combination of in-person and telehealth services? And what are the biggest barriers that schools or school boards encounter in forming these types of partnerships?

Dr. HOOVER. Thank you for the question, Senator Thune. Absolutely. We have seen, actually, tremendous partnerships that rely almost exclusively on telehealth, especially for some of our rural communities. Some of the best examples started in South Carolina several years back, where they have the Medical University of South Carolina providing telehealth services to schools across some of their most rural districts in South Carolina.

So we have seen these community behavioral health partnerships with schools through kind of the standard memorandum of understanding with schools and community behavioral health, where sometimes they will do some onsite supports, but really much of the service that is provided is through telehealth.

As we mentioned earlier, some of the real barriers to that are reimbursement. Sometimes schools are not allowable as sites of service, and certain provider types are not allowable, which really does require taking a look at State Medicaid plans and thinking about how to expand school health programs under school Medicaid—and certainly just a lack of awareness of some of the guidelines for how you can set up these partnerships and get reimbursed and supported.

Senator THUNE. Thank you.

Doctors Benton and Hoover—and Dr. Benton, if you want to take this first—youth mental health in Indian Country has been a significant challenge for some time now. Some of the stories are heartbreaking. There was a 2017 Department of Education report that confirmed that kids in public schools on the reservations have a greater risk of behavioral health challenges, including increased risks of suicide.

Do you have suggestions for how this committee can help improve access to culturally appropriate care on the reservations, es-

pecially how we could grow the workforce there, which is a challenge? Finding providers, recruiting, and then being able to retain providers in Tribal communities has really been a challenge.

Dr. BENTON. Well, thank you, Senator, for that question. And we too struggle with the challenges that you identified. The Certified Community Behavioral Health Clinics are an excellent way to attract clinicians of diverse backgrounds. Clinicians like myself of diverse background tend to focus on supporting populations that are similar. And so, the chances of working in your community are greater if you are a member of the community.

How do we increase providers in those communities? By targeting the communities who need the treatment, identifying individuals in those areas, and providing the support needed.

So many of the challenges for minority populations relate to finances: high student loan burdens, low support for strong academics in the community. Those are all areas where we would be able to support education, increase interest, and support individuals who would go on to get education in those areas.

And some of our focus could be on supporting them in their communities. So many times in academia, we are all familiar with the idea that we recruit people away from their communities, as opposed to providing resources in that community to educate young people through their high schools, the community colleges, training programs, and then diversifying opportunities for support.

So, in line with Dr. Hoover's comments about task shifting, it is teaching people to provide services at the bachelor's level, or other levels that would allow them to expand support for care in their communities.

Senator THUNE. Thanks.

Dr. HOOVER. To piggyback on that, in addition to recruiting members within communities and retaining them in their communities to support their communities, also investing in technical assistance and training centers and resources within their communities. A great example of that is the National American Indian and Alaska Native Mental Health Technology Transfer Center, which is funded as part of the Substance Abuse and Mental Health Services Administration.

And then I will just also add, really expanding the Federal workforce development programs that we have already mentioned, including loan repayments, but also things like the Minority Fellowship Program, the National Health Service Corps, can really help in this regard.

Dr. BENTON. And I would add to that some of our national organizations that support children's mental health, like the American Academy of Child and Adolescent Psychiatry. All those programs actually have minority-focused fellowships to support the development of other mental health professionals. And partnering with the HBCUs for Black families, for programs and educational systems that primarily serve Hispanic and Native American youth, would be places that we would be able to support development of professionals who remain in those communities.

Senator THUNE. Thank you, both.

Mr. Chairman, my time has expired. Thank you.

The CHAIRMAN. Thank you.

Senator Bennet is next.

Senator BENNET. Thank you very much, Mr. Chairman. Can you hear me?

The CHAIRMAN. We can.

Senator BENNET. Great. I really appreciate you and the ranking member for continuing this series of hearings on mental and behavioral health for youth. We are having a crisis in Colorado. In fact, Colorado's Children's Hospital was the first hospital in the country, I think, to declare a state of emergency in mental health for youth.

So I want to thank the witnesses for being here to testify, and I am particularly grateful for having Mr. Terrell here advocating on behalf of his peers and his generation.

I have a second question for him, but let me start first with this on reimbursement and prevention. Last week the Surgeon General was here, and I raised the importance of reimbursement for mental and behavioral health services, something our committee has jurisdiction over, through CMS. And while I was going through your testimony, the common theme was that we need improved reimbursement for services across the continuum of care, and meeting youth where they are. And I wholeheartedly agree with this.

So I would ask Dr. Benton, first maybe, what kind of services should be reimbursed by Medicare or Medicaid or private payers that are not usually covered? And what services need increased reimbursement? Can you highlight where you believe reimbursement parity is failing the American people?

Dr. Benton, let's start with you and anybody else who would like to add after that.

Dr. BENTON. Well, thank you. Thank you, Senator, for that question. So currently, most of the early childhood services are not reimbursed. So there are services that are required in the medical and mental health setting that are comprehensive services that should start from birth through adulthood. But services that do not necessarily have a psychiatric diagnosis attached are frequently not reimbursed.

So, for example, if a mother who was having difficulties attaching or parenting her newborn, those services are not necessarily reimbursed by traditional mental health providers.

Furthermore, for pediatricians—who are typically the best people to identify early childhood problems, because children have frequent visits in the first year of life—they are not reimbursed for the time it takes to provide the level of counseling that is needed for new parents who have new infants.

And so, if we target it, the reimbursement for those services, the pediatricians would be allowed to do their jobs. The nurse practitioners could do their jobs. People who are working with young children could do their jobs. And for young children who are not yet impaired by a mental health condition, preventive services would allow families to seek that care in appropriate facilities, and reimbursement could occur at the same time.

So I think that early childhood services currently are under-reimbursed for the ones that are available. And for children who do not necessarily have a mental health condition already, they are

not able to seek the services they need and get the payment that is required.

Senator BENNET. Thank you for that answer. I very much appreciate it.

Let me ask my second question, because I know time is short. As I mentioned, it is so important to have a young person here, Mr. Chairman—and thank you for doing that—to give their perspective on the crisis. We should think about things, including young people, here more often. As you know, the National Suicide Prevention Lifeline will be transitioned to 988 by July 16, 2022. In Colorado, we are having, I am sad to say, an epidemic of teenage suicide. The numbers are just staggering. And Senator Cornyn and I have introduced legislation to increase funding to make sure that this transition to the prevention lifeline is successful. And we are thinking about how to incorporate texting to connect individuals with services. They call or text in to make it more effective.

And I just wonder, Mr. Terrell—could you share your thoughts on all of this, and what types of resources and improvements we should be thinking about that would be most meaningful, in your mind?

Mr. TERRELL. Yes, thank you, Mr. Bennet. That is a great question, and I think one that takes a lot of conversation to actually get to a good policy solution. But statistics show that teens talk to their friends more than anything. So the more that we can empower and equip youth with the skills needed to support their friends in crisis, I think the more we will see kind of general health and well-being trends for youth increase.

All YouthLine volunteers get the opportunity to go through pretty extensive training. So I personally went through 63 hours of training, where I got suicide alert training, applied suicide intervention skills training, youth mental health first aid, and CPR. And those are all master's kind of clinician-level training.

And so we know that youth have the capacity to take on this role if supported in their communities. And so, like I mentioned in my testimony, I think the idea of a national YouthLine where we expand across the country, and we really invite youth from all different communities to be involved in this process and help destigmatize the conversation around mental health, would be really helpful. And I think I would be really happy to connect with you later on that.

Senator BENNET. Very good. I will take you up on that. I know the chairman has your contact information, so I will track you down. And I very much appreciate it.

Thanks, Mr. Chairman; I know I am out of time.

The CHAIRMAN. Thank you for all your leadership, Senator Bennet.

The next two are Senator Lankford and Senator Brown.

Senator LANKFORD. Mr. Chairman, thank you. And to all our witnesses, thanks for being here as well, and talking through this important conversation.

Dr. Benton, I do want to be able to start with you. For individuals within the school, whether it be a school counselor or a teacher who may discover some mental health challenges the child would have, are there any barriers to communicating right now in

the system, whether it be HIPAA issues, or legal issues, or just process issues, with that individual communicating with parents, other school counselors, or engagement with law enforcement or outside medical entities? Are there barriers that are there that we need to be aware of?

Dr. BENTON. Yes; thank you, Senator Lankford, for that question. And I will start my comments then defer to Dr. Hoover, who has more expertise. But yes, there are barriers currently. So you are not able to have a conversation between a mental health clinician, who actually may be caring for a youngster, and his teacher or school counselors without permission, either through FERPA for the school, and for HIPAA for the provider. And those two groups do not often communicate with each other, posing barriers for care.

It creates a situation where, for teachers and for counselors, addressing mental health concerns may require sending that young person off to an emergency department in order to get the care that they need. So yes, there are definitely barriers in communication related to privacy laws.

Dr. Hoover, I don't' know if you have further——

Dr. HOOVER. I agree. The good news is that many school systems, in partnership with behavioral health systems, have really navigated those HIPAA-FERPA privacy issues, for example, by initially sending paperwork home to families, even at the start of school years, to inquire about whether they are willing to give consent for communication to occur when in the best interests of the child's health and well-being and academic success, allowing for some of that communication to occur—again, with privacy in mind, but also supporting academics.

The other area that I would say is critical is really expanding data systems that allow for the seamless sharing of data between health and education sectors. And that has been done well in several districts and States. So there are good examples. It is just not widespread enough yet.

Senator LANKFORD. So are there needs that we have as far as a change in statute to allow more of that communication to occur at this point? Or do you think the statute is appropriate, we just need additional permissions and access points?

Dr. HOOVER. Good question. I mean, frankly I think that technical assistance and training, and just raising awareness that HIPAA and FERPA do not have to be barriers to communication as long as you have family engagement and consent, that may be enough. It has been enough in several communities to actually bridge the divide here.

Dr. BENTON. I will say, there are also State laws that govern who actually can release information. And so that also becomes a barrier, because sometimes the young person actually has control over that information, and the parents don't. And so, I think in some places it works, but I think greater guidance and standardization of these processes would help all of the communities.

Ms. Lubarsky, I know that this must come up for you, often.

Ms. LUBARSKY. So, it does come up for us quite a bit, but I think the training involved, I think making sure that schools and the mental health providers—I think about our examples of where we are integrated in over 25 schools in our region, providing mental

health care, where we are delivering that for our staff and working collaboratively with the school, with the family system, parent, guardian, and caregiver, to make sure everybody is involved. I think honestly, where we see this as a barrier, where it comes up as a challenge is when there is failure to communicate with the family system about the youth's needs, and making sure in advance of providing care or suggesting care, that those conversations are happening as well.

So I think that is where training is a big component.

Senator LANKFORD. I would agree. In Oklahoma, we just had a law passed within our State that has allowed for training for everyone with the school on suicide prevention. We have 13,000 people in schools who have been trained just in the last couple of years, just to be able to help with suicide prevention and to be able to know how to engage, and then the next steps on that.

So in our State, we have been very forward-leaning to be able to do what we can to be able to help.

Mr. Chairman, a conversation that we could have at some point, to be able to have on this whole issue as well, is the "whys" and the prevention behind the scenes. We always, on the Finance Committee, we look at it and say, "What can we do with more Medicare or Medicaid, and the tools that we have?" The next big question behind it is—as we watch suicide rates rise 57 percent among teenagers and young adults over just the last 15 years, as we watch all these other things occur—to ask the practical question of "why?"

Our Nation has been through difficult challenges in the past: World War II, the Great Depression, all these other things. Why are we watching some of the rise now? What is happening in technology? What is happening in engagement? And for myself personally, I worked with students for 22 years before I came to Congress, working with middle school and high school students. This is an area I worked with extensively, and I think there are a lot of questions that we have not asked, the ones behind the issue—not just how do we fix it, but why are we seeing the rapid rise? And what do we need to be able to do it? The issue of technology and telehealth is really important, but there is another angle with technology as well that is driving comparisons among individuals that is pretty toxic.

So we have to be able to help resolve some of these issues in the days ahead as well.

The CHAIRMAN. Thank you, Senator Lankford. A very important point with respect to suicide. And Senator Barrasso took note of how important it was as well. This is an area he is going to focus on. So I think this will be another opportunity for both sides to work together, and I appreciate both you and Senator Barrasso bringing it up.

Senator Brown is next.

Senator BROWN. Thank you, Chairman Wyden. Mr. Chairman, I ask that written testimony offered by the director of pediatric psychiatry and psychology at the Akron Children's Hospital be included in the record for today's hearing.

The CHAIRMAN. Without objection, so ordered.

[The statement appears in the appendix beginning on p. 59.]

Senator BROWN. Thank you, Mr. Chairman.

Dr. Benton, as you probably recall from your time, some time ago, spent in my State for medical school, Ohio has excellent children's hospitals in almost every part of the State: Cincinnati Children's, Nationwide Children's in Columbus, Akron Children's, and Rainbow Babies and Children's in northeast Ohio, home to several outstanding centers of excellence.

Despite the resources our State has, Ohio's children and health workers are still struggling during this pediatric mental health crisis. Ohio is just like counterparts across the country: our children's hospitals need our support to rise to meet the needs of children and adolescents in addressing this serious, serious public health crisis.

Experts tell me that one of the biggest challenges is meeting the needs of a multi-system youth. Could you talk about actions, Dr. Benton, actions Congress can take to better support children's hospitals and their work to support youth served by multiple systems? For example, those who are in foster care or justice-involved, or have a developmental disability in addition to a mental health diagnosis—how can we ensure effective communications between and among juvenile justice and child welfare systems to best support these children, who so often just get left out?

Dr. BENTON. Thank you, Senator Brown, for that question. And just so you know, Cincinnati is my home town. So I am an Ohioan. So I just wanted to say that that is an excellent question, and one of the greatest challenges that we face in mental health care now.

So the systems in which children exist, as you have highlighted—child care education, juvenile justice, foster care, and others—have little or no collaboration. And systems are actually not in place to facilitate that collaboration. The attempts to coordinate it are either stifled by bureaucratic challenges or unwillingness to acknowledge that the systems are actually connected.

And so what would be required is a focus on requirements among those organizations that there is better coordination. You know, we talk often about case management as a broad term, but those individuals are often the ones who are facilitating communication between organizations that do parallel work caring for the same kids, but do not necessarily have an effective means for coordination.

You know, some of the data shows us pretty clearly that about 50 to 75 percent of the over 2 million children who are adolescents in juvenile detention actually have had limited mental health treatment, or limited mental health support.

So essentially, communicating expectations that those agencies collaborate around the care of the same kids by establishing systems that facilitate that, could go a long way. For children's hospitals, we struggle at times with children who are admitted to the children's hospital with a medical condition and a mental health condition. The medical condition is resolved. The mental health issues are resolving, yet they are waiting for placement in foster care, sometimes remaining in the hospitals for up to a year.

And at that juncture, payers are not accountable. The agency who acts as the parent is not accountable. And then the hospital is accountable for providing all of those services that require multiagency collaboration. Expectations of accountability for those agencies that are often managed by the Federal Government and States

would be essential for being responsible for coordinating care of young people.

Senator BROWN. Thanks, Dr. Benton.

I have a question that I would like all of you to answer, but very briefly, because my time is short—and the chair is always tolerant, but his patience probably wears thin.

I asked the Surgeon General last week how we better integrate mental health resources within our schools. And my question to each of you is, based on—actually, in Dr. Benton's home town, there is a community school in Cincinnati, Oyler, which has become a bit of a template for the whole State, and the whole country.

Briefly describe, if you had a chance to offer a suggestion, one thing schools can do to leverage relationships with community partners, State or local health departments, hospitals, service centers, whatever. Give one simple recommendation of what we can do better, schools can do better to leverage——

Dr. Hoover, do you want to start, and then Ms. Lubarsky and then Trace, and then finish with Dr. Benton, briefly.

Thank you.

Dr. HOOVER. Happy to. Thank you, Senator Brown, and I am familiar with the school in the Cincinnati area that does this well. And as you said, it serves as a model for the Nation.

So one simple thing that can be done is, there are good templates for memoranda of understanding and requests for proposals that can go out to districts to solicit community behavioral health partners to come in and engage in school behavioral health provider services in the schools. Instead of it just being kind of a hodgepodge of services, it can be organized through a request for proposals process with standardized memoranda of understanding with community behavioral health.

Senator BROWN. Thank you.

Ms. Lubarsky next, and then Trace.

Ms. LUBARSKY. Sure. First of all, I say, "Go Bearcats," as a graduate of the University of Cincinnati. This is something we have done really well in our community. It is really establishing, not only those agreements of understanding, but it is really finding a standardized assessment tool that schools will feel comfortable utilizing in order to be able to do that screening, to pass it on to the behavioral health-care providers, whether it is utilizing our mobile crisis team at the Center for youth who are going into crisis in the school setting, or being accepting of the behavioral and mental health supports that our staff can provide. Frankly, using some standardized screens that school districts feel comfortable with is one step in that direction as well.

Senator BROWN. Thank you.

Trace?

Mr. TERRELL. I also think a part of the big reason is we need to invite youth and kind of see what they actually need and what resources would be helpful for them. Because it is one thing to offer resources, and it is another for teens to actually access them.

So, when we conduct needs assessments and really see what works for youth, I think we will experience better outcomes in that regard.

Senator BROWN. Well said.

Dr. Benton, we will close with you. Thank you, Mr. Chairman.

Dr. BENTON. Thank you. I just want to say that I support all of those things that were just mentioned—and putting a system in place to make sure those things can happen easily and accessibly.

Senator BROWN. Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Brown. And thank you for having brought me to Ohio over the years to meet with a number of your health-care providers. And we have seen his advocacy in action.

Next is Senator Casey.

Senator CASEY. Mr. Chairman, thanks very much. In light of all the references to Ohio that Senator Brown made possible, I want to make sure that we emphasize that Dr. Benton is now at the Children's Hospital of Philadelphia. So we are honored that she settled, at least most recently, in Pennsylvania.

But, Dr. Benton, I wanted to start with you, and start with a critically important program that so many Americans know the name of, and so many Americans have a sense of what it does, but maybe none of us fully appreciate how important it is, and that is Medicaid.

I have often said that Medicaid often tells us who we are as a Nation, but maybe more importantly, it tells us whom we value, whether it is children, or people with disabilities including children, or older Americans who need skilled care in nursing homes paid for by Medicaid. We also know that Medicaid is the largest insurer for children, but it pays, unfortunately, significantly lower Medicaid rates than commercial rates, which has terrible consequences often for the pediatric health workforce in equitable access to care.

I know in your testimony you highlighted low reimbursement rates in mental health-care access, the concerns that you have about that, particularly with regard to underserved communities. On page 7 of your testimony you said, quote, "Better reimbursement for mental health services in Medicaid would make it possible to resource the full continuum of care our children and youth need," unquote.

So the additional years to specialize in child psychiatry are not financially rewarded in the current payment structure with Medicaid, where a provider could earn more providing care to adults. So this makes it hard for a child-focused provider, and particularly challenging for families covered by Medicaid.

So how would aligning Medicaid reimbursement for children's mental health services with Medicare levels impact kids' access to care?

Dr. BENTON. Well, thank you for that question, Senator Casey. You know, aligning those incentives would increase the reimbursement for Medicaid at a rate that would be more acceptable to most institutions. And that is key. Community mental health centers really struggle to meet the needs of young people based on reimbursement. Children's hospitals really struggle to meet the care for children with reimbursement.

And in addition to that, lower pay for providers is discouraging for subspecialists not only to serve the populations of young people,

but to even train to serve the populations of young people. You know, general psychiatry training takes 4 years. Child psychiatry training takes 6 years. Six years of accumulated debt, which has resulted in mental health professionals opting out of payment structures for reimbursement for mental health care.

And so, increasing the Medicaid reimbursement rates to be on par with Medicare, and medical rates, would increase our opportunity to address the gaps in the continuum. So there are areas in the United States where there are no services on any continuum available to young people.

Medicaid reimbursement would allow us to develop a full continuum of care, not just emergency and inpatient crisis services, but ambulatory services, home-based services, day hospitals, intensive outpatient programs where young people could be with their families and be at home getting the level of services that they need.

And so, the current Medicaid reimbursement rates impact all of those things. And increasing them to be better, which would be consistent with the Medicare rates, would allow us to provide the services that we need, and would allow us to encourage young people to pursue careers where they provide mental health care for young people.

Senator CASEY. Doctor, thanks very much. I might submit an additional question for the record for Dr. Benton.

[The question appears in the appendix.]

Senator CASEY. And I will give back time, but I did want to again thank the panel for their testimony today. In particular I wanted to thank Mr. Terrell for coming forward on behalf of his generation, and I hope there are other opportunities for us to engage. But thanks very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Casey.

Trace, you are now clearly the people's choice, because both Democrats and Republicans are praising you to the skies, and it is richly deserved.

Okay, Senator Hassan, we welcome you and all your good work.

Senator HASSAN. Well, thanks so much, Mr. Chairman. Thanks to you and the ranking member, again, for this hearing. And I will add my thanks to Trace as well, and also just note that the good news for America is Trace is representative of his generation, and there are lots of wonderful young people in my State, and I know across the country, really advocating for the mental health of their peers.

In New Hampshire, it is very true. I actually had a 9-year-old look at me one day and say, "What are you doing about mental health, Senator?" And so, thank you all for just being the kind of advocates that make a difference.

I want to touch on a few topics that have been discussed, but I want to drill down a little bit. Let me start with Ms. Lubarsky.

In New Hampshire, a small pool of mental health providers is working overtime to help the growing number of children with mental health needs. And it is just not sustainable. And we have all talked about that. Following up on the testimony you have already given, what are the main causes for this mental health workforce shortage in New Hampshire? And what can we do to help alleviate the crisis?

Ms. LUBARSKY. Thank you very much, Senator Hassan. I mean, I think we have all spoken to this very well this morning, and now going into the afternoon. It is really the ability for centers to reimburse their staff at a rate that they can survive on.

When we look at the cost of living—and we just spoke about Medicaid rates being significantly low. So we have a workforce that is burdened because of other providers in our community and within our State and country who could accept Medicaid and choose not to because reimbursement is so low, and we burden those providers who are accepting of it. But the facilities themselves cannot reimburse to sustain the staff long-term. We hear that all the time in our exit interviews.

Senator HASSAN. Thank you.

Dr. Hoover, you have also touched on this, but I want to drill down on mental health in schools. Schools are often the only place that children can receive mental health care, but many schools lack the personnel and infrastructure to meet demand. What are the barriers that schools face, particularly when it comes to recruiting and retaining mental health providers?

Dr. HOOVER. Thank you, Senator Hassan, for your leadership on this and for the question.

We know that we suffer from the same issues the general workforce shortage reflects as well. So simply put, we do not have enough providers. They are not trained well enough, and they are not paid enough.

And what I mean by that, really, is that not only do we have shortages in workforce coming into the field, but they do not really represent the population being served in terms of race, ethnicity, language spoken, so we have to do a better job of recruiting and retaining diverse and representative providers.

They are not trained well enough. And what I mean by that is that we have many mental health providers—not enough but many—but they are not trained to specialize in child and adolescent mental health, nor to work in schools. And as we have already said, they are not paid well enough. So reimbursement rates are a large issue.

Again, I go back to that we also need to reenvision how we think about our mental health workforce, and think about all of the other professionals, and even nonprofessionals, who can do this work well. I love the idea of a grandmother providing cognitive behavioral therapy to grandchildren, as our child psychiatrist, Dr. Benton, mentioned. But also our peer and family navigators; we need to be doing more to invest in that workforce as a way to support mental health.

Senator HASSAN. Thank you. And I know in New Hampshire, peer-to-peer training and student empowerment has been really, really critical as well.

Ms. Lubarsky, mental health resources need to meet children where they are. And during the school year, that is in the classrooms, but mental health does not end when the school year does.

So, you have led an innovative program based on that insight, working with the Community Behavioral Health Association and the State Government. Your clinic offered mental health training

for camp counselors and provided onsite resources at summer camps throughout the State.

So kind of following up on where we were just going with Dr. Hoover, what was the impact of this program? And how can we scale up this model so that more children have support year-round?

Ms. LUBARSKY. So, I was so excited about this program. Our Commissioner of Education labeled it "rekindling curiosity." And it was really a means to tackle the mental health needs of students, after being isolated from their peers.

So we began last summer by training summer camp staff in recreation programs in camps across our State. And we are allowed to carry that funding into the school year. So we have continued to utilize it to provide professional development days to educators, to do mental health youth training for educators. I have staff right now who are planning for February vacation week here in New Hampshire to go out and support young people to be maintained in camp settings or recreation settings that may otherwise not be able to be maintained because of their behavioral health needs.

So, rather than excluding them or expelling them from these programs, we have staff going onsite to support the counselors and the youth to stay with their peers and really get a meaningful camp or recreation experience.

Senator HASSAN. Well, thank you so much. It is a great program. Thank you for everything you are doing for New Hampshire. We really, really appreciate you.

And the last thing is, I am going to follow up, Dr. Benton, with a question for the record for you. I am particularly concerned about the isolation of children who are immunocompromised right now during the pandemic, and whether there are specific ways we can help those kids. So I will follow up with you on that.

[The question appears in the appendix.]

Senator HASSAN. Thank you all. What an excellent panel.

The CHAIRMAN. Thank you, Senator Hassan. And that last question is particularly important, and it has not gotten enough attention, and thank you for asking.

Senator Cortez Masto is next, and then Senator Young, and we will wrap up one of the best hearings I have certainly been to.

Senator Cortez Masto?

Senator CORTEZ MASTO. Mr. Chairman, I agree. I just have to thank the witnesses for being here. It has been a long morning, but a fruitful discussion. I thank you, Mr. Chairman, and the Ranking Member of the committee so much for having this hearing.

You know, let me just say, I hear every day that one of the most critical ways we can protect kids' mental health is by keeping our schools open. And that is one of the reasons why I have been working to make sure that our schools stay open and have what they need to keep and help our kids in the classroom and provide the important services and support that we are talking about today.

One of the areas though—and I am going to start, Ms. Lubarsky, with you—is stigma. My goal has been to tear down that barrier and do away with stigma. I think that anybody who goes to a doctor and talks about their physical health, and has a funding source for that, that should be on par with mental health. It should be the same thing. You walk in, get help for your mental health, and it

should be funded, and there should be no stigma associated with that.

But, Ms. Lubarsky, let me ask you. Can you talk about the impact that telehealth has had there? Do you see patients more inclined to follow through on the course of treatment through telehealth? And does that knock down some of the stigma associated with receiving services for mental health?

Ms. LUBARSKY. Absolutely, Senator. Thank you for your question. And when I hear your question, it makes me think of a young lady I worked with years ago, and at the conclusion of every one of our sessions, regardless of the weather, she would pull over her hooded sweatshirt, sunglasses, and a hat, and say, “I don’t want anybody to see me walking out of this building, with a giant sign that says ‘Mental Health Center’ out front.”

So for a youth like her, having that option to sit in the comfort of her home behind a screen, and nobody knowing that she was accessing care with me, I think would be a complete game changer for many of the youth in our world.

So yes, I think the addition of telehealth not only knocks down barriers to giving care, but eliminates the stigma that many youth and families see around mental health care.

Senator CORTEZ MASTO. Thank you.

And one of the things that everybody has been talking about, and I so agree, is access to the resources, the funding to support your services when you seek those for mental health. That is one of the reasons why I partnered with Senator Daines on legislation that actually enabled families with high-deductible health plans to access no-cost telehealth services before they meet their deductible. What I find is, that is often a barrier as well, just accessing the payment funds, the resources to pay for these services. So, thank you.

Let me ask you this, Mr. Terrell, because I saw you nodding your head. Based on your work with YouthLine, can you talk a little bit about the value that peer-to-peer relationship has, as well as how these kids feel less isolated and more willing to seek services for their mental health?

Mr. TERRELL. Absolutely. Thank you, Senator.

I think that is a really great question, because part of the reason that YouthLine works so well is that it is peer-to-peer. And we know from statistics that youth are more likely to turn to their friends than anyone else.

So, when we foster that natural partnership, it really helps to destigmatize mental health in that regard. But I also think YouthLine works so well because it is a crisis support service. And there is a difference in that, right?

So a lot of times when we talk about mental health, there is this conception that you only have to be suicidal or experiencing kind of acute high-stress situations, when that is not true, right? We know that mental health encompasses a lot of things. And so, when we talk about support, YouthLine is one of the only crisis lines in the country that offers teens the ability to talk about their mental health struggles without the fear of the problem being too small or too big. We really emphasize that there is no problem that is too big or too small. And when we talk about mental health, we really

need to recognize that. And just something that my supervisor always says is that we teach young people to call 911 when they are in emergency settings. And unfortunately that permeates over to how we view the national suicide prevention line, 988. So the sooner we can teach children that it is okay to call a crisis line, that it is okay to reach out for support for mental health, I think the better we will see this issue become in the future.

Senator CORTEZ MASTO. Thank you, and I could not agree more. I just so appreciate the comments today on the need for more robust crisis services for kids.

The chairman and I have worked on this. I truly believe that when they are in crisis mode, there should be a place to call. And it is not law enforcement on the phone, it is a mobile crisis intervention. That is why—the chairman knows this—the bill that he and I worked on together is based on the best practices in Oregon, in his State.

I think really, the focus for me is directing that crisis mode and bringing those essential services at that time. You know, Senator Cornyn and I have introduced legislation that would actually set flexible standards for crisis services and, again, provide insurance coverage, which we see as lacking as well.

So I know my time is up. I cannot thank you enough for this conversation, Mr. Chairman. I am hoping that, with telehealth services and so many other areas that we have to focus on, we are actually going to implement more work around bringing essential mental health services to so many in our community.

Thank you again, everyone.

The CHAIRMAN. Well, I thank my colleague for her leadership. And you made mention of the fact that, working together, we were able to put together a model that brings together mental health folks and law enforcement folks.

And so, if you go off and you talk to Senator Booker, he is really interested in the program. If you go off and talk to Senator Scott, which I have done repeatedly, I know my colleague is very interested in the program. So the Finance Committee is really trying, as you sugggest, to break some new ground and fill in these gaps. I just thank my colleague for all her leadership on these issues. She has just been invaluable, and I thank her.

Senator Young, you are next.

Senator YOUNG. Thank you, Mr. Chairman. And I want to thank all of our panelists today. It is such an important hearing.

While we may not fully understand the pandemic's long-term impact on America's youth, early data is alarming, especially to this father of four teens. According to the Indiana Youth Institute, teen suicide deaths in my State increased 73 percent in 2020 compared to 2019, while teen deaths by overdoses increased 66 percent from the previous year.

Dr. Hoover, what additional research do you believe is needed to better understand these trends and identify effective evidence-based interventions?

Dr. HOOVER. Thank you, Senator Young, for that important question, and for raising awareness again about the dire statistics that we are seeing, both with respect to mental health and suicide and also substance use. We cannot forget substance use in this con-

versation on mental health, but I appreciate you lifting that issue up.

With respect to research, we are fortunate that we are seeing greater investments in research, in both mental health prevention and intervention, and also in the substance use arena. So we would certainly urge Congress to continue supporting research in those areas.

Some of the areas that we think we need more investment in would be novel treatments, specific to certain populations—racial, ethnic populations, immigrant populations, different student populations in rural versus suburban versus urban settings—so really thinking about how we develop and implement interventions that are specific and tailored to the community.

We also need to understand who is actually thriving or succeeding in these environments of adversity, trauma, and stress. So often, the research looks at those who are suffering and how we can provide treatment, but it is really important that we also look to research to understand what are the protective factors, whether it is individual protective factors or community factors, that actually promote thriving and flourishing, and how we can bolster those through school-based centers and other community interventions.

Senator YOUNG. Well, thank you. That is quite helpful.

I would open this up to our panel, if you can keep your response really brief, if you have one, panelists. What steps can the Federal Government take right now—right now—to help reach at-risk teens at their individual moment of crisis?

Dr. BENTON. I have two brief suggestions. One would be educating our front-line providers right now around addressing mental health challenges. And the second is setting up more crisis programs—mobile crisis services that can go into families' homes and their environments and provide crisis intervention.

Ms. LUBARSKY. I would add to that, Senator, having worked with school educators recently, they are feeling like mental health is walking through their classroom doors every day. So I think we need to afford educators the professional development time, and give them that fundamental training in something like youth mental health first aid so they can recognize the signs and symptoms and know how to bring that young person over to the next level of mental health care that they need.

Mr. TERRELL. I think we should also make sure that this is not the last conversation that we have about teen mental health. As a teen, we need you to continue to have these conversations, and to continue to involve us in this work. We deserve a seat at the table, and I think that's it.

Senator YOUNG. Trace, I think that is really important. I mean, all our solutions need to be grounded in the realities of individual human beings, folks on the front line of this crisis, right, which is our teens.

Dr. Benton, in your testimony you discussed the web of systems beyond health care that impact the well-being of children and adolescents, such as foster care, education, food programs, and how these systems rarely collaborate—or, when they try, they are foiled by bureaucratic barriers or an unwillingness to acknowledge their interconnected nature.

Research has indeed shown that addressing these types of factors, which we often refer to as social determinants of health, can positively impact the health and well-being of the most vulnerable Americans, including our Nation's youth.

Doctor, how can we better leverage existing programs to help children and their families address the barriers to coordination between mental health and social services programs?

Dr. BENTON. Well, thank you for that question, Senator. One of the things that we could do right now is demand a higher level of accountability for agencies responsible for coordinating these services. And I will just take child welfare as an example.

So child welfare, as the parent, is acting *in loco parentis* for any child in their custody, and is responsible for coordinating schools, mental health, medical care, and all the services. And I am assuming there are barriers to them doing that, because it is challenging to make that happen. But I think for those agencies, there needs to be clarity and reinforcement around expectations that that coordination happens.

And from where I sit, the greatest challenge that I am facing in the care of young people at Children's Hospital right now, is the child welfare system.

Senator YOUNG. We need accountability metrics, and we need to identify who is responsible for achieving these metrics. Is that accurate?

Dr. BENTON. You summed it up well. Thank you.

Senator YOUNG. Thank you, much, Mr. Chairman.

The CHAIRMAN. I thank my colleague. And there is a vote on the floor, so I am going to have to be very brief, but I just want to say this has been one terrific panel. I mean, each of you has really made the case that Trace started talking about 2½ hours ago. Trace Terrell of La Pine, OR, basically said, "Look, what we've got to do in America, and we students are starting it, is mobilize. Get active and mobilize for real reforms of America's health care."

And each of our witnesses, Trace, in their own way sort of reaffirmed what you are saying. And so the first thing I want to say is, Trace, we are going to dedicate our efforts for mobilizing the Congress for these fundamental reforms the way you have said you are mobilizing young people. So that is number one.

Number two is, the message of so many young people getting lost in the system is another extraordinary takeaway from today's hearing. I noted in your testimony you said that at your school, with respect to referrals to mental health services, 80 percent of them went nowhere. And what was so striking to me, Trace, is the number of experts from around the country who said, "Hey, Trace is speaking for his school but, by the way, that is pretty much the pattern around the country. It might not be 80 percent, but we are just losing too many young people." And by the way, that is what Dr. Murthy said last week: we are just losing too many young people.

So I am going to close with this, and we will dedicate this to you, Trace, because this is a hearing on young people, and I want to thank all our experts for being so helpful. Trace, I want you to know, right at the heart of our work is our judgment, Democrats' and Republicans', that our country is better than this. We are bet-

ter than this. And as we go forward, you are going to have a seat at the table. You are going to have a seat at the table. We are going to reach out to young people across the country, and we are going to stay at our work until we find some real solutions to the issues we have talked about.

Big thanks to everybody. It was just a terrific hearing, one of the best I have been part of, and I just want to thank all of you, because you have really laid out the path that we have to follow, and we are determined to do it.

Thank you all. The Finance Committee is adjourned.

[Whereupon, at 12:35 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

PREPARED STATEMENT OF TAMI D. BENTON, M.D., PSYCHIATRIST-IN-CHIEF, EXECUTIVE DIRECTOR, AND CHAIR, DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY AND BEHAVIORAL SCIENCES, CHILDREN'S HOSPITAL OF PHILADELPHIA

Chairman Wyden, Ranking Member Crapo, and members of the committee, my name is Dr. Tami Benton. I am psychiatrist-in-chief and chair of the Department of Child and Adolescent Psychiatry and Behavioral Sciences (DCAPBS) at Children's Hospital of Philadelphia (CHOP) and the Frederick Allen professor of psychiatry at the Perelman School of Medicine at the University of Pennsylvania. I also serve as director of the Child and Adolescent Mood Program and the Youth Suicide Center at CHOP, a multidisciplinary clinical and research program focused on depression and suicide among children and adolescents, with an emphasis on minority youth. Finally, I am the president-elect of the American Academy of Child and Adolescent Psychiatry (AACAP). Thank you for the opportunity to testify today about the crisis in the mental, emotional, and behavioral health [1] of our children.

CHOP was founded in 1855 as the Nation's first pediatric hospital. Its longstanding commitment to exceptional patient care, training new generations of pediatric health-care professionals, and pioneering major research initiatives has resulted in many discoveries that have benefited children worldwide. Its pediatric research program is among the largest in the country, and we conduct research focusing on all aspects of mental, emotional, and behavioral health, including preventing a child with elevated symptoms from moving into crisis. Based on this research and the work of others, we are greatly expanding both the type and the reach of our pediatric mental health efforts. *However, this crisis cannot be addressed without your help.*

OVERVIEW

I wish there were no need for me to appear before you today, but young children and adolescents in the U.S. are experiencing mental health stress at higher rates and with more dire consequences than ever before. Fifty-three percent of adults with children in their household are concerned about their children's mental well-being, and they are not wrong to have these concerns. In the first half of 2021 alone, children's hospitals reported cases of self-injury and suicide in ages 5–17 at a 45-percent higher rate than during the same time frame in 2019, and, for children under 13, the suicide rate is twice that for Black children than for White children.

I know you've heard many of these statistics before, but I see them play out firsthand in my daily work. A few recent examples come to mind: a 5-year-old with suicidal ideation and a plan to follow through, an adolescent waiting months for a placement with appropriate services while occupying a medical bed needed by others, a youth sent several States away because finding a placement for children with both physical and mental health concerns is nearly impossible, and other stories too numerous to mention.

Clearly, our kids are falling through cracks in the system. While these cracks predate the COVID–19 pandemic, the additional traumas and challenges for children presented by the pandemic made them both worse and more visible. This dire situation led the Children's Hospital Association, the American Academy of Pediatrics,

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[1] For brevity, I will refer simply to "mental health" in my testimony, but the intention is to encompass mental, emotional, and behavioral (MEB) health throughout.

and the American Academy of Child and Adolescent Psychiatry to declare a national emergency in pediatric mental health, and they have joined together in an awareness campaign called Sound the Alarm for Kids.[2]

Already, more than 50 other national groups and 70 children's hospitals have joined the campaign, a clear acknowledgement that it is, indeed, time to sound the alarm. We have not one but two urgent tasks before us:

1. Addressing the immediate and undeniable crisis facing kids today; and
2. Reframing our pediatric mental health system to provide the right care, at the right place, and at the right time.

This latter point may sound obvious; however, the reality is that we commonly only address pediatric mental health *after* the onset of a crisis. Delayed care is costly in many ways, including:

1. Emotional burden and social cost to the patient and their family,
2. Strain on our child-care and educational systems,
3. Excess cost and poor outcomes associated with providing inadequate care,
4. Delays in pediatric health care when medical hospital beds are overutilized for boarding children in mental health crisis, and
5. Wrongful placement of children in the juvenile justice system.

The current state of care is unacceptable, and we must pivot to proven models of prevention to reduce the number of our children entering a period of crisis and assure access to appropriate pediatric services both across the entire continuum of care and close to home.

SHORTER-TERM SOLUTIONS

In the immediate-term, this means greater reliance on those on the front lines—parents, teachers, general pediatricians, and other caregivers. They need whatever proven tools we can give them, and they need them as soon as possible. Examples include supplemental training, ready access to phone consultations and referrals, pediatric mobile crisis units to help children (and their caregivers) manage from home, and school-based interventions, including telehealth. While a good number of schools have a school psychologist, school counselor and/or nurse on hand, they tend to have untenable student ratios. While these providers may not have capacity at present, it makes sense to build on these existing models of care through evidence-based training and supplementing their efforts with telehealth.

Not only are these front-line workers lacking the support they need, in some cases there are financial *disincentives* to providing mental health services. For example, although up to half of all pediatric primary care office visits involve a mental health concern,[3] primary care pediatricians who do additional training to offer a mental health assessment necessary for appropriate referral, do so without receiving compensation for the 1.3 to 2.8 times longer the mental health assessment takes, compared to other primary care visits.

We need more appropriately trained pediatric mobile behavioral health crisis units. These provide mobile, short term, face-to-face, therapeutic responses to youth experiencing a behavioral health crisis and can help reduce psychiatric emergency department visits.[4] Notably, there are effective models to build on in both urban and rural settings, and these mobile crisis units can be stood up almost immediately.

Twenty-four-hour crisis hotlines, staffed with those trained in child and adolescent mental health, can assist with de-escalation and assessment. If linked with updated local resource and provider information, these crisis lines can also refer to treatment facilities. Depending on how they are configured, the crisis lines could be utilized by providers, educators, families and even the kids themselves. They would work best if connected to a frequently updated collection of local resources. For this, it may be possible to build out the existing 211 network or expand on the 988 network established by the FCC last year to connect people to the National Suicide Prevention Lifeline.

[2] *See* list of Sound the Alarm for Kids campaign partner organizations in Appendix A, *https://www.soundthealarmforkids.org/*.

[3] Martini, R., Hilt, R., Marx, L., Chenven, M., Naylor, M., Sarvet, B., and Ptakowski, K.K. (2012). *Best principles for integration of child psychiatry into the pediatric health home,* American Academy of Child and Adolescent Psychiatry.

[4] Fendrich, M., Ives, M., Kurz, B., Becker, J., Vanderploeg, J., Bory, C., Lin, H., and Plant, R. (2019). "Impact of Mobile Crisis Services on Emergency Department Use Among Youths With Behavioral Health Service Needs." *Psychiatric Services:* 70 (10) 881–887.

FIXING A BROKEN SYSTEM

In the longer term, the whole continuum of care must be addressed so that the right types and levels of care are available, *e.g.,* the emphasis should not be on inpatient mental health beds (although more of those are also needed). If we are doing things right, children will be treated more and more *outside of a hospital inpatient setting,* but this will only be possible if intensive outpatient programs (IOPs), partial hospitalization programs (PHPs), day programs, a full range of additional step-down services, and preventive services are available. *Today, every one of these services is in short supply.* As a result, children often go without the services they need, or families find themselves seeking services for their child far from home (including out of State).

It is also important to acknowledge that there is a web of systems beyond health care that impact the well-being of children and adolescents. These include foster care, juvenile justice, childcare, education, food programs and more, layering on additional complexities to achieving the end goal of doing better by our kids. The many systems that touch our kids rarely collaborate, and, when they try to, these attempts are too often foiled by bureaucratic barriers or an unwillingness to acknowledge the interconnected nature of the services offered. Although a daunting prospect, we recommend a thorough examination of how various agencies intersect in children's lives and policy recommendations aimed at making those intersections synergistic rather than counterproductive.

WORKFORCE SHORTAGES AND PEDIATRIC BEHAVIORAL HEALTH BOARDING

Not surprisingly, the shortage of pediatric mental health-care providers and facilities means many children show up at emergency departments (EDs), brought there by distraught caregivers, sent there by overwhelmed schools, or taken there by police who see plainly in a particular case, that care, not confinement, is what is needed. EDs are not the ideal setting for these kids if they do not have medical needs. EDs can be stressful environments and starting a mental health journey that way often results in delayed care when children are "boarded" either in the ED itself or admitted to a medical patient bed. Neither option satisfies the "right care, right place, right time" mantra, and both can be detrimental.

At CHOP, we have up to 50 patients waiting for mental health beds on any given day. As we typically operate at (or over) capacity, this means that we cannot use that space for a child with more complex medical needs. The kids who are boarding are kept physically safe, but generally must wait for an appropriate treatment slot to open before having their mental health crises fully addressed. Sometimes this wait is only a few hours, but weeks of waiting is far too common, months is not unheard of, and there are even instances of a child or adolescent missing more than a year of their life, removed from school and family, while waiting for the services they need to safely return to home and school.

According to the American Psychiatric Association, there are an estimated 15 million children nationwide in need of care from mental health professionals. However, there are just 8,000 to 9,000 psychiatrists treating youth in the United States. Even when staffing ratios are reasonable, resources are not distributed evenly across the country, essentially resulting in pediatric mental health service deserts.

While I can speak most directly to the shortage of child and adolescent psychiatrists, there are also severe shortages of psychologists, mental health therapists, nurse practitioners, case managers, and community mental health workers to support children in need.[5] To increase the number of pediatric mental health providers available to care for these children, incentives, including educational funding and loan forgiveness programs should be directed at all licensed pediatric mental health providers in all settings across the continuum of care, including in schools. It is especially important to include mental health professionals of all disciplines. While there is a severe shortage of new pediatric psychiatrists coming into the system, and that must be addressed, increasing the number of clinical social workers with pediatric training, mental health therapists, psychologists, nurse practitioners, case managers and community mental health workers, who are all needed to expand access to mental health care, could be done more quickly and in greater numbers.

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[5] National Projection of Supply and Demand for Selected Behavioral Health Practitioners: 2013–2025. U.S. Department of Health and Human Services. Health Resources and Services Administration. Bureau of Health Workforce. Published November 2016, *https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf.*

THE UNIQUE NEEDS OF MILITARY FAMILIES

Children in military and veteran families are experiencing mental health challenges much like their civilian counterparts, but also face some unique challenges due to the nature of their parents' service such as frequent moves, prolonged separation resulting from parents' deployments, and exposure to returning parents who themselves have been affected by the trauma of combat deployment. How these children can be connected to the full continuum of care described above must be determined and then implemented.

IMPROVED ACCESS TO INTEGRATED CARE AND PREVENTIVE SERVICES

For an overwhelmed system in which training enough providers will, at best, take time, easing pressure on the system now is essential. The best way to do this is support for both preventive services as well as care that is integrated into settings where youth are likely to be, such as the pediatrician's office, school, or other community-based centers to help stem the tide of youth entering crisis.

When care isn't easily accessible (the ideal being true integrated care, with a warm hand-off to someone in the same building), too often a referral to mental health services ends in no services. When patients are referred from primary care to free-standing mental health clinics, only 25–50 percent of patients attend an appointment. When behavioral health providers are on site, as part of the primary care team, treatment initiation is dramatically improved.[6] The pediatric patient-centered medical home model offers opportunities for family-centered, team-based care, and pediatric mental health providers are increasingly being recognized as key members of primary care teams.[7] Insurance carve outs for behavioral health care are among the barriers to implementation, but targeted incentives related to integrated behavioral health could further speed expansion and serve as a pathway to mental health parity.

Certified Community Behavioral Health Clinics (CCBHCs) are another important access point to mental health care for children and youth, particularly for those in underserved communities. In a recent survey, 79 percent of CCBHCs reported coordinating with hospitals to support diversion from emergency departments and inpatient care,[8] and a similar proportion of CCBHCs directly employ child and adolescent psychiatrists as part of their care teams. Providing these clinics with additional resources could be another way to have more appropriate care available closer to home, for kids in need.

Ultimately, of course, prevention is the best approach as it both serves are children better and it helps to alleviate an over-burdened system. Preventive mental health interventions reduce the risk of a child suffering a mental health crisis and are cost-effective,[9,10] but it is not well understood how early these interventions can and should start. Remarkably, just by giving parents and other caretakers tools to effectively address behaviors and emotions as they come up, better trajectories are started as early as infancy. Early intervention, services for young children that build upon the natural learning opportunities that occur within the daily routines of a child and their family, can effectively give children tools to overcome delays and manage disabilities.[11,12] For older kids, there are several effective depression pre-

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[6] Blount, A. "Integrated primary care: Organizing the evidence." (2003). *Families Systems and Health.* 21:121–133.

[7] Asarnow, J., Kolko, D.J., Miranda, J., and Kazak, A.E. (2017). "The pediatric patient-centered medical home: Innovative models for improving behavioral health." *American Psychologist,* 72, 13–27. *https://doi.org/10.1037/a0040411.*

[8] According to a 2021 impact report *(https://www.thenationalcouncil.org/resources/2021-ccbhc-state-impact-report-transforming-state-behavioral-health-systems/?daf=375atetbd56)* that surveyed 128 CCBHCs, 79 percent report coordinating with hospitals/emergency departments to support diversion from emergency departments and inpatient care. Additionally, according to a 2020 ASPE implementation report *(https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/196051/CCBHCImpFind.pdf?_ga=2.126261899.727227857.1643912188-731445304.1625598149)*, 76 percent of CCBHCs employs child and adolescent psychiatrists.

[9] Mihalopoulos, C., Vos, T., Pirkis, J., and Carter, R. (2012). "The Population Cost-effectiveness of Interventions Designed to Prevent Childhood Depression." *Pediatrics* 129 (3): e723–e730.

[10] Bodden, D.H.M., van den Heuvel, M.W.H., Engels, R.C.M.E., and Dirksen, C.D. (2021). "Societal costs of subclinical depressive symptoms in Dutch adolescents: A cost-of-illness study." *Journal of Child Psychology and Psychiatry, https://doi.org/10.1111/jcpp.13517.*

[11] Bailey, D.B., Hebbeler, K., Spiker, D., Scarborough, A., Mallik, S., and Nelson, L. (2005). "36-month outcomes for families of children with disabilities participating in early intervention." *Pediatrics,* 116, 1346–1352

[12] Richard C. Adams, Carl Tapia, and The Council on Children With Disabilities. "Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best

vention programs, which, if more widely delivered, could prevent 22–38 percent of depression episodes.[13, 14]

Unfortunately, current mental health payment models do little to support prevention services. Most billing codes required for use by behavioral health clinicians usually necessitate the presence of a diagnosed psychiatric condition. This means that a mental health concern that could have been resolved relatively quickly can devolve into crisis, which is far worse for the child and far more costly, both literally and figuratively, for society. Even with early intervention, which is inexpensive and effective, there are barriers that can significantly delay services.

Although we understand the challenges of fully realizing savings in a 10-year legislative budget window, it is nonetheless essential to increase funding for and access to preventive services for our children. To this end, dedicated grant programs could further enable community-based systems of care. Additionally, increasing health-care payment flexibility with new billing codes that support preventive services without a diagnosed psychiatric condition would better enable these services to be embedded into pediatric primary care (where most families already visit regularly) and other settings that children and families frequent. Also, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for youth in Medicaid provides an important opportunity to support early identification even before diagnosis. The Department of Health and Human Services should be instructed to working with States to test innovative strategies and sustainable payment models within Medicaid's EPSDT services[15] to allow children at risk of mental health concerns, but without a diagnosis to receive preventive services.[16]

SETTING CHILDREN UP FOR SUCCESS FROM THE EARLIEST YEARS AND ADDRESSING EQUITY CONCERNS

Early care and education programs, child care, and preschool prevention programs have been overlooked and underfunded. As noted above, these services have a key role in prevention. When using proven techniques, they help young children build social-emotional life skills, which can set the child on a pathway to greater resilience and prevent mental health crises at later ages.

Within early education, there is another distinct crisis that exists as the result of suspensions and/or expulsions of babies and toddlers from childcare and Pre-K settings for behavioral concerns, and this problem falls disproportionately on Black boys. If you take a moment to imagine being told that nothing can be done for your 2-year-old's behavior, and he is being expelled from child care—the message to both the child and the parents is damaging in the moment longitudinally. Promptly investing in basic behavioral health technique training for child-care providers and Pre-K teachers will give our educators the support they need to teach our youngest the social-emotional life skills and regulation tools they need to participate in these important developmental settings and enter kindergarten ready to learn and thrive.

Care provided in communities offers the opportunity for early identification and intervention for children and families with mental health challenges at the right level and at the right time. It also helps to address longstanding access disparities and overcome stigma. Instead of this, our current system relies heavily on private facilities which often pick and choose their patients. While they are entitled to do so under current law, additional standards could be set nationwide both to ensure

Outcomes," *Pediatrics,* October 2013, 132 (4) e1073–e1088; DOI: *https://doi.org/10.1542/peds.2013-2305.*

[13] Cuijpers, P., van Straten, A., Smit, F., and Mihalopoulos, C. "Preventing the Onset of Depressive Disorders: A Meta-Analytic Review of Psychological Interventions." (2008). *The American Journal of Psychiatry;* 165, 10; ProQuest Social Sciences Premium Collection pg. 1272.

[14] Cuijpers, P., Muñoz, R.F., Clarke, G.N., and Lewinsohn, P.M. (2009). "Psychoeducational treatment and prevention of depression: The 'coping with depression' course 30 years later." *Clinical Psychology Review* 29 449–458.

[15] "Early and Periodic Screening, Diagnostic, and Treatment." *Medicaid.gov (https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html#:~:text=PDF%2C%2068.09%20KB)-,The%20Early%20and%20Periodic%20Screening%2C%20Diagnostic%20and%20Treatment%20(EPSDT),who%20are%20enrolled%20in%20Medicaid.&text=Treatment%3A%20Control%2C%20correct%20or%20reduce%20health%20problems%20found).*

[16] We can look to Massachusetts for innovation in this area. Revisiting and realigning health insurer capitated payment rates to reflect expanded preventive services would also facilitate earlier interventions. Please refer to the relevant MassHealth Bulletin *(https://www.mass.gov/doc/managed-care-entity-bulletin-65-preventive-behavioral-health-services-for-members-younger-than-21-0/download).*

kids get to open pediatric mental health slots in facilities that accept Federal funding and to reduce bias in these decisions.

Of course, inadequate Medicaid reimbursement for mental health services disproportionately impacts communities that are already medically underserved, in which those services are especially needed. Better reimbursement for mental health services in Medicaid would make it possible to resource the full continuum of care our children and youth need, such as intensive outpatient, partial hospitalization, and limited residential treatment facilities—and, importantly, bring that care closer to home.

HOW TELEHEALTH CAN ENHANCE CARE

Tele-mental health services have been described as an ideal application of digital health services, and since the onset of the COVID–19 pandemic, behavioral health providers at CHOP have completed more appointments via telehealth than any other specialty; nearly 83,000 across the CHOP Care Network. This is an essential tool for addressing the pediatric mental health crisis. To reach the underserved, we recommend the inclusion of audio-only services as well as coverage across sites of care including a child's home, school, or childcare center. Increased reimbursement rates for telehealth services supported the rapid expansion of telehealth and should be continued at an appropriate level to maintain children's access to tele-behavioral health services.

Telehealth across State lines is also an important way to improve access to pediatric mental health services, particularly in States where there is a shortage of providers. However, the process is both complicated and expensive for providers to become licensed in multiple States and/or obtain the credentials (like PsyPact) that allow care provision across State lines. There is also no longer a State-by-State standard of care, making State-based professional licensure a barrier to care that is difficult to justify, especially in federally recognized health professional shortage areas (HPSAs) and the dearth of providers accepting Medicaid.[17]

IMPROVING REIMBURSEMENT THROUGH BOTH PAYMENT REFORM AND HIGHER RATES

The behavioral health payment system is archaic and convoluted, further restricting access to care. As it stands today, arranging for care and payments can be confusing and administratively burdensome. There is often disagreement as to which payer is responsible and where the care can be provided. For boarded children, the result is something close to nonpayment, where neither insurer assumes responsibility when the services assigned to them are not being provided or not in what they consider to be the approved setting. The disfunction is only greater when a child or adolescent reports with both a medical and mental health issue,[18] and few settings are equipped to address these complex cases.

Many key pieces of the needed continuum of care are simply not covered or are reimbursed at such low levels that too few providers will offer them. Day programs,[19] which provide trauma-informed, behaviorally based therapeutic services, which teach children how to develop safe adaptive behaviors, emotional self-regulation, and pro-social skills, are an important example. Without a significant enough increase in rates for pediatric mental health services, we will never be able to provide the full continuum of care that our youth need. This is not acceptable, especially when getting this right will mean our children receive the care they need at the appropriate level, maximizing the likely success of the treatment, ensuring that they are not taking a higher acuity spot desperately needed by another child, and more wisely spending health-care dollars.

CONCLUSION

Our mental health-care system is not equipped to give our children the support they need when they need it. If the right interventions are put in place, they would build on our children's remarkable resilience and place them on a better trajectory. Our children are in crisis, which means we are in crisis as a Nation. Although the

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[17] Health Professional Shortage Areas *(https://data.hrsa.gov/topics/health-workforce/shortage-areas)*.

[18] We have been able to provide limited relief of this latter problem by providing full-time medical staff to a facility that otherwise only addresses MEB issues, but this only works when the medical issue is relatively easily managed, like diabetes, not for more severe comorbidities.

[19] More information on CHOP's Intensive Emotional and Behavioral Services can be accessed here *(https://www.chop.edu/centers-programs/childrens-intensive-emotional-and-behavioral-services)*.

pandemic deepened the crisis, it has raised awareness on this issue, creating an important and rare opportunity to make fundamental changes in the way we care for our children.

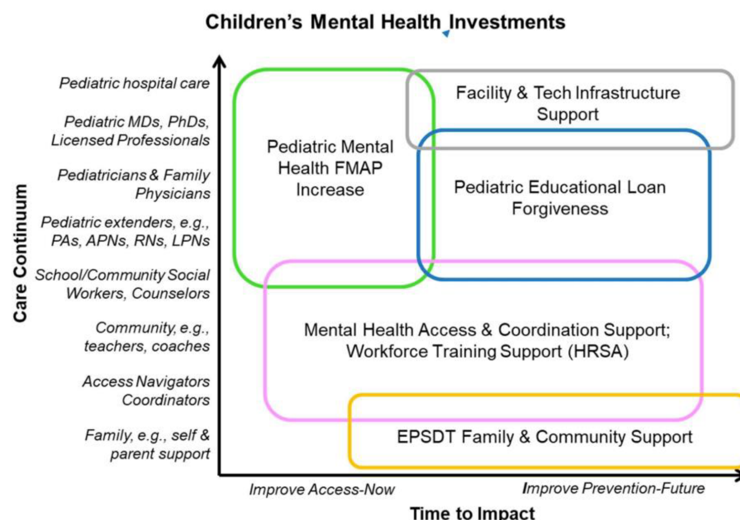
Thank you again for the opportunity to provide this testimony. I urge you to take this opportunity to act swiftly and decisively to save children in crisis and diminish the chances of a repeated emergency of this magnitude.

Appendix A: Organizations Participating in the Sound the Alarm for Kids Campaign, along with the Children's Hospital Association, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and 70+ *(https://www.soundthealarmforkids.org/a-national-emergency/)* Children's Hospitals

- AIDS Alliance for Women, Infants, Children, Youth and Families
- American Academy of Family Physicians
- American Foundation for Suicide Prevention
- American Hospital Association
- American Mental Health Counselors Association
- American Muslim Health Professionals (AMHP)
- American Psychiatric Association
- American Psychological Association
- America's Essential Hospitals
- Association of Children's Residential and Community services (ACRC)
- Catholic Health Association
- Center for Law and Social Policy (CLASP)
- Child Welfare League of America
- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
- Children's Defense Fund
- Clinical Social Work Association
- Eating Disorders Coalition for Research, Policy and Action
- Exceptional Families of the Military
- Family Voices
- Federation of American Hospitals
- First Focus on Children
- Global Alliance for Behavioral Health and Social Justice
- International Society of Psychiatric Mental Health Nurses
- Juvenile Protection Association (JPA)
- Mental Health America
- National Alliance on Mental Illness (NAMI)
- National Association for Behavioral Healthcare
- National Association for Children's Behavioral Health
- National Association for Rural Mental Health
- National Association of County Behavioral Health and Developmental Disability Directors
- National Association of Pediatric Nurse Practitioners
- National Association of School Psychologists
- National Association of State Mental Health Program Directors
- National Council for Mental Well-being
- National Latinx Psychological Association
- National League for Nursing
- National Military Family Association
- On Our Sleeves—The Movement for Children's Mental Health
- Psychotherapy Action Network (PsiAN)
- REDC Consortium
- RI International, Inc.
- Sandy Hook Promise
- School Social Work Association of America
- School-Based Health Alliance
- Social Current
- Society for the Prevention of Teen Suicide
- Society of Adolescent Health and Medicine
- The Baker Center
- The Barry Robinson Center
- The Jed Foundation
- The Kennedy Forum
- The National Alliance to Advance Adolescent Health
- The Trevor Project
- Tricare for Kids Coalition
- Trust for America's Health

- United Way Worldwide
- WellSpan Health
- Youth Villages

Appendix B: Visual Representation of Recommendations Along the Care Continuum and Time to Impact (Now vs. Future)[20]



QUESTIONS SUBMITTED FOR THE RECORD TO TAMI D. BENTON, M.D.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. On page 6 of your testimony, you note that "early care and education programs, child care, and preschool prevention programs have been overlooked and underfunded." I strongly agree that we must invest in and work through evidence-based early childhood programs to equip kids with socio-emotional life skills and increase their resilience. When it comes to preventing mental health challenges later in life, we should think about what support we can provide every stage of a child's life, including their earliest years.

How can we better integrate infant and early childhood mental health into the continuum of care for children?

Answer. When using proven techniques, services provided to young children help them build social-emotional life skills, which can set the child on a pathway to greater resilience and prevent mental health crises at later ages. Promptly investing in basic behavioral health technique training for childcare providers and Pre-K teachers will give our educators the support they need to teach our youngest the social-emotional life skills and regulation tools they need to participate in these important developmental settings and enter kindergarten ready to learn and thrive. Preventive mental health interventions reduce the risk of a child suffering a mental health crisis and are cost-effective.

Within early education, there is another distinct crisis that exists as the result of suspensions and/or expulsions of babies and toddlers from child care and Pre-K settings for behavioral concerns, and this problem falls disproportionately on Black boys. If you take a moment to imagine being told that nothing can be done for your

[20] *Strengthening Kids' Mental Health Now.* Children's Hospital Association *(https://www.childrenshospitals.org/content/public-policy/policy-position/strengthen-kids-mental-health-now-bill-would-invest-in-mental-health)*.

2-year-old's behavior, and he is being expelled from child care—the message to both the child and the parents is damaging in the moment and over time.

Remarkably, just by giving parents and other caretakers tools to effectively address behaviors and emotions throughout children's development, as they occur, will improve developmental outcomes, preventing emotional and behavioral problems across the life span. At CHOP, we provide behavioral health support to parents, supporting healthy social, emotional and behavioral development. One such program is the Child Adult Relationship Enhancement in Primary Care (PriCARE) program, a 6-session group parent training designed to teach positive parenting skills; other programs include the Early Head Start Program for at-risk parents. Early intervention, services for young children that build upon the natural learning opportunities that occur within the daily routines of a child and their family, can effectively give children tools to overcome delays and manage disabilities.

QUESTION SUBMITTED BY HON. MAGGIE HASSAN

Question. We know that youth anxiety and depression rates are skyrocketing, and that strong social relationships improve a child's overall well-being. I worry about children and youth who are immunocompromised and might have trouble safely reconnecting with their peers during the ongoing pandemic.

What can parents do to help their immunocompromised children socialize with other youth while staying safe?

Answer. We know that children who are immunocompromised are at higher risk of being infected with and suffering complications from COVID–19. Parents can make sure kids and family members are vaccinated (if eligible) and wear masks when seeing friends, as well as providing opportunities for children to socialize with their peers outside where the risk of infection is lower. It is also important that school personnel be aware of a youth's need for distancing and masking, and that there is an opportunity for private space if needed. Communication with the school about the child's management at school and daily activities and contacts will allow the parents and child to feel supported. All will feel better with effective communication.

Additionally, communities should prioritize in-person learning for school-age children. This will require not only ensuring there is adequate financial support to safely return to the classroom, but also making plans to support the emotional well-being of youth as they reacclimate to in-person socialization and catch up on missed academics. Expanding the settings in which mental health services are delivered to meet families where they are, including in schools as students return to classrooms, can help ease this transition.

SUBMITTED BY HON. SHERROD BROWN,
A U.S. SENATOR FROM OHIO

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Statement of Steven Jewell, M.D.,
Director of Pediatric Psychiatry and Psychology

Chairman Wyden, Ranking Member Crapo, members of the United States Senate Committee on Finance, thank you for the opportunity to submit our statement, which outlines the position and perspective of Akron Children's Hospital regarding behavioral health.

Acknowledgement of Surgeon General's Advisory

We appreciate the Surgeon General's recent advisory on "Protecting Youth Mental Health," that highlights the long-standing access and workforce issues that have plagued the mental health system for children and youth across the country for decades, and which have been significantly aggravated by the COVID–19 pandemic. In fact, pre-pandemic in 2019 suicide became the leading cause of death for children ages 10–14 in the State of Ohio, and the second leading cause of death for those ages 15–34. Reflective of the increasing demand for behavioral health services even

before the pandemic struck, that same year Akron Children's Hospital's behavioral health outpatient volumes increased over 45 percent for mental health therapy services and over 29 percent for psychiatric services.

Within just a few months of the beginning of the pandemic, experts began predicting a mental health pandemic that would inevitably follow on the heels of the viral pandemic. As the stress and trauma to children and families caused by the pandemic persisted, we saw further increases in demand for behavioral health services, as well as increasing rates of suicide attempts and completed suicides among youth, especially girls. By late 2021 (ironically the year that the Annapolis Coalition on the Behavioral Health Workforce celebrated 20 years since it was founded to address the behavioral workforce shortage), there was a general recognition that the longstanding workforce shortage had also been exacerbated by the pandemic, as it became increasingly difficult to recruit mental health professionals (especially those with specialized training in serving the needs of youth) to address the increasing needs of youth presenting in crisis.

Leaders in the field soon began calling for action. In October 2021 the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics and the Children's Hospital Association declared a "national state of emergency" in child and adolescent mental health, which they correctly noted required "urgent government action." Surgeon General Dr. Vivek Murthy answered that call in December 2021 with his advisory, calling for "a swift and coordinated response to this crisis." We are grateful for his decision to shine a light on this crisis, and his comprehensive set of recommendations that all of us can begin to implement with the goal "to improve the mental health of children, adolescents, and young adults."

Akron Children's Perspective

During the pandemic, Akron Children's Hospital has experienced an increase in youth and adolescents presenting in the emergency department with suicidal ideation and suicide attempts. The complexity and acuity of patients admitted to the inpatient psychiatric unit has increased significantly as evidenced by the number of nursing specialties required for patient care. In addition, aggressive behaviors among the patient population have resulted in more serious staff injuries resulting in an increasing number of days absent from work. In the ambulatory settings, referral volumes are extremely high. In some areas, families seeking services are waiting up to six months to be seen by a behavioral health specialist.

Current Efforts

Facing the same challenges to providing behavioral health services to children and youth that other organizations do, Akron Children's Hospital has embarked on a strategic plan to create a system of care that not only capitalizes on our existing resources, but also leverages those by partnering with pediatric primary care providers (PCPs) and community mental health centers (CMHCs) across our more than 30-county service area in northeast Ohio, in an attempt to mitigate existing barriers to care. The challenges we are attempting to address include the stigma of mental illness, under-identification of children in need of services, the above-noted behavioral health workforce shortage, and significant gaps in available services in the community (especially for youth with more severe mental illness). Our strategy includes the following interventions:

1. Addressing stigma by embedding masters' level therapists in all of our pediatric primary care offices, thereby providing care in a natural setting, allowing for "warm hand-offs," and encouraging informal consultation between therapists and PCPs;
2. Addressing under-identification of youth with mental illness by an annual screening process in the primary care offices for all youth 12 years of age and older, to identify youth in need of services earlier in the course of their illness;
3. Addressing the behavioral health workforce shortage by enhancing PCPs' confidence and competence managing mild to moderate mental illness in their office through various supports (including telepsychiatry, electronic consults, and telementoring using the Project ECHO format), and creating a structured triage process to identify and prioritize referral of more severely mentally ill youth from primary care to more specialized services; and
4. Addressing the gaps in available services in the community by bringing up several regional behavioral health centers across our geographic footprint, each of which house programming for more severely mentally ill youth, tailored to the needs of the local community.

The overall intent of the plan is to create a "meta-system" of care layered on top of and in collaboration with the existing county-based systems of care, but taking care not to compete with existing community mental health system resources.

In another effort to address the workforce issues, we are expanding our child and adolescent psychiatry and pediatric psychology fellowship programs, and are in the process of establishing a fellowship for child psychiatric advanced practice nurses. This will include partnering with local agencies and universities to create clinical rotations that offer a comprehensive learning experience. The goal of these programs is to expose fellows to multiple clinical settings and patient populations while retaining them within the local community workforce.

For Your Consideration

Finally, as we move forward with this strategic plan we recognize that there are interventions that could be beneficial not only in our local service area, but also on a national scale in this effort to protect youth mental health, and would like to share those with you.

(1) Increase availability of behavioral health promotion/prevention/early intervention services in the community, such as:

(a) Enhance suicide prevention activities in communities (many have a structure addressing needs of adults, but not youth);

(b) Enhance mental health screening of children and youth in primary care for the purpose of case-finding, early identification and early intervention; and

(c) Enhance availability of screening, mental health services, and risk assessment capacity in schools.

(2) Integration of behavioral health services into primary care:

(a) Successful and meaningful integration of behavioral health services into primary care on a national level holds the promise of resolving many of the most vexing barriers to the effective provision of behavioral health services to youth, including (as noted above) stigma, workforce shortage, and the need for early identification and intervention.

(b) However, this requires a number of activities that are not billable in a fee-for-service environment. These include, among other activities:

(i) developing the capacity in the primary care practice for regular screening and ongoing monitoring of response to treatment using standardized tools;
(ii) creation of a roster of patients within the practice identified as needing behavioral health services, and conducting an ongoing systematic case review of their progress in treatment;
(iii) embedding a behavioral health-care manager within the primary care practice to take responsibility for conducting/overseeing the above activities; and
(iv) providing ongoing psychiatric consultation to the PCPs, thereby leveraging the psychiatrist's time to serve a larger population than could be served with direct visits alone.

(c) The Collaborative Care Model (CoCM)—developed and studied by the University of Washington's AIMS Center *(http://uwaims.org)*—for treating common mental disorders in primary care settings is an evidence-based strategy recognized as a best practice for improving patient outcomes and includes all of the above-described elements. CoCM services are currently reimbursable by Medicare, and a few State Medicaid programs (*e.g.,* Maryland, New York, North Carolina, and Washington, but not on a national level).

(d) Thus, authorizing Medicaid (and incentivizing private insurers) to reimburse primary care practices for implementation of the evidence based CoCM for youth could have a substantial impact on the behavioral health needs of the youth across the Nation, and address many of the challenges described above.

Thank you for your time and attention to this issue of critical importance to the overall health of the children, youth and young adults of this Nation. If we can be of any further support or assistance to this initiative, please do not hesitate to contact us.

PREPARED STATEMENT OF HON. MIKE CRAPO,
A U.S. SENATOR FROM IDAHO

Thank you, Mr. Chairman, and thank you to our witnesses for joining us today as we discuss ways to respond to mental health challenges impacting children and adolescents across the country.

According to recent reports from the CDC, the number of young people dealing with depression, anxiety, and suicidal thoughts has unfortunately risen during the pandemic, as social isolation has taken its toll on far too many children and adolescents. Although it appears the pandemic is subsiding and our return to normalcy may be imminent, we cannot ignore the lasting effects of the past 2 years on the social and emotional well-being of children.

We should do all that we can, within our jurisdiction, to increase access to high-quality mental health services, and reduce the causes of delayed and forgone treatment. While mental health issues affect people of all ages, children's needs are often different from those of adults, necessitating carefully tailored solutions.

As this committee works in a bipartisan way to advance the conversation on mental health, we must not only identify the complexity and scope of the problems at hand, but also explore innovative, sustainable, and concrete policy solutions. I look forward to working with my colleagues on both sides of the aisle to develop meaningful measures to meet some of the Nation's mental health challenges, including by expanding access to telehealth services, supporting our mental health workforce, and better integrating physical and mental health-care services.

Children can—and often do—benefit from services delivered via telehealth. While we often focus our telehealth discussions on Medicare, where key access gaps and barriers remain, this committee should also prioritize clarifying and expanding care delivery options for children covered by Medicaid, regardless of geographic location.

Additionally, we should work to maintain a strong mental health workforce with the capacity to care for all who need services. These efforts will prove particularly crucial as health-care professional burnout, steep regulatory demands, and other strains jeopardize long-term provider retention and capacity.

We have clear opportunities for improvement at every level. I regularly hear from front-line providers, as well as State policymakers, seeking the flexibility to innovate and craft targeted, local solutions to the challenges facing their communities.

Their ideas and input will play a critical role in this process, especially as we look to bridge gaps in care, better integrate physical and behavioral health services, and promote value-based payment models that put patients first. If structured effectively, these reforms could prove game-changing for populations of all ages, including young people.

Finally, no conversation on mental health-care reforms for children and young adults would be complete without input from those whom the policies intend to empower and support. To that end, Trace, thank you for your willingness to join us today to share your perspective.

We have the opportunity to better support children, their families, and their providers, by enhancing mental health outcomes across the United States. Moreover, we can—and must—do so while honoring this committee's strong tradition of member-driven, bipartisan, and fiscally responsible legislative solutions.

Thank you to our witnesses for agreeing to share their expertise from across the continuum of care. They have provided invaluable services during these unprecedented times, and I look forward to hearing their testimonies.

PREPARED STATEMENT OF SHARON HOOVER, PH.D., PROFESSOR, CHILD AND ADOLESCENT PSYCHIATRY; AND CO-DIRECTOR, NATIONAL CENTER FOR SCHOOL MENTAL HEALTH, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

I want to express my thanks to you, Chairman Wyden, for the invitation to speak with the committee today and for your leadership on the issue of mental health in our Nation, including the impact on youth. Thank you also to ranking member Senator Crapo and to all of the committee members for your vision to improve the mental health and well-being of our young people and for the opportunity to be here with you today to discuss these important issues.

I am speaking to you from my perspective as a co-director of the National Center for School Mental Health, funded by the U.S. Department of Health and Human Services, and as a professor of child and adolescent psychiatry. I also speak to you through my lens as a parent to three teenagers, all of whom had their learning landscape significantly altered during COVID, with almost a year of virtual education. They, along with most children across the globe, had significant disruption to their learning and well-being, though I am fortunate that my kids are now in school and doing well.

But we know that many are suffering. Even before the pandemic, youth mental health challenges were rising, with suicide being the second leading cause of death for youth ages 10–24.

As noted by Surgeon General Murthy during last week's hearing, one of the most central tenets of creating accessible and equitable systems of care is to meet people where they are. For most young people, this is in schools.

I often think back to a story that my dad, who is now 85, told me about his first day of school. He grew up in a very small town in rural West Texas called Spur. They didn't have pre-K or Kindergarten, so it was first grade, and on that first day he recalls that he and his peers received toothbrushes from their classroom teacher; It was the first toothbrush he ever owned.

I remember asking him, "You didn't have toothbrushes?", to which he replied, "No, my family wouldn't have spent money on toothbrushes back then." Mind you, my dad went on to a long career in computer science where he helped create the coding to put our astronauts on the moon. He often credits those teachers in his early years who cared about him with setting him on that path. When I consider that moment when he received his toothbrush on the first day of school, I think of it as a classic example of how our schools are a vital place to promote our children's health and well-being.

We cannot rely on our health-care system alone to support the mental health and well-being of young people. We know on average people do not get into care for over a decade after their initial onset of symptoms and half of mental illnesses begin during the school age years.

Our traditional approach to mental health care has not leveraged the natural venues where our young people access support; It is akin to waiting for toothaches, cavities, and abscesses until a child gets proper dental care. Instead, we should do the equivalent of passing out toothbrushes and providing preventive and early dental care, by offering every child in every school the social, emotional, and mental health supports they need to be successful.

Increasingly, schools have comprehensive school mental health systems, reflecting partnerships between the education and behavioral health sectors to support a full continuum of mental health supports and services, from promotion to treatment.

Every child deserves to have this type of mental health support in their school. Schools that have these systems in place are doing this because they recognize that:

- Poor mental health leads to poor learning; and
- Positive mental health promotes academic and life success.

When we provide mental health promotion for *all* students and accessible mental health interventions in schools, we take positive steps to remedy student inequities in both education and health care. When treatment is delivered in the school setting, youth are far more likely to be identified early, and to initiate and complete care.

There are many policy and funding opportunities advance a full continuum of mental health supports and services in all schools, and Congress has the opportunity to support investment and technical assistance to ensure that young people get the mental health support they need.

In my written testimony, I provide detail on several steps that Federal and State leaders can take to advance comprehensive school mental health systems.

We have witnessed many States adopt new policies to advance school mental health systems. Tomorrow, the Hopeful Futures Campaign, a coalition of national organizations committed to ensuring that every student has access to effective and supportive school mental health care, is releasing the first ever "America's School Mental Health Report Card and Action Center," with individual report cards for all 50 States and DC. These school mental health report cards highlight accomplish-

ments and provide important action steps to help address the children's mental health crisis in every State. They serve as a great starting point for policymakers who want to strengthen school mental health supports and policies in their communities. You can find the report cards at *https://hopefulfutures.us/* starting tomorrow morning.

Today, Americans across the country are united in their concern about the mental health of our young people and the impact it has throughout their lives.

I want to express my gratitude to you all for opening up this important discussion on youth mental health, for recognizing schools as an essential place to strengthen our children's well-being, and for committing to investing now to create hopeful futures for our Nation's youth.

All schools in the United States should have Comprehensive School Mental Health Systems that:

- Implement organizational and individual strategies to promote **educator well-being.**
- Offer **mental health literacy** for K–12 staff and students including knowledge of obtaining and sustaining positive mental health, understanding mental illness, and promoting help-seeking.
- Integrate **social emotional learning** into the K–12 curricula to promote self-awareness, self-management, responsible decision-making, relationship skills, and social awareness.
- Assess and engage in continuous improvement toward **positive school climate.**
- Conduct regular **student well-being check-ins** to assess subjective well-being, mental health, connectedness, and supports.
- Hire, retain, and offer ongoing professional development to a **full complement of student support professionals,** including school psychologists, school social workers, and school counselors.
- Establish **formal partnerships (*e.g.*, memoranda of understanding) with community behavioral health providers** to offer on-site school mental health services and supports and to facilitate referrals and coordination of community-based mental health services.
- Offer **school-based, multi-tiered mental health supports and services** to promote students' academic, social, and psychological development

Policies to Support Universal Mental Health Promotion and Prevention Policies

- **Require the selection of indicators of student mental health and well-being** as a core metric of school performance under Federal education funding, with provisions to assist schools as they strive to perform well on these indicators. Indicators may include school climate, student-reported subjective well-being and distress, and reports of school connectedness.
- **Incentivize teaching education programs to include mental health literacy** to improve the capacity of the educator workforce to: promote mental health of all students in the classroom, including teaching of social-emotional learning competencies; identify mental health concerns and link students to needed supports and services; reduce stigma related to mental illness; and promote student and family help-seeking.
- **Establish mental health as a State-required component of K–12 curricula,** with efforts in New York and Virginia as examples. The Federal Government could support this State-level effort by passing a resolution encouraging States to follow existing State efforts to integrate mental health into curricula and by providing direct funding for educator training and ongoing professional development.
- **Leverage Federal title I and title IV funding to provide universal mental health programming for students,** including social-emotional learning programming. Joint guidance by the U.S. Department of Education and the U.S. Department of Health and Human Services could support States as they navigate these funding mechanisms to support universal mental health in schools.

- **Expand Federal grants to State and local education and behavioral health authorities to increase mental health awareness and promotion in schools.** This could include the expansion of grant programming initiated in recent years by SAMHSA (*e.g.,* Project AWARE) and the U.S. Department of Education (School Climate Transformation) that require funded States to partner with three local jurisdictions to promote student well-being and mental health training and awareness for school staff, and then to scale successful efforts statewide.

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

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

***Additional detail on financing school mental health:**

Successful systems draw from a wide array of sources, including (but not limited to) legislative earmarks and Federal block and project grants (*e.g.,* Project AWARE State Education Agency Grants), State or county funding, fee-for-service revenue from third-party payers (including State Children's Health Insurance Programs,

Medicaid, and commercial insurance), and private individual donors and private foundations.

Of note, Medicaid is the backbone of the school mental health system in all 50 States and DC, providing sustainable funding for services to students delivered by mental health professionals, including school psychologists, school counselors, school social workers and more.

Sixteen States have successfully expanded their school-based Medicaid programs to cover services—including mental health—delivered in schools to all students. These States have experienced or predict a significant increase in Medicaid funding allowing school districts to hire more staff and better support the school health and mental health professionals in schools.

Medicaid also allows school districts to set up partnerships with community-based mental health providers, like community mental health centers. Through these partnerships, schools can increase access to services.

Congress can support student mental health by encouraging all States to cover all medically necessary mental health services, including prevention services, for all Medicaid enrolled students and by ensuring school Medicaid programs have updated guidance, best practices, and the technical assistance they need.

Questions Submitted for the Record to Sharon Hoover, Ph.D.

Questions Submitted by Hon. Sherrod Brown

school-based mental health care

Question. In the midst of the pandemic, children and young adults have faced unprecedented challenges, ranging from dramatic shifts in social interactions and schooling to the tragic loss of family members and caregivers, among numerous other struggles. Depressive and anxiety symptoms have doubled, with 25 percent of youth experiencing depressive symptoms and 20 percent experiencing symptoms of anxiety. In early 2021, emergency department visits for suspected suicide attempts were 51 percent higher for adolescent girls and 4 percent higher for adolescent boys compared to rates for the same period in 2019. Yet, preliminary data show a 32-percent drop in mental health service use among children covered by Medicaid and CHIP from March 2020 to February 2021 compared to the same period in the prior year. Many experts attribute this disparity to pandemic-related school closures, which limited or suspended access to mental health care through those settings.

1. As outlined in the 2019 Joint Informational Bulletin from The Centers for Medicaid and Medicare Services (CMS) and SAMHSA, several States already access Medicaid and other payers, including private insurers, to cover school and community professionals' delivery of mental health services in schools.

- **How can full service community schools [1] and schools that provide comprehensive mental health-care services better coordinate with local service providers to meet the needs of students covered by Medicaid and CHIP?**

Answer. Better coordination between full service community schools and schools that provide comprehensive mental health services and local services providers is key to meeting the needs of students covered by Medicaid and CHIP. Detailed below are best practices States are implementing to improve coordination:

Issue Clear Guidance That Encourages Partnerships Between Local Service Providers and School Districts

Many States do not provide school districts and local service providers with guidance to support partnerships. When in place, guidance can play a key role in facilitating partnerships and ensuring both parties understand the value of collaborating and how to establish effective partnerships.

For example, a key element of Missouri's expansion of their school-based Medicaid program was the way it encouraged partnerships with community-based mental

[1] *https://oese.ed.gov/offices/office-of-discretionary-grants-support-services/school-choice-improvement-programs/full-service-community-schools-program-fscs/.*

health providers to increase behavioral health services in schools.[2] This leveraged the existing relationships that many school districts had with community-based providers, by clarifying that these providers can be reimbursed for delivering services in schools, as long as they are a qualified Medicaid provider with the required licensure and credentials. Partnering with community-based providers also offered a route to expanding school-based behavioral health services for the many school districts in the State that do not participate in the school-based Medicaid program, or had concerns about their bandwidth to do additional Medicaid billing.[3]

The National Center for School Mental Health (NCSMH, *www.schoolmentalhealth.org*), funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, established national performance standards for school-community teaming. The NCSMH issued the corresponding School Mental Health Systems Quality Guide: Teaming,[4] providing States and districts guidance and tools for establishing effective school-community partnerships that leverage multiple funding resources, including Medicaid. As outlined in the Guide, a process that has been successful in many communities to foster school-community partnerships is the establishment of a request for proposals (RFP) issued by school districts to solicit engagement of community behavioral health partners with clear expectations for school-based service provision, data gathering, target outcomes, and funding.

Facilitate Data Sharing Between Local Service Providers and School Districts

Ensuring data, both aggregated and disaggregated, can be shared between local services providers and school districts is needed to support care coordination and ensure the children in greatest need of services are identified and supported. Multiple States are taking steps to facilitate data sharing across child serving agencies to better target services and supports.

For example, the District of Columbia improved coordination and service delivery by implementing a data sharing agreement between the District of Columbia State Board of Education, District of Columbia Department of Health, and the DC Department of Health Care Finance (the District of Columbia's Medicaid agency). The agencies collaborated to ensure compliance with the Family Educational Rights and Privacy Act and used the data to target outreach and resources to schools and students with the greatest unmet needs.[5]

The State of Connecticut partnered with a purveyor organization, the Child Health and Development Institute (CHDI, *www.chdi.org*), to establish a statewide electronic platform, the EBP Tracker, to collect data on evidence-based interventions being delivered in schools and other community settings. Results from their analyses show that the use of EBPs delivered in schools resulted in improved psychosocial and educational outcomes and reduced or eliminated disparities for children of color compared to usual care.[6]

Additional examples and best practices for data sharing between community providers and school districts are available in Data Sharing Across Child-Serving Sectors: Key Lessons and Resources, a report by Nemours Children's Health System and Mental Health America.[7]

Leverage Telehealth to Connect School Districts With Local Service Providers

Across the country, telehealth is increasingly being used to connect students to local service providers to ensure they receive necessary school health services. The partnerships require coordination between all parties and create an important opportunity to amplify the impact of available providers.

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[2] Missouri Department of Social Services, Behavioral Health Services in a School Setting, *https://dss.mo.gov/mhd/providers/pdf/bulletin40-54_2018apr17.pdf.*

[3] Healthy Schools Campaign, Expanding School-Based Medicaid in Missouri, *https://drive.google.com/file/d/1cWfagNHY_tuxD7PbI_Iqbnk8uAMU7cmn/view.*

[4] National Center for School Mental Health, School Mental Health Quality Guide: Teaming, *https://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Teaming-7.16.21.pdf.*

[5] Healthy Schools Campaign, Sharing Data to Meet Student Health Needs in Washington, DC, *https://healthyschoolscampaign.org/blog/sharing-data-meet-student-health-needs-washington-d-c/.*

[6] Child Health and Development Institute, EBP Tracker, *https://www.chdi.org/our-work/mental-health/evidence-based-practices/ebp-tracker/.*

[7] Data Sharing Across Child-Serving Sectors: Key Lessons and Resources, Nemours Children's Health System and Mental Health America, *https://www.movinghealthcareupstream.org/wp-content/uploads/2020/01/data-sharing-brief.pdf.*

For example, in 2016, South Carolina's Governor signed S.B. 1035 into law to increase access to telehealth, including in schools. As of 2019, the State's telehealth program has expanded to over 80 schools, focusing on schools with students who experience the greatest health disparities. The South Carolina Department of Education and South Carolina Medicaid were key in expanding telehealth services. Through the telehealth program, school nurses are linked with community providers to coordinate acute and chronic disease management services as well as mental health services.[8]

Question. In your testimony, one of the policies you recommend to better support early identification, intervention, and treatment in schools is to "maximize Medicaid, CHIP, and private reimbursement for school mental health services."

Can you please elaborate on this recommendation?

Answer. Sustainable funding streams are critical to better supporting early identification, intervention and treatment in schools. Currently, school districts fund the delivery and implementation of these services and programs through a patchwork of funding, often including one-time grant funds that are not sustainable and time-bound. Supporting States and school districts in leveraging health-care funding to deliver this work is necessary to fully leverage the role schools can play in meeting the mental health needs of children and youth.

Currently, many school districts access Medicaid and CHIP funding to support the delivery of school health services but very few are able to access private insurance since private insurers rarely recognize schools as eligible sites of service delivery. When it comes to Medicaid and CHIP funding, only 16 States allow school districts to bill Medicaid for services delivered outside of an Individualized Education Program (IEP). Since early identification and intervention services are rarely included in a students' IEP, there is a need to ensure the remaining 34 States and the District of Columbia expand their school Medicaid programs to allow school districts to bill for all medically necessary services delivered to all Medicaid enrolled students.

Community-based and community-linked providers, including school-based health centers, also bill Medicaid and CHIP for eligible services and are better positioned to seek reimbursement from private insurers. However, there is still a need to support these providers in maximizing funding for services delivered in schools since providers may not understand they can bill insurance for school health services, understand how to bill, or understand how to establish partnerships to deliver these services. Ensuring community-based and community-linked providers understand the opportunities for reimbursement is critical to supporting partnerships between school districts and outside providers and meeting student mental health needs.

Question. Would you suggest the Centers for Medicaid and Medicare Services (CMS) and the U.S. Department of Education provide best practices to States seeking to improve Medicaid and other payer coverage of school mental health, in addition to offering technical assistance?

Answer. Yes, there is a tremendous need for best practices to support States and school districts in leveraging Medicaid and other payer coverage and for additional technical assistance. In our work and the work of partners with States and school districts across the country, the need for best practices and technical assistance continue to emerge as top requests of CMS and the U.S. Department of Education.

A best practices document that highlights the different ways States and school districts are leveraging Medicaid funding and funding from other payers to expand access to school mental health services and programs can help break down siloes that exist between Medicaid and education and ensure States and school districts understand the menu of options for structuring their school Medicaid programs.

Question. As you state in your testimony, Medicaid is the backbone of the school mental health system, and helps school districts establish partnerships with other community-based mental health providers which help increase access to services for students and the broader community.

Can you please elaborate on the 16 States that have successfully expanded their programs to cover services in schools? What are their best practices for using Medicaid to build out services, hire additional staff, and meet children where they are?

[8] Building a School-Based Telehealth Program in South Carolina, Healthy Schools Campaign, *https://healthystudentspromisingfutures.org/wp-content/uploads/2019/07/SouthCarolinaTelehealthCaseStudy.pdf.*

Answer. There are now 17 States that have successfully expanded their school Medicaid programs: Arkansas, Arizona, California, Colorado, Connecticut, Florida, Georgia, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, North Carolina, New Hampshire, Nevada, and South Carolina.[9] In addition, Illinois, Indiana, New Mexico, Oregon, and Virginia are in the process of expanding their school Medicaid programs. All 50 States and the District of Columbia have school Medicaid programs that allow school districts to seek Medicaid reimbursement for Medicaid eligible services included in a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). The 17 States that have expanded their programs allow school districts to bill for additional services not included in a student's IEP or IFSP. In the majority of these States, this means allowing school districts to bill Medicaid for all medically necessary services delivered to all Medicaid enrolled students. Expanding school Medicaid programs to include services delivered outside of students' IEPs or IFSPs presents a significant opportunity to increase access to and resources for school mental health services.

The majority of the 17 States that have expanded their school Medicaid programs did so in the last 3 years. As a result, implementation and documentation of the impact of this policy change was impacted by COVID–19 and the resulting school building closures. For many States, the 2021–2022 school year was the first full year of program implementation. As a result, data is still being collected on the overall impact. With that being said, initial data and projections are promising and indicate a significant increase in Medicaid revenue generated by the program and, in many cases, an increase in school health providers. For example, Michigan is one of the 16 States that has expanded their program. The State has been able to use the increase in Medicaid funding, coupled with an investment from the State, to go from 1,738 school-based behavioral health providers statewide to 2,975 school-based behavioral health providers statewide and increased school nursing staff from 253 to 307.[10]

Best practices for using Medicaid to build out services, hire additional staff, and meet children where they are include the following:

- Align State education and State Medicaid qualifications for school health providers. Many States are working to align their State education and State Medicaid standards to ensure all qualified school health providers are recognized as Medicaid eligible. This is a key strategy to ensure that school districts are able to maximize Medicaid reimbursement for the school Medicaid program and to incentivize school districts to hire qualified school mental health professionals. For example, States are increasingly adding marriage and family therapists, behavior health analysts, registered behavior technicians and alcohol and drug counselors as Medicaid eligible in the school-based setting. Recognizing all qualified mental and behavioral health providers as Medicaid eligible in the school-based setting is a key strategy to ensuring schools are able to maximize the available mental health workforce and receive sustainable funding to support access to these providers in the long run.
- Invest in State infrastructure to support implementation. States with strong State infrastructure to support implementation of the school Medicaid program are able to better leverage Medicaid funds to expand access to school health services. This infrastructure includes training for school districts on program implementation, a designated website to house all program related materials, ongoing technical assistance for school districts including regular trainings and help desks and technology platforms, including those that support the use of telehealth and electronic health records.
- Build cross-agency collaboration. Dedicated school Medicaid staff in both the State education agency and State Medicaid agency level who can collaborate to implement a State's school Medicaid program is critical. The States that have the strongest school Medicaid programs are those with dedicated school Medicaid staff in both the State education agency and State Medicaid agency who can coordinate program implementation, oversee training and technical assistance and collaborate to develop program resources. For example, Louisiana was the first State to expand their school Medicaid program and has used the additional Medicaid revenue, in addition to COVID relief funding,

[9] State Efforts to Expand School Medicaid Through the Free Care Policy Reversal, Healthy Schools Campaign, *http://bit.ly/freecareupdate.*

[10] U.S. Department of Education, Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs, *https://www2.ed.gov/documents/students/supporting-child-student-social-emotional-behavioral-mental-health.pdf.*

to hire dedicated staff in both the State education and State Medicaid agencies to oversee the program. In addition, the State agencies have worked together to build out a school Medicaid resource library to support school district implementation.[11]

- Reinvest school Medicaid revenue in school health and wellness programs: In many States, revenue generated by the school Medicaid program goes to school districts' general revenue fund and is not required to be reinvested in school health and wellness programs and services. A few States, including California, Colorado, and Louisiana, require revenue generated by the school Medicaid program be reinvested in school health and wellness activities. This is a key strategy to ensure additional Medicaid revenue ultimately supports school health and wellness and is used to strengthen and expand the delivery of school health services.

Question. What can the other 34 States learn from what these 16 States are doing well?

Answer. In addition to the best practice highlighted above, the States that have not expanded their programs to date can learn the following from those that have:

- States should expand their programs to cover all medically necessary services delivered in the school-based setting. States are amending their State Medicaid plans to allow school districts to bill Medicaid for services delivered to Medicaid enrolled students that are included in an IEP, IFSP, 504 plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established. This is important because it allows States and school districts the flexibility to cover all the services a student may need that can be provided in a school-setting by a qualified provider. Further, it signals that the school is simply the site of service at which a Medicaid enrolled student can get care—rather than as a unique benefit. CMS has been highly supportive of States making this change.
- States should include the school Medicaid program under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Under the advice of CMS, States are recognizing their school Medicaid programs as a part of their EPSDT benefit. This is an important change that enables school districts to bill for any EPSDT service delivered by any Medicaid enrolled provider recognized under EPSDT.
- Cross-agency coordination is key to successful expansion and implementation. As States move forward with expanding their school Medicaid program it is critical that one agency does not lead this work alone. While the Medicaid State plan amendment must ultimately be submitted by the State Medicaid agency, States are best setup for success when the State Medicaid agency collaborates with the State education agency to make policy decisions and ideally collects input from school districts as well. It is also critical that the State education agency plays an active role in implementation of the expanded program, including supporting school district training and communicating with school districts about the programmatic changes.

Question. How can Congress support and encourage more States to expand their school-based Medicaid programs to cover more services, including mental health services?

Answer. Congress can support school Medicaid by working with CMS to modernize the existing school guidance and promoting best practices in school Medicaid, including in prevention and mental health services. CMS' school Medicaid guides were last updated in 2003 and 1997. Updated guidance is key to ensuring States and school districts understand how to implement the school Medicaid program without exposing themselves to risk of audit. A number of States are hesitant to move forward with expanding their school Medicaid programs because the current guides from 1997 and 2003 explicitly state that schools cannot bill Medicaid for services delivered outside of an IEP or IFSP. While this position was clearly changed with a 2014 State Medicaid directors letter, States are hesitate to move forward until guidance is updated to reflect this policy change.[12]

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[11] Louisiana Department of Education, School-Based Medicaid Resources, *https://www.louisianabelieves.com/schools/public-schools/school-based-medicaid-services.*

[12] Centers for Medicare and Medicaid Services, Medicaid Payment for Services Provided Without Charge (Free Care), *https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.*

Additional ways in which Congress can support and encourage States to expand their school-based Medicaid programs include the following:

- Provide funding to CMS for the establishment of a technical assistance center to support States and school districts who want to improve the delivery of Medicaid mental health services in schools.
- Provide funds to States to work with small and rural school districts to do planning and technological improvements to participate in school Medicaid.
- Provide an increased FMAP for any mental health service delivered in a school-based setting by a district-employed provider or a community-based provider.

PREPARED STATEMENT OF JODIE L. LUBARSKY, M.A., LCMHC, VICE PRESIDENT OF CLINICAL OPERATIONS, YOUTH AND FAMILY SERVICES, SEACOAST MENTAL HEALTH CENTER, INC.

Chairman Wyden, Ranking Member Crapo, Senator Hassan, and members of the U.S. Senate Committee on Finance, I want to thank you for the opportunity to testify and submit a written statement regarding pediatric mental health.

In March of 2020, life as we once knew it changed for all of us. As adults, we made many quick pivots to respond and adapt to the COVID–19 pandemic. As we made many adaptations in both our personal and professional lives, we had our past experiences to reflect upon. When faced with the new and often unpredictable challenges the pandemic created, we pulled from our toolbox of coping strategies. We knew who we could turn to for the extra support we might have needed as we navigated those challenges. But, for most of the youth in our country, they were left feeling paralyzed, stymied, hopeless, and scared. For many youth, this was their first experience with grief, trauma, depression, or anxiety. Life for them had completely changed and their worlds were turned upside down. The uncertainty, social isolation, and stressors related to the pandemic, have left many kids unable to cope or understand the breadth and depth of this experience. For some youth, there is no trusted adult to support them during this critical developmental period. Many lack a social support network. Many remain isolated from peers and other trusted adults. And, for too many youth, their only means of symptom relief is contemplating death.

We are learning that teenage girls have begun to demonstrate an increase in the acuity of their symptom presentation. Data from the Centers for Disease Control and Prevention indicates a 51 percent increase in suicide attempts by teenage girls ages 12 to 17. LGBTQ+ youth continue to have higher rates of suicide than their heterosexual peers. And, according to a Wisconsin NPR piece in March 2021, data from 2020 demonstrated that "the percentage of emergency department visits for mental health emergencies rose by 24 percent for children between the ages of 5 and 11 and 31 percent for those 12 to 17, compared with 2019." Youth mental health has become the secondary pandemic to the COVID–19 pandemic.

As mental health needs rose for pediatric patients, the availability of services continues to become more scarce. Youth are presenting to hospital emergency rooms in a state of psychiatric crisis. Many who are assessed and meet the criteria for psychiatric inpatient level of care will be faced with boarding in an emergency room for days, weeks and sometimes months until a bed becomes available. Emergency room boarding often creates more distress, decompensation in psychiatric symptoms, and increased traumatic exposure, while receiving no mental health care until the inpatient bed becomes available. Staffing shortages in both outpatient and inpatient settings due to an exhausted, depleted, and underpaid mental health workforce has only prolonged access to care for pediatric patients. Without adequate funding and reimbursement structures from both Medicaid and private payers, mental health providers are left with the difficult decision to leave the nonprofit world and enter the for-profit world in order to make a livable wage. During the pandemic, there were two 3-percent increases to Medicaid rates.

And while that is appreciated, prior to those two increases there had not been meaningful increases in Medicaid rates in over 20 years. Without a realistic reimbursement structure based on current cost of living, centers are losing staff who can no longer afford to work in mental health settings. Some mental health centers are reporting a 40-percent turnover in staffing, during the pandemic, leaving no workforce available to attend to the critical and fragile needs of pediatric patients. And for the mental health workforce that remains, they are often left supporting higher caseloads than their private practice peers, with limited time while attending to sig-

nificant administrative tasks that private mental health providers are not expected to complete.

While we can discuss an ideal service array, evidence-based practices, and the ideal care setting, none of this can be provided without a robust, well-trained, adequately compensated, and sustainable mental health workforce from all professional disciplines and degree levels. Simply put, we need to be able to adequately compensate the mental health workforce in order to have a sustainable and robust mental health workforce to provide high-quality, timely, adequate care to our pediatric population.

Mental health care needs to be both accessible and realistic. A continuum of care must include prevention, intervention, and education. As schools return to in-person learning environments, teachers, paraprofessionals, guidance counselors, and building administrators are witnessing the exacerbated mental health needs of the students entering school buildings every day. Faced with the added pressures of testing students and overwhelming them with missed academic instruction, teachers report feeling professionally stretched and uncertain of how to support the social and emotional health needs of students. Teachers are not provided training on pediatric mental illness. Teachers do not know how to intervene. A component of prevention should be affording schools the professional development time needed to better understand pediatric mental health and for educators to become certified in Youth Mental Health First Aid. Youth Mental Health First Aid would provide educators with a foundational understanding of the signs and symptoms of an emerging mental health need, how to offer timely support, and bridging a student to the appropriate mental health professional and level of care to attend to the student's mental health needs.

There is no one-size-fits-all option for mental health care. The pandemic created the opportunity to reduce barriers to accessing care with the expansion of telehealth services. In addition to telehealth, mental health care provided in the office, home, community, and school settings needs to be supported and adequately reimbursed for by both Medicaid and private payers. Different levels of care need to exist within the intervention continuum. Traditional office-based therapy does not meet all mental health needs and not all pediatric mental health patients will require an inpatient level of care. Intensive outpatient or partial hospitalization programs need to be established and adequately funded to be sustained in the mental health treatment continuum. Mental health providers should be adequately reimbursed by all payers to sustain a variety of treatment and programming options. And, evidenced-based practices should be reimbursed at enhanced rates to account for the required clinical consultation, professional development, and time to complete required fidelity implementation reviews.

A bipartisan spirit to adequately fund pediatric mental health services is one of many ways to address the growing pediatric mental health surge. Care must be affordable, available, and mental health providers must be adequately reimbursed to sustain a mental health-care workforce. Telehealth and telephonic services must remain an option within the service array to reduce barriers to accessing care, but not be the primary option for care delivery. But we must erase the stigma associated with mental illness to make a meaningful impact! The stigma and shame that continues to persist for individuals struggling with mental illness continues to be a significant barrier to recognizing the need for and accessing mental health care. Respect, compassion, and patience must be afforded to every person struggling with their mental health. We must all act as ambassadors for reducing the stigma associated with having a mental illness and accessing appropriate care. One in five individuals will struggle with a serious mental illness, yet most individuals will delay accessing care for 10 years after the onset of symptoms. Fifty percent of all lifetime mental illness begins by age 14 and 75 percent by age 24. We have an obligation to provide prevention and early intervention and to offer hope and recovery for all children and adolescents struggling with their mental health. We know that suicide is the second leading cause of death among people age 10–34, yet we continue to stigmatize those who seek care. We continue to shame those with struggle. Until we can acknowledge, treat, and offer respect to all individuals with mental illnesses and offer mental health patients the same respect we would provide any individual receiving care for a physical health issue, we will never be able to make a meaningful difference. We all need to challenge the stigma that persists. We all need to advocate on behalf of those who are struggling with their mental health because at any moment, they could be us, our child, or a loved one.

QUESTIONS SUBMITTED FOR THE RECORD TO JODIE L. LUBARSKY, M.A., LCMHC

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

SCHOOL-BASED MENTAL HEALTH CARE

Question. In the midst of the pandemic, children and young adults have faced unprecedented challenges, ranging from dramatic shifts in social interactions and schooling to the tragic loss of family members and caregivers, among numerous other struggles. Depressive and anxiety symptoms have doubled, with 25 percent of youth experiencing depressive symptoms and 20 percent experiencing symptoms of anxiety. In early 2021, emergency department visits for suspected suicide attempts were 51-percent higher for adolescent girls and 4-percent higher for adolescent boys compared to rates for the same period in 2019. Yet, preliminary data show a 32-percent drop in mental health service use among children covered by Medicaid and CHIP from March 2020 to February 2021 compared to the same period in the prior year. Many experts attribute this disparity to pandemic-related school closures, which limited or suspended access to mental health care through those settings.

Teachers, staff, and faculty are often the first line of defense when identifying signs of mental distress in a student.

What structural supports can schools adopt so that educators are better equipped to conduct regular student well-being check-ins and identify and support students exhibiting signs of mental distress or trauma, including signs of Adverse Childhood Events (ACEs)?

Answer. As a mental health provider within a community mental health center, we have been able to partner with schools in our region to deliver mental health services to students during their academic day. It has offered insight into both the needs of the students and what the education staff encounter when providing instruction.

When considering the structural supports that a school may need to adopt in order to better equip themselves to support student well-being, we must begin with better education to community members, school boards, administrative leaders, and parents about pediatric mental health. There seems to be a large cohort of individuals who do not understand that one in five children will be diagnosed with a mental health condition or that 40 percent of all mental health needs arise during childhood and adolescence. These community members have failed to recognize the importance of early intervention as a tool for preventing long-term mental health decompensation in children. Simply stated, the sooner we intervene the greater opportunity for recovery. As a result, schools in our State report having to change their consent to provide mental health care in schools from using language that says, “mental health” to “behavioral health” due to community protests. Rather than utilizing an opt-in process for participation, schools are shifting to opt-out language in consent for participation forms. When community members create barriers to providing care in school settings, it seems to leave very few options for interventions. In an ideal world, all guardians of children enrolled in public and private school settings would be required to participate in social emotional programs to provide them with a foundational understanding of pediatric mental health, signs and symptoms, and treatment options for pediatric patients. Programs would be targeted at erasing the stigma, so schools and mental health providers can deliver care without barriers or interruption. Utilizing evidenced-based universal screeners like the PHQ–9 or Brief Columbia Suicide Severity Rating Scale will allow for early identification of a student’s needs and an opportunity to bridge the student to mental health supports outside of the school setting in an informed manner. This early identification would provide early assessment of adverse childhood experiences and an opportunity to provide clinical and social supports to pediatric patients. When schools adopt the usage of screeners used by pediatricians and mental health-care providers, it allows them to speak a common language with those professional in order to support pediatric mental health needs and refer patients to the most appropriate level of care.

Question. What tools, resources, and guidance are necessary to ensure schools meet current student needs and adopt a model of prevention moving forward?

Answer. I must acknowledge that my background is not one of academics but of community mental health. As someone who has worked with schools in my current role for over 15 years and more specifically reflecting upon the last 2 years, it appears schools could use more support on the implementation of social emotional programs in academic settings. Educators in our community have reflected on the sig-

nificant pressure they are facing to catch students up on the academics that they may have been lost during the pandemic. They report pressure from school boards, administrators, and caregivers to force an accelerated style of learning in order to cover missed material and increase test scores. Many educators report having no background or knowledge about pediatric mental health care, yet they see the mental health needs of their students walk into their classrooms every day. They report a frequent dilemma of trying to support unique emotional needs without foundational mental health training and the stress of administrating assessment exams while trying to complete their classroom instruction.

A clearinghouse for educators similar to Substance Abuse and Mental Health Services Administration that mental health-care providers use that recommends evidence-based social emotional programs for schools that are culturally and linguistically considerate of the unique pediatric emotional and developmental needs will allow districts to select programming that can be braided into academic curriculums without directly disrupting academics. Schools should be viewed as a component of the prevention spectrum. Schools should consider their role to identify pediatric mental health needs in students as an opportunity to bridge a student over to structured mental health-care supports. Programs like Project AWARE that utilize multi-tiered systems of identification and support in collaboration with mental health-care providers allows schools to play a role in pediatric mental health care without having to deliver all the mental health supports that a student might need, especially since many educators and guidance counselors do not have the same training can mental health-care providers to diagnose and treat mental illness.

Training all educators, paraprofessionals, auxiliary staff, and building administrators in Youth Mental Health First Aid is another component of prevention spectrum. YMHFA trains adults to recognize signs and symptoms, strategies for offering support, and bridging a youth and their family to appropriate mental health services when the need arises. It provides the foundational understanding that many educators lack and would offer much needed training and resources to those adults who might be the first point of contact for a student experiencing a mental health crisis in the classroom, on the playground, in the cafeteria, or at after school activities.

Question. What resources, technical assistance, or other supports can Congress provide to attract and retain high-quality, certified mental health providers in schools, particularly in low-income areas?

Answer. As Congress considers more resources, technical assistance, or other supports to attract and retain high quality certified mental health providers, Congress should continue to support and expand loan forgiveness programs. While the Student Loan Repayment Program (SLRP) has been helpful, access by professionals has been limited. With a limited number of eligible spots and funding, not every professional who could be eligible is able to access the program when the funding has been exhausted. Increased funding to SLRP and creating more eligibility opportunities for staff employed in settings than serve disadvantaged populations would attract and retain more staff based on the forgiveness expectations of the SLRP. Many staff view the forgiveness of their student loans as a benefit when considering employment in non-profit settings. For many staff, after completing their forgiveness expectation, they continue to remain employed at the organization and take advantage of additional educational or professional development opportunities.

Creating a deliberate crosswalk between higher education settings and mental health centers that offer accessible and affordable education at both the bachelor's and master's level would assist in attracting and retaining staff. For full-time employees who need to continue working while attending school, being able to access their academics in their work environments promotes and supports professional development. This concept of offering class work on-site at organizations also creates a direct funnel of internship candidates who then can become employed at those organizations. Two goals are achieved: (1) The employee achieves a higher education degree without financial or occupational disruption, and (2) the employer has access to a pool of mental health-care candidates for the mental health workforce. When considering educational opportunities for mental health-care professionals, a structure needs to be created to offer paid internships. Most bachelor's and master's level interns are not compensated for their internship experiences. They are often faced with going to school full-time and engaging in a meaningful internship, while potentially maintaining part- or full-time employment to meet their basic needs.

The opportunity to pay interns is impacted by funding and reimbursement rates. Although there were two 3-percent increases to Medicaid rates in the past 2 years, there had not been meaningful rate increases in over 20 years. Mental health serv-

ices should be reimbursed at rates that are competitive with a private practice market to allow employers to offer competitive wages to the mental health-care workforce if the workforce is to be sustained. A colleague reported that at her center, staff at the bachelor's level can make more working in the retail market than they can delivering behavioral supports to pediatric patients. Over the past 2 years, Centers report a rolling turnover rate in staffing of 40 percent. Staff often cite poor wages, stress, and administrative burdens associated with mental health-care documentation as reasons for seeking other employment, often outside of the mental health-care field.

Increasing reimbursement rates and compensating providers for non-billable events related to the implementation of Evidence-Based Practices (EBPs) are two considerations for sustaining the workforce. While EBPs are highly beneficial, they are expensive in relation to nonbillable activities involved with implementation and ongoing utilization. True implementation of an EBP is more than providing a staff person with a manual and setting them off to their office to provide the work if we want to guarantee that it is done correctly and to fidelity. For most EBPs, in order to practice to fidelity, there should be weekly consultation with a trained expert, ongoing review of the materials that are used for the EBP during and outside of consultation, preparation time by the practitioner for sessions, data collection, and a lengthy fidelity review process with expert trainers. None of these activities are eligible for reimbursement and often create drift from EBP utilization.

Prepared Statement of Trace Terrell, Lead Intervention and Outreach Specialist, YouthLine

Thank you, Chairman Wyden, Ranking Member Crapo, and the other members of the committee, for the opportunity to represent the youth perspective as it pertains to mental health.

My name is Trace Terrell, I use he/him pronouns, and I am a 17-year-old from Oregon. Before I share more about myself, I would first like to tell you some things I have heard from teens across the country: 4:07 p.m.: I just need someone to talk to; 4:37 p.m.: my dad hit me but you can't call the cops; 9:45 p.m.: I'm afraid I might be pregnant; 5:23 p.m.: I need therapy but my family can't afford it; 6:28 p.m.: I just failed my math test; 8:07 p.m.: I just lost my dad and I can't stop crying; 6:42 p.m.: I want to kill myself.

These are just some examples of the many conversations that I respond to as a volunteer with YouthLine, a free, confidential, teen-to-teen crisis help support hotline located in Oregon. Whether helping someone navigate complicated feelings about their sexuality or working with others to develop comprehensive safety plans, I spend 3½ hours every week responding to a variety of mental health challenges experienced by teens across the country, with an emphasis on the fact that no problem is ever too big or too small.

I became involved with YouthLine during my freshman year of high school. As someone who struggled with depression, suicidal ideation, eating disorder behavior, and anxiety throughout middle and early high school, I, for the longest time, believed that no one could relate to my experiences. However, as I became more involved with YouthLine, I began to see my challenges reflected in those who contacted the line. Whether it was the shared experience of wishing to wake up straight or the common struggle of access to care, I realized that my challenges were a microcosm of public health issues that affected hundreds of thousands of teens across the country.

As more and more teens start to have conversations about mental health and engage in help-seeking behaviors, the need for expansive and intersectional mental health efforts has never been so needed. Since YouthLine's inception, we have experienced an annual increase in contact volume of about 15 percent annually, with an additional increase of 3 percent–5 percent since the COVID–19 pandemic started 2 years ago.

So, what can we do to address the youth mental health crisis?

1. We must centralize our efforts in schools.

From my experience and many of my peers, mental health efforts in schools are lacking. Day after day, I hear my friends and those on the line voice about how inaccessible school counselors are due to being overworked and overloaded. This is an especially difficult challenge for the many teens who rely on school mental health

professionals for crisis care. We must either provide funding for more mental health professionals or funding for additional staff who can assume some of the overwhelming workload placed on counselors.

We must also create a streamlined approach to free mental health screenings and referrals. At my school, four out of every five referrals to external resources are not carried out. Let that sink in: 80 percent of referrals go nowhere. Someone who needs help, should receive help. We need funding for schools to develop meaningful and sustainable partnerships with School-Based Health Centers, CCBHCs, county and State governments, community organizations, and primary care facilities.

Last, we need to provide funding and technical support for State mental health education standards. In ninth grade, my health class spent less than a week on our mental health curriculum that only addressed the symptoms of mental illnesses. Students should learn about engaging in real-world help-seeking behaviors, developing systems of self-care, and supporting our friends with mental health struggles, because statistics show we turn to each other before anyone else. That can only be done with a comprehensive and evidence-based mental health curriculum that invites the active participation of school, community, and youth leaders.

2. We need to address the pressing challenges that young people continue to face in accessing mental health care.

While I'm no expert in policy solutions, I am someone with lived experience. I know what it's like to be a teen—today—struggling with mental health. And I know what it's like to offer support to teens in crisis.

On and off the lines, the most common struggles I see expressed by my peers in regard to accessing mental health care are: (1) financial, transportation, and broadband barriers; (2) the urban/rural divide in mental health care; (3) the lack of mental health professionals and adequate follow-through care; and (4) the stigma around mental health.

These issues are incredibly real.

When I sought help from a mental health professional, my options were limited. In my rural community, there is only one State-funded behavioral health clinic. While I was able to attend virtual appointments, I'm not sure I would have been able to get the help I needed without Telehealth. For someone who lives on the outskirts of town like I do, coordinating safe transportation would have been a challenge.

Sadly, my experience isn't isolated. My friends have struggled to receive professional mental health services because it's too expensive for their families, not covered entirely by their insurance, too far away to be accessed, or inaccessible because of unreliable Internet access. Financial, transportation, and broadband barriers are even more prevalent and intensified in rural areas, which is why we need funding for isolated communities to develop robust mental health infrastructure. Most importantly, we need to bring care to where people are—and for teens, that's in schools or at home. We must fund accessibility before we fund new initiatives.

In addition, the lack of mental health professionals and adequate follow-through care prevents teens from receiving the help they need. On the lines, we often have people who reach out more than once, whether that's between therapy appointments or simply because there is no one in their lives they can go to for support. Although YouthLine is a crisis service and not meant for long-term care, we're often some teens' first step in accessing professional mental health services.

We know from a study of the National Suicide Prevention Lifeline that about 18 percent of the 2 million people who call every year are under 25 years of age, which means there are about 360,000 young people reaching out for help. We also know that teens are more likely to talk to teens. One of the ways we could approach the lack of mental health professionals is by funding a national YouthLine. What youth need is to be able to call the National Suicide Prevention Line, press a number, and have the opportunity to connected with another trained teen. Think of it as an off-ramp like the Veterans Crisis Line.

Finally, addressing the stigma around mental health means building on our existing efforts and encouraging people with lived experience to share their stories. I share my story to ensure others in similar situations know that they're not alone. However, too often our lived experiences are overlooked in legislative work. We must make every effort to invite and incorporate personal storytelling in this work.

3. We must invite youth to the table and value their insights as natural partners in this work.

I am just one of 165 YouthLine volunteers.

What does that tell you?

Youth aren't afraid to talk about mental health—if anything, adults are.

Across the country, young people are mobilizing and advocating for mental health like never before. Beyond YouthLine, I have been involved with organizations like Active Minds, through whom I and millions of my peers help to change the narrative for how we talk about, value, and seek care for our mental health. I have also been able to serve as part of the National Mental Health Advisory Board, facilitated by Well Being Trust, Young Invincibles, and Active Minds. During my time, I helped to guide the development of a digital mental health advocacy toolset to empower future youth mental health leaders in enacting change on a local, State, and national level. In all of this, I have seen my peers speak at school board meetings about the importance of mental health excused absences, foster upstream suicide prevention in elementary and middle schools, and meet with local and State legislators.

We believe in the power of peer-to-peer mental health support.

We believe in the power of robust, youth-led mental health coalitions.

We believe in the power of our generation to create meaningful and sustainable change.

But most of all, we believe that we deserve a seat at the table.

We need to recognize youth as stakeholders in this work. We can do this by funding the countless youth-led mental health coalitions across the country; by funding new opportunities for youth to be involved in legislative work on the local, State, and national level; and by funding organizations that can make sure the voices and sentiments of youth are captured and shared.

If there's anything I want to leave with you today, it's this: teens are talking—and we need you to listen.

At YouthLine, we know that what we do makes a difference in the lives of young people across the country. And we know that because of what we hear from teens after—after we've connected them to help, after we've talked about self-care, and after we've helped them find a path forward.

6:26 p.m.: I feel so much better talking.
7:34 p.m.: there's no one else in my life I could have talked to.
8:34 p.m.: if it weren't for this conversation, I wouldn't be here today.

Thank you.

PREPARED STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

During this morning's hearing on the youth mental health epidemic, the committee has an opportunity to build on last week's excellent discussion with Surgeon General Dr. Murthy. Last Tuesday, Dr. Murthy told us that mental health problems often show up first when people are young, but the average delay between the onset of mental health symptoms and the beginning of treatment is 11 years. Those are, in his words, "11 long, confusing, isolating, and painful years."

That is a figure worth a thousand words, but more than anything, it says that our approach to mental health care is severely out of whack, and it's failing our young people from the very beginning.

First, mental health care must start much earlier. Earlier screenings. Earlier interventions. Earlier discussions with primary care doctors. There's also a big need to step up our mental health efforts in schools and in the community.

Those are also places where trained professionals can spot symptoms right from the outset and refer young people to a psychiatrist when necessary. The challenge is, school counselors are overwhelmed, community-based programs are too few, and referrals are inconsistent. Mental health care simply isn't starting early enough, and it's not reaching young people where they are, particularly kids in rural areas.

Number two, the country must have better crisis care. The 11-year treatment gap is a sign that young people are struggling, going without the treatment they need, and heading down a path toward crisis. The fact is, the system too often fails them when they're in crisis too.

The pandemic has driven a shocking increase in self-harm among young people. Suicide attempts among teen girls resulting in hospitalizations recently jumped more than 50 percent. Far too many of these young people in distress are spending days or weeks boarded in emergency departments. For the bulk of that time, they're probably alone. Imagine feeling a sense of extreme isolation clashing with the chaos and commotion of the emergency department buzzing outside your door.

Just yesterday I spoke with a group of Oregon health-care providers and physicians who are concerned that in many of these situations, young people who wind up in emergency rooms aren't even seeing practitioners with the right training in mental health. The emergency room is no place for a kid in crisis to spend day after day after day, but it's all too common. Young people deserve better.

Third, solving these challenges is going to require creativity from the public and private sectors. The Children's Health Insurance Program and Medicaid, which is the largest single payer of mental health care for young people, can help spark new solutions. These efforts will be essential to make sure mental health is treated with the same consistency and focus given to physical health.

Bottom line, you cannot have mental health business as usual, because business as usual is failing too many young people at every point—from the first sign of symptoms to the most critical moments of crisis. There's a lot for the committee to discuss today on these issues.

We're fortunate to be joined by an excellent panel, whom I'll introduce shortly. Again, I want to thank Senators Carper and Cassidy for heading up our efforts on youth mental health. Next, I'll turn to Senator Crapo for his opening remarks.

COMMUNICATIONS

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record as the Committee on Finance examines ways to protect the mental health of our nation's youth. We applaud you for your leadership in this area, and we look forward to continuing to work with you to advance the health of the communities we serve.

As America enters the third year of the COVID–19 pandemic, health care providers are confronting a landscape deeply altered by its effects, including the emergence of behavioral health care as an even greater challenge than in previous years.

While behavioral health care has long been underfunded, underappreciated and stigmatized, the pandemic has intensified the unmet need for services and has led to heightened difficulties for individuals with behavioral health conditions in accessing care.

In freestanding psychiatric hospitals, behavioral health units of acute care hospitals, emergency departments and hospital outpatient departments across the nation, our member hospitals are facing increasing demand for services to help patients deal with anxiety, depression, substance use disorder and other behavioral health conditions. Reported increases in domestic violence and child abuse cases, financial stress, and a lack of community resources have set the stage for an exacerbated behavioral health crisis. For children and adolescents who have faced disrupted daily routines or who see parents dealing with job loss and other stressors, the consequences of the COVID–19 pandemic on their behavioral health are even more pronounced, as is their inability to access needed services on a timely basis.

To amplify the call to address these urgent issues, the AHA has joined the Sound the Alarm for Kids initiative, which comprises more than 50 organizations united to raise awareness and urge immediate action to support the mental health of children, adolescents and their families. We are proud to work alongside these many organizations in this effort.

Over the past two years, Congress has enacted several significant laws aimed at providing relief from the social and economic impacts of the pandemic. Several provisions contained in these laws are designed to address the behavioral health care crisis, but some gaps remain. To further address the issues brought about or intensified by the pandemic, the AHA supports additional approaches to help ensure improved access to needed comprehensive, affordable and quality behavioral health services for youth.

PSYCHIATRIC BED SHORTAGES

As behavioral health needs are increasing across the nation, we see an alarming trend of decreasing behavioral health services in many communities, leading to severe challenges in providing inpatient psychiatric care to children and adolescents. Bed shortages lead to "boarding" in acute-care hospital emergency departments (EDs) and in non-psychiatric units as patients await available inpatient psychiatric beds. Although little data is available regarding boarding times for children and

adolescents, our hospital members report untenable crowding in their EDs, with some describing a crisis in their communities.

Many young patients are presenting in the ED with suicidal ideation or after having attempted suicide, but our members report that the patients frequently must wait days or even weeks to be admitted to a psychiatric hospital or unit for treatment. According to the Centers for Disease Control and Prevention (CDC), over the past decade, suicide rates in the United States have increased dramatically. Suicide now ranks as the tenth leading cause of death for all Americans and the second leading cause of death for Americans between the ages of 10 and 34.

The demand for mental health treatment after suicide attempts has increased during the pandemic; as reported by the CDC, the number of ED visits by adolescent girls following suicide attempts was more than 50% higher in 2021 than in 2019. However, at the same time the number of beds has decreased, as some hospitals have had to reduce bed capacity due to COVID–19 concerns, as well close units temporarily to accommodate COVID–19 patients.

PROVIDER SHORTAGES

As with psychiatric beds, the demand for child and adolescent psychiatrists far outstrips the supply. Prior to the COVID–19 pandemic, in 2019, the Academy of Child and Adolescent Psychiatry estimated the number of practicing child and adolescent psychiatrists in the U.S. at 8,300 and the number of youths in need of their services at more than 15 million. That figure fell far short of the U.S. Bureau of Health Professions' projection that in the year 2020, more than 12,000 child and adolescent psychiatrists would be necessary just to maintain the level of services that had been provided in 2000. Lack of access to providers is even more acute in rural areas, according to the Health Resources and Services Administration, which reports that 61% of areas with a mental health professional shortage are rural or partially rural.

Because the number of Medicare-funded residency slots for all physicians, including psychiatrists, has only increased by 1,000 since 1996, Congress needs to act to increase the number of slots available. The AHA supports legislation that would lift the caps on residency positions, thereby helping to alleviate physician shortages that threaten access to care.

Additionally the AHA urges Congress to establish scholarships, bolster loan forgiveness programs and provide additional financial supports that will encourage providers to specialize in children's behavioral health care. Congress also should examine payment rates to ensure that reimbursement structures pay providers fairly for the services they render.

The AHA also supports robust funding for the Health Resources and Services Administration's Title VII and Title VIII programs, including the National Health Service Corps and the nursing workforce development program. To support diversity in the behavioral health workforce, we support increasing funding for Centers of Excellence and the Health Careers Opportunity Programs, which bolster recruiting and retaining underrepresented groups in the health care workforce.

THE CHILD SUICIDE PREVENTION AND LETHAL MEANS SAFETY ACT

In working to care for survivors of suicide and implement preventive services for those who may be at risk, hospitals recognize the importance of identifying and mitigating suicide risk factors, such as ready access to lethal means. However, millions of Americans live in areas with severe shortages of mental health professionals, and these shortages are especially acute in rural and low-income urban communities.

To help remedy this situation, the AHA has endorsed the Child Suicide Prevention and Lethal Means Safety Act (S. 2982/H.R. 5035), legislation that would fund training programs to help health care workers identify those at high risk for suicide or self-harm. The bill also would promote expertise among the emerging health care workforce by providing grants to facilitate suicide prevention training at health professions schools.

MITIGATING THE IMPACT OF VIOLENCE ON CHILDREN AND ADOLESCENTS

Every day, hospitals and health systems provide critical, lifesaving care to victims of violence. However, when violence occurs, the victims are not limited to those killed or physically injured; the impact on families and the surrounding community can affect the health of the entire community. Numerous studies have documented the behavioral and physical health effects on children and adolescents who have been exposed to violence.

Through the AHA's Hospitals Against Violence (HAV) initiative, our members share information about their efforts to help combat community violence using Hospital-based Violence Intervention Programs (HVIPs). HVIPs work to reduce retaliation and recidivism by engaging patients in the hospital during their recovery. This valuable and effective work continues after patients are discharged, providing an important network of support during their outpatient care.

To reinforce the work of these important programs, the AHA supports the Preventing and Addressing Trauma with Health Services (PATHS) Act (S. 2873), a bill that would provide grants for high-quality, culturally competent trauma support and mental health services for individuals in communities affected by violence. The funds authorized by this bill would assist hospitals and health systems in advancing the work of HVIPs and their goal of fostering safer communities.

INTEGRATING BEHAVIORAL HEALTH AND PHYSICAL HEALTH

Behavioral health disorders have significant impact on the physical health of children and adolescents. Many of our member hospitals and health systems are working to create one system of care with multiple entry points for patients with multiple conditions and to integrate behavioral health services into every patient's experience. This approach enables providers to effectively treat the whole patient—both their physical and behavioral health care needs.

As providers work to integrate behavioral health care for children, major factors to consider are developmental challenges and delays, including issues related to autism, speech and sexual reaction. These factors influence how behavioral conditions present and are best treated, as well as which non-medical services children might need to realize improvement, such as speech-language pathology and case management involving a child's family and support system.

Another major consideration is the influence of, and interaction with, other entities, including the child's family members, school and the judicial system. For children, any treatment or screening procedures will almost certainly overlap with other institutional protocols.

AT-RISK CHILDREN AND ADOLESCENTS

The needs of at-risk children and adolescents deserve special attention. First and foremost, focusing sufficient resources on their needs, such as eligibility for and access to early screening for behavioral health conditions, will help reduce the likelihood of their involvement in the child welfare or juvenile justice systems. The input of parents, foster parents, the foster care system and schools are essential in ensuring optimal, culturally sensitive behavioral health care for these youth. In addition, close coordination is necessary with programs that support their social needs and provide meaningful health care coverage upon transition out of the child welfare or juvenile justice system. This includes partnerships with crisis intervention organizations that can respond to school-based issues.

ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY LAWS

In addition to needing access to behavioral health care services, children, adolescents and their families need the behavioral health care benefits that our laws mandate. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, enacted in 2008, requires insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions. Most insurers and health plans comply with the more straightforward aspects of the law that relate to cost sharing and numerical limits on treatment, such as annual inpatient day limits—known as Quantitative Treatment Limits.

Unfortunately, health plans and insurers generally are not yet meeting the requirements of the law that govern how they design and apply their managed care rules, called Non-Quantitative Treatment Limits, or NQTLs, to these services. NQTLs are related to benefit plan design, such as requiring preauthorization before services are rendered, or imposing extra review processes for medical necessity or medical appropriateness. To save money, some plans limit coverage for medicines prescribed to treat behavioral health conditions by requiring patients to try less expensive drugs first before "stepping up" to the more costly drug actually ordered by the provider. This approach is called step therapy protocol, and its use can delay needed treatment with often catastrophic consequences for patients.

However, the federal entities charged with enforcing mental health and substance abuse parity laws have not done a thorough job, and insurers have taken advantage

of that. To resolve the issue of insurance companies' noncompliance, we need greater transparency, accountability and enforcement of current laws. In the 116th Congress, the AHA supported the Mental Health Parity Compliance Act introduced by Senators Chris Murphy (D–CT) and Bill Cassidy (R–LA), legislation whose provisions were incorporated into the Consolidated Appropriations Act, 2021[1] (CAA). Those provisions require health plans and issuers that cover mental health and substance use disorder services as well as medical and surgical benefits to create a comparative analysis of any NQTLs that apply, and to provide such analyses whenever requested by federal agencies. The CAA also requires the Departments of Labor, Treasury and Health and Human Services to report to Congress annually and issue additional guidance on NQTLs.

Unfortunately, the 2022 report found that none of the comparative analyses reviewed by the federal departments were in full compliance with the law, and none contained required information. The AHA urges Congress to exercise vigorous oversight of the federal agencies responsible for ensuring that health plans comply with the MHPEA and all its reporting requirements. Further, we support an increase in federal penalties for noncompliance to help ensure that patients can receive the behavioral health care benefits they are entitled to under the law.

BATTLING STIGMA

Finally, the AHA continues to fight the stigma associated with seeking behavioral health care. Children and adolescents may not seek the help they need due to the stigmatization of mental health care. Often parents may avoid seeking care for their children due to apprehension that a mental health diagnosis will unfairly label them for the rest of their lives. AHA member hospitals and health systems work to dispel misperceptions about mental health disorders and treatment, and we have launched the People Matter/Words Matter poster series to help health care workers adopt patient-centered, respectful language around behavioral health.

CONCLUSION

As a nation, we are just beginning to fully comprehend the effects of the COVID–19 pandemic on the emotional well-being of the nation's youth. America's hospitals and health systems recognize that our collective efforts today to protect the mental health of children and adolescents can have a lasting impact on their lives and the overall health of our communities well into the future. We appreciate the Committee's efforts to examine this issue and look forward to working with you to advance policies to that end.

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Statement of Arthur C. Evans, Jr., Ph.D., Chief Executive Officer

On behalf of the American Psychological Association (APA), please accept our organization's written comments for the consideration of the Senate Finance Committee for its hearing on "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care." APA is the nation's largest scientific and professional organization representing the discipline and profession of psychology, with more than 133,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in the field of psychology. Through the application of psychological science and practice, our association's mission is to have a positive impact on critical societal issues.

To respond to the children's mental health crisis, APA urges policy initiatives in the following key areas. While not all the policies and programs referenced in this document are directly within the jurisdiction of the Finance Committee, we raise them in keeping with the committee's comprehensive consideration of policies affecting youth mental health:

- Strengthen the behavioral health workforce;
- Improve Medicaid coverage policies and payment rates;

[1] *https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.*

- Increase access to school-based behavioral health services;
- Promote integration of pediatric primary care and behavioral health; and
- Maintain and extend access to behavioral health services provided via telehealth.

The COVID pandemic is particularly harming the mental health of children and youth. During the first three-quarters of 2021, children's hospitals reported a 14% increase in mental health-related emergencies and a 42% increase in cases of self-injury and suicide, compared with the same period in 2019.[1] In recent months, children's hospitals experienced their highest number of children "boarding" in hospital emergency departments awaiting treatment.[2] Surveys of households with young children found high levels of childhood hunger, emotional distress among parents, and frequent disruptions in child-care services.[3] Nearly 10% of U.S. children lived with someone who was mentally ill or severely depressed,[4] and since the start of the pandemic over 167,000 children have lost a parent or caregiver to the virus,[5] further contributing to anxiety, depression, trauma, and stress-related conditions in children. Aggressive action is needed to address the adverse long-term impacts of the pandemic on the mental health and well-being of children and adolescents.

It is important to note that people of color remain at disproportionately higher risk of infection, hospitalization, and death from the virus.[6] The pandemic has also exacerbated the impact of historic disparities in access to behavioral health care among communities of color, which has further harmed their mental well-being since the start of this crisis.[7] Rates of suicide, which have traditionally been high predominantly among White and Native American children, have risen sharply among Black youth.[8] Black and Hispanic children lost a parent or a caregiver at more than two times the rate of White children, while American Indian, Alaska Native, Native Hawaiian, and Pacific Islander children lost caregivers at nearly four times that rate.[9] Additionally, young people within other marginalized populations, including those who identify as LGBTQ+ and children with developmental and physical disabilities, have been disproportionately impacted as well.[10]

The need for greater investment in behavioral health care existed long before COVID–19. Establishing a robust and effective mental health and substance use disorder treatment system capable of delivering the mental health resources our

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[1] Children's Hospital Association. (2021). COVID–19 and Children's Mental Health. Retrieved from: *https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Mental-Health/2021/covid_and_childrens_mental_health_factsheet_091721.pdf?la=en&hash=F201013848F9B9C97FAE16A89B01A38547C7C5C7.*

[2] Children's Hospital Association. (n.d.). Emergency Room Boarding of Kids in Mental Health Crisis. Retrieved from: *https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Mental%20Health/2021/Boarding_fact_sheet_121421.pdf.*

[3] Center for Translational Neuroscience. (2021). *RAPID–EC Fact Sheet: Still in Uncertain Times; Still Facing Hunger.* University of Oregon. Retrieved from: *https://www.uorapidresponse.com/our-research/still-in-uncertain-times-still-facing-hunger;* Center for Translational Neuroscience. (2021). *RAPID–EC Fact Sheet: Emotional Distress On the Rise for Parents . . . Again.* University of Oregon. Retrieved from: *https://www.uorapidresponse.com/emotional-distress-on-rise-again?utm_medium=email&utm_source=email_link&utm_content=baby_monitor_11042021&utm_campaign=Q1_2022_Policy+Center_Resources.*

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

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

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

[7] McKnight-Eily, L.R., Okoro, C.A., Strine, T.W., et al. (2021). Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID–19 Pandemic—United States, April and May 2020. *Morbidity and Mortality Weekly Report, 70*(5), 162–166, *http://dx.doi.org/10.15585/mmwr.mm7005a3.*

[8] Sheftall, A.H., Vakil, F., Ruch, D.A., Boyd, R.C., Lindsey, M.A., and Bridge, J.A. (2021). Black Youth Suicide: Investigation of Current Trends and Precipitating Circumstances. *Journal of the American Academy of Child and Adolescent Psychiatry, https://doi.org/10.1016/j.jaac.2021.08.021.*

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

[10] Morning Consult and the Trevor Project. (2021). Issues Impacting LGBTQ Youth. Retrieved from: *https://www.thetrevorproject.org/wp-content/uploads/2021/12/TrevorProject_Public_Final-1.pdf.*

children and young people need will require action across multiple fronts, ranging from improving access to the full spectrum of high-quality treatment to addressing social determinants of health. We must use the current crisis as an opportunity to make major structural improvements and new, sustained investments.

Strengthen the Behavioral Health Workforce

A strong behavioral health workforce is critical to combating the long-term impact of the pandemic and remedying longstanding access gaps. Even before COVID–19, the U.S. lacked an adequate supply of behavioral health providers, including psychologists, with shortages expected to worsen significantly by 2030.[11, 12, 13] Rural communities, in particular, face major challenges in recruiting licensed behavioral health care professionals.[14] The rising behavioral health needs associated with COVID–19 will make an already bad situation worse.

Congress can strengthen the behavioral health workforce by providing support for psychologist training programs in a manner similar to the support it provides to medical professional training programs. Unlike physicians, doctoral-level psychologists are not eligible for Medicare-funded residency programs, which provide billions of dollars to support the expansion of the physician workforce through Graduate Medical Education (GME).

The lack of support for psychology trainees under the nation's single largest health insurance program makes it difficult to support training programs. We urge Congress to establish Medicare coverage of behavioral health services provided by psychology interns and postdoctoral fellows ("trainees") by directing the Centers for Medicare and Medicaid Services (CMS) to develop a Medicare modifier—like the GE modifier used for billing for services provided by medical residents—to allow psychology trainees to bill for behavioral health-care services provided under the supervision of a licensed psychologist. Simultaneously, Congress should establish an add-on code to compensate behavioral health clinicians for the non-clinical time they devote to working with trainees, so that time spent teaching does not have to be effectively donated by the clinician and carried out at the expense of providing billable services.

Although some state Medicaid programs are already covering services provided by psychology trainees, encouraging and incentivizing such coverage in all state Medicaid programs would support training programs and their growth. Both Congress and CMS previously endorsed providing payments for clinical psychology training programs.

In addition to Medicare and Medicaid policy changes, reauthorization and funding for programs administered by the Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA) is needed to strengthen the behavioral health workforce.

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

Because of the high level of training required, the cost of attending graduate school is a significant barrier for entering the field of psychology. Most psychology graduate students finance their education by taking on substantial student debt, and graduate with an average debt load of between $95,000 and $160,000. Close to half of doctoral-level psychologists rely on loans to pay for graduate school, which takes

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[11] Bureau of Health Workforce. (2019). *Designated Health Professional Shortage Area Statistics.* Health Resources and Services Administration; U.S. Department of Health and Human Services. Retrieved from *https://data.hrsa.gov/hdw/Tools/MapToolQuick.aspx?mapName=HPSAMH.* Health Resources and Services Administration. (n.d.). Behavioral Health Workforce Projections, 2016–2030: Clinical, Counseling, and School Psychologists. Retrieved from: *https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/psychologists-2018.pdf.*

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

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

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

on average 5–6 years to complete.[15] Data show that psychology graduate students worry about the affordability of completing their training requirements, experience difficulties focusing on their studies as a result of trying to make ends meet, and struggle to afford health care.[16] At the same time, the imposition of higher interest rates and multiple loan origination fees, as well as the elimination of subsidized federal loans for graduate students, further increased the cost of financing graduate education.[17]

High levels of student loan debt impede workforce diversity in mental health care fields, where demand for representative, culturally competent providers is high.[18] Due to a variety of factors, such as lack of generational wealth, many students—including first-generation students, those from communities of color, and those with a lower socioeconomic background—working toward doctoral psychology degrees disproportionately rely on student loans.[19] The prospect of adding further debt often disincentivizes the pursuit of advanced degrees, and research shows that debt also impacts career choice by reducing the probability that qualified professionals will enter public service careers.[20]

Accordingly, APA calls for the expeditious reauthorization of the following programs, which are set to expire at the end of Fiscal Year (FY) 2022:

The **Graduate Psychology Education Program (GPE)** is the nation's primary federal program dedicated solely to the education and training of doctoral-level psychologists. GPE provides grants to accredited psychology doctoral, internship, and postdoctoral training programs to support the interprofessional training of psychology graduate students while also providing behavioral health services to underserved populations in rural and urban communities. APA urges reauthorization of this vitally important program at $50 million per year.

The **Minority Fellowship Program (MFP)** serves a dual purpose: to both increase the number of mental health professionals of color and increase access to mental health services in underserved areas. Decades of psychological research has shown that youth of color report less use of behavioral health services than non-Hispanic white youth,[21] in part due to the lack of bilingual and culturally competent providers. MFP provides funding for the training, career development, and mentoring of behavioral health professionals—including trainees in psychology, nursing, social work, psychiatry, addiction counseling, professional counseling, and marriage and family therapy—to work in ethnically diverse communities and provide culturally and linguistically competent services to meet the needs of individuals in underserved areas.

The **Behavioral Health Workforce Education and Training (BHWET) Program** supports pre-degree clinical internships and field placements for a broad array of behavioral health professionals, including doctoral-level psychology students, master's-level social workers, school social workers, professional and school counselors, psychiatric mental health nurse practitioners, marriage and family therapists, and occupational therapists. The program is also a key source of support for other behavioral health training programs and substance use disorder prevention efforts. Preserving this program is key to reaching underserved populations, as

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

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

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

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

well as meeting the needs of patients wherever they are on the spectrum of mental health needs, from early screening and prevention services for those who may be experiencing symptoms of a behavioral health disorder to mobile crisis services for those in need of immediate intervention.

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

Improve Medicaid Coverage Policies and Payment Rates

Medicaid is the largest payer of behavioral health services in the U.S., and yet many patients cannot access quality, affordable care in their communities, instead seeking care in emergency rooms or facing interminable wait lists for services. Despite their status as "essential health benefits" that many private plans must cover under the Affordable Care Act, mental health and substance use services are not mandatory benefits under state Medicaid programs. Accordingly, APA urges enactment of Senator Smith's Medicaid Bump Act (S. 1727), which incentivizes state Medicaid programs to increase their coverage of mental and behavioral health services. Without access to crisis services, patients often find themselves languishing in emergency rooms or seeking treatment in other inappropriate settings. We strongly support the inclusion of Chairman Wyden's CAHOOTS Act (S. 764) to incentivize state Medicaid coverage of services provided by round-the-clock mobile crisis teams.

Research consistently demonstrates connections between low Medicaid reimbursement rates and low rates of provider participation in the program.[22, 23, 24, 25] Psychologists and other providers often accept Medicaid patients as a public service, but low reimbursement rates can be a barrier to participation. In surveys we have conducted, psychologists who have chosen not to participate in Medicare cite the program's low reimbursement rates as the primary reason for their decision. Similarly, a recent report issued at the request of the Oregon Legislature documented behavioral health providers' significant concern over low Medicaid reimbursement rates, and the authors' conclusion that "wage increases are a necessary but insufficient component to improving behavioral health workforce shortages" (p. 5).[26]

Medicaid provider payment rates remain substantially below Medicare reimbursement rates.[27] Given the dire need to increase access to behavioral health services for children and youth, we urge Congress to consider assisting states in raising Medicaid reimbursement rates to match Medicare reimbursement rates for behavioral health services for this population.

Increase Access to School-based Behavioral Health Services

Meeting the need for behavioral health services for children and youth will only be possible if all available venues are utilized effectively for reaching those in need of help, so that there is "no wrong door" for obtaining care. Schools are an essential component of such an approach. In fact, in many communities, they are an essential—and often the only—source of meeting the physical and mental health needs of students and families. While some school districts leverage Medicaid funds to stretch scarce resources and create school-based behavioral health programs, shortages of school-based behavioral health professionals continue to persist.[28]

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[22] Holgash, K., and Heberlein, M. (2019). Physician acceptance of new Medicaid patients. Medicaid and CHIP Payment and Access Commission, January, 24.

[23] Candon, M., Zuckerman, S., Wissoker, D., Saloner, B., Kenney, G.M., Rhodes, K., and Polsky, D. (2018). Declining Medicaid fees and primary care appointment availability for new Medicaid patients. *JAMA Internal Medicine,* 178(1), 145–146.

[24] Chatterji, P., Decker, S.L., and Huh, J. (2021). Medicaid physician fees and access to care among children with special health care needs. *Review of Economics of the Household,* 1–33.

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[26] Zhu, J.M., Howington, D., Hallett, E., Simeon, E., Amba, V., Deshmukh, A., and McConnell, K.J. (2022). Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature.

[27] Zuckerman, S., Skopec, L., and Aarons, J. (2021). Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019: Study compares Medicaid physicians fees to Medicare physician fees. *Health Affairs,* 40(2), 343–348.

[28] National Association of School Psychologists. (2017). *Shortages in school psychology: Challenges to meeting the growing needs of U.S. students and schools.* Retrieved from: *https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-psychology/shortages-in-school-psychology-resource-guide.*

Improving the behavioral health and emotional well-being of all students, including by instituting evidence-based comprehensive behavioral health systems in schools, can help mitigate the impacts of pandemic-related learning loss,[29] and reduce the frequency and severity of mental health and substance use disorders.[30] Such a holistic approach provides a full complement of supports and services that establish multi-tier interventions and promotes positive school environments. They are built on collaborations between students, parents, families, community health partners, school districts, and school professionals, such as administrators, educators, and specialized instructional support personnel, including school psychologists.

As the third-largest stream of federal funding for school-based health care services, Medicaid remains a critical mechanism for meeting many of these needs among our most vulnerable students by broadening access to physical and mental health care available through school-based health centers. School districts can use Medicaid reimbursement to fund health professionals and specialized instructional support personnel, including school psychologists,[31] purchase and update specialized equipment and connect eligible students with providers outside of school settings. Medicaid can also be used to pay for services described in a Medicaid-enrolled student's individual education plan (IEP) under the Individuals with Disabilities in Education Act.

To meet the growing need for child and adolescent behavioral health care and increase access to school-based behavioral health services, APA urges the Committee to strengthen Medicaid-funded services in schools by directing CMS to update its guidelines on Medicaid in schools to ensure that Medicaid reimbursement can be utilized for school-based physical and behavioral health care. CMS must also periodically review Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) requirements to determine whether they are being implemented successfully in support of access to prevention, early intervention, and developmentally appropriate services.

Additionally, we strongly oppose restrictions on Medicaid payments to schools for necessary services, as well as the implementation of per-capita caps or block grant funding for Medicaid programs. Finally, we urge the Committee to support a permanent extension of the Children's Health Insurance Program (CHIP) as a stable source of coverage for low-income children.

Further, we urge Congress to pass legislation that increases access to behavioral health services in schools and addresses disparities in behavioral health care among Black youth, including:

- The Mental Health Services for Students Act (S. 1841), to build partnerships among local educational agencies, tribal schools, and community-based organizations;
- The Comprehensive Mental Health in Schools Pilot Program Act (S. 2730), to provide resources for low-income schools to develop a holistic approach to student well-being;
- The Increasing Access to Mental Health in Schools Act (S. 1811), to expand the school-based mental health professional workforce; and
- The Pursuing Equity in Mental Health Act (S.1795), to authorize funding for research on Black youth suicide and improve the pipeline of culturally competent providers.

Promote Integration of Pediatric Primary Care and Behavioral Health

Increasing implementation of evidence-based integrated pediatric primary and behavioral healthcare could significantly increase access to care, improve treatment outcomes, promote healthy development, and aid in addressing social determinants

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

[30] American Psychological Association. (2020). *APA's Guide to Schooling and Distance Learning During COVID–19.* Retrieved from: *https://www.apa.org/ed/schools/teaching-learning/recommendations-starting-school-covid-19.pdf.*

[31] Pudelski, S. (2017). Cutting Medicaid: A Prescription to Hurt the Neediest Kids. AASA, The School Superintendent's Association, *https://www.aasa.org/uploadedFiles/Policy_and_Advocacy/Resources/CuttingMedicaid2018Addendum.pdf.*

of health.[32] A substantial percentage of patients visiting primary care practices are experiencing behavioral health issues affecting their well-being, including both mental health and substance use disorders or difficulties, and behavioral factors associated with physical conditions or chronic disease management.[33]

More than a decade of research has documented the effectiveness of programs implementing the primary care behavioral health (PCBH) model, the collaborative care model (CoCM), and blended models of integrated care. One of the leading models of integrated care is the Primary Care Behavioral Health Model (PCBH), in which primary care providers, behavioral health consultants (BHCs), and care managers work as a team, sharing the same health record systems, administrative support staff, and waiting areas, and collaborate in monitoring and managing patient progress in order to improve the management of behavioral health problems and conditions. In the PCBH model, the behavioral health consultant role is often, but not always, filled by a clinical psychologist.

The PCBH model is a truly population-based approach to integrated care, in which the goal is to improve both mental and physical health outcomes for the clinic's patients of every age and condition by managing behavioral health problems and biopsychosocially influenced health conditions.[34] Generally, the BHC strives to see patients on the same day the primary care provider (PCP) requests help, ideally through a "warm hand-off," and works with the PCP to implement clinical pathways for treatment. An integrated care psychologist's day may include meeting with a parent of a child exhibiting behavioral difficulties or hyperactivity, seeing a new mother experiencing symptoms of depression, helping another patient manage chronic pain or diabetes, and working with another patient who has recently discontinued using psychotropic medication. Both patients and providers have reported high levels of satisfaction with PCBH model services.[35,36] From the patient's perspective, behavioral health services are seamlessly interwoven with medical care, mitigating the stigma often associated with behavioral health services.

The PCBH model is particularly well-suited for use in pediatric care. Interventions and supports to promote children's physical, behavioral, and emotional health can positively influence the long-term trajectory of their health and well-being into adulthood. Almost all children are seen in primary care, and it is estimated that one in four pediatric primary care office visits involves behavioral health problems. Psychologists can be especially helpful in pediatric care because assessing behavioral and emotional issues in children is generally more difficult than in adults, and pediatric education traditionally focuses on children's physical health. In addition to improving treatment in this area, early childhood behavioral health services can help mitigate the effect of adverse social determinants of health. Ideally, integrated pediatric primary care includes a whole-family approach to services that encompasses screening and services for perinatal and maternal depression, domestic violence, and adverse childhood experiences.

Investing in evidence-based integrated primary and behavioral health care across multiple delivery models would help us meet the current crisis, as more than a decade of research has shown that programs implementing the PCBH model, the collaborative care model (CoCM), and blended models of integrated care can increase access to care and achieve the health care triple aim of improving patient outcomes, increasing satisfaction with care, and reducing overall treatment costs.

Adoption of PCBH and other integrated care models is often challenging for primary care providers, as they face barriers related to physical office space, the need for improved information technology systems, management procedures, clinical staffing

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[32] McCabe, M.A., Leslie, L., Counts, N., and Tynan, W.D. (2020). Pediatric integrated primary care as the foundation for healthy development across the lifespan. *Clinical Practice in Pediatric Psychology,* 8(3), 278.

[33] Crowley, R.A., Kirschner, N., and Health and Public Policy Committee of the American College of Physicians. (2015). The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: Executive summary of an American College of Physicians position paper. *Annals of Internal Medicine,* 163(4), 298–299.

[34] Reiter, J.T., Dobmeyer, A.C., and Hunter, C.L. (2018). The primary care behavioral health (PCBH) model: An overview and operational definition. *Journal of Clinical Psychology in Medical Settings,* 25(2), 109–126.

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

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

and policies, health records and data tracking practices, and provider education and training.

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

Maintain and Extend Access to Behavioral Health Services Provided via Telehealth

The decisions by Congress and CMS to expand access to tele-mental health services represented a rare positive outcome of the COVID–19 pandemic, as it extended evidence-based mental behavioral health care to many individuals in areas and communities that traditionally lacked access to these services and made access to care easier and/or safer for many others. There is ample evidence demonstrating that mental and behavioral health services delivered via telehealth can be at least equally effective as services delivered in person.[37] Audio-only telehealth is an especially important treatment modality for those residing in areas lacking accessible or affordable broadband Internet services, as well as individuals who lack the technological familiarity with video conferencing platforms. Telehealth will remain in use long after the pandemic ends; According to a recent survey of practicing psychologists, 93% of respondents said that they intend to continue offering telehealth as an option in their practice after the pandemic.[38]

APA urges enactment of the bipartisan Telehealth Improvement for Kids' Essential Services (TIKES) Act (S. 1798) introduced by Senator Carper and Senator Cornyn to provide guidance to states on increasing coverage of telehealth services through state Medicaid and CHIP programs. APA also supports several other bills before Congress to cement the gains in access achieved under recent improvements in telehealth and audio-only services coverage, including the Telemental Health Care Access Act (S. 2061), introduced by Senators Cassidy, Smith, Cardin, and Thune, which would eliminate a new Medicare telehealth coverage requirement that unnecessarily requires patients to be periodically seen in person.

To incentivize providers to continue offering telehealth services, coverage of and reimbursement for telehealth services should be equivalent to their in-person counterparts. Reimbursing at a lower rate and requiring coverage on more stringent terms would drive providers to offer more in-person services, making it more difficult for the many patients who rely on services delivered via telehealth to access care. APA recommends that Congress enact the Telehealth Coverage and Payment Parity Act (H.R. 4480), which requires private insurance plans to cover telehealth services on equal terms and equal rates as their in-person counterparts.

APA is heartened by the focus on mental health in Congress, and eager to work with this Committee and its members to develop legislation to carry out these and other initiatives. We urge Congress to regard the COVID–19 pandemic as an opportunity to address the longstanding shortcomings of our behavioral health treatment system.

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[37] *See, e.g.,* Turgoose, D., et al., (2018) *Journal of Telemedicine and Telecare,* Vol. 24, No. 9, *https://doi.org/10.1177/1357633X17730443;* Varker, T., et al. (2019), *Psychological Services,* Vol. 16, No. 4, *https://doi.org/10.1037/ser0000239;* Slone, N.C., et al. (2012) *Psychological Services,* Vol. 9, No. 3, *https://doi.org/10.1037/a0027607.*

[38] American Psychological Association (October 19, 2021), Worsening Mental Health Crisis Pressures Psychologist Workforce: 2021 COVID–19 Practitioner Survey, *https://www.apa.org/pubs/reports/practitioner/covid-19-2021.*

Committee on Finance

RE: COVID–19, Mental Health Care in Adolescents and Young People, and the Role of Recreational Therapists

Dear Chairman Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee,

On behalf of the American Therapeutic Recreation Association (ATRA), we appreciate the opportunity to submit this statement for the record regarding the Committee's hearing on "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care." The hearing highlights the pressing issues facing today's youth and the gaps in mental health treatment in our current healthcare system. We look forward to working with you to develop solutions to address America's mental health crisis.

ATRA is committed to advancing access to recreational therapy and ensuring that individuals, in particular adolescents, are able to receive care that suits their interests and needs and supports the development of functional skills for daily living and stress release. ATRA is the largest professional association representing recreational therapy. Recreational therapists are nationally certified, and where applicable, state-licensed to provide evidence-based treatment services for individuals with a range of disabling conditions across the lifespan. Recreational therapy is active treatment, medically necessary, and can be prescribed by a physician as part of a client's plan of care.[1]

ATRA has watched with interest and concern as new data has highlighted the significant impact COVID–19 has had on adolescents and young people's mental health outcomes. As recreational therapists, we are trained to use a variety of interventions to help clients address mental health challenges, as well as other areas like physical health and emotional/social well-being. Therefore, we recognize the critical need to ensure that resources are in place following the public health emergency to ensure that young people are able to successfully manage the stress and anxiety associated with COVID–19.

In mental health care, recreational therapists support clients with cognitive, social, leisure, and physical interventions, as well as stress management techniques, to improve a client's overall health. Recreation therapy (RT) for mental health incorporates activities including music, sports, dance, art, and outdoor activities to help a client find strategies that work for them to manage stress and ensure they have a healthy outcome for managing their mental health. RT also uses meaningful engagement in life activities or leisure as a means to increase coping and therefore reduce depression and anxiety. This type of therapy can be particularly helpful and attractive to individuals, including adolescents, as an alternative, non-pharmacological outlet.

As illustrated during the hearing, the impact of the COVID–19 pandemic highlights the next public health emergency: stress, depression, and anxiety among young people and adolescents. To respond to this, serious steps must be taken to support young people as they cope and adjust to different normalcy with resiliency. The use of interdisciplinary health teams that include recreational therapy is required to ensure that young people have the necessary skills and resources to improve their mental health. **We urge Congress to include recreational therapists in any legislation addressing youth mental health.**

The Important Role that Recreational Therapists Play

Recreational Therapy (RT) embraces a definition of "health" which includes not only the absence of "illness," but extends to the enhancement of physical, cognitive, emotional, social, and leisure development so individuals may participate fully and independently in chosen life pursuits. Recreational therapists address assessed client needs related to behavior, cognition, function, pain management, physical activity level, socialization, recreation, and leisure.[2] Recreational therapists have the competencies to assess and implement interventions necessary to promote improved mental health, quality of life, and prevent secondary conditions[3, 4] by reducing depression, stress, and anxiety in their clients and helping build confidence to socialize in their community. Recreational therapists work in a variety of settings that promote youth and adolescent mental health including community mental health centers, public and alternative schools, co-occurring disorder programs, day hospitals for outpatient treatment, inpatient psychiatric hospitals, inclusive recreation programs, residential living facilities, nature-based recreation programs, and addiction recovery centers.

In the United States, recreational therapists at a minimum must have a bachelor's degree in recreational therapy (or therapeutic recreation) or a related field.[5] Anatomy and physiology, assessment, salient characteristics of illness and disabilities, medical terminology, the therapeutic process, and 560 hours of fieldwork are required courses.[6] The Certified Therapeutic Recreation Specialist (CTRS) is the required certification for recreational therapists by NCTRC and shows that the recreational therapist has passed an all-encompassing national certification exam demonstrating extensive knowledge and skill-based training in core therapy skills (assessment, planning, implementation, documentation, and evaluation), a team-oriented approach to care delivery, and training in group processes.[5] The CTRS credential is required for practice as a recreational therapist in Veterans Affairs[7] and designated as the accepted certification for recreational therapists by the Centers for Medicare and Medicaid Services federal guidelines for skilled nursing facilities. Ethical conduct is mandated by the professional organization, the American Therapeutic Recreation Association (ATRA)'s code of ethics, and quality indicators of RT practice are supported by the ATRA Standards of Practice.[1]

Research has shown the effectiveness of recreational therapy services for young people's mental health outcomes. Through recreational therapy interventions, youth with mental health challenges saw increases in health-related quality of life,[8] positive changes in their perceived self-esteem,[9] and decreases in feelings of social isolation and loneliness.[10] Through outdoor adventure interventions, recreational therapists also helped some young people with substance abuse disorder and post-traumatic stress disorder to learn effective strategies for their personal recovery.[11]

To better explain the role of RT, we have provided some examples of recreational therapy services specific to adolescents with mental health conditions:

- A recreational therapist in Virginia works at a residential treatment center for adolescents with mental health diagnoses. Utilizing stress management interventions like guided imagery, progressive muscle relaxation, Tai Chi, and yoga, recreational therapy services help adolescents reach goals like decreasing symptoms of depression and anxiety while increasing self-confidence and personal grounding.
- Another recreational therapist works in a school in New Mexico with high school students with intellectual and developmental disabilities (IDD) who are experiencing increased anxiety during COVID–19. Recreational therapy services help the students cope with feelings of fear, worry, and hopelessness through after-school, group therapy sessions for teaching emotional identification, coping skills, and adjustment strategies to navigate their ever-changing daily schedules.
- Lastly, a recreation therapist in Colorado utilizes nature-based, adventure therapy interventions for adolescents with mental health diagnoses. Goals of improving adolescents' self-confidence, problem-solving skills, and sense of community are achieved through outcomes-based, recreational therapy modalities that include kayaking, rock climbing, high and low ropes courses, and wilderness hiking.

Conclusion

As Congress considers new legislative efforts to improve youth mental health, **we ask that recreational therapy services be considered essential to addressing the mental health crisis for youth and adolescents as a result of the COVID–19 pandemic. Specifically, we urge Congress to include recreational therapists in any legislative language dedicated to reducing stress, anxiety, and depression among youth and adolescents.** We welcome the opportunity to speak with you more about what RT is, and how it can help in responding to the mental health emergency as a result of COVID–19. Please do not hesitate to reach out to the American Therapeutic Recreation Association (ATRA) directly, please contact Brent Wolfe, ATRA Executive Director, at brent@atra-online.com or by phone at (703) 234–4140.

Sincerely,

Brent Wolfe

End Notes

[1] Kemeny B, Fawber H, Finegan J, Marcinko D. Recreational therapy: Implications for life care planning. *J Life Care Plan.* 2020;18(4):35–58.

[2] Commission on Accreditation of Rehabilitation Facilities. 2020 Medical Rehabilitation Standards Manual. 2020.

[3] Hawkins B, Kemeny B, Porter H. Recreational therapy competencies, Part 2: Findings from the ATRA competencies study. *Ther Recreation J.* 2020;54(4). doi:10.18666/trj-2020-v54-i4-10238.
[4] Kinney J. Analysis of services performed by recreational therapists. *Ther Recreation J.* 2020;54(3):227–243. doi:10.18666/trj-2020-v54-i3-10248.
[5] National Council for Therapeutic Recreation Certification. The CTRS is the qualified provider of Recreational Therapy Services. 2020.
[6] Bureau of Labor Statistics U.S. Department of Labor. Occupational Outlook Handbook, Recreational Therapists. 2020.
[7] U.S. Department of Veterans Affairs. VA Handbook 5005, Part II, Appendix G60. The Recreation and Creative Arts Therapist.
[8] Bennett JR, Negley SK, Wells MS, Connolly P. Addressing well-being in early and middle childhood: Recreation therapy interventions aimed to develop skills that create a healthy life. *Spec Issue Strengths-based Pract—Part 1.* 2016;50(1): unpaginated. *http://js.sagamorepub.com/trj/article/view/6782.*
[9] Concepcion H. Video game therapy as an intervention for children With disabilities. *Ther Recreation J.* 2017;(3):221–228.
[10] Luchies LB, Barbour AL, Anderson SR. Children's Healing Center involvement reduces social isolation and loneliness among immunocompromised children and their family members. *Am J Recreat Ther.* 2019;18(3):37–47.
[11] Leighton J, Lopez KJ, Johnson CW. "There is Always Progress to Be Made": Reflective Narratives on Outdoor Therapeutic Recreation for Mental Health Support. *Ther Recreation J.* 2021;55(2):185–203.

Letter Submitted by Stephanie Barrett

U.S. Senate
Committee on Finance

To the honorable members of the Senate Finance Committee:

I've worked on the social service delivery and government sides of the system of care for youth with mental health challenges over the last 27 years, in direct service to teens facing adversity, sexual assault services (including child sexual abuse), and child protective field work before moving to the bureaucratic role. There are numerous challenges in accessing effective mental health services for children and youth.

Most recently, the Private Equity Stakeholder Project released a report on the rising impact of private equity in children's mental health services. This is a concerning trend, as equity has turned an eye to extracting profits from an industry with slim margins. Whatever approaches to this problem are taken must account for the vultures, circling what is an apparent cash cow in the birthing, as attention (and as it follows, money) is turned toward this vital sector. See report: "The Kids Are Not Alright: How Private Equity Profits Off of Behavioral Health Services for Vulnerable and At-Risk Youth," Eileen O'Grady, February 2022, *https://pestakeholder.org/wp-content/uploads/2022/02/PESP_Youth_BH_Report_2022.pdf.*

Having been elbows deep in treatment programs for the last 14 years, I can share some essential observations regarding factors that affect quality services to children and youth:

– Bureaucratic focus on Evidence-Based Practices (EBPs): I have repeatedly seen EBPs embraced, at considerable expense, then delivered to those outside the basis of the evidence. There are good EBPs and there are bad EBPs. At the end of the day, no EBP will be effective if safety, both physical and emotional in a way the nervous system can perceive it, is not established.

– The longest-running, most well-established factor (evidence base) that predicts success of treatment is the quality of the relationship with the clinician.

– Mental health treatment for children and youth is delivered, broadly, by the least qualified and capable clinicians in the field, typically the new grads and those with "conditional" licenses.

– Children's program clinicians experience low wages for the field and poor supervision.

– As conditional clinicians gain any skill and experience, and their full licensure, they often move on to work outside of residential programs and beyond, to private practice.

– With the turnover in children's clinicians, it's difficult to establish a trustworthy relationship. Oftentimes, the broken relationships just reinforce the relational trauma of those in services.

My suggestions for improvement include:

- Wage standards, identified in rate, to increase starting pay for clinicians in children's treatment settings with the aim of attracting and retaining high-quality, capable clinicians.
- Enforceable standards for quality clinical supervision of conditional licensees, and accounted for within the rates.
- Enforceable standards for clinical quality—I have read terrible, terrible work, over and over, with few to no teeth to force a change.
- Standards for providers that emphasize safety at all levels, and freedom from intrusive behavioral interventions. The Qualified Residential Provider language under FFPSA takes a huge stride in the right direction.
- Statute that obligates investigation of ANY allegation of sexual abuse or impropriety by a clinician or residential program staff against any child or youth receiving services.
- Enforceability. Not just through cost recovery, but through public information and a clearly delineated quality and corrections process that is uniform regardless of the state or entity providing oversight and that is impervious to swings in policy that is common at the state level with changes in administration.

This last suggestion will also give bones and hope to dedicated public servants who are trying to fulfill their duties in the public trust. I have stories I can tell about how administrations can quickly dismantle oversight structures and how hard it is to recover. Meanwhile, children and youths suffer with their struggles and poor quality services. Meanwhile, the child welfare system has a role to play as well. I once evaluated a number of youth suicides occurring in our state and nearly all had or should have had effective child welfare involvement. Those youths (age 8–17) were living in dangerous homes and several had taken their own lives after yet again meeting a child welfare worker who unsubstantiated the allegations of abuse. When the worker walked out the door, that kid had no hope that anyone would be able to help them. Meanwhile, the 8-year-old's family didn't have a CPS record, but should have. Sadly, the most challenging cases I handled as a CPS worker were intergenerational trauma and when I knocked on the door, with the tools I had, I was failing the fourth generation.

I'm happy to provide any additional info or context as requested. With respect,

Stephanie Barrett
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To access the **CDS Amin and Trainers list** self-service, please use this link: *https://forms.office.com/g/TDA1A8p9zU.*

DirectCourse ON-DEMAND ADMINISTRATOR TRAINING:
Select "Resource Center" from bottom of DirectCourse landing page. Then select "DirectCourse" from second page and "Training" from top of final landing page.

California Youth Connection et al.

March 1, 2022

U.S. Senate
Committee on Finance
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Washington, DC 20510–6200

Dear Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee:

Thank you for your interest and focus on improving access to mental health services and supports for children and youth. The testimony provided at the hearings on February 8th and February 15th was insightful, sobering, and provided many helpful recommendations on how to address the mental health crisis that children, youth and families are confronting across the country. We write to add our voice and the voices of young people with experience in foster care for your consideration as you begin to develop solutions that will improve access to and the quality of mental health care for children, youth, and families.

Young people in and leaving foster care are at the center of the mental health crisis. The removal and separation of children from their families in and of itself can be a traumatic experience requiring mental health treatment. Many young people have entered the child welfare system because of unmet mental health needs. Their family members may also be experiencing mental health challenges as well. Once in the foster care system, young people often experience additional trauma and mental health challenges which frequently last long beyond their time in care. Failing to address the needs of these young people has dire consequences for their health and well-being as youth and as adults, yet large numbers of youth report that their needs are not met and that their healing is not a priority in the child welfare and mental health systems. We hope that designing a better approach to providing mental health services, addressing the impact of trauma, and centering healing will be a priority for both mental health and child welfare reform and improvements.

We agree with Trace Terrell from Youth Line in Oregon who testified on February 15th; it is critical to hear from young people and families who are impacted by the mental health system. We're grateful to the members of the Senate Finance Committee and the Committee's commitment to listening to young people and families. With this in mind, our recommendations were developed in collaboration with young people with experience in foster care and the organizations that serve them.

Young people who have been in foster care have consistently called for mental and behavioral health reforms that are youth-driven, supportive, gender-affirming, and culturally responsive. Our suggested reforms follow their lead because the first step in healing is establishing an environment where young people feel safe to develop trusting relationships with those who are helping them on their journey. Services and treatment must be trauma-informed, constructive, and healing. Even more importantly, we have to base our reforms in an anti-racist framework. Healing is thwarted when the behavioral health care system ignores the historical harms, present realities, unique needs, and cultural strengths of young people of color. Changes to the behavioral health care system must work against the pathologizing of non-white cultural practices, values, and familial norms. Reforms must be sensitive to the systemic oppressions that have harmed the mental and behavioral health of youth who have experienced foster care and actively remove barriers to equity at the intrapersonal, interpersonal, community, and system levels.

We have submitted detailed recommendations in response to the Committee's Request for Information in the Fall of 2021, which are attached. **Below we summarize our key recommendations.**

RECOMMENDATION 1:

Connect young people with behavioral and mental health care providers in their communities and ensure that healing is at the center of case planning and service delivery in the child welfare system.

RECOMMENDATION 2:

Ensure that young people have education, agency, and access to available behavioral and mental health services in their communities.

RECOMMENDATION 3:

End systemic racism and all forms of oppression in mental health systems by requiring training, ensuring and enforcing anti-discrimination provisions, requiring affirming practices, and supporting the provisions of services in the communities of youth and their families.

RECOMMENDATION 4:

Radically reduce the use of psychotropic medications and enhance federal and state oversight of their use for youth in the foster care system.

RECOMMENDATION 5:

Ensure that young people in and leaving foster care have access to—and that Medicaid can fund—holistic and alternative treatment other than medication and talk therapy, including specialized treatments and enrichment activities.

RECOMMENDATION 6:

Ensure that young people in and leaving foster care have access to the effective intervention of peer support as a part of the behavioral health array of services in every state.

RECOMMENDATION 7:

Ensure that behavioral health providers serving youth with experience in foster care have a caseload, the training, and expertise that allows them to provide excellent and age-appropriate services.

RECOMMENDATION 8:

Ensure and enhance the EPSDT guarantee to better promote the health and well-being of young people in and leaving foster care by (1) providing presumptive eligibility for Medicaid to all youth in foster care for all available mental health services that a youth elects to receive, (2) improving and enhancing planning and support for mental health care and Medicaid coverage when youth leave the child welfare system due to permanency or age, and (3) incentivizing specialized care coordination through the development of a national foster care enhanced case management definition that is Medicaid reimbursable.

Submitted by:

California Youth Connection

Children's Law Center of California

Children's Rights

First Focus Campaign for Children

FosterClub

Juvenile Law Center

National Foster Youth Institute

Think of Us

Youth Law Center

Youth Villages

November 1, 2021

RE: Request for Proposals to Address Unmet Mental Health Needs

Dear Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee:

The undersigned organizations are writing to submit a joint response to the Committee's September 21, 2021 request for proposals from the public about how Congress can make data-driven policy to improve health-care access for "Americans with mental health and substance use disorders." We comprise the Mental and Behavioral Health Subgroup of the Federal Older Youth Coalition, which advocates for services and support for older and former youth in foster care. We have collaborated with young people with experience in foster care and the organizations that serve them to identify federal legislative and administrative reforms.

Young people who have been in foster care have consistently called for behavioral health reforms that are youth-driven, supportive, gender-affirming, and culturally responsive. Our suggested reforms follow their lead because the first step in healing is establishing an environment where young people feel safe to develop trusting relationships with those who are helping them on their journey. Through policy papers, presentations and reports, young people with foster care experience have told us what they need from the behavioral health system and so we are proposing reforms that facilitate youth's connection to services and treatment that are trauma-informed, constructive and healing.

Comprehensive reform in the area of behavioral health care is needed to ensure that young people with experience in foster care receive the services and support they

need to heal and thrive. “Comprehensive reform” means we need to change what services and supports are offered and the frequency and timing that they are offered. Even more importantly, we have to base our reforms in an anti-racist framework. Changes to the behavioral health-care system must work against the pathologizing of non-white cultural practices, values, and familial norms. Healing is thwarted when the behavioral health-care system ignores the historical harms, present realities, unique needs, and cultural strengths of young people of color. Therefore, these reforms have to be driven by an anti-racist approach that is sensitive to the systemic oppressions that have harmed the mental and behavioral health of youth who have experienced foster care and that actively removes barriers to equity at the intrapersonal, interpersonal, community and system levels.

We believe that comprehensive reform, which is detailed in our recommendations below, must achieve the following:

- Educate young people about the impact of trauma and the range of treatment, supports, and activities that are available to them to help them cope and heal;
- Make improvements to screening and assessment that are informed by knowledge of the impact of trauma on behavior, acknowledges the trauma of removal from family, and does not result in anthologizing and labeling expected reactions to trauma;
- Provide timely connection to treatment;
- Provide timely connection with the supports that young people identify, including alternatives to traditional forms of clinical care, supports, and activities that center healing and the development of well-being; and
- Make high quality, effective treatment, supports, and interventions available at multiple intervals.

Under each of our recommendations, we have highlighted their overlap with the five areas referenced in the Request for Information: (1) Strengthening the workforce; (2) Increasing integration, coordination and access to care; (3) Ensuring parity between behavioral and physical health care; (4) Expanding the use of telehealth; (5) Improving access to behavioral health care for children and young people.[1] We have also addressed Funding, Cultural Humility, Racial Equity, and Research within several of our recommendations. We urge the Committee to ensure that all reforms advance racial equity and to elevate policies aiming to eliminate racism in the mental and behavioral health arena.

RECOMMENDATION 1:

Congress should take the following actions to connect young people with behavioral and mental health-care providers authentically and ensure that healing is at the center of case planning and service delivery.

Strengthening the Workforce

- Provide funding for grants and technical assistance to build state and local agencies’ psychosocial services capacity to ensure that transition-age youth and their parents or caregivers have access to mental health screenings and comprehensive, trauma-informed, evidence-based psychosocial services.

Increasing Integration, Coordination, and Access to Care

- Develop a plan to improve coordination among maternal and child, youth, and family programs (HRSA, ACF, etc.) and plans to integrate trauma-informed and resilience training and programming on a systematic basis.
- Develop standards of practice and highlight models of service delivery that are most effective for expectant and parenting youth.

Calls for Research

- Establish a demonstration program within the Centers on Medicaid and Medicare Services (CMS) that: Reviews research and makes recommendations on the use of non medical interventions for the treatment of trauma, the current availability of those treatments, and how they are funded.

RECOMMENDATION 2:

Congress should take the following action to ensure that young people have education, agency, and access to available behavioral and mental health services in their communities.

[1] While some of our recommendations may fall into a few of the categories in area (5), we noted the category that seemed most relevant.

Strengthening the Workforce

- Adjust reimbursement rates to better compensate and attract mental and behavioral health-care providers.

Increasing Integration, Coordination, and Access to Care

- Congress should require coordination between HHS and CMS to improve the availability of trauma-informed, evidence-based psychosocial services to transition-age youth via additional grants and technical assistance. This should include additional funding for wrap-around services to facilitate access to and receipt of behavioral health services for transition-age youth, including transportation costs, child care costs, and reimbursement for lost wages.
- Congress should ensure the availability of and accessibility to comprehensive preventative health-care services guaranteed in federal law through EPSDT for children younger than 21.

Improving Access for Children and Young People

- Congress should amend Title IV–B, Subpart 2 to include more explicit requirements around post permanency supports, including additional funding for post-adoption, guardianship and reunification services that are available until the age of 26.
- Congress should take action to allow youth exiting Adoption Assistance to apply early for SSI as an adult so that their Medicaid coverage continues during the determination period.

Calls for Research

- Congress should authorize a study on transition-age youth access to mental health services and outstanding providers that work with transition age youth that show positive outcomes on mental health services. The study should also include how youth are provided the following: information about the terms of their health insurance coverage, coverage for behavioral health services, information about how to renew their coverage, and a listing of available health-care providers in their area who will accept their coverage prior to their discharge from care.

RECOMMENDATION 3:

Congress should take the following action to end systemic racism and all forms of oppression in mental health systems.

Strengthening the Workforce by Promoting an Anti-Racist Approach

- Require that providers of behavioral health services participate in pre-service and ongoing anti-racism and trauma-informed training and collect data on the receipt of training.
- As a condition of receiving federal funds, require that all service providers follow non-discrimination policies and provide services that are culturally competent and developmentally appropriate.
- Require child welfare agencies contract with medical and behavioral health providers in sufficient numbers to reflect the racial and cultural diversity of children and youth in care, and with medical and behavioral health providers that can support transgender and gender nonconforming children and their caregivers.

Funding Reforms and Cultural Humility

- Fund research on culturally responsive evidence based mental health prevention and treatment services for children and families of color. Allow for the cultural adaptation of existing evidence based mental health service models to address the disparities and inequities for children and families of color, especially those who are Indigenous and Alaska Native, LGBTQ+ or Two-Spirit, and those that are intersectional.

RECOMMENDATION 4:

Congress should take the following actions to radically reduce the use of psychotropic medications and enhance federal and state oversight of their use for youth in the foster care system.

Increasing Integration, Coordination, and Access to Care

- Congress should increase federal oversight of states' prescription and use of psychotropic medications among children and young people in foster care and require that states' health-care coordination and oversight plans are included in a state's Title IV–E plan. States should have the following in place:

- ○ Policies to ensure meaningful informed consent and assent to psychotropic medication are obtained for each new or continuing psychotropic medication prescription, including documentation that the youth has been offered other evidence-based interventions besides psychotropic medication;
- ○ Clear guidance to caseworkers, prescribers, caregivers, biological parents, and youth on which individuals are responsible for the informed consent and assent decisions, including: the role(s) of a protective adult and pre-TPR biological parent in a informed consent; youth-friendly process(es) for refusal, complaints, and grievances by the youth; and process(es) to be heard by a neutral decision-maker in the event of conflict;
- ○ Best practices around metabolic baseline screening and monitoring prior to psychotropic medication authorization and continuance;
- ○ Access to a secondary medical review by a licensed child and/or adolescent psychiatrist for outlier or off-label prescriptions with known risks, such as those above the maximum adult dosage, prescription of multiple medications in the same class and across classes, prescription of psychotropics to children under the age of 6, and others;
- ○ An oversight process to routinely assess the safety of prescribed psychotropic medications, including an analysis of appropriate dosages, strength, necessity, generics and substitutions, and contraindications of combined medications;
- ○ A red flag or independent second opinion system with a licensed child psychiatrist;
- ○ An up-to-date medical passport containing essential information on the child, including health history, diagnoses, medications, dosages, potential side effects, and observed side effects, is delivered with the child upon placement and moves with the child from placement to placement;
- ○ Details regarding how the state will provide first-line psychosocial services, reducing over-reliance on psychotropic medications, and how it will help young people that may develop an addiction.

- Congress should also:
  - ○ Ensure that states are incorporating professional practice guidelines and that the prescription of and monitoring of psychotropic medications is done in compliance with professional practice guidelines for the state;
  - ○ Ensure that states provide an opportunity for young people to voice their wishes on whether they are prescribed psychotropic medication.

RECOMMENDATION 5:

Congress should take the following actions to ensure that young people have access to holistic and alternative treatment other than medication and talk therapy, including specialized treatments that are currently not billable to Medicaid.

Increasing Access for Children and Young People

- Develop a national peer certification protocol that will enable the expansion of peer support programs.
- Ensure that holistic and alternative treatments can be funded through Medicaid and other federal funding streams.

Funding Proposals

- Establish a demonstration program within the Centers on Medicaid and Medicare Services (CMS) that reviews research and makes recommendations on the use of non- medical interventions for the treatment of trauma, the current availability of those treatments and how they are funded.

RECOMMENDATION 6:

Congress should take the following actions to ensure that young people have access to the effective intervention of peer support as a part of the behavioral health array of services in every state.

Increasing Access for Children and Young People

- Develop a national peer certification protocol that will enable the expansion of peer support programs.
- Ensure that Medicaid and other funding streams support the delivery of outreach, treatment and ancillary support services that improve mental health and well-being by individuals with lived experience, including federal protocols for peer certification that streamline the process in the states.

RECOMMENDATION 7:

Congress should take action to ensure that behavioral health providers serving youth with experience in foster care have a caseload, the training, and expertise that allows them to provide excellent and age-appropriate services.

Funding Reforms

- Increase funding for statewide family networks currently administered through SAMHSA discretionary funds and set aside for child welfare and juvenile justice involved children.
- Increase the Medicaid reimbursement rate for behavioral health providers that are effectively able to respond to the treatment needs of young people in foster care by delivering treatments that have been identified as effective through research, are trauma sensitive, informed by a racial equity approach, and informed by the feedback of young people.

RECOMMENDATION 8:

Congress should take the following actions to preserve and enforce the EPSDT guarantee to better promote the health and well-being of young people.

Increasing Integration, Coordination, and Access to Care

- Provide presumptive eligibility for Medicaid to all youth in foster care for all available behavioral health services that a youth elects to receive.
- Congress should require all states to provide a final needs assessment if a youth wishes, to assess the mental and emotional well-being of all youth achieving permanency and/or when their case closes and ensure an adequate plan for services, including for young people who are transitioning to adulthood. In the assessment, youth should be evaluated for their mental and emotional well being to determine a plan of recommended service(s) to ensure a successful healing and growth process for youth beyond placement. States will also benefit from this assessment, as it will be a tool to address the gap in services specific to their population.
- For young people who are transitioning out of foster care to adulthood, amend the transition planning requirement of the Social Security Act to ensure that there is documentation of the following:
    - That the young person's Medicaid eligibility as a former foster youth has been established, that eligibility under another category has been established, or other health insurance coverage if the young person is not eligible for Medicaid;
    - The transition plan includes a list of behavioral health or mental health treatment providers if the young person wanted continued treatment and services.
    - That the young person with a disability or special need has been assisted in applying for any federal and state benefits that will support their care and well-being, including, but not limited to SSI, SSDI, and Home and Community Based Waivers.

Increasing Access for Children and Young People

- Develop a national foster care enhanced case management definition that is Medicaid reimbursable so that children and youth in foster care can receive improved care coordination. Conduct a study on evidence-based case management services (*i.e.,* Motivational Interviewing, Solution-Based) and provide Medicaid reimbursement.
- Mandate Medicaid coverage for all children and youth in foster care regardless of their in-state or out of state status,[2] receipt of a foster care maintenance payment or their immigration status.

Strengthen the Workforce

- Increase the Federal Match Assistance Percentage (FMAP) to 90% for all children's mental health and supportive services provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) entitlement, covering all children under the age of 21 in all states and territories.

[2] Effective January 2023, The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. 115–271) will expand Medicaid coverage for former foster youth so that all states will cover youth regardless of the state in which they were in foster care. We propose that the effective date of this vital reform be moved up to 2022.

- Apply the 90% FMAP to Medicaid Administrative Activities (MAA) related to youth behavioral health including workforce training, technical assistance, outreach and education. Gradually reduce the 90% FMAP over a 5-year period to 80%.

Submitted by:

California Youth Connection

Children's Rights

First Focus Campaign for Children

FosterClub

Juvenile Law Center

National Foster Care Institute

Think of Us

Youth Law Center

Youth Villages

For more information, please contact:

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CHILDREN NOW (CALIFORNIA) ET AL.

Elissa Hyne
On behalf of the undersigned organizational members of
the State Policy Advocacy and Reform Center (SPARC)
c/o Partnership for America's Children
5335 Wisconsin Ave., NW, Suite 440
Washington, DC, 20015

March 14, 2022

Chairman Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

Ranking Member Mike Crapo
239 Dirksen Senate Office Building
Washington, DC 20510

RE: Testimony regarding the mental health of children and youth in the foster care system for the "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care" hearing held on Tuesday, February 15, 2022

Dear Chairman Wyden and Ranking Member Crapo:

The undersigned organizations are members of the State Policy Advocacy and Reform Center (SPARC), a network of state multi-issue child advocacy organizations, legal advocates, and organizations focused on children and families involved with the child welfare system. We submit testimony to the Senate Committee on Finance regarding the hearing that took place on February 15, 2022, entitled "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care." SPARC commends the Committee for its continued attention to the mental health needs of children and youth. Children and youth involved with the child welfare system are a particularly vulnerable population and the systems and processes meant to address their mental health needs require special consideration and improvement.

On any given day there are over 400,000 children in foster care in the United States, and an estimated 80 percent of those children have significant mental health issues.[1] That is four times the incidence found in the general population (approxi-

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[1] Dore, M. (2005). "Child and adolescent mental health." In G. Mallon and P. Hess (eds.), *Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies and Programs* (148–172). New York: Columbia University Press.

mately 18 to 22 percent).[2] In fact, children in foster care and those who have aged out of foster care experience Post-Traumatic Stress Disorder (PTSD) at a rate that is double that of war veterans.[3] Children in foster care have a history of complex trauma, have experienced frequent home and life changes, have suffered the loss of family relationships, and have had inconsistent and inadequate access to mental health services. The very act of the child welfare agency removing a child from their family and home and placing them in foster care is a traumatizing experience. Given the prevalence of mental health issues in the foster care population, providing quality mental health services and care coordination is essential.

Despite the prevalence of mental health issues among the child welfare population, there is an overall lack of adequate access to mental health services. In fact, the American Academy of Pediatrics has identified mental and behavioral health as the "greatest unmet health need for children and teens in foster care." Without appropriate mental health care, children in foster care are prescribed psychotropic medications at a much higher rate than children in the general population. Some studies have found that children in foster care are prescribed psychotropic medications at a rate 3 times that of other children enrolled in Medicaid and have higher rates of polypharmacy.[4] Not only is this practice incredibly harmful to the children themselves, it costs states millions each year.

Notwithstanding the clear and compelling evidence that children and youth in foster care experience a wide array of mental health issues, the processes and systems created to meet those needs are falling short. There are multiple barriers to providing adequate and appropriate mental health care to children in foster care: incomplete or unavailable health information, difficulty identifying who has the authority to consent for health care on behalf of the child, deficient care coordination between agencies, and inadequate resources for evaluation and treatment. For example, although most children in foster care are eligible for Medicaid, many pediatric mental health care providers are unwilling to accept Medicaid patients—only approximately one third of psychiatrists accepted new Medicaid patients.[5]

The situation for children and youth in foster care has only worsened during the COVID–19 pandemic as providers have witnessed an alarming number of children and adolescents with severe mental health issues. During the hearing held on February 15, Senator Wyden stated that America's children are "on a path to crisis." In fact, children and youth in the foster care system are already experiencing that mental health crisis.

There is general acceptance that there needs to be cross-system collaboration and care coordination to ensure that behavioral health care is coordinated between Medicaid and other child-serving systems, including the child welfare system. There must be more effective psychotropic medication management for children in the foster care system, including red-flag systems and consent processes. Children in foster care need more access to appropriate and effective mental health services for children and youth up to age 26, including using Medicaid to support intensive care coordination, wraparound services, family and youth peer support, in-home services, treatment foster care, and other home and community-based services and supports. Child welfare systems must provide the required, but not always administered, periodic thorough mental health assessments and screenings for all children and youth in their care. And there must be systems in place to ensure continuity of mental health care at all points throughout the child's life: at entry into care, between placements while in care, and at exit from care (whether that be reunification, adoption, or aging out).

We commend the Senate Committee on Finance's willingness to focus on this mental health crisis for children and youth in foster care and we thank you for your consideration of our views. If you have any questions, please feel free to contact SPARC's

[2] Dore, M. (2005). "Child and adolescent mental health." In G. Mallon and P. Hess (eds.), *Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies and Programs* (148–172). New York: Columbia University Press.

[3] Casey Family Programs, *Assessing the Effects of Foster Care: Mental Health Outcomes from the Casey National Alumni Study.* Retrieved March 4, 2022 from: *http://www.casey.org/media/AlumniStudy_US_Report_MentalHealth.pdf.*

[4] Zito, J.M., Safer, D.J., Said, D., et al. (2008). "Psychotropic medication patterns among youth in foster care." *Pediatrics,* 121 (1). Available at: *www.pediatrics.org/cgi/content/full/121/1/e157[PubMed].*

[5] Holgash, K., and Heberlein, M. (2019). "Physician acceptance of new Medicaid patients: What matters and what doesn't." Retrieved March 4, 2022 from *https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/.*

Senior Child Welfare Policy Manager, Elissa Hyne at (203) 561–7212 or ehyne@foramericaschildren.org.

Sincerely,

Children Now (California)
Children's Action Alliance (Arizona)
Children's Trust of South Carolina
Florida's Children First
Foster Success (Indiana)
FosterAdopt Connect (Missouri and Kansas)
Hawai'i Children's Action Network
Juvenile Law Center (Pennsylvania)
Kansas Appleseed
Kentucky Youth Advocates
Maine Children's Alliance
Marion County Commission on Youth (MCCOY) (Indiana)
Michigan's Children
Nebraska Appleseed
Our Children Oregon
Partners for Our Children (Washington)
Pennsylvania Partnerships for Children
Rhode Island KIDS COUNT
Tennessee Voices for Children
TexProtects (Texas)
Texans Care for Children
Voices for Utah Children
Voices for Vermont's Children
Voices for Virginia's Children

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Statement of Jeanne Nightingale, MS, BSN, R.N.,
Senior Director for Psychiatry Services

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for convening two hearings on youth mental health and for the opportunity to submit a statement for the record.

As Senior Director for Psychiatry Services at Children's Health in Dallas, Texas, I oversee clinical operations related to pediatric psychiatry programs at Children's Health—including inpatient services, partial hospitalization, intensive outpatient, outpatient, consultative and research services—as well as the embedded psychological services for patients who are being treated throughout the hospital for a chronic or acute medical diagnosis. Children's Health has seen firsthand the growing crisis in pediatric mental health, which has only been compounded by COVID–19.

The pandemic has taken a toll on children, whose lives were disrupted at a critical time in their development. Children and families—especially those in underserved communities disproportionately impacted by the virus—have experienced significant social isolation, economic stress, fear and grief. These challenges have contributed to a sharp increase in the number of children with mental health concerns, including depression, anxiety, suicidal ideation, disordered eating, anger and substance use. As a result, more children and families in crisis are presenting to pediatric emergency departments without anywhere else to turn.

The Pediatric Mental Health Crisis at Children's Health

Since the start of the pandemic, Children's Health has seen a larger percentage of children in the emergency department (ED) with mental health needs than ever before. In 2021, more than 5,400 children presented to our Dallas and Plano EDs in need of mental health evaluations and services. This is a 43% increase from 2020 and a 273% increase in the past five years. Often, these children are presenting with acute mental and behavioral health needs—including aggression, intentional self-harm and suicidal ideation—that require significant resources to keep patients and staff physically safe.

In addition to the increasing number and acuity of behavioral health patients, we are also seeing these children stay in the ED longer due limited alternative placement options such as available inpatient psychiatric hospitalization and outpatient psychiatric treatment programs. North Texas lacks sufficient pediatric inpatient psychiatric beds and facilities to meet the growing need in our community. In 2021, 49% of children (1,787) seen for mental health concerns at Children's Medical Center Dallas waited in the ED for more than 8 hours, and 16% of children (583) waited for more than 24 hours. Inpatient psychiatric beds are increasingly hard to find and wait times for outpatient psychiatric programs can be weeks or months long. These

children have no better option but to board in our ED for extended periods of time while they wait for space to become available in an appropriate pediatric mental health care setting. Not only does ED boarding delay appropriate treatment and recovery for the child, but it also drains staff and resources.

Psychiatry Programs at Children's Health

Despite this broken system and limited resources, Children's Health is implementing strategies to mitigate ED volumes and ensure more children can access appropriate mental health care. Last year we launched a multifaceted response that included integrating an electronic bed search tool for inpatient placement to psychiatric facilities, as well as the launch of a mental health coordinator program to increase efficiencies in transferring patients from direct patient care to inpatient psychiatric care. Together, these initiatives decreased ED throughput times for patients with mental health chief complaints by 29% from January 2021 to year end and reduced the percentage of patients in the ED for more than 24 hours from 24% in April 2021 to 12% by year end.

Children's Health has also developed and grown unique programs and strategies to address pediatric mental health needs, including:

- **Suicide Prevention and Resilience at Children's Health (SPARC),** an innovative, nationally renowned teen suicide prevention program that aims to help teens manage intense emotions and reduce risk for self-harm and suicidal behaviors. Suicide is the second leading cause of death in adolescents. The SPARC program was developed to help adolescents who have had a recent suicidal event and need intensive care and support. It is the only program in Texas that uses a combination of teen skills group therapy, multifamily therapy, individual therapy and family therapy and is specifically designed to target the risk and protective factors associated with suicidality.
- The **Center for Pediatric Eating Disorders** at Children's Health, the nation's only pediatric program that has earned the Joint Commission's Disease-Specific Certification for eating disorders treatment. The program is a part of the Psychiatry Department, and our highly trained psychologists and psychiatrists have decades of experience treating eating disorders and other mental health issues that may play a role in a child's overall well-being. The program includes an inpatient program as well as a partial hospitalization and intensive outpatient program, designed to support the child and family throughout their journey towards recovery.
- The **Teen Recovery Program,** the only program in North Texas offering intensive outpatient care—designed just for teens—to address substance use and mental health conditions at the same time.
- The **Center for Autism and Developmental Disabilities,** which brings together experts in different specialties to provide care to children living with autism and developmental disabilities. This includes psychiatry services that help children cope with anxiety, aggression and other emotional or behavioral disorders.
- The **Children's Health School-Based Tele-Behavioral Health Program,** which connects students with licensed behavioral health specialists via telemedicine and is currently available to students in more than 250 schools across North Texas. The program expands access to behavioral health services for students experiencing common behavioral health issues such as depression, anxiety and self-esteem. Last year, Children's Health launched a new virtual reality technology that is being successfully used with students to treat their anxiety and depression in telehealth visits. Virtually reality can help teach positive coping skills and self-management techniques, such as muscle relaxation and deep breathing, to manage behavioral health issues.
- Strengthening our relationship with community behavioral health providers. Improving access to pediatric behavioral health requires hospitals and community providers work together. In 2021, Children's Health established an agreement with a community-based behavioral health care provider to reserve 40 beds for Children's Health patients. Ten of these beds are intensive beds for children who require more oversight, which is especially important as these children are often the hardest to find community placements and treatment for. Since September 1, 59% of behavioral health patients in our ED requiring inpatient psychiatric treatment have been admitted to this community provider, allowing more children to access care in an appropriate mental health setting.

Request for Robust Support to Enhance Access to Pediatric Mental Health Care

While our current programs help us meet the needs of community, Congress must act to bolster the pediatric mental health care infrastructure. Simply put, the behavioral health needs of our children will not go away, and we must invest in services and supports that promote access to pediatric mental health care. The solution must have two parts:

1. **Address the immediate need for more beds and acute care services by investing in pediatric mental health infrastructure to build capacity, and**
2. **Strengthen the continuum of care by increasing access to community-based services and intermediate levels of care, such as partial hospitalization, intensive outpatient and residential treatment programs.**

Specifically, Children's Health encourages Congress to consider bipartisan policy solutions like the Children's Mental Health Infrastructure Act (H.R. 4943, *https://www.congress.gov/117/bills/hr4943/BILLS-117hr4943ih.pdf*), which would establish a grant program for children's hospitals to expand mental health capacity, ranging from construction or modernization of facilities to other additional pediatric behavioral health services. This investment would help regions like North Texas reallocate existing resources and create new capacity to accommodate more pediatric behavioral health patients. Further, resources would be leveraged in a way that allows communities to come up with localized, flexible solutions to address shortages of beds and acute care services.

Children's Health also supports the Helping Kids Cope Act (H.R. 4944, *https://www.congress.gov/117/bills/hr4944/BILLS-117hr4944ih.pdf*), which would provide flexible funding to support a range of community-based activities including community health navigators, pediatric practice integration, telehealth, crisis response services, school-based partnerships, and workforce development. More community resources will go a long way to decompress emergency departments, address gaps in "in-between" care, and ensure children and families receive support beyond the hospital. With earlier support and improved resources, children can better avoid, navigate and recover from mental health crises.

Children's Health sincerely appreciates the committee's attention to this pressing issue. The impact of the COVID–19 pandemic on children's mental health will be felt for years to come, and it is imperative that we make the right investments now to ensure the right level of care is available for children with immediate and future behavioral health needs. This includes providing more resources for early identification and preventative care, a full continuum of acute care and stepdown services, and long-term care services with improved care coordination for our most seriously ill children. Building capacity and addressing profound gaps in the care continuum will take collaboration, and children's hospitals are ready to be a part of the solution.

About Children's Health

Children's Health is the leading pediatric health care system in North Texas and one of the largest pediatric health care providers in the nation. A private, not-for-profit organization, Children's Health is anchored by two full-service hospitals and one specialty hospital. The system includes an extensive network offering specialty, urgent, primary, virtual care and more to the children of North Texas and beyond. In addition, Children's Health is affiliated with UT Southwestern as the official pediatric teaching hospital for the medical school. This provides families with access to a world-renowned medical faculty and transformative biomedical research. For more information about Children's Health, visit *www.childrens.com.*

For more information, contact **Matt Moore,** Senior Vice President, Government and Community Relations, Children's Health at 214–456–1971 or Matt.Moore@childrens.com.

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The Children's Hospital Association (CHA), representing over 220 children's hospitals, thanks the Senate Finance Committee for holding this hearing, "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," focused on this critical issue for children, families, the pediatric health care workforce and our entire nation. We call on this committee to join us in recognizing the magnitude of the situation and advancing meaningful and transformational solutions to address it.

Children's hospitals serve as a vital safety net for all children across the country, regardless of insurance status, including those that are uninsured, underinsured and enrolled in Medicaid. Medicaid is the single largest health insurer for children in the U.S. and serves as the backbone of children's health coverage. Children account for over 40% of Medicaid enrollees, and a large portion of children served by children's hospitals are covered by the program.

The challenges facing children's mental, emotional and behavioral health are so dire that we joined the American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry in declaring a national emergency *(https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/)* in child and adolescent mental health last fall. On the same day that we declared a national emergency, we launched the Sound the Alarm for Kids initiative *(https://www.soundthealarmforkids.org/)* to raise the visibility of the children's mental health crisis and build momentum for action. The emergency for our children is broadly recognized—now we need to work together on immediate action.

We strongly encourage the committee to put forward tailored and dedicated policies and support for children to better address their emotional, mental and behavioral health needs. The current mental health system for children has been under-resourced for years and now requires significant attention by this committee. It is an historic opportunity to make a national impact for children and prevent larger and more costly problems in the long term. As the single largest payer for children, Medicaid investment, through better support for services, integrated care and consistent implementation of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, is critical to supporting children's mental health needs across the continuum and before diagnosis to prevent future and more serious problems. We ask the committee to remember that broader supports and those provided through Medicare do not reach children. There is a need in your work for focus on children's unique needs and the major programs, like Medicaid, that support much of the pediatric mental health services provided in our country.

The statistics illustrate an alarming picture for our children. Prior to the pandemic, almost half of children with mental health disorders did not receive care they needed.[1] This is not limited to one state or one community—children in states across the country face the same challenges accessing the necessary mental health care to address their needs.[2] Children's mental health conditions are common. One in five children and adolescents experience a mental health disorder in a given year,[3] and 50% of all mental illness begins before age 14.[4] For children needing treatment, it takes 11 years on average after the first symptoms appear before getting that treat-

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[1] Daniel G. Whitney and Mark D. Peterson, "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children," *JAMA Pediatrics* 173, no. 4 (2019): 389–391, doi:10.1001/jamapediatrics.2018.5399, *https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377.*

[2] *Ibid.*

[3] Centers for Disease Control and Prevention (CDC), "Key Findings: Children's Mental Health Report," March 22, 2021, *https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html*.

[4] Substance Abuse and Mental Health Services Administration (SAMHSA), "Adolescent Mental Health Service Use and Reasons for Using Services in Specialty, Educational, and General Medicaid Settings," March 5, 2016, *https://www.samhsa.gov/data/sites/default/files/report_1973/ShortReport-1973.html.*

ment.[5] Significant investments are needed now to better support and sustain the full continuum of care needed for children's mental health. These investments will significantly impact our children and our country for the better as we avoid more serious and costly outcomes later—such as suicidal ideation and death by suicide.

As reported from children's hospitals:

- Between March and October of 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.[6]
- In 2021, children's hospitals reported emergency room visits for self-injury and suicide attempts or ideation in children ages 5–18 at a 44% higher rate than during 2019.[7]
- There was also a more than 50% increase in emergency department visits for suspected suicide attempts among girls ages 12–17 in early 2021 as compared to the same period in 2019.[8]

Demand is outstripping supply causing kids in crisis to wait in children's hospital EDs for long periods of time, otherwise known as boarding. Medicaid investments in the full spectrum of pediatric mental health services are critical in making immediate strides to address the crisis end of the continuum, which is overstretched right now, and prevent emergencies in the future.

The challenges and limitations of the current mental health care system are affecting all children, but the pandemic has exacerbated and highlighted existing disparities for children of color in mental health outcomes and access to high-quality mental health care services. In 2019, the Congressional Black Caucus found that the rate of death by suicide was growing at a faster rate among black children and adolescents, and that black children were more than twice as likely to die by suicide before age 13 than their white peers.[9] Studies of Latino communities have found higher reported rates of depression symptoms and thoughts of suicide among Latino youth, but comparatively lower rates of mental health care utilization. As the Senate Finance Committee weighs recommendations to promote children's mental health and strengthen access to care, the needs of children from racial and ethnic minority communities and the added barriers they frequently face must be addressed.

Military and veteran families are also affected. Military and veteran families face additional challenges with separation from parents and caregivers, frequent moves and caregivers or parents with their own trauma and mental health pressures.

We appreciate the Senate Finance Committee's recognition of the children's mental health emergency and continuing focus on this specific population and their unique needs. As you work to develop legislative solutions, we ask you to advance the following policy priorities, which will result in improved access to mental health services for children, from promotion and prevention through needed treatments:

- **Increase Medicaid investments in pediatric mental health services to address the current crisis and better support coordination and integration of care.** Medicaid is the largest payer for behavioral health services, but there continue to be access issues. In 2018, only 54% of non-institutionalized children on Medicaid and CHIP who experienced a major depressive episode received mental health treatment.[10] According to MACPAC, "Just 35 percent of psychiatrists accepted new patients enrolled in Medicaid in 2014–2015, in contrast with 62 percent accepting new patients covered by Medicare and private

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[5] National Alliance on Mental Illness, "Mental Health Screening," accessed on November 10, 2021, *https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Screening.*

[6] CDC, "Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID–19 Pandemic—United States, January 1–October 17, 2020," *https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm,* November 13, 2020 .

[7] Children's Hospital Association (CHA), analysis of CHA PHIS database, n=38 children's hospitals.

[8] CDC, "Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID–19 Pandemic—United States, January 2019–May 2021," *https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm,* June 18, 2021.

[9] Congressional Black Caucus, "Ring the Alarm: The Crisis of Black Youth Suicide in America," December 17, 2019, *https://watsoncoleman.house.gov/imo/media/doc/full_taskforce_report.pdf.*

[10] MACPAC, Response to Senate Finance RFI on behavioral health, November 15, 2021, *https://www.macpac.gov/wp-content/uploads/2021/11/MACPAC-response-to-Senate-Finance-RFI-on-behavioral-health.pdf.*

insurance (Heberlein and Holgash 2019)."[11] We believe creating equity between what Medicaid and Medicare pay for similar services will improve access for the millions of children who rely on this program for care. Low payment rates weaken provider engagement and participation in the Medicaid program and directly relate to the mental health workforce shortages and access challenges for children. The primary care payment bump passed in 2010 was found to increase access to these services and to support continued engagement of primary care physicians.[12]

- **Direct CMS to review how EPSDT is implemented in the states to support access to prevention and early intervention services, as well as developmentally appropriate mental health services across the continuum of care, and provide guidance to states on Medicaid payment for evidence-based mental health services for children that promotes integrated care.** The EPSDT benefit is tailored to children's unique needs and provides an important opportunity to support early identification even before diagnosis. Children's hospitals report that there are significant gaps in the intermediate level of care, including intensive outpatient services and day programs, which can prevent hospitalizations and help transition children back to their homes and community after a hospitalization. We can do a better job of implementing and supporting this benefit more consistently for children to ensure they receive care as early as possible and at every point along the continuum when needed.
- **Facilitate access to mental health services through telehealth.** Throughout the COVID–19 pandemic, greater state and federal regulatory flexibilities have increased the availability and convenience of telehealth services for children and families. Psychiatry continues to rely on telehealth at a far greater rate than any other physician specialty. Congress should extend these flexibilities past the COVID–19 public health emergency, including covering audio-only services, lifting originating site restrictions and geographic limitations, and encouraging state Medicaid programs to continue telehealth coverage and payment. For children, Medicaid and private insurance are major insurers, and we ask the committee to ensure that telehealth support and flexibilities are supported across payers, in addition to Medicare, to give everyone the opportunity that telehealth provides.
- **Ensure strong implementation, oversight and proactive enforcement of the Mental Health Parity and Addiction Equity Act.** It is unacceptable that payers and plan administrators are failing to cover needed mental health and substance use disorder care by creating barriers to in-network mental health care, limited provider networks and establishing non-qualitative treatment limits not otherwise seen in medical and surgical benefits. In addition, public and private payers routinely exclude payment for mental health services provided by a primary care provider. Congress should work to remove payment barriers that hinder access to mental health services in the primary care setting.
- **Increase investments to support the recruitment, training, mentorship, retention and professional development of a diverse clinical and nonclinical pediatric workforce.** Currently, there are dire shortages of minority mental health providers, which represents an added burden on racial and ethnic minority communities who already face inequitable access to care. More dedicated support for a larger and more diverse pediatric workforce is critical to addressing children's mental health needs now and in the future. Stronger Medicaid investments supporting children's mental health services will improve engagement in the program and encourage more people to enter these fields.

At the core of a strong pediatric mental health care delivery system is a strong, interconnected network of pediatric mental health providers and supportive services that are available to deliver high-quality developmentally appropriate care. To expand and strengthen these networks at the community level, the Senate should consider H.R. 4944, the Helping Kids Cope Act of 2021 *(https://www.congress.gov/bill/117th-congress/house-bill/4944)*, bipartisan legislation that provides flexible funding for communities to support a range of child and

[11] *Ibid.*
[12] Laura Tollen, "Health Policy Brief: Medicaid Primary Care Parity," *Health Affairs,* May 15, 2015, *https://www.healthaffairs.org/do/10.1377/hpb20150511.588737/full/healthpolicybrief_137.pdf.*

adolescent-centered community-based services, as well as efforts to better integrate and coordinate across the continuum of care. It also invests in pediatric mental health workforce development for a wide array of physician and non-physician mental health professions, to ensure children's long-term access to providers and services across the continuum of care.

- **Dedicate support for the pediatric mental health system and infrastructure, which is currently woefully underfunded.** Children's hospitals recommend that lawmakers take additional actions this year to strengthen pediatric behavioral health infrastructure and improve access to care, both immediately and long term. We urge Congress to provide resources to support efforts to scale up inpatient care capacity, including costs associated with the conversion of general beds to accommodate mental health patients. There is also a vital need to increase access to alternatives to inpatient and emergency department care including step-down, partial hospitalization, intensive outpatient services and day programs. These types of programs ensure that children and adolescents continue to receive intensive services and supports they need while alleviating pressure on acute care settings. We note that bipartisan legislation has been introduced in the House, H.R. 4943, the Children's Mental Health Infrastructure Act of 2021 *(https://www.congress.gov/bill/117th-congress/house-bill/4943)*, which would provide grants to children's hospitals to increase their capacity to provide pediatric mental health services such as those described above.

Children's hospitals are eager to partner with you to advance policies that can make measurable improvements in children's lives. Please call on us and our members as you develop these important policy improvements to stem the tide of the national emergency for children's mental health. Children need your help now.

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March 1, 2022

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

RE: Testimony Submitted for "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," Hearing Held on February 15, 2022

Dear Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance,

Thank you for your interest in improving access to mental and behavioral health services for children, young people, and their families. Testimony provided during the hearings on February 8th and 15th demonstrated the urgent need to improve these services, the importance of involving young people and included ideas for improvement.

We write to you as add our voices organizations with networks of individuals with lived experience in foster care and kinship care and elevate the voices of those lived experience leaders.

The Children's Trust Fund Alliance is a national leader in promoting and supporting the voices of parents in policy and practice areas, in helping families build protective factors to gain capacity for life-long changes and in preventing parental and societal neglect of children. Its national network of state children's trust funds invests almost $300 million annually in statewide and community-based initiatives to strengthen families and protect children.

Generations United's mission is to improve the lives of children, youth, and older people through intergenerational collaboration, public policies, and programs for the enduring benefit of all. We are home to the National Center on Grandfamilies, and

our work is informed and driven by a national network of grandparents and other relatives raising children.

FosterClub is the national network for young people who experience foster care. FosterClub believes when young people have the support they need and opportunity to drive change in their life, they become self-determined and do better. We also believe when the system listens to young people, it does better.

We bring together young people, birth parents and relative caregivers to drive change within foster care. Collectively, these voices are referred to as lived experience leaders—each bringing their own experience engaging with the child welfare system.

During the February 15th hearing, Mr. Trace Terrell stated: "My peers and I believe we deserve a seat at the table. While there are many ways we can do this, it starts by ensuring young people can meaningfully contribute to and be involved with legislative work on the local, state and federal level." Our organizations agree fully and we are thankful for Chairman Wyden's, Ranking Member Crapo and the Committee Members' commitment to ensuring young people have a seat at the table as work on this critical issue continues. In addition to young people, we are asking that parents and kinship caregivers be included at the table when identifying challenges and solutions.

While the February 8th and 15th hearings were focused on protecting youth mental health, we know providing mental health support to parents and caregivers, along with young people, leads to better outcomes. Robust, quality and accessible mental and behavioral health services can lead to children and youth staying safely together with their family, rather than experiencing the trauma of entering the foster care system.

In April 2021, we asked young people, parents and relative caregivers about the support services for families that are facing mental or behavioral health challenges (including addiction). We received 80 total responses that came through with 5 key themes of recommendations. Lived experience leaders discussed the types of support services and resources that will help families who are facing mental, behavioral health and/or addiction challenges receive support, build on their strengths and stay safely out of the foster care system, wherever possible.

It is clear from the responses, that the whole family must be able to access and engage in mental and behavioral health services and supports.

The recommendations from young people, parents and caregivers are below:

1. Provide us with timely, unbiased, culturally relevant, and evidence-based prevention services that center family engagement.
2. We need rehabilitation and treatment programs that serve and support the entire family, to include caregivers, and children, when providing treatment services for mental health or substance use.
3. Create space for individuals with lived experience to serve as peer mentors and work to deliver treatment programming and services to families.
4. Connect us with trauma-informed mental health and family engagement services that address the root and systemic challenges and reasons for addiction including adverse childhood experiences and trauma.
5. Address and support our basic needs by providing services such as: housing, transportation, food, education, employment, and child care assistance.

We've selected perspectives and quotes from lived experience leaders to further demonstrate the above recommendations.

1. **Provide us with timely, unbiased, culturally relevant, and evidence-based prevention services that center family engagement.**

> Having equitable mental health services like being able to do therapy through the phone, having a daycare connected, every insurance covered or no cost at all to get help. Teaching children and parents and adults about boundaries, and how to communicate when they are disrespected.
> —Grace Gold, Former Foster Youth from New York with New York State Youth Advisory Board and BraveHearts MOVE

> Culturally appropriate services.
> —Robyn Wind-Tiger, Kinship caregiver from Oklahoma

> A parent's mental health and or behavioral health is often thought of as a weakness because of the parent's inability to receive the appropriate care.

The child welfare system and or child protection does not realize the difficulty that families have to try to receive the health care benefits to begin to access services. In addition, are the services located in the community in which they live? Are the services family-friendly allowing for the consideration of holistic treatment which considers the entire family and is culturally sensitive? Child welfare/child protection [can] help expedite services with the family without judgment and when parent/parents cannot do homework with the family to establish a care plan specifically for their family. It's important for the caseworker, child welfare/child protection to know what's available in the community and how to tap into those resources in a way that families that may not have access to. Understanding the wait list and the lack of appropriate services in all communities. Most importantly acknowledge the strength of the family that may not be like your family or any other family but unique family strengths to their culture and environment.
—Sandra Killett from New York with We All Rise and The Alliance

2. We need rehabilitation and treatment programs that serve and support the entire family, to include caregivers, and children, when providing treatment services for mental health or substance use.

Preventative resources that could support families staying together could be youth and parent peers and mentors with lived experience who can illuminate hope, offer support and connect a parent or youth to other resources and model recovery. Also, support groups and community volunteer programs that focus on prevention and support keeping families together. One example of a good model is Safe Families whose focus is to prevent children from entering into the foster care system and another great model program for support is the Parents Anonymous support groups.
—Leanne Walsh, Birth parent from Oregon with Oregon Parent Advisory Council

As a former foster child of a mother who struggled with substance addiction, my siblings and I were separated and placed in different foster homes at an early age. This was devastating for the entire family. I believe it could have been avoided if support services would have included rehabilitation services for my mother and an in-home caregiver (with temporary conservatorship) for my siblings and me vs. foster care. Perhaps counseling services for the entire family as well."
—Lorna Jackie Wilson, Former Foster Youth from Michigan

From my personal experience, I didn't have enough support and that is why some of my children went into foster care and some went to kinship care. I truly believe that if we had more facilities that welcome both mom and dad to get treatment while children remain with them in the facility would help with the prevention of going into care, but the root is truly more support. Some families don't have relatives or people that would want to help out during a crisis and the unfortunate event is entering foster care.
—Pasqueal Nguyen, Birth parent from Louisiana with The Extra Mile and Youth Law Center

3. Create space for individuals with lived experience to serve as peer mentors and work to deliver treatment programming and services to families.

Working with a Certified Peer Support Specialist (someone with lived experience with addiction/mental health) or a Family Partner (someone with lived experience in child welfare). Access to MAT-Medication-Assisted Treatment for Substance Misuse.
—Kelly Kirk, Birth parent from North Carolina with Sandhills Opioid Response Consortium, NC DHHS Child Welfare Family Advisory Council, Drug Free Moore County, Richmond County DSS, Richmond County—DEFT (Drug Endangered Families Task Force)

I think support groups would help a parent's mental health, I think that if they had a group they would be able to share their thoughts vs. having to go through struggling with inside problems alone.
—Former Foster Youth from South Carolina

For African American families, education and awareness campaigns run by grassroots trustworthy organizations to decrease the stigma of mental health and provide resources,[including] access to culturally relevant men-

tal health services. Anything that encourages early awareness of problems and a safe place for caregivers to share and explore options would help. This is such a HUGE problem in communities of color and progress in this area would definitely benefit the welfare of our families.
—Melodye James, Kinship caregiver from Ohio with Restored Vision

4. **Connect us with trauma-informed mental health and family engagement services that address the root and systemic challenges and reasons for addiction including adverse childhood experiences and trauma.**

A trauma-informed therapist would have helped me process what I went through and aided my dad's understanding of my behavior and how to properly support me.
—Zoe Jones-Walton, former foster youth, Texas, FosterClub

When there are not affordable centers to treat and give mental therapy, people don't go. We all know addiction and mental health issues go hand in hand, but when there is no access . . . they continue on their journey with drugs.
—Terri, Kinship caregiver from Alabama

As a former foster youth who aged out of care and as a parent who returned to the system and accused of having undiagnosed mental health issues, and the biases that it brings is heartbreaking. It would have been helpful to receive dialectical behavioral therapy or cognitive processing therapy as a mechanism to help revert the issues they were bringing me in for and remove my children as a consequence of something I didn't have.
—Ashley Alber, current foster youth from Washington with Washington State Parent Ally Committee

5. **Address and support our basic needs by providing services such as: housing, transportation, food, education, employment, and child care assistance.**

Extended family and friends should be considered as resources with funding being provided to aid them in keeping the family together.
—Marquetta King, foster/adoptive parent, Maryland, Treatment Foster Care Parent Advisory Board, Arc Northern Chesapeake; Together as Adoptive Parents

Such resources as therapy, skills training, transportation assistance, food assistance, housing assistance can make a big change in a family's life. Prevention and Education are key to helping families stay out of the system.
—Isabel, Birth parent from Arizona

I went into foster care for the first time when I was 11, it was due to my mother's addiction to methamphetamine. I think being able to provide an adequate amount of support for the parent, whether it be resources in the community or even a government stipend for the right treatment would help immensely. Most parents feel as if they are fighting this battle on their own and I think helping them realize they aren't would be incredible for them and the reunification process.
—Charles Lewis, Former Foster Youth from Indiana

Our organizations are pleased to share these priorities with the Committee as you continue looking at how to improve mental health supports for young people and their families. If you would like to discuss further, please contact Binley Taylor, System Change Director at FosterClub, 503–717–1552 or systemchange@fosterclub.com, Jaia Lent, Deputy Executive Director at Generations United, 202–777–0115 or jlent@gu.org and Teresa Rafael, Executive Director at Children's Trust Fund Alliance, 206–650–5317 or teresa.rafael@ctfalliance.org.

Sincerely,

Children's Trust Fund Alliance

Generations United

FosterClub

CITIZENS COMMISSION ON HUMAN RIGHTS
1701 20th Street, NW
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Statement of Anne Goedeke, Executive Director

The Citizens Commission on Human Rights (CCHR) recognizes that children have faced unprecedented and stressful disruptions in their lives during the pandemic. However, we have a serious concern, supported by substantial research, that increased screening of children and at earlier ages, as now called for by mental health providers, will result in many more children being inaccurately diagnosed with mental disorders and further escalate the number of American children prescribed powerful psychotropic drugs, putting them at risk of serious physical and psychological side effects.

Research studies have found mental health screening is ineffective and potentially harmful to children.

Allen Frances, M.D., a psychiatrist and Professor and Chairman Emeritus of the Department of Psychiatry and Behavioral Sciences at Duke University School of Medicine, chaired the task force on the 4th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders.*

Writing in *The Wall Street Journal* in 2016, Dr. Frances stated: "Screening for depression is one of those ideas that is terrific in theory but terrible in practice. Proponents see only the potential benefits and remain blind to the many risks. They imagine an ideal world in which troubled teens are accurately identified as depressed or pre-depressed and receive just-in-time care that reduces the burden of illness and the risk of suicide. They fail to imagine the many limitations and unintended consequences that make testing much more harmful than helpful."

Dr. Frances stated that no screening method can differentiate between the sadness which is very common in teens, and clinical depression requiring treatment. He says that teens are "especially tough to diagnose" because their symptoms are fluid and highly responsive in the short run to pressure from family, friends and school. He warns that "mislabeling a teen as mentally ill changes the way they see themselves and can ruin their lives." He further notes that "medical efficacy in adolescence is questionable and medications may increase the risk of agitation, impulsivity, suicide and/or violent behavior."

The late Karen Effrem, M.D., a well-known pediatrician and researcher, found that increased screening results in the increased psychiatric drugging of children and adolescents, with significant evidence of harmful, even life-threatening side effects, including suicide, violence, psychosis, hallucinations, diabetes, and movement disorders.

A study by researchers at McGill University, published in 2016 in the *Canadian Journal of Psychiatry,* found after an exhaustive search of medical literature that there was not a single screening tool with even moderate evidence of sufficient accuracy to effectively identify depressed children and adolescents without also mistakenly identifying many non-depressed children and adolescents. They noted that screening leads to the unnecessary prescribing of potentially harmful psychiatric drugs, as well as giving negative messages about their mental health to children who do not have mental health disorders.

That was precisely the case from 1999 to 2012, when an untold number of adolescents were screened for depression using the TeenScreen questionnaire. The screening tool was widely promoted and utilized, even though psychiatrist David Shaffer, M.D., who led the Columbia University team that developed TeenScreen, admitted the screening tool would result in 84 non-suicidal teens being referred for further psychiatric evaluation for every 16 youths correctly identified—a staggering number of false positives. CCHR was instrumental in ending the use of TeenScreen.

Further confirming the lack of evidence of effectiveness in screening, research published in 2017 in *BMC Medicine* found there have been no randomized, controlled trials, considered the gold standard for research, with any direct evidence of improved health or other beneficial outcomes from depression screening.

The United Kingdom National Screening Committee and the Canadian Task Force on Preventive Health Care recommended against all questionnaire-based screening because of the lack of direct evidence of benefit and the potential harm to patients and waste of resources. The U.S. Preventive Services Task Force did recommend

screening of adolescents ages 12 and older, but "with adequate systems in place to ensure accurate diagnosis."

However, accuracy in psychiatric diagnoses cannot be ensured. A fundamental flaw in the present-day field of mental health is that there are no objective, scientific diagnoses of psychiatric conditions, as there are in physical medicine, a fact which was acknowledged by the former director of the National Institute of Mental Health, Thomas Insel, M.D.

Therefore, what constitutes a child's "elevated symptoms" requiring treatment is entirely subjective—and can vary from one provider to the next. There is no consistency and no valid standards in the determination of a psychiatric diagnosis and, therefore, no accuracy.

The result of this subjectivity in diagnosing is reflected in the ever-growing number of children and adolescents estimated by mental health providers to need mental health treatment.

CCHR has long recommended that before any rush to judgment about a child having a mental disorder, the child should receive a complete physical exam with laboratory tests to discover any undiagnosed physical condition—illness, infection, injury or other condition—that could account for the child's behavioral symptoms. If found and corrected, this spares the child from being inappropriately labeled and treated for a psychiatric condition the child does not have.

CCHR further recommends the child should be checked for allergies, food intolerances, nutritional deficiencies, and environmental toxins, which are all known to cause behavioral symptoms. A recent study published in *JAMA Pediatrics* found that of the 1.1 million American children tested for lead, 50.5% have detectable levels of lead in their blood. Even the lowest levels of lead in children can cause irritability and nervous system damage.

The diagnosis of a psychiatric condition in a child with a behavioral problem in school often overlooks the fact that the child's educational needs are not being met, resulting in unwanted classroom behavior. This applies both to children falling behind in their studies and children bored because they are not sufficiently challenged. Screening the child for a mental disorder is the wrong approach. Applying correct educational solutions would prevent children from being diagnosed with ADHD and prescribed stimulant drugs.

As Mary Ann Block, M.D., author of *No More ADHD,* has stated, "By taking a thorough history and giving these children a complete physical exam as well as doing lab tests and allergy testing, I have consistently found that these children do not have ADHD, but instead have allergies, dietary problems, nutritional deficiencies, thyroid problems and learning difficulties that are causing their symptoms. All of these medical and educational problems can be treated, allowing the child to be successful, without being drugged."

In 2020, some 6.2 million American children ages 0 to 17—roughly one in 12—were prescribed psychiatric drugs, including antidepressants, antipsychotics, antianxiety drugs and ADHD drugs, according to IQVia, a healthcare data source. This includes 418,000 youngsters 0 to 5 years old. These troubling numbers of drugged youth could dramatically increase with even more widespread screening.

Of note, the number of children and adolescents taking psychiatric drugs has decreased by 8% since 2017. This may reflect a growing awareness on the part of parents and others of both the ineffectiveness and the unwanted side effects of these drugs, which may have led to their refusal to consider giving them to children. The CCHR psychiatric drugs side effect search engine currently lists some 300 warnings from international drug regulatory agencies and research studies on the adverse effects of psychiatric drugs for children 0 to 17 years old.

Half of these warnings pertain to antidepressants' adverse effects on children, especially suicide and aggressive behavior. The FDA's most serious black box warning is required on the labels of antidepressants, advising they can cause suicidal thoughts and actions in children and young adults. Nearly 2.2 million children and adolescents ages 0 to 17 are currently taking antidepressants, 35,000 of them during the tender ages of 0 to 5.

Researchers led by professor of psychology Glen I. Spielmans, Ph.D., analyzed data from antidepressant clinical trials for a study, published in *Frontiers in Psychiatry* in 2020, that concluded, "Increasing antidepressant prescriptions are related to

more youth suicide attempts and more completed suicides among American children and adolescents.”

In 2017, researchers Martin Plöderl, Ph.D., a clinical psychologist, and Michael P. Hengartner, Ph.D., a senior researcher and lecturer in clinical psychology and psychopathology, concluded: “If you look at the past 10 years, antidepressant rates are associated with increased suicide rates,” adding that antidepressants “most likely cause suicidal behavior in young people” and that the “data strongly suggest that antidepressants can cause suicides and aggressive behavior.”

A study from the Nordic Cochrane Centre and the University of Copenhagen published in the British medical journal, *The BMJ,* in 2016 also concluded that antidepressants are linked to suicide and aggression in teens and that “children and young people are more likely to think about or attempt suicide while taking antidepressants.”

Peter Breggin, M.D., a Harvard-trained psychiatrist and former consultant to the National Institute of Mental Health, describes antidepressants as neurotoxins because they harm and disrupt the functions of the brain, causing abnormal thinking and behaviors that include anxiety, irritability, hostility, aggressiveness, loss of judgment, impulsivity and mania, which can lead to violence and suicide. He says that the harmful mental and behavioral effects of antidepressants are especially prevalent and severe in children and adolescents.

In draft guidance published in November, the London-based National Institute for Health and Care Excellence advised that antidepressant drugs should not be considered first-line treatment for any patients. Instead, those with depression should be offered and able to choose from a variety of treatment options, including non-drug options. CCHR supports this shift in thinking to non-drug solutions to children’s emotional problems.

Another 829,000 children ages 0 to 17 are prescribed antipsychotic drugs, 31,000 of them age 0 to 5 years, for ADHD, aggression, mood swings, and conduct problems. The CCHR psychiatric drugs side effect search engine currently lists 42 research studies and 13 drug regulatory agency warnings about adverse effects of antipsychotic drugs for children and adolescents. Among the many adverse effects, the drugs are widely known to cause weight gain, diabetes, cardiovascular problems, and the risk of sudden death.

A study published in *JAMA Psychiatry* in 2018 found that children and teens taking higher doses of antipsychotics were 1.8 times more likely to die for any reason, 3.5 times more likely to die unexpectedly (excluding overdose), and 4.29 times more likely to die from cardiovascular or metabolic problems.

Antipsychotic drugs have long been linked with akathisia, a state of restlessness and agitation that can induce suicidality or violence in children. David Healy, M.D., a psychiatrist and professor of psychopharmacology, stated in a 2009 interview for a blog on the Psychology Today website that antipsychotics are universally recognized as causing akathisia and that akathisia is recognized as increasing the risk of suicidality and violence. He stated that since the introduction of antipsychotics, the rates of suicide have risen 10- or 20-fold.

The drugs are also known to cause the devastating neurological damage called tardive dyskinesia, an involuntary jerkiness of the face, tongue, torso and limbs that can be disabling and permanent and may also lead to suicide.

An analysis of those aged 10–18 found that antipsychotic drug use was associated with a 50% increase in the risk of developing type 2 diabetes. This was higher for youth who used antidepressants and antipsychotics concurrently.

For all the risk to children of psychiatric drugs, research studies show the drugs may be largely ineffective and do more harm than good.

In a study recently published in *The BMJ Drug and Therapeutics Bulletin,* researchers reviewed meta-analyses of studies of newer generation SSRI and SNRI antidepressants. They found no clinically significant difference in measures of depression symptoms between children and adolescents treated and not treated with antidepressants. They noted that published accounts of clinical studies involving adolescents exaggerated benefits and understated adverse events, such as by coding suicide attempts as “mood swings.”

In a 2018 study published in *Frontiers in Psychiatry,* Michael P. Hengartner, Ph.D., a senior researcher and lecturer in clinical psychology and psychopathology, con-

cluded after thoroughly examining the medical literature that antidepressants are largely ineffective and potentially harmful.

Researchers led by Paul W. Andrews, Ph.D., a professor psychology and evolutionary biologist, analyzed previous studies to determine the overall physical impact on the human body of antidepressants that target serotonin. Serotonin regulates emotion, development, nerve cells, attention, electrolyte balance and reproduction. The study, published in *Frontiers in Psychology* in 2012 found that antidepressants generally do more harm than good by disrupting a number of adaptive processes regulated by serotonin.

Jose Luis Turabian, M.D., Ph.D., reviewed the medical literature and concluded in a study, published in 2021 in the *Journal of Addictive Disorders and Mental Health,* that psychiatric drugs can lead to a structural remodeling of the brain that adversely affects emotions and other aspects of mental function and may become irreversible. He says that the drugs block the expression of feelings, affect the problem-solving process, and make the person passive.

Decades of increasing mental health screening and the drugging of children with mind-altering psychotropic drugs has done nothing to reduce the rate of child and adolescent suicide, reduce school violence, or improve students' educational performance, but has exposed children to substantial harm.

There are global concerns about a growing dependency upon a biological approach to treating mental health issues. In 2017, Dainius Pūras, the United Nations Special Rapporteur on the right to physical and mental health, reported: "There is now unequivocal evidence of the failures of a system that relies too heavily on the biomedical model of mental health services, including the front-line and excessive use of psychotropic medicines, and yet these models persist."

A 2020 report from the World Health Organization (WHO) criticizes the mental health field's "entrenched overreliance on the biomedical model in which the predominant focus of care is on diagnosis, medication and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human rights-based approach."

The WHO calls for holistic mental health services to replace today's narrow focus on the diagnosis and drugging of individuals to suppress symptoms, a mental health approach that results in "an over-diagnosis of human distress and over-reliance on psychotropic drugs."

CCHR's co-founder, the late Thomas M. Szasz, M.D., a professor of psychiatry and humanitarian recognized by many academics as modern psychiatry's most authoritative critic, wrote: "Labeling a child as mentally ill is stigmatization, not diagnosis. Giving a child a psychiatric drug is poisoning, not treatment."

CCHR advocates against mental health screening, which experts have proven does not reduce the burden of mental health issues or the risk of suicide in children and teens, but does lead to mislabeling normal children and prescribing them psychiatric drugs that are harmful to them.

CCHR advocates that children experiencing emotional difficulties should be given a complete physical exam with lab tests to discover any underlying physical cause for their behavioral symptoms, and that parents be made aware of the importance of proper sleep, nutrition, and exercise for their children's mental health. It advocates for proper educational solutions to be used for children's problems in school. It advocates for the full disclosure of the risks of serious side effects when taking and withdrawing from psychiatric drugs, so that parents can make fully informed decisions about the use of these drugs for their children.

CCHR supports evidence-based, non-drug and educational solutions for youth mental health issues and public funding directed to programs utilizing those solutions, handling the underlying causes of children's behavioral problems instead of compounding their problems with psychiatric labels and drugs that are proving to do more harm than good.

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Statement of Dr. Mary Dale Peterson

Chairman Wyden, Ranking member Crapo and members of the Senate Finance Committee, my name is Dr. Mary Dale Peterson and I am the Executive Vice President and Chief Operating Officer for the Driscoll Health System (Driscoll), which comprises Driscoll Children's Hospital, Driscoll Health Plan (DHP), physician practices, clinics, and specialty centers. We serve over 31 counties in South Texas, which is roughly the size of Senator Scott's State of South Carolina. We would like to thank Senator Cornyn for his continued leadership in South Texas. He visited our hospital back in February 2020 to promote his vaping legislation and we support his and the Committee's commitment to strengthen pediatric behavioral health's infrastructure, personnel, and services. He also cosponsored legislation (S. 1798, called the TIKES Act) allowing the pediatric workforce to identify and break down barriers in using telemedicine and telehealth, so we understand and support his passion for the issue. Driscoll welcomes working with the Committee in addressing complex behavioral and mental health issues that impact service delivery in our service region. We submit comments in support of the Committee identifying critical issues, but more importantly, we respectfully request a commitment in funding to address barriers of care for children's hospitals.

The Driscoll Way

Historically, the inequalities along the Texas-Mexico border in healthcare are prevalent and COVID–19 exposed new challenges. Poverty in South Texas exacerbates healthcare inequities by limiting access to transportation, Internet, and food. Additionally, retention and recruitment of pediatric physicians, nurses and medical support personnel is challenging. Despite these barriers to care, in 2020 Driscoll provided $126.6 million in community benefits for South Texas and provided 93% of pediatric, in-patient care in the Rio Grande Valley, the most southern portion of our services area. Additionally, our health plan, a Medicaid Care Organization, covers over 220,000 children and families with many value added services.

Our commitment to our service area is so strong that Driscoll is building the only designated, freestanding children's hospital in the Rio Grande Valley and want to invite the Senate Finance Committee to visit the new hospital when completed. Without Driscoll's commitment to the US-Mexico border, the region would experience significant delays in preventative pediatric care that would cost the State of Texas massively. In 2020, Driscoll flew over 600 flights to the region with pediatric subspecialists who provided over 40,000 clinic visits. If Driscoll did not transport this care or build infrastructure and cover these costs, pediatric services would be limited or unavailable in these communities. We call our commitment to ensure all children remain well the "Driscoll Way."

Pandemic's Impact on Behavior Health in South Texas

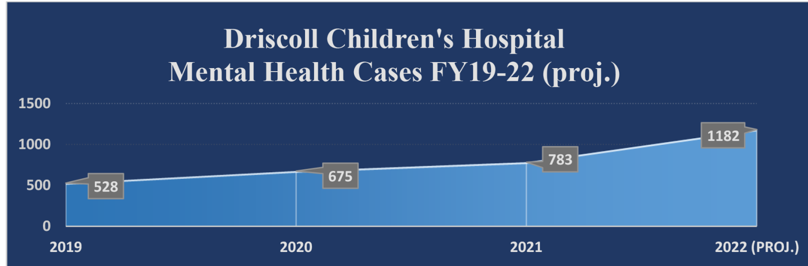
From Driscoll's perspective, evaluation, stabilization, case management, inpatient discharge, and transport process is complicated further by COVID–19. Our Emergency Department (ED) requires more space capacity to ensure that injured and sick children do not impede children presenting with mental health issues. Additionally, children and adolescents with mental health issues require additional separate, safe spaces that are age appropriate. As experienced before and during the COVID–19 pandemic, recruiting and retaining mental health professionals continues to be an issue in South Texas. These professionals are needed to ensure adequate staffing for children suffering from extreme emotional or mental distress. When Driscoll completes its assessment and medical clearance approved, locating safe transport for a child to a local mental health facility from our facility is currently not available in South Texas. It is important to note a child may have to travel hundreds of miles to an inpatient behavioral health facility in South Texas, further complicating the needed family interactions in the care plan and discharge.

Driscoll Mental and Behavioral Health Data

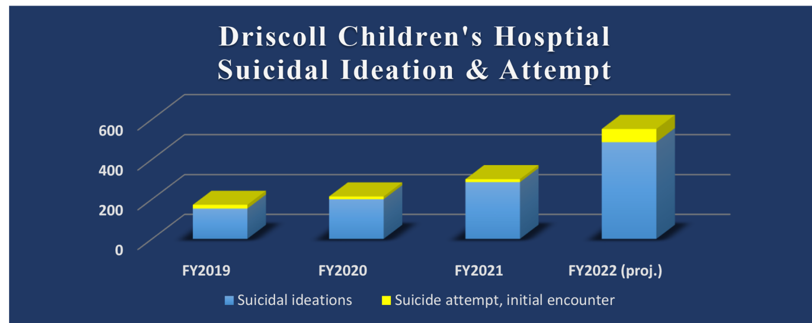
In 2021, Driscoll had 652 ED visits, 100 observations, and 43 admissions (including 20 in the ICU) for medical stabilization of behavioral health patients.We have transferred 428 patients to psychiatric facilities, about 155 of those hundreds of miles away. Average length of stay in the ED is about 7 hours with some difficult placements up to 26 hrs. Most of these patients require a 1:1 staffing ratio throughout

their stays, which is quite challenging in our current labor shortage environment. When looking at year over year data, the ED visits are slightly down but the acuity is significantly up, as evidenced by the 80 patient increase in transfers to psychiatric facilities.

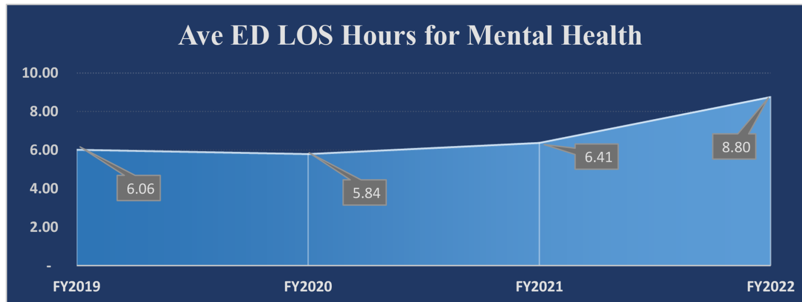
Additionally, mental health cases grew at Driscoll by 48% from FY2019 thru FY2021. FY 2022 is on target to increase another 51% over FY2020.



In just the first two months of FY2022, Driscoll already accumulated 73% of the suicide attempts experienced in FY2021, and on track for a 70% increase in suicidal ideation for the same period.



Mental health patients ED length of stay times are increasing.



Recommendations

Driscoll recommends the Committee study the feasibility and funding for the following items:

- Additional **funding for children's hospitals for construction and expansion** of sites for pediatric mental health services, digital infrastructure such as telehealth, and conversion of existing beds used for non-mental health care.

  - We recommend continuing to fund Internet infrastructure development in rural and economically disadvantaged areas, similar to South Texas, is critical to improve children's access to telehealth and mental health professionals.
- Additional **funding to support workforce initiatives for children's hospitals** to support and improve training, retention, and recruiting their mental health workforce.
  - We recommend incentivizing community partnerships between children's hospitals and higher education programs that improve the number of pediatric and family counselors, pediatric social workers, care coordinators, child and adolescent psychiatrists, and other support professionals.
  - Full and rapid tuition reimbursement for programs that place professionals directly in communities of need like South Texas. Develop stipends that children's hospitals can utilize for relocation costs, continued education and training.
- Additional **funding to fill in the gaps in the continuum of care** which include early intervention, detention through crisis intervention and stabilization, safe transportation between facilities, and improved case management that follows the child to adolescent to adulthood.
  - We recommend funding transportation partnerships in rural communities. In many communities with limited resources, a child and their family have no support after discharge.
  - Long distances between a child's home and facilities prevents the child from seeking care if reliable transport is not available. COVID complicates this transport further.
- Additional **funding for mobile mental health clinics** that travel to rural areas so that professionals and support personnel can go out to the community.

Conclusion

The COVID–19 pandemic's impact on the mental health of children is difficult to assess. The pandemic compromised children's mental health as they lost loved ones suddenly, were forced into isolation as schools went virtual, and ongoing family violence and abuse went unreported. Further, before the pandemic, modern anxieties such as social media bullying and school violence plagued children and adolescents. Now add the complexities and awkwardness of simply growing up, the need to assist children's mental health is overdue. Because of these external factors, children's hospitals require adequate funding and resources to support early intervention, physical and IT infrastructure capacity, and filling in the gaps of the continuum of care to ensure children do not fall through the cracks. As illustrated in the data provided from Driscoll in my testimony, we have cause for concern.

The U.S. Senate now has the opportunity to develop a solution that assists all partners of care—children's hospitals, mental and behavior health professionals, school districts, juvenile services, and other community stakeholders. It is unfortunate that it took a pandemic to shed light on the long-standing void in youth mental health services, but getting it right now is critical and COVID–19 offers us an opportunity to reset. The fact is we may never know the impact COVID–19 has on our children's mental health, but they were struggling well before the pandemic. We need to act quickly to alleviate this mental health crisis in children. Driscoll is ready to work with the Senate Finance Committee on solutions to erode barriers and improve how children's hospitals around the nation can better serve the communities they call home.

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Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance, we thank you for the opportunity to submit this statement for the record. First Focus on Children is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions.

Our country is facing a youth mental health crisis, and the COVID–19 pandemic has only sharpened the lens on an existing issue. Even before the pandemic, 13–

20% of children under the age of 18[1] experienced a mental disorder, and the suicide rate among youth aged 10 to 24 has increased nearly 60%[2] since 2007. The issue has only worsened due to the pandemic. In the first 6 months of 2021, children's hospitals reported a 45% increase[3] in the number of cases of self-injury and suicide in children ages 5 to 17 compared to the first 6 months of 2019. While children from all backgrounds have been impacted by mental health challenges during the pandemic, children of racial and ethnic minorities are disproportionately impacted.

Unfortunately, demand for services has gone up, but there is a severe lack of resources available to children and teens. Currently, there are 10 child psychiatrists per 100,000 kids; it is estimated that we need 47 per 100,000[4] to address the current crisis. Many parents, regardless of whether they have private insurance or are covered through Medicaid, are not able to find providers for their children because insurance networks are limited and there is a severe workforce shortage. These issues must be addressed to get our children the care they need.

In addition to school closures and isolation, the COVID–19 pandemic has caused 175,000 children and youth[5] in this country to lose a primary caregiver, exacerbating the mental health crisis even further and disproportionately impacting children of racial and ethnic minorities.

In December 2021, the Surgeon General issued a report[6] on youth mental health, citing the alarming increases in the prevalence of mental health challenges. We appreciated his powerful testimony at the February 2022 hearing before this Committee, in which he outlined what steps need to be taken to address this crisis for our children.

Below are a few of our recommendations to address the youth mental health crisis in America.

Expand and Improve the Mental Health Workforce

Demand for mental health services has gone up dramatically, but there is a severe lack of providers to meet this increased need. The federal government should bolster training programs for providers in children's mental health. Currently, the government spends $15 billion[7] on health care workforce development but only 1% of that is spent on children's mental health workforce development.

Some ideas to address the workforce shortage include:

- Expand loan repayment programs, access to scholarships, and training programs for mental health professionals committed to practicing in rural and other underserved communities.
- Raise the Medicaid reimbursement rate for mental health providers.
- Integrate mental health services with primary care.
- Encourage young people to consider the mental health profession as a career to expand the pipeline of behavioral health providers.

Invest in Community-Based Mental Health Services

Children need improved and increased access to community-based mental health services. These are often more appropriate and effective for children and youth than in-patient care, and they are less expensive. The Certified Community Behavioral Health Clinics (CCBHCs) model is an example of a program that increases access to comprehensive mental health and substance use disorder services for populations including children. This model encourages collaboration between social service systems and school-based settings, reaching children where they are. Making mental health services as accessible as possible is vital to decreasing the stigma attached to these services and allowing children to continue living their lives in their communities, with their families.

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[1] *https://www.cdc.gov/childrensmentalhealth/basics.html.*

[2] *https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr-69-11-508.pdf.*

[3] *https://www.soundthealarmforkids.org/a-national-emergency/.*

[4] *https://pubmed.ncbi.nlm.nih.gov/31685696/.*

[5] *https://publications.aap.org/pediatrics/article/148/6/e2021053760/183446/COVID–19-Associated-Orphanhood-and-Caregiver-Death?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000.*

[6] *https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

[7] *https://www.gao.gov/products/gao-18-240#:~:text=Federal%20agencies%20and%20state%20Medicaid,Medicaid%20agencies%20spent%20%252$15%20billion%20annually.*

Invest in School-Based Mental Health Models to Meet Children Where They Are

School-based mental health models are an extremely effective way to deliver mental health services to children. However, such programs vary across states and many schools are underfunded and understaffed. These programs need additional investments and support to ensure they are reaching all children who need help.

Schools should provide a continuum of supports to meet student mental health needs, including evidence based prevention practices and trauma-informed mental health care. Tiered supports should include coordination mechanisms to ensure students get the right care at the right time.

The school-based mental health workforce needs to be expanded. This can be done through the sustained use of local, state, and federal funds to hire and train additional staff, such as school counselors, nurses, social workers, and school psychologists, including dedicated staff to support students with disabilities.

School districts should be encouraged to access Medicaid funding for health and mental health services. The Centers for Medicare and Medicaid should update guidance to states that will enable them to equitably access Medicaid reimbursement and require Medicaid to simplify the billing process for schools to ensure access and decrease the money spent on administration expenses.

Mental health needs to be fully integrated into our education system. Social and emotional learning should be integrated into K–12 curriculums, and discussions on mental health should be included in health discussions the way schools currently do for nutrition, exercise, cancer prevention, and other physical health topics.

Ensure All Children Have Access to High-Quality and Affordable Mental Health Care by Addressing Parity

By law, children (whether on Medicaid or covered by private insurance) are entitled to preventive services which include mental health diagnosis, prevention and treatment but they are often not receiving services because these laws are not being strongly enforced. Therefore, millions of children are falling through the cracks and unable to receive the care they need. On average, nearly 11 years lapse between the presentation of mental health disorders and the professional diagnosis of symptoms. We are failing our children when we force them to wait on average 11 years for treatment.

Three laws are important to the improvement of our mental health system for children. The Social Security Amendments of 1967 included provisions to ensure that early and periodic screening, diagnostic, and treatment services (EPSDT) are available to children in Medicaid. Over forty years later, the Affordable Care Act (ACA) defined "essential health benefits" for children as mental health, preventive care and pediatric care, as well as requirements to ensure the adequacy of provider networks to offer those services. For children covered by private health insurance, these provisions guarantee access to a relatively similar scope of preventive services as EPSDT under Medicaid. Finally, the passage of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) promotes equal access to treatment for mental health and substance abuse disorders by prohibiting coverage limitations that apply more restrictively for mental health and substance abuse than for medical and surgical benefits.

The high rates of depression, anxiety and suicides are a result of these laws not being enforced, a lack of investment in the mental health workforce and the failure of our school systems to provide more support to children with mental health needs. Together, these laws provide the framework for a more comprehensive and equitable system. We have the right laws, we simply need to implement and enforce them.

Network adequacy is a critical piece to the mental health continuum of care. It is important to all children to have access to a range of services from qualified providers in a geographic area—whether the children are on Medicaid or have private health insurance. Without adequate networks, parents may not be able to find providers who accept Medicaid or their particular type of private insurance. Oftentimes, once a provider is identified, wait lists can be one to four months which is not acceptable when a crisis occurs for a child, teen or adolescent. Or, parents with Medicaid may only be able to find in-patient care for their children when research suggests that in most cases, community-based care delivers better outcomes. Those parents with private insurance might find a "provider network list" but cannot find anyone in their geographic area, or the list might only have a few names on it, or the providers may not be taking new patients, or lists may be outdated—all of

which can lead to roadblocks and barriers to finding viable provider options for their children.

Improve Crisis Response Services

We have seen the numbers of children in mental health crises increase dramatically in recent years, and we must ensure that these children and youth are able to access services when and where they need them.

This year, states must implement the new 988 behavioral health crisis response system. This should be a more responsive crisis system that avoids unnecessary and often harmful interventions such as a police presence and visits to emergency rooms. This approach is especially important for children and youth and for achieving equity in mental health. These crisis systems must address the special needs of children, youth, and young adults as well as be culturally competent and able to help populations including LBGTQ youth.

One helpful tool in responding to mental health crises for children and youth in appropriate and accessible ways is the mobile crisis response unit. Several states, including Oregon,[8] are implementing mobile crisis response systems that increase equity and accessibility for children and youth in addressing their mental health needs, and these should be incorporated into states' implementation of the new 988 number.

Address the Needs of Children Who Have Lost Caregivers Due to COVID–19

In October 2021, even prior to the arrival of the Omicron variant, the number of children who had lost a parent or grandparent primary caregiver due to COVID–19 was 175,000,[9] a staggering statistic. And over five million children worldwide[10] have lost a parent or primary caregiver. Children of racial and ethnic minorities accounted for 65% of those who lost a primary caregiver,[11] while making up only about 50 percent of the child population. These children currently have great needs and will continue to have many into the future.

The needs of this population of children should be met in a comprehensive way after identifying who they are. These children should have expanded access to mental health services, including in schools, regardless of their insurance coverage (public or private.) We must ensure that children who have lost caregivers during the COVID–19 pandemic receive the benefits that they are entitled to under current law and make them categorically eligible for other public programs and economic aid including early learning programs like the Child Care and Development Block Grant and Head Start, the Temporary Assistance for Needy Families, the Supplemental Nutrition Assistance Program, Medicaid, the Child Tax Credit, and others.

Conclusion

We appreciate the Committee's focus on the mental health crisis of our country's children and youth and the two valuable and impactful hearings that the Committee hosted in February 2022. First Focus on Children commends the Committee's bipartisan approach to this topic and we look forward to seeing the proposals that emerge from the five work groups that the Committee has established. We share your concern for the mental health of America's children and youth and we look forward to continuing to work with you as you craft legislation and funding proposals.

For questions or comments, please reach out to Averi Pakulis, Vice President of Early Childhood and Public Health Policy (AveriP@firstfocus.org), Elaine Dalpiaz, Vice President of Health Systems and Strategic Partnerships (ElaineD@firstfocus.org) or Olivia Gomez, Director of Health and Nutrition Policy (OliviaG@firstfocus.org).

[8] *https://www.clasp.org/publications/report/brief/youth-mobile-response-services-investment-decriminalize-mental-health/.*

[9] *https://www.npr.org/sections/health-shots/2021/10/07/1043881136/covid-deaths-leave-thousands-of-u-s-kids-grieving-parents-or-primary-caregivers.*

[10] *https://www.nytimes.com/live/2022/02/24/world/covid-19-tests-cases-vaccine#children-parents-caregiver-covid-deaths.*

[11] *https://spectrumlocalnews.com/tx/south-texas-el-paso/news/2021/10/25/175-000-children-parentless-due-to-covid-deaths.*

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March 1, 2022

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

RE: Testimony Submitted for "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," Hearing Held on February 15, 2022

Dear Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance,

Thank you for your interest in improving access to mental and behavioral health services for children, young people, and their families. Testimony provided during the hearings on February 8th and 15th demonstrated the urgent need to improve these services and the importance of engaging young people. During the February 15th hearing, Mr. Trace Terrell stated: "My peers and I believe we deserve a seat at the table. While there are many ways we can do this, it starts by ensuring young people can meaningfully contribute to and be involved with legislative work on the local, state and federal level." We agree fully and we are thankful for Chairman Wyden's, Ranking Member Crapo and the Committee Members' commitment to ensuring young people have a seat at the table as work on this critical issue continues.

FosterClub is writing to ask for assistance in adding the voices of young people who have lived experience in the foster care system who face unique challenges in accessing and receiving mental and behavioral services and support.

FosterClub is the national network for young people who experience foster care. While foster care provides a critical safety net in our society for children and youth, we know that being in foster care can be a very difficult experience for a young person. FosterClub believes that when young people have the support they need and the opportunity to drive change in their life, they are able to develop into self-determined individuals. We also believe that when the system listens to young people, it develops a better understanding of how best to support them.

For the past two decades, FosterClub has worked with young people about the need for mental and behavioral health support in child welfare. We've heard from young people about the diverse challenges they face. These include but are not limited to: a lack of awareness about available health care and services; difficulty getting to the resources that will help their needs; changes in services available from jurisdiction to jurisdiction and state to state; and difficulty forming close relationships with peers while in foster care.

The challenges young people elevated inspired them to find creative solutions to the problems they and their peers are facing. The continued meaningful engagement of young people is critical to solving both these and future challenges to improve the well-being of young people in and from foster care. The involvement of young people in service delivery should extend beyond their role as recipients of services. Young people should be involved in every aspect of the design, implementation, delivery and evaluation process.

Increase awareness of health care eligibility.

Although states have been enrolling former foster youth in Medicaid for several years, implementation varies. Some states automatically enroll young people and some states ask young people to complete a several-page application. Some states cover young people who relocate to a new state and some do not.

States need to improve outreach to young people, simplify the enrollment process and cover young people who experienced foster care in another state.

> I think that the need to do outreach is so important. Had it not been for some former foster youth campaigning and doing outreach I would not have found out that I could get insurance and I honestly don't know if I would have still been here today. I didn't know I could still get insurance and be-

> cause of that I failed to go to the hospital and get the help I needed and that made things worse in the long run.
>
> —Dashun Jackson, FosterClub Lived Experience Leader who spent 4 years in Nevada's foster care system.

> I could have lost my health care if I had left New York to go to Texas for a surgery that I needed. Losing my health care could have jeopardized all of my hard work and progress toward earning my college degree.
>
> —Cody Rivera, FosterClub Lived Experience Leader who spent 12 years in New York's foster care system

Facilitate improved navigation to services.

Young people need support in navigating the services that can meet their unique needs. FosterClub frequently receives calls from young people and professionals who are trying to support young people to connect with services. Currently, the resources that exist to provide these services are not accessible for young people, and frequently, they are not accessible for professionals.

We need dedicated foster care navigators who can support connection to the right mental health resources and understand what foster youth are eligible for. Navigators can be young people with lived experience who are trained and equitably compensated.

Streamline services young people are eligible for.

When young people come together from across the country, they report vastly different services that they are eligible for. Large disparities exist in the quality of services available to young people across the country.

Regardless of their location, young people should have access to and be eligible for a core set of services. We must ensure diverse communities have equitable access to both services and supports.

Increase Access to Peer Support

Young people who are in foster care often feel isolated, as they know few other young people who are also in foster care. Young people are often more likely to listen to and accept information from their peers than they are from professionals.

We must ensure young people have access to peer-delivered services and peer support groups, including those with the expertise to conduct initial conversations on the importance of health and well-being, provide accurate information on the benefits of regular health care coverage. Peer support can occur in structured, ongoing opportunities for youth in foster care to gather in person or virtually to connect with one another. Youth should be supported by trained facilitators who are themselves foster youth. There are strong examples of successful peer support implementation including in Oregon where FosterClub has hosted teams of Peer Navigators who are providing support to fellow foster youth during the pandemic.

In summary, FosterClub recommends the following considerations from young people with lived experience in foster care in order to improve mental and behavioral health supports:

1. Meaningfully engage young people in the design, implementation, delivery and evaluation process.
2. Increase awareness of health care eligibility.
3. Facilitate improved navigation to services.
4. Streamline services young people are eligible for.
5. Provide regular access to peer support.

FosterClub is pleased to share these priorities with the Committee as it continues discussions about how to improve mental health supports for young people in and from foster care. If you would like to discuss further, please contact Celeste Bodner, FosterClub, 503–717–1552 or systemchange@fosterclub.com.

Sincerely,

Celeste Bodner
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March 1, 2022

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

RE: Testimony Submitted for "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," Hearing Held on February 15, 2022

Dear Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance,

Thank you for investing in improving the access and resources children, young people and their families have to mental and behavioral health supports. Testimony given during the hearings on February 8th and 15th revealed the urgency of improving these services and the importance of engaging young people in these improvements.

FosterClub is the national network for young people who experience foster care. FosterClub believes when young people have the support they need and opportunity to drive change in their life, they become self-determined and do better. We also believe when the system listens to young people, it does better.

Foster Care Alumni of America's vision is that all people in and from foster care are connected, empowered, and flourishing.

During the February 15th hearing, Mr. Trace Terrell stated: "My peers and I believe we deserve a seat at the table. While there are many ways we can do this, it starts by ensuring young people can meaningfully contribute to and be involved with legislative work on the local, state and federal level." FosterClub and Foster Care Alumni of America agree with Mr. Terrell fully. We are writing to elevate the recommendations that we've received from members of our networks regarding mental health services and supports that can improve the well-being of young people in and from foster care. We are thankful for Chairman Wyden's, Ranking Member Crapo and the Committee Members' commitment to ensuring young people have a seat at the table as work on this critical issue continues.

Young people and alumni in our networks consistently share challenges they encounter in accessing and engaging in high-quality mental and behavioral health services. Our networks haven't stopped at raising challenges; they've developed solutions. We've included several key solutions that we have heard from young people in our networks below. Much of the information we are outlining can be viewed in further detail in the referenced published documents.

(1) **Educate and inform us of our choices regarding treatment and medication.**[1] This includes education for our families before reaching a crisis point and grief services. Young people must be provided with youth-friendly information regarding the medications they receive.

> Mental health services offered to me never felt like they were presented as a choice. It was as if my trauma and the subsequent behavior challenges that came with it was a burden and something to be fixed. I almost always felt like my autonomy was denied
> —Brittney Lee, experienced foster care in Washington State

> People think that, because you've been removed from your home of origin, you've been "saved." Youth are rarely provided with support to grieve. Un-

[1] *See* Older Youth Successful Transition to Adulthood (December 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/_Older%20Youth%20Successful%20Transition%20to%20Adulthood.pdf*); Quality Residential Services (February 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/Quality%20Residential%20Services_Feb.%202020_Final%20.pdf*); and Improving Youth Engagement and Access to Mental Health Services, (April 2013, *https://nationalpolicycouncil.org/sites/default/files/docs/landingpage/Mental%20Health%20Priorities.pdf*).

resolved loss can prevent us in moving forward in finding and retaining permanence.
—Youth Voice

(2) **Provide us with peer support and peer navigation.**[2] Build opportunities for youth to have access to peer groups throughout their transitions into adulthood as young people tend to turn to peers for support. Youth organizations have had youth and alumni speak out about mental health challenges and witnessed attitudes among youth in care shift instantly.

(3) **Curb over-reliance on medication.**[3] Based on personal experiences, medication is often offered as the "first fix" when we start to exhibit issues due to trauma. Part of curbing the over-reliance of medication is to ensure informed consent and have an established and independent appeal process available to us if we have a medication regimen (especially while the regimen is being considered regardless of whether the medication is over the counter or prescribed including off label use).

When I was thirteen I was given 7 medications at one time and later came to find out two of those medications were found to be dangerous when used together and one of those medications was not even approved for use for anyone under the age of 18.
—Former Foster Youth from Iowa

(4) **Prevent "diagnosis-for-dollars."**[4] We've heard anecdotal stories from young people who portray a diagnosis being made in their case to bump-up the reimbursement rate for caregivers. In some states, caregivers receive triple or quadruple reimbursement rates for youth with a mental health diagnosis. Placement in foster care should be sufficient for our eligibility for Medicaid services.

(5) **Guide us so we are adequately prepared to transition to adult mental health services.**[5] Ensure we are aware of how to access mental health support after we transition out of foster care to permanency or to adulthood. Peer navigators and opportunities for group therapy are valuable supports.

(6) **Ensure special populations, including those of us who are LGBTQ2S+,**[6] can access specific and inclusive services to bolster our health and well-being foundations.[7] This can be accomplished through training for caregivers and child welfare professionals.

(7) **Ensure we know our rights.**[8] Ensure we have access to and are educated on our rights; we must be able to report violations of our rights.

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[2] *See* Older Youth Successful Transition to Adulthood (December 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/_Older%20Youth%20Successful%20Transition%20to%20Adulthood.pdf*); and Improving Youth Engagement and Access to Mental Health Services (April 2013, *https://nationalpolicycouncil.org/sites/default/files/docs/landingpage/Mental%20Health%20Priorities.pdf*).

[3] *See* Quality Residential Services (February 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/Quality%20Residential%20Services_Feb.%202020_Final%20.pdf*); and Improving Youth Engagement and Access to Mental Health Services (April 2013, *https://nationalpolicycouncil.org/sites/default/files/docs/landingpage/Mental%20Health%20Priorities.pdf*).

[4] *See* Improving Youth Engagement and Access to Mental Health Services (April 2013, *https://nationalpolicycouncil.org/sites/default/files/docs/landingpage/Mental%20Health%20Priorities.pdf*).

[5] *See* Older Youth Successful Transition to Adulthood (December 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/_Older%20Youth%20Successful%20Transition%20to%20Adulthood.pdf*).

[6] When we use the acronym LGBTQ2S+, we are referring to members of the LGBTQ community, Two-Spirit youth and queer-identifying youth.

[7] *See* Improving Youth Engagement and Access to Mental Health Services (April 2013, *https://nationalpolicycouncil.org/sites/default/files/docs/landingpage/Mental%20Health%20Priorities.pdf*).

[8] *See* Older Youth Successful Transition to Adulthood (December 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/—Older%20Youth%20Successful%20Transition%20to%20Adulthood.pdf*); Quality Residential Services (February 2020, *https://nationalpolicycouncil.org/sites/default/files/docs/blogs/Quality%20Residential%20Services_Feb.%202020_Final%20.pdf*); and Improving Youth Engagement and Access to Mental Health Services (April 2013, *https://nationalpolicycouncil.org/sites/default/files/docs/landingpage/Mental%20Health%20Priorities.pdf*).

> Mental health professionals were talking to others involved with my case. There was a sense of violation and disempowerment. I knew that information I shared could be used against me.
> —Youth Voice

We are pleased to share these priorities with the Committee as you continue looking at ways to improve mental health outcomes for young people. If you would like to discuss further, please contact Angel Petite, Senior Policy Manager at FosterClub, 503–717–1552 ext. 105 or systemchange@fosterclub.com or Kodi Baughman, Lived Expertise Policy Director at Foster Care Alumni of America, (515) 402–2238, or kodi@fostercarealumni.org.

Sincerely,

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Dear Chairman Wyden and Ranking Member Crapo:

On behalf of Healthy Schools Campaign, thank you for the opportunity to submit a statement for the record for the hearing, "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care." We commend the U.S. Senate Committee on Finance for developing bipartisan legislation to address the challenges facing the United States' mental health care system. Schools play a critical role in meeting the behavioral health care needs of children and young people across the country and strengthening and supporting schools and school-based providers is a critical component of any policy solution.

The COVID–19 pandemic has impacted the behavioral health and emotional well-being of students across the country. Mental Health America reported that in 2020, 14% of youth suffered from at least one major depressive episode in the past year. Data from the Centers for Disease Control and Prevention (CDC) indicates that mental health-related emergency department visits are up 24% for children (age 5–11) and 31% for youth (age 12–17). While schools serve as a key source of mental health programs and supports for children and youth, 68% of principals report having insufficient school-based mental health professionals to meet student needs.

While student and staff mental health issues are increasing as a result of the pandemic, this problem is not new. Mental health issues present a major challenge for students. Prior to the pandemic, it was estimated that as many as one in five children living in the United States experience a mental disorder in a given year, and approximately 40% of adolescents experience a mental health condition each year. Three quarters of all students receiving mental health services receive those services in schools.

Through Healthy Schools Campaign's work at the national, state and local levels, we have seen the critical role schools play in supporting coordinated, comprehensive and equitable access to behavioral health care. Healthy Schools Campaign leads the Healthy Students, Promising Futures Learning Collaborative which was launched by the U.S. Department of Education and U.S. Department of Health and Human Services in July 2016 and brings together 15 state teams focused on expanding Medicaid funded school health services. Core to the learning collaborative's work is identifying policy solutions that support expanded access to and resources for school-based behavioral health services. In addition, Healthy Schools Campaign has over two decades of experience providing on the ground support to school stakeholders, including families, school staff, youth and community members to advance healthy school environments, including access to behavioral health services and supports.

Through this work, Healthy Schools Campaign has identified a number of federal and state policy solutions that, if implemented, can ensure schools are supported as key providers of behavioral health services and programs.

1. Strengthen school-based Medicaid programs.

A key strategy for improving access to behavioral health care for children and young people is ensuring school districts are able to receive Medicaid reimbursement for behavioral health services delivered in schools. While Medicaid has a 30-year history of reimbursing for school-based health services, that reimbursement has primarily been limited to eligible services included in students' Individualized Education Programs or Individualized Family Service Plans. This means that the majority of behavioral health services delivered to Medicaid enrolled students in school settings are not Medicaid eligible.

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a state Medicaid director letter allowing states more flexibility in their school-based Medicaid programs by permitting school districts to bill Medicaid for health services delivered to all Medicaid-enrolled children, not just those with a special education plan documented by an Individualized Education Program (IEP). In order to implement this change, some states need to submit a state plan amendment (SPA) to CMS; other states are able to implement this change administratively without a SPA. This policy change presents a critical opportunity to expand access to and resources for school-based behavioral health services and yet, only 16 states have leveraged the opportunity to expand their school-based Medicaid programs. Federal support and guidance are needed to ensure the remaining states leverage this opportunity

Solutions to strengthen school Medicaid programs across the country include:

- Require that all states implement the free care policy to expand their school Medicaid programs to cover all medically necessary services—including prevention and early intervention—delivered to all Medicaid eligible students in a school setting.
- Require Centers for Medicare and Medicaid Services to update both the Medicaid School Health Technical Assistance Guide and the Administrative Claiming Guide to better support states in designing and implementing their school-based Medicaid programs, including how to address significant implementation barriers faced by schools. The last federal guidance on school Medicaid programs was issued in 2003 and the lack of updated guidance presents a significant challenge to states and school districts seeking to strengthen and expand their school Medicaid programs. The guidance should be updated with significant input from states and stakeholders.
- Provide an increased Federal Medical Assistance Percentage (FMAP) for health services provided in a school-based setting, including behavioral health services. An increased FMAP would both incentivize states and school districts to expand their school Medicaid programs and ensure school districts had access to sustainable funding to deliver behavioral health services to Medicaid enrolled students.
- Deepen funding for technical assistance (TA) to schools and state Medicaid programs by establishing a national Medicaid technical assistance center to support states and school districts in operating their school Medicaid programs. This could be modeled after the Mental Health Technology Transfer Center Network *(https://mhttcnetwork.org/)*.
- Provide states with funding to support small and rural school districts implement and/or expand school mental health Medicaid programs—and provide ongoing technical assistance. This could include funds to train school health providers, educate school district billing departments, and provide dedicated state staff to coordinate between state Medicaid and Education departments. Initial funding can help ensure states and school districts are able to serve the most students possible.
- Issue a Request for Information on school-based Medicaid programs to better understand the challenges and opportunities facing school districts in billing Medicaid for school health services, including behavioral health services.

2. Support the delivery of school-based telehealth services.

During the COVID–19 pandemic, students have faced disruptions in access to school-based physical and behavioral health services as schools shifted from in-person to virtual learning. Many schools adapted by delivering services through telehealth and states leveraged federal flexibilities to implement policies that allow Medicaid to reimburse for school-based telehealth services to support the health needs of students. These policies promote access to critical health services for students and support schools in meeting federal requirements to provide services to students with disabilities while reducing risk of COVID–19 transmission. Supporting states in continuing to maximize the use of telehealth to deliver school-

based behavioral health services is a key strategy to meeting student behavioral health care needs.

Solutions to strengthen the use of telehealth to deliver school-based behavioral health services include reimbursing behavioral telehealth services at the same rate as in-person services. Given the significant investments required of school districts to offer and maintain telehealth services, it is critical to ensure school districts are able to maximize resources for school-based telehealth services to support ongoing access for students.

3. Address shortages of school-based behavioral health providers.

School districts across the country are facing workforce shortages of school-based health providers, particularly school-based behavioral health providers. This issue is particularly critical as school districts develop and implement plans to spend American Rescue Plan funding. Many school districts have prioritized spending COVID–19 relief funding on expanding access to school-based behavioral health providers and yet, they are unable to find enough providers to meet students' behavioral health care needs.

Solutions to strengthen the school-based behavioral health workforce include:

- Create and expand loan forgiveness, repayment and scholarships for healthcare students and professionals who pledge to work within school settings.
- Develop a National School Health Services Corp under the National Health Service Corp.
- Simplify the Public Service Loan Forgiveness program (PSLF) to make it easier for individuals who commit to serving as health professionals in schools to qualify for loan forgiveness. This could include partial, up-front loan forgiveness, as an alternative to the all-or-nothing back-end loan forgiveness currently provided by the PSLF program as well as forgiving a portion of the borrower's eligible loans every two years.
- Expand Health Resources and Services Administration's (HRSA) State Loan Repayment program to include school health professionals as eligible members of the healthcare workforce.
- HHS and ED should establish national certifications for all school health providers, such as the National Certified School Psychologist credential and grant state reciprocity for all school healthcare workers to remedy the shortages in rural and other underserved communities.

Thank you for considering our feedback on this important issue. We care deeply about the ability to meet the behavioral healthcare needs of students and believe strengthening the delivery of school-based behavioral health services is a key strategy to improve access to behavioral health care for children and young people.

Sincerely,

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Hello, my name is Alexis Andino; I go by Lexi. I am 24 years old, and I have been working with the Juvenile Law Center's Youth Advocacy Program as part of their Youth Fostering Change program for 4 years.

I was 10 years old when I first went into foster care. They picked us up from lunch, and I never got to go back home. I was scared, I was frustrated, being with a whole bunch of people I didn't know. We waited in one of the rooms in the DHS building for hours. I was in care for the whole time until I was about 17. I got discharged, because I got approved for Kinship care. I thought I could be with my great grandmother, but I had to move, and I had to find a place to go because shortly after I got out of care she passed away, and then I was homeless again.

It was hard to get in contact with people. When I was 18 and 19, they told me it would be hard to reenter, and that I'd be in a shelter for over a year before I got housing. They basically told me I would have to go back to a shelter, and that basi-

cally was my only option. I was hopping around from home to home. I tried to go back into foster care at age 19 and I didn't get help with anything until after I was 20.

It wasn't until a few months after I was 20 that I got help through AIC (The Achieving Independence Center). I wound up still staying with a family friend. I kept trying to get connected to Valley Youth House though AIC. AIC finally got me connected to Valley Youth House after I was 20. I only got about 10 months of support. The system is messed up. It shouldn't be like that. There's no reason that they can say that we can come back and get help and that we're able to get help until we're 21 but when you try to get help, they literally deny you and tell you no and that you'll be in a shelter for over a year. They were basically telling me don't get back in the system because you're basically not going to get any help. They kept denying me services and resources until it was kind of too late. I ended up only getting services for less than a year when I should have been able to get it for that whole 3 or 4 years, when I really needed it. Someone just told me that they think that AIC was extended until 23, and there are all of these other things like this Ombudsman hearing, and all of these other services—nobody tried to contact me or help me with anything. And of course, all of that stuff changed and extended because of COVID but I already turned 23 so I couldn't receive those extra services.

Every time I tried to get connected to services, they acted like I should know who my family is, like I haven't been in the system for 10 years. They separate you from your family, don't let you communicate, don't use to not let them come and see me or vice versa, sometimes for a punishment, that's not right. Literally restricted phone calls and you're supposed to magically know your family and have somewhere to live with when you age out. It doesn't make any sense, it's so dumb. They wonder why we age out of the system and don't have a support system or family. It's ridiculous.

Being in foster care growing up, I did go through a lot of things related to race. I was always in other people's homes—foster homes and group homes, of people I didn't relate to. They would look at me as if I was different. There was a lot of time I was the only white person in the home, or school, I got picked on a lot. Staff would be talking *at* youth instead of talking *with* youth. They wouldn't give you a chance to speak. This was the rule and that's it. You can't say how you feel, and you have to follow it or you're getting punished. I never had a sense of normalcy or a good childhood. They would take away stuff. I didn't have a cell phone until I was like 15. I was coming in and out of the city at the age of 13 on the buses with no phone. I was making my own doctor's appointments, I did almost everything on my own. Every time I asked for help, they would look at me like "what do you need help for?, you can do it yourself."

I felt like every time I asked for help they would give me the run around—"you gotta contact this person", "I don't know, you gotta go to this person", "I can't help you with this, go to this agency". I didn't get help until I was going to everyone's supervisor and telling people in court that I was trying to get help, and nobody wanted to help me. I didn't get help with getting back into therapy until after I got discharged from DHS. I asked for help getting services and it was so much of a process that took forever. I didn't know if it was the process or if they weren't trying to help me in the beginning.

Youth questions about their case can often go unanswered by attorneys and the case workers assisting them. For example, I followed up every time I was experiencing challenges, or had questions, or when I needed help or wanted access to service. However, despite how many times I reached out, I never seemed to get clear answers, the outcome remained the same. I had no final answer, and no clear help to get answers. It seemed like I needed to figure out how to help myself and get myself access to services, even at such a young age. This made me feel frustrated and like I didn't want to follow up because they would give me general statements instead of action steps. This inconsistency process, and lack of clear follow-up impacts youth emotional health and well-being. For me, it made it feel alone, helpless, and truly I felt belittled, like I didn't matter, or neither did my opinions, or my life. I felt stuck, and like there was no value on my future- that people didn't care about me. My case planning team should have been honest and realistic about what was happening and what my options and next steps were. They should have explained my case to me and got me help and support much sooner than 3 months before I aged out. Since no one really taught me, anything growing up, this is why I'm struggling now. I believe if they would have been honest with me and communicated with me about my case and what I could do to better my life, to help myself, and directly

connected me to supportive services I would have been better. I wouldn't have just been living day to day.

I recommend that there is a requirement to ensure that it is written in a youth case plan of which staff are required to actively engage with youth in their case planning, the specific services needed for youth, and who on the youth's team will connect them to these services and supports. This needs to be completely detailed for youth and written out more comprehensively so that it happens. I believe if this happened for me, I would be in a better place, because all I really needed was resources, a sense of guidance. All I needed was someone to tell me "this is life, you need X,Y,Z", and I will help you through it, especially as a child and a teen. I was never able to be a child. I'm still learning and unlearning things. If I would have been more active in my case, I would have been engaged and have a say in my life.

Youth deserve a sense of normalcy, guidance, a good and reliable support system, someone to show them how to navigate through life. It's really not easy when nobody tells you or teaches you important things. To ensure what happened to me doesn't happen to other youth, I would also recommend **incentivizing states and counties to Designate a mental health point person who can discuss youth therapeutic options and the benefits of therapies and work with youth and families to connect them with community agencies that will fit their needs—whether outpatient, partial, weekly, art therapy etc.** This process must include discussing that various types of therapy are dependent on the age of the youth, and if there is an immediate mental health crisis taking place. I believe if there was someone like this available in my state or county it would have helped my case and me a lot. I still struggle every day because I don't have any guidance, anybody to call when I have questions. If I had someone involved in my life, I would have felt like I would have finally had someone in my life who cared about me.

Thank you.

My name is Aqilah David. I am 21 years old. This is my fourth year serving as an advocate with Juveniles for Justice at the Juvenile Law Center.

I first entered the child welfare system at age 15. It was a long, horrible journey. I've been bounced around through a few juvenile youth residential treatment facilities. I've had workers assigned to me through DHS and the courts. To this day I feel like I've encountered so many harmful and traumatic events while in the child welfare systems. I was expelled in the 11th grade due to truancy, ODD, and feeling frustrated with things happening in my life. After being expelled, I was sent to an alternative school, on probation, and later forced to go to a juvenile placement because of a GPS violation. When I got to the juvenile holding facility, no one notified the alternative, so they did not know I was in placement and constantly marked me absent while I was in the juvenile facility.

They held me at the juvenile holding facility until a placement became available. Finally placed at an official placement I suffered from depression, and I felt spiritless. I met with a psychiatrist there who I explained to that I was having trouble sleeping and was always sad. I was glad to talk to anyone, because I just wanted to express to someone how things were making me feel while I was at a residential treatment placement. **The placement prescribed me medicine as a child, that was too high in dosage and made me lightheaded, dizzy and made me throw up. I told this to my Philly CUA worker who then told me the medicine was for my own good.** So, I told the psychiatrist I did not feel the medicine was making me feel better, I made a mistake telling her because this only led to them increasing the medication they were giving me throughout my whole stay. I gained weight and I am scared of medicine to this day as an effect. **Congress must work with HHS to develop policies that require first utilizing therapeutic services first, and medication must be provided only as needed, and after individualized assessments by qualified professionals and following full consideration of alternatives to pharmaceuticals.**

While at placement I felt I had to advocate for myself a lot, including attending a school off-grounds from the placement; a local community school where I had to be tested and was accepted. I was glad because the placement school was horrible. I was discharged from the placement at age 18. I did not leave with the documents that I needed like my school documents, my health records, or vital docs. I had to

find my vital documents on my own. The placement or the local public school never gave me my diploma, so I had no proof that I graduated from high school.

There was no aftercare support after I left placement. No one talked to me about my safety when I got home. I wish I had more support to prepare for college or had someone who could have guaranteed my educational transition would be successful. Also, any mental wellness support and medications that were started in placement needed to be continued but when youth leave, there is no person ensuring anything. **There should also be a state office, like a Youth Ombudsman office in every state where youth could go there to file complaints and get accurate information on who is supposed to help and report when people are not supporting them.** I could have used an Ombudsman office in my state this office when I was over-medicated, and when I didn't receive appropriate support in placement, and when I left. No child or youth should have to do this alone, but I did. I was a kid, I deserved better. To expect that youth who go to placement will experience success and complete school is unrealistic because youth are not given enough guidance support. We need better options.

Thank you.

Hello, my name is Alexandria Rivera. I am 21 years old, and I have entered eight different placements, including Foster Care. I have been working with the Juvenile Law Center, Youth Advocacy Program, as part of their Juveniles for Justice program for three years, and I have been an active alumna for one year. The reason I continue to work on issues youth face is because I was a youth who had issues. Now, I am an adult still trying to fix the damage the system causes. I believe that we don't need generation after generation to fall apart due to a broken system, so it is important for us to share our testimonies to fix the damaged system.

Before I even walked into the courtroom, my worker told me I was not going home. They did not tell me how long I was staying. They stated that I wasn't going home. That was a lot for me to think about so fast, because it happened before I even walked in and then,—when I walked into court, I didn't even understand what they were saying. They said that I would be with my brother at an "on-grounds school" because he was placed a week before me. My mom started crying. I figured I was being sent to placement because of the things that were going on at school—a school I didn't even want to go to because I knew what would happen to me if I went there. Before I entered the justice and foster care system, I was living at home and going to Edison, my community high school, but the school had a bad reputation. I knew that if I went to that school things would not go well. It had a lot of police and was a really chaotic environment with little to no structure. We didn't have a principal for about 2 months, or any support or programs. I didn't feel comfortable showing up to school, I felt like there was no point in going to school because I wasn't learning. It wasn't safe and was so unorganized in class. I remember my teacher gave me an assignment to complete that already had all the answers filled in. I told my mom I wanted to go to a better school that had more structure and more afterschool programs so I would have a better experience, but I was sent to Edison instead. Instead of help, or the court asking me why I didn't want to go to school or what was happening at school- I was sent to placement.

When I got to the placement it was freezing, I didn't even know the name or location, how long or where or even the real reason why I was placed. The second day at the placement, there was a "house meeting" with two groups of youth housed at the placements and a big fight broke out. I didn't know what was going on. I was supposed to be meeting a staff member who would be assigned to me, but I didn't meet her until a week later. I should have met her within 24–48 hours. I wanted to talk with someone at the facility to know why I was placed, and why I did not get a warning. I kept thinking, did I get sent to placement, because my siblings went to placement, am I being sent here as a warning? I couldn't understand why they sent me when I had never been in trouble until I went to Edison.

Being in placement kind of destroyed my life. It destroyed my education. I didn't get proper education and none of my credits transferred. Being in placement feels like you're in a "halfway" house for children. Placement is what made me feel like I was a delinquent. No one offered me support from my community to go to a good school, the court should have given me support to stay home and offered to help me get into the right school I wanted to get into, not sending me to an unsafe community school. If our community had support for youth, I wouldn't have felt like I had to make certain choices to protect myself. I went from having to defend myself

in school, to defending myself in a placement, just to go back home on my own and have to deal with the effects of all I went through before placement and while I was in placement. That is too much to worry about as a child. If I was offered support at home, I would have only had to worry about what a child should have been worrying about: how I was going to finish out my classes at the school.

I was a kid. I deserved better. We all deserve better. **We deserve someone really fighting for us and for all youth in placement to require all states to have a Youth Ombudsman Office to be a place where youth can go, to have someone on their side.** Someone who we could have gone to who worked outside of the placement, and outside of the system. The least people can do is give youth an alternative. **Congress should also work to ensure that before a youth is placed in a group facility, agencies exhaust all efforts to make sure youth are placed in family-based settings.** Many people don't know what it's like to feel scared not knowing where you are going, and that you're going to be in placement. We deserve chances to get alternatives. We deserve support. We deserve to be offered programs, better schools, and resources. We deserve something better than being put away.

Thank you.

Hi, my name is I-sha-le Watson. I first entered into placement around 15 and then entered into foster care. Being in group placements did not help me, especially not with school. The first placement that I went to did not have school. I did not know that I was supposed to have educational support in placement, so I did not ask about it. If I was never sent to placement, I would have graduated on time. While I was in juvenile placement, I experienced discrimination because I'm a LGBTQ youth. Discrimination and mistreatment in these facilities is a constant problem and one no person or child should ever have. Sometimes it happens because of our race, orientation, or sexuality and no one ever really knows, or is held accountable for what happens to us. **Congress should work to enact legislation that would reduce the impact of racial bias in the foster care system, including requiring that states develop policies and protocols to ensure that all options for support are provided in the home and with other family members before removal.**

We need an Ombudsman office, because obviously, youths are not being cared for in these placements. Youth deserve care and respect. Adults should have been carefully going through children's and youths' complaints and should be evaluating these places. How can you all look at these complaints, and cases and say to yourself, "oh, a youth reported that," and then you just throw out or "unfound" these claims? That's wrong and it doesn't make any sense. The system needs to be held accountable for what has happened to us in these facilities.

As a society we should be investing money in youth and families, instead of the over $211,000 per kid it can costs in states like mine, in Pennsylvania to lock youth up. The same amount of money you all spent to incarcerate youth can be used to create many programs to keep youth off the street and in family-based setting. Youth need more physical activity programs, sports, like basketball, and recreational activities that support our mental health and physical growth. Youth and families shouldn't have their only option to be to go into foster care or to have them put into placement when they need help. Placing a child in a juvenile and or group facility is not helpful. It did not help me at all, especially with school. I'm still not sure I ever got credits while in placements. I found out because when I got home, I was trying to get into a local community school, and they couldn't locate any credits from the placement school I needed to transfer back to my community school.

My experiences in placement and in foster care are why I think that it should be a requirement to have all states have Ombudsman offices. If we had an office like this in our state maybe a lot of youth in placements and group homes might not be behind in their schooling, having to graduate after 19, 20 or older because they could report that they are not getting any education, or not getting the educational support they're supposed to get, and get help faster. This office could have also helped address when I was experiencing discrimination in placement from staff. **Furthermore, Congress must work to develop policies and practices that end racism and all forms of oppression by ensuring child welfare staff, and child welfare agencies provide required training, and have process' to enforce all anti-discrimination practices.** It also just means

a lot to me if Congress works to address these issues and to know that someone is trying to help to make sure that youth have what they need when they need it.

Thank you.

Hello, my name is Briannah Stoves. I am 17 years old. I have been in seven different placements since I was 12 years old. This is my first year working at the Juvenile Law Center with their Youth Advocacy Program. I got involved with Juvenile Law Center's Youth Advocacy Program because I heard I could verbally advocate, and I've been in the juvenile system so I know how the system is, and if I can have a say so in changing it, then I want to.

The very first time I was arrested for running away, I was taken to a mental hospital. I felt safe at the hospital, but I was under medication the whole time. If there was any sort of conflict, they would always choose to sedate me. This was not the best method, what I needed was therapy for me and my family, I would like there to be less reliance on medication for children who are experiencing a crisis. We are resilient and can heal not only from medication. I wish they first would have provided me with another alternative before medication, because there are sometimes harsh side effects and long-term effects.

The second time I was arrested, it was a mistake. I let my anger get the best of me. Me and the police officer both could have done better, but I was immediately placed from that experience. We both could have deescalated. We both played a part in it, but I'm the only one that paid the consequences. I was 14 years old. I feel like the cop should have de-escalated the situation. He approached me with an angry attitude, which wasn't helpful. You cannot approach anger with anger. I wish the cop might have taken another second to have talked to me to de-escalate the situation, because as a teen I was experiencing a lot of traumas and was visibly upset. I don't think I needed to have been arrested immediately, as the first option. More steps could have been taken so that everything didn't have to occur the way that it occurred.

When I was placed after that experience, being in placement showed me that nowhere was safe. Staff was allowing the other kids to bully me, so I ran away. There was always a lot of fighting. Especially with a lot of females in one house. My sense of safety was gone. I stayed in my room a lot of the time and just read books.

I learned about the grievance procedures in a more disciplinary setting. I didn't file any grievances because I didn't believe that anything would be done. I know how long it takes to go through the chain of command, and it would have been dismissed before anything was one. **I recommend Congress require federally funded, and state funded facilities to develop a truly youth-friendly grievance policy and connect youth to independent advocates who can assist youth in navigating the process.** This should include reviewing and assisting youth with the grievance procedure. **There also should be more staff support and training for staff running not only juvenile, but residential treatment and foster care group homes.** There should not be limited staff members who also lack skills in working with kids. I remember the staff where I was staying didn't know how to deescalate situations and a lot of times when the kids would get upset, the staff would too.

Having safer environments for youth It would allow them to build healthy relationships that are helpful for growth and healing. Thank you for listening to my story and I hope you understand what is really going on and that you will help make a change.

Thank you.

MENDING MINDS VILLAGE
1594 West 400 South #28
Salt Lake City, Utah 84104

Senators,

We had the privilege of listening to the hearing the U.S. Senate held today regarding protecting youth mental health on a national level. Mending Minds Village was created specifically to facilitate change in the State of Utah, as well as on the national level to provide much needed resources for our youth starting immediately.

We wanted to provide you a statement on this issue today, and provide our stance on this issue.

Thank you to Senators Wyden and Crapo for putting bipartisan support on this very critical issue nationwide. The youth in Utah are having large difficulty in finding resources and treatment for their mental health issues across the board here. We have seen a major uptick in suicide and violence, especially across our minority groups in the state. We have heard from families and therapists alike in the mental health field, and what we are finding is very much equal across the board in the needs and detriments. We have found that the programs dedicated to providing services in this state are being highly slowed by details such as billing and reporting requirements, and in some cases they are not able to bill for certain services (*i.e.,* autism care) that is preventing them from helping the clients they care for.

My team at Mending Minds Village is dedicated to bridging the gap between families who need support, the providers who are trying to address those needs, and the medicaid and state/federal systems that are preventing them from doing their jobs. In listening to the testimony given in this hearing, we are moved to see such amazing, bipartisan leadership being dedicated to helping our youth and creating the changes that will help families going forward. Having recently heard of the CCBHCs, we have done our research on the program, and we are having the conversation with state and local leaders to bring that movement to Utah as well. We believe strongly that this program was dedicated to creating a better mental health system going forward, and to have the support and funding of the federal government could drastically change some lives of the families in our great state.

We began Mending Minds Village in January of 2022, after having spent the last 4 years consecutively addressing the mental health needs of our amazing 7 year old daughter. In the last 4 years, we have been turned away, told there is no testing for her age (4–6), told that she did not qualify for mental health treatment, and many more frustrating and difficult things along the way. As we have delved into this organization and tried to understand the needs of providers and families alike, we are finding a general theme in those conversations: the need for financial and state assistance for both. We have created an organization (working on our 501(c)(3) status) that we feel could help provide the assistance needed to desperate families, as well as provide a private forum for providers and directors to create some much needed intervention and conversation.

We come to you in support of the work that you are trying to accomplish, and in support of the members of your committee who spoke today regarding this issue. We applaud your work and constant attempts at bettering life for those with mental health concerns. We plead with you to work diligently to pass bills that will provide much needed relief for these families who have needed it for so long, and are losing the battle waiting on intervention. Too often we hear of families who have lost a child or a loved one due to mental health concerns that were not addressed by those they reached out to the most. Too often we hear of families being torn apart due to a child's uncontrolled behavior thanks in part to severe mental health. It is time these families are heard and their needs are met. And we know you are working hard to come to a resolution that will do just that.

We would love the opportunity to address the committee in person (or on Zoom), and discuss with you the voices we are hearing in our short time since being formed. The providers voices who are working the frontlines and know what is so desperately needed. The families who are begging for help before their world falls apart and being at the mercy of the State and medicaid boards. We would love to share their stories with you in hopes of creating another strong push for intervention and assistance.

Thank you for your time and your work in this matter, Senators. And thank you for your time, and allowing this statement to go on record.

Sincerely,

Kaden Mattinson
Founder and Director

MENTAL HEALTH LIAISON GROUP
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Washington, DC 20005
https://www.mhlg.org/

February 20, 2022

The Honorable Ron Wyden	The Honorable Mike Crapo
Chairman	Ranking Member
U.S. Senate	U.S. Senate
Committee on Finance	Committee on Finance
Washington, DC	Washington, DC

Re: Full Committee Hearing: "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care"

On behalf of the Mental Health Liaison Group (MHLG), we submit this statement for the record for the U.S. Senate Finance Committee hearing entitled "Youth Mental Health: Part II—Identifying and Addressing Barriers to Care." MHLG is a coalition of national organizations representing consumers, family members, mental health and addiction providers, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and addiction care. We strongly support the committee's continued attention to addressing the needs of individuals with mental health and substance use disorders, including among children and adolescents. We are grateful for your leadership in convening this bipartisan hearing at a critical moment for our nation's youth.

Significant unmet child and adolescent behavioral health needs existed nationwide, even prior to COVID–19.[1] Since 2007, suicide rates among children aged 10 and older have climbed significantly each year, making suicide the second most common cause of death among adolescents before the pandemic.[2] COVID–19 has only exacerbated these trends, including among children who did not previously exhibit symptoms of a behavioral health disorder.[3] This led to the American Academy of Pediatrics, the Children's Hospital Association, and the American Academy of Child and Adolescent Psychiatry to declare a national state of emergency on children's mental health, last fall.[4] This was followed by a December 2021 U.S. Surgeon General advisory calling for a unified national response to the mental health challenges young people are facing.[5] Considering the rarity of such advisories, this further underscores the need for action to help stem the long-term impacts of the pandemic on the mental health and well-being of children and adolescents. We applaud you for inviting the Surgeon General to speak before the committee to discuss the steps which can be taken to promote child and adolescent mental health and improve their access to care.

The stakes of untreated mental and behavioral health symptoms for children and adolescents are exceptionally high, both on an individual and societal level. Failing to detect and address early indicators of a mental or behavioral health disorder can have profound consequences on the overall trajectory of a child's life, including a greater likelihood of difficulties with learning, addiction to substances, lower employment prospects, and involvement with the criminal justice system.[6]

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[1] Centers for Disease Control and Prevention. (2020). Youth Risk Behavior Surveillance. Retrieved from: *https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901-H.pdf;* Substance Abuse and Mental Health Services Administration. (2017b). Age and gender-based populations.

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

[3] Osgood, K., Sheldon-Dean, H., and Kimball, H. (2021). 2021 Children's Mental Health Report: What we know about the COVID–19 pandemic's impact on children's mental health—and what we don't know. Child Mind Institute. Retrieved from: *http://wvspa.org/resources/CMHR-2021-FINAL.pdf.*

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

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

[6] Sacks, V., and Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity. Bethesda, MD: Child Trends; National Collaborative on Education and Health. (2015). Brief on chronic absenteeism and school health. Chicago, IL: Healthy Schools Campaign.

The mental health of children is frequently tied to the overall health, safety, and stability of their surroundings. The social isolation, upheaval, and disrupted routines brought on by COVID–19, has placed considerable stress on children and their families, which typically has a downstream effect on their mental health. Ongoing national surveys of households with young children have found high levels of childhood hunger, emotional distress among parents, and frequent disruptions in childcare services.[7] Even before COVID–19, nearly 10% of U.S. children lived with someone who was mentally ill or severely depressed.[8] Furthermore, since the start of the pandemic, over 167,000 children have lost a parent or caregiver to the virus.[9] This kind of profound loss can have significant impacts on the mental health of many children, leading to anxiety, depression, trauma, and stress-related conditions.

Additionally, the COVID–19 pandemic has not been a short-term event. As we move into the third year of this emergency, it is essential to recognize that the pandemic has impacted children for multiple years of their social, emotional, and cognitive development, allowing challenges and adversities to compound. Parents continue to report being more concerned about their children's social and emotional development and well-being than they were prior to the pandemic,[10] and recent data show increased behavioral concerns among students who are having difficulties transitioning back from remote to in-person learning.[11]

Youth within marginalized populations, including racial and ethnic minority children and adolescents, those who identify as LGBTQ+, and children with developmental and physical disabilities, disproportionately have experienced some of the most severe consequences of the pandemic. Black and Hispanic children lost a parent or a caregiver at more than two times the rate of White children, while American Indian, Alaska Native, and Native Hawaiian and Pacific Islander children lost caregivers at nearly four times that rate.[12] Two thirds of LGBTQ+ teens and young adults report that the combination of COVID–19 and recent state actions targeting transgender youth participation in school sports, has negatively impacted their mental health.[13] At the same time, young people from these communities faced significant barriers accessing behavioral health services, even before the pandemic.[14]

Increases in demand for pediatric inpatient mental health services are also a concerning indicator of the growing crisis in child and adolescent mental health. Between April and October 2020, the proportion of children between the ages of 5 and 11 and adolescents ages 12 to 17 visiting an emergency room due to a mental health crisis, increased by 24% and 31%, respectively.[15] Moreover, due to the lack of alternative placement options, hospitals are boarding a growing number of children awaiting treatment in their emergency departments. In recent months, several children's hospitals reported boarding their highest number of children at one time and for longer stays before they could be discharged to an appropriate alternate care set-

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[7] Center for Translational Neuroscience. November 2021. Still in Uncertain Times; Still Facing Hunger. RAPID–EC Fact Sheet. Eugene, OR: University of Oregon; Center for Translational Neuroscience. November 2021. Emotional Distress On the Rise for Parents . . . Again. RAPID–EC Fact Sheet. Eugene, OR: University of Oregon; Center for Translational Neuroscience. November 2021. Child Care Shortages Weigh Heavily on Parents and Providers. RAPID–EC Fact Sheet. Eugene, OR: University of Oregon.

[8] Ullmann, H., Weeks, J.D., and Madans, J.H. Disparities in stressful life events among children aged 5–17 years: United States, 2019. NCHS Data Brief, no 416. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: *https://www.cdc.gov/nchs/data/databriefs/db416.pdf.*

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

[10] Jung, Kwanghee, and Barnett, W. Steven. 2021. Impacts of the Pandemic on Young Children and Their Parents: Initial Findings from NIEER's May–June 2021 Preschool Learning Activities Survey. New Brunswick, N.J.: National Institute for Early Education Research

[11] Kurtz, H. (January 12, 2022). Threats of Student Violence and Misbehavior Are Rising, Many School Leaders Report. Education Week. Retrieved from: *https://www.edweek.org/leadership/threats-of-student-violence-and-misbehavior-are-rising-many-school-leaders-report/2022/01.*

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

[13] Morning Consult and the Trevor Project. (January 2021). Issues Impacting LGBTQ Youth. Retrieved from: *https://www.thetrevorproject.org/wp-content/uploads/2021/12/TrevorProject_Public_Final-1.pdf.*

[14] Austin, A., and Wagner, E.F. (2010). Treatment attrition among racial and ethnic minority youth. *Journal of Social Work Practice in the Addictions,* 10, 63–80.

[15] Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., and Holland, K.M. Mental Health—Related Emergency Department Visits Among Children Aged <18 Years During the COVID–19 Pandemic—United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: *https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm.*

ting.[16] In the first three quarters of 2021, children's hospitals reported a 14% increase in mental health related emergencies and a 42% increase in cases of self-injury and suicide, compared to the same time period in 2019.[17] Shortages of mental and behavioral health professionals, including those specifically trained to treat young people,[18] further exacerbate insufficient capacity to provide needed care and support more effective integration of services.

Taken individually, these data are striking, but in aggregate, they further illuminate the urgent need for action. In November, MHLG responded to Chairman Wyden's and Ranking Member Crapo's request for policy proposals on improving mental health outcomes and addressing unmet needs, which included the following specific recommendations for improving access to coverage and care for young people and children:

- **Passing the permanent authorization of CHIP and the bipartisan Stabilize Medicaid and CHIP Coverage Act (S. 646/H.R. 1738),** which will provide 12 months of continuous enrollment for Americans who are eligible for Medicaid and CHIP.
- **Passing the bipartisan Helping MOMS Act (H.R. 3345)** to permanently ensure that all pregnant women on Medicaid and CHIP retain their health coverage during the critical first year postpartum to address serious health inequities in maternal health.
- **Directing the Centers for Medicare and Medicaid Services (CMS) to review the early and periodic screening, diagnostic, and treatment (EPSDT)** requirements and whether they are being implemented successfully at the state level to support access to prevention, early intervention services, and developmentally appropriate services across the continuum of care.
- **Directing CMS to coordinate with the U.S. Department of Education to help the Department, states, and other stakeholders remove barriers to full participation in school-based Medicaid programs.**
- **Passing the bipartisan Telehealth Improvement for Kids' Essential Services (TIKES) Act (S. 1798),** which would promote access to telehealth services for children through Medicaid and CHIP and study children's utilization of telehealth to identify barriers, opportunities, and outcomes.

The workforce shortage of mental and behavioral health clinicians existed before the pandemic, but it is now a top concern throughout the sector. The shortage of practitioners specializing in mental and behavioral health care for infants, children, and adolescents is particularly acute. MHLG therefore recommends that Congress increase investments to support the recruitment, training, retention, and professional development of a diverse clinical and non-clinical workforce, both generally and with specialized training for child and adolescent populations. This should include new incentives and opportunities to practice in rural and underserved areas, additional measures to incentivize more individuals to enter the field, and increasing reimbursement rates. Low payment rates to providers for the provision of behavioral health services heavily contribute to the workforce shortage. We therefore recommend increasing payment rates for mental and behavioral health care by **passing the Medicaid Bump Act (S. 1727/H.R. 3450),** which proposes to raise the federal reimbursement rate for mental health and substance use disorder care under Medicaid.

MHLG also calls the Committee's attention to additional measures that, while not focused specifically on children and youth, are all critical components of a comprehensive and more effective mental health system able to meet the increased need for services among children and adolescents. We therefore recommend the following additional measures be included in any forthcoming legislative package:

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[16] Children's Hospital Association. Emergency Room Boarding of Kids in Mental Health Crisis. Retrieved from: *https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Mental%20Health/2021/Boarding_fact_sheet_121421.pdf.*

[17] Children's Hospital Association (September 17, 2021). COVID–19 and Children's Mental Health. Retrieved from: *https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Mental-Health/2021/covid_and_childrens_mental_health_factsheet_091721.pdf?la=en&hash=F201013848F9B9C97FAE16A89B01A38547C7C5C7.*

[18] Ellison, K. (August 14, 2021). Children's mental health badly harmed by the pandemic. Therapy is hard to find. *The Washington Post.* Retrieved from: *https://www.washingtonpost.com/health/child-psychiatrist-counselor-shortage-mental-health-crisis/2021/08/13/844a036a-f950-11eb-9c0e-97e29906a970_story.html.*

- Ensuring parity in reimbursement for mental health and substance use treatment, both through Medicaid and TRICARE;
- Promoting the integration of primary and mental health care through a range of measures, including by passing the **Excellence in Mental Health and Addiction Treatment Expansion Act of 2021 (S. 2069/H.R. 4323);** and
- Bolstering vital crisis response systems by passing the **Crisis Assistance Helping Out On The Streets (CAHOOTS) Act (S. 764/H.R. 1914)** to expand mobile response and the bipartisan **Behavioral Health Crisis Services Expansion Act (S. 1902)** to provide comprehensive support for developing and sustaining crisis services.

As necessary as these proposals are, however, many of these actions are long-term. The current crisis also requires a more immediate response. **To act expeditiously in addressing the current mental health needs of young people and meet the call to action in the Surgeon General's advisory, Congress must also pass an FY 2022 Appropriations package, as quickly as possible.** This would be the most immediate way to increase resources for a variety of already authorized Substance Abuse and Mental Health Services Administration (SAMHSA) and Department of Education programs that provide mental health services for young people. This includes Project AWARE, the National Child Traumatic Stress Initiative, the Student Support and Academic Enrichment Grant Program, Safe Schools National Activities, and the Community Mental Health Services Block Grant, which provides care for children with serious emotional disturbances and would include a set aside for prevention and early intervention. MHLG calls on Congress to fund these programs at the highest levels possible in a final FY 2022 omnibus bill.

Once again, we applaud you for convening this crucial hearing, which recognizes the challenges facing the mental health of our youth and the potential damage that lack of action can have on an entire generation. We thank you for your continued bipartisan leadership on issues related to mental health and substance use disorders. MHLG and its members stand ready and willing to work with you in your efforts to advance policies that support the mental and behavioral health of individuals, families, and communities.

Sincerely,

2020 Mom
American Academy of Child and Adolescent Psychiatry
American Art Therapy Association
American Association for Psychoanalysis in Clinical Social Work
American Counseling Association
American Dance Therapy Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Psychological Association
American Foundation for Suicide Prevention
Anxiety and Depression Association of America
Association for Ambulatory Behavioral
Healthcare
Centerstone
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Children's Hospital Association
CLASP
Clinical Social Work Association
Depression and Bipolar Support Alliance
Eating Disorders Coalition
Eating Disorders Coalition for Research, Policy and Action
Education Development Center
Global Alliance for Behavioral Health and Social Justice
International OCD Foundation
The Jed Foundation
The Jewish Federations of North America
Maternal Mental Health Leadership Alliance
Mental Health America
NAADAC, the Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Behavioral Healthcare
National Association for Children's Behavioral Health
National Association of Counties

National Association of Pediatric Nurse Practitioners
National Association of School Psychologists
National Association of Social Workers
National Federation of Families
National League for Nursing
National Register of Health Service Psychologists
Nemours Children's Health
Network of Jewish Human Service Agencies
PsiAN
Psychotherapy Action Network
REDC Consortium
RI International, Inc.
Sandy Hook Promise
SMART Recovery
The Kennedy Forum
The National Alliance to Advance Adolescent Health
The Trevor Project

NATIONAL ADVOCACY ON SERIOUS NEUROBEHAVIORAL ILLNESS (NASNICARES)
P.O. Box 99501
Pittsburgh, PA 15233

NATIONAL SHATTERING SILENCE COALITION
P.O. Box 563
Shapleigh, ME 04076–0563

February 12, 2022

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

RE: Hearing on "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," Tuesday, February 15, 2022

Dear Chairman Wyden and Ranking Member Crapo:

We thank the Senate Finance Committee for the opportunity to share our perspectives on the topic of mental health. We appreciate that in holding these hearings, the Senators on this committee are demonstrating that the mental well-being of Americans and particularly America's youth is a matter of importance.

We must not belabor getting to the pivotal questions that underlie this communication:

What is Mental Health?
What is Mental Illness?

What are the implications of the definitions and meanings attached to these terms as it relates to medical care, healthcare, social services, and the construct of parity?

The concept of parity is that mental health is as important to overall well-being as physical health. The term mental health is a metaphor that refers to non-medical psychosocial issues—the problems of everyday living . . . from the relatively benign to the very serious. Yet, in societal discourse, the term "mental health," specifically poor mental health, is conflated with "mental illness."

According to content on the CDC's website:

> Although the terms are often used interchangeably, poor mental health and mental illness are not the same.

We agree with this statement although we do not subscribe to other statements on the site, such as what causes "mental illness"—yet, this pivots on what someone means when they use the term "mental illness." Inasmuch as the term "mental illness" is also a metaphor, there is no distinction between the terms.

That is why, although we must still use the term "mental illness" for the sake of clarity, stakeholders in this network of advocates strongly object to the use of the term "mental illness' to classify and describe what are truly medical disorders. Segments of this advocacy network are calling on the medical establishment to reclas-

sify illnesses such as "Bipolar," "Schizophrenia" and Neurogenic "Depression" as the neurological conditions that they truly are, and moreover, are calling for these medical disorders to be renamed.

There is a federal definition of Serious Mental Illness (SMI) for administrative and regulatory purposes, but we do not subscribe to it. It was forged by the same influences that gave rise to what NASNIcares refers to as the crisis of conflation. The most serious "mental illnesses" are in fact brain function disorders—they are medical, they are physical in that they can involve physical anomalies of brain structure and/or systemic bodily functions that disorder the brain's semblance of mind. NASNIcares refers to these medical conditions as Cerebral Illness and across our network of advocacy we refer to these medical conditions as Serious Brain Disorders (SBD) or Brain Function Disorders (indicating that the brain's semblance of mind can be disordered due to systemic factors arising outside of the brain organ, such as in an encephalopathy).

NASNIcares describes Cerebral Illness or SBDs as:

> Disorders of the brain's semblance of mind and consciousness that can involve structural anomalies of the brain organ, and or dysfunctions of neurocircuitry involving metabolic, hormonal, and other systemic factors that affect cognition, metacognition, motor behaviors, volition and actualization, perceptual processing, identity of self (ipseity) and others, the sense of one's habitus, and other faculties and functionalities. These disorders are predominantly hereditary, neurodevelopmental, organic and not caused by childhood adversity, trauma (except for physical injury—such as traumatic brain injury—TBI), or poor mental health.

In the context of parity, we need to consider that it is not logical or just to require one class of medical disorders to have access to healthcare under the construct of parity while other medical disorders are covered under regular medical benefits.

In in a 1996 Senate Hearing, Dr. E. Fuller Torrey spoke to this matter of the illogic of parity within this context and the relevance of how these illness are classified to the IMD Exclusion (the misguided and tragic policy premised on the fallacious notion of "diseases of the mind"). Excerpting from the full text of this hearing which is available online: *https://archive.org/stream/deinstitutionali00unit/deinstitutionali00unit_djvu.txt.*

> My fourth and final point is that the Senate Finance Committee today has the opportunity to correct both of these errors. Number one, you should ensure that health care reform covers brain diseases such as schizophrenia and manic depressive illness in exactly the same way it covers brain diseases such as multiple sclerosis and Parkinsons disease and Alzheimers disease. The brain is a single organ and it is both illogical and discriminating to provide full coverage for some diseases of the brain and not for other diseases of the brain. . . . It would be exactly like covering some diseases of the heart but not covering other diseases of the heart.

Excerpting from an article in *jscimedcentral.com:*

> Advances in neuropsychiatry are increasing our understanding of brain-behavior relationships. With this knowledge, the classification of illnesses as psychiatric and neurologic appears increasingly outdated.

There are historical reasons for the conflation of Mental Health with "Mental Illness" and the demedicalization (psychologization) of neurologic illnesses that afflict consciousness, cognition, and mentation. These historical influences are the origin of the acute attentions that are being paid in the present to mental health—reaching back to the divergence of psychiatry from neurology, the rise of psychosocial psychiatry stemming from that separation, the subjugation of what can be called biological psychiatry, and the Mental Hygiene Movement of the early 20th century.

Prioritization of Funding—Mental Health Versus Serious Brain Function Disorders

On the matter of how we allocate what can be, in some circumstances, scarce resources in terms of funding and the infrastructure of healthcare systems as a whole, we feel that it is important to give careful consideration to priorities when crafting programmatic solutions under the rubric of "mental health." Mental Health relates to non-medical interventions, such as psychotherapy or CBT, peer support programs, and other complimentary services delivered by mental health providers.

Cerebral Illnesses or Serious Brain Function Disorders (which are not mental health issues) relate to inpatient and outpatient medical services—specifically pharmacological treatment, intensive case management, and supported housing with 24/7 onsite staff for the most severely ill individuals that cannot benefit from AOT or who cannot live safely in the family home or independently with social service supports. There is a paucity of these services, especially supported housing and ideologically-driven state recovery models and the IMD exclusion curtail services for most seriously ill.

We do not mean to devalue the importance of mental health and we certainly do not align with dismissive judgements that tag people struggling with mental health issues as the "worried well." We do recognize that mental health problems can be serious enough to lead to suicide. But it is also important for policy makers to be aware that there is what a Bipolar expert within our network describes as "a different type of suicide." This is a neurobehavioral/neurological phenomenon that can be deemed accidental suicide in a sense because the individual's state of consciousness is severely disordered. This is a type of suicide that society generally does not understand. Suicide is generally conceptualized as an act of psychological and emotional distress. Someone in the throes of neurogenic dysmentation within a disordered state of consciousness (psychosis) may be in a state of repose rather than distress and unaware that they are dangerously ill (anosognosia). Despite what professionals with a psychosocial orientation to psychiatry believe, anosognosia is not denial.

However, we do not describe ourselves as mental health advocates and we are aware that what underlies the intense focus on mental health in part are ideas that informed the mental hygiene movement—the belief that poor mental health leads to "mental illness" and that we must funnel the resources of government into the cultivation of good mental health and in doing so, work assiduously to stave off "mental illness."

Excerpting from a paper published in *ncbi.nln.nih.gov* titled "The roots of the concept of mental health":

> What today is broadly understood by "mental health" can have its origins tracked back to developments in public health, in clinical psychiatry and in other branches of knowledge.
>
> . . . more than a scientific discipline, mental health is a political and ideological movement. . . .

Most of America's youth will be okay as mental health is concerned despite some of the alarmist messaging that is promulgated by today's mental health movement, unless by this intense focus on mental health more harm is done to them than good. We want to protect children and young people by promoting mental wellness and resilience, but we need to be circumspect that serious brain function disorders typically encroach upon people during adolescence when the brain is undergoing dramatic changes. The needs of people afflicted by these neurodevelopmental conditions are dire. Failure to identify and treat these grave medical conditions can have catastrophic consequences. We recommend Dr. Henry A. Nasrallah as a preeminent resource to consult on this topic.

Sincerely,

Jennifer Bailey
Project Director
NASNIcares

Jeanne Gore
Coordinator and Co-Chair, Steering Committee
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February 22, 2022

The Honorable Ron Wyden Chairman	The Honorable Mike Crapo Ranking Member

U.S. Senate
Committee on Finance
Washington, DC 20510

U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The National Association for Children's Behavioral Health (NACBH) appreciates the opportunity to provide a written statement for the record, following up on the two excellent Finance Committee hearings on youth mental health held on February 8 and 15.

First, we congratulate the committee for organizing such a huge topic into five areas of inquiry and action. Focusing input from the field, the public, and hearing witnesses in this way will allow a lot to be accomplished in a relatively short time frame.

Hearing witnesses were particularly well-chosen, and NACBH supports the many concrete suggestions they offered, especially around school-based services, crisis intervention, other community-based services, and examples of best practices that could be replicated. In addition, we appreciate the attention called to the pending implementation of the 988 suicide prevention hotline and the need to competently respond to young people who dial in, which includes ensuring that treatment services are actually available and accessible to youth reaching out for help. That is a looming challenge as the July 2022 hotline implementation approaches, and we link it with the longstanding issue of boarding in emergency departments to reiterate NACBH's response to the committee's September 2021 request for information:

Please provide Medicaid funding for the full range of necessary mental health and substance use treatment services by passing H.R. 2611, the Increasing Behavioral Health Treatment Act. This would remove the antiquated and discriminatory IMD exclusion for states that establish: a full array of community-based services; assessment and oversight to ensure treatment placements at the clinically indicated level; engagement strategies for specific populations such as youth and young adults; particular attention to transitions from institutional treatment settings; and annual reporting of demographic and utilization data for system accountability.

With the additional requirements of H.R. 2611, this approach would bring Medicaid mental health and substance use disorder treatment into the 21st century with guardrails to prevent unnecessary institutionalization, and allow low-income and disabled beneficiaries to enjoy the promise of parity offered to most privately insured Americans. The nearly 50-year-old Institutions for Mental Diseases exclusion is the largest violation of parity principles allowed to stand in this country, and truly inexplicable in light of Congressional champions' many passionate and eloquent statements on parity in the private sector.

As Chairman Wyden said on the recent release of the tri-department parity report, "If given the right tools," he is "confident that true mental health parity can become a reality in the American health care system." For child and adolescent services in Medicaid, those tools could include the provisions of H.R. 2611 to fund a comprehensive array of services, use of validated assessment instruments such as CASII and ECSII to guide appropriate placement decisions, and federal definitions of additional 24-hour settings (in Medicaid) and congregate care settings (in child welfare) to ensure federal oversight of safety and quality.

This would be a great opportunity to tackle some of the unfinished business of the Children's Health Act of 2000 and the Family First Prevention Services Act (FFPSA) which is also under this committee's jurisdiction. Part I of the Children's Act has never been implemented, leaving the use of seclusion and restraint in "certain non-medical, community-based facilities for children and youth" entirely unregulated at the federal level. Under FFPSA, four types of child caring institutions are eligible for Title IV–E federal matching funds, but only one is defined: Qualified Residential Treatment Programs. At a minimum, federal definitions should be established for the other three IV–E-eligible child caring institutions—settings specializing in providing prenatal, post-partum, or parenting supports for youth; supervised independent living settings; and settings providing high-quality residential care and support services to children who have been or are at risk of becoming sex trafficking victims—and Part I regulations promulgated for all four. Clearly, these are all programs serving children and youth with unique vulnerabilities and mental health needs, and not only should there be appropriate federal oversight of safety and quality, the Medicaid IMD exclusion should not continue as a barrier for health services reimbursement.

Thank you again for the opportunity to provide a written statement for the record. We will follow up with the staff identified for the five work groups, including additional information on the IMD exclusion and proposed cost offsets for NACBH's policy recommendations.

Sincerely,

Patricia Johnston
Director of Public Policy
pat.johnston@nacbh.org

NATIONWIDE CHILDREN'S HOSPITAL

Statement of David Axelson, M.D., Medical Director of Behavioral Health Services and Chief of Psychiatry and Behavioral Health

The crisis in pediatric behavioral health has become increasingly clear over the last decade, and it has only been exacerbated by the COVID–19 pandemic. Before the pandemic, approximately 1 in 5 children had a mental illness, but less than half of the estimated 7.7 million children who needed services received them from a mental health provider.

Physical distancing, isolation, stressful home environments, and the loss of nutrition and other supports that youth access in schools contribute to the growing crisis. Nationwide, mental health emergencies among children have significantly increased during the pandemic, including:

- A 25% increase in overall mental health-related emergency department visits for 5- to 11-year-olds from 2019 to 2020.
- A 31% increase in overall mental health-related emergency department visits for 12- to 17-year-olds from 2019 to 2020.
- A 14% increase in mental health emergencies for 5- to 17-year-olds seen at children's hospitals in the first two quarters of 2021 compared to the same time period in 2019.

Prior to the pandemic, Nationwide Children's Hospital expanded capacity to serve children with mental and behavioral health concerns. In March 2020, at nearly the exact same time as the pandemic was closing schools, triggering stay-at-home orders and delaying certain kinds of medical treatment, we opened the Big Lots Behavioral Health Pavilion—a behavioral health hospital within Nationwide Children's.

It is the largest pediatric mental health care and research facility of its kind in the United States and a model for integrated care through every level of acuity. The Big Lots Behavioral Health Pavilion enabled an extraordinary expansion of our services and staff. In 2014, we had 418 staff members; today, we have more than 1,100 staff members providing or supporting behavioral health services. With expanded infrastructure and an incredibly dedicated team of providers, allied health care professionals, and support staff, we have dramatically increased the number of patients served. In 2014, Nationwide Children's provided 128,000 outpatient visits. By 2021, this number had grown to more than 257,000.

The Big Lots Behavioral Health Pavilion expanded services and capacity to include a state-of-the-art Psychiatric Crisis Department for children experiencing a mental health crisis; created a 10-bed Extended Observation Unit, allowing for more time to observe and treat patients; expanded from six to 16 the number of beds at the Youth Crisis Stabilization Unit; launched a new inpatient program, which now has 36 beds; and added a Partial Hospitalization Program and two intensive outpatient therapy programs.

Just as importantly, our Pavilion functions as a hub for a community-wide system of pediatric behavioral health care, created with the help of many partners. Our system ranges from prevention services in schools through inpatient services in our Pavilion. The expertise and resources at Nationwide Children's, working in collaboration with community organizations and providers, serve to expand the capacity for child behavioral health in our region.

Despite the significant expansion in infrastructure and workforce, Nationwide Children's is struggling to serve children given the surging demand for services. Referrals to Nationwide Children's Behavioral Health services have continued to climb, reaching 63,000 in 2021, up nearly 20% from 2018. Those referrals have driven growth in ambulatory services, which have expanded significantly over the past five

years, often increasing more than 10% annually. In 2021, Nationwide Children's experienced nearly 260,000 visits in the ambulatory setting, serving 38,751 unique children.

Additionally, patients are continuing to present to the Psychiatric Crisis Department at record numbers, nearing 50 patients in a 24-hour period during peak times. The Psychiatric Crisis Department topped 8,100 visits in 2021, up 35% from the prior year and more than double the number in 2016, when Nationwide Children's Hospital began directly seeing patients in the emergency setting with behavioral health clinicians.

Over the last year, Nationwide Children's has experienced record volumes and high levels of acuity, driving demand for more intensive care, including inpatient services. That, in turn, has had an impact on the number of patients with acute mental health needs who must be "boarded" at our hospital. A boarder is a person in immediate need of inpatient-level psychiatric care, but who must be kept in a medical or observation bed because no behavioral health-specific inpatient beds are available. The boarder census indicates the demand for high acuity behavioral health services in excess of capacity. In 2021, Nationwide Children's Behavioral Health Pavilion, a facility with 56 mental health beds, experienced a daily average of 12 boarders. During peak periods the number was as high as 35.

Recruiting and hiring mental health providers has always been a challenge, and Nationwide Children's continues to struggle to secure the highly specialized workforce needed to serve our patients. In Ohio, 52 of 88 counties don't have a single practicing child and adolescent psychiatrist, and 33 counties are in extreme shortage. That is, only three of Ohio's 88 counties have anything approaching an appropriate number of child and adolescent psychiatrists. Hiring psychiatric nursing and mental health clinicians is also a challenge. For the year ending 2021, Nationwide Children's had 209 budgeted positions unfilled, with the largest percentage of vacancies among therapists/clinicians (66%) and mental health technicians (21%).

Nationwide Children's is a health system committed to youth mental health and that has made historic investments in facilities, mental health promotion programing, and its workforce. Despite these investments, Nationwide Children's, like children's hospitals across the country, struggles to meet the needs of the kids we serve.

In an effort to address the challenges, Nationwide Children's collaborated with peer hospitals in the Children's Hospital Association to develop the Strengthening Kids' Mental Health Now proposal, a set of recommendations focused on mitigating the negative trends in pediatric mental health.

As the Senate Finance Committee examines the youth mental health crisis, I respectfully request the consideration of the Strengthening Kids' Mental Health Now proposal that addresses the needs of children, adolescents, young adults and providers by:

- Increasing investments to support the recruitment, training, mentorship, retention and professional development of a diverse clinical and non-clinical pediatric workforce.
- Expanding pediatric mental health care infrastructure to ensure sufficient capacity to meet the needs of children in crisis who require higher intensity care, such as inpatient services, partial hospitalization or step-down programs.
- Ensuring payment models and reimbursement support for clinical and non-clinical pediatric mental health providers and workers and eliminating implementation barriers hindering coordinated or integrated care.
- Addressing existing inequities within the pediatric mental health care system that contribute to mental health disparities in racial and ethnic minority populations and underserved communities.

Beyond the Strengthening Kid's Mental Health Now proposal, Congress should examine the unfulfilled promise of congressional efforts to ensure mental health parity. Since the enactment of the Mental Health Parity Act of 1996, Congress has pursued the policy goal that coverage for mental health services should be equal to medical and surgical coverage. Legal protections and oversight of mental health parity requirements were strengthened in 2008 with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), and in 2021 with the passage of the Consolidated Appropriation Act.

The 2022 MHPAEA Report to Congress, titled *Realizing Parity, Reducing Stigma and Raising Awareness: Increasing Access to Mental Health and Substance Use Dis-*

order Coverage, highlights the current enforcement challenges. With the passage of the Consolidated Appropriations Act of 2021, the Department of Labor, Department of Health and Human Services and the Department of the Treasury for the first time are proactively reviewing non-quantifiable treatment limitations (NQTLs).

The report indicates that very few health plans are required to document that NQTLs comply with MHPAEA requirements. For example, of the 2 million self-insured health plans regulated by the Employee Benefits Service Administration (EBSA), only 156 plans were required to submit documentation to ESBA justifying compliance: "ESBA concluded that many plans and issuers were deficient in their statutory obligation to perform and document the necessary analyses."

Further, the report states that "a significant number of plans sought extensions on the grounds that the requested analyses either were not complete, or in some cases not yet begun." ESBA documents systemic insufficiency in the comparative analyses submitted by many plans and issuers. During a seven-month period in 2021, all comparative analyses submitted to ESBA were initially insufficient in terms of information provided, plan details, and demonstration of parity compliance among other factors.

While Congress has enacted multiple bills in pursuit of mental health parity, regulation of plans and issuers as described in the 2022 report remains a challenge. Variation in the state-by-state enforcement of fully insured commercial health plans presents another variable in considering why parity remains elusive. These parity issues have an effect on access to mental health services. Anecdotally, we know that children wait months for access to mental health services, or as previously mentioned, children in need of inpatient level mental health care must board in a medical bed until an inpatient psychiatric bed is available. Most frequently, families and youth are waiting 3 months for outpatient services, but in some specialty areas the wait can be 8–12 months before services begin.

Providers observe commercial reimbursement for mental health services at significantly lower levels than reimbursement for medical and surgical health services. Private practice youth mental health providers often accept cash pay only, due to low reimbursement rates and extremely high demand for services.

According to a 2019 Milliman Report titled *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement,* there are significant disparities between medical/surgical and mental health services in terms of both out-of-network utilization levels and provider in-network reimbursement rates. The report utilized a robust claims data analysis to explore the impact of two non-qualitative treatment limitations (network adequacy and reimbursement rates) on access to mental health services.

Among the key findings about network adequacy:

- In 2017, a youth mental health office visit was 10.1 times more likely to be out-of-network when compared to medical/surgical claims.
- In 2017, patients in behavioral health inpatient facilities were 5.2 times more likely to be out of network when compared to similar medical/surgical claims.
- In 2017, patients seeking outpatient behavioral health services were 5.7 times more likely to be out-of-network when compared to similar medical/surgical claims.
- In 2017, 17.2% of behavioral health office visits were out-of-network, compared to 3.2% for primary care providers and 4.3% for medical/surgical specialists.

Comparing average reimbursement as a percentage of Medicare-allowed amounts in 2017:

- Primary care provider reimbursement was 23.8% higher than behavioral health reimbursement.
- Low complexity evaluation and management codes for primary care providers were 22.3% higher than behavioral health reimbursement.
- Moderate complexity E & M codes for primary care providers were 19.7% higher than behavioral health reimbursement.

The Milliman quantitative analysis of claims data from years 2013–2017 demonstrate that in the domains of network adequacy and reimbursement rates, disparities between mental health and medical/surgical health services remain. A claims data analysis alone does not indicate systemic violations of MHPAEA, but it informs our understanding of the current mental health crisis and encourages additional review of the marketplace.

I am grateful to the Senate Finance Committee for taking the time to explore the ongoing youth mental health crisis and public policy aimed at promotion of mental health and expanding access to high quality mental health services for our nation's youth.

NEMOURS CHILDREN'S HEALTH
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February 22, 2022

The Honorable Ron Wyden	The Honorable Mike Crapo
Chairman	Ranking Member
U.S. Senate	U.S. Senate
Committee on Finance	Committee on Finance
219 Dirksen Senate Office Building	219 Dirksen Senate Office Building
Washington, DC 20510	Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of Nemours Children's Health, thank you for holding this important hearing, *Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care,* on February 15, 2022. We are pleased to submit this letter as written testimony for your consideration as you develop a mental health legislative package. We urge you to include the policies outlined below that support the health and well-being of children and families, as well as the mental health infrastructure needed to provide them with accessible, high-quality care.

Nemours Children's Health is one of the nation's largest multistate pediatric health systems, including two free-standing children's hospitals and a network of nearly 75 primary and specialty care practices. Nemours Children's seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child beyond medicine. Nemours Children's also powers the world's most-visited website for information on the health of children and teens, *KidsHealth.org*.

The Nemours Foundation, established through the legacy and philanthropy of Alfred I. duPont, provides pediatric clinical care, research, education, advocacy, and prevention programs to the children, families and communities it serves.

Background

The COVID–19 pandemic has exacerbated a host of stressors for children and families and contributed to the pediatric mental health crisis we are currently facing. Children have experienced more stress from changes in their routines, breaks in the continuity of learning and health care, missed life events, and an overall loss of security and safety.[1] In addition, sentinel agencies are reporting declines in referrals as fewer child-serving professionals are making reports of concern for child safety, such as the decline in referrals for concerns about maltreatment and neglect to child welfare agencies since March 2020.[2]

Nationally, mental health-related emergency department visits increased by nearly 25% for children age 5–11 and by over 30% for those 12–17 years during April through October 2020, compared to the same period in 2019.[3] Many children are requiring more immediate and intensive treatments, have a higher probability of admission, and are staying in the hospital longer.[4] These challenges may result in lasting impacts on children if they do not receive appropriate supports. Unfortu-

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[1] Centers for Disease Control and Prevention. (2020). *COVID–19 parental resources kit.* Retrieved 2021, May 11th from: *https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/parental-resource-kit/index.html.*

[2] Brown, S.M., Orsi, R., Chen, P.C.B., Everson, C.L., and Fluke, J. (2021). The impact of the COVID–19 pandemic on child protection system referrals and responses in Colorado, USA. *Child maltreatment,* 10775595211012476.

[3] Leeb, R.T., Bitsko, R.H., Radhakrishnan, L., Martinez, P., Njai, R., and Holland, K.M. (2020). Mental health-related emergency department visits among children aged <18 years during the COVID–19 Pandemic—United States, January 1–October 17, 2020. *MMWR. Morbidity and mortality weekly report,* 69(45), 1675–1680, *https://doi.org/10.15585/mmwr.mm6945a3.*

[4] Krass, P., Dalton, E., Doupnik, S.K., and Esposito, J. (2021). US pediatric emergency department visits for mental health conditions during the COVID–19 Pandemic. *JAMA Network Open,* 4(4), e218533–e218533, *https://doi.org/10.1001/jamanetworkopen.2021.8533.*

nately, it is estimated that more than 45% of children diagnosed with a behavioral health disorder do not receive treatment.[5]

At Nemours Children's Hospital, Delaware, our emergency department saw an increase of more than 80% in visits for suicidality or intentional harm in 2021 compared to 2020. Nemours Children's Hospital, Florida from 2020 to 2021, saw a 55% increase in patients in our emergency department with chief concerns of suicidality or intentional harm. Our behavioral health providers across our system have shared that our patients are increasingly experiencing higher levels of anxiety and depression, and grief from deaths of caregivers or family members. In outpatient and ambulatory care across our Florida operations, 85% of children screened had anxiety, depression, or another form of a behavioral health symptom.

We applaud the Surgeon General for raising the youth mental health crisis as a priority public health challenge. As the Surgeon General notes in his advisory, it will take time to resolve the many mental, emotional and behavioral (MEB) health challenges that children and youth are facing. However, the time to begin is now. We urge Congress to consider these five priorities to address barriers to providing high quality pediatric and youth mental health preventive services, supports and care:

- Address the social factors that contribute to poor mental health.
- Support the pediatric MEB health workforce.
- Strengthen reimbursement for MEB health services.
- Sustain and expand access to telehealth.
- Invest in pediatric MEB health infrastructure.

Address the Social Factors that Contribute to Poor Mental Health

We urge Congress to center its approach to addressing MEB health issues for children and youth in prevention. With a healthy start in life and appropriate care and developmental supports, a child's health trajectory can be significantly improved.

There is great opportunity through the Centers for Medicare and Medicaid Services (CMS) to go well beyond medicine to advance innovative, multi-sector, integrated care models that address the unique providers, settings and needs of children, with a focus on prevention and optimal development. The Medicaid program is an important lever because it covers 27 million children and 42% of births nationally.[6]

Over the past few years, CMS and the Department of Health and Human Services (HHS) have taken significant strides to test new models as well as improve interoperability and exchange of health data, which is critical to promoting holistic approaches. Additionally, CMS has promoted options for states, providers and payers to address social determinants of health (SDOH) and advance value-based care through guidance, waivers and new models. For the most part, these efforts have been limited to a few vanguard states. To help support a broader segment of the pediatric population while focusing on prevention and early identification of MEB health needs, we need to incentivize holistic pediatric payment and delivery models that address physical health, MEB health and SDOH. CMS can help catalyze these models that have great potential for long-term impact.

We suggest that Congress authorize and fund a Whole Child Health demonstration model within the Centers for Medicaid and CHIP Services (CMCS). The demonstration would support and test integrated, community based pediatric collaborations that align financial incentives and resources across Medicaid and other public and private programs to address SDOH, improve MEB health and well-being, and reduce health disparities among pediatric populations. Models would be designed with input and engagement from community residents, Medicaid beneficiaries, and organizations, and be informed by a comprehensive needs and assets assessment in target communities.

Additionally, we encourage Congress to direct CMS to review the early and periodic, screening, diagnostic and treatment (EPSDT) requirements and how they are being implemented across the states to support access to needed mental health services and early intervention services critical to children's well-being. CMS should provide guidance to ensure consistent application across states on what is required to ensure children are better supported at the community and family levels, addressing

[5] Centers for Disease Control and Prevention. (2021, March 22). *Data and statistics on children's mental health.* Retrieved 2021, May 27th from: *https://www.cdc.gov/childrensmentalhealth/data.html.*

[6] MACPAC states that Medicaid covers 43% of births: *https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf.*

the social challenges contributing to health disparities and a lack of healthy early development and prevention services.

Finally, we support enactment of the LINC to Address Social Needs Act (S. 509, *https://www.congress.gov/bill/117th-congress/senate-bill/509?r=1*), which would provide states with up to $150M for public-private partnerships to develop or enhance integrated, cross-sector solutions to better coordinate health and social services.

Support the Pediatric MEB Health Workforce

MEB health provider shortages are persistent and severe in pediatric health care, and these shortages are projected to worsen over time. There is an opportunity to ensure that workforce development programs support a broad base of provider types, including MEB health specialists, primary care physicians, developmental and behavioral pediatricians, nurses, social workers, community health workers, and others. Developing this capacity and integrating more providers into the MEB health care model would help address the provider shortage by promoting identification of concerns and referrals from a variety of providers. To ensure children have care options that meet their needs, resources must support a range of child and adolescent-centered, community-based prevention and treatment services.

We support the Helping Kids Cope Act of 2021 (H.R. 4944, *https://www.congress.gov/bill/117th-congress/house-bill/4944?q=%7B%22search%22%3A%5B%22hr+4944%22%5D%7D&s=1&r=1*). This bill would provide funding for pediatric behavioral health care integration and coordination, allowing flexibility to fund a range of community-based activities such as recruitment and retention of community health workers or navigators to coordinate care, pediatric practice integration, supporting pediatric crisis intervention, community-based initiatives such as school-based partnerships, and initiatives to decompress emergency departments.

The high cost of education is another contributing factor to current provider shortages. Students who graduate with psychology doctorates, for example, have a median student loan debt of $82,000.[7] We support pediatric mental health workforce training and loan repayment programs such as the Health Resources and Services Administration's (HRSA) Pediatric Subspecialty Loan Repayment Program, and recommend that funds are made available for MEB health providers across adult and pediatric specialties. Additionally, we support loan repayment incentives, such as those offered through the Minority Fellowship Program, to increase workforce diversity across child-serving behavioral health providers.

Strengthen Reimbursement for MEB Health Services

Provider shortages are compounded by low reimbursement, discouraging individuals from entering the profession. Commercial health insurers, Medicaid, the Children's Health Insurance Program (CHIP) and other payers have historically provided insufficient coverage and payment for MEB health services.[8] Payment rates for behavioral health providers are typically based on a fee schedule that is considerably lower than that of a medical/surgical provider. Lower rates based on these fee schedules has spillover effects on contract negotiation with payers, challenging children's hospitals to successfully contract with payers in a way that appropriately reimburses for MEB health services. When such negotiations are not successful, access to services becomes even more limited in a patient's covered provider network.

Sustainable reimbursement that supports Medicaid providers is needed to enhance children's access to the full continuum of care. We urge Congress to increase Medicaid reimbursement rates for pediatric MEB health services to Medicare levels, or to increase the Federal Medical Assistance Percentage (FMAP) for pediatric MEB health services to 100%. We also support inclusion of an increased FMAP for a *High Performing Child Medical Home.* A High Performing Child Medical Home would include components that promote prevention, child development, parenting supports, behavioral health, and referrals to various service providers that can address social needs, risk factors and determinants of health. Such an approach—which includes coordinated, team-based, whole-person care models—could help to promote positive

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[7] Stamm, K., Doran, J., Kraha, A., Marks, L.R., Ameen, E., El-Ghoroury, N., Lin, L., and Christidis, P. (2015). How much debt do recent doctoral graduates carry? *American Psychological Association's Center for Workforce Studies,* 46(6): *https://www.apa.org/monitor/2015/06/datapoint.*

[8] Melek, S., Davenport, S., and Gray, T.J. (2019, November 19th). *Addiction and mental health vs physical health: Widening disparities in network use and provider reimbursement.* Milliman, Inc.: *https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.*

social and emotional development and potentially prevent MEB health issues from arising.

Finally, we support expanded utilization of family and youth peer support specialists through enhanced Medicaid reimbursement, funding to train and certify peer support specialists, and technical assistance for state Medicaid programs interested in expanding the model. Peer specialists can extend the existing provider workforce by using their lived experience with MEB health needs to support others. In bright spots across the country, peer support specialists are integrated into care teams or into schools, and peer-led organizations as valued community partners. Grief counseling, rising to new importance during COVID–19, has long found benefits of peer support in normalizing experiences for children, youth, and caregivers.[9] Unfortunately, youth and family peer support is not systematic, and few children have access, while many peer supporters do not receive the reimbursement and support they need. The same is true for many other professionals and paraprofessionals in supporting roles, such as community health workers (CHWs).

Sustain and Expand Access to Telehealth

Throughout the COVID–19 pandemic, greater state and federal regulatory flexibilities have increased the availability and convenience of telehealth services for children and families. Nationwide, psychiatry continues to rely on telehealth at a far greater rate than any other physician specialty. Between January 2021 to February 2022, nearly 65% of all Nemours Children's telehealth visits were psychology and psychiatry visits.

Extending and expanding telehealth for children and families also helps address regional shortages with respect to the availability of mental health care generally (*e.g.,* in underserved rural areas), and specific competencies (*e.g.,* evidence-based approaches to grief counseling) that are not widely available. This is a pathway to increase access and address inequity, though additional barriers including access to technology and broadband Internet will remain for some families. These infrastructure deficiencies must also be addressed.

We strongly recommend permanent extension of the telehealth flexibilities provided during the pandemic, particularly those that allow providers to care for patients across state lines. One intermediate step would be to pass the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act (S. 168/H.R. 708, *https://www.congress.gov/bill/117th-congress/senate-bill/168/text?q=%7B%22search%22%3A%5B%22TREAT+Act%22%2C%22TREAT%22%2C%22Act%22%5D%7D&r=4&s=3*), which would provide temporary licensing reciprocity for health care professionals for any type of services provided, within their scope of practice, to a patient located in another state during the COVID–19 pandemic.

Additionally, we support the Enhance Access to Support Essential Behavioral Health Services (EASE) Act (S. 2112/H.R. 4036, *https://www.congress.gov/bill/117th-congress/senate-bill/2112/text?q=%7B%22search%22%3A%5B%22EASE+Behavioral+Health+Act%22%2C%22EASE%22%2C%22Behavioral%22%2C%22Health%22%2C%22Act%22%5D%7D&r=1&s=1*) to expand the scope of required guidance, studies, and reports that address the provision of telehealth services under Medicaid, including in schools. Another important bill is the Telehealth Improvement for Kids' Essential Services Act (TIKES) Act (S. 1798/H.R. 1397, *https://www.congress.gov/bill/117th-congress/senate-bill/1798/text?q=%7B%22search%22%3A%5B%22TIKES+Act%22%2C%22TIKES%22%2C%22Act%22%5D%7D&r=1&s=2*), which would promote access to telehealth services for children through Medicaid and CHIP, as well as study children's utilization of telehealth to identify barriers and evaluate outcomes.

Invest in Pediatric MEB Health Infrastructure

Finally, investments in pediatric mental health infrastructure are critical and urgently needed to prevent children in crisis from boarding in emergency departments and to enable their swift placement in appropriate care. There is also a vital need to increase access to alternatives to inpatient and emergency department care including step-down, partial hospitalization, intensive outpatient services and day programs. These types of programs ensure that children and adolescents continue to receive intensive services and supports they need while alleviating pressure on acute care settings. We support the Children's Mental Health Infrastructure Act (H.R. 4943, *https://www.congress.gov/bill/117th-congress/house-bill/4943?q=%7B*

[9] McClatchey, I.S., Vonk, M.E., and Palardy, G. Efficacy of a camp-based intervention for childhood traumatic grief. *Res Soc Work Pract.* 2009;19(1):19–30.

%22search%22%3A%5B%22hr+4943%22%5D%7D&s=5&r=1) to support additional pediatric care capacity for behavioral and mental health services.

CONCLUSION

Nemours stands ready to leverage our expertise and relevant experiences to assist the Committee as it works to develop a comprehensive mental health legislative package. Thank you for your consideration of our recommendations, and we look forward to continued collaboration. Please do not hesitate to reach out to me at Daniella.Gratale@nemours.org or to Katie Boyer at katie.boyer@nemours.org with questions or requests for additional information.

Sincerely,

Kara Odom Walker, M.D., MPH, MSHS	Daniella Gratale, MA
Executive Vice President	Director,
Chief Population Health Officer	Office of Child Health Policy and Advocacy

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February 24, 2022

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for holding this month's hearings, "Protecting Youth Mental Health: Part I—An Advisory and Call to Action" and "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," held February 8 and February 15, 2022, and for initiating a process to advance legislation to address the mental health and addiction crises. We appreciate the opportunity to have this letter entered into the hearing record.

Partnership to End Addiction is a national nonprofit uniquely positioned to reach, engage, and help families impacted by addiction. With decades of experience in research, direct service, communications, and partnership-building, we provide families with personalized support and resources—while mobilizing policymakers, researchers, and health care professionals to better address addiction systemically on a national scale.

We greatly appreciate the Committee dedicating two hearings to the issue of youth mental health. We are also concerned by this growing crisis, as untreated mental illness is a significant risk factor for substance use, and mental illness and substance use disorder frequently co-occur. As highlighted by many witnesses and committee members, school-based mental health services are critically needed to reach more youth. We urge the Senate to advance the Mental Health Services for Students Act (S. 1841), the Pursuing Equity in Mental Health Act (S. 1795), and the Suicide Training and Awareness Nationally Delivered for Universal Prevention (STANDUP) Act (S. 1543). We encourage Congress to facilitate an earlier and broader approach to substance use prevention [1] that includes mental health, as well as other fields that promote child health and resilience and structural changes that fa-

[1] *https://drugfree.org/reports/rethinking-substance-use-prevention-an-earlier-and-broader-approach/*.

cilitate healthy and stable families. As described in our blog[2] published by *Health Affairs,* there are a number of policy initiatives to improve family stability and security and child health and resilience that Congress has recently undertaken in COVID–19-related legislation or is currently exploring in the Build Back Better Act. While these policy changes are seemingly outside the realm of substance use, they are critically important for prevention and will also reduce the risk for other negative mental and behavioral health outcomes that have the same risk and protective factors as substance use. As explained by the Surgeon General in response to questions from Sen. Warren, increasing access to affordable child care, for example, is important for improving children's mental health, along with other early investments in health and well-being. Sen. Casey and the Surgeon General similarly highlighted that children's mental health does not exist in a vacuum, and that broader family, community, and societal circumstances must also be addressed in order to protect youth. We encourage the Committee to consider such policies for inclusion in a legislative package.

To address many of the issues raised during the hearing, including the lack of access to evidence-based treatment and barriers to care, inadequate insurance coverage, inappropriate crisis response, and the need to meet people where they are with services and integrate services into the many systems with which youth interact, we encourage you to advance the following bills currently before your committee:

Medicaid Reentry Act (S. 285)

As noted in the hearings, youth with mental health disorders are overrepresented in the juvenile justice system. While using Medicaid to cover school-based mental health services was repeatedly discussed, another place Medicaid can have a role in expanding access to care is the criminal justice system. Individuals in jails and prisons have disproportionately high rates of mental health and addiction, and they face significant risk upon release. Individuals released from incarceration are often unable to afford or access care due to a lack of insurance coverage, as they lose their Medicaid benefits upon incarceration, and it can often take weeks or months to reinstate coverage. The Medicaid Reentry Act would help ease connections to community-based mental health and addiction services by allowing Medicaid-eligible individuals to restart coverage 30 days prior to release.

Crisis Assistance Helping Out On The Streets (CAHOOTS) Act (S. 764)

As both Chairman Wyden and Sen. Cortez Masto highlighted in the hearings, the CAHOOTS program in Eugene, Oregon, can serve as an exemplary model for other states and localities to improve their behavioral health crisis response systems by sending trained behavioral health providers to address such crises, rather than police. People in crisis related to mental illness and substance use disorder are more likely to encounter police than get medical attention, resulting in millions of people with mental health and addiction being jailed every year. As you know, mental health and substance use disorders are health care issues, not crimes, and an appropriate crisis response should connect people to care, not jail. We encourage the Committee to advance the CAHOOTS Act to provide states with enhanced Medicaid funding and grants to adopt community-based mobile crisis services.

Non-Opioid Prevent Addiction in the Nation (NOPAIN) Act (S. 586)

Despite the existence of effective non-opioid pain management options, availability remains limited due to misaligned reimbursement policies that incentivize the use of opioids over the use of non-opioid alternatives. Under current law, hospitals receive the same payment from Medicare regardless of whether a provider prescribes an opioid or non-opioid, which leads hospitals to largely rely on opioids dispensed at a pharmacy after discharge at little or no cost to the hospital. The NOPAIN Act would help address this by directing the Centers for Medicare and Medicaid Services to provide separate Medicare reimbursement for non-opioid treatments used to manage pain in the hospital outpatient department and ambulatory surgery center settings. This can help ensure that safe, non-addictive therapies are available and reduce unnecessary exposure to opioids and the likelihood of opioid misuse or addiction.

Tobacco Tax Equity Act (S. 1314)

While tobacco and nicotine were not directly discussed during the hearing, nicotine is one of the most commonly used addictive substances among youth. One of the most effective ways to reduce tobacco use among youth is to increase the price of

[2] *https://www.healthaffairs.org/do/10.1377/forefront.20210607.239986/full/.*

tobacco products. The Tobacco Tax Equity Act currently before the Committee would increase the federal tax rate on cigarettes, peg it to inflation to ensure it remains an effective public health tool, and set the federal tax rate for all other tobacco products at the same level (including e-cigarettes, which are particularly popular among youth).

We also encourage you to address:

Insurance Parity

As several witnesses and members, including Chairman Wyden, noted, lack of parity creates many barriers to behavioral health care for youth. Existing parity law must be better enforced, as insurance companies continue to violate it, as highlighted by the administration's recent report cited by the Surgeon General. Further, despite Congress's prior work to improve insurance coverage for mental health and addiction treatment, it will be impossible to ensure parity unless the Mental Health Parity and Addiction Equity Act is fully extended to Medicare, all of Medicaid, and TRICARE. In addition to leaving millions of people without adequate mental health and addiction coverage, Medicare's exclusion from parity laws is additionally problematic because Medicare serves as a benchmark for other forms of health coverage.

Thank you again for your commitment to addressing the mental health and addiction crises and for considering the above bills for inclusion in a legislative package. We would be happy to answer any questions or provide additional information to assist in your work.

Sincerely,

Partnership to End Addiction

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February 15, 2022

The Honorable Ron Wyden	The Honorable Mike Crapo
Chairman	Ranking Member
U.S. Senate	U.S. Senate
Committee on Finance	Committee on Finance
Washington, DC 25510	Washington, DC 25510

Dear Chairman Wyden and Senator Crapo,

I write today to submit this letter as the Primary Care Collaborative's statement for the record regarding the Committee on Finance's hearing, "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care," held February 15, 2022. PCC commends the Committee's ongoing work to develop a bipartisan response to the mental health and substance abuse crises in the United States, including the emergency in children's mental health and well-being. This letter describes the Primary Care Collaborative's (PCC) recommendations as this work proceeds.

PCC is a nonprofit, nonpartisan, multi-stakeholder coalition of 60+ organizational Executive Members (*https://www.pcpcc.org/executive-membership*) ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships, and "upstream" determinants for better patient experience and better health outcomes. (See the Shared Principles of Primary Care, *https://www.pcpcc.org/about/shared-principles#Continuous*.)

America's specialty behavioral health delivery system is overwhelmed by increasing suicide rates,[1] accelerating rates of substance use disorder deaths,[2] and a tripling

[1] Hedegaard, H., Curtin, S.C., and Warner, M. Suicide mortality in the United States, 1999–2019. NCHS Data Brief, no 398. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: *https://dx.doi.org/10.15620/cdc:101761.*

[2] Hedegaard, H., Miniño, A.M., and Warner, M. Drug overdose deaths in the United States, 1999–2019. NCHS Data Brief, no 394. Hyattsville, MD: National Center for Health Statistics. 2020.

in the prevalence of depressive symptoms since the beginning of the pandemic.[3] Moreover, noted disparities in mental health by rurality and economic circumstances exist, and for the first time in several years, there are proportionally more drug-induced deaths among Blacks than whites.[4] Your public, bipartisan commitments to meaningful legislation are an important step toward a national response to these crises. However, your legislation and the United States can only successfully meet this challenge by leveraging team-based primary care that includes behavioral health integration and is available in *all* communities.

Primary care teams with strong, ongoing patient-relationships are uniquely able to identify behavioral health concerns, triage challenges, and help patients find the right level and setting of care. More mental health care is rendered in the primary care setting than anywhere else, including the mental health care sector where this has been the case for at least the past four decades.[5] An adequate response to the multiple current behavioral health crises demands recognizing that reality. It also requires recognizing that primary care clinicians, particularly those that serve populations who have been historically marginalized, are overextended and desperately in need of enhanced support. Team-based integrated behavioral health can improve outcomes and decrease costs. By leveraging the full healthcare team, the U.S. can most appropriately leverage behavioral health professionals to help those in need of care.

The Foundation for Progress: Payment Reform and Investment in Primary Care

Efforts to scale behavioral health-primary care integration are hampered by the overall chronic underinvestment in the primary care sector. To assure a strong foundation for comprehensive, integrated advanced primary care, it will be necessary to change both how the U.S. pays and how much the U.S. invests in primary care. The U.S. currently devotes just 5–7 percent of health spending to primary care, a proportion lower than other nations.[6] Primary care practices need pathways to rapidly transition from a predominantly fee-for-service (FFS) model, to a predominantly population-based prospective payment models that would include adjustments for health status, risk, social drivers, and other factors. The National Academies of Science Engineering and Medicine has recommended making hybrid models (part FFS, part per member per month payment)[7] as the default for Medicare and Medicaid, rather than the fee-based system that consistently and systematically undervalues the cognitive work reflected in primary care and behavioral health services.

Over the medium and long term, broader change in how we pay and how much we pay for primary care is vital. PCC is working with our Executive Members and other stakeholders to identify bold steps to strengthen the primary care foundation needed for a health system that achieves equitable outcomes through high-quality, affordable, patient-centered care.

However, in the interim, primary care teams and many of their patients live daily with a national crisis of poor mental well-being and substance use. Exacerbated by COVID–19 and associated economic disruptions, this crisis hits hardest in communities already grappling with health inequities. Because improvements in overall physical health can be more difficult to achieve when individuals face behavioral health comorbidities, this crisis also threatens to derail the fight against other chronic health challenges including heart disease, diabetes, and cancer.

The Finance Committee's legislative work must both respond to the urgency of the immediate behavioral health crisis and lay the groundwork for transformed and integrated whole-person primary care.

[3] Ettman, C.K., Abdalla, S.M., Cohen, G.H., Sampson, L., Vivier, P.M., and Galea, S. Prevalence of Depression Symptoms in US Adults Before and During the COVID–19 Pandemic. *JAMA Network Open*. 2020;3(9):e2019686. doi:10.1001/jamanetworkopen.2020.19686

[4] Pain in the Nation: Alcohol, Drug and Suicide Epidemics. Trust for America's Health and Well-Being Trust. May 2021. *https://www.tfah.org/wp-content/uploads/2021/05/2021_PainInTheNation_Fnl.pdf.*

[5] Regier et al., *JAMA* 1978; Jetty et al., *Journal of Primary Care and Community Health,* 2021.

[6] Investing in Primary Care: A State-Level Analysis. Primary Care Collaborative. July 2019. *https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf.*

[7] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. *https://doi.org/10.17226/25983.*

Paying for Behavioral Health Integration in Medicare and Medicaid

When provided adequate resources, primary care has the capacity to be flexible. It can effectively provide what patients need and/or connect those patients to other care or resources. At present, evidence supports multiple integrated behavioral health delivery models in primary care, including the collaborative care model and the primary care behavioral health model.[8, 9] To maximize the number of patients that can benefit from integrated care across diverse practice settings and communities, primary care payment options must be available to support a variety of evidence-based models of integration. Payment policy that supports multiple care integration models has two additional merits; it can support the development of real-world implementation evidence across diverse populations, and spur further innovation in behavioral health integration at the practice level and in practice/payer collaboration.

For these reasons, PCC supports a multi-component policy approach to behavioral health integration. This approach would provide immediate support for scaling integration through the fee-based payment methodologies most broadly in use today while testing new ways to integrate behavioral health into comprehensive advanced primary care payment models.

Promote Medicare's Existing Collaborative Care and Behavioral Health Integration Codes

Existing behavioral health integration codes, currently available in the Medicare Physician Fee Schedule, are underutilized in Medicare relative to the prevalence of behavioral health conditions among beneficiaries. Existing Medicare payment values for behavioral health integration should be reassessed to determine whether they are sufficient to expand utilization and meet the exigencies of the present crisis.

Waive the Medicare Fee Schedule Budget Neutrality Requirements for Primary Care—Behavioral Health Integration

The Medicare Physician Fee Schedule's budget neutrality requirements are a barrier to increased payment and new payment codes for primary care-behavioral health integration. When new codes are adopted, these neutrality requirements can result in across-the-board cuts that affect other primary care services. Insofar as Medicare depends on fee-based payment to expand access to integrated behavioral health care in the current behavioral health crisis, the Congress should exempt new investments in behavioral health integration codes from the current fee schedule budget neutrality requirements.

One approach would be to establish a new code available as an add-on code for all Evaluation and Management claims when a practice can demonstrate the capacity for integrated behavioral care. Such a code would complement and support broader utilization of the existing behavioral health codes, rather than replacing them. Practices would be required to attest to certain core functionalities, such as the ability to screen for behavioral health challenges, offer care management, medication management, participate in measurement-based care through a registry, deliver short-term psychosocial therapy in the practice, and integrate evidence-based treatment for behavioral health conditions, either in person or virtually.

Test Behavioral Health Integration Strategies as Part of a Per Member Per Month Approach to Primary Care Payment

Moving more of the American health care financing system to a value-based model is key to supporting care integration. When payers place emphasis on outcomes rather than services, primary care practices are put in a better situation to focus on the health of their patients rather than the volume of their service. Policymakers should pursue the development and testing of prospective primary care payment models, such as per-member per-month approaches, that adequately support integrated advanced primary care addressing both physical and behavioral health care needs. However, work may be needed to optimize the balance between external referrals and services delivered in the primary care practice itself. Various integration thresholds, standards, and performance measures should be tested using CMS Innovation Center authorities, Medicaid 1115 demonstrations, other CMS demonstration

[8] Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model. American Psychiatric Association. 2016. *https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn.*

[9] Kearney, L.K., Post, E.P., Pomerantz, A.S., and Zeiss, A.M. (2014). Applying the interprofessional patient aligned care team in the Department of Veterans Affairs: Transforming primary care. *American Psychologist,* 69, 399–408. *http://dx.doi.org/10.1037/a0035909.*

authorities, and/or Congressionally authorized demonstrations. PCC encourages the Committee to work with CMS to ensure that primary care integration remains a priority.

Address Low Medicaid Payment Rates in Some States for Pediatric Mental Health Services and Access to Services in Schools

The American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association declared a national emergency in child and adolescent mental health last fall, an assessment endorsed by several of PCC's Executive Member organizations including the American Academy of Family Physicians, American Psychiatric Association, American Psychological Association, and Mental Health America.[10] Low payment rates, common in many state Medicaid programs, weaken provider engagement and participation in Medicaid and directly relate to the mental health access challenges for children. Additionally, children's behavioral health needs should be identified and access to services should be provided where they are. Better assistance and technical guidance to schools regarding appropriate reimbursement can help support service delivery to Medicaid-eligible and enrolled students, in coordination and collaboration with their behavioral health providers.

Addressing Other Barriers to Behavioral Health Integration

Investing in and paying for integrated care, as described above, is fundamental. But these changes alone may not be sufficient without addressing certain specific barriers to broader integration of primary care and behavioral health.

Remove In-person Requirements for Tele-mental Health Services

Once the current COVID–19 Public Health Emergency expires, current Medicare statute and regulation bar reimbursement for tele-mental health services unless a patient has had an in-person encounter with a member of the same provider group in the previous six months and require an in-person visit every twelve months. This limits the ability of primary care practices to leverage tele-mental health services to deliver comprehensive and integrated care. The CY 2022 Medicare Part B Physician Fee Schedule Final Rule promulgated these in-person visit requirements for Medicare reimbursement of tele-mental health services, both prior to the initial telehealth service and every twelve months thereafter. The Committee's legislation should remove the requirement for in-person visit for tele-mental health visits enacted by the Consolidated Appropriations Act of 2021, repeal the promulgated requirements and leave the decision of the appropriate modality of tele-mental health care to the care team and the patient.

Assure Access to Upfront Resources to Support Transition to Integrated Care

For any primary care practice, the transition to new integrated models of care delivery can involve significant expense, training, technology upgrades and workflow changes. It may involve retraining or expanding the primary care team, including, but not limited to, nurse case managers, psychiatrists, nurse practitioners, psychologists, social workers, counselors and peer support workers.

To support these changes, practices pursuing integration typically must rely on time-limited grants or partnerships with larger entities, like health plans or health systems. Others have depended on limited duration demonstrations or CMS Innovation Center Models to resource these changes. Yet this limited, ad-hoc approach has failed to enable widespread, sustained implementation of behavioral health integration in primary care.

HHS should work with Congress to develop and enact a broadly available program of forgivable loans to finance costs associated with transformation. Practice support for these transitional costs is particularly crucial for primary care practices which are smaller in size, operate independently, and/or serve lower-income communities. To support rapid scaling, transitional support should be available on a nationwide basis, not confined to a limited-scope demonstration.

Ensure Resources for Ongoing Practice Transformation

The reality is that practice transformation is not a one-time expense. The best models of behavioral health integration may evolve based on experience and new medical and implementation science. Moreover, the challenge of practice transformation extends beyond behavioral health integration. Some primary care practices are shifting to more comprehensive models of care that integrate across more domains

[10] *See https://www.soundthealarmforkids.org/partners/.*

of care including those that address health-related social needs and oral health.[11, 12] Permanent, long-term sources of training and technical assistance for comprehensive, integrated care models are necessary to assure access to the best evidence-based approaches over time.

One potential policy vehicle to encourage practice transformation over the long term—the Primary Care Extension Program (PCEP)—has already been statutorily authorized.[13] As the U.S. Agricultural Extension service has promoted evidence-based practices in agriculture and community development, the PCEP could assist primary care through practice facilitation and community-based collaborations. Yet Congress has so far failed to appropriate resources for this important work. PCC urges the Committee to explore whether this program could provide the technical assistance and support that primary care practices need or whether other programs should be established.

Promoting Behavioral Health Integration Across Payers

Convene Stakeholders to Align Integration Efforts

Payers that work together to align documentation, measurement and model design related to integrated care face potential anti-trust action. However, state and/or federal bodies can convene payers and clinician representatives with the goal of aligning documentation, measurement, and payment innovations associated with behavioral health integration.

The Committee should seek to ascertain whether all states have the resources necessary and whether CMS has the capacity to support the states in this vital work.

Incorporate Behavioral Health Coding and Billing as Standard Features in Electronic Health Records

Vendors require practices to pay extra for the module that supports billing for existing integrated care codes. PCC has asked CMS, working with the Office of the National Coordinator for Health Information Technology, to adjust the definition of CEHRT technology to address this challenge. PCC encourages the Committee to work with CMS to realize this important policy goal.

Even as the COVID–19 pandemic continues to sweep American communities, the depth of the mental and behavioral health crisis is difficult to understate. The inequities in well-being that underlie that crisis are glaring. The time is now for bold action to support behavioral health integration in primary care. PCC urges you to work on a bipartisan basis to enact strong legislation this year. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions.

Sincerely,

Ann Greiner
President and CEO

STATEMENT SUBMITTED BY ETHAN J.S.H. REED

Honorable Chairman Wyden, Ranking Member Crapo, and members of the Finance Committee, thank you for giving me this opportunity and platform as a young person in this country to express my concerns in regards to the youth mental health crisis the young people are facing across this country.

Currently, I am beginning work with congressional leadership and other members of Congress—including several committees with jurisdiction on mental health, to ensure Congress passes critical funding and investments towards mental health serv-

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[11] The Primary Care Collaborative. (January 2021). Innovations in Oral Health and Primary Care Integration: Alignment with the Shared Principles of Primary Care. *https://www.pcpcc.org/resource/innovations-oral-health-and-primary-care-integration-alignment-shared-principles,* National Academies of Science, Engineering and Medicine. (2019). Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. *https://www.nap.edu/read/25467*.

[12] Kreuter, M.W., Thompson, T., McQueen, A., and Garg, R. Addressing Social Needs in Health Care Settings: Evidence, Challenges, and Opportunities for Public Health. *Annu Rev Public Health.* 2021;42:329–344. doi:10.1146/annurev-publhealth-090419-102204.

The Primary Care Collaborative. (January 2021). Innovations in Oral Health and Primary Care Integration: Alignment with the Shared Principles of Primary Care, *https://www.pcpcc.org/resource/innovations-oral-health-and-primary-care-integration-alignment-shared-principles.*

[13] 42 U.S.C. § 280g–12.

ices and professionals to provide adequate support to the thousands of young people across this country who are suffering from a mental health issue.

One of the most important things Congress can do right now to take action on combating the current youth mental health crisis is to pass immediate federal funding to mental health professionals and services. Right now, there are multiple funding investments towards mental health in the original Build Back Better Act, and so I am urging congressional leadership to transfer the funding provisions into another form of legislation to further expedite the funding. It is something I've constantly heard as concerns from associates of Mental Health America, experts in the field, and even members of Congress. It is with my best hope that the honorable committee will support this effort on getting much needed funding immediately passed.

As I understand, mental health telehealth capabilities are of major concern to this Committee, and I share this concern for thousands, if not millions of Americans across this country who do not have easier access to facilitate mental health services and professionals. A few years ago when I served on a state youth advisory council for the Colorado legislature, I had the opportunity to speak with other young people across the state—and more specifically, those in the rural parts of Colorado such as the Eastern plains. Some of the youth expressed the troubles of having readily access to mental health services and professionals due to their area. I am proud to stand with Congressman Joe Neguse of Colorado on his bill, H.R. 6076, the CARE for Mental Health Professionals Act, which would allow providers to enter into interstate compacts that would expand the workforce of credentialed mental health professionals to serve patients whom may not be in the same state as they are. This will help close the gap between rural and urban communities across this country to be able to get the services and support they need whenever, and wherever they may reside.

While those are some of the only pieces of legislation I've focused on in regards to mental health, I am proud to support dozens of mental health pieces of legislation that I believe as a young person will truly provide adequate services and support to my generation as we continue to face the mental health crisis. I thank each and every member of Congress (including those in leadership) who have been fighting the good fight with me, and I appreciate the efforts made by so many—especially including Congressman Tony Cardenas of California.

Let's get to work for the young people of this country who are struggling.

I welcome any and all comments, concerns, or questions about the work or legislation I am proud to advocate and support. Thank you again for giving me this opportunity to speak today.

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March 1, 2022

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Re: The Trevor Project Statement for the Record, Senate Committee on Finance's Hearing on *Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care*

Dear Chairman Wyden and Ranking Member Crapo,

The Trevor Project (Trevor) submits the following statement for the February 15, 2022 Full Committee hearing, "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care." We respectfully request that this statement be entered into the hearing record.

There is a mental health crisis in our nation, and it is having particularly harmful impacts on marginalized communities such as LGBTQ youth. These youth already confront a range of barriers to quality mental health care, and it is more important than ever to open doors to essential mental health services for these youth by ensuring that when the 9-8-8 number for the National Suicide Prevention Lifeline (NSPL or Lifeline) is activated in July, the Lifeline is equipped with the specialized services that these young people need. It is also important to ensure that access to quality mental health services is not impeded by the marketing of dangerous practices that masquerade as mental health care for LGBTQ youth. Thank you for your attention to this issue and we look forward to working with you to address this crisis.

Founded in 1998, The Trevor Project is the world's largest suicide prevention and crisis intervention organization for LGBTQ youth, and it is the only accredited national organization providing crisis intervention and suicide prevention programs, as well as a peer-to-peer social network support for LGBTQ youth. Specifically, The Trevor Project offers life-saving, life-affirming programs and services that create safe, accepting, and inclusive environments over the phone, online, and through text. With operations in all 50 states and approximately 440 trained counselors, The Trevor Project is able to reach thousands of youth with its services every week.

What is The Trevor Project's perspective on the current youth mental health crisis?

There is no question that our nation is in the midst of a serious and troubling mental health crisis. Unfortunately, for LGBTQ youth the current crisis has only compounded the existing barriers that these young people face to receiving the type of mental health care they need and deserve. We are on the front lines of the national mental health crisis, and our counselors hear from young people every day whose mental health has been negatively impacted by the COVID–19 pandemic, recent politics, and a wide range of instances of anti-LGBTQ victimization.

The national mental health crisis is hitting our young people especially hard. And for marginalized young people, such as those who are LGBTQ and/or people of color, the crisis is hitting even harder. U.S. Surgeon General Vivek Murthy recently explained in his Advisory on the youth mental health crisis that LGBTQ youth often lost access to key services during the pandemic, were sometimes confined to homes where they were not supported or accepted, and face discrimination in the health care system that makes them more hesitant to seek help.[1]

At The Trevor Project, we have seen firsthand how these factors have converged to put LGBTQ youth at tremendous risk. Suicide is the second leading cause of death among young people,[2] and CDC data[3] shows that LGBTQ youth are more than four times as likely to attempt suicide compared to their straight and cisgender peers. The Trevor Project estimates that more than 1.8 million LGBTQ youth (13–24) seriously consider suicide each year in the United States, and at least one attempts suicide every 45 seconds.[4]

The Trevor Project's annual National Survey on LGBTQ Youth Mental Health (National Survey), which includes some of the largest and most diverse samples of LGBTQ youth ever conducted, seeks to amplify the unique stressors, challenges, and disparities that place LGBTQ youth at elevated risk for poor mental health and suicide. It is important to remember that LGBTQ youth are not inherently prone to suicide because of their sexual orientation or gender identity. Rather, they are

[1] HHS, "Protecting Youth Mental Health: The U.S. Surgeon General's Advisory," available at *https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

[2] Hedegaard, H., Curtin, S.C., and Warner, M. (2018). Suicide mortality in the United States, 1999–2017. National Center for Health Statistics Data Brief, 330, Hyattsville, MD: National Center for Health Statistics.

[3] Johns, M.M., Lowry, R., Haderxhanaj, L.T., et al. (2020). Trends in violence victimization and suicide risk by sexual identity among high school students—Youth Risk Behavior Survey, United States, 2015–2019. Morbidity and Mortality Weekly Report, 69 (Suppl–1):19–27. *See also* Johns, M.M., Lowry, R., Haderxhanaj, L.T., et al. (2020). Trends in violence victimization and suicide risk by sexual identity among high school students—Youth Risk Behavior Survey, United States, 2015–2019. Morbidity and Mortality Weekly Report, 69,(Suppl–1):19–27.

[4] The Trevor Project, "Estimate of How Often LGBTQ Youth Attempt Suicide in the U.S.," available at *https://www.thetrevorproject.org/research-briefs/estimate-of-how-often-lgbtq-youth-attempt-suicide-in-the-u-s/*.

placed at significantly increased risk because of how they are mistreated and stigmatized by society. Some of the most noteworthy findings from our 2021 National Survey, which captured the experiences of nearly 35,000 LGBTQ youth across the country, include:

- 42% of LGBTQ youth seriously considered attempting suicide in the past year, including more than half of transgender and nonbinary youth. Yet, nearly half (48%) of LGBTQ youth reported wanting mental health care in the past year but were not able to get it;
- 75% of LGBTQ youth reported that they had experienced discrimination based on their sexual orientation or gender identity at least once in their lifetime, and those who experienced discrimination in the past year attempted suicide at more than twice the rate of those who did not;
- 12% of white youth attempted suicide compared to 31% of Native/Indigenous youth, 21% of Black youth, 21% of multiracial youth, 18% of Latinx youth, and 12% of Asian/Pacific Islander youth.
- Half of all LGBTQ youth of color reported discrimination based on their race/ethnicity in the past year, including 67% of Black LGBTQ youth and 60% of Asian/Pacific Islander LGBTQ youth;
- 13% of LGBTQ youth reported being subjected to conversion therapy, with 83% reporting it occurred when they were under age 18; and
- Transgender and nonbinary youth who reported having pronouns respected by all of the people they lived with attempted suicide at half the rate of those who did not have their pronouns respected by anyone with whom they lived. However, more than 60% of transgender and nonbinary youth under the age of 18 said that none of the people they lived with respected their pronouns.

The Trevor Project has also examined the impacts of the pandemic and recent politics and public debates on the mental health and well-being of LGBTQ young people and found:

- 70% of LGBTQ youth stated their mental health was "poor" most of the time or always during COVID–19;
- More than 80% of LGBTQ youth stated that COVID–19 made their living situation more stressful—and only 1 in 3 LGBTQ youth found their home to be LGBTQ-affirming;
- Nearly 60% of transgender and nonbinary youth said that COVID–19 impacted their ability to express their gender identity; and
- 85% of transgender and nonbinary youth—and 66% of all LGBTQ youth—say recent debates about state laws restricting the rights of transgender people have negatively impacted their mental health.

Youth, and in particular LGBTQ young people, face significant barriers to accessing mental health services. The Trevor Project has conducted research that found that marginalized groups such as Black and Latinx LGBTQ communities don't have access to healthcare resources, and when they are available, they do not have the ability to address LGBTQ issues or understanding of the experiences of minorities or the LGBTQ community. Help when you are struggling is hard to ask for, and financial and cultural barriers shouldn't exist to make that brave action harder to take.

The crisis in front of us is clear to see. It should be a cause for concern to everyone, regardless of political party. Our young people are suffering, and LGBTQ young people are among those suffering the most. What we do to help our young people matters, and countless young lives are at stake. Fortunately, there are concrete steps Congress can take to lower barriers to accessing essential mental health services and help our young people now, including ensuring the Lifeline will be ready to serve the country and specifically LGBTQ youth when 9-8-8 goes live in July 2022 and that our LGBTQ youth are being protected from forms of health care fraud so-called "conversion therapy," sometimes referred to as "reparative therapy" or "sexual orientation or gender identity change efforts."

How can we ensure 9-8-8 ready is ready to serve youth in crisis?

The designation of 9-8-8 as the new dialing code for the NSPL in 2020 was an important step towards lowering barriers to care and addressing the mental health crisis, particularly for LGBTQ youth. 9-8-8 is scheduled to become the new dialing code for the NSPL in July 2022, and the American public will only fully benefit from the implementation of 9-8-8 if the Lifeline is appropriately funded, and specialized services are provided for LGBTQ youth as an acutely at-risk community.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has previously reported that they expect call volumes to nearly double as a result of the

new dialing code and that 9-8-8 will receive approximately 7.6 million calls in FY23. We estimate that NSPL could receive more than 400,000 contacts from LGBTQ youth in 2023. Alarmingly, this call volume will substantially increase wait times for youth in crisis, operators are not specially trained to handle these emergency calls and there is no standard of care for LGBTQ callers. These wait times and lack of training serve as operational barriers for LGBTQ youth seeking mental health services.

Ensuring that 9-8-8 is equipped with appropriate specialized services for LGBTQ youth is a matter of life and death. The absence of specialized mental health resources for LGBTQ youth will mean that young people will not get critical, life-saving services. This is the very reason The Trevor Project exists, and according to a formal, external evaluation of Trevor's services, almost three-quarters of youth stated that they either would not or were unsure if they would have contacted another service if The Trevor Project did not exist. More than 80% of LGBTQ youth said it was important that a crisis line include a focus on LGBTQ youth, should they need it.

Specialized services for LGBTQ youth must include the training of existing counselors in LGBTQ cultural competency and the establishment of an Integrated Voice Response (IVR) option for LGBTQ youth to receive more specialized care. The implementation of an IVR option can transfer LGBTQ youth callers to specialized groups like The Trevor Project, where we have additional trained counselors, who are part of a pre-existing nationwide response infrastructure and can take some of the increased burden from existing NSPL call centers. Importantly, use of IVR would facilitate efficient access to specialized care without the delays and miscommunication that come with efforts to make "warm transfers" between the Lifeline and specialized service providers.

Minimizing the barriers that allow LGBTQ youth to access services from group such as The Trevor Project is essential because it allows these young people to speak to counselors who can best help them. A multi-year evaluation conducted by third party researchers found that over 90% of youth in crisis who reach out to The Trevor Project are successfully de-escalated (meaning they are moved out of a state of crisis) and that de-escalation is sustained even weeks later. It is through these same proven training methods that the Lifeline will be able to provide the highest quality of services to its contacts.

The inclusion of specialized services, and specifically an IVR option, can play an important role in reducing barriers to mental health care because it would both increase the capacity of the Lifeline to handle calls, reducing wait times, and would ensure that LGBTQ youth can access counselors that have knowledge of their experiences and are specially trained to interact with individuals like them.

Fortunately, the need for 9-8-8 to include specialized services for LGBTQ youth is a matter of bipartisan agreement. Congress has repeatedly recognized the need for specialized services for LGBTQ youth. When Senator Orrin Hatch argued for the enactment of the 9-8-8 legislation in 2018, he explained that:

> The prevalence of suicide, especially among LGBT teens, is a serious problem that requires national attention. No one should feel less because of their gender identity or because of their orientation. They deserve our unwavering love and support. They deserve our validation and the assurance that not only is there a place for them in this society but that it is far better off because of them. These young people need us, and we desperately need them.[5]

Leaders from both parties, including the former Republican FCC Chair, have recognized the vital role that specialized services play in saving lives. The Act, passed with widespread bipartisan support, built on this promise and highlighted the need for specialized services for LGBTQ youth. The FY20 and FY21 Labor, Health and Human Services Appropriations Act Explanatory Statements directed SAMHSA to pursue the implementation of specialized services for LGBTQ youth, including both counselor training and the establishment of an IVR. Additionally, FY22 appropriations language currently under consideration by Congress would allocate $7.2 million for specialized services, including IVR.

However, right now it is not clear if 9-8-8 will be ready for action in July. There are positive signs. SAMHSA has stated that more than $560 million will be required to strengthen local crisis call capacity, including their ability to address the needs

[5] *https://www.govinfo.gov/content/pkg/CREC-2018-06-13/html/CREC-2018-06-13-pt1-PgS3866-3.htm.*

of high-risk populations. The agency has also announced that $282 million are being invested in efforts to "shore up, scale up and staff up" the NSPL,[6] and recently reported to Congress that the agency "has begun collaborating with the Trevor Project" in the effort to provide specialized services to LGBTQ youth.[7] However, time is running short, formal agreements and funding have yet to be finalized, and it is not clear that essential specialized services will be ready for LGBTQ youth in July.

Overall, a properly functioning Lifeline is an essential tool to reducing barriers to mental care, particularly for LGBTQ youth. As the July activation date approaches, Congress should fully fund the NSPL and specialized services. This includes the training of counselors in LGBTQ cultural competency, the establishment of an IVR option for LGBTQ youth to receive specialized care, and the use of text and chat services. Taking these steps would help ensure that LGBTQ young people can get access to mental health resources and crisis intervention services that can be the difference between life and death. In the midst of a mental health crisis, no response is more important. The Trevor Project is ready, willing, and able to help make sure that 9-8-8 succeeds.

How can we protect LGBTQ youth from conversion therapy?

One of the barriers that LGBTQ youth and their families face when seeking appropriate mental health care is the continue prevalence of dangerous and fraudulent practices that seek to exploit the mental health challenges faced by these families. LGBTQ youth, already placed at increased risk for mental health challenges is because they face unique stressors and the threat of anti-LGBTQ victimization, should not also have to worry about being the victims of conversion therapy.

Conversion therapy is not "therapy" at all—it is a dangerous and discredited practice that harms both LGBTQ young people and their families. The American Psychiatric Association (APA) has stated that "The potential risks of reparative therapy are great, including depression, anxiety, and self-destructive behavior." The Trevor Project's 2021 National Survey found that:

- LGBTQ youth who were subjected to conversion therapy reported more than twice the rate of attempting suicide in the past year compared to those who were not; and
- 13% of LGBTQ youth reported being subjected to conversion therapy, including 21% of Native/Indigenous LGBTQ youth and 14% of Latinx LGBTQ youth.

That's why twenty states and more than 100 localities have prohibited licensed mental health providers from subjecting LGBTQ youth to conversion therapy—but gaps in federal and state prohibitions persist, and medical billing procedure makes it difficult to track the occurrence and frequency of conversion therapy.

In order to effectively respond to the current mental health crisis, it is time for this dangerous practice to end once and for all. While we wait for Congress and states to close gaps in prohibitions against providing or funding conversion therapy, Congress should encourage agencies such as the Federal Trade Commission (FTC) to rigorously investigate and prosecute instances of deceptive or fraudulent advertising in connection with conversion therapy.

The mental health crisis has put more families with children in need of effective mental health services, strained the ability for effective provision and regulation of those services, and created an environment that makes it easier anti-LGBTQ practitioners to prey on marginalized families and children. For this reason, an effective response to the current mental health crisis should include efforts to ensure both that LGBTQ youth have access to the quality mental health care services they need, and that they are not victimized by fraudulent conversion therapy practices. These steps are an essential part of the necessary response to the current mental health crisis, to ensure that we are protecting LGBTQ youth in every corner of our country. They would reduce barriers to care by helping effective and reputable mental health care providers respond to families seeking help during the mental health crisis, saving the lives of some of the most marginalized young people, and assisting groups such as The Trevor Project in ending the harmful practice of conversion therapy.

[6] SAMHSA, HHS Announces Critical Investments to Implement Upcoming 988 Dialing Code for National Suicide Prevention Lifeline, December 20, 2021, available at *https://www.samhsa.gov/newsroom/press-announcements/202112201100.*

[7] SAMHSA, 988 Appropriations Report, December. 2021, available at *https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf.*

Conclusion

Reducing barriers to care in order to address the mental health crisis facing our country requires a comprehensive, dynamic, and urgent response. Making sure that 9-8-8 is ready to serve all who need it when the number goes active in July—including providing specialized services to LGBTQ youth—and helping end conversion therapy are necessary components of any effective response to the unique mental health challenges facing LGBTQ youth.

Too many young lives are at stake, and I urge you to take action—through your position of power and in your personal life. Our research has found that having at least one accepting adult can reduce the risk of a suicide attempt among LGBTQ young people by 40 percent. Isn't that profound—the impact that just one adult can make in the life of a young person? When having these conversations, we must always remember that suicide is preventable, and each and every one of us has the power to help end this public health crisis.

Thank you again for your attention to and action on this issue. The Trevor Project appreciates the opportunity to submit this statement and looks forward to continuing to work with Congress and the administration in addressing the mental health crisis and supporting our most marginalized young people.

For any questions, please contact Preston Mitchum (he/him), The Trevor Project's Director of Advocacy and Government Affairs at Preston.Mitchum@TheTrevorProject.org.

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Statement of Joe Kroll, Interim Director

Voice for Adoption (VFA) was established in 1996 to shape the public debate on permanency for children in the U.S. foster care system and the families who care for them. We advocate, educate, and collaborate with members of Congress, policymakers, partner organizations, agencies, and individuals to advance federal policies that promote and sustain permanence for children and youth in foster care. We envision a day when all children and youth in the U.S. foster care system will have a safe, loving, and supported permanent family through reunification, adoption, or guardianship.

In the federal fiscal year 2019, according to the Adoption and Foster Care Analysis and Reporting System (AFCARS), more than 66,000 children and teens were adopted from foster care in the U.S.—the highest number ever reported. The number of children waiting to be adopted has trended upward over the past five years, with 122,216 children in 2019 waiting to be adopted. Sadly, approximately 20,000 youth (ages 18 to 21) age out of the foster care system each year without a family.

The physical and mental health needs of children who have experienced abuse, neglect, trauma, and losses are significant. The State Policy Advocacy and Reform Center, in *Medicaid to 26 for Former Foster Youth: An Update on the State Option and State Efforts to Ensure Coverage for All Young People Irrespective of Where They Aged Out of Care,* explains it: "Children who have been abused or neglected often experience a range of physical and mental health needs, physical disabilities and developmental delays, far greater than other high-risk populations. For example, foster children are more likely than other children who receive health coverage through Medicaid to experience emotional and psychological disorders and have more chronic medical problems."

Nearly 70 percent of children in foster care exhibit moderate to severe mental health problems and 40 to 60 percent are diagnosed with at least one psychiatric disorder. Lewis et al. explain, "Depression, reactive attachment disorders, acute stress responses, and post-traumatic stress disorders are some of the common mental health diagnoses of children in foster care." Researchers Kerker and Dore note that being taken into foster care compounds existing problems, "Although children frequently enter foster care with preexisting conditions that put them at high risk for mental health problems, . . . the very act of separating children from their biological family may affect children's mental health as well."

For many years, the conventional wisdom was that once children were adopted, any previous trauma a child experienced would be eliminated by joining a permanent family. Thus, it was generally assumed that once a child achieved legal permanence, their families would not need to seek services or support from the child welfare system. However, research has revealed that the trauma, abuse, and neglect children experience has serious, often lifelong repercussions. Childhood trauma and abuse affect brain development and have consequences throughout an individual's life. Among other things, complex trauma can affect children's ability to express and control emotions, concentrate, handle conflict, form healthy relationships, interpret social cues, and distinguish safe from threatening situations.

As a result, many children and families need help and support long after permanence has been obtained, including when children reach different milestones and experience transitions. In a longitudinal study of adopted children, Rosenthal found difficulties several years after adoption, particularly in adolescence: "The study's core finding—one that those in the special-needs adoption field know from their everyday practice experience—is that 'problems' in special needs adoption do not dissipate in a steady, predictable fashion. Instead, children and families continue to present complex challenges throughout the adoption. In particular, behavioral problems are quite persistent and may even intensify."

The challenges for young people who leave care without permanency are even more significant since they don't always have supportive, caring adults in their lives. Youth who leave foster care due to age continue to experience poor health outcomes into adulthood, including high rates of drug and alcohol use, unplanned pregnancies, and poor mental health outcomes. More than half of those who aged out of foster care report being uninsured. More than one-fifth report unmet needs for medical care—research findings from Chapin Hall at the University of Chicago highlight additional troubling statistics. One-third of youth aging out reported two or more emergency room visits in the past year, 22 percent were hospitalized at least once, three-quarters of young women had been pregnant, and 19 percent received mental or behavioral healthcare in the past year.

At this time, there is no single access point for children, youth, and parents dealing with serious mental health and substance abuse issues to access services, treatments, and support. Foster care, juvenile justice, and education appear to be the primary points of access for the child welfare community, frequently exacerbating or creating much more significant issues such as specific populations being disproportionately over represented. In contrast, others may be denied services and experience discrimination. This fragmented model of mental health care provides no room for accountability. Instead of addressing the failure to provide services, blame is often pushed to systems not designed to provide these services, like the three above. In the end, that accountability has to be placed on a mental health system whose responsibility it is to ensure access, quality, and oversight are provided.

Regardless of which agency has the responsibility to provide access and ensure treatment effectiveness, no child or family involved with the child welfare system, especially those taken into foster care and promised our government's protections, should experience any form of abuse or neglect, including discrimination based on race, religion, sexual orientation, gender identity, or gender expression. The well-being of our children, especially the well-being of their mental and behavioral health, demand that we improve access and provide children and families with trauma-informed, evidence-based, mental and behavioral health systems with a single point of entry—creating a mental health system that can be held accountable for failures in treatment, but also responsible for ensuring that all services providers and treatment options promote racial equity, strive to block discrimination, and dismantle system racism—ensure that mental health of those impacted by the System is preserved and nurtured and reduce trauma rather than inflict it.

Given the body of scientific evidence regarding the long-term effects of trauma on child development, child welfare, and behavioral health, systems must ensure they offer children and families a robust array of mental health and other post-permanency support and services.

VFA is pleased to provide recommendations to the Senate Finance Committee and welcomes opportunities to meet with committee members to discuss our requests further.

Fund Post-Permanency Support Services

- **Congress should require and fund a core set of support services for children and families exiting foster care to a permanent family, with such services to include trauma-informed and permanency-competent mental and behavioral health services.**

As noted above, research on the short- and long-term impact of trauma has revealed that many children and families need support long after legal adoption or guardianship has been obtained, including when children reach different milestones and experience transitions. As a result, child welfare systems must make a comprehensive array of services available to adoptive and guardianship families, including critical mental health services. These services must be available when needed and without waiting times and responsive to the needs of each family; a "one size fits all" approach is not acceptable. Importantly, professionals must deliver them with the expertise and training to meet adoptive and guardianship families' unique needs. Delay of services and inadequately trained mental health providers can exacerbate family problems and ultimately disrupt a child's adoption or guardianship placement.

State, local, and tribal child welfare systems need to have federal guidance and funding so they can fully develop and maintain comprehensive and responsive post-permanency services. Several states, including Tennessee, Alabama, and Illinois, provide a model of providing comprehensive, in-home mental health services to adoptive or guardian families.

Improving Access for Children and Young People

- **Congress should maintain access to Medicaid for youth who age out of foster care up until age 26 and assure this coverage extends across state lines when a young person moves to a new state. This requirement should take effect immediately rather than in 2023 as currently written.**
- **Congress should protect this Medicaid benefit in every state by precluding work requirements for youth who have experienced foster care.**
- **Congress should extend access to Medicaid to children who leave foster care to adoption and guardianship, just as it extends the benefit to those who emancipate from care.**

More than 20,000 youth age out of the foster care system every year. Statistics about their uncertain futures are dire, and the lifetime societal costs are astronomical. The Affordable Care Act (ACA) is a critical lifeline for these youth. As a result of the ACA, young people who aged out of care without a permanent family can remain on Medicaid until age 26, just as other young people can stay on their parent's health care plans. The Congressional Research Service reported that in 2015, 70 percent of 21-year-olds who had aged out of care were on Medicaid, showing how necessary this provision is to this population.

For those who age out of care or who exit to adoption or guardianship, access to Medicaid is a critically important way to meet the lifelong, significant mental health, substance use, and behavioral health care needs of young people who have experienced abuse and neglect and the challenges of separation from their birth parents. Losing coverage at age 18, when so many other transitions and changes are happening, is particularly risky for this population with a much higher rate of mental and behavioral health challenges.

Strengthening Workforce

Congress should:

- **Support the expansion of adoption-competency training for mental health providers and caseworkers and encourage their participation by providing ongoing funding to the National Adoption Competency Mental Health Training Initiative and other similar adoption-competency programs.**
- **Provide federal incentives to recruit and train more master's-level clinicians. There is a shortage of well-trained mental health specialists who can meet the complex and unique needs of the child welfare and adoption community.**

- **Provide funding for targeted recruitment and retention initiatives to recruit, train, and support BIPOC and LGBTQ+ clinicians to address the unique needs of BIPOC and LGBTQ+ children and families in foster care and adoption.**

Although funding is critically important to ensure access to post-placement support services, it is equally essential that services be permanency and adoption competent—reflecting the impact of trauma, grief, loss, and other critical issues in adoption and permanency. Children, youth, and families must have workers and other service providers who understand and respond to these issues and build their skills to serve children with their specific experiences. Families must have professionals who understand adoption and provide mental health services designed to respond to clinical issues and build parenting skills for families parenting children who have experienced trauma and broken attachments.

But more than training is needed. We have an urgent need to recruit additional highly skilled, diverse providers into the field. BIPOC and LGBTQ+ children and youth are over-represented in the foster care population. Having a workforce and service providers who reflect their background and understand their experiences will improve outcomes for children.

Services provided by highly trained staff who reflect the population of children and families in adoption and guardianship will be more effective at ensuring that families thrive and remain together, preventing foster care re-entry.

Increasing Access to Care

- **Congress should increase Medicaid rates to align with private insurance.**

The vast majority of children in and exiting foster care have Medicaid as their insurance provider. But these children and their families face significant obstacles accessing services due to low reimbursement rates and too few providers who accept Medicaid (often due to low rates), particularly in non-urban communities. Clinicians must be reimbursed at fair rates through Medicaid, which authorizes just a fraction of the rates clinicians get privately or through some other insurance providers. Reasonable reimbursement rates will ensure that skilled clinicians are willing to see our children and families.

- **Congress should ensure that Medicaid includes coverage for family therapy, not just services to individuals, as well as nontraditional treatments that effectively help those affected by trauma.**

Too often, Medicaid (and other insurance policies) covers only services to the insured individual, when the issues facing those in adoption, guardianship, and foster care are often related to the family system. Medicaid should explicitly cover therapeutic services provided to the entire family of children, including the children, their siblings, and birth, foster, and adoptive parents and guardians.

Youth and families must also have access to Medicaid coverage for nontraditional forms of therapy (such as neurofeedback, mind-body-sensory trauma interventions, and other alternative innovations).

- **Congress should support the development and advancement of services sensitive to racial and cultural and other needs of LGBTQ+ and BIPOC individuals, including ensuring that Medicaid and other insurers cover them.**

In addition to recruiting and retaining diverse providers as recommended above, we must do more to ensure that the various children and families served by the child welfare system have access to mental health and behavioral health services designed to address their unique needs, including the impact of racism, homophobia, transphobia, and other discrimination. Funding should support ongoing development and research on new or adapted interventions sensitive to the racial, cultural, and different needs of LGBTQ+ and BIPOC children and families. In addition, Congress should ensure that these services are supported by Medicaid and other insurers and are accessible to those who need them.

- **Congress should require Medicaid and other insurers to cover the subspecialty of therapists to include competence in child welfare and adoption.**

There currently is no recognized "subspecialty" of adoption/permanency competence despite the wide recognition of the unique needs of children in adoption and other

permanent families. Congress should support and incentivize the creation of such a subspecialty whereby therapists complete either accredited adoption competency training or trainings that have an evidence base to show a positive change in practice and child and family outcomes. This is consistent with Medicaid managed-care companies' needs to ensure they spend their capped dollars on effective treatments specific to the audience.

- **Congress should amend the Dosha Joi Immediate Coverage for Former Foster Youth Act (S. 712) and the Expanded Coverage for Former Foster Youth Act (S. 709) to include explicit language stating that Medicaid covers individual therapy and telehealth therapy services for young people who are or were in foster care.**

Currently, young people who have Medicaid coverage may not have access to a full range of services that they need to meet their well-documented needs. Congress should ensure that those covered by Medicaid can access the type of services they specifically need, including individual therapy rather than simply group care and telehealth services.

- **Congress should also support expanded telehealth options, including allowing reimbursement to providers in other states, maintaining equal reimbursement rates for telehealth and in-person visits, and setting national standards for telehealth services.**

Expanding telehealth services is vital to supporting many children, youth, and families, including, but not limited to, those residing in more remote locations. These individuals have limited access to providers and a reduced selection of treatment options. This may prevent access to services at all or, at a minimum, result in delays in access. Such limitations can cause additional problems as untreated mental and behavioral health problems worsen untreated.

By lifting geographic barriers to telehealth, children and families would have access to services from providers who can best meet their needs, with reduced wait times and choices for more adoption- or permanency-competent providers.

National standards for telehealth services would ensure that the provided services are of high quality and are most likely to serve each client effectively.

- **Congress should increase the Federal Match Assistance Percentage (FMAP) rate for all children's mental health and supportive services provided under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) entitlement, covering all children under the age of 21 in all states and territories. In addition, Congress should expand access to these services for children and youth in foster care and who have exited care to adoption and guardianship while ensuring that such services are adoption/permanency-competent for this population.**

Increasing the FMAP would encourage states to use this vital, underused resource for children covered by Medicaid. According to MACPAC, more than 40 million children were eligible for EPSDT services in 2014, but less than 60 percent of children who should have received at least one screening received one. Such screenings are essential concerning psychiatric care, which typically requires a determination of the medical necessity for future coverage. As noted above, children in and exiting foster care to permanency have significantly higher mental and behavioral health needs rates. They would particularly benefit from such screenings and the coverage that the screening results may make available to them. But for the screening and services to be effective for this population, they must consider specific issues common in foster care, including the impact of trauma, grief and loss, and broken attachments.

- **Congress should refine language in the Timely Mental Health for Foster Youth Act (S. 3625) to mandate all jurisdictions to participate and require an additional mental health screening by trauma-informed professionals conducted 60 days before youth exit care to permanency or due to emancipation. Ensure that professionals work with families or young people to arrange for services to address any needs identified.**

In many cases, children receive mental health assessments soon after entering foster care to determine their needs and identify services to be provided. Because needs change over time, such screening must also be done before children exit the system—and thus lose access to some services and supports—so that their current state of health is determined. The assessment process must include identifying and connecting to access services that address the child or youth's identified needs.

- **Congress should mandate that the National Youth in Transition Database (NYTD) measure outcomes for healing and trauma through a qualitative question that addresses how to best support youth with their mental health and healing needs.**

The NYTD current data collection falls short of identifying the needs of youth who have exited care and what is helping them heal. Additional questions, developed with the input of young people who have been in care, will help assess needs and identify which services and supports are successfully meeting those needs. The reported data would also hold states accountable for assisting young people in their healing process.

Ensuring Parity

- **Congress should ensure that all health insurance provides true parity for mental and behavioral health services in all health insurance plans. Congress should hold more hearings, issue state report cards, and direct HHS to craft model state laws to reach parity.**

In 2020, the *Psychiatric Times* noted that we had not achieved mental health parity despite previous legislation and other action. Citing a report card based on 2017 data, the *Times* reported on "continued and increased disparities between behavioral health care and physical health care coverage, indicating possible evidence of non-compliant insurance practices." Data showed more out-of-network visits and higher co-pays for behavioral health than physical health in many states. Many of these disparities can be attributed to managed care rules.

There should not be limits on the number of visits and other mental and behavioral health services if such limits are not put on physical health needs. Services should be provided based on the individual's needs and the professional opinion of the service provider.

The mental health needs of children and young people who have been in foster care are significant. Their experiences and their families as they struggle to access appropriate services show us how fractured this country's mental health system is. We need a robust, comprehensive mental and behavioral health system that serves all Americans while also providing targeted investments and support for those children for whom the government accepted responsibility when it removed the children from their families and placed them in foster care.

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March 1, 2022

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
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Chairman Wyden, Ranking Member Crapo, and Members of the U.S. Senate Committee on Finance, I want to thank you for the opportunity to submit a written statement regarding the Committee's continued support and interest in youth mental health in the United States as evidenced by your recent hearings on February 8, 2022: "Protecting Youth Mental Health: Part I—An Advisory and Call to Action" and February 15, 2022: "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care."

As you may know, Youth Villages [1] is a national leader in children's mental and behavioral health committed to building strong families, delivering effective services, and significantly improving outcomes for children, families and young people involved in child welfare and juvenile justice systems across the country. Founded in 1986, the organization's 3,300 employees help more than 30,000 children annually in 23 states and the District of Columbia.[2]

We full-heartedly agree with the members of the Senate Finance Committee and Surgeon General Dr. Murthy that there is a youth mental health crisis and that as

[1] *https://youthvillages.org/.*
[2] *https://youthvillages.org/about-us/locations/.*

a nation we must do more. We are extremely grateful for the Committee's leadership on the issue and your desire to work with young people and organizations that serve them to craft and implement solutions to the challenges this unique population faces. The challenges as mentioned in the hearings span beyond kids in crisis, but to parents, caregivers, and the workforce dealing with a range of challenges from access to services to burnout.

We know that when youth and families have the services and support that they need, they will be successful even when dealing with the most severe mental health challenges. Prevention is key to combatting the mental health crisis through investment in effective high-quality services and supports that offer timely support and flexibility for children, youth, and family's needs. I want to tell you about a young person who overcame difficulties with mental health that we served through our Intercept[3] program, which is designated as "Well-Supported" by the title IV–E Prevention Clearinghouse.

Cassidy was 16 years old and had multiple stays in in-patient mental health centers. She struggled with depression, anxiety, and suicidal ideation. In just one year, Cassidy was hospitalized for her mental health nine times. Approximately five million children across the country have a serious mental health condition, and hospital stays can cause significant trauma to a young person.

Youth Villages helps keep kids at home and in their communities while receiving mental health treatment by working with the whole family to provide intensive support, new parenting and communication skills, and evidence and strengths-based mental health intervention services.

As part of the Intercept program, Cassidy and her mother, Ellen had the ability to call the 24/7 Youth Villages crisis line to help de-escalate crisis situations when they arose as well as meeting with their family intervention specialist three times every week, sometimes at home, sometimes in the community—even at Cassidy's favorite coffee shop. They would work on coping skills and grounding techniques, affirmations, communication, and Cassidy's self-esteem. Her specialist would conduct safety sweeps at home and would work with them to create safety plans. Thanks to her time and success in Intercept, it has been more than a year since Cassidy's last hospitalization. She is enrolled in a therapeutic school and is on the honor roll. Ellen and Cassidy both feel comfortable and safe leaving Cassidy at home alone now—something Ellen never thought she would be able to do again. Cassidy sometimes still struggles with self-image and negative thoughts; however, her specialist created a personalized affirmation book for her to use as a tool when she is having a tough time. For the first time, Cassidy is looking forward to what is next. She now envisions a future for herself and dreams big. She has started visiting colleges and wants to pursue a career in art.

Cassidy should not be the exception for youth with mental health issues. She should be the norm. We share this story because Youth Villages knows what is at stake as the Committee continues to work on solutions for the youth mental health crisis America is facing. Without the proper services and supports, especially those that are intensive, trauma informed, community based, and family oriented, young people's lives could be in jeopardy. Youth Villages stands with you, ready and committed to doing our part to help end this crisis and ensure that children, youth, and families can live successfully.

We would like to thank the Committee for including youth voice in the conversation on mental health reform. Youth Villages agrees with Trace Terrell that young people should not get lost in the system(s) and should be able to obtain the level of care they need and where it is developmentally appropriate. Youth Villages LifeSet program, which was designed to help young people ages 17 to 23 who are aging out of child welfare, juvenile justice or children's mental health systems get a good start on independent adulthood, shows a positive impact with meeting the needs of multi-systemic young people. For young people transitioning from the foster care system, there is a need for increased coordination and targeted case management that focuses on a youth's mental health care and all their needs outside of clinical support.

Young people who experience foster care are resilient and capable. Still, they need support as they move toward adulthood. Nathe'anna's journey—overcoming health issues, the COVID-19 shutdown and a natural disaster—proves that point. Nathe'anna, the youngest of four children, came into foster care around 7 years old. When she turned 18 in a group home, COVID–19 hit. Then, she had to have gall

[3] *https://youthvillages.org/services/intensive-in-home-treatment/intercept/.*

bladder surgery, alone because of visitor restrictions. Her LifeSet specialist Kelly Adams was there, through phone calls, offering support and encouragement.

After her recovery, Nathe'anna returned to school virtually. Soon after, her community was struck by Hurricane Ida. There were weeks with no electricity and roads closed. Kelly stayed connected. LifeSet turned into a lifeline. Today, Nathe'anna is working toward becoming an emergency medical technician.

"I watched every one of my brothers and sisters age out of foster care. This program wasn't around for them, and they had negative outcomes," she said. "LifeSet is a program that gives you a chance, that gives you hope."

Thank you again for the Committee's interest and commitment to addressing the youth mental health crisis and the opportunity to submit Cassidy's story for the record. Last October, Youth Villages submitted a letter to the Senate Finance Committee addressing numerous concerns surrounding the mental health crisis and its impact on youth and families. We offered some of the following policy solutions, if included in the bipartisan legislation, will help improve mental and behavioral health outcomes for children, youth, and families:

- We would like to reiterate that to address the high turnover and burnout among behavioral health practitioners, the Committee should find ways to increase payment rates to providers and provide educational incentives for mental health professionals.
- Prior to the pandemic, many children and youth with complex needs faced barriers in accessing high-quality services, especially young people in foster care. The Committee should provide additional funding for research and evidence-based programs to expand high quality services for young people, specifically those with foster care or juvenile justice experiences.

If you have any questions about our Intercept program, how we address youth mental health, or the solutions we see to this crisis, please contact Director of Federal Policy, Shaquita Ogletree at Shaquita.Ogletree@youthvillages.org.

Respectfully submitted,

Pat Lawler
CEO