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STRENGTHENING FEDERAL MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAMS: OPPORTUNITIES, CHALLENGES, AND EMERGING ISSUES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING STRENGTHENING FEDERAL MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAMS, FOCUSING ON OPPORTUNITIES, CHALLENGES, AND EMERGING ISSUES

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C O N T E N T S

STATEMENTS

WEDNESDAY, MARCH 23, 2022

STRENGTHENING FEDERAL MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAMS: OPPORTUNITIES, CHALLENGES, AND EMERGING ISSUES

Wednesday, March 23, 2022

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

The Committee met, pursuant to notice, at 10:01 am, in room 430, Dirksen Senate Office Building, Hon. Patty Murray, Chair of the Committee, presiding.

Present: Senators Murray [presiding], Baldwin, Murphy, Kaine, Hassan, Smith, Rosen, Burr, Collins, Cassidy, Murkowski, Braun, Marshall, Scott, and Tuberville.

OPENING STATEMENT OF SENATOR MURRAY

The CHAIR. Good morning. Senate Health, Education, Labor, and Pensions Committee will please come to order. Today we are holding a hearing on our Nation's growing mental health and substance use disorder crisis. I will have an opening statement, followed by Ranking Member Burr. We will then introduce our witnesses. And after they give their testimony, Senators will each have 5 minutes for a round of questions.

Again, we are unable to have the hearing fully opened to the public or media for in-person attendance. As always, live video is available on our Committee website at *help.senate.gov,*. And if you are in need of accommodations, including close captioning, you can reach out to the Committee or to the Office of Congressional Accessibility Services.

I hope that everyone on this Committee found our hearing in February with mental health and substance use disorder experts, care providers, and advocates to be informative and compelling. We are all hearing from families in our States about the need for action.

Parents worried about their kids well-being after the stress and trauma of this pandemic. People struggling with depression and anxiety themselves and unsure where to go for help. Communities fighting a rise in substance abuse, as well as a surge in overdose deaths fueled by a deadly increase in fentanyl use.

Mental health and substance use disorder professionals who are feeling overworked, overwhelmed, and just burned out. We all want to address these challenges, which is why Senator Burr, and I are

working in a bipartisan way on legislation to support our communities and help people get the services for mental health and substance use disorders that they need. We continue to make progress on that effort, and our hearing today represents another important step forward.

I spoke last time about the work that Lifeline Connections and Neighborhood House and the Confederated Tribes and bands of Yakama Nation and other local organizations are doing to address the mental health needs of families in Washington State. And I am glad to have this opportunity to discuss how the Federal Government can better support frontline efforts to screen and provide services for mental health challenges, support people who are struggling with substance use disorder, increase access to addiction treatment, prevent drug overdoses and suicide, and more.

Because COVID–19 has made it clearer than ever that while our communities are doing valuable, lifesaving work, we need to do much more to help them. Youth health emergencies have skyrocketed during this pandemic, with sharp increases in kids' visits to the emergency room for mental health crises, thoughts of suicide, suicide attempts, especially among girls, and as of February, over 200,000 children have had their world shattered after losing a parent or caregiver to COVID–19.

This pandemic has also set us back catastrophically when it comes to substance use disorders. We saw an estimated 106,000 drug overdose deaths in a single year. That is a record high. And fentanyl has been especially devastating for families in my state. Fentanyl deaths in our largest county doubled last year. But nationally we are also seeing a concerning rise in methamphetamine and cocaine use.

Meanwhile, our mental health and substance use disorder workforce, which was already stretched thin, is nearly threadbare. I said this before, but it really stands out to me that almost 130 million Americans live in areas with less than one mental health provider per thousand people. And in my home State of Washington, our mental health care workforce is only able to meet 17 percent of our state's needs.

Meanwhile, nationwide, not even a tenth of people who need treatment for substance use disorder actually get it. And these problems are especially pronounced for rural areas, communities of color, and people with disabilities. And it is important to remember that the many people who are personally facing mental health and substance use disorders or struggling to get the support they need, aren't the only ones feeling this. We all have friends and family who are, whether we realize it or not.

We all rely on first responders, health care providers, and other frontline workers who are experiencing burnout and trauma. We all have a stake in making sure people can get the help they need. So let's make sure we act accordingly. Now we are starting here on square one. We have a long, bipartisan track record of addressing mental health and substance use disorders in this Committee.

But we are also not close to where we need to be, especially considering the ways this pandemic has worsened preexisting challenges. We need to rise to this moment by strengthening the tools

that communities are already using effectively to help people get care and providing new ones to address the gaps and emerging issues this pandemic has made so much worse.

That means putting together a bipartisan package that supports suicide screening and prevention, help schools and communities meet kids' mental health needs, reduces drug overdose deaths and gives patients more options to get substance use disorder treatment, addresses the mental health needs of new mothers, tackles barriers that make it hard for people to get the care they need, like stigma, health inequity, and a strained workforce, and more.

I know Members on both sides of the aisle share these goals and have ideas about how to make them a reality, and I look forward to continuing to work with all of you on this. As Ranking Member Burr and I have announced, it is our goal to pull the Committee's mental health package together in early summer so we can move legislation to the floor. We both hope to have more to say on that in the days ahead and appreciate the many ideas that Members on and off this Committee have for the package as we work together to address this crisis.

This pandemic has done so much to damage our Nation's mental well-being. There are so many people who are stressed and anxious and traumatized, struggling with addiction, or who are grieving over the loss of a loved one and don't know where to turn. But there are also people in our communities who care about them and who are working right now to get them help.

As this Committee works on bipartisan legislation to reauthorize and improve Federal programs on mental health and substance use disorder, I look forward to hearing from all of our witnesses today about the steps that we can take to help bolster the efforts of those on the front lines of our mental health and substance use disorder crisis, and make sure that every person who is struggling can get the care they need without worrying about stigma or cost, without having to travel for hours or wait for weeks, and without feeling like they are all on their own.

With that, I will turn it over to Senator Burr for his remarks.

OPENING STATEMENT OF SENATOR BURR

Senator BURR. Thank you, Madam Chair. Thank you for holding this hearing. Even before the pandemic, we knew the need to address mental health and substance use disorders were dire. Opioids took hold and the result was a crisis, with families and communities who had not dealt with that for some time. As we look to reauthorize a number of these programs, we face problems that have been compounded by the pandemic but can be informed by our COVID response.

We learned that research, innovation, partnerships, and real time data are the key to our success in overcoming an unprecedented public health challenge. Today's hearing will help us determine how to apply these lessons and those actions to mental health and substance use challenges that continue to devastate our communities.

The last time the Committee examined our mental health and substance use programs, we heard from Sam Quinones, excuse me, on opioids, who shared his belief that isolation and lack of community was a driving factor in the substance use disorder crisis facing America. Isolation only worsened when the pandemic struck. Months on end of remote learning, time separated from aunts, uncles, grandparents, friends, teachers, families, were critical—with critically ill and dying loved ones who could not say goodbye has taken a tremendous toll on America, especially on children.

We are seeing the results of the past 2 years at an alarming rate of people, particularly young children, arriving in the emergency room in a state of mental health crisis. In 2020 alone, the number of young people seeking care for their mental health in the emergency room increased by 31 percent. Between 2016 and 2020, the number of children experienced depression increased by 27 percent.

The number of children experiencing anxiety rose by 29 percent. Last year, more than 100,000 people lost their lives to drug overdose, a nearly 30 percent increase from the year before. Two-thirds of these adults were linked to synthetic opioids such as fentanyl. But in the face of these tragedies, we see strength and resilience, families turning tragedy into action to bring awareness and understanding to help others.

In hearings over the past year, we have heard examples of leaders in local communities ready to meet these challenges, partnering to bring local solutions to address local challenges. As we consider reauthorizing these programs, it would serve us well to remind to remember this too. Since 2016, we have authorized or reauthorized more than 40 different Federal programs to address mental health and substance use disorder.

In addition, the Fiscal Year 2022 omnibus appropriations bill provided nearly $5 billion for mental health and substance use disorder related programs. But at least nine of these authorized programs did not receive funding. We have seen time and time again that creating a new program that does not get funded is a false promise. That creating new programs for the press release of a markup isn't actually a solution.

We need to figure out what we can do with the tools that we have and improve the current programs and fund the programs that we do create. We should be honest with ourselves and the country and terminate the programs that haven't received funding in the last 5 years. If a program hasn't received funding, it shouldn't stay on the books. We will have to prioritize and answer key questions like how to better target our programs to make sure that they are both meeting the needs of today, but also have the flexibility to address the needs of tomorrow.

To our witnesses, welcome. We need your expertise to ensure we have the right performance measures in place to track progress in the programs you oversee. GAO recently found that many of our mental health and substance abuse programs lacked the measures we need to know whether the programs work. You only know what you can measure. If we cannot track programs in a meaningful way, we will not know how to improve the programs to better meet

the needs of the people that are intended to be served and reprioritize those that are underperforming.

Additionally, we need to make sure that we are using up to date data to inform our response and addressing emerging issues. States and local communities must be empowered to address these issues, and they need accurate information to identify the problems that they are facing, like emergence—or emergence or reemergence of a new drug in an area or identifying increased rates of suicide in certain populations. Sometimes this requires thinking outside the box.

We saw communities pull together during the pandemic to come up with solutions that worked, and we need the same spirit and ingenuity with this challenge. One of the trends in that success was partnerships with the private sector. Local public, private partnerships are the foundation of many of our successful Federal mental health and substance disorder programs.

I look forward to hearing more about how SAMHSA is encouraging partnerships and facilitating local engagement through these programs, and how this can be improved going forward. Leveraging innovation to help address our mental health and substance use disorder crisis is another area I look forward to focusing on and hearing more about. Critical to all of this strong workforce, this Committee reauthorized a number of health workforce programs in 2020, in addition to those included in the pandemic package.

The health workforce, particularly our doctors, nurses, counselors, and therapists, have been through a lot. They rose to the challenge during this pandemic, and it has taken its toll. Earlier this Congress, the Committee passed the Dr. Lorna Breen Health Care Provider Protection Act, which was just signed into law, to make sure that these providers get the support and care they need for their own mental health and substance use concerns, especially if they continue to care for all of us.

Madam Chairman, I look forward to hearing more about how HRSA is leveraging and prioritizing existing Federal health workforce programs to fill gaps in the mental health and substance use disorder workplace. I yield floor.

The CHAIR. Thank you very much. With that, I will introduce today's witnesses. Our first witness is Dr. Miriam E. Delphin-Rittmon. She is the Assistant Secretary for Mental Health and Substance Use at the Department of Health and Human Services, who leads the Substance Abuse and Mental Health Services Administration. Welcome. Good to see you here today.

Our next witness is Ms. Carole Johnson. She is the Administrator of the Health Resources and Services Administration. Welcome to you. We are also joined today by Dr. Joshua Gordon, the Director of the National Institute of Mental Health. We appreciate you being here today.

Our final witness is Dr. Nora Volkow, Director of the National Institute on Drug Abuse. Thank you for being with us as well. With that, we will start with you, Assistant Secretary Delphin-Rittmon.

STATEMENT OF MIRIAM E. DELPHIN-RITTMON, PH.D., ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ROCKVILLE, MD

Ms. DELPHIN-RITTMON. Thank you, and good morning, Chair Murray, Ranking Member Burr, and Members of the Committee for inviting me here to testify today. I am the Assistant Secretary for Mental Health and Substance Use at SAMHSA, the agency that leads the public health efforts to advance the behavioral health of the Nation and improve the lives of individuals living with mental health and substance use disorders, as well as their families. It is an honor to lead this agency, and I am a proud product of one of its programs, the Minority Fellowship Program.

I am pleased to be here with my colleagues from HHS, from HRSA, NIH to discuss the growing mental health and substance use challenges that we are facing as a country. As President Biden noted, our Country faces an unprecedented mental health crisis among people of all ages and backgrounds. Even before the pandemic, rates of depression and anxiety were inching higher. But grief, trauma, physical isolation of the last 2 years have driven Americans to a breaking point.

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

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

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

The second is enhancing access to suicide prevention and crisis care. Preparing the National Suicide Lifeline for full 9–8–8 operational readiness requires a bold vision for a system that provides direct lifesaving services to all in need and links them to community based providers uniquely positioned to deliver a full range of crisis care services.

SAMHSA sees 9–8–8 as a linchpin and a critical catalyst to transform the behavioral health system of care. The third is promoting children and youth behavioral health. To focus our efforts on improving behavioral health wellness for our Nation's youth,

SAMHSA has developed the HOPE framework, health, opportunity, potential, and equity for children, youth, and families across the country.

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

The fifth is using performance measures, data, and evaluation. For example, SAMHSA recently released the Behavioral Health Equity Report 2021, drawing on data from our national survey on drug use and health. My written testimony also outlines four additional cross-cutting principles, several SAMHSA programs that bolster our work to support these priorities.

These principles are greater equity within the behavioral health system, enhancing the behavioral health workforce, promoting and supporting recovery practices, and working to ensure financing of a robust behavioral health system of care. I will close by echoing President Biden's call in his State of the Union to support the millions of Americans who are in recovery. Early on and throughout my career, I have been inspired both personally and professionally by family members, friends, colleagues, and acquaintances who with courage and resilience have striven for wellness and recovery.

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

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

PREPARED STATEMENT OF MIRIAM E. DELPHIN-RITTMON

Good morning Thank you, Chair Murray, Ranking Member Burr, and Members of the Committee for inviting me to testify during this hearing focusing on mental health and substance use.

My name is Miriam Delphin-Rittmon, and I am the Assistant Secretary for Mental Health and Substance Use at the U.S. Department of Health and Human Services (HHS) In this role, I lead the Substance Abuse and Mental Health Services Administration, also known as SAMHSA, SAMHSA is the agency within HHS that leads public health efforts to advance the behavioral health of the Nation and improve the lives of individuals living with mental and substance use disorders, as well as their families.

It is an honor to lead this agency In fact, I am a proud product of one of SAMHSA's programs—the Minority Fellowship Program (MFP) The MFP program provided me, and other mental health and substance use disorder clinicians, an educational scholarship and training to more effectively treat and serve people of different cultural and ethnic backgrounds.

I am pleased to be here, along with my HHS colleagues from the Health Resources and Services Administration and the National Institutes of Health to discuss the growing mental health and substance use crisis.

As President Biden has noted, our Country faces an unprecedented mental health crisis among people of all ages and backgrounds Two out of five adults report symptoms of anxiety or depression and minoritized communities are disproportionately undertreated Even before the pandemic, rates of depression and anxiety were inching higher But the grief, trauma, and physical isolation of the last 2 years have driven Americans to a breaking point In addition, drug overdose deaths have reached a historic high, devastating families and communities More than 104,000

Americans died due to a drug overdose in the 12-month period ending in September 2021 For these reasons, President Biden included addressing mental health and addiction as two of the four pillars of the unity agenda he outlined in the State of the Union Address.

SAMHSA is actively working to advance the unity agenda and the national mental health strategy, which includes strengthening system capacity, connecting more Americans to care, and creating a continuum of support that aims to transform our health and social services infrastructure to address mental health holistically and equitably.

Though this testimony, I will expand on how SAMHSA is working to achieve the goals of the President.

SAMHSA's Role, Priorities, and Principles

SAMHSA's mission of reducing the impact of substance use and mental illness on American communities is more relevant than ever To help advance our mission, I have identified five core near-term priorities for the agency:

1. Preventing overdose;
2. Enhancing access to suicide prevention and crisis care;
3. Promoting child and youth behavioral health;
4. Integrating primary and behavioral healthcare; and
5. Using performance measures, data, and evaluation

I have also outlined four critical cross-cutting principles to bolster SAMHSA's work on our near-term priorities These principles include:

1. Greater equity within the behavioral health system;
2. Enhancing the behavioral health workforce;
3. Promoting and supporting recovery practices; and
4. Working to ensure financing of a robust array of behavioral health services

These priorities and principles are aligned with the focus of the HHS Behavioral Health Coordinating Council (BHCC), which I have the honor of co-chairing with Admiral Rachel Levine, the Assistant Secretary for Health The purpose of the BHCC is to more efficiently identify and facilitate collaborative, innovative, transparent, equitable, and action-oriented approaches to addressing HHS's behavioral health agenda, priorities, and strategic planning.

RECENT SAMHSA DATA

2020 National Survey on Drug Use and Health

In October 2021, SAMHSA released findings from the 2020 National Survey on Drug Use and Health (NSDUH)[1,2] The data suggest that the COVID–19 pandemic had a negative impact on the nation's well-being Americans responding to the NSDUH survey reported that the coronavirus outbreak adversely impacted their mental health, including by exacerbating use of alcohol or drugs among people who had used drugs in the past year.

Based on data collected nationally from October to December 2020, it is estimated that 259 million past-year users of alcohol and 109 million past-year users of drugs other than alcohol reported they were using these substances "a little more or much more" than they did before the COVID–19 pandemic began During that same time period, youth ages 12 to 17 who had a past-year major depressive episode (MDE) reported they were more likely than those without a past-year MDE to feel that the COVID–19 pandemic negatively affected their mental health "quite a bit or a lot" Adults 18 or older who had any mental illness (AMI) or serious mental illness (SMI) in the past year were more likely than adults without mental illness to report that the pandemic negatively affected their mental health "quite a bit or a lot".

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[1] Substance Abuse and Mental Health Services Administration (2021) Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No PEP21–07–01–003, NSDUH Series H–56) Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration Retrieved from *https://wwwsamhsagov/data*.

[2] Several changes to the 2020 NSDUH prevent its findings from being directly comparable to recent past-year surveys.

SAMHSA PRIORITIES

Preventing Overdose:

Although overdose deaths involving heroin and prescription opioids have decreased, the overdose crisis continues to be a challenge for this country Synthetic opioids like illicitly manufactured fentanyl and the use of other substances, like stimulants such as cocaine and methamphetamine, and polydrug use, have led to significant increases in overdose deaths. [3]

Given the escalating overdose crisis and the negative impact of the COVID–19 pandemic, HHS experts came together to create a new, comprehensive Overdose Prevention Strategy (Strategy) meant to strengthen our primary prevention efforts and increase access to the full continuum of care and services for individuals with substance use disorder (SUD) and their families [4] I will discuss several SAMHSA efforts that support this Strategy and the care continuum below.

Establishing an Office of Recovery and Advancing Peer Supports

Recovery is a key pillar in our Overdose Prevention Strategy That is why during Recovery Month last fall, SAMHSA announced it would be establishing a new Office of Recovery This office will promote the involvement of people with lived experience throughout agency and stakeholder activities, foster relationships with internal and external organizations in the mental health and addiction recovery fields, and identify health disparities in high-risk and vulnerable populations to ensure equity for support services across the Nation.

We know that recovery is enhanced by peer-delivered services These services have proven to be effective as the support, outreach and engagement with new networks help sustain recovery over the long term Investing in peer services is critical, given the significant workforce shortages in behavioral health That is why, as part of the President's Strategy to Address Our National Mental Health Crisis, SAMHSA will convene stakeholders to explore the benefits of national certified peer specialist certification and how it could accelerate universal adoption, recognition, and integration of the peer mental health workforce across all elements of the health care system.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant (SABG) helps states in addressing substance use treatment and prevention needs through support of prevention, treatment, and other services not covered by commercial insurance and non-clinical activities and services that address the critical needs of state substance use service systems The SABG supports state prevention, treatment, and recovery systems' infrastructure and capacity, thereby increasing availability of services and development and implementation of evidence-based practices.

The Administration supports the addition of a 10 percent set-aside within the SABG for recovery support services aimed at significantly expanding the continuum of care both upstream and downstream This proposed set-aside would support the development of local recovery community support institutions (ie, recovery community centers, recovery homes, recovery schools); develop strategies and educational campaigns, trainings, and events to reduce addiction/recovery-related stigma and discrimination at the local level; provide addiction recovery resources and support system navigation; make accessible peer recovery support services that support diverse populations and are inclusive of all pathways to recovery; and collaborate and coordinate with local private and non-profit clinical health care providers, the faith community, city, county, state, and Federal public health agencies, and criminal justice response efforts.

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[3] O'Donnell J, Tanz LJ, Gladden RM, Davis NL, Bitting J Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls—United States, 2019—2020 MMWR Morb Mortal Wkly Rep 2021;70:1740–1746 DOI: *http://dxdoiorg/1015585/mmwrmm7050e3external—icon*.

[4] Haffajee, RL, Sherry, TB, Dubenitz, JM, White, JO, Schwartz, D, Stoller, B, Swenson-O'Brien, AJ, Manocchio, TM, Creedon, TB, Bagalman, E U.S. Department of Health and Human Services Overdose Prevention Strategy (Issue Brief) Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services October 27, 2021.

State and Tribal Opioid Response Grants

The State Opioid Response (SOR) grant program aims to address the overdose crisis by increasing access to FDA-approved medications for the treatment of opioid use disorder (OUD), reducing unmet treatment needs, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD.

States and communities across the country are also dealing with rising rates of stimulant use and its negative health, social, and economic consequences To address the growing rate of stimulant-involved overdose deaths, Congress has allowed the use of State Opioid Response grants to include methamphetamine and other stimulants to give states and tribes flexibility to address their unique community needs.

Harm reduction is also an important pillar of the Strategy That is why HHS announced, in April 2021, that grantees in certain programs such as SOR may now purchase rapid fentanyl test strips to help curb the dramatic spike in drug overdose deaths largely driven using strong synthetic opioids, including illicitly manufactured fentanyl. [5]

Like the SOR program, the Tribal Opioid Response Grants program also aims to address the overdose crisis, but directs funding to tribal communities.

Pregnant and Postpartum Women Program

The Pregnant and Postpartum Women program (PPW) uses a family centered approach to provide comprehensive residential substance use disorder treatment, prevention, and recovery support services for pregnant and postpartum individuals, their minor children, and for other family members The family centered approach includes partnering with others to leverage diverse funding streams, encouraging the use of evidence-based practices, supporting innovation, and developing workforce capacity to meet the needs of these families The PPW program provides services not covered under most public and private insurance SAMHSA continues to prioritize states that support best-practice collaborative models for treatment, as well as provide support to pregnant individuals with OUD The Comprehensive Addiction and Recovery Act increased accessibility and availability of services for pregnant individuals by expanding the authorized purposes of the program to include the provision of outpatient and intensive outpatient services.

Harm Reduction Grants

This year, SAMHSA launched its first-ever Harm Reduction grant program and expects to issue $30 million in grant awards This opportunity, authorized by the American Rescue Plan Act, will help increase access to a range of community harm reduction services and support harm reduction service providers as they work to help prevent overdose deaths and reduce health risks often associated with drug use Providing funding and support for innovative harm reduction services is a key pillar for the Strategy This funding will allow organizations to expand their distribution of overdose-reversal medications and fentanyl test strips, provide overdose education and counseling, and manage or expand syringe services programs, which help control the spread of infectious diseases like HIV and hepatitis C.

DATA Waiver, Treatment Capacity, and Buprenorphine Guidelines

In an effort to get evidenced-based treatment to more Americans with OUD, last April SAMHSA and HHS announced buprenorphine practice guidelines that remove certain training and certification requirements which some practitioners have cited as a barrier to treating more people [6] The Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder (Practice Guidelines) provides an exemption from certain statutory certification requirements for eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives, who are state licensed and registered by the Drug Enforcement Administration to prescribe controlled substances Specifically, the exemption allows these practitioners to treat up to 30 patients with OUD using buprenorphine without having to make certain training-related certifications This exemption also allows practitioners to treat patients with

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[5] Centers for Disease Control and Prevention, "Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips", (April 7, 2021).

[6] Substance Abuse and Mental Health Services Administration, "HHS Releases New Buprenorphine Practice Guidelines, Expanding Access to Treatment for Opioid Use Disorder" (April 27, 2021) *https://wwwsamhsagov/newsroom/press-announcements/202104270930*.

buprenorphine without certifying as to their capacity to provide counseling and ancillary services As of March 11, 2022, 12,005 providers have obtained a waiver through the revised Practice Guidelines.

Enhancing Access to Suicide Prevention and Crisis Care:

Suicide rates increased 30 percent between 2000—2018 and declined in 2019 and 2020 Suicide is a leading cause of death in the United States,[7] with 45,979 deaths in 2020 This is about one death every 11 minutes The number of people who think about or attempt suicide is even higher In 2020, an estimated 122 million American adults had serious thoughts of suicide in the past year, 32 million made a suicide plan, and 12 million attempted suicide[8] Among adolescents 12 to 17, 12 percent had serious thoughts of suicide, 53 percent made a suicide plan, and 25 percent attempted suicide in the past year These findings vary by race and ethnicity, with people of mixed ethnicity reporting higher rates of serious thoughts of suicide Among people of mixed ethnicity 18 or older, 11 percent had serious thoughts of suicide, 33 percent made a suicide plan and 12 percent attempted suicide in the past year Among Hispanics or Latinos 18 or older, 42 percent had serious thoughts of suicide, 12 percent made a suicide plan and 06 percent attempted suicide in the past year.

Suicide is a complex public health problem There is no single cause and no single solution As we work with our Federal agency partners to improve suicide prevention efforts across the Nation, we are focused on addressing upstream risk factors, expanding access to mental health and substance use services, and improving the crisis services infrastructure.

SAMHSA has several programs aimed at supporting Americans in crisis.

The National Suicide Prevention Lifeline and Transition to 988

The National Suicide Prevention Lifeline (Lifeline), currently 1–800–273-TALK, is a network of more than 200 local, independent crisis centers equipped to help people in mental health related distress or experiencing a suicidal crisis via call, chat, or text The Lifeline provides free and confidential support to people in suicidal crisis or mental health related distress 24 hours a day, 7 days a week, across the United States.

In 2020, the FCC and Congress designated the number 988 as the nation's new, three-digit, national suicide prevention and mental health crisis number On July 16, 2022, the U.S. will transition to using the 988-dialing code The creation of 988 is a once-in-a-lifetime opportunity to strengthen and expand the Lifeline and transform America's behavioral health crisis care system to one that saves lives by serving anyone, at any time, from anywhere across the Nation.

Preparing the Lifeline for full 988 operational readiness requires a bold vision for a system that provides direct, life-saving services to all in need and links them to community-based providers uniquely positioned to deliver a full range of crisis care services SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis system in much the same way that, over time, 911 spurred the growth of emergency medical services in the United States.

Through the American Rescue Plan Act, the Administration has provided $180 million to support local capacity to answer crisis calls and establish more community-based mobile crisis response and crisis stabilizing facilities to minimize unnecessary emergency department visits.

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant (MHBG) continues to serve as a safety net for mental health services for some of the nation's most vulnerable populations By statute, MHBG funds must be used to address the needs of adults with SMI and children with serious emotional disturbances (SED) Ten percent of MHBG funds are set-aside for evidence-based programs that address the needs of

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[7] CDC WONDER: Underlying cause of death, 1999—2019 Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2020 *https://wondercdcgov/Deaths-by-Underlying-Causehtml*.

[8] Substance Abuse and Mental Health Services Administration (2021) Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No PEP21–07–01–003, NSDUH Series H–56) Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration Retrieved from *https://wwwsamhsagov/data/*.

individuals with early serious mental illness, including psychotic disorders The set-aside helps reduce costs to society, as intervening early helps prevent deterioration of functioning in individuals experiencing a first episode of serious mental illness MHBG also includes a set-aside to support state efforts to build much needed crisis systems to address the needs of individuals in mental health crisis in a high quality, expeditious manner The development of these services will promote 24/7 access to well-trained mental health professionals in the time of acute mental health crisis.

Garrett Lee Smith Grant Program

The Garrett Lee Smith (GLS) Memorial Act authorizes SAMHSA to manage two significant youth suicide prevention programs and one resource center The GLS State/Tribal Youth Suicide.

Prevention and Early Intervention Grant Program supports development and implementation of youth suicide prevention and early intervention strategies involving public-private collaboration among youth serving institutions The GLS Campus Suicide Prevention program supports institutions of higher education, including tribal colleges and universities, working to prevent suicide and suicide attempts A peer reviewed research paper found that a sustained reduction in youth suicide mortality rates was observed among youths in counties exposed to GLS Memorial Youth Suicide Prevention Program programming compared with matched control counties that were not exposed to GLS. [9]

Adult Suicide Prevention Grants

The 2012 National Strategy for Suicide Prevention (NSSP) seeks to reduce the overall suicide rate and number of suicides in the U.S. nationally. The NSSP grant program supports the efforts of states, tribes, primary and behavioral healthcare organizations, public health agencies, and emergency departments to implement the NSSP While the NSSP addresses all age groups and populations with specific needs, the goals and objectives of the NSSP grants focus on preventing suicide and suicide attempts among adults over the age of 25.

The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems The purpose of the Zero Suicide program is to implement suicide prevention and intervention programs for individuals who are 25 years of age or older by systematically applying evidence-based approaches to screening and risk assessment, developing care protocols, collaborating for safety planning, providing evidence-based treatments, maintaining continuity of care during high risk periods, and improving care and outcomes for such individuals who are at risk for suicide being seen in health care systems.

Promoting Child and Youth Behavioral Health:

Even before the pandemic, our nation's children and youth were struggling with mental health and substance use challenges, and during the pandemic rates of anxiety and depression have skyrocketed, which is why it is critical that we promote the behavioral health of young people across the country To focus our efforts on improving behavioral wellness for our nation's youth, SAMHSA has developed the "Health, Opportunity, Potential and Equity (HOPE) Framework for Children, Youth and Families".

SAMHSA wants to bring HOPE to children and families across the country by creating and expanding programs and initiatives that provide Health for every young person—and you can't have health without mental, emotional, and behavioral health—improve Opportunity for youth who may be at-risk through early identification and intervention, and ensure that young people who experience serious emotional disturbances or substance use disorders can reach their full Potential and we will emphasize the need for Equity to deliver all our services and supports in culturally and linguistically appropriate ways.

The HOPE Framework will guide efforts to expand access to proven treatments, interventions, and other recovery supports, while developing new and innovative solutions to strengthen behavioral health services for America's children and young adults.

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[9] Garraza, Kuiper, Goldston, McKeon, Walrath Long-term impact of the Garrett Lee Smith Youth Suicide Prevention Program on youth suicide mortality, 2006—2015, Journal of Child Psychology and Psychiatry (2019).

Project AWARE

Project AWARE (Advancing Wellness and Resiliency in Education) is comprised of the Project AWARE grants, Resilience in Communities after Stress and Trauma (ReCAST) grants, and the Mental Health Awareness Training (MHAT) grants Project AWARE grants promote comprehensive, coordinated, and integrated state efforts to make schools safer and increase access to mental health services ReCAST assists high-risk youth and families to promote resilience and equity in communities struggling with civil unrest, trauma, and violence through implementation of evidence-based violence prevention and community youth engagement programs and linkages to trauma-informed mental health services The MHAT grants train school personnel, emergency first responders, law enforcement, veterans, armed services members, and their families to recognize the signs and symptoms of mental disorders.

Project LAUNCH

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) works to ensure that the systems that serve young children (including childcare and education, home visiting, and primary care) have the resources and knowledge to foster their social, emotional, cognitive, and behavioral development The program also ensures that the systems intervene to prevent, recognize early signs of, and address mental, emotional, and behavioral disorders in early childhood and into the early elementary grades.

Children's Mental Health Initiative

The Children's Mental Health Initiative (CMHI) supports "systems of care" (SOC) for children and youth with SED and their families to increase their access to evidence-based treatment and supports SOC is a strategic approach to the delivery of services and supports that incorporates family driven, youth-guided, strength-based, and culturally and linguistically competent care to meet the physical, intellectual, emotional, cultural, and social needs of children and youth throughout the U.S. Services are delivered in the least restrictive environment with evidence-supported treatments and interventions Individualized care management ensures that planned services and supports are delivered with an appropriate, effective, family driven, and youth-guided approach This approach has demonstrated improved outcomes for children at home, at school, and in their communities For example, CMHI grantee data show that suicide attempt rates significantly decreased within 12 months after children and youth accessed CMHI-related services.

Infant and Early Childhood Mental Health

The purpose of the Infant and Early Childhood Mental Health program is to improve outcomes for children, from birth to 12 years of age, who are at risk for, show early signs of, or have been diagnosed with a mental illness, including an SED Grantees improve outcomes for children through training early childhood providers and clinicians to identify and treat behavioral health disorders, including in children with a history of in utero exposure to substances such as opioids, stimulants, or other drugs that may impact development, and through the implementation of evidence-based multigenerational treatment approaches that strengthen caregiving relationships.

National Child Traumatic Stress Initiative and the National Child Traumatic Stress Network

The National Child Traumatic Stress Initiative (NCTSI) aims to improve behavioral health services and interventions for children and adolescents exposed to traumatic events SAMHSA funds a national network of grantees known as the National Child Traumatic Stress Network (NCTSN) to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events The NCTSN has grown to 116 funded and over 150 affiliate centers located nationwide in universities, hospitals, and a range of diverse community-based organizations with thousands of national and local partners The NCTSN's mission is to raise the standard of care and improve access to evidence-based services for children experiencing trauma, their families, and communities A component of this work has been the development of resources and delivery of training and consultation to support the development of trauma informed child-serving systems.

Center of Excellence on Social Media and Mental Wellness

While technology platforms have improved our lives in some ways, there is mounting evidence that social media is harmful to many kids' and teens' mental health, well-being, and development Therefore, over the next year, SAMHSA will launch a National Center of Excellence on Social Media and Mental Wellness, which will develop and disseminate information, guidance, and training on the full impact of adolescent social media use, especially the risks these services pose to their mental health.

Integrating Primary and Behavioral Healthcare:

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

Certified Community Behavioral Health Clinics Expansion Grants

The Certified Community Behavioral Health Clinics (CCBHC) Expansion program is designed to increase access to and improve the quality of community mental and substance use disorder treatment services CCBHCs funded under this program must provide access to services for individuals with SMI or SUD, including OUD; children and adolescents with SED; and individuals with co-occurring mental and substance use disorders This program improves the mental health of individuals by providing comprehensive community-based mental and substance use disorder services; treatment of co-occurring disorders; advancing the integration of mental/substance use disorder treatment with physical health care; utilizing evidence-based practices on a more consistent basis and promoting improved access to high quality care.

Data from intake to most recent reassessment for individuals served in the CCBHC program demonstrate that as of March 2022, clients have a 72 percent reduction in hospitalization and a 69 percent reduction in Emergency Department visits, as well as a 25 percent increase in mental health functioning in everyday life Additionally, the data demonstrates that 12 percent had an increase in employment or started going to school.

Primary and Behavioral Health Care Integration

The Primary and Behavioral Health Care Integration (PBHCI) program addresses the intersection between primary care and treatment for mental illness and co-occurring disorders This program awards grants to community mental health centers and states to support coordination and integration of primary care services and publicly funded community behavioral health services for individuals with SMI and a co-occurring substance use disorder served by the public mental health system The PBHCI program encourages grantees to engage in necessary collaboration, expand infrastructure, and increase the availability of primary healthcare and wellness services.

Screening, Brief Intervention and Referral to Treatment Program

The Screening, Brief Intervention and Referral to Treatment (SBIRT) program is intended to help primary care physicians identify individuals who misuse substances and help them intervene early with education, brief treatment, or referral to specialty treatment The program's goal is to increase the number of individuals who receive treatment and reduce the rate of substance misuse Studies have shown that this approach is effective in helping reduce harmful alcohol consump-

[10] 7 Bertholet, N, Daeppen, J-B, Wietlisbach, V, Fleming, M, & Burnand, B (2005) Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis Archives of Internal Medicine 165, 986—995.

[11] Kahan, M, Wilson, L, & Becker, L (1995) Effectiveness of physician-based interventions with problem drinkers: A review Canadian Medical Association Journal, 152, 851—859.

tion [10], [11], [12] A SAMHSA-funded cross-site evaluation found that allied health professionals, rather than the physicians themselves, were more likely to implement SBIRT with their patients The SBIRT Student Training and Health Professionals Training grant programs support SBIRT training efforts for medical students, medical residents, nurses, social workers, psychologists, pharmacists, dentists, and physician assistants These efforts aim to develop further the primary healthcare workforce in substance use disorder services.

Using Performance Measures, Data, and Evaluation:

Behavioral Health Equity Report

In October 2021, SAMHSA released its "Behavioral Health Equity Report 2021: Substance Use and Mental Health Indicators Measured from the National Survey on Drug Use and Health (NSDUH), 2015—2019" [13] This report disaggregates the behavioral health indicators by selected determinants of health: race and ethnicity (White, Black or African American, Native Hawaiian or Other Pacific Islander, American Indian/Alaska Native, Asian, Two or More Races, and Hispanic or Latino), income level, county type, and health insurance status In this report, the array of indicators presented across racial/ethnic groups and other selected determinants of health provides a unique overview of population-based variations in behavioral health at a point in time.

This effort—although a beginning step in addressing the complexity of behavioral health issues and social determinants of health—provides a mechanism for systematically tracking changes, trends, and disparities over time.

Drug Abuse Warning Network

SAMHSA re-established the Drug Abuse Warning Network (DAWN) in 2018 as a nationwide public health surveillance system to monitor emergency department visits related to recent substance use, including those related to opioids Authorized by the 21st Century Cures Act, DAWN provides necessary information such as patient demographic details and substances used in order to respond effectively to the overdose crisis in the United States and to better inform public health, clinicians, policymakers, and other stakeholders to respond to emerging substance use trends.

Updating SAMHSA's Government Performance and Results Act Tools

The Government Performance and Results Act (GPRA) requires agencies to engage in performance management tasks such as setting goals, measuring results, and reporting progress SAMHSA's discretionary grants and block grants are required to collect and report GPRA data Based on feedback from the field, SAMHSA is working to modify its existing client-level GPRA tools with the goal to improve the agency's ability to assess the impact of our programs on key outcomes of interest and to gather vital information about clients served.

CONCLUSION

On behalf of my colleagues at SAMHSA, thank you for your interest in, and support for, our programs, and for supporting the nation's behavioral health I would be pleased to answer any questions you may have.

The CHAIR. Thank you.

Administrator Johnson.

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[12] Wilk, AI, Jensen, NM, and Havighurst, TC (1997) Meta-analysis of randomized control trails addressing brief interventions in heavy alcohol drinkers Journal of General Medicine, 12 (5), 274–283.

[13] Center for Behavioral Health Statistics and Quality (2021) Behavioral health equity report 2021: Substance use and mental health indicators measured from the National Survey on Drug Use and Health (NSDUH), 2015—2019 (Publication No PEP21–07–01–004) Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from *https://wwwsamhsagov/data*.

[1] Behavioral health is inclusive of mental health and substance use disorders.

[2] *https://wwwhhsgov/sites/default/files/surgeon-general-youth-mental-health-advisorypdf*.

[3] National Research Council and Institute of Medicine (2009) Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities E O'Connell, T Boat, & K E Warner Eds Washington, DC The National Academic Press.

STATEMENT OF CAROLE JOHNSON, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, ROCKVILLE, MD

Ms. JOHNSON. Good morning Chair Murray, Ranking Member Burr, and Members of the Committee. I am Carole Johnson, Administrator of the Health Resources and Services Administration. I appreciate the opportunity to speak with you today about HRSA's programs that support the mental health and well-being of our Nation.

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

HRSA also plays an important role in supporting the health care workforce. We provide scholarship and loan repayment assistance to thousands of clinicians in return for them practicing in underserved communities. This year marks our largest scholarship and loan repayment cohort yet, with more than 22,000 clinicians in these programs. We also invest in recruiting, training, and retaining health professionals, from community health workers to mental health professionals to advanced practice nurses.

Like you, we recognize that mental health is essential to overall health for people of all ages, including for parents and children who have been affected by the pandemic. So today I would like to highlight two HRSA maternal and child mental health programs that are currently up for reauthorization, the Screening and Treatment for Maternal Depression Program and the Pediatric Mental Health Care Access Program.

The Screening and Treatment for a Maternal Depression Program supports states in integrating mental health care into maternal health care. There is tremendous demand for this program, but to date we have only been able to fund about a quarter of the applicants. Grantees provide training to help maternal health care providers screen and treat their patients' mental health conditions.

In a critical part of the program design, grantees give maternal health care providers the opportunity to connect with mental health care clinical experts through teleconsults to help them treat their individual patient's mental health conditions. As a result, more pregnant and postpartum women are being screened for depression, and maternal care providers are growing their capacity to support the mental health needs of their patients. Of note, where those needs are more complex, maternal care providers have the benefit of an expert teleconsult to support them.

For example, through our program, a midwife in Montana and her pregnant patient with emergent mental health needs got real time mental health help from a perinatal psychiatrist through teleconsultation. In the normal course of business, the midwife would

have had to refer the patient to a provider hours away who likely would have had troubles easily squeezing the patient in.

Similarly, the Pediatric Mental Health Care Access Program promotes mental health care integration in pediatric primary care. These grants provide teleconsultation, training, and care coordination to help local pediatric primary care providers diagnose, treat, and refer children for mental health care.

Similar to the Maternal Depression Program, our Pediatric Program both provides training that is building the capacity of pediatric primary care providers to respond to children's immediate mental health care needs, while also giving them the additional support of teleconsultation with a mental health expert to ensure that they have backup and the resources they need to serve their patients.

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

In addition to our programs that support mental health services, HRSA's workforce programs are training the behavioral health workforce and creating incentives to encourage them to practice in the communities where they are needed most. Our Behavioral Health Workforce Education and Training Program supports the training of psychologists, school and clinical counselors, marriage and family therapists, as well as the critical community connectors to mental health and substance use disorder care, like community health workers and peers and others.

Our scholarship and loan repayments are increasingly supporting behavioral health care providers as well. We also recently launched a new program with American Rescue Plan funding to help support health care workers' mental health resilience and reduce provider burnout. In closing, I want to thank the Committee for your ongoing support for HRSA's programs and your commitment to the mental health and well-being of America's families. Thank you.

[The prepared statement of Ms. Johnson follows:]

PREPARED STATEMENT OF CAROLE JOHNSON

Chair Murray, Ranking Member Burr, and Members of the Committee:

Thank you for the opportunity to speak with you about the Health Resources and Services Administration's (HRSA) programs to support the mental health and well-being of our Nation I am Carole Johnson, Administrator of HRSA.

As you know, the Biden-Harris Administration is committed to bipartisan solutions to address mental health challenges In his State of the Union Address, the President announced a national strategy to tackle the nation's mental health crisis as part of his Unity Agenda This strategy centers on three pillars: strengthening system capacity, connecting Americans to care; and, supporting Americans by creating healthy environments Secretary Becerra has launched a national tour focused on strengthening mental health and is hearing directly from Americans across the country about the mental health challenges they are facing and the opportunities to improve our mental health and crisis care systems At HRSA, we recognize that mental health is essential to overall health I appreciate the opportunity to speak with you today about how HRSA is working to achieve the President and Secretary's goals and how we are actively working to advance mental health priorities through our programs.

HRSA supports health care services in communities across the country, including for the nearly 29 million people who receive care through HRSA-funded health centers; the more than a half a million people diagnosed with HIV who receive care through the Ryan White HIV/AIDS program; an estimated 60 million pregnant individuals and children who benefit from HRSA-funded infant screenings, preventive care visits, and other services; and individuals in more than 1,500 rural counties who receive HRSA-supported substance use disorder services HRSA also supports multiple programs to grow and sustain the health care workforce, including providing scholarship and loan repayment assistance to more than 22,700 clinicians in return for working in underserved communities—the highest number ever for these programs—and investing in recruiting, training, and retaining a wide range of health professionals, from community health workers to psychiatrists to advance practice nurses.

Two of HRSA's mental health programs are currently up for reauthorization:

- The **Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program** helps train maternal health care providers on how to screen for, assess, treat, and, as necessary, refer pregnant and postpartum individuals with mental health conditions or substance use disorders as part of routine maternal health care Maternal health care providers also receive real-time psychiatric consultations for their patients through telehealth services and care coordination support.
- The **Pediatric Mental Health Care Access Program** aims to make early identification, diagnosis, treatment, and, as needed, referral for behavioral health conditions a routine part of children's health care services The program promotes the integration of behavioral health services into pediatric primary care through statewide and regional pediatric mental health care telehealth programs These statewide or regional networks provide tele-consultation, training, technical assistance and care coordination to community-based pediatric health care providers in order to expand the reach of critical mental health services and support children's needs.

HRSA also received COVID-response funding to enhance our investments in supporting the mental health needs of parents and children, grow the mental health workforce, and reduce health care provider burnout and promote resiliency HRSA has many other investments that support behavioral health initiatives. [1]

HRSA Health Workforce Programs that Support Behavioral Health.

HRSA programs play an important role in growing and training the behavioral health workforce and creating supports and incentives to help encourage providers to practice in the communities that need them most Our programs include **the Behavioral Health Workforce Education and Training Program,** which supports the training of social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, marriage and family therapists, community health workers, outreach workers, social services aides, mental health workers, substance use disorder workers, youth workers, and peers; **the Graduate Psychology Education Program,** which supports innovative doctoral level health psychology programs that foster a collaborative approach to providing mental health and substance use disorder prevention and treatment services in high need and high demand areas through academic and community partnerships; **the Children's Hospitals Graduate Medical Education Program,** which supports the training of pediatric residents, including pediatric psychiatry residents, in freestanding children's teaching hospitals; **the Teaching Health Center Graduate Medical Education Program,** which supports residency training, including for psychiatry, in community-based ambulatory care settings; and the **National Health Service Corps,** which provides scholarships and loan repayment for clinicians, including mental health and substance use disorder providers, who commit to practice in underserved communities we also launched new programs with American Rescue Plan funding to address mental health and promote resilience in the health care workforce through the **Promoting Resilience and Mental Health Among the Health Professional Workforce** and the **Health and Public Safety Workforce Resiliency Training Program**.

Our workforce programs also include initiatives specifically focused on substance use disorder training, which is a vital component of behavioral health training

[1] Behavioral health is inclusive of mental health and substance use disorders.

These programs include the **Addiction Medicine Fellowship Program,** which focuses on increasing the number of board certified addiction medicine and addiction psychiatry specialists trained in providing behavioral health services, including prevention, treatment, and recovery services in underserved, community-based settings; the **Integrated Substance Use Disorder Treatment Program,** which supports training and expansion of the number of nurse practitioners, physician assistants, health service psychologists, and social workers trained to provide mental health and substance use disorder services in underserved community-based settings that integrate primary care and mental health and substance use disorder services; the **Substance Use Disorder Treatment and Recovery Loan Repayment Program,** which focuses on recruiting and retaining medical, nursing, and behavioral health clinicians and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a substance use disorder through loan repayment in return for providing services in high need areas; and the **Opioid-Impacted Family Support Program,** which trains paraprofessionals to support children and families living in underserved areas who are impacted by opioid use disorder and other substance use disorders.

HRSA Health Care Services Programs that Support Behavioral Health

HRSA's health care services programs also play a key role in providing mental health and substance use disorder services, with a focus on delivering care and supports in underserved and rural communities These programs include the **Health Center Program,** which helps provide primary care in underserved communities across the country and are increasingly focused on integrating behavioral health into primary care services; the **Health Care for the Homeless Program,** which supports coordinated, comprehensive, integrated primary care including substance abuse and mental health services for individuals experiencing homelessness; the **Rural Communities Opioid Response Program,** which supports high need rural communities in establishing, expanding, and sustaining prevention, treatment, and recovery services for opioid use disorder; the **Ryan White HIV/AIDS Program,** which funds and coordinates with cities, states, and local clinics/community-based organizations to deliver HIV care, treatment, and support, including mental health and substance use disorder services, to people with HIV who have low incomes.

In addition to the two programs up for reauthorization, our programs focused on maternal and child health include the **Maternal, Infant, and Early Childhood Home Visiting Program,** which supports voluntary, evidence-based home visiting services during pregnancy and to parents with young children where trained professionals address needs such as conducting screenings and providing referrals to address caregiver depression, substance use, and family violence; the **Maternal and Child Health Block Grant,** which supports states in improving access to and the quality of health services for mothers, children, and their families, including initiatives to address national or regional needs, priorities, or emerging issues including mental health and substance use disorder; and the **Bright Futures Preventive Services Program,** which develops national guidelines to support children receiving high quality, efficient, and comprehensive pediatric care, including behavioral health services Bright Futures' recommended preventive services are covered without cost-sharing by most health plans In 2022, Bright Futures updates include adding universal screening for suicide risk to the current depression screening category for individuals ages 12 to 21, and new guidance for behavioral, social and emotional screening.

Mental Health is Essential to Maternal and Child Health

Last week, HRSA published a study in the American Medical Association's journal *JAMA Pediatrics* based on our *National Survey of Children's Health* that found significant increases in the number of children diagnosed with mental health conditions between 2016 and 2020 During the study timeframe, the number of children ages 3–17 years old diagnosed with anxiety grew by 29 percent and those with depression grew by 27 percent The survey also showed declines in parental well-being during this time: there was an 11 percent decrease in parents' reported ability to cope with the demands of raising children and a 5 percent decrease in parents' mental and emotional well-being.

HRSA funds the *National Survey of Children's Health,* which is the largest national and state-level annual survey of the health and health care needs of children, their families, and their communities to regularly assess the state of children' health Data from the 2020 national survey found that 149 percent of U.S. children ages 3–17 years—just over 9 million—had a current, diagnosed behavioral health

condition, and about one-third (347 percent) of these children had two or more conditions Yet only half (505 percent) of those with a current behavioral health condition received treatment or counseling from a mental health professional in the past year This can have long-term effects on health, well-being, and opportunity As noted in the 2021 Surgeon General's Advisory on Protecting Youth Mental Health, the pandemic has compounded many of these adverse impacts by disrupting educational, social, and service supports and opportunities upon which so many vulnerable children, youth and families depend [2] Children and families have weathered the sudden interruption of in-person learning, prolonged isolation during stay-at-home orders, loss of regular school-based behavioral health services, family economic stressors like housing instability and food insecurity, and the trauma and grief associated with personal and family experiences and loss during the COVID–19 pandemic.

The Centers for Disease Control and Prevention reports that nearly 1 in 5 children [3] have a mental, emotional, or behavioral disorder and that suicide is the second leading cause of death for people ages 10 to 24 [4] In 2019, 188 percent of high school students, ages 14–18 years, had seriously considered attempting suicide, and 89 percent had attempted suicide one or more times, based on self-reporting [5] Data from the Substance Abuse and Mental Health Services Administration's 2016–2019 National Surveys of Drug Use and Health found that while nearly half of White adolescents with a depressive episode (460 percent) received treatment in the past year, the same was true for only one-third of their Black and Hispanic counterparts (363 and 356 percent, respectively) and one-quarter of Asian adolescents (262 percent) [6] In 2017–2018, depression, anxiety, and behavioral conditions were more prevalent among rural children ages 3–17 years compared to urban children. [7]

Research also shows that maternal mental health conditions are the most common complications of pregnancy [8] About 1 in 8 women experience symptoms of postpartum depression [9] Mental health conditions, including suicides, drug overdoses or poisonings, and unintentional injuries related to a mental health condition, are among the leading underlying causes of pregnancy——related deaths [10] As a result of pandemic-related worries and stressors, pregnant and postpartum people in the United States and internationally report elevated symptoms of depression, anxiety, post-traumatic stress, and loneliness [11, 12] Several empirical studies related to the pandemic have reported higher prevalence of mental health problems among women compared to men In this context, pregnant and new mothers could be more vulnerable [13] Yet, only 75 percent of mothers who need treatment are finding and getting it [14, 15] Without treatment, mothers are at increased risk for a range of poor

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[2] *https://wwwhhsgov/sites/default/files/surgeon-general-youth-mental-health-advisorypdf*.

[3] National Research Council and Institute of Medicine (2009) Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities E O'Connell, T Boat, & K E Warner Eds Washington, DC The National Academic Press.

[4] *https://wwwcdcgov/injury/wisqars/indexhtml*.

[5] *https://wwwresearchgatenet/publication/343795548—Suicidal* Ideation and Behaviors Among High School Students-Youth Risk Behavior Survey United States 2019.

[6] Substance Abuse and Mental Health Services Administration Report: Racial/Ethnic Differences in Mental Health Service Use among Adults and Adolescents (2015–2019).

[7] *https://mchbhrsagov/sites/default/files/mchb/data-research/rural-urban-differencespdf*.

[8] Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM The Prevalence of Anxiety Disorders During Pregnancy and the Postpartum Period: A Multivariate Bayesian Meta-Analysis J Clin Psychiatry 2019 Jul 23;80(4):18r12527 doi: 104088/JCP18r12527 PMID: 31347796; PMCID: PMC6839961.

[9] *https://wwwcdcgov/mmwr/volumes/69/wr/mm6919a2htm's—cid=mm6919a2—w*.

[10] Davis NL, Smoots AN, Goodman DG Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008–2017 Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2019.

[11] Liu, CH et al "Risk Factors for Depression, Anxiety, and PTSD Symptoms in Perinatal Women during the COVID–19 Pandemic" Psychiatry Review DOI: 101016/jpsychres2020113552.

[12] Basu A, Kim HH, Basaldua R, Choi KW, Charron L, Kelsall N, et al (2021) A cross-national study of factors associated with women's perinatal mental health and well-being during the COVID–19 pandemic PLoS ONE 16(4): e0249780 *https://doiorg/101371/journalpone0249780*.

[13] Thapa SB, Mainali A, Schwank SE, Acharya G Maternal mental health in the time of the COVID–19 pandemic Acta Obstet Gynecol Scand 2020 Jul;99(7):817–818 doi: 101111/aogs13894 PMID: 32374420; PMCID: PMC7267371.

[14] Byatt, Nancy et al "Enhancing Participation in Depression Care in Outpatient Perinatal Care Settings: A Systematic Review" Obstetrics and gynecology vol 126,5 (2015): 1048–1058 doi:101097/AOG0000000000001067.

[15] Wright, TE, Terplan, M, Ondersma, SJ, Boyce, C, Yonkers, K, et al (2016) The role of screening, brief intervention, and referral to treatment in the perinatal period American Journal of Obstetrics & Gynecology, 215(5), 539–547.

outcomes In addition, substance use during pregnancy can have serious consequences for maternal and infant health, including preterm labor and complications related to delivery.

Access to mental health care is related to the volume and distribution of maternal and child mental health and substance use disorder providers In fact, ratios of child and adolescent psychiatrists range by state from 1 to 60 per 100,000 children, with a median of 11 child and adolescent psychiatrists per 100,000 children [16] As of December 2021, an estimated 136 million people in the United States—over 40 percent of the total U.S. population—live in designated "Mental Health Professional Shortage Areas" [17] Only 28 percent of the need for mental health care in these Mental Health Professional Shortage Areas has been met The need for prevention, treatment, and recovery services to support children and families' mental health are important drivers of the President's national strategy to tackle the nation's mental health crisis and Secretary Becerra's National Tour to Strengthen Mental Health.

HRSA's Maternal and Child Behavioral Health Programs.

HRSA's maternal and child health work focuses directly on improving the health and well-being of our nation's mothers, children and families so they can thrive and reach their full potential Our program investments in behavioral health have four primary aims:

First is to **increase identification** of behavioral health conditions By that, we mean linking women and families to treatment and supports through routine screening, referral, and direct service to prevent mental health and substance use disorders whenever possible and treat them appropriately when necessary.

The second aim is to **improve access** to quality services Patients should be able to see care providers either in person in their local communities or through telehealth This care should be high quality, patient-centered, and culturally and linguistically appropriate.

The third aim is to **advance equity** we must eliminate health disparities, including racial and geographic disparities that affect far too many Our programs seek to address systemic and social inequities and promote protective factors for families.

The fourth aim is to **strengthen the maternal and child health workforce** to meet the behavioral health needs of families That includes offering the training that our health care workers need to integrate all best practices—including those that are culturally and linguistically appropriate, equitable and trauma informed.

The two HRSA programs up for reauthorization, the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program and the Pediatric Mental Health Care Access Program, are key investments that support primary care providers' ability to routinely screen and treat behavioral health conditions.

Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program

HRSA's Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program supports states in integrating behavioral health into maternal health care using telehealth The 21st Century Cures Act (PL 114–255) authorized the program through fiscal year (FY) 2022 This program supports new or expanding state telehealth access programs, including in rural and underserved areas The Screening and Treatment for Maternal Depression program gives providers the tools to integrate behavioral health care into routine maternal health care through telehealth services that can help local providers bridge the gap in access to psychiatrists, especially perinatal psychiatrists [18] With telehealth support from the program, maternal health care providers are able to receive real-time psychiatric consultations and care coordination support Community-based maternal health providers also are offered training on how to screen for, assess, treat, and refer pregnant and postpartum individuals for mental health and substance use disorders.

The Screening and Treatment for Maternal Depression program is implemented through 5-year cooperative agreements to states and funded at approximately $45

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[16] *https://wwwaacaporg—AACAP—Press—Press—Releases/2018/Severe—Shortage—of—Child—and—Adolescent—Psychiatrists—Illustrated—in—AAACP—Workforce—mapsaspx*.

[17] Health Services and Resources Administration (2021) Fourth Quarter of Fiscal Year 2021 Designated HPSA Quarterly Summary As of December 31, 2021 Available at *https://datahrsagov/Default/GenerateHPSAQuarterlyReport*.

[18] *https://bhwhrsagov/data-research/projecting-health-workforce-supply—demand/behavioral—health*.

million in total per year Each state health department receives approximately $650,000 per year we are currently in the fourth of 5 years of funding HRSA received tremendous interest in the program—demonstrating the acute need for it—but is only able to fund approximately a quarter of applicants The seven states that currently receive awards are Florida, Kansas, Louisiana.

Montana, North Carolina, Rhode Island and Vermont In fiscal year 2020, awardees trained 1,085 health care providers, participating providers screened 24,500 pregnant and postpartum individuals for depression, and providers sought and received expert mental health consultation for nearly 7,500 pregnant and postpartum individuals, with nearly half being from rural and underserved areas.

One example of the impact of the program is the story of a pregnant, Native American woman from a Montana reservation who went to a satellite site of a large hospital system to seek prenatal care Her midwife noticed that the patient presented with symptoms of psychosis and was not receiving medication or therapy The patient lived in a part of the reservation that does not have cell service or internet, so the only time the patient could seek telehealth services was when she was at the satellite clinic The midwife called the Montana Screening and Treatment for Maternal Depression program, which is called PRISM for Moms, in order for the patient to be seen by the perinatal psychiatrist The psychiatrist was able to see the patient that day and made medication recommendations The psychiatrist also talked with the midwife about options to get the patient to see a mental health provider regularly If this midwife did not have access to Montana's teleconsultation line, she likely would have referred the patient to a prescribing provider in Billings (the largest city in the state), a 2-hour drive from the reservation.

As another example, the Vermont awardee is helping to build a statewide system of supports and services for expectant parents and families with young children The program helps the perinatal population in accessing perinatal mental health providers and other resources Through this program, medical and mental health clinicians are able to screen and provide culturally respectful and tailored services to patients Over time, there has been an increase in the complexity of calls from maternal health care providers to the program's mental health expert consultation line, suggesting that the program's training not only expands access to expertise, but also results in maternal health providers addressing more and more of their patients' needs.

In short, the Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program has provided important tools to support the mental health of pregnant and post-partum individuals The fiscal year 2022 appropriation of $65 million, a $15 million increase, will help us further address the maternal behavioral health needs we are seeing in the Nation, and we look forward to working with the Committee on its reauthorization.

Pediatric Mental Health Care Access Program

Just as the Screening and Treatment for Maternal Depression program helps fill the gaps in behavioral health care for pregnant and postpartum mothers, the Pediatric Mental Health Care Access program helps do the same for pediatric care providers.

The 21st Century Cures Act (PL 114–255) authorized the Pediatric Mental Health Care Access program through fiscal year 2022 The program promotes behavioral health integration in pediatric primary care through new or expanded statewide or regional pediatric mental health care telehealth programs These statewide or regional networks of pediatric mental health care teams provide tele-consultation, training, technical assistance and care coordination With this support, pediatric primary care providers can diagnose, treat and refer children to the care they need for behavioral health concerns The telehealth technologies promote long-distance clinical health care, clinical consultation, and patient and provider education, helping to address challenges in accessing psychiatrists, developmental-behavioral pediatricians, and other behavioral health clinicians who treat behavioral concerns in children and adolescents.

Beginning in fiscal year 2018, HRSA initially funded 18 awardees for 5 years In fiscal year 2019, we funded 3 additional awardees for 4 years These awards are funded at $445,000 per year The American Rescue Plan allowed HRSA to broaden the program's reach to 45 awards in 40 states, the District of Columbia, the U.S. Virgin Islands, the Republic of Palau, and two Tribal areas—the Chickasaw Nation and the Red Lake Band of the Chippewa Indians On January 5, 2022, HRSA released a Notice of Funding Opportunity for a second round of American Rescue Plan funding to further expand the Pediatric Mental Health Care Access program This

funding will support up to 10 awards at $445,000 each for a 4-year period In addition, in the coming year, HRSA plans to establish a technical assistance resource center for program grantees The resource center will develop online resources accessible to all states.

Grantee work in Alabama, particularly in rural areas, illustrates the program's impact The Alabama Pediatric Access to Tele-Mental Health Services (PATHS) program consultation team is composed of psychiatrists, psychologists, psychiatric Nurse Practitioners, licensed counselors and social workers An early childhood mental health consultant on the PATHS consultation team enables team members to address a broad range of questions during consultations before providing a psychiatric diagnosis Through PATHS, pediatric providers have access to consultation typically within an hour, and all consultations are usually addressed the same day PATHS also offers Project ECHO, a tele-mentoring program that links providers with the PATHS team to review cases together as a group PATHS can provide children and adolescents with specialty interventions not available in the community through tele-therapy at Children's Hospital of Alabama Care coordinators provide community-based resources to providers and families The program reaches children and families across the state. As one pediatric provider noted about the impact of the program: "Participating in PATHS has improved my education to treat psychiatric illnesses in patients PATHS has had a huge impact on my patient population I can treat illnesses more immediately and not have my patients waiting months for care".

As the program expands to new states through funding provided through the American Rescue Plan Act, we expect to see more providers and children benefit from these services For example, the Washington Partnership Access Line (PAL) received a HRSA Pediatric Mental Health Care Access grant in September 2021 that will allow the program to expand existing and offer new supports and services PAL has been in operation since 2008, and currently delivers over 2,000 consultations a year for primary care providers, four mental health training conferences a year, and distributes thousands of copies of the program's care manual for primary care mental health The service also delivers a statewide mental health referral service for parents, provides training and support to primary care clinic based mental health therapists, and provides second opinion psychiatric medication reviews for Washington State Medicaid.

With Pediatric Mental Health Care Access funding, PAL will expand efforts to provide crisis support services for youth in rural Washington In the remote, primarily rural counties of eastern Washington State, the numbers of children and adolescents showing up in primary care and at community hospitals with suicidal ideation and psychological distress is of significant concern Through a partnership with the Department of Health, Seattle Children's Hospital, and Frontier Behavioral Health, the Supporting Adolescents and Families Experiencing Suicidality (SAFES) project will address the behavioral health patient surge due to the COVID pandemic, assist children in crisis and their families, develop enhanced access to telehealth behavioral services, provide access for primary care providers to psychiatric consultation for children and adolescents, increase the capacity of community therapists to safely care for suicidal youth in outpatient settings, decrease the need for mental health emergency department utilization, and address disparities in behavioral health care in rural eastern Washington communities.

In short, the Pediatric Mental Health Care Access Program is helping states fill critical needs for children's mental health The fiscal year 2022 appropriation of $11 million will help us to continue to address the pediatric behavioral health needs we are seeing across the Nation, and we look forward to working with the Committee on reauthorizing the program.

Conclusion

Thank you for the opportunity to discuss HRSA's key investments to address the nation's behavioral health with you today we are looking forward to working with the Committee on this critical issue and reauthorizing the Screening and Treatment for Maternal Depression Program and the Pediatric Mental Health Care Access Program.

The CHAIR. Thank you.

Director Gordon.

STATEMENT OF JOSHUA A. GORDON, M.D., PH.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD

Dr. GORDON. Chairman Murray, Ranking Member Burr, Members of the Committee, the Biden Administration is committed to addressing the unprecedented mental health crisis affecting communities across the United States, using a strategy built on a foundation of research carried out by the National Institute of Mental Health, the lead Federal agency charged with setting and supporting the national agenda for mental health research. It is my privilege to represent NIMH before you today and to discuss our ongoing collaborations with partner agencies to support the President's strategy.

The NIMH is one of 27 institutes and centers of the National Institutes of Health. NIMH's mission is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. Guided by our strategic plan, NIMH supports a research pipeline that includes basic efforts to understand the brain and behavior, translational science focused on developing transformative new therapies, and clinical research aimed at maximizing the public health impacts of these therapies.

The translational pathway is well illustrated by considering one recent advance, in the treatment of postpartum depression, a mental illness that impacts one in nine mothers and can be life threatening. Working diligently over decades, neuroscientists supported by NIMH discovered that a naturally occurring brain chemical might have a role in postpartum depression.

This led to the eventual FDA approval of brexanolone and analog of that chemical as the first ever drug specifically for postpartum depression. NIMH's role doesn't stop with the development of transformative therapies like brexanolone. We also collaborate extensively with other Federal agencies with the goal of ensuring that effective treatments are accessible to all who need them.

One such collaboration has transformed care for psychosis in the United States. An ambitious NIMH supported research program, the RAISE initiative, proved that coordinated specialty care could cost effectively improve outcomes for those experiencing their first episode of psychosis. Based on these findings, our colleagues at SAMHSA used the Mental Health Block Grant Program to fund first episode psychosis clinics across the country.

Now, over 350 such clinics are providing this cutting edge care to thousands of Americans each year. NIMH collaborations are also making progress in preventing suicide. NIMH research forms the backbone of the zero suicide approach, a systematic framework for suicide prevention supported by SAHMSA, the Department of Defense, the Indian Health Service, and numerous others.

For example, NIMH research has demonstrated that emergency room screening for suicidal thoughts, combined with brief interventions and follow-up contacts, can reduce suicide attempts by 33 percent. NIMH continues to work with public and private partners to promote the use of zero suicide and other evidence based approaches.

While it is too early to declare victory, we were gratified to see rates of death by suicide decline for two consecutive years following 2018, after two decades of inexorable increases. The COVID–19 pandemic has brought additional challenges to the mental health system.

The rates at which individuals note symptoms of depression, anxiety, substance use, and suicidal thoughts have all gone up, as has the demand for mental health services, especially among children. These impacts have not been felt equally, with black, latino, and other underserved communities, as well as care practitioners and others on the front lines of the pandemic, bearing the brunt of both the physical and mental health impacts.

Yet even during the pandemic, research has offered hopeful solutions, NIMH research so that mental health care can be as effective as in-person mental health care, supporting the rapid switch to remote care in early 2020.

NIMH research during the pandemic has also demonstrated that social supports, such as providing meals to families threatened by food insecurity, builds resilience to the mental health impacts of the pandemic.

Additional challenges await solutions. The Surgeon General has declared a crisis in youth mental health, noting the impact of media and technology use and the rise in suicide rates among black youth and other vulnerable groups.

We also face continuing challenges in caring for individuals with serious mental illness and the equitable delivery of mental health services. To address these challenges, NIMH continues to collaborate with our Federal partners, including those joining us today, to ensure that evidence based solutions reach those in need.

In short, we stand ready to help. Thank you for your opportunity to provide this testimony, and I would be pleased to answer any questions you might have.

[The prepared statement of Dr. Gordon follows:]

PREPARED STATEMENT OF JOSHUA A. GORDON

Chair Murray, Ranking Member Burr and Members of the Committee, The Biden administration is committed to addressing the unprecedented mental health and substance use disorder crisis that is affecting adults and children of all races in urban and rural communities across the United States During the State of the Union, President Biden announced the strategy to address our national mental health crisis as part of his Unity Agenda[1] The three pillars of the President's mental health strategy are: (1) Strengthen System Capacity; (2) Connect Americans to Care; and (3) Support Americans by Creating Healthy Environments A These three pillars are built on a foundation of research carried out by the National Institute of Mental Health (NIMH) the lead Federal agency charged with setting and supporting the national agenda for mental health research It is my privilege to represent NIMH before you today, and to discuss our ongoing collaborations with partner agencies to support the President's strategy.

The NIMH is one of the 27 Institutes and Centers that make up the National Institutes of Health (NIH), the largest biomedical research agency in the world The NIMH mission is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure The NIMH Strategic Plan for Research guides the Institute's priorities for funding research, from basic neuroscience aimed at understanding how the brain produces behavior, to translational efforts to develop transformative treatments, to

clinical studies testing novel approaches in community settings[1] Indeed, research has driven significant progress in several key areas of public health, providing hope that drives us forward.

This translational pathway from basic science to clinical application is well illustrated by considering one recent advance in the treatment of postpartum depression (PPD), a mental illness that impacts 1 in 9 mothers and can be life-threatening[2] Until recently, there were no specific treatments for PPD But thanks to NIMH-supported science, that is no longer the case This pathway to treatment development started in the early 1990's, when scientists with NIMH and the National Institute of Neurological Disorders and Stroke discovered that naturally occurring brain chemicals called neurosteroids were important for reducing the adverse effects of stress in laboratory animals Subsequent work funded by NIMH showed that levels of one of these chemicals, allopregnanolone, fluctuate through pregnancy and drop rapidly at the time of birth, suggesting that low levels of allopregnanolone might lead to PPD and that giving extra allopregnanolone to women might treat PPD Subsequent clinical trials published in 2018 confirmed this hypothesis, finding that brexanolone, a synthetic version of the natural chemical, can rapidly reverse the symptoms of PPD This decades-long scientific effort culminated in the spring of 2019 with Food and Drug Administration (FDA) approval of brexanolone as the first ever treatment specifically for PPD.[3]

We are proud of NIMH research, and its role in developing transformational new therapies like brexanolone and NIMH's role does not stop there; we also collaborate extensively with other Federal agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS), and others, with the goal of achieving mental health equity by ensuring that effective treatments are accessible to the people who need them.

One such collaboration has transformed care for psychosis in the United States Maximizing the likelihood of recovery for individuals with schizophrenia and other psychotic illnesses requires delivering the very best care as early as possible in the course of their illness But just what "the very best care" meant was unclear as recently as a decade ago In the late 2000's and early 2010's, NIMH supported an ambitious research program—the Recovery After an Initial Schizophrenia Episode (RAISE) initiative—that tested the efficacy of Coordinated Specialty Care for those experiencing their first episode of psychosis.[4] This research showed that individuals receiving this set of wraparound services did significantly better than those who received treatment as usual, particularly when interventions were offered early on Perhaps even more importantly, the RAISE study showed that these services can be effectively delivered in community settings and are cost-effective when compared to usual care Based on these findings, our colleagues at SAMHSA have used the Mental Health Block Grant program to fund First Episode Psychosis clinics around the country that offer Coordinated Specialty Care Now over 350 such clinics are providing cutting-edge evidence-based care to thousands of Americans each year In other interagency collaborations related to the treatment of early psychosis, NIMH has partnered with SAMHSA in their efforts to establish community treatment programs for those at clinical high risk for psychosis, partnered with HRSA to implement psychosis screening in primary care settings, and assisted the Department of Veterans Affairs (VA) in assuring high-quality services for Veterans with early psychosis.

Similarly, in the area of suicide prevention, NIMH is collaborating in science-to-service and service-to-science cycles of learning healthcare NIMH research has shown that the majority of those who have died by suicide were seen by their doctor or another healthcare provider in the weeks or months prior to their death Accordingly, NIMH has worked with numerous partners to improve suicide prevention efforts in healthcare settings[5] For example, findings from NIMH research have been incorporated into the "Zero Suicide" model, a systematic framework and multilevel approach to implementing evidence-based practices; this framework is now supported by grants from SAMHSA, the Department of Defense, and the Indian Health

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[1] *https://wwwnimhnihgov/about/strategic-planning-reports*.

[2] *https://wwwnimhnihgov/about/director/messages/2019/a-bench-to-bedside-story-the-development-of-a-treatment-for-postpartum-depression*.

[3] *https://wwwfdagov/news-events/press-announcements/fda-approves-first-treatment-postpartum-depression*.

[4] *https://wwwnimhnihgov/health/topics/schizophrenia/raise*.

[5] Gordon JA, Avenevoli A, Pearson JL Suicide Prevention Research Priorities in Health Care JAMA Psychiatry 2020 Sep 1;77(9):885–886 doi: 101001/jamapsychiatry20201042 PMID: 32432690.

Service [6] Initiated by the National Action Alliance for Suicide Prevention—a public-private partnership—the Zero Suicide model is based on systematic implementation and continuous improvement of suicide reduction efforts, resulting in fewer suicide events within healthcare systems.

NIMH research has yielded relevant, practice-ready tools that form the backbone of the Zero Suicide approach [7] For example, NIMH funded the Emergency Department Screen for Teens at Risk for Suicide (ED-STARS) study, conducted in HRSA-supported pediatric emergency rooms, to demonstrate the efficacy of screening for suicide prevention in these settings A similar study in adults showed that emergency room screening combined with brief interventions and follow-up contacts can reduce suicide attempts by 33 percent NIMH research has also supported the development of computational methods to identify suicide risk using electronic health records, an approach that has already been implemented in the Army, Veterans Affairs clinics, and many healthcare systems around the United States [8] Finally, NIMH research has demonstrated the efficacy and cost-effectiveness of interventions that can reduce suicide risk once detected, including Cognitive and Dialectical behavioral therapies, safety planning, caring contacts, and treating underlying mental illnesses.

To ensure that these evidence-based approaches to identifying and reducing suicide risk in individuals are being utilized, NIMH is working with SAMHSA, HRSA, CMS, the Centers for Disease Control and Prevention and other public and private partners to promote the use of Zero Suicide and other suicide prevention approaches throughout the United States and while it is too early to declare victory, we are gratified to see rates of death by suicide decline for two consecutive years since 2018, after two decades of inexorable increases.

These and other efforts to improve mental health services through evidence-based solutions have been confronted with another challenge; the Coronavirus Disease 2019 (COVID–19) pandemic The impact of the pandemic on mental health in the United States has been significant Research supported by NIMH and others has confirmed much of what we knew based on prior research on disasters and epidemics Through the course of the pandemic, the rates at which individuals note symptoms of depression, anxiety, substance use, and suicidal thoughts have all gone up [9] The demand for mental health services has also increased, especially amongst children and the effects on our youth, though still not fully quantified, are substantial These impacts have not been felt equally across American communities, with Black, Latinx, and other underserved communities as well as care practitioners and others on the front lines bearing the brunt of both the physical and mental health impacts of COVID–19 Suicide rates among Black youth, for example, have been rising for the past 5 years, eclipsing rates among White youth for the first time ever.

Yet even during the pandemic, research has offered hopeful solutions Prior NIMH research conducted over the past two decades has demonstrated that telemental health care can be as effective as in-person mental health care when delivered appropriately; this research supported the rapid switch to remote care delivery in early 2020 NIMH research during the pandemic has demonstrated that social supports, such as the provision of meals to families threatened by food insecurity, help build resilience to the mental health impacts of the pandemic and subsequent economic disruption and perhaps the most optimistic finding is that despite the increased rates of mental illness symptoms and increased demand for mental health services, overall suicide rates in the United States continued to decline through the first year of the pandemic. [10]

Of course, we must nonetheless strive to do better NIMH continues to gather evidence and collaborate with Federal agencies and other partners to widely disseminate evidence-based preventative and therapeutic interventions Some additional examples include:

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[6] Hogan MF, Grumet JG Suicide Prevention: An Emerging Priority For Health Care Health Aff (Millwood) 2016 Jun 1;35(6):1084–90 doi: 101377/hlthaff20151672 PMID: 27269026.

[7] *https://wwwnimhnihgov/archive/news/2016/nimh-funds–3-zero-suicide-grants.*

[8] *https://wwwnimhnihgov/news/science-news/2018/predicting-suicide-attempts-and-suicide-deaths-using-electronic-health-records.*

[9] Czeisler M, Lane RI, Petrosky E, et al Mental Health, Substance Use, and Suicidal Ideation During the COVID–19 Pandemic—United States, June 24—30, 2020 MMWR Morb Mortal Wkly Rep 2020;69:1049—1057 DOI: *http://dxdoiorg/1015585/mmwrmm6932a1.*

[10] Curtin SC, Hedegaard H, Ahmad FB Provisional numbers and rates of suicide by month and demographic characteristics: United States, 2020 Vital Statistics Rapid Release; no 16 Hyattsville, MD: National Center for Health Statistics November 2021 DOI: *https://dxdoiorg/1015620/cdc:110369.*

- **Family Navigator Models,** which provide assistance to youth and families to navigate healthcare and social service systems with the goal of improving outcomes and retaining more people in care;
- The **Collaborative Care Model** for integrated care, which uses a team-based approach to incorporate mental health care into primary care;
- **Learning Healthcare Networks,** which utilize clinical data to constantly improve and innovate in providing effective, high-quality care to all patients; and,
- **School-based Mental Health programs,** which provide behavior management skills training and other interventions to reduce symptoms of depression and other serious emotional disturbances.

One quick fact to underscore this last example: NIMH-sponsored research has shown that mental health care for school-aged children is more readily accessed and more effective when delivered through school-based programs, especially for Latinx and other children from underserved communities. [11]

We are faced with numerous challenges to the mental health of Americans, including the lingering effects of the COVID–19 pandemic, the crisis in youth mental health, including the impacts of media and technology use, challenges in caring for individuals with serious mental illness, rising suicide rates among Black youth and other vulnerable populations, and the limited efficacy of many existing treatments for mental illnesses In this context, research to develop novel, effective, and scalable preventive and therapeutic interventions is more urgent than ever At the same time, recent advances—such as novel technologies that are revolutionizing the understanding of the human brain, discoveries in the genetics of mental illnesses, and the successful development of novel, rapid-acting interventions for depression—provide an unprecedented opportunity to capitalize on mental health research and make significant progress for the future Meanwhile, NIMH continues to collaborate with our Federal partners, including those joining us here today, to ensure that evidence-based solutions reach those in need now In short, we know what works, and we stand ready to help.

Thank you for the opportunity to provide this testimony, and I would be pleased to answer any questions you might have.

The CHAIR. Thank you.

Director Volkow.

STATEMENT OF NORA D. VOLKOW, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD

The CHAIR. If you can turn your mic on.

Dr. VOLKOW. Can you hear me?

The CHAIR. Yes, yes.

Dr. VOLKOW. Good morning, I was saying, Chairwoman Murray, Ranking Member Burr, and Members of the Committee. Thank you for inviting me to speak to you today. The Biden Administration is committed to addressing the unprecedented mental health and substance use disorder crisis affecting our Country, and I welcome the opportunity to discuss how research supported by the National Institute on Drug Abuse is advancing this goal. We are experiencing the worst drug overdose crisis in the Nation's history.

Exacerbated by the COVID pandemic, overdose deaths have escalated across states and demographics. Now, for the first time ever, we are seeing fentanyl overdoses in adolescents rising dramatically. Substance use disorders frequently co-appear with other mental ill-

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[11] Sanchez AL, Cornacchio D, Poznanski B, Golik AM, Chou T, Comer JS The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis J Am Acad Child Adolesc Psychiatry 2018 Mar;57(3):153–165 doi: 101016/jjaac201711022 Epub 2017 Dec 24 PMID: 29496124.

nesses. Half of people with mental illnesses will have a substance use disorder at some point in their lives, and the reverse is also true.

These conditions share many common biological and environmental risk factors, such as discrimination, trauma, and economic deprivation. Since 2016, the rise in overdose fatalities has been driven by potent synthetic opioids, primarily fentanyl. In the meantime, social isolation and stress during the pandemic have contributed to a rise in emotional suffering and an increase in substance use and overdoses.

This and twin public health crisis highlights the need to implement prevention and treatment interventions. Preventions, interventions work. They protect from the devastation of drug use, and when delivered early in life, they can also help avert adult mental illnesses. Prevention interventions aim to decrease risk factors while enhancing resiliency and are implemented through family, schools, communities, and health care.

Evidence based prevention saves lives and money. And some studies show these benefits even extend to future generations. The Healthy Brain Study and the Child and the Adolescent Brain Cognitive Development Study are two large longitudinal investigations of human brain development. Together, they span the prenatal period through young adulthood. And the findings have already started to illuminate biological and environmental influences on mental health and are expected to inform prevention interventions.

The health care system can also play a key role in prevention and treatment, through screening for substance use and delivery of brief interventions or referral to specialty treatment. Identification of drug use can also serve as a sentinel symptom of a mental disorder that can then be treated. When substance use disorders occur along with other mental illnesses, both disorders must be treated.

Medications and behavioral therapies are effective in treating substance use disorders with or without comorbidities. However, less than 13 percent of people with substance use disorders receive treatment. This percentage is even lower among black Americans, among whom we are currently seeing the fastest rate of growth in overdose deaths.

Even for individuals with substance use disorders and psychiatric conditions, fewer than half received any treatment. To address this gap, NIDA is prioritizing implementations and services research. The NIDA clinical trial network or CTN has shown that opioid use disorders can be successfully treated in emergency departments and other health care settings. CTN is now assessing new models of treatment delivery through pharmacies and telehealth.

The NIDA Justice Community Opioid Innovation Network is testing ways to expand addiction treatment in jails and other justice settings. And are Healing Communities Study conducted in conjunction with SAMHSA is investigating how evidence based interventions can reduce opioid overdoses in some of the hardest hit communities in our Country.

NIDA also helps biotech startups develop technologies that connect people to care, provide or support treatment, help people sustain their recovery, and even facilitate overdose prevention. While there are effective medications for opioid, alcohol, and tobacco use disorders, high relapse rates still remain.

Critically, there are no medications for other drug use disorders. Thus, NIDA is prioritizing the development of addiction medications and treatment, including those that address the intersection between substance use and other mental illnesses.

The escalating loss of life due to drug addiction has made evident the urgent need for interventions to prevent and treat emotional distress and mental disorders as key strategies for addressing the overdose crisis. Thanks for inviting me to testify.

[The prepared statement of Dr. Volkow follows:]

PREPARED STATEMENT OF NORA D. VOLKOW

Chair Murray, Ranking Member Burr, and Members of the Committee, thank you for inviting the National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH), to participate in this hearing NIDA's mission is to advance the science on the causes and consequences of drug use and addiction and apply that knowledge to improve individual and public health I am pleased to speak to you today about the intersection of substance use and mental health.

The Administration is committed to addressing the unprecedented mental health, and substance use disorder crisis that is affecting adults and children of all races in urban and rural communities across the United States During the State of the Union, President Biden announced his Unity Agenda This includes a focus on fighting the overdose epidemic as well as addressing our national mental health crisis [1] The three pillars of the President's mental health strategy are: (1) Strengthen System Capacity; (2) Connect Americans to Care; and (3) Support Americans by Creating Healthy Environments Today I will detail for you how NIDA science is advancing these goals.

We are experiencing the worst drug overdose crisis in the nation's history Exacerbated by the COVID–19 pandemic, overdose deaths exceeded 100,000 from September 2020 to September 2021, the highest number ever recorded in a 12-month period and a staggering 50 percent increase over the previous 2 years Large increases in many kinds of drug use have been seen over the course of the pandemic: Several reports have revealed increases in positive urine drug screens for fentanyl, cocaine, heroin, and methamphetamine [2, 3, 4] There have been increases in cannabis and alcohol use, especially among people with anxiety and depression and those experiencing COVID–19-related stress, [5, 6, 7] underscoring the close relationship between drug use and mental health.

Substance use disorders (SUDs) are considered mental illnesses, and these conditions frequently co-occur with other mental illnesses including depression, anxiety, post-traumatic stress disorder (PTSD), and others Half of people with mental illnesses will have an SUD at some point in their lives, and the reverse is also true The reasons that SUDs often co-occur with other mental illnesses are complex Sometimes they arise independently as a result of shared risk factors (common genetics, common environmental adverse factors) Their development may also be

[1] FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union—The White House.

[2] Millennium Health's Signals Report to COVID–19 Special Edition Reveals Significant Changes in Drug Use During the Pandemic (prnewswirecom).

[3] Analysis of Drug Test Results Before and After the U.S. Declaration of a National Emergency Concerning the COVID–19 Outbreak—Emergency Medicine—JAMA—JAMA Network.

[4] The Opioid Epidemic Within the COVID–19 Pandemic: Drug Testing in 2020—Population Health Management (liebertpubcom).

[5] Alcohol Consumption during the COVID–19 Pandemic: A Cross-Sectional Survey of U.S. Adults (nihgov).

[6] Increased alcohol use during the COVID–19 pandemic: The effect of mental health and age in a cross-sectional sample of social media users in the U.S.—ScienceDirect.

[7] Changes in Alcohol Consumption Among College Students Due to COVID–19: Effects of Campus Closure and Residential Change: Journal of Studies on Alcohol and Drugs: Vol 81, No 6 (jsadcom).

intertwined, with one contributing to the other Chronic, problematic drug use can disrupt the activity of the brain's reward, stress, and executive-control systems, making it more difficult for people to experience the pleasures associated with daily living and contributing to negative emotional states, such as depression, stress, and anxiety while impairing their capacity for self-regulation In other cases, people use drugs to self-treat an underlying mental disorder Over time, chronic drug use can lead to an SUD, which in turn can worsen the original mental illness Genetics may also mediate the relationship between drug use and mental illness For example, cannabis use raises risk of psychosis in those who have an underlying genetic vulnerability Research also points to a concordance between increases in schizophrenia associated with cannabis use disorder and concurrent rises in cannabis use and cannabis potency over the past two decades.

Although genes play a role in some of the synergies between drug use and mental illness, many of the common risk factors are social determinants of health such as racial and other forms of discrimination, adverse childhood experiences like abuse and neglect, and economic deprivation including poverty and lack of access to quality education and healthcare The stigma that attaches to both SUDs and other mental illnesses is another important factor, which contributes to and compounds adverse social determinants of health including social isolation, job loss, incarceration, and reluctance to seek care or difficulties accessing it.

Social isolation and stress have likely contributed to the rise in substance use and overdose observed over the course of the pandemic Social isolation can make people with SUDs more vulnerable to negative outcomes because it interferes with many of the support systems that can help them to reach and sustain recovery Although exposure to stress is a common occurrence for many of us, it is also one of the most powerful triggers for relapse to substance use for people with SUD, even after long periods of abstinence and for the exacerbation of depression and anxiety among with people with mental illnesses.

Notably, there are increased reports of mental distress since the COVID–19 pandemic emerged, including among individuals with no history of mental disorders and among younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers[8, 9, 10, 11] This increased mental distress is occurring in the context of a drug supply that is dominated by potent synthetic opioids and psychostimulants, underscoring the need for focused investment in prevention and treatment to mitigate the impact of the pandemic on the ongoing overdose epidemic Suicide is often linked to depression and other mental illnesses including SUDs, and in the United States, and it has significantly risen particularly among youth and, to a lesser extent, the elderly Moreover, in a recent study, we found that although suicide by overdose went down in most groups between 2015 to 2019 (the most recent year available), it rose in young people aged 15–24, in older adults aged 75–84, and in Black women The highest suicide-by-overdose rate in all years studied was seen in women aged 45–64.[12]

NIDA Is Advancing Research on SUDs and Other Mental Illnesses

NIDA-supported research has led to the development of effective prevention and treatment interventions for SUD, providing hope for the more than 20 million people in the United States with SUD and their loved ones Although significant strides in establishing evidence-based practices have been made, there is far more work to be done to develop new prevention and treatment interventions and to deliver existing effective interventions with fidelity, for diverse populations, and at scale There is a particularly urgent need for interventions for comorbid SUD and mental illness; just as SUD and other mental illnesses may exacerbate one another, effective treatment for each of a person's psychiatric condition improves overall outcomes.

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[8] Mental Health—Household Pulse Survey—COVID–19 (cdcgov).

[9] Early Release of Selected Mental Health Estimates Based on Data from the January—June 2019 National Health Interview Survey (cdcgov).

[10] Mental distress during the COVID–19 pandemic among U.S. adults without a pre-existing mental health condition: Findings from American trend panel survey—ScienceDirect.

[11] Mental Health, Substance Use, and Suicidal Ideation During the COVID–19 Pandemic—United States, June 24—30, 2020—MMWR (cdcgov).

[12] Intentional Drug Overdose Deaths in the United States American Journal of Psychiatry 2022 179:2, 163–165.

Prevention

Two large NIH-funded longitudinal studies, the Adolescent Brain Cognitive Development (ABCD) study and the HEALthy Brain and Child Development (HBCD) study, will add greatly to our understanding of risk and protective factors for SUDs and other mental illnesses Launched last year, the HBCD study will examine, from the prenatal period through age 9–10, both normal brain development and how environmental factors, including social determinants of health, maternal drug exposure, substance use, and COVID–19 influence brain development and clinical outcomes ABCD is following nearly 12,000 children from age 9–10 through the subsequent decade This study, too, has been examining how childhood experiences affect brain development and social, behavioral, academic, and health outcomes, including substance use and COVID–19 Together, these studies will provide valuable information for the development and implementation of prevention interventions.

It is already clear that interventions in early childhood or adolescence can be beneficial for averting substance use and other mental illnesses later in life Research has also provided evidence that interventions for low-income families can ameliorate some of the adverse neurobiological impacts of poverty [13] Substance use and behavioral disorders exact a monetary as well as a human cost, with impacts felt across sectors of society including healthcare, the justice system, education, and taxpayers in general Studies of prevention's return on investment show that communities could not only save lives but save money by investing in prevention programs A recent analysis of one state's healthcare costs incurred by various risky behaviors in pre-adolescents and adolescents pointed to great potential cost savings from implementing relatively low-cost measures including screening in primary care and referral to family based prevention. [14]

Indeed, screening is crucial to better prevention of SUD and other mental illnesses, and it is an important area to focus our efforts As it now stands, within primary and ambulatory care settings, rates of screening for depression are quite low [15], [16] Screening for depression and other mental health conditions needs to become part of standard practice along with asking about substance use Only when providers screen for and diagnose all coexisting psychiatric conditions can treatment plans be developed that address the patient's unique and combined needs.

Under the Helping to End Addiction Long-term or HEAL Initiative, NIDA leads prevention research aimed at adolescent and young adult populations that are at highest risk for opioid misuse and opioid use disorder. (OUD) [17] Ongoing studies are modifying an existing alcohol and drug prevention intervention designed for American Indian/Alaska Native (AI/AN) youth to be appropriate for opioid prevention in young adults; preventing OUD among adolescents/young adults experiencing homelessness; exploring whether providing housing in addition to risk reduction services could improve outcomes; and leveraging technology that is appealing to adolescents and young adults to facilitate delivery of an emergency-department-based intervention via health coaches Preventing harms related to substance use is another critical priority and includes strategies to prevent overdose and other medical consequences of substance use such as infectious diseases.

Behavioral Treatments

Only 13 percent of people with drug use disorders receive any treatment, and more than half of those with co-occurring conditions in a given year will receive treatment for neither Behavioral therapies can be effective for treating SUDs For example, contingency management, a therapy that provides incentives for behavior change, is the most effective treatment for stimulant use disorders, though it is un-

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[13] Family centered prevention ameliorates the longitudinal association between risky family processes and epigenetic aging—Brody—2016—Journal of Child Psychology and Psychiatry—Wiley Online Library.

[14] Addressing Barriers to Primary Care Screening and Referral to Prevention for Youth Risky Health Behaviors: Evidence Regarding Potential Cost-Savings and Provider Concerns—SpringerLink.

[15] National Rates and Patterns of Depression Screening in Primary Care: Results From 2012 and 2013—PubMed (nihgov).

[16] Depression Screening Patterns, Predictors, and Trends Among Adults Without a Depression Diagnosis in Ambulatory Settings in the United States—Psychiatric Services (*psychiatryonlineorg*).

[17] Preventing At-Risk Adolescents from Developing Opioid Use Disorder—NIH HEAL Initiative.

[18] Justice Community Opioid Innovation Network—NIH HEAL Initiative.

[19] HEALing Communities Study—NIH HEAL Initiative.

fortunately not widely available to patients Other behavioral treatments, like cognitive behavioral therapy, have been shown to be effective in treating both SUDs and some other mental illnesses together But by and large, treating SUDs and other mental illness will require a combined approach and coordination of care among different specialists In a person with OUD and depression, for instance, it could mean a combination of buprenorphine and an antidepressant, ideally in combination with some form of behavioral therapy Overall interventions need to be personalized to the severity of the disorder and the different needs of patients NIDA is supporting research to develop behavioral treatments to reduce substance use by addressing symptoms of anxiety and depression; to simultaneously intervene on substance use and symptoms of PTSD in adolescents; and to develop SUD treatment approaches that are tailored to the needs of people with schizophrenia or symptoms of psychosis.

Medication Development

Developing effective medications for SUDs is one of NIDA's highest priorities and is critical to improving treatment for people with addiction While effective medications exist for OUD, these medications are underutilized Suboptimal patient retention in treatment regimens, policy barriers that limit opioid prescribing, and stigma around opioid agonist medications all contribute to their underutilization More options are needed to help people with OUD achieve long-term recovery NIDA is supporting research on medication development for OUD and overdose, including through funds provided by the NIH HEAL Initiative The NIH HEAL Initiative has allowed investigators to file 21 Investigational New Drug Applications with the Food and Drug Administration (FDA) in the past 25 years to initiate clinical trials These studies focus on a variety of drug targets, as well as monoclonal antibodies and vaccines that could prevent opioids from entering the brain.

An increased focus on patient wants and needs, as well as a growing understanding that SUD treatment needs to be personalized and responsive to patients' unique changing sets of symptoms, is leading to a broadened conception of treatment that can include addressing multiple co-occurring symptoms of a disorder Sleep problems, depression, and anxiety, for instance, are among SUD-associated symptoms identified at patient-focused drug development meetings held by the FDA in partnership with NIDA to solicit input from SUD patient populations to help guide drug development Studies are underway to investigate the possibility of repurposing existing medications for OUD indications, such as the FDA-approved insomnia medication, suvorexant, based on known overlaps between brain signaling systems involved in sleep and addiction.

We are also prioritizing the development of medications to treat stimulant use disorders for which there are currently no FDA-approved medications Numerous compounds are being tested, and approaches span identifying novel biological targets for new medications, developing anti-cocaine and anti-methamphetamine vaccines, repurposing existing FDA-approved medications, and testing the benefits from medication combinations (ie, naltrexone buprenorphine for the treatment of moderate to severe methamphetamine use disorder) NIDA's medication development program is also supporting research on compounds that specifically address intersecting substance use and psychiatric symptoms, including potential treatments for mood disorder symptoms associated with cocaine use and co-occurring bipolar and cannabis use disorders.

More coordinated and targeted approaches to incentivize drug development related to addiction are sorely needed The pharmaceutical industry has historically underinvested in research and development of substance use disorder treatments, due to the biological complexity of these disorders, the stigma that surrounds them, and concerns around the profit potential of substance use disorder medications.

Harm Reduction

Abundant research shows the value of interventions and services aimed at reducing harms associated with drug use Overdose deaths are significantly reduced in communities that distribute naloxone to people who use drugs and to their families or other potential bystanders An important part of NIDA's medication-development research involves developing new and improved overdose reversal medications, particularly formulations of naloxone that are effective for high-potency opioids like fentanyl, as well as compounds that could reverse opioid overdoses involving other drugs such as methamphetamine Syringe-services programs are effective at reducing the spread of HIV and other infectious diseases like hepatitis C, and they also help link people who inject drugs to addiction and HIV screening and treatment

NIDA continues to support research on these and other harm reduction practices such as drug checking technologies like fentanyl test strips.

Translating Research into Practice in Diverse Settings

Providing prevention and treatment services across health care, justice, and community settings is key to addressing SUD and is the most promising way to improve access to treatment Persistent challenges continue to keep mental health care largely separate from general medical care, and addiction care is often further sequestered to specialized settings This leads to difficulty in providing patients with coordinated, wholistic treatment In order to promote provision of quality care, NIDA places a high priority on implementation research in diverse settings, including through the NIDA Clinical Trials Network (CTN), the Justice Community Opioid Innovation Network (JCOIN), and the HEALing Communities Study (HCS).

Clinical Trials Network

The primary goal of CTN, which comprises 16 research nodes and more than 240 community-anchored treatment programs across the country, is to bridge the gap between the science of drug treatment and its practice through the study of evidence-based interventions in real-world settings NIDA's CTN allows medical and specialty treatment providers, treatment researchers, patients, and NIDA to cooperatively develop, validate, refine, and deliver new treatment options to patients The CTN is conducting studies to evaluate strategies for integrating OUD screening and treatment into emergency departments, primary care clinics, infectious disease programs and rural and AI/AN communities It also tests alternative models of care for SUD such as the use of pharmacies for delivering medication for OUD and the integration of telehealth for support of treatment The CTN supports research based on data relevant to SUD by taking advantage of electronic health record (EHR) systems It is currently developing and testing a clinical decision support tool that integrates with EHR systems to help doctors diagnose OUD and provide treatment or refer patients to appropriate care The CTN also supports research to examine the role of pharmacies in providing medications for OUD, an approach that could be especially useful in rural communities located far away from traditional treatment programs.

Justice Community Opioid Innovation Network

NIDA's JCOIN, which is funded though the NIH HEAL initiative, is testing strategies to expand effective OUD treatment and care for people in justice settings in partnership with local and state justice systems and community-based treatment providers.[18] JCOIN includes a national survey of addiction treatment delivery services within the justice system; studies on the effectiveness and adoption of new medications, prevention and treatment interventions, and technologies; and use of existing data sources in novel ways to understand care in justice populations Together, these studies are generating real-world evidence to address the unique needs of individuals with OUD in justice settings JCOIN also responded in real time to the COVID–19 pandemic with additional research to study COVID testing protocols in justice-involved populations.

HEALing Communities Study

The HEALing Communities Study, also funded through the NIH HEAL Initiative, is a multisite implementation research study investigating coordinated approaches for deploying evidence-based strategies to prevent and treat opioid misuse and OUD and prevent overdose deaths that is tailored to the needs of local communities Research sites are partnering with 67 communities highly affected by the opioid crisis across four states (NY, MA, KY, and OH) to measure the impact of these efforts.[19] The ambitious goal of the study is to reduce opioid-related overdose deaths by 40 percent over 3 years Despite the impacts of COVID–19 on research and its severe exacerbation of the overdose crisis, the HEALing Communities study was able to launch a key aspect of its program, a diverse communications campaign to increase awareness and demand for evidence-based practices and to reduce stigma against people with OUD and those taking medications for OUD.[20]

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[18] Justice Community Opioid Innovation Network—NIH HEAL Initiative.
[19] HEALing Communities Study—NIH HEAL Initiative.
[20] Introduction to the special issue on the HEALing Communities Study—ScienceDirect.

Leveraging Telehealth, Digital Solutions, and Innovation to Expand Access to Care

A component of translating research into practice is leveraging existing opportunities and developing new ways to bring healthcare to hard-to-reach populations The COVID–19 pandemic brought about significant drug treatment policy changes that expanded telehealth and facilitated access to medications for OUD—including by facilitating remote prescribing of buprenorphine and take-home dosing of methadone These flexibilities were rapidly implemented by providers, and evidence to date suggests that they were not associated with an increase in adverse outcomes NIDA is funding research on telehealth utilization and the effects of recent changes in policy and practice.

NIDA is also leveraging the Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs and other funding mechanisms to help biotech startups develop technologies that connect people with SUDs to care, provide or support treatment, help individuals sustain their recovery, and even facilitate overdose prevention For example, a smartphone app originally designed to connect patients to open acute care beds has been adapted to facilitate referrals to addiction treatment facilities and is currently being used by several state governments and hospital systems NIDA has also helped develop tools that put evidence-based psychosocial treatment for SUDs right in the hands of anyone with a smartphone For example, reSET and reSET-O are apps that deliver cognitive behavioral therapy in conjunction with treatment that includes buprenorphine and contingency management to people with non-opioid SUDs (reSET) and OUD (reSET-O), and were the first prescription cognitive behavioral therapy mobile apps to receive FDA clearance to help increase retention in an outpatient treatment program A NIDA SBIR grant is now being used to make these apps more accessible by converting them into a game Other apps help doctors and patients monitor and maintain their OUD medication, and connect individuals to behavioral therapies, peer support groups, and community interventions Research is also ongoing to develop automatic overdose detection devices that can inject naloxone when a person overdoses, along with tools and methods to accurately assess types of drugs detected in blood or urine for use in healthcare or by medical examiners and coroners, among many other innovations These and other innovative products demonstrate that pairing sound science with biotechnology entrepreneurship has great potential to expand the research of addiction treatments and support services.

Addressing Health Inequities and Disparities

Disparities by race, socioeconomic status, sex, and geography have always created an inequitable landscape in care for SUDs and other mental illnesses For example, Black people are much less likely to be prescribed buprenorphine for OUD than white people and despite parity laws, insurance coverage for SUD and other mental health treatment remains limited, meaning that less advantaged populations have less access to needed, potentially life-saving services The COVID pandemic has illuminated and, in many ways, exacerbated many of these disparities However, flexibilities in healthcare practice adopted during the pandemic (eg, expanded telehealth) along with new tools to facilitate telehealth may help overcome some of the existing barriers to finding SUD treatment and psychiatric care, particularly for currently underserved populations Ongoing research will help optimize the most cost-effective interventions to mitigate the exacerbation of health disparities due to COVID–19 Indeed, finding solutions to reduce and ultimately eliminate health disparities, especially those related to structural racism, is a NIDA research priority Racial disparities also persist in the addiction science workforce NIDA's Racial Equity Initiative is working to identify disparities and systemic barriers and implement programs and funding opportunities to equitably enhance, promote, and sustain engagement of people from diverse backgrounds, including those from historically underrepresented groups, in addiction science.

Substance use impacts women differently than men, conferring unique challenges that warrant particular attention Women are more likely to use substances to cope, progress more quickly from use to addiction, and have greater co-occurrence of addiction with symptoms of mood disorder.[21],[22] This increased vulnerability bears out in women experiencing homelessness, who have higher rates of substance use than their male counterparts and are a group more likely to have been victim to physical

[21] Full article: Women and Addiction: The Importance of Gender Issues in Substance Abuse Research (tandfonlinecom).

[22] Sex differences in vulnerability to addiction—ScienceDirect.

and sexual abuse [23], [24] Worldwide, women are less likely than men to receive treatment for their SUD. [25] Negative outcomes associated with substance use are also a serious concern among women; women who use drugs experience gender-related violence at much higher rates than those who do not, women have a greater likelihood than men of contracting blood-borne infections from injection drug use, and women are more likely than men to intentionally overdose. [26], [27] These elevated risks not only impact women who use drugs, but their children and family units as well It is imperative that the specific needs of women are considered—from biological differences, through childcare, personal safety, and transportation needs—to ensure that addiction prevention and treatment are as effective as possible.

Building Partnerships

Partnerships are critical to make a positive impact on public health, and NIDA is engaged in productive collaborations at all levels of government we value our partnerships with our sister agencies in HHS, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), as well as the FDA, which is crucial to our efforts to develop medications and devices for SUD medications NIDA also partners closely with the Centers for Medicare & Medicaid Services (CMS) to build the evidence base for healthcare funding decisions, with the Office of National Drug Control Policy (ONDCP) to advance the far-ranging goals of the National Drug Control Strategy, and with the Department of Justice to improve addiction care in incarcerated populations and promote research on controlled substances.

Collaborations also provide valuable and complementary perspectives and infrastructures that NIDA leverages to advance research and maximize its benefit for all people Some of the largest projects funded under the NIH HEAL Initiative rely on such collaboration with our Federal partners and others The HEALing Communities Study is led by NIDA in close partnership with SAMHSA to ensure that this research is poised to impact service delivery toward ameliorating the opioid crisis in hard hit areas JCOIN fosters collaboration between investigators, justice, and behavioral health stakeholders in search of creative ways for improving the capacity of the justice system to respond to the opioid crisis.

Conclusion

The issues of substance use and SUD are inseparable from the larger landscape of mental health and mental illness Consequently, we cannot hope to make headway against the drug overdose crisis unless we make screening, preventing, and treating all mental illness, including SUDs, one of our top priorities Continued research is also critical, and NIDA is actively supporting research in each of these areas with a focus on SUDs, their entwined psychiatric problems, and overcoming the various infrastructural barriers and stigma that have historically impeded these goals Thank you for the opportunity to address these critical issues.

The CHAIR. Thank you very much to all of our witnesses. We appreciate your being here today. We will now begin a round of 5 minute questions. And I again ask my colleagues to keep track of your clock and stay within those 5 minutes. Assistant Secretary Delphin-Rittmon, this pandemic, as I said, has been especially difficult for children. They have dealt with major disruptions in their daily lives.

Many have lost loved ones due to COVID–19. And meanwhile, parents and caregivers are really stressed, making what has been a really difficult time even harder for families and for kids. I know

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[23] Women, Homelessness, and Substance Abuse: Moving Beyond the Stereotypes—Lisa J Geissler, Carol A Bormann, Carol F Kwiatkowski, G Nicholas Braucht, Charles S Reichardt, 1995 (sagepubcom).

[24] Recognizing and responding to women experiencing homelessness with gendered and trauma-informed care—BMC Public Health—Full Text (biomedcentralcom).

[25] WDR21—Booklet—2pdf (unodcorg).

[26] Women who inject drugs more likely to be living with HIV—UNAIDS.

[27] Intentional Drug Overdose Deaths in the United States—American Journal of Psychiatry (psychiatryonlineorg).

as a mother and a grandmother and a former preschool teacher, I am very committed to making sure we are doing everything to meet the needs of our children and our adolescents, and to address this real national emergency in youth mental health.

Can you tell all of us why it is important to provide kids with high quality mental health screening and prevention and intervention and treatment services?

Ms. DELPHIN-RITTMON. Thank you so much again for convening us, Chair Murray. You know, it is so critical to address the mental health needs of young people. We know even before the pandemic, young people were struggling with a range of mental health challenges. And as a function of the pandemic, we have seen those challenges increase.

Putting programs and strategies and training and technical assistance in place to be able to address the needs of children struggling with mental health challenges is a priority of SAMHSA. For example, one program that we have is Project Aware, that is promoting awareness and resiliency in schools.

It is a wonderful program that provides training and technical assistance for school personnel to be able to recognize children that are struggling, but then also connect children who are struggling to care and to resources. And so that is a program that we, in fact, have been able to scale up through American Rescue Plan resources and one where we are seeing significant impacts across the country.

We will also develop, as I mentioned, the HOPE framework. So working to ensure that children and families are connected to health, so healthy opportunities and opportunities to be able to improve and advance health, again, opportunity to be able to reach their full potential and be screened for any risks.

Then equity, you know, certainly ensuring that those services are equitable. And so that is a framework that essentially encapsulates a range of programs and initiatives across SAMHSA to be able to ensure that—and promote the mental health and well-being of children. But this, especially now, is an important time to address mental health. And again, we have a range of programs.

To include mental health first aid, that is an additional training program that provides training and support for communities, again, for schools and individuals on request really, faith communities as well, to be able to recognize the needs of—and recognize when young children are struggling.

The CHAIR. Great. Okay, thank you. According to estimates released actually just last week, more than a 105,000 Americans died from drug overdoses from October 2020 to October 2021. That is the highest annual total on record. In my home State of Washington, we have seen a real drastic rise in synthetic opioid use. Our largest county, King County, set a record high of overdose deaths.

Those are really tragic and unacceptable numbers, and they make clear that we really need to invest in treatment, including medication assisted treatment, or MAT, and prevention services for opioid use disorder. But right now, as I said, just one in five Ameri-

cans with opioid use disorder receive MAT, and there are significant disparities in access to that treatment.

Overdose rates are rising fastest among black people, we also know black communities are less likely than white ones to have access to those that they need. So as this Committee looks at putting together legislation to combat substance use disorders and overdose deaths, I really think we have to do everything we can to expand access to prevention and treatment services and reduce those disparities in care.

Director Volkow, I wanted to ask you, how would you improve access to treatment, including medication assisted treatment, help reduce those disparities?

Dr. VOLKOW. We know that the most effective intervention that we have against overdoses is providing medication for opioid use disorder. It increases your risk of overdosing by at least 60 percent.

But unfortunately, as you mention, a very relatively small percentage of people that can benefit are given access to treatment, and the treatment also is not necessarily continued. So we need to not only expand the number of individuals that can be treated but ensure that we have the support systems that will allow them to remain in treatment.

We have to take advantage of health care systems and involve partnerships with justice settings so that we ensure absolute equity in access to these treatments. The parity law determines that you should be treating addiction as a medical condition. And yet this has not been properly implemented, and we need to ensure that the workforce is able to provide the treatment, so.

The CHAIR. Okay, thank you. Thank you very much. And Senator Burr, you are deferring to Senator Collins. Senator Collins.

Senator COLLINS. Thank you. Thank you, Senator Burr. Dr. Delphin-Rittmon, in Maine last year we had 636 deaths, a 23 percent increase, primarily as a result of fentanyl. This is the highest level we have ever experienced. But what is equally traveling is if you look at total overdoses in 2021, the number exceeds 9,500.

What I am hearing from law enforcement and public health officials is that they need data on non-fatal overdoses in order to identify and investigate the sources of opioids and fentanyl and other drugs in their communities, and to be able to direct people to drug treatment programs.

I am working on a bill based on recent GAO recommendations, which would require the Administration to improve the timeliness, accuracy, and accessibility of both fatal and non-fatal overdose data. During our meeting, prior to your confirmation, you described yourself as a data person. Would you support legislation to provide better information on non-fatal overdoses? Because if we are just looking at the tragic deaths we are missing the picture.

Ms. DELPHIN-RITTMON. Yes, you know, thank you so much for that question. And, you know, I think it is right on. It is so important that we have a good sense of both overdose data as well as non-overdose data.

Would be definitely interested in talking with you further about that. I think to the extent that we can understand some of the non-

overdose trends as well, it could help to inform programs and services and interventions. So happy to have further conversations about that. I do believe that will be an important area of work.

Senator COLLINS. Thank you. The next question I want to ask is for you also. Maine has the terrible distinction of having the second highest rate of neonatal abstinence syndrome in our Country, even though the number of babies born in our state with neonatal abstinence syndrome has declined somewhat.

But still, in 2020, 901 babies were born drug affected. As some Members of the Appropriations Committee, I have encouraged the Administration to enhance efforts to screen, treat, and support infants through the WIC program. USDA designates neonatal abstinence syndrome as a nutrition risk, but WIC programs do not currently have uniform, evidence based nutrition educational materials.

Does SAMHSA coordinate with USDA on this issue?

Ms. DELPHIN-RITTMON. Yes, so the WIC program is, and thank you for that question, is a USDA program, although we do have coordination and collaborations with USDA and can certainly, you know, develop additional work in this area. We currently have collaborations related to rural technical assistance related to opioid use but can certainly expand our work in collaboration in terms of the WIC program as well which they administer.

Senator COLLINS. I certainly hope that you will. It is really a terrible problem. Ms. Johnson, my final question is for you. It has to do with the STAR Loan Repayment Program that is administered by HRSA. It offers loan repayment to eligible substance abuse disorder professionals who agree to work in areas that are located in the country with overdose races that are greater than the national average or have mental health professionals shortages.

Unfortunately, what we are finding in Maine is said some clinicians have been denied loan repayment because HRSA does not consider telehealth patient care unless both the originating site where the provider is located and the distant site where the patient is, meet the geographic criteria.

That is in conflict with the flexibilities that Congress enacted to enable access to telehealth during the COVID public health emergency. I have written to HRSA on this, and I am told that you need a legislative fix. Would you support making such a change to ensure that qualified substance abuse disorder professionals are not disadvantaged because the care delivery for vulnerable patients has shifted to telehealth during this pandemic, particularly for rural areas and underserved communities?

Ms. JOHNSON. Thank you so much, Senator, for the question. As you know, HRSA is the home of the Federal Office of Rural Health Policy. We are very dedicated to making sure that we are doing everything we can to get services and supports to rural communities. And increasingly, as you note, our loan repayment programs are reaching into rural communities, and we are doing everything we can to ensure those programs continue to grow in rural areas.

We also have used a number of COVID flexibilities, as many as we can, throughout the pandemic for our loan repayment program,

so I am very interested in having a follow-up conversation with your staff about the opportunities here because we want to support rural communities as much as possible.

Senator COLLINS. Thank you.

The CHAIR. Thank you very much.

Senator Smith.

Senator SMITH. Thank you, Madam Chair. Thank you to all of you for being here today. Just following up on Senator Collins' line of questioning. This issue of building out and expanding the mental health care workforce is a crucially important issue. I hear about this all the time.

People who finally kind of break through the stigma and the systemic challenge is to say, okay yes, I am ready to get help, and then they face long waiting lists, wait times that sometimes that Minnesota will reach to months. And of course, we would never put up with that kind of waiting time if somebody was having a heart attack or had a broken limb. And so I think addressing this workforce shortage, which is often the cause of this waiting challenge, is really important.

Let me just ask Ms. Johnson a follow-up question. I mean, I get from what you were saying that these loan repayment programs work to build out the mental health care workforce across the broad spectrum of providers. Because it is not just psychiatrists. It could be a whole—you know, across a whole range of providers. Is that right?

Ms. JOHNSON. That is correct. There are a whole range of mental health professionals who are eligible to participate in the National Health Service Corps. We also have a nurse corps, a loan repayment program.

The advantage of these programs is that not only are we helping those individuals with loan repayment in return for service in underserved communities, but our data consistently shows that people tend to stay in the communities in which they originally practice. And so it is a long term investment in those communities.

Senator SMITH. Now, another issue that I hear about all the time is that we have loan repayment programs that are getting folks into—you know, that are getting people ready to go into training but then we have a shortage of trainers. We have a shortage of educators. This is a challenge in Minnesota around nurses, not only in mental health training programs, but more broadly. So could you just talk about what we need to do to address that challenge of educators in the field?

Ms. JOHNSON. I just really appreciate you raising the question, Senator, because before the pandemic, nurse faculty was a challenge. The critical issues that our heroic frontline nurses have dealt with throughout the pandemic has made it even harder for us to recruit individuals who have the time and resources and capacity to apply to function in nurse faculty roles.

We have a loan repayment program to encourage people into nurse faculty. We would love to continue to grow and expand that work. But we also are—in my role in HRSA, I am increasingly reaching out to health professions, leaders, and health systems

leaders who have a shared interest in ensuring that we have a viable nursing workforce for the future.

Because I think this is, as Ranking Member Burr pointed to earlier, a place for public, private partnership to encourage individuals to work in nurse faculty is an important partnership.

Senator SMITH. Right. Because if you might have been a practitioner, the thing you would like to see is practitioners who then come into training and become an instructor. But often that requires—I mean, you know, people are going to be hard pressed to do that if they are taking a salary cut.

Ms. JOHNSON. That is right. I mean, what we can offer is the loan repayment for you to be able to do the educational piece. But given the current dynamics of where the workforce is, it is a challenge on the salary side.

Senator SMITH. I, so I think there is more work that we should think about doing together on this because if we are—I see in Minnesota pumping lots of resources, good resources into loan repayment and scholarships, but then there aren't any spots because of this issue that we are talking about.

Ms. JOHNSON. I would welcome the opportunity to work with you on this. This is a huge priority for us as well.

Senator SMITH. That is fantastic. That is great. Dr. Delphin-Rittmon, I would like to ask you—would like take a bit of time to talk about this question of how we integrate behavioral health care better into primary care settings. We know that this is a powerful way to expand our national mental health treatment and behavioral and substance abuse treatment capacity. And this strategy, of course, recognizes that it is health, it is not mental health separate from physical health.

The better we integrate, the more we are going to undo the barriers that we have up there to block access to mental health care. So in just a few seconds I have left, can you just talk a little bit about some of the models that are out there for doing this kind of integration and where you see the greatest opportunity?

Ms. DELPHIN-RITTMON. Yes, and thank you for that question. So, absolutely. I mean, this is an area that is one of the SAMHSA priorities as well. We have an initiative called PBHCI, Primary Care Behavioral Health Integration, that is a grant program that essentially integrates behavioral health screening into primary care settings.

We know that is so important because often individuals will go to a primary care setting first before they will contact or connect with a behavioral health provider. So if screenings can be done in that setting, it allows for the individual to be connected to appropriate services and supports.

We also have a CCBHC model which integrates behavioral health or primary care integration into behavioral health settings, so Certified Community Behavioral Health Clinics, provides that integration as well, which is critical.

Senator SMITH. Madam Chair, I know there is lots of interest in this topic. On the Committee, I am working with Senator Moran, among others, to try to figure out how to support this, and I want

to just thank the Biden Administration. I know that both of these issues I have raised are part of their broad national strategy to address these challenges, so appreciate it very much.

The CHAIR. Thank you. Senator Cassidy. And Senator Cassidy, just let me say to you, we are all thinking of you and all the people in New Orleans for the horrific tornadoes that we were watching. Wish you all the best.

Senator CASSIDY. Well, thank you. Thank you. Thank you, Madam Chair. Thank you all for your service to our Country on this issue. Ms. Volkow, you in your written testimony, and then several years ago, mentioned the potential role of marijuana, cannabis upon the adolescent brain as being a precipitate of serious mental illness. Is that a correct statement of your concern?

Dr. VOLKOW. Definitively, this is one of the areas that we are most concerned off with the legalization of marijuana.

Senator CASSIDY. So let me ask you, that would suggest that states which have had a more liberal legalization of marijuana, say Colorado, would have an increased incidence of serious mental illness among adolescents and young adults than a state with more restrictive laws and presumably less prevalence of usage. Is that a finding that you have had?

Dr. VOLKOW. In the United States, there are no studies that have documented that. In Europe and across the world, yes.

Senator CASSIDY. Now, hang on. It is documented that more relaxed legalization of marijuana is associated on a population scale with increased incidence of serious mental illness, just to be sure.

Dr. VOLKOW. Specifically, in the United States, legalization by some states of marijuana has not been associated with an increase in adolescents marijuana use. That is something that has not happened.

Senator CASSIDY. Well, that surprises me because increased—if you relax blue laws for alcohol, there ends up being more alcohol use by adolescents in that given county or parish.

Dr. VOLKOW. We are seeing significant increases in adult use of marijuana and young people, but not in adolescence, which is different exactly from what you are saying with the alcohol.

Senator CASSIDY. Now what about the young adults? Because the brain, as I recall, continues to develop maybe up to 30. If you are a male, probably 35. So does that young 20, is there an association with increased incidence?

Dr. VOLKOW. Yes, there is. There is—for example, there is a significant increase in the risk for suicidal behaviors and suicidality associated with marijuana use among young people.

Senator CASSIDY. And that is when controlling for other factors. And so that is just not a cause—that is just not an association, but it is suspected that it is causal?

Dr. VOLKOW. It is an association after controlling for factors like depression. But in order to establish causality, you need to—you require prospective studies that we are currently carrying on, on the ABCD.

Senator CASSIDY. Now let me ask, and you may not have this data, but we have worked hard to expand the ability of Medicaid to address addiction disorder. Have you found that states with Medicaid expansion and, or state regulations being more—employing these tools Congress has given, have had better outcomes for adolescent and adult addiction or not?

Dr. VOLKOW. There is evidence that some of the states that have expanded Medicaid have been able to provide extended access to medications for opioid use disorders among young adults and adults. The data for adolescents is not as clear. There is—because very—the sample sizes are much smaller.

Senator CASSIDY. And are we seeing better outcomes or are we just seeing greater utilization of drugs?

Dr. VOLKOW. We are seeing better outcomes.

Senator CASSIDY. That is great. Dr. Delphin-Rittmon, Dr. Gordon spoke about RAISE Grant, and Senator Murphy and I worked in 2016 to expand access to these RAISE grants. Now in my state, though, I just found out I got 30 people statewide enrolled, 20 in New Orleans, 10 in Baton Rouge, and no other city has these programs.

Now is that a function of inadequate funding or is that a function of my state not completely employing, because adolescent suicide we hear is a huge issue, serious mental illness, and yet something that Murphy and Cassidy were attempting to employ has not been widely deployed. What can we learn from you about this?

Ms. DELPHIN-RITTMON. And thank you for that question. And we can certainly have, you know, additional follow-up conversations about this as well. I would have to look specifically in terms of, you know, were there other organizations that applied for the resources or applied for——

Senator CASSIDY. Is there adequate money there for it?

Ms. DELPHIN-RITTMON. For the——

Senator CASSIDY. RAISE Grant, for the coordinated specialty care, I think it is called, the CSC. As a 10 percent set aside within SAMHSA for mental illness, is that adequate or does Congress need to look at that? Because from Dr. Gordon's testimony and what I have learned before, this highly effective. So I guess my question is, do we need to give you more money for this or is it just get our states to apply for it?

Ms. DELPHIN-RITTMON. Yes, I mean, it is definitely an effective program, and if we are appropriated more money, we will gladly receive it because it is a program that——

Senator CASSIDY. I still not getting an answer to my question, is more money needed or is a state just not applying?

Ms. DELPHIN-RITTMON. You know, I would have to go back and look specifically in terms of the number of states that have applied for that. I don't have that with me, but we certainly could follow-up.

Senator CASSIDY. Can I ask Dr. Gordon—Dr Gordon any insight on that?

Dr. GORDON. In regards to the—I mean, whether additional moneys would——

Senator CASSIDY. No, no whether or not—what is the reason why it is not more widely deployed?

Dr. GORDON. Well, I think we—it is a challenging program to administer. You have to be willing to implement some changes at a clinic level. But I can't speak to Louisiana's case, but we—one of the things that the research project demonstrated is that you can implement it in clinical settings, but you still have to have the will at local level to do so. I can't speak to the level of funding and whether it is adequate for the situation.

I will say that while there are thousands of Americans currently enrolled in these clinics, there are probably thousands more who would benefit from it. And so expanding access to coordinated specialty care for first episode psychosis is a good thing.

Senator CASSIDY. Got it. Thank you, Madam Chair.

The CHAIR. Thank you. I am going to call on Senator Baldwin next. I am going to turn the gavel over to Senator Kaine while I go and vote.

Senator BALDWIN. Thank you, Madam Chair. Along with the increase in overdose deaths that we have seen in the past few years, I have been very alarmed to learn of really heartbreaking reports of college students in my home state dying from accidental fentanyl overdoses on campus.

Dr. Delphin-Rittmon, what can we do to bolster the efforts of the residential colleges and universities to play a role in preventing these tragic overdose deaths on campus, particularly deaths as a result of fentanyl contamination?

Ms. DELPHIN-RITTMON. Thank you for that question. And it is true, the patterns and trends are we are seeing as it relates to the fentanyl related overdoses is truly troubling across the country, on college campuses and communities, really across the board.

In terms of college campuses and, you know, within each state, there are prevention networks, really robust prevention networks that we fund through our prevention, in part through the prevention set aside as well as the SPF Rx Grant.

Those grants provide opportunities for community based training related to the dangers of fentanyl. It allows for dissemination, wide dissemination of naloxone and training around naloxone Administration. As you know, naloxone is a vital overdose reversal medication.

Continuing to scale up programs and initiatives like that to blanket college campuses and you know, our strategy has really been to work to disseminate naloxone far and wide across the country as part of the—in fact, the HHS overdose prevention strategy. But certainly some of the prevention work that is happening at the community level, again funded by Block Grant but also funded by SOR, the State Opioid Response Grant, can be real valuable resources that states can use to provide training, you know, and technical assistance to college campuses and others about the dangers of fentanyl.

Senator BALDWIN. Thank you. You actually anticipated my second question, which is how can we get more naloxone distributed on and available in community settings, at college campuses, and the like. So I will move onto the implementation of the 9–8–8 three digit suicide prevention hotline.

In 2019, I introduced that measure and it was signed into law in 2020, converting from the ten digit numbers that are available throughout the states to 9–8–8, to make it easier for Americans to get the help they need. I am concerned that states may not be ready to respond to calls when the new dialing code becomes available in July of this year.

Dr. Delphin-Rittmon, how is SAMHSA working with states to make sure they are prepared for the 9–8–8 launch this summer, and how many states are ready right now for this transition?

Ms. DELPHIN-RITTMON. And thank you for that question. And I have to say also, thank you for your leadership in terms of helping this important piece of legislation come about. It is significantly transformative for our Nation in terms of how we approach crises responsiveness and addressing the needs of individuals that are in crisis and experiencing suicidal ideation. So I mean, there are many—states are in many different places.

We have recently invested $282 million in the crisis infrastructure within states. That is allowing them to shore up, scale up, staff up the crisis call centers. That is an integral part of the 9–8–8 transformation, as you know. But we are thinking beyond that. It is not really just about the crisis call center, it is also about the full continuum of care.

States are getting ready, and we are watching their metrics regularly and they are improving in terms of the influx of calls and their responsiveness to the calls, texts, and chats, in fact that they are getting.

In fact, later this week, we have a convening with states as well as a number of other community providers and national organizations around just this thing, operational readiness and working to ensure that the 9–8–8 launch in July, that we are ready to go.

Senator BALDWIN. Yes. So right now, I am aware only four states have taken action to approve additional funding needed to support the 9–8–8 services, and my home State of Wisconsin is not one of them, so I am very concerned that states will not act to make this funding available.

I believe that we should be taking a look at additional Federal funding opportunities for states to make sure that this works across the country for people regardless of where they live. Can you comment—is that your knowledge also that the states are not accepting and implementing this additional funding yet?

Ms. DELPHIN-RITTMON. You know, states are taking different strategies. I mean, some states have put legislation in that will that add in an additional tax that will help to support the call center.

Other states and in fact, we had a convening in partnership with CMS around thinking about Medicaid resources and funding to be able to support the crisis care continuum. So states are looking at

a number of different strategies to include in some instances state funding. Many—all states except for two applied for, you know, the $282 million that I mentioned and otherwise all states and in fact territories are engaged with us on a regular basis, having discussions around operational readiness, we will be doing resource materials and guides to ensure that states have the materials that they need.

Senator BALDWIN. Thank you.

Senator KAINE. Senator Tuberville.

Senator TUBERVILLE. Good morning. Welcome. Thank you for what you do. You are kind of on a boat that is taking on a lot of water, and you got one cup trying to get it out. I have been in a coach in preparation for 40 years. I felt like that every day when it came to mental health addiction around kids. It is tough. I just hope we start getting some answers to this. But you know, I walk to work every day, not too far from here. And the see 6 to 8, 10 people on drugs, passed out.

You can go within several blocks here and you probably find one person a day that passed away from it. Seemed like we just—we want to do something about it, but we really don't know how, how to start from the bottom up. And again, I have dealt with it all my life, and it is a sad situation. It is something that if we don't get in control of it, we are going to look at a huge—we have got an epidemic now, but we are going to—we are looking at 400,000 that are going to start dying from this.

Is there any work with any of you all with Homeland Security that determines or gets any reports from what is happening at the border from fentanyl? I am not getting into a border wall—I am not getting into all this political stuff, but I was down there not too long ago. I saw enough fentanyl in the back of a truck to kill everybody in this country.

Most of us hadn't heard of fentanyl. Most people in here hadn't heard of fentanyl until last year or so. And it is getting bad. It is going—it is an epidemic. So anybody got any thoughts on that?

Dr. VOLKOW. I guess definitively. I mean, what happens with fentanyl, it is very lucrative for the illicit drug market. So it started in 2016 and it just has grown increasingly. Extraordinarily potent drug, so very few milligrams actually can generate a very intense high, but it can also kill you.

It is much easier to transport across the border. You don't need to cultivate. The synthesis of this compound is relatively easy. So what we have seen was initially it was used to contaminate heroin, and now we are seeing it contaminated basically almost all illicit drugs. And that includes prescriptions—illicit prescriptions.

This is probably one of the reasons why we are seeing increases in deaths from overdoses among teenagers and young people. Is being used to contaminate methamphetamine and cocaine. And these accounts for the very steep rise in deaths. So it is a lucrative drug, and it is much harder to contain.

Senator TUBERVILLE. And it is synthetic.

Dr. VOLKOW. And it is synthetic.

Senator TUBERVILLE. Chinese are making it, and a lot of it has been made in Mexico and it is coming up to our border. And hopefully sooner or later, you know, we wake up. You know, they could put just a certain amount in our air duct system in this building and either make all of us sick or kill us all. I mean, that is how deadly this stuff is.

I don't—I really don't understand it. But I want to thank all of you for your work. One problem that I ran into when I was coaching is, I would bring in 25 kids a year that I would sign, and a few years ago—it went over 10 years ago, one or two of them would have insulin problems, you know, diabetics, and not very many of them on drugs.

Recently, you can ask coaches now have two, three, four on something, Adderall or Ritalin. Where is that taking us, Dr. Gordon? Where are we headed with this?

Dr. GORDON. ADHD is an illness that strikes many young people around the globe and in the United States.

Senator TUBERVILLE. Is it a disease? Do you inherit it?

Dr. GORDON. It is a good question. There is a genetic component, as well as likely environmental factors that contribute to the risk for ADHD. The treatment of ADHD with Adderall and other drugs can be very, very effective, but we have both an undersupply and oversupply problem.

We have many, many children who could benefit from treatment for ADHD who are not getting adequate treatment or evidence based treatment. And then we probably also have children who are getting it that maybe don't need it or misusing it. And so you have both of those situations in the United States.

I think what we try to urge at the NIMH is an adherence to evidence based principles. So quantitative evaluation of symptoms, appropriate treatment with medication for those symptoms. And when that happens, children with ADHD can do very well.

Senator TUBERVILLE. Yes. Well, thank you. All this symptom—is kind of like the—you can buy it anywhere, you know, in colleges now. A lot of these kids, I don't know which one of them they take, but they take it to stay up all night, to absorb, you know, cramming for a test. Which one would that be? Would it be Adderall?

Dr. GORDON. It could be. There are several different versions.

Senator TUBERVILLE. Yes, and you know, it is just—that is another drug that we are going to have a huge problem with. But I just hope we understand we are dipping water out by spoon in a boat, and we are going to be in real deep trouble if we don't get control of the substances coming in this country. We got enough problems without those. But thank you for your help and dedication in dealing with this because it is an ongoing problem that is getting worse and worse. Thank you.

Senator KAINE. Senator Murphy.

Senator MURPHY. Thank you very much. Thank you to all of you for your tremendous work and for your time before the Committee today. Senator Cassidy and I, along with Senator Murray help and others, have been really focused on this issue of mental health par-

ity. We have passed several different pieces of legislation through this Committee, got signed by the President since 2016.

The latest piece of legislation we passed required the Administration to do audits of insurance plans to see if they were actually in compliance with Federal parity laws. What we know is that, well your statement of benefits will often tell you that you have access to mental health treatment. When you go to get that treatment, you will face what we call non quantitative treatment limitations, all sorts of prioritization, bureaucracy, red tape that stands in the way of you getting that treatment.

I forget the exact number that the Department surveyed, but about 50 plans and the report we were given in January essentially came to the conclusion that not a single one of these plans was in compliance with parity laws. And interestingly, when they notified the plans that they had set up these burdensome barriers to mental health care that they didn't have on the physical health side, the plans fixed those issues, and all of a sudden thousands of people had access to mental health that they didn't have.

Secretary Delphin-Rittmon, great to see you. I want to ask you a question because I noticed that in the SAMHSA Joint Block Grant application, there is some language in there that says resources should be used to support, not supplant, services that will be covered through the private—through private and public insurance.

You kind of reference the fact that, you know it is supposed to be insurance that is on the front lines here and then we are going to come in on the back end. But that sentence also sort of suggests a knowledge that insurance is not actually providing the kind of reimbursement that it should.

Can you talk a little bit about how you approach this issue? I mean, we don't want Federal dollars to essentially be filling in what insurers should be covering. And this report we got in January tells us that we just have massive noncompliance in the insurance industry with existing parity laws.

Ms. DELPHIN-RITTMON. Yes, thank you, Senator Murphy, and it is good to see you as well. And, you know, parity is such an important issue for the American people in terms of health care and ensuring that both primary care and behavioral health is appropriately covered. I mean, as you know, SAMHSA has no regulatory authority here, but we do see ourselves as a, in some instances, a convener or we help to give states information around how they can advocate and even families.

You know, we have been policy academies. We feel that it is important for individuals as well states and communities to know what the parity laws are. And so those policy academies that we are looking to bring back, additional policy academies, are one strategy for helping states have information around how to, you know, how to work with providers and to promote advocacy in this area.

We have resources as well for individuals and families, and we feel that is important as well because people need to know how to

advocate if they are not having coverage for services and support which they feel that they should be covered.

Senator MURPHY. I think that is important but insufficient, right. I mean, families ultimately are not going to be able to enforce this right because the sort of details of obstruction of care are so byzantine. Often it really is has to be regulators that do this job, and we definitely have more opportunity at the Federal level to enforce those laws. Just one quick another topic for you, Ms. Johnson.

I want to talk to you about the state of pediatric mental health. We talk about this problem we have with getting enough practitioners, but we have got tens of thousands of pediatricians who often frankly don't have a lot of background in mental health.

It seems to me one of the easy things we could do is just have a conversation with the profession to make sure that either in the initial training or in some post-graduate training opportunity, more pediatricians have a background in mental health and substance abuse, but particularly in mental health.

Ms. JOHNSON. Thank you for the question, Senator. I think that is where we should be headed in pediatric and all clinical training, that clinicians across the board need to have training and exposure to mental health and substance use disorder needs and conditions. We need, in my view, we need primary care to be inclusive of mental health.

That is what we are working on at HRSA, and we are going to continue to push forward, ongoing forward. Thank you for your leadership on the Pediatric Mental Health Access Program. We really see that as an exciting model for how we can continue to help clinicians who are in practice now get the kind of mental health support that they need, buildup their capacity.

What we are seeing anecdotally from that program is really people being able, clinicians being able to handle more and more mental health conditions and refer fewer. So we are excited about continuing to grow that program.

Senator MURPHY. And it is very clear, that program is a mechanism by which pediatricians can get a phone or virtual consult with a mental health practitioner. I agree that program, which is included in the 2016 Mental Health Reform Act, has already shown positive results, but that can be partnered with the pediatricians themselves having a greater level of expertise and something that hopefully this Committee will work on. Thank you, Mr. Chairman.

Senator KAINE. Absolutely. At the request of Senator Cassidy, we will introduce a statement for the record submitted by the Children's Hospital Association. Senator Murkowski, you are up next.

Senator MURKOWSKI. Thank you, Mr. Chairman. And thank you to the panel here. I just came from a meeting of a group of Close Up Kids from Taylor, Alaska, pretty remote little community north of Nome. And Close Up Kids have all kinds of probing questions that they want to ask. But when I told them that I was coming to a hearing on mental health and particularly mental health as it may impact young people, all of a sudden the chatter stopped because they knew that this issue was something that was immediate, it was real.

I think they were somewhat relieved to know that the grownups were talking about it. So I want to ask you, Dr. Delphin-Rittmon, specific to these behavioral health issues that we are seeing in younger kids and the number, the rising number of suicide attempts. I have worked with Senator Rosen to introduce the youth mental health and suicide prevention, which would authorize SAMHSA to expand their work and services to address mental health in K–12 schools.

I have got a letter that I would asked to be included as part of the record, where we have a statement from the President and CEO of the Mat-Su Health Foundation, and she shares that they had a forum with all of them at Mat-Su Borough School District nurses and the nurses were effectively demanding that we change our conversation from access to health care to access to behavioral health care.

What they did in the program there, they would launched this back in 2017, they launched a behavioral health in schools program. They then did a survey just recently. When schools were asked whether they felt that the providers have helped support students and whether they are satisfied with the responsiveness of providers to meet the changing needs of students and staff, 100 percent strongly, strongly agreed, 100 percent of the parents surveyed that they were satisfied, and 66 percent of those parents said that they made changes as parents to better support their child.

I mean, when you have this level of, wow, we didn't know we needed this, but I guess we needed this, and this is actually something that makes us feel better or allows us to feel that we have got a place to speak to this.

I would ask whether—I would ask you to speak to the importance of authorizing SAMHSA to provide this kind of support, direct funding to local schools, so that we can be in the schools talking, raising this issue, not just talking about health care, but talking about access to behavioral care. So if you would speak to that, if you would.

Ms. DELPHIN-RITTMON. Yes, thank you for that question. And, you know, we are in full support of something like that. I mean, we have seen significant impacts and positive impacts from our Project Aware grant, which is, you know, very much what you are talking about. It is a program, a school based program that is about increasing mental health awareness. It provides training and education for school personnel.

It also provides components around linking students to services and supports. And we see positive impacts there. We see students being connected to care, being identified who are struggling, who might not be connected otherwise. So I think behavioral health with programs, initiatives within school settings, are highly valuable. We know students are there, you know, throughout the week.

If they are struggling, if teacher or school personnel, if they are trained to be able to identify a student that is struggling, can help to connect that student to services. So I think those types of programs are very valuable.

Senator MURKOWSKI. Well, I know that this is something that we want to continue to push on. And let me then ask this next question. Equally concerning in Alaska, but really around the country, and that is military suicides.

We have seen really an alarming increase up North that has caused a real focus to this from the top of the military command as they are trying to do everything to improve quality of life and just address everything from sleep deprivation, because it is sunny most of the day in the summer and dark most of the day in the wintertime, how you deal with all of this. But we know there were still dealing with stigma.

We know that we are still dealing with concerns from those that say that seeking care is going to harm their career opportunities. I have been—I have worked over the years on the Garrett Lee Smith Memorial Act and we are looking to reauthorize that. It has proven itself, I think, to be effective.

The law always authorizes the Suicide Prevention Resource Center, which ensures that the grantees get appropriate information training, technical assistance on suicide prevention. So a question, again, to you, if I may, as to whether or not you think there are opportunities for the Suicide Prevention Resources Center to collaborate with DOD to provide technical assistance?

I want to make sure that we are not just leaving DOD alone in its own silo there to address suicide issues that unfortunately are more broadly symptomatic of what is happening across our society. So can you speak to whether or not there might be some relationship there with these two programs?

Ms. DELPHIN-RITTMON. Yes. And thank you for that question. You know, I think there are opportunities there. I in fact co-chair the Interagency Task Force on Veterans Mental Health with DOD and VA. And this is one of the very issues that we are looking at, suicide. And so there are—it is an ongoing collaboration.

There are a number of—it is a whole of Government approach. So a number of different Federal agencies there. But I think there certainly are opportunities here in terms of collaboration and providing technical assistance, you know, for VA as well and DOD as well.

Senator MURKOWSKI. Thank you. Thank you, Madam Chair.

The CHAIR. Thank you. And Senator Murkowski asked unanimous consent to introduce a letter. Without objection, so ordered.

The CHAIR. And I believe Senator Kaine introduced a statement on behalf of Senator Cassidy that needs unanimous consent. Without objection, so ordered on that.

The CHAIR. Senator Hassan.

Senator HASSAN. Thank you, Madam Chair. I want to thank you and the Ranking Member for holding this hearing and for your—for the witnesses, for the work that you do and to be here today to discuss what are incredibly important issues.

Dr. Delphin-Rittmon, the last time you testified before the Committee, we discussed the State Opioid Response Grant program. You spoke about the importance of reliable, consistent funding and

firmly committed to ensuring that states like New Hampshire would avoid significant cliffs in state opioid response grants.

I very much appreciate that commitment. I know that our staff have been working together to develop a solution so we can achieve the shared goal and I look forward to continuing those efforts.

How do large swings in Federal funding to states from year to year, particularly funding for programs that are responding to the substance use disorder crisis, undermine those state's public health infrastructures?

Ms. DELPHIN-RITTMON. Yes, you know, appreciate that question, and you know, our staff did have a productive conversation this week, and so we are looking to continue the work that we discussed. You know, consistent, stable funding, it is important.

As a former State Commissioner, I am aware of that, that funding cliffs or swings or changes in funding can be destabilizing for the system. So some of our work around looking at the current SOR grant is around looking to sort of mitigate or reduce any of those impacts. Some of our challenge there though is that we receive significantly less than what was proposed in the President's budget.

We are working with the resources we have to try to minimize those cliffs that we discussed.

Senator HASSAN. Thank you.

The CHAIR. Senator Hassan, let me just say that I agree that we need consistent and reliable funding. It is really critical to our state's efforts to respond and prevent those drug overdoses. And it is important that Federal funding is allocated in ways that don't result in usually large funding restrictions—reductions between years, so I appreciate you bringing that up.

Senator HASSAN. Well, thank you. I appreciate that very much. And I just wanted to note as well, I know there was a discussion earlier about the importance of medication assisted treatment as we deal with substance use disorder. And I want to note that there are still barriers at the Federal level that prevent more providers from prescribing medication assistant treatment.

It is why I am so grateful to be working with Senator Murkowski on this bipartisan Mainstreaming Addiction Treatment Act to eliminate these outdated prescribing restrictions for medication assisted treatment. So I look forward to working with all of you and with my colleagues on the Committee to get this done.

Following along the line of the substance use disorder crisis, I want to ask you another question, Dr. Delphin-Rittmon. Frontline workers in New Hampshire have shared with me that they are seeing a resurgence in methamphetamine use, and data show that deaths involving methamphetamines roughly doubled between 2018 and 2021. How is HHS responding to that trend?

Ms. DELPHIN-RITTMON. So one thing that we have done there, because we are looking at that data and we see some of those trends as well, is states are now able to use the state opioid response grant to be able to address the patterns and trends and needs that they are seeing related to methamphetamine usage as well.

The saw resources can be used to address and put together programs or initiatives, awareness campaigns to be able to address the methamphetamine challenges as well.

Senator HASSAN. Okay, thank you. That is an important step forward. This is a question to the panel. Maternal mental health conditions are among the most common complications of pregnancy and childbirth. However, these conditions often go undiscussed and untreated due to insufficient resources and pervasive stigma.

I would like to ask the panel, what barriers have you seen to a federally coordinated maternal mental health response? And why don't we start with you, Dr. Volkow, and just work down on the panel.

Dr. VOLKOW. Yes, thanks for the question. And for us, we have focused very much on the challenges of ensuring that we are able to screen and provide for treatment for women when they are pregnant, ideally before they get pregnant, for any substance use disorder. Because the data shows that without treatment, the outcomes can be very negative for the mother herself and also for the newborn infant.

The research shows that intervention is necessary not just during pregnancy, but also the support that follows post-pregnancy to ensure that the woman is able to stop taking drugs or maintain—or stay in treatment. The data also shows that pregnancy actually is a moment where women are much more likely to be receptive for accessing treatment, and thus, is a lost opportunity not to provide it.

Our research is ongoing to try to figure out which are the models of care that are most effective and which medications we can give to pregnant women safely, and how to monitor once the baby is born to ensure that they will have the greatest likelihood of success.

Senator HASSAN. Thank you. And Dr. Gordon, if we can just go down quickly because we are running out of time here and then I can follow-up.

Dr. GORDON. Yes. One quick challenge I see is ensuring that maternal health care providers have the expertise and consultation necessary. So expanding collaborative care for maternal health care providers is one potential solution to that challenge.

Senator HASSAN. Well, thank you because I have introduced the bipartisan Plan for New Moms Act to improve this kind of coordination. The bill would create a Federal task force, a national strategy to expand mental health resources for new mothers. So I look forward to working with my colleagues and all of you, and I don't know, Madam Chair, if the last two panelists can quickly answer—?

The CHAIR. If they could do it for the record, that would be great.

Senator HASSAN. Okay. We will do it for the record. Thank you so much.

The CHAIR. Thank you. Senator Braun.

Senator BRAUN. Thank you, Madam Chair. Thank you all for coming in today. It is obviously an important topic. The question will be for Dr. Gordon and then one for all of you. And after being

subjected for so many—such a long time on wearing masks and when the guidelines came out recently, most Americans in the country can now be mask free. And of course, it always comes back to kids.

That still seems that there is an err on the side of masking when maybe they are in that group that is least prone to significant impacts from it. So what is your feeling on, you know, whether that is a good decision?

How has that impacted other developmental, emotional issues that come along with, you know, being confined with a mask for all this time?

Dr. GORDON. Data show that across a broad range of social, behavioral, and emotional outcomes, allowing kids to attend school in person is of the utmost importance. Accordingly, the Biden Administration has prioritized that in their COVID response plan. Now, mask wearing can be a crucial part of a layered prevention strategy to allow children to remain in school when the conditions of the pandemic merit it.

It has been shown to reduce closures of at least daycare centers. The data for schools are not yet available. NIMH and other institutes, including NICH, continue to study the impacts of both the pandemic and mitigation strategies like mask wearing on social, cognitive, and emotional development.

To date, there are no studies that reveal any significant harms of mask wearing, but they have shown significant harms of school closures. So we look forward to continuing that research and making sure that we know for sure the effects of mask wearing and other mitigation measures to the COVID pandemic on children.

But so far, we have not seen any adverse consequences of those particular ones.

Senator BRAUN. Thank you. And one of the tragic consequences of trying to manage COVID from the mental health side has been, you know, the overdoses that we have had to contend with. I would like you to comment, particularly on fentanyl, and is there anything else that has cropped up, you know, or is contributing to that, and the other three panelists as well. We have got about two and a half minutes left.

Dr. VOLKOW. Yes, there are two elements that are contributing. One of them is the social isolation and the uncertainty of stress can increase the risk of people to take drugs, and those are more likely to be exposed to synthetic drugs like fentanyl and others. And the second crucial element, since the pandemic, the seizures of fentanyl has been increasing quite dramatically, making it very available.

Also as I have mentioned before, it is increasingly used to contaminate other drugs. So those two elements, people being more vulnerable to taking drugs while at the same time access to extremely dangerous drugs in the illicit drug market.

Ms. JOHNSON. I certainly defer to Dr. Volkow on the fentanyl question. On the other, as an agency that focuses on maternal and child health, let me just reinforce Dr. Gordon's point about the critical importance of children being in school, we have seen because we serve underserved communities, how important it is for children

to be in school to receive a series of services, whether those are health care services or whether that is cooking, nutritional support and the like.

In order to do that, we want to make sure that children are following the appropriate public health mitigation guidance and responding to that as CDC continues to update that.

Ms. DELPHIN-RITTMON. Yes. And I will just add that, you know, in terms of the fentanyl, because of the patterns and trends that we are seeing, it is increasingly more important that we have naloxone disseminated far and wide. So again, through our state opioid response grant, as well as block grant dollars even, states and communities can purchase naloxone to help reverse overdoses.

Senator BRAUN. Very good. And I think it is sad that most of it gets produced somewhere else, comes through the Southern border, and I think fixing that source would make a job a lot easier for all of you that have to contend with it.

I just hope that we get our hands around it to stop it at its source, and that looks like it is still to be accomplished. So keep up in the meantime, all the good work to try to remediate it. Thank you.

The CHAIR. Yes, Senator Rosen.

Senator ROSEN. Thank you, Chair Murray. Thank you for holding this hearing, for your commitment to a bipartisan process to reauthorize, to improve, to expand these key Federal mental health and substance abuse disorder programs. And I just look forward to ensuring that Nevada's voices are heard throughout the process.

I want to build a little bit about, Senator Murkowski and I have been doing a lot of work together on this and so one program that has been incredibly helpful in Nevada is SAMHSA's Mental Health Awareness Training Grant Program, you alluded to it earlier. We have a dire shortages of mental health care providers, workforce training. That is a subsequent question we have to address.

We can give all these dollars, but we need a workforce. But this Federal program has been a critical lifeline, particularly in rural parts of our state like Nye, Esmeralda, and Lincoln Counties. They have used this grant funding to improve access to evidence based mental and behavioral health training for first responders, for parents, teachers, school staff, community members, to first of all, better recognize and then respond to unmet mental health needs of our communities and help prevent mental and behavioral health issues from escalating.

Dr. Delphin-Rittmon, as this Committee works to reauthorize this important program, what has SAMHSA learn over the past 5 years about potential improvements we might make to make it more accessible for everyone, particularly in our underserved or rural communities? What should Congress be looking at to help fix this?

Ms. DELPHIN-RITTMON. Yes. Thank you for that question and for your leadership on this issue. This has been such a critical program for us. Mental health first aid and the mental health awareness training programs provide a wonderful opportunity just to increase awareness about mental health challenges.

These trainings are done across the board, in school settings, in faith communities, within, you know, other community centers. And what it does is it allows community members to be able to recognize children that are struggling or just anyone that is struggling. What we find is that people do get connected to care. And I actually have some data on that I would like to share.

Last year alone, so 2021, 38,000 individuals were trained in mental health, mental health awareness training, and 125,000 individuals were connected to care as a function of those trainings. So I think one thing we have learned is that it makes a difference, it makes an impact. People are being connected to care as a function of this increased awareness.

Senator ROSEN. Well, I think it just increases our compassion and empathy for others and allows us to reach out. Sometimes that is maybe the most important first step, right. But speaking of reaching out, I am working with Senator Murkowski and being sure that we use these SAMHSA dollars down at our K through 12 schools because Nevada's Clark County School District were top of a list that no one wants to be top of. We have lost 20 students in 2020 to suicide.

We have to do a lot more to be sure that our students are just being taken care of, particularly through COVID. And so we have to get that funding directly to the students. We need workforce training. I know you have spoken about this about, but Project Aware doesn't allow the funding to go directly to local school districts, and you would think that is really important.

I know you have already committed to working with Senator Murkowski. We work together on this bill, so I won't ask you to repeat your answer. I know you will be glad—I hope you will be glad to work with all of us, and I am sure you will on that. And to your point, what I really want to talk about in the remaining time is address that workforce issue or training issue, whether it is lay people or people who are going to be put to the schools, because if we bring this money down, it is no good if we don't have the counselors.

Can you talk to us about the workforce shortage, and how do you think Congress can help provide—expand our provider capacity for health, in the health professional area?

Ms. DELPHIN-RITTMON. Yes, thank you for that. I mean, we certainly are seeing a workforce shortage. You know, programs like Minority Fellowship Program make a difference or other fellowship programs. Loan repayment programs make a difference as well. And, you know, my colleague, HRSA, can share about that as well. But you know, I think programs that essentially create incentives for people going to—you know, entering the behavioral health professions. For me, it made an impact.

As it came up earlier in this Committee, often individuals will stay and continue to work in the communities where they do their internships or where they do, you know, some of their training programs. So those types of programs do make a difference. And then also, certainly our loan repayment programs make a difference as well.

Senator ROSEN. Thank you. I appreciate that. I am out of time. I just will ask Dr. Gordon for the record, you can submit it offline, about seniors' mental health. We also have a lot of issues there with social isolation and some of those challenges. So we will submit that——

Dr. GORDON. Happy to do that.

Senator ROSEN [continuing]. submit your response for the record. Thank you. Thank you, Madam Chair.

The CHAIR. Thank you very much. And I will turn to Senator Kaine for wrap up and thank you again for filling in for me.

Senator KAINE. Absolutely, Chair Murray. And thanks to the witnesses. This has been a really good hearing. I want to stick right where Senator Rosen was at the end of her questioning about workforce issues, and particularly workforce in helping folks with substance use disorders. My experience has been, and I wonder if this is more than anecdotal, that some very effective folks in this workforce are people who have had substance use disorders themselves.

But I also find as I travel around Virginia and talk to people, that they—and how legit this is, or whether it is a perception, they still feel like if they have had a substance use disorder, particularly that has led to any criminal conviction, that they can be challenged in licensure and regulations often get in their way in terms of being able to be in the workforce.

They can volunteer, they can be part of a support group, but if they want to make it a profession and help others using the experience that they have gone through, there can be barriers in their way.

I wonder if you might talk about that because if we are looking for a bigger workforce, we wouldn't want to keep out of the workforce people who have had a life experience that would make them particularly effective.

Ms. DELPHIN-RITTMON. Yes. I am happy to comment on that. I mean, we have absolutely seen that individuals in recovery, so peer support specialists, recovery support specialists make a meaningful difference in terms of connecting people to care and giving people hope. Often we find recovery coaches share their own stories of lived experience and often are able to help connect people to services and supports.

In fact, we have seen with our state opioid response grant, many states now have programs where they have recovery coaches connecting with emergency departments. So when an individual is brought to an emergency department, they are linked up with a recovery coach, and then the recovery coach helps with system navigation, helps them get connected to care, or helps them with whatever they need.

Often, they say their first question is, you know, how can I help you in your recovery today? So those programs make a difference. We have seen recovery coaches also in working in methadone programs, working in supported employment programs. And it is an area in terms of SAMHSA that is a priority for us in terms of expanding our recovery work, and we recently announced a recov-

ery—Office of Recovery. Recovery is also one of the pillars of the HHS Overdose Prevention Strategy as well.

Ms. JOHNSON. I would just add——

Senator KAINE. Ms. Johnson——

Ms. JOHNSON [continuing]. if you don't mind, sorry. Peers, people with lived experience are part of the solution here, and we are not going to succeed in the way that we want to in combating the opioid epidemic, combating the substance use disorder challenges, without engaging people who have lived experience. They have a unique ability to connect people to care, and we want to support that.

The licensure issue that you raise, I suspect, is a state by state issue. Prior to this role, I was the Human Services Commissioner in New Jersey. We didn't experience that issue there. But I will commit to you, if you are seeing that in other places, Miriam and I want to be vocal and help address those issues because we want peers to be part of the solution.

Senator KAINE. Excellent. A related topic that I want to ask about is folks who are incarcerated. So 2 million people in the United States, 25,000 in Virginia. Of this population, about two-thirds have a substance use disorder history, often a current challenge, and about one-quarter of those have opioid use disorders.

The data shows that folks who receive treatment, including medication assisted treatment, are more likely to engage in post-conviction—post-release treatment and to stay in treatment longer.

There is challenges with medication assisted treatment in prisons and jails. What might we do to enable people to get this kind of treatment that is going to help them while they are incarcerated, but more particularly when they are no longer incarcerated?

Ms. DELPHIN-RITTMON. Yes, thank you for that question. And such an important area that individuals who are connected to the justice system get connected to services and supports. So SAMHSA has a drug court initiative and grants which help to divert individuals from further involvement in connection with the justice system and into behavioral health treatment.

Individuals are then able to get connected to medication assisted treatment or other services and supports that they need. So that is one initiative. I think diversion programs really make a difference in terms of connecting people to care. But also In Reach Programs. So programs that connect people to services and supports prerelease, and those programs can help to ensure——

Senator KAINE. How about particularly the issue of medication assisted treatment for those who are incarcerated?

Ms. DELPHIN-RITTMON. Yes. So we are supporting a number of prisons and providing technical assistance around administering buprenorphine or other forms of MAT within criminal justice settings. So we have done some technical assistance there. And so it is—that is an important area as well. So for individuals that are in prison for them to get connected to MAT as well.

Senator KAINE. I have one last question that I want to raise. The Committee was very helpful in getting a bill passed that President Biden signed last week, called the Lorna Breen Health Care Pro-

vider Protection Act, which was to try to provide mental health assistance to our frontline health care workers who have had a lot of challenges even before COVID and in particularly since COVID.

I was thinking about that bill and talking with the Breen family when we were at the bill signing last Friday, I started to think about other parts of our workforce who have really had challenges during COVID. And a friend of mine said, what about last responders? And I said, I haven't heard that phrase, what do you mean by that? And talking about people who work in nursing homes and long term care facilities where the illness and death tolls have been extremely high.

Often these workers are paid very little. These are some of the, you know, lowest paid workers in our system, and yet they have seen and experienced themselves, many of them have gotten sick and died, too. What have you seen with our long term care workforce in COVID, and how might we approach this issue of mental health resources for them?

Ms. JOHNSON. I would say, thank you, Senator, for your leadership on this issue and to the Chair as well. We were with American Rescue Plan resources able to do $103 million in awards to 45 grantees to support health care provider resilience and help reduce burnout.

As part of that, one of those awardees is a Technical Assistance Center, which we are hoping to leverage all the learnings from this work so that it is not just the 44 grantees and the Technical Assistance Center that get the benefit of those resources, but that we can help health care providers across the country in addressing this issue.

But you raise a very important point about frontline long term care workers who have been heroes throughout the pandemic, and I look forward to working with you on ways that we can address their mental health needs going forward.

Senator KAINE. Great. Thank you. Thank you, Chair Murray.

The CHAIR. Thank you. Very, very good point. That concludes our hearing today. And I want to thank all of our colleagues and all of our witnesses, Assistant Secretary Delphin-Rittmon, Administrator Johnson, Director Gordon, and Director Volkow. Really important hearing and appreciate all of your thoughtful input.

For any Senators who wish to ask additional questions, questions for the record will be do in 10 business days, April 6th at 5 p.m.. And the Committee will next meet Tuesday, March 29th in 430 Dirksen for a hearing on how we can strengthen families' finances and improve their retirement security. With that, the Committee stands adjourned.

QUESTIONS AND ANSWERS

RESPONSE BY MIRIAM E. DELPHIN-RITTMON TO QUESTIONS FROM SENATOR CASEY, SENATOR BALDWIN, SENATOR HICKENLOOPER, SENATOR MURKOWSKI, SENATOR BRAUN, AND SENATOR TUBERVILLE

SENATOR CASEY

Question 1. There are more than 26 million grandfamilies and kinship families in the United States who are at a higher risk of experiencing challenges related to mental health and substance use disorder The pandemic has exacerbated the difficulties that many of these families face, and more than 200,000 children have been orphaned by COVID–19, losing at least one parent or primary caregiver to the disease The Advisory Council to Support Grandparents Raising Grandchildren, established by the Supporting Grandparents Raising Grandchildren (SGRG) Act (Public Law 115–116), has emphasized the importance of addressing the trauma experienced by grandfamilies Page 3 of the SGRG Act Initial Report to Congress notes that many children in need of homes have experienced multiple adverse childhood experiences and require support beyond what a kin or grandparent caregiver can provide Without connections to publicly available assistance, grandfamilies and kinship families may spend down their savings on services or go without needed support The SGRG Act Initial Report to Congress identifies awareness of and outreach to kin and grandparent caregivers as a priority.

> *Question 1(a)*. What, if any, systematic efforts have been undertaken by the Biden administration to identify (1) children who have been orphaned and now live with multi-generational families and (2) the adults now serving as caretakers?
>
> *Question 1(b)*. What efforts are underway, or being planned, to expand outreach to kinship families and grandfamilies—including through schools and community organizations—to connect them with information, services, and supports? How can Congress support these efforts?

Answer 1. SAMHSA is a member of the Administration for Community Living's Recognize, Assistant, Include, Support, and Engage (RAISE) Family Caregiving Advisory Council, which is responsible for developing a national family caregiving strategy The RAISE Family Caregiving Advisory Council delivered its initial report to Congress on September 22, 2021 The report outlines a review of the current state of family caregiving and includes 26 recommendations on how the government and private sector can better Recognize, Assist, Include, Support, and Engage family caregivers, including grandparents.

> Answer 1(a). SAMHSA also administers the Mental Health Technology Transfer Center (MHTTC) Network and National Child Traumatic Stress Network (NCTSN) These entities have hosted webinars, developed resources,

and provided resources about trauma, grief, and loss related to the pandemic.

Answer 1(b). MHTTC's training, technical assistance products, and resources are all available online (Responding to COVID–19 Grief, Loss, and Bereavement) The site also includes a compilation of resources from other reputable organizations.

The NCTSN has several resources to assist parents/caregivers cope with trauma, guides for mental health providers on family resilience, and other resources to promote theoretical and practical perspectives on family resilience and the clinical and research implications for children and families who have experienced trauma The NCTSN has hosted and issued the following webinars and fact sheets specifically related to the COVID–19 pandemic:

- Applying Evidence-Based Treatments for Child Traumatic Stress Reactions to COVID–19-Related Deaths webinar and fact sheet.
- Child and Adolescent Traumatic Stress Reactions to COVID–19-Related Deaths webinar and fact sheet.
- Grief, Loss, and COVID–19 webinar.
- Grief, Loss, and COVID–19: Recommendations for Supporting Children and Families webinar.
- Helping Children with Traumatic Separation or Traumatic Grief Related to COVID–19 fact sheet:
- The Power of Parenting During the COVID–19 Pandemic: Mourning the Death of a Loved One fact sheet.
- Schools and COVID–19: Recommendations for Supporting Students, Families, Educators and Staff webinar.
- Trauma-Informed School Strategies during COVID–19 fact sheet.
- Suicide, Substance Use, and COVID–19: Recommendations for Supporting Children and Families webinar.
- Understanding The Impact of COVID–19 Through the Lens of the Core Concepts webinar.
- Where Do we Go from Here? A Call to Action in Response to the Impact of COVID–19.

Finally, SAMHSA administers multiple school-based mental health and early childhood grant programs, in which teachers, healthcare professionals, families, and community members are trained to identify, screen, and assess children and youth who are experiencing distress (including grief and loss) and ensure that they receive the services that they need These programs include the Infant and Early Childhood Mental Health Consultation, Project LAUNCH (Linking Actions to Unmet Needs of Children), and Project AWARE (Advancing Wellness and Recovery) SAMHSA's Mental Health Awareness Training program provides mental health literacy to teachers, school personnel, first responders, and other important community members so children can be connected with needed supports and services, such as when a child has experienced a familial loss.

All too often, when someone has a mental health crisis, 9–1–1 is called and law enforcement arrives, putting both the person having the crisis and police officers in situations they should not be expected to be in My Human-services Emergency Logistic Program (HELP) Act would divert non-criminal, non-fire, and non-medical emergency calls from 9–1–1 to state and regional 2–1–1 or 9–8–8 systems to address both immediate and longer-term needs.

Question 2. What is being done or needs to happen to support the 2–1–1 and 9–8–8 system in being able to handle mental health and substance use crisis calls that do not require law enforcement and would benefit from human service professionals? How is SAMHSA working to coordinate the two systems?

Answer 2. In most states, the 211 system provides health and social service assistance information and referrals At the same time, 988 crisis counselors will provide support for people in suicidal crisis, mental health or substance use crisis, or any other kind of emotional distress in the very moments they need it most While generally being different in scope, these systems need to be aligned, and in many cases, local Lifeline centers also respond to 211 contacts That is why, for example, SAMHSA partnered with the National Association of State Mental Health Program Directors to publish 988 Playbooks, such as the playbook for Lifeline Contact Centers, which provides examples of what a solidified relationship between a contact center and 211 service may look like Ultimately, we envision that 988 crisis centers will need to continue to coordinate with 211 and other warmlines This will help ensure an all-inclusive approach regardless of which number a person may use first.

SAMHSA's Minority Fellowship Program (MFP) aims to reduce health disparities and improve behavioral health outcomes for racial and ethnic minority populations Grants through this program increase the number of professionals who can support patient-centered care for underserved populations with mental health or substance use disorders.

Question 3. How has the Minority Fellowship Program (MFP) worked to address child and adolescent mental health in minority populations, and how many child and adolescent psychiatrists or residents are currently supported through the program?

Answer 3. Through national behavioral health professional organizations (American Academy of Addiction Psychiatry; American Association for Marriage and Family Therapy; American Nurses Association; American Psychiatric Association; American Psychological Association; Council on Social Work Education; NAADAC: The Association for Addiction Professionals; and National Board for Certified Counselors and Affiliates), SAMHSA's Minority Fellowship Program (MFP) assists people who seek doctoral-and master's-level degrees and plan to work to improve behavioral health outcomes for minority communities The program increases behavioral health practitioners' knowledge of issues related to prevention, treatment, and recovery support for mental illness and drug/alcohol addiction among racial and ethnic minority populations, including children and adolescents Each professional organization supports their fellows in addressing youth mental health by providing net-

working opportunities with mentors who specialize in that area, hosting webinars, guest lectures, virtual simulations, additional readings, and trainings One professional organization, the American Association for Marriage and Family Therapy, has developed its MFP-Master's program with a goal to increase the number of culturally competent marriage and family therapists whose specialty will be racial and ethnic minority youth and adolescents as they transition into adulthood.

The program also seeks to encourage more racial and ethnic minorities to join the behavioral health workforce, which in turn will help address child and adolescent mental health in minority populations Racial and ethnic minorities make up more than 28 percent of the Nation's population, while less than 20 percent of the behavioral health workforce consists of racial or ethnic minorities The relative scarcity of professionals who are from culturally and linguistically diverse backgrounds constitutes a workforce issue that contributes to the current disparities in quality of care and access to behavioral health treatment.

Currently, the MFP is supporting 26 psychiatric residents (through the American Psychiatric Association) who plan to pursue the child and adolescent psychiatric sub-specialty The MFP is also supporting nearly 150 other healthcare professionals (nurses, psychologists, counselors, social workers, and therapists) who plan to pursue work in child and adolescent mental health.

SENATOR BALDWIN

Question 1. 988 and State Fees:. In 2019, I introduced the bipartisan National Suicide Hotline Designation Act, which was signed into law in 2020 Converting from the existing ten-digit number to 988 will make it easier for Americans to get the help they need, but I'm concerned that states may not be ready to respond to calls when the new dialing code becomes available.

- *Question 1(a)*. How many states have enacted service fees to provide the additional state funding needed to support 988?
- *Question 1(b)*. Given that many states will not enact services fees, what information is SAMHSA making available to states regarding additional options for funding 988?

Answer 1. As you mention, the National Suicide Hotline Designation Act gave states the ability to enact new telecommunications fees to financially support 988 operations, yet very few states have done this so far As of March 2022, four states have passed legislation creating a 988-cell phone fee.

Success of 988 will rest heavily upon state, territorial and local leadership in leveraging the resources already available, in addition to making new investments That is why SAMHSA has awarded nearly $105 million in grant funding to 54 States and territories in advance of the transition of the National Suicide Prevention Lifeline to help strengthen our crisis care infrastructure.

We will continue to work in close partnership with them to meet the crisis care needs of people across our Country For example,

there are several existing Federal resources that can be leveraged to support 988 implementation Examples from SAMHSA include the crisis set-aside through the Community Mental Health Services Block Grant as well as funding through the Certified Community Behavioral Health Clinic (CCBHC) program Last, SAMHSA, in coordination with the National Association of State Mental Health Program Directors and others, issued 988-related playbooks for states and other entities to help states transition to 988.

Question 2. Performance Metrics:. In order to make sure that 988 works, we need goals and metrics in place to make sure that calls and texts are answered, and answered quickly.

- *Question 2(a)*. Right now, what percentage of calls to the National Suicide Prevention Lifeline are answered within 20 seconds? What is SAMHSA's goal for the percentage of calls answered within 20 seconds once 988 goes live this summer?
- *Question 2(b)*. What percentage of texts are answered in less than 5 minutes? What is SAMHSA's goal for the percentage of texts answered within 5 minutes once 988 goes live this summer?
- *Question 2(c)*. How is SAMHSA conducting oversight of the administration of 988 and what tools does SAMHSA have at its disposal in the event that SAMHSA's established performance metrics are not met?

Answer 2(a),(b),(c). With almost 200 crisis call centers across the U.S., the Lifeline has increased the size of its network, expanded training, and improved response rates since it began in 2005—yet demand continues to exceed capacity For years, this network has been massively underfunded and under-resourced In the past, this patchwork of local, state, and private funding for the network has fallen way short of meeting the need Despite the tireless work of crisis call centers across the country, the network has not been able to keep pace with demand.

Given the extent to which the Lifeline has been historically under resourced, current demand significantly exceeds available capacity The 988 Appropriations Report highlighted that Lifeline capacity was only sufficient to address 85 percent of calls, 56 percent of texts, and 30 percent of chats.

These deeply challenging statistics were one of the driving forces for investing 10 times more in funding in fiscal year 2022 than fiscal year 2021 to support crisis call center services across our Country we are hopeful that these investments will play a meaningful role in driving higher answer rates No call, text, or chat should ever go unanswered That said, key metrics of success will include data around the number of calls, chats, and text received and answered by the Lifeline, and the average speed to answer, among other things.

In terms of specific answer rates, in February 2022, the Lifeline answered 81 percent of incoming calls The average speed to answer was 53 seconds In June 2022, the Lifeline answered 83 percent of incoming calls The average speed to answer was 45 seconds These statistics represent a roughly 13 percent increase in calls answered

and a roughly 15 percent improvement in average speed to answer in the last 4 months The long-term aspirational targets for response are answering 95 percent of all contacts within 20 seconds, consistent with standards for 911 and the Veterans Crisis Line While SAMHSA expects recent investments to continue improving system performance over the coming months, it will take time and continued investments to reach these long-term targets Since calls are first routed locally, overall network performance will rest heavily on the pace of state crisis call center capacity increases.

Additionally, in February 2022, the Lifeline answered 44 percent of incoming texts The average speed to answer for these answered texts was 29 minutes and 43 seconds However, In June 2022, the Lifeline answered 96 percent of incoming texts The average speed to answer for these answered texts was 6 minutes and 47 seconds These statistics represent a roughly 200 percent increase in texts answered and a roughly 400 percent improvement in average speed to answer in the last 4 months These significant improvements in system performance were driven mainly by the influx in Federal funding, which began to reach centralized chat/text centers in March 2022 The long-term aspirational targets for response are answering 95 percent of all contacts within 20 seconds, consistent with standards for 911 and the Veterans Crisis Line While SAMHSA expects recent investments to continue improving system performance over the coming months, it will take time and continued investments to reach these long-term targets.

Over the course of several decades, 911 has developed sufficient capacity to address 95 percent of calls within 20 seconds Robust and sustainable funding across all levels of government will be essential in building toward this vision.

To help steer us toward these goals, SAMHSA has a number of ways to oversee network performance, both through the Cooperative Agreement with the Lifeline administrator and directly with states and territories through the 988 state and territory grant program There are regular reporting requirements, and SAMHSA will engage in corrective action planning processes in the event performance is off track or not meeting expectations.

We are grateful for the support Congress provided for the Lifeline so far However, the success of 988 will also rest heavily upon state and local leaders, as well as local crisis centers in the Lifeline network, as we work in concert with them to meet the crisis care needs of people across our Country.

SENATOR HICKENLOOPER

Suicide Prevention

When I was Governor of Colorado, we passed a suicide prevention plan modeled on the Zero Suicide approach.

Studies have shown that about 45 percent of those who die by suicide saw a primary care provider in the month before their death.

The idea behind this approach is that no person slips through the cracks.

The approach, which has been adopted in many communities across the country, has shown significant reductions in suicides among those receiving care.

Question 1. How can we incorporate on-the-ground examples like these, to our national approach to the growing mental health crisis?

Answer 1. SAMHSA oversees the Zero Suicide grant program, which funds a comprehensive, multi-setting approach to suicide prevention in health systems and tribes The purpose of this program is to implement suicide prevention and intervention programs for individuals who are 25 years of age or older by systematically applying evidence-based approaches to screening and risk assessment, developing care protocols, collaborating for safety planning, providing evidence-based treatments, maintaining continuity of care during high-risk periods, and improving care and outcomes for such individuals who are at risk for suicide being seen in health care systems.

Zero Suicide is an effective strategy in the national approach to the growing mental health crisis The model addresses goals 8 and 9 of the National Strategy for Suicide Prevention (NSSP) goals: (8) for suicide prevention to become a core component of health care, and (9) to promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

In fiscal year 2021, SAMHSA supported the continuation of 30 Zero Suicide continuation grants and a new cohort of 10 Zero Suicide grants The fiscal year 2023 President's Budget request for the Zero Suicide program is $232 million This funding will support 25 Zero Suicide continuation grants and 21 new Zero Suicide grants Continuing the Zero Suicide program is an important part of our Nation's mental health strategy and we look forward to continuing to see promising results come from more grantees.

988 Implementation and Staffing Issues.

988, the Suicide Prevention Lifeline, can be exactly that for people in crisis, a lifeline.

We are looking forward to the official transition to the three-digit 988 number this summer.

It is critical that as 988 is stood up, we support increased staffing at the crisis centers that get the phone calls we know these crisis centers have been stretched quite thin as it is.

We passed critical investments in the recent Omnibus bill to further support the transition to 988.

Question 2. How is SAMHSA prioritizing this investment to support a robust and resilient workforce to adequately implement the 988 Lifeline?

Answer 2. To support transition to 988, SAMHSA significantly increased—by over 10 times—the Federal Government's contribution to the Lifeline in fiscal year 2022.

SAMHSA announced a $282 million investment to support 988 efforts across the country to shore up, scale up and staff up the lifeline Most of these funds are going to Lifeline crisis centers around

the country to ensure crisis centers that will be answering 998 have the staff that they need, SAMHSA issued a grant opportunity that will provide direct workforce support for state, regional, territorial, and tribal call centers that are part of the Lifeline 988 Network.

The President's Fiscal Year 2023 budget will build on this investment with an additional nearly $700 million to staff up and shore up local crisis centers while also building out the broader crisis care continuum: someone to call, someone to respond, and somewhere for every American in crisis to go.

Preparing for 988 is an imperative for SAMHSA and all of HHS—we are steadfast in our planning efforts A smooth transition to national access to the Lifeline via 988 in July 2022 is SAMHSA's top priority.

Upskilling

We are facing a constantly growing need for behavioral health providers, particularly in rural and underserved areas.

During a recent Subcommittee hearing that I Chaired on the health care workforce, we heard from Dr. Margaret Flinter with the National Nurse Practitioner Residency and Fellowship Training Consortium.

The Consortium is using innovative approaches to train Nurse Practitioners in behavioral health.

Question 3. How can we further support the inclusion of behavioral health within primary care settings?

Answer 3. SAMHSA administers the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) program The purpose of the PIPBHC program is to promote full integration and collaboration in clinical practice between primary and behavioral healthcare; support the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED); and promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases In fiscal year 2021, the PIPBHC grant program served over 12,028 consumers and provided training to over 9,000 individuals in the mental health and related workforce.

SAMHSA also funds a technical assistance center, the National Center of Excellence for Integrated Health Solutions (CIHS) CIHS offers technical assistance and training for communities, individual practitioners, providers, and states on evidence-based and effective strategies to address the integration of primary and mental health care for individuals with mental disorders or co-occurring mental and substance use disorders In 2020, CIHS provided training to 23,880 individuals in the mental health and related workforce.

Congress can further support the inclusion of behavioral health within primary care settings by continuing to authorize and fund the PIPBHC program and National Center of Excellence for Integrated Health Solutions The President's fiscal year 2023 Budget request is $103 million The proposed funds increase will fund a new

cohort of 37 PIPBHC grants and continue to fund the National Center of Excellence for Integrated Health Solutions.

SENATOR MURKOWSKI

Question 1. Fentanyl Overdose Deaths: Overdose deaths from fentanyl are on the rise, including in Alaska, which saw deaths triple from 2019 to 2020 The loss of a loved one impacts friends, families, and communities who continue to bear the trauma of addiction long after someone passes I have heard directly from Alaskans who have lost their children, and are now dedicating their lives to prevent future overdose deaths from fentanyl.

Unfortunately, this drug has a high lethality that can harm both the user and responder I was horrified to learn about five young men and women who overdosed on fentanyl-laced cocaine a couple weeks ago while on spring break in Florida What is particularly distributing, is that two of these young men didn't consume the substance, but were performing CPR on their friends when they went into respiratory arrest They were exposed to fentanyl while they were performing mouth-to-mouth resuscitation.

Congress needs to take action before fentanyl claims one more American we need to start by educating people about the lethality of fentanyl and the risk of contaminated drugs.

> *Question 1(a).* Dr. Delphin-Rittmon, I understand that SAMHSA is broadly tasked with addressing substance use, but what action is SAMHSA taking to educate Americans, particularly at-risk youth, on the lethality of fentanyl and the dangers of contaminated drugs?

Answer 1. On April 7, 2021, SAMHSA and CDC issued guidance aimed at reducing drug overdose deaths, specifically that certain Federal funding (eg, SAMHSA's State Opioid Response—SOR grant) may be used to purchase rapid fentanyl test strips (FTS) Providing tools to identify the presence of fentanyl combined with referrals to evidence-based treatment options complements SAMHSA's daily work to reduce the impact of substance use disorders and mental illness on communities FTS save lives by allowing individuals to rapidly determine the presence of a lethal substance in their drug supply, while also facilitating education on the harms of fentanyl and methods to avoid it.

Additionally, the Drug Abuse Warning Network reports fentanyl cases across various demographics and monitors trends in the hospitals recruited SAMHSA is planning to use this information to educate the public on fentanyl and the risks associated with fentanyl use.

In December 2021, SAMHSA issued a Notice of Funding Opportunity for a new Harm Reduction Grant Program, which will help increase access to a range of community harm reduction services and support harm reduction service providers as they work to help prevent overdose deaths and reduce health risks often associated with drug use Purchase of FTS for community distribution are an allowable expense.

More broadly, SAMHSA has taken concrete steps to educate providers and those who misuse substances on the harms of fentanyl

Through this, the treatment community and providers receive education on the impact of fentanyl, empowering them to educate individuals on the harms of synthetic opioids and to provide evidence-based advice on avoiding exposure to this substance This work is augmented through cross-agency collaboration SAMHSA representatives regularly meet with other agencies to foster synergy in the expansion or improvement of SUD treatment, and how public education might be augmented.

SAMHSA also encourages the inclusion of robust curriculums on substance misuse, addiction and treatment among all medical and professional schools, and residency programs Robust education on substance misuse is essential as it not only normalizes discussions around substance misuse and treatment in the provider's office, but it also reduces stigma and treatment hesitancy A health workforce that is knowledgeable and skilled in the treatment of SUDs means that there is no wrong door through which an individual can seek treatment or information about substance misuse.

Lastly, below are several training and technical assistance resources on fentanyl which are available via the Prevention Technology Transfer Centers and the Addiction Technology Transfer Centers:

- Fentanyl Test Strips: Fact Sheet—*https://pttcnetworkorg/centers/great-lakes-pttc/news/fentanyl-test-strips-fact-sheet-now-available*.
- Fentanyl Test Strips: A Grassroots Harm Reduction Strategy—*https://pttcnetworkorg/centers/great-lakes-pttc/product/fentanyl-test-strips-grassroots-harm-reduction-strategy*.
- Cross-promotion of DEA press release—*https://pttcnetworkorg/centers/central-east-pttc/news/urgent-press-release-and-public-safety-alert-issued-dea*.
- De-escalating the Opioid Crisis—An overview of promising prevention strategies—*https://pttcnetworkorg/centers/northeast-caribbean-pttc/event/de-escalating-opioid-crisis-overview-promising-prevention*.
- Fentanyl Related Products and Events—*https://attcnetworkorg/centers/attc-network-coordinating-office/fentanyl-resources*.

Medication Assisted Treatment

Question 2. The Anchorage Daily News reported recently that the U.S. has passed a "never-before-seen milestone" in losing more than 100,000 Americans to drug overdoses in a year Sadly, the CDC reports that the number of drug overdoses in Alaska rose by more than 45 percent as of June 2021 That's more than double the rate of increase for the United States.

One treatment that we know is critical to stemming the overdose crisis is medication that prevent withdrawal symptoms and stem opioid cravings These medications, like buprenorphine, can cut the risk of overdose death in half when a person starts taking them But, outdated Federal laws and stigma are restricting access to these life-saving medications I have introduced the Mainstreaming

Addiction Treatment Act with my colleague, Senator Hassan, to help more Americans have access to life-saving medication and eliminate burdensome Federal red tape.

Question 2(a). How is the administration supporting expanding access to medications to treat substance use disorder so they reach all communities in need?

Answer 2. Medications for Opioid Use Disorder (MOUD) save lives, and we have seen the importance of MOUD during the COVID–19 Public Health Emergency (PHE) To expand and improve access to MOUD, SAMHSA has approved 81 additional opioid treatment programs (OTPs) since August 2021 and during the PHE, it issued guidance related to flexibilities in the provision of unsupervised doses of methadone, and in the provision of buprenorphine through telehealth by OTPs The response from SAMHSA's monthly meetings with the State Opioid Treatment Authorities has been overwhelmingly positive These entities as well as individual Opioid Treatment programs have reported greater patient and provider satisfaction The lack of increased reports of methadone overdoses or diversion further demonstrates that these flexibilities are safe and that they promote patient centered paradigms of care that enhance engagement in treatment and promote recovery.

Moreover, HHS published new buprenorphine practice guidelines that have expanded access to buprenorphine by exempting certain practitioners from certification requirements related to training, counseling, and other ancillary services Indeed, implementation of these guidelines has seen the addition of 12,822 waivered providers since April 28, 2021, almost double the number of practitioners who were certified during the same timeframe in the prior year In all, 22,561 more providers were certified in the last year, bringing the total number of waivered prescribers to 121,111 (as of March 2022) This further expands access to buprenorphine with SAMHSA also supporting prescribers through technical assistance programs and continued production of evidence-based guides and resources.

We further support access through the expansion of SAMHSA's grant programs and the recent announcement that funds for the State Opioid Response (SOR), Substance Abuse Block Grant (SABG), and Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) could be used to purchase mobile treatment units This reduces geographic disparity and promotes innovation in the delivery of care Evaluation efforts also allow for an understanding of what is working, and what requires innovation SAMHSA is engaged in an HHS-wide evaluation of the revision to the buprenorphine practice guidelines, and this expansive undertaking will assess disparity in the provision of treatment as well as factors that support the provision of care to those with substance use disorders, or hinder treatment activities Such information will allow for data driven decision making that will facilitate SAMHSA's work moving forward.

SAMHSA's grant programs such as the State Opioid Response (SOR), Tribal Opioid Response (TOR) program, and Medication Assisted Treatment for Prescription Drug and Opioid Addition (MAT-PDOA) seek to address urgent, unmet, and emerging substance use

disorder treatment and recovery support service capacity needs that remain a critical issue for the Nation The SOR program provides resources to states, territories, and tribes to continue to enhance the development of comprehensive strategies focused upon preventing, intervening, and promoting recovery from issues related to opioid misuse, and increasingly stimulant misuse The TOR program provides dedicated resources for this to Indian Tribes and Tribal organizations Both of these programs aim to address the overdose crisis by increasing access to the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid-related overdose deaths through the provision of prevention, harm reduction, treatment, and recovery activities for OUD (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs) and stimulant use disorder as so elected by states Since the SOR program began, approximately 971,372 patients have received treatment services, including 409,086 who have received an FDA-approved MOUD Of that number, 166,091 received methadone, 218,518 received buprenorphine, and 24,477 received naltrexone Through the SOR program, 686,998 patients received recovery support services.

Similarly, the MAT-PDOA program for community-based organizations addresses treatment needs of individuals who have an OUD by expanding/enhancing treatment system capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MOUD and recovery support services Medications are often combined with evidence-based psychosocial interventions tailored to an individual's needs This approach is a safe and effective strategy for decreasing the frequency and quantity of opioid misuse and reducing the risk of overdose and death Recovery support services include linking patients and families to social, legal, housing, and other supports to improve retention in care and increase the probability of positive outcomes.

SAMHSA also subsidizes recovery housing as one component of the SUD treatment and recovery continuum of care through various grant programs Recovery houses are safe, healthy, family like substance-free living environments that support individuals in recovery from SUD SAMHSA supports recovery houses that do not prohibit prescribed medications taken as directed by a licensed practitioner, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of OUD as well as other medications with FDA-approved indications for the treatment of co-occurring health conditions Additionally, recovery housing facilities must have mechanism(s) in place in their jurisdiction to assure that the funding they receive supports and provides clients access to evidence-based treatment, including all forms of medication for opioid use disorders, in a safe and appropriate setting SAMHSA funding recipients must also confirm how recovery housing supports appropriate and legitimate facilities (eg, state or other credentialing or certification or an established or recognized model).

Last, in order to further the evidence base, the administration supports the CDC to conduct a study of MOUD that will examine how health and other patient outcomes vary across the three types

of medications used in MOUD and for patients receiving counseling only treatment Patient, site, and provider characteristics will also be examined to determine how they may impact health and other outcomes

Infant and Early Childhood Mental Health

Question 3. The first years of life are an incredible opportunity to promote positive mental health for babies, and health and well-being during this time period affects future learning, behavior and health.

> *Question 3(a)*. Have you seen a marked impact by Federal investment in infant and early childhood mental health (IECMH)?

Answer 3. SAMHSA's Infant and Early Childhood Mental Health Consultation (IECMH) program aims to improve outcomes for children, from birth to 12 years of age, who are at risk for, show early signs of, or have been diagnosed with a mental illness, including a serious emotional disturbance IECMHC has been shown to improve children's social skills and emotional functioning, promote healthy relationships, reduce challenging behaviors, reduce the number of suspensions and expulsions, improve classroom quality, and reduce provider stress, burnout, and turnover.

Grantees improve outcomes for children through service provision to children and families, mental health consultation to early childhood programs such as Head Start, and training early childhood providers and clinicians to identify and treat behavioral health disorders of early childhood, including in children with a history of in utero exposure to substances such as opioids, stimulants or other drugs that may impact development, and through the implementation of evidence-based multigenerational treatment approaches that strengthen caregiving relationships.

In fiscal year 2021, grantees accomplished the following:

- Trained 4,003 clinicians and early childhood providers on evidence-based mental health treatments for infants and young children.
- Screened and assessed 9,883 young children for developmental and behavioral disorders (including screening parents for behavioral health issues such as depression and substance misuse).
- Referred 3,551 children and parents for treatment.
- Provided infant and early childhood mental health treatment (including multigenerational therapies) to 5,009 children and families

Suicide Screening in the Emergency Department

A recent CDC report on emergency department visits for people age 12–25 found an over 50 percent increase visits for suspected suicide attempts during early 2021 This underscores the devastating mental health impact of the pandemic on our youth and highlights yet another way that COVID–19 has strained our hospitals and medical staff.

I introduced a bill, the Effective Suicide Screening and Assessment in the Emergency Department Act, to improve the screening and treatment of patients in hospital emergency departments who are at high risk for suicide It will make sure that we can better identify our most vulnerable mental health patients so they do not slip through the cracks when they are treated in hospitals, and make sure hospitals have the resources they need to provide these critical services

Question 4. What is the need for improved suicide screening protocols in the Nation's emergency rooms?

Question 4(a). Do you support efforts to bolster the resources available to emergency rooms so they can enhance their screening for high-risk suicide patients?

Answer 4. Screening is a key component in SAMHSA's Zero Suicide grant program The Zero Suicide program funds a comprehensive, multi-setting approach to suicide prevention in health systems and tribes, including in emergency departments The purpose of this program is to implement suicide prevention and intervention programs for individuals who are 25 years of age or older by systematically applying evidence-based approaches to screening and risk assessment, developing care protocols, collaborating for safety planning, providing evidence-based treatments, maintaining continuity of care during high-risk periods, and improving care and outcomes for such individuals who are at risk for suicide being seen in health care systems In fiscal year 2021, SAMHSA supported the continuation of 30 Zero Suicide continuation grants and a new cohort of 10 Zero Suicide grants.

As you correctly noted, suicide risk screening is particularly important in emergency departments A multi-site research study found that suicide risk screening, discharge resources, and brief interventions resulted in a 5 percent decrease in the proportion of patients who attempted suicide in the year after the visit and a 30 percent decrease in the number of suicide attempts in that period Screening tools validated for use in emergency departments include the Ask Suicide-Screening Questions screening tool and Patient Safety Screener.

In addition to the Zero Suicide grant program, the Suicide Prevention Resource Center (funded under a grant by SAMHSA) has publicly available resources on suicide screening and assessment.

The fiscal year 2023 President's Budget request for the Zero Suicide program is $232 million This funding will support 25 Zero Suicide continuation grants and 21 new Zero Suicide grants.

FASD

During COVID, we have seen a sharp rise in substance misuse specifically alcohol, the most widely used and misused substance Unfortunately, a landmark NIH study in 2018 established that 1 in 20 school-aged children are affected by fetal alcohol spectrum disorders—FASD Due to its significance and status as an overlooked disability that includes debilitating stigma, I introduced S 2238, the FASD Respect Act My legislation establishes common standards of care and increases the capacity to manage FASD in medical and mental health settings.

Question 5. How can we address the social and environmental factors that contribute to prenatal alcohol exposure and reduce the traumas FASD creates for individuals and families?

Question 5(a). What steps are being taken by the administration to provide more education and training on FASD? How can stigma be lessened for individuals living with behavioral health conditions, like FASD?

Answer 5. SAMHSA participates in the Federal Interagency Coordinating Committee on FASD (ICCFASD) The mission of the ICCFASD is to enhance and increase communication, cooperation, collaboration, and partnerships among disciplines and Federal agencies to address health, education, developmental disabilities, alcohol research, health and social services and justice issues that are relevant to disorders caused by prenatal alcohol exposure This Committee fosters improved communication, cooperation, and collaboration among disciplines and Federal agencies that address issues related to prenatal alcohol exposure The Committee also coordinates the activities of all Federal agencies who seek to solve the challenges posed by FASD, such as stigma.

Additionally, SAMHSA administers two programs that support screening of pregnant and postpartum women, minor children of the mothers, and other non-residential adults or family members who are included in treatment planning, age 18 years or older, for alcohol misuse or Fetal Alcohol Spectrum Disorders (FASD).

One program works to expand comprehensive treatment, prevention and recovery support services for women and their children in residential substance use treatment facilities, provide services for non-residential family members of both the women and children, and support evidence-based parenting and treatment models including trauma-specific services in a trauma—informed context.

The other pregnant and postpartum women program, which is a pilot, is meant to support family based services for pregnant and postpartum individuals with a primary diagnosis of a substance use disorder, including opioid disorders, help state substance abuse agencies address the continuum of care, including services provided to individuals in nonresidential-based settings, and promote a coordinated, effective and efficient state system managed by state substance abuse agencies encouraging new approaches and models of service delivery.

SAMHSA also has a Screening, Brief Intervention and Referral to Treatment (SBIRT) Program that aims to implement screening, brief intervention, and referral to treatment services for children, adolescents, and/or adults in primary care and community health settings (eg, health centers, hospital systems, health maintenance organizations, preferred-provider organizations, federally Qualified Health Care systems, behavioral health centers, pediatric health care providers, Children's Hospitals, etc) with a focus on screening for underage drinking, opioid use, and other substance use There are several grantees focused on SBIRT with pregnant and postpartum women and women of childbearing age The SBIRT programs in this area are targeted at reducing the use of alcohol and

other drugs during pregnancy to reduce the incidence of FASD and increase child and maternal health.

SENATOR BRAUN

In December 2020, a *GAO report* found that as of May 2020 only 6 percent of U.S. counties have all levels of substance use disorder treatment available—that includes outpatient, residential, and hospital inpatient services Even more unsettling: nearly one-third of counties had no levels of treatment available at all GAO concluded that SAMHSA's lack of reliable reporting data contributes to these persistent gaps in the treatment system.

Question 1. What concrete actions is SAMHSA taking to address these issues?

Answer 1. SAMHSA has been focused on expanding access to medication for opioid use disorder (MOUD) by promoting and supporting opioid treatment programs (OTP) services and increasing the number of practitioners able to address opioid use disorder (OUD) in their practices Since March 2021, over 22, 500 practitioners were certified (as of the end of March 2022), and since August 2021, 81 more OTPs were added to the treatment system To target these efforts, SAMHSA has been mapping services and highest areas of need to enable greater focus on local needs, using a regional approach to identify needs and plan for support.

To help overcome geographic disparity in the provision of comprehensive substance use disorder (SUD) treatment, since November 2021 SAMHSA has allowed mobile treatment units to provide OTP services, and it has been fostering telehealth activities and assessing ways in which the COVID–19 Public Health Emergency flexibilities might be made permanent , including work to review 42 CFR part 8 to make permanent some regulatory flexibilities for opioid treatment programs to provide extended take home doses of methadone SAMHSA also promotes innovative models of care through the State Opioid Response grant In addition, SAMHSA has been focusing on expanding SUD education and supports for providers seeking to treat OUD in their offices It has augmented provider education through the Provider Clinical Support System, fostering the development of a robust and responsive workforce that is capable of providing compassionate and evidence-based care to vulnerable individuals.

To further align services with areas of need, SAMHSA is engaged in evaluation of the revised buprenorphine practice guidelines This revision removed the education and attestation requirements for those wishing to treat up to 30 patients with buprenorphine As part of this evaluation effort, we will assess geographic disparity, prescribing practices and prescriber barriers and facilitators in the provision of MOUD The information underlying this evaluation is obtained from existing data sets as well as voluntary provider surveys Such information provides detailed insight into the provision of SUD treatment across America, while not imposing a reporting burden on providers.

SAMHSA is also working to augment its data collection and evaluation practices This undertaking recognizes the need to collect data that provides insight into the provision of comprehensive SUD

treatment across America, the impact of such treatment, and emerging practices that should be fostered through grant funding or further assessment It is also important to consider ways to collect this data so that it provides detailed information without imposing a burden on providers or institutions.

Question 2. Prior to the COVID–19 pandemic, patients typically had to travel to an opioid treatment program on a daily or near-daily basis Studies show that opioid treatment programs that took advantage of the methadone take-home flexibility have experienced significant increases in the number of patients receiving take-home doses and the number of take-home doses per patient, without increases in diversion or overdose Importantly, patients indicate they've benefited from reduced travel time to opioid treatment programs while still feeling they are receiving the care they need.

> *Question 2(a)*. Given SAMHSA has already announced it will extend the methadone take-homes flexibilities for 1 year post the public health emergency declaration, does the agency plan to make this change permanent?

Answer 2. The 1-year extension of this flexibility was designed to allow SAMHSA the opportunity to engage in processes that will make this flexibility permanent SAMHSA has indicated in the HHS Unified Agenda that it intends to issue a notice of proposed rulemaking for this purpose.

SENATOR TUBERVILLE

Question 1. we know that one in four Americans reports having been a victim of crime in the past 10 years, and half of those were victims of a violent crime Most report receiving no help in the aftermath Police, corrections leaders, and the courts agree that untreated mental health or co-occurring substance abuse disorders are core drivers of the cycle of crime and that they lack the infrastructure to respond appropriately.

> *Question 1(a)*. What do you see as the individual and societal impacts of untreated trauma as it relates to mental health and substance use disorder?

Answer 1. Trauma is a common experience for adults and children SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being".

The effects of traumatic events can place a heavy burden on individuals, families, and communities Although many people who experience a traumatic event will go on with their lives without noticeable lasting negative effects, others may have difficulties and experience traumatic stress reactions.

Research has shown that traumatic experiences are associated with both behavioral health and chronic physical health conditions, especially those traumatic events that occur during childhood Substance use (such as smoking, excessive alcohol use, and drug use), addiction, and mental health conditions (including depression, anx-

iety, or PTSD) have been linked with traumatic experiences, as have asthma, stroke, and heart disease Because its symptoms appear as other health conditions, trauma can be overlooked in medical and behavioral health assessments.

Although experiencing trauma may contribute to developing risk factors for violence, it is important to note that the majority of individuals who experience trauma do not engage in violent crime [1] However, the behavioral health concerns associated with trauma can present challenges in relationships, careers, and other aspects of life For this reason, SAMHSA believes addressing trauma is an important part of effective behavioral health care and an integral part of the healing and recovery process SAMHSA addresses the impact of trauma on individuals, families, and communities by leading the Interagency Task Force on Trauma-Informed Care and overseeing programs such as National Child Traumatic Stress Initiative (NCTSI) and ReCAST (Resiliency in Communities after Stress and Trauma).

Question 2. Federal data shows that 37 percent of people sentenced to prison, and 44 percent of people arrested and jailed, have experienced a mental health issue At the same time, we know that an estimated 1 in 10 police service calls are responding to an untreated mental health issue Across the country, we've seen community-based programs that seek to divert individuals experiencing mental health issues, direct individuals to treatment and resources, and do so in a way so the police department does not have to be involved.

> *Question 2(a)*. What is the Federal Government doing to ensure that mental health emergencies are being responded to appropriately, early on, before a treatable illness becomes a safety issue?

Answer 2. There is, unfortunately, an inaccurate perception that mental illness is a cause of violent crime, wherein in actuality, people with mental illness are more likely to be victims of violent crime than perpetrators [2] Most people who have mental illness are never violent toward others and research has found only 3–5 percent of violent acts in the United States are attributable to mental illness alone [3]

This bias extends to the criminal justice system, where people with mental illness are over incarcerated and often experience worse outcomes compared to the general population People with serious mental illness (SMI) are often booked into jail for non-violent, minor offenses [4] Once in jail, these individuals are incarcerated twice as long, and few receive needed treatment Many of these sit-

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[1] Daniel J Neller PsyD & John Matthew Fabian PsyD (2006) Trauma and its contribution to violent behavior, Criminal Justice Matters, 66:1, 6–7, DOI: 101080/09627250608553387.

[2] Desmarais SL, Van Dorn RA, Johnson KL, Grimm KJ, Douglas KS, Swartz MS Community violence perpetration and victimization among adults with mental illnesses Am J Public Health 2014 Dec;104(12):2342–9 doi: 102105/AJPH2013301680 Epub 2014 Feb 13 PMID: 24524530; PMCID: PMC4133297

[3] Swanson JW Mental disorder, substance abuse, and community violence: an epidemiological approach In: Monahan J, Steadman H, editors Violence and mental disorder University of Chicago Press; Chicago: 1994 pp 101—136.

[4] Swanson JW, Frisman LK, Robertson AG, et al Costs of criminal justice involvement among persons with serious mental illness in Connecticut Psychiatr Serv 2013;64:630—7

uations could be diverted if there was more awareness and resources available. [5]

SAMHSA supports community-based programs that seek to divert individuals experiencing mental health issues, direct individuals to treatment and resources, and do so in a way so the police department does not have to be involved One such programs is the Behavioral Health Partnerships for Early Diversion (BHP-ED) This grant program supports grantees in establishing or expanding programs that divert adults with serious mental illness or co-occurring mental and substance use disorder from the criminal justice system to community-based services prior to arrest and booking Early diversion programs establish collaborative partnerships between law enforcement and community providers Special consideration is given to programs that support early diversion services for veterans.

There are certain periods when a subset of individuals with serious mental illness may be at elevated risk for violence, such as the period around first episode psychosis To best support these individuals, SAMHSA oversees the Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness (AOT) program and the Assertive Community Treatment (ACT) program AOT aims to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness (SMI) AOT facilitates the delivery of community-based outpatient mental health treatment services to individuals with SMI that are under court order as authorized by state mental health statute.

RESPONSE BY CAROLE JOHNSON TO QUESTIONS FROM SENATOR CASEY, SENATOR ROSEN, SENATOR HICKENLOOPER, SENATOR MURKOWSKI, SENATOR BRAUN, AND SENATOR TUBERVILLE

SENATOR CASEY

The National Health Service Corps (NHSC) programs help expand the health care workforce in underserved areas, including the workforce for mental health care services Currently, the NHSC Loan Repayment Program (LRP) offers behavioral health care clinicians loan repayment in exchange for serving communities with limited access to care Programs require participants at approved sites to work full-time or half-time.

Question 1. Has HRSA-NHSC considered program flexibilities to encourage greater provider participation in its programs to address urgent mental health workforce needs, such as a reduction in the number of hours required?

Answer 1. HRSA's National Health Service Corps (NHSC) offers a number of flexibilities to recruit, maintain and support the health care workforce, including behavioral health care providers NHSC awardees are able to select a half-time service option over 2 years or a full-time service option over 2 years, at NHSC approved sites.

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[5] *https://bjsojpgov/content/pub/pdf/imhprpji1112pdf.*

COVID–19 Flexibilities

Another flexibility is through the CARES Act (Section 3216) which allows the Secretary to assign members of the NHSC to provide health services as the Secretary determines necessary to respond to the COVID–19 Emergency, which gives participants more options as to where they can complete their service The CARES Act COVID–19 flexibilities are not permanent.

HRSA also has provided COVID–19 flexibilities for NHSC participants to adjust their commitment if their work is impacted by the pandemic.

Unless an NHSC participant is eligible for a waiver as a result of experiencing an "extreme hardship" under section 338E(d) of the Public Health Service Act, and implementing regulations under 42 CFR 6212, 6228, the Secretary does not have the statutory authority to shorten the length of a participant's service requirement or cancel a participant's obligation under a contract Section 338E(d)(2) states that the Secretary may waive a participant's service obligation in whole or in part whenever compliance is impossible or would involve extreme hardship, and if enforcement of the obligation would be unconscionable .

There are more than 26 million grandfamilies and kinship families in the United States who are at a higher risk of experiencing challenges related to mental health and substance use disorder The pandemic has exacerbated the difficulties that many of these families face, and more than 200,000 children have been orphaned by COVID–19, losing at least one parent or primary caregiver to the disease The Advisory Council to Support Grandparents Raising Grandchildren, established by the Supporting Grandparents Raising Grandchildren (SGRG) Act (Public Law 115–116), has emphasized the importance of addressing the trauma experienced by grand families Page 3 of the SGRG Act Initial Report to Congress notes that many children in need of homes have experienced multiple adverse childhood experiences and require support beyond what a kin or grandparent caregiver can provide Without connections to publicly available assistance, grand families and kinship families may spend down their savings on services or go without needed support The SGRG Act Initial Report to Congress identifies awareness of and outreach to kin and grandparent caregivers as a priority.

Question 2. What efforts are underway, or being considered, at HRSA and other relevant agencies to expand outreach to kinship families and grand families to connect them with information, services, and supports? How can Congress support these efforts?

Answer 2. HRSA reaches families and caregivers, including kinship and grand families, with information, services, and other supports to address behavioral health needs.

For example, HRSA's Infant-Toddler Court Program (ITCP) funds a National Resource Center (NRC) to improve the health, well-being, and development of infants, toddlers, and families in the child welfare system The program aims to improve direct services, ensure community-level partnership-building, and strengthen early childhood systems to serve families with significant trauma and substance use histories ITCP provides technical assistance and

implementation supports to child welfare judicial systems to educate judges, case workers, and other professionals on the importance of kinship care and ways to support young children and families in kinship placements As part of direct support to families and caregivers, local court teams also provide information, connection to services and care coordination, and other supports for families, including kindship and grand families ITCP received an increase of $3 million in the fiscal year 2022 annual appropriations for HRSA to provide state grant awards which will support states to build capacity for or expand implementation of the ITC approach in local ITC sites.

The HRSA-funded School-Based Health Alliance maintains and updates resources for families to learn about school-based health, including behavioral health HRSA's Collaborative Improvement and Innovation Network on School-Based Health Services increases children's access to behavioral health care by promoting evidence-based models of school-based health services, including Comprehensive School Mental Health Systems Additionally, HRSA, in collaboration with CDC, leads the National Coordinating Committee on School Health & Safety (NCCSHS), which is a partnership among Federal and non-governmental organizations to coordinate communication and support implementation at the state/local levels of school-based approaches including expanding comprehensive, trauma-informed mental health services in schools and the Whole School, Whole Community, Whole Child Model.

The Family to-Family Health Information Center Program is another investment that HRSA supports to assist families and children Family to-Family information centers provide information, education, and peer support to families with children and youth with special health care needs, including behavioral health needs—in addition to health professionals who serve families Families served through the program can include kinship and grand families.

SENATOR ROSEN

Question 1. As we talk about addressing the mental health workforce shortage, we need to also think about the diverse needs of children—especially those who have experienced significant trauma Over the last 2 years, that number has unfortunately grown It is estimated that in the U.S., 167,000 children have lost a parent or caregiver due to COVID–19, and 13,000 lost their only caregiver Others dealt with social isolation and now struggle with the challenge of two lost years The pandemic caused stress and anxiety for so many children, only compounding the trauma that some children already faced due to abuse, homelessness, or living in foster care These children not only need mental health support, they need care from a professional who has been specifically trained to address their particular needs Ms. Johnson, what recommendations do you have for Congress on how to expand our provider capacity by helping mental health professionals become further specialized?

Answer 1. Integrating behavioral health into primary care and growing the behavioral health workforce, are two of HRSA's strate-

gies for expanding provider capacity to address the mental health needs of children.

HRSA's **Behavioral Health Workforce and Education Training (BHWET) Professionals Program** has a particular emphasis on the integration of behavioral health into primary care, , and a special focus in the BHWET Program is placed on the knowledge and understanding of children, adolescents, and transitional-aged youth at risk for behavioral health disorders The program helps increase the supply of children's behavioral health professionals as well as to increase access to children's behavioral health services by funding institutions of higher education and accredited professional training programs that expand field placement programs in school social work, school psychology, behavioral pediatrics, and school counseling The program's emphasis on community-based partnerships promotes the integration of behavioral health into primary care by increasing the number of experiential training sites where such training takes place In this way, the program emphasizes interdisciplinary collaboration by utilizing team-based care in integrated behavioral health and primary care settings By 2025, the BHWET Professionals Program is projected to eliminate over 40 percent of the projected shortfall of behavioral health providers Thanks to the American Rescue Plan, HRSA made 56 additional BHWET awards to behavioral health and training programs in June 2021 In fiscal year 2022, HRSA is supporting 168 BHWET Program professional grantees, totaling $66 million Continued funding for the BHWET Program allows HRSA to build on this important work of integrating the behavioral health workforce.

Continued investments in training and workforce development that help providers prevent and treat diverse child health conditions, including behavioral health, are key to expanding provider capacity This includes integrating culturally and linguistically appropriate, equitable, and trauma-informed best practices HRSA supports several programs that are helping to increase access to specialized mental health providers and build provider capacity.

HRSA supports the **Pediatric Mental Health Care Access Program (PMHCA)**. This program promotes behavioral health integration in pediatric primary care through new or expanded statewide or regional pediatric mental health care telehealth programs These statewide or regional networks of specialized pediatric mental health care teams provide tele-consultation, training, technical assistance, and care coordination to assist pediatric primary care providers.

Through the Pediatric Mental Health Care Access Program, pediatric primary care providers are able to diagnose, treat and refer children to the care they need for behavioral health concerns The telehealth technologies promote long-distance clinical health care, clinical consultation, and patient and provider education, helping to address challenges in accessing psychiatrists, developmental-behavioral pediatricians, and other behavioral health clinicians who treat behavioral concerns in children and adolescents In fiscal year 2020, approximately 3,000 children and adolescents benefited directly from telehealth consultations through the PMHCA Program, (with approximately 2/3 living in rural and underserved counties) How-

ever, the reach of the program extends far beyond the children for whom providers contact the consultation line.

- 61 percent of participating providers report screening more patients in their practices, extending the impact of the program to more children and adolescents.
- 61 percent of participating providers also report that they are now providing behavioral health treatment in their practices, expanding the availability of these services within our communities.
- The number of primary care providers enrolled in the PMHCA Program increased from 1,963 in fiscal year 2019 to 4,511 in fiscal year 2020.

Authorization for the PMHCA program expires at the conclusion of fiscal year 2022.

In addition, the **Developmental Behavioral Pediatrics Training Program (DBP)**. trains Fellows in developmental behavioral pediatrics to address the broad range of behavioral, psychosocial, and developmental concerns that present in primary care pediatric practice The program also builds capacity for practitioners to provide evidence-based interventions to children's behavioral and developmental concerns, including for individuals with autism spectrum disorder and other developmental disabilities who may have co-occurring behavioral health disorders In fiscal year 2020, the DBP Training Program provided training to over 1,400 DBP Fellows, medical students and pediatric residents DBP graduate survey results indicate that 100 percent of DBP Fellows demonstrated leadership, worked in an interdisciplinary manner, and worked with maternal and child health populations, including those considered to be underserved (5 years following completion of the program).

HRSA's **Leadership Education in Adolescent Health (LEAH) Program** prepares maternal and child health leaders in adolescent and young adult health The program builds MCH workforce capacity by preparing health professionals for leadership roles in public health, health services, and academic sectors to address the unique needs of adolescents, including their behavioral health The program incorporates evidence-based patient-centered, culturally relevant care to build provider capacity and promote optimal mental health and well-being for adolescents and young adults LEAH graduate survey results show that 98 percent were engaged in work related to MCH populations (5 years following completion of program). [1]

While HRSA leads a number of programs to address mental health care needs of children, there is so much more to do when it comes to mental health care, especially considering the impact the pandemic has had on the mental and emotional well-being of people all ages HRSA looks forward to working with you to build on these efforts as we carry out the President's national strategy to tackle the Nation's mental health crisis.

[1] Data from 2020 Discretionary Grants Information System.

SENATOR HICKENLOOPER

Behavioral Health Workforce

If we are serious about building the pipeline of behavioral health workers, we need to make it easier for those without college degrees, working parents, and those without previous experience to break into early stage health care jobs According to the Bureau of Labor Statistics, we will need more than 150,000 new mental health support staff over the coming decades Even greater than the outstanding demand for psychologists.

Question 1. How can we more effectively recruit for these jobs to address this growing need?

Answer 1. HRSA has multiple pathways to recruit, train and place new behavioral health care providers in communities that need them most Below are examples of HRSA programs that support the priorities you have shared for building a pipeline of behavioral health workers.

HRSA's **Behavioral Health Workforce Education and Training (BHWET) Program** for Paraprofessionals develops and expands community-based experiential training to increase the supply of students preparing to become peer support specialists and other mental health-related support workers while also improving distribution of a quality behavioral health workforce In fiscal year 2022, HRSA supported 44 paraprofessional grantee organizations.

The **Opioid-Impacted Family Support Program (OIFSP)** trains health support workers to support children and families impacted by opioid use disorder (OUD) and other substance use disorders (SUD) in underserved areas The Program also provides professional development opportunities and educational support to increase the number of paraprofessional trainees receiving a certificate upon completion of the Program.

HRSA's **Rural Public Health Workforce Training Network Program** expands public health capacity by supporting health care job development, training and placement in rural communities HRSA supports rural health networks (which may be composed of, but are not limited to, minority-serving institutions, community colleges, technical colleges, rural hospitals, community health centers, nursing homes and substance use providers) to address the critical need for more trained health professionals, which has been amplified by the COVID–19 pandemic.

HRSA also funds several pipeline programs to help people prepare for and enter health professions The **Health Careers Opportunity Program (HCOP):** National Academies provide individuals from economically and educationally challenging backgrounds opportunities to develop skills to help enter and graduate from schools of health professions, including allied health professions Program support includes tailored academic counseling and highly focused mentoring services, scholarships and stipends, financial planning resources, and health care careers and training information.

Additionally, HRSA offers the **Centers of Excellence (COE) Program,** which provides grants to health professions schools and other public and nonprofit health or educational entities to serve

as innovative resource and education centers for the recruitment, training, and retention of underrepresented minority (URM) students and faculty.

Upskilling

We are facing a constantly growing need for behavioral health providers, particularly in rural and underserved areas.

During a recent Subcommittee hearing that I Chaired on the health care workforce, we heard from Dr. Margaret Flinter with the National Nurse Practitioner Residency and Fellowship Training Consortium The Consortium is using innovative approaches to train Nurse Practitioners in behavioral health.

Question 1. How can upskilling opportunities, like these training programs, help train more providers to increase access to behavioral healthcare?

Answer 1. Upskilling increases the number of providers and health support workers in the field with the skillset required to treat mental and behavioral health issues One of the most effective ways HRSA is growing the behavioral health workforce is by integrating behavioral health into primary care training while providing opportunities for providers across different disciplines such as pediatricians and maternal care providers to receive training in behavioral health care needs.

For example, HRSA funds two mental health programs that are currently up for reauthorization The first program, the **Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program,** helps train maternal health care providers on how to screen for, assess, treat, and, as necessary, refer pregnant and postpartum individuals with mental health conditions or substance use disorders as part of routine maternal health care Maternal health care providers also receive real-time psychiatric consultations for their patients through telehealth services and care coordination support.

The second program, the **Pediatric Mental Health Care Access Program** aims to make early identification, diagnosis, treatment, and, as needed, referral for behavioral health conditions a routine part of children's health care services The program promotes the integration of behavioral health services into pediatric primary care through statewide and regional pediatric mental health care telehealth programs These statewide or regional networks provide tele-consultation, training, technical assistance and care coordination to community-based pediatric health care providers in order to expand the reach of critical mental health services and support children's needs.

Additionally, HRSA funds a training program focused on integration of primary care and behavioral health through the Primary Care Training and Enhancement: Integrating Behavioral Health and Primary Care Program, which aims to increase the preparedness of primary care providers to identify and treat mental health and substance use disorders In fiscal year 2021, HRSA supported nine Primary Care Training and Enhancement: Integrating Behavioral Health and Primary Care Program grants.

HRSA also has funded a new and innovative initiative to train community health workers, through the Community Health Worker and Health Support Worker Training Program This new program will expand the public health workforce through the training of CHWs and other health support workers These CHWs will provide services, including behavioral health services in underserved communities Training community health workers and supporting job placement creates new opportunities to bring people into the health professions and grow their career ladder and upskilling opportunities over time.

HRSA's **Rural Public Health Workforce Training Network Program** expands public health capacity by supporting health care job development, training and placement in rural communities HRSA supports rural health networks (which may be composed of, but are not limited to, minority-serving institutions, community colleges, technical colleges, rural hospitals, community health centers, nursing homes and substance use providers) to address the critical need for more trained health professionals, which has been amplified by the COVID–19 pandemic Similarly, HRSA's **Regional Public Health Teaching Center Program** seeks to increase the number of individuals in the public health workforce, enhance the quality of such workforce, and improve the ability of this workforce to meet national, state, and local health care needs Specifically, this program aims to strengthen the public health workforce through tailored training and technical assistance through collaborative community-based projects.

Another way we are integrating behavioral health into primary care is by growing the behavioral health provider pipeline by promoting the inclusion of health support workers as members of behavioral health treatment teams For example, the Behavioral Health Workforce Education and Training Program for Paraprofessionals develops and expands community-based training for students preparing to become peer support specialists and other behavioral health-related health support workers

SENATOR MURKOWSKI

Mental Health Workforce

Question 1. I am deeply concerned by the worsening, widespread shortage of mental health professionals, which has only been exacerbated by the COVID–19 pandemic Over half of Alaska's population—380,000 people—live in a designated Mental Health Professional shortage area Workforce shortages create another serious barrier to accessing mental health care services, especially for those living in rural communities, like many Alaskans Last May, I joined Senator Smith in introducing the Mental Health Professionals Workforce Shortage Loan Repayment Act This bill establishes a student loan repayment program for mental health professionals who work in these shortage areas My hope is that this legislation will help expand the mental health workforce and incentivize professionals to provide much-needed mental health care to those living in rural communities and other underserved areas.

Question 1(a). What steps is the administration taking to address mental health workforce shortages, specifically with regard to the shortages facing Americans in underserved and rural areas?

Answer 1. HRSA is investing in both growing the behavioral health workforce in underserved and rural communities and in integrating behavioral health training into primary care training and practice to expand access to care.

HRSA's **National Health Service Corps** program provides scholarships and loan repayment assistance to clinicians who agree to work in health professional shortage areas Thanks to American Rescue Plan funding, we now have a record number of participants in this program, with over 9,000 participants providing mental health services, and more than a third of these providers are providing mental health services in rural areas.

With American Rescue Plan funding, we also have expanded our Behavioral Health Workforce and Education Training Program, which has increased the number of behavioral health providers entering and continuing practice.

To address workforce needs in rural areas, HRSA funds several programs that either focus on workforce development in rural communities or allow communities to propose a unique workforce program to meet the needs of a community In fiscal year 2021, HRSA funded the Rural Behavioral Health Workforce Centers—Northern Border Region as part of the Rural Communities Opioid Response Program (RCORP), a multi-year HRSA initiative with the goal of reducing morbidity and mortality resulting from substance use disorder (SUD) These centers are improving behavioral health care services in rural areas through educating and training health professionals and community members to care for individuals with behavioral health disorders, including SUD This program supports HRSA's collaboration with the Northern Border Regional Commission (NBRC) to provide career and workforce training activities that assist individuals with behavioral health needs, particularly SUD HRSA will continue funding for these centers in fiscal year 2022.

More broadly, through RCORP's other community-based grant programs, award recipients serving over 1,500 rural communities in 47 States and two territories have been able to leverage grant funds to recruit, train, and retain interdisciplinary teams of health and social service providers to support behavioral health care interventions Since RCORP's inception in 2018, Alaska has received $22 million in RCORP funding.

In fiscal year 2022, HRSA will be awarding new grants under the Rural Public Health Workforce Training Network Program to expand the public health capacity by supporting health care job development, including around behavioral health Additionally, several of HRSA's rural community-based programs offer funding opportunities that allow applicants in rural communities to propose and build a program in response to an area of need HRSA has funded many programs that focus on workforce development through the Rural Health Network Development, Rural Health Care Coordination, Rural Health Care Services Outreach, and Delta States Rural Development Network grant programs.

Question 2. What can and should be done to grow the employee pipeline in this field?

Answer 2. HRSA is regularly working to grow the pipeline including through multiple pathways to recruit, train and place new behavioral health care providers in the communities that need them most One way we are growing the behavioral health provider pipeline is by promoting the inclusion of health support workers as members of behavioral health treatment teams For example, the Behavioral Health Workforce Education and Training Program for Paraprofessionals develops and expands community-based training for students preparing to become peer support specialists and other behavioral health-related support workers HRSA will also support a new program this year to expand the public health workforce through the training of community health workers (CHWs) and other health support workers and to extend the knowledge and skills of current CHWs and other health support workers These CHW's will provide services, including behavioral health services in underserved communities.

Question 3. Provider Burnout: Throughout the pandemic, I have been concerned about our health care workforce Now, with a workforce shortage across the country, acute shortages in workers as infected staff isolate, and mounting burnout as we enter year three of this pandemic, I am more concerned than ever about the future of our health workforce.

Question 3(a). In the mental health care sector, what steps are you taking to help support the mental health needs of health providers, and expand and improve retention in an already-depleted workforce?

Answer 3. Supporting the mental health needs of health care providers is a top priority for HRSA This past January, HRSA announced $103 million in new grant awards to help support our health professionals' resilience as they continue to face the stress and challenges of responding to COVID–19 and other health care needs These awards are funding evidence-informed programs, practices and training, with a specific focus on providers in underserved and rural communities.

Funding is allocated across the following programs:

- *Promoting Resilience and Mental Health Among Health Professional Workforce*. HRSA awarded $286 million to 10 grantees to help health care organizations establish, improve, or expand evidence-informed programs and practices to promote mental health and well-being among the health workforce, including their employees.
- *Health and Public Safety Workforce Resiliency Training Program*. HRSA awarded $682 million to 34 grantees to support tailored evidence-informed training development within health profession and nursing training activities This curriculum will help reduce burnout and promote resilience among health care students, residents, health care professionals, paraprofessionals, trainees and public safety officers, such as firefighters, law enforcement officers, and ambulance crew members.

- *Health and Public Safety Workforce Resiliency Technical Assistance Center*. HRSA awarded $6 million to provide tailored training and technical assistance to the awardees discussed above.

HRSA also has several programs under the Behavioral Health Workforce Development Program that aim to expand and support the behavioral and mental health workforce, including:

- **Behavioral Health Workforce Education and Training (BHWET) Programs:** BWHET increases the number of behavioral health providers entering and continuing practice, with special emphasis on prevention and clinical intervention and treatment for those at risk of developing mental and substance use disorders, and the involvement of families in the prevention and treatment of behavioral health conditions BWHET includes the activities described below.
- **BWHET Program for Professionals:** The BHWET Program for Professionals aims to increase the supply of behavioral health professionals while also improving distribution of a quality behavioral health workforce and thereby increasing access to behavioral health services In fiscal year 2022, HRSA supported 168 BHWET Professional grantee organizations.
- **BHWET Program for Paraprofessionals:** The BHWET Program for Paraprofessionals develops and expands community-based experiential training to increase the supply of students preparing to become peer support specialists and other behavioral health-related paraprofessionals while also improving distribution of a quality behavioral health workforce In fiscal year 2022, HRSA supported 44 paraprofessional grantee organizations.

Other programs to expand the behavioral and mental health care provider workforce include:

- **Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP):** The STAR LRP recruits and retains medical, nursing, behavioral/mental health clinicians and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a substance use disorder STAR LRP participants must provide services in either a county (or a municipality, if not contained within any county) where the mean drug overdose death rate per 100,000 people over the past 3 years exceeds the national average, or in a Health Professional Shortage Area (HPSA) designated for Mental Health.
- **Graduate Psychology Education (GPE) Program:** This Program supports innovative doctoral-level health psychology programs that foster an inter-professional approach to providing behavioral health and substance use prevention and treatment services in high-need and

high-demand areas through academic and community partnerships.

- **OIFSP:** OIFSP trains paraprofessionals to support children and families impacted by OUD and other SUD in underserved areas The Program also provides professional development opportunities and educational support to increase the number of paraprofessional trainees receiving a certificate upon completion of the Program.
- **Addiction Medicine Fellowship (AMF) Program:** The AMF Program seeks to increase the number of board-certified addiction medicine and addiction psychiatry specialists trained in providing inter-professional behavioral health services, including OUD and SUD prevention, treatment, and recovery services, in underserved, community-based settings The AMF Program is designed to foster robust community-based clinical training of addiction medicine or addiction psychiatry physicians in underserved, community-based settings who see patients at various access points of care and provide addiction prevention, treatment, and recovery services across health care sectors.

Question 3(b). What more do you need from Congress to support these efforts?.

Answer 3(b). HRSA continues to prioritize and grow our provider resiliency efforts to retain and maintain a strong health care workforce To ensure success in our efforts, we hope to continue to have regular communication, collaboration and support from Congress.

Question 4. Maternal Mental Health: Studies have found that approximately 800,000 mothers are affected by maternal mental health conditions each year, and yet 75 percent will go entirely untreated In Alaska, only 1 in 4 pregnant and postpartum women impacted by maternal mental health conditions is diagnosed and receives the treatment needed I recently worked with Senators Gillibrand, Capito, and Baldwin on a bill, the Into the Light for Maternal Mental Health Act, that focuses on supporting mothers mentally as well as physically, so that they can better support their babies The bill would support maternal mental health specific training and resources for health care professionals to identify and treat patients at-risk for or suffering from maternal mental health conditions.

Question 4(a). How is HRSA working to ensure pregnant and postpartum mothers are screened, supported, and treated for maternal mental health?

Answer 4(a). HRSA supports several programs that are focused on maternal mental health The **Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program (MDRBD)** gives providers the tools to integrate behavioral health care into routine maternal health care through teleconsultation services that help local providers bridge the gap in access to psychiatrists, especially perinatal psychiatrists With teleconsultation support, maternal health care providers are able to receive real-time psychiatric consultations and care coordination support

In addition, community-based maternal health providers are offered training on how to screen for, assess, treat, and refer pregnant and postpartum individuals for mental health and substance use disorders.

HRSA has received tremendous interest in the MDRDB program—demonstrating the acute need for it—but is only able, with current resources, to fund approximately a quarter of applicants The seven states that currently receive awards are Florida, Kansas, Louisiana, Montana, North Carolina, Rhode Island, and Vermont.

HRSA will also launch the **National Maternal Mental Health Hotline** later this year The Hotline will be available 24/7 to provide free, confidential support, resources and referrals to any pregnant and postpartum mothers facing mental health challenges and their loved ones Those in need can contact the Hotline via phone or text and will receive culturally appropriate support from counselors in English or Spanish; interpreter services are also available in 60 languages Parents and families who contact the Hotline will speak to licensed or certified counselors The Hotline's counselors also are trained in providing trauma-informed support.

HRSA additionally supports the **Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)**. This program supports voluntary, evidence-based home visiting services for pregnant people and parents with young children up to kindergarten entry living in communities at risk for poor maternal and child health outcomes Home visiting programs support maternal mental health by screening for maternal depression and connecting caregivers to needed treatment and services The MIECHV Program also funds a Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) that supports home visiting programs to use quality improvement strategies to better screen for and address maternal depression and intimate partner violence, and disseminate best practices widely.

The **Healthy Start Program** supports community-based strategies to reduce the rate of infant mortality, improve perinatal outcomes, and address disparities in perinatal health Healthy Start grantees provide screening and referral to services for depression, substance use and interpersonal violence Grantees support client and family behavioral health, address toxic stress, and employ trauma-informed care Grantees also address maternal depression through health education and support groups to promote mental wellness for mothers Currently, there are 35 States, the District of Columbia, and Puerto Rico which have a Healthy Start site.

Finally, HRSA's **Title V Maternal and Child Health Services Block Grant (Title V) Program** is a Federal-state partnership that awards formula grants to 59 States and jurisdictions to address the health needs of mothers, infants, and children, including children with special health care needs The purpose of the Maternal and Child Health Block Grant is to improve the health of the Nation's mothers, children, and families through Federal/state partnerships that provide each state with needed flexibility to respond to its unique maternal and child population needs An estimated 60 million pregnant women and children benefited from a

service supported by the Title V MCH Block Grant in fiscal year 2020 While states have always used their Block Grant to address mental and behavioral health needs, there was a dramatic increase in the number of states identifying it as a priority need in the past two reporting years—from 36 States in 2015 to 51 States and territories in 2020 Access to behavioral health care, including integration of behavioral health and primary care, is a major priority for states and territories Title V strategies for women and maternal health include promoting screening and referral for mental health and substance use among pregnant women, training providers on maternal mental health needs, and continuing work to address opioid and other substance use and its impact on women, infants, and families.

Question 5. Medication Assisted Treatment: The Anchorage Daily News reported recently that the U.S. has passed a "never-before-seen milestone" in losing more than 100,000 Americans to drug overdoses in a year Sadly, the CDC reports that the number of drug overdoses in Alaska rose by more than 45 percent as of June 2021 That's more than double the rate of increase for the United States.

One treatment that we know is critical to stemming the overdose crisis is medication that prevent withdrawal symptoms and stem opioid cravings These medications, like buprenorphine, can cut the risk of overdose death in half when a person starts taking them But, outdated Federal laws and stigma are restricting access to these life-saving medications I have introduced the Mainstreaming Addiction Treatment Act with my colleague, Senator Hassan, to help more Americans have access to life-saving medication and eliminate burdensome Federal red tape.

Question 5(a). How is the administration supporting expanding access to medications to treat substance use disorder so they reach all communities in need?

Answer 5. Health centers remain at the forefront in addressing behavioral health issues nationwide, as many health centers offer a wide range of integrated primary care, mental health, and substance use disorder services including but not limited to counseling and psychiatry, Screening, Brief Intervention, and Referral to Treatment (SBIRT), medication-assisted treatment, and recovery support HRSA provides all health centers with access to technical assistance resources to promote the integration of behavioral health/substance use disorder services in primary care and support improvements in access to SBIRT, MAT, and tele-behavioral health services Nearly 8,400 health center providers were eligible to prescribe MAT in 2020.

HRSA also provides payments to physicians and practitioners to furnish opioid use disorder treatment services through its implementation of Section 6083 of the SUPPORT for Patients and Communities Act (SUPPORT Act), which authorizes payments to federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for completing training and obtaining a DATA 2000 waiver The payments were intended to increase the availability of treatment by incentivizing FQHCs and RHCs to have their providers receive the training that was originally required to receive a waiver

to prescribe medication assisted treatment Though providers are no longer required to take the training in order to prescribe medication assisted treatment, HRSA has obligated the $6 million appropriated for FQHCs and continues to promote the program for payments to Rural Health Clinics.

HRSA has also increased the availability of substance use disorder treatment through targeted health workforce programs The National Health Service Corps (NHSC) Substance Use Disorder Workforce Loan Repayment Program provides loan repayment assistance to medical, nursing, and behavioral health clinicians in exchange for a service commitment to provide direct services at substance use treatment facilities in underserved areas These sites include outpatient services at opioid treatment programs and office-based opioid treatment facilities Additionally, the NHSC Rural Community Loan Repayment Program has made loan repayment awards in coordination with the Rural Communities Opioid Response Program initiative within the Federal Office of Rural Health Policy to provide evidence-based substance use treatment, assist in recovery, and to prevent overdose deaths across the Nation.

The Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP) recruits and retains medical, nursing, behavioral/mental health clinicians and paraprofessionals who provide direct treatment or recovery support of patients with or in recovery from a substance use disorder STAR LRP participants must provide services in either a county (or a municipality, if not contained within any county) where the mean drug overdose death rate per 100,000 people over the past 3 years exceeds the national average, or in a Health Professional Shortage Area designated for Mental Health.

HRSA's Primary Care Training and Enhancement Program further supports efforts to expand access to medications for SUD treatment Specifically, this program funds innovative training programs that integrate behavioral health care into primary care, particularly in rural and underserved settings with a special emphasis on mental health and the treatment of opioid use disorder Additionally, the Residency Training in Primary Care Program requires that residents in the program are provided with dedicated clinical experiences with at least one provider with a DATA–2000 waiver who provides MAT services for patients with opioid use disorder.

HRSA's Addiction Medicine Fellowship, Graduate Psychology Education and Rural Communities Opioid Response Programs also contribute to expanding access to SUD medications and treatments across a variety of communities in need The Addiction Medicine Fellowship Program supports the clinical training of addiction medicine or addiction psychiatry physicians in underserved, community-based settings The Graduate Psychology Education Program supports innovative doctoral-level health psychology programs that foster an inter-professional approach to providing behavioral health and substance use prevention and treatment services in high need and high demand areas through academic and community partnerships The Rural Communities Opioid Response Program aims to reduce the morbidity and mortality associated with SUD, including

opioid use disorder, in high need rural communities by establishing, expanding, and sustaining prevention, treatment, and recovery services at the county, state, and/or regional levels.

Question 6. Infant and Early Childhood Mental Health: The first years of life are an incredible opportunity to promote positive mental health for babies, and health and well-being during this time period affects future learning, behavior and health.

Question 6(a). Have you seen a marked impact by Federal investment in infant and early childhood mental health (IECMH)?

Answer 6. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) supports voluntary, evidence-based home visiting services for pregnant people and parents with young children up to kindergarten entry living in communities at risk for poor maternal and child health outcomes The program is built on decades of scientific research, which shows that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life, improve child and family outcomes like maternal and newborn health MIECHV programs support Infant and Early Childhood Mental Health (IECMH) Consultation, which pairs a mental health specialist with a home visitor to help them strengthen and support the healthy social and emotional development of children ages 0—5 HRSA provides technical assistance to state awardees and local programs to expand use of IECMH in home visiting Federal investment in IECMH improves the capacity of home visiting programs to meet families' needs and promote healthy child development Authorization and funding for the MIECHV program expires at the conclusion of fiscal year 2022 without further legislative action.

Suicide Screening in the Emergency Department

Question 7. A recent CDC report on emergency department visits for people aged 12–25 found an over 50 percent increase visits for suspected suicide attempts during early 2021 This underscores the devastating mental health impact of the pandemic on our youth and highlights yet another way that COVID–19 has strained our hospitals and medical staff.

I introduced a bill, the Effective Suicide Screening and Assessment in the Emergency Department Act, to improve the screening and treatment of patients in hospital emergency departments who are at high risk for suicide It will make sure that we can better identify our most vulnerable mental health patients so they do not slip through the cracks when they are treated in hospitals, and make sure hospitals have the resources they need to provide these critical services.

Question 7(a). What is the need for improved suicide screening protocols in the Nation's emergency rooms?

Question 7(b). Do you support efforts to bolster the resources available to emergency rooms so they can enhance their screening for high-risk suicide patients?

Answer 7. The HRSA Emergency Medical Services for Children (EMSC) Program's Pediatric Emergency Care Applied Research Network (PECARN) examined suicide among adolescents to help identify those most at-risk Although the second leading cause of

death among youth, only a fraction of adolescents who die of suicide have ever been treated for a mental or behavioral health problem [2] As many at-risk adolescents remain unidentified, emergency departments are particularly suited for suicide risk screening PECARN investigators implemented an observational study to validate the Computerized Adaptive Screen for Suicidal Youth (CASSY) survey which predicts adolescent suicidality using a 1–2 minute screening strategy Investigators found that the CASSY correctly identified 824 percent of youth who went on to attempt suicide in the 3-months following screening The results suggest this screener could serve as an easy-to-use way for providers to detect youth suicide risk in emergency department settings [3] Though this looks to be a promising screening tool for use in emergency departments, the study suggests that it needs further testing for validity and reliability HRSA continues to support efforts to improve suicide screening protocols and bolster the resources available in emergency departments to prevent youth suicide.

FASD

Question 8. During COVID, we have seen a sharp rise in substance misuse specifically alcohol, the most widely used and misused substance Unfortunately, a landmark NIH study in 2018 established that 1 in 20 school-aged children are affected by fetal alcohol spectrum disorders—FASD Due to its significance and status as an overlooked disability that includes debilitating stigma, I introduced S 2238, the FASD Respect Act My legislation establishes common standards of care and increases the capacity to manage FASD in medical and mental health settings How can we address the social and environmental factors that contribute to prenatal alcohol exposure and reduce the traumas FASD creates for individuals and families?

Question 8(a). What steps are being taken by the administration to provide more education and training on FASD? How can stigma be lessened for individuals living with behavioral health conditions, like FASD?

Answer 8. HRSA supports the Supporting Fetal Alcohol Spectrum Disorders (FASD) Screening & Intervention Program, called the SAFEST Choice Learning Collaborative This program trains primary care providers with the aim to reduce the incidence of prenatal alcohol exposure, and improve developmental outcomes in children with suspected or diagnosed FASDs This program reaches providers in states, territories, tribes, or communities that have high rates of binge drinking among pregnant women, especially in rural areas The SAFEST Choice program successfully recruited providers from community health centers to participate in the first cohort, including 10 maternal health practices and 12 pediatric practices from seven states: IA, MA, ME, MI, MN, RI, SD Five of the 22 practices are in tribal health clinics and several other prac-

[2] King CA, Brent D, Grupp-Phelan J, Gibbons R, etal (2021) Prospective Development and Validation of the Computerized Adaptive Screen for Suicidal Youth Pediatric Emergency Care Applied Research Network JAMA Psychiatry 2021 May 1;78(5):540–549

[3] King CA, Grupp-Phelan J, Brent D, etal (2019) Predicting 3-month risk for adolescent suicide attempts among pediatric emergency department patients J Child Psychol Psychiatry 2019 Oct;60(10):1055–1064 doi: 101111/jcpp13087 Epub 2019 Jul 21.

tices serve tribal communities SAFEST Choice offers a range of technical assistance to providers such as strategies to improve practice, change systems including quality improvement approaches, and identify and access community resources Provider trainings include a focus on reducing stigma and bias

SENATOR BRAUN

Senior caregivers working across assisted living and memory care have been instrumental in successfully mitigating the spread of COVID–19 among the most vulnerable populations, even without Federal relief Nearly half of the 30,000 seniors in assisted living in Indiana have Alzheimer's or dementia, which created complex challenges for their caregivers during the pandemic Assisted living and memory care communities continue to be proven effective in addressing the social determinants of senior health: proper nutrition, housing, and most importantly, social interaction.

Question 1. Administrator Johnson, how does HRSA plan to engage assisted living and memory care communities as important stakeholders as alarming data finds the need for 14 million additional senior caregivers to keep pace with America's rapidly aging population, which shows 10,000 individuals turning 65 every day?

Answer 1. HRSA's Geriatrics Workforce Enhancement Program improves health care for older adults by developing a health care workforce to provide value-based care that improves health outcomes for older adults by integrating geriatrics and primary care delivery sites/systems The Program maximizes patient and family engagement in health care decisions and provides training focusing on inter-professional and team-based care across the educational continuum (students, faculty, providers, direct service workers, patients, families, and lay and family caregivers).

An essential component of the program is developing academic-primary care-community-based partnerships to address gaps in health care for older adults and transforming clinical training environments into integrated geriatrics and primary care sites/systems to become age-friendly health systems and dementia-friendly communities

SENATOR TUBERVILLE

Question 1. we know that one in four Americans reports having been a victim of crime in the past 10 years, and half of those were victims of a violent crime Most report receiving no help in the aftermath Police, corrections leaders, and the courts agree that untreated mental health or co-occurring substance abuse disorders are core drivers of the cycle of crime and that they lack the infrastructure to respond appropriately.

Question 1(a). What do you see as the individual and societal impacts of untreated trauma as it relates to mental health and substance use disorder?

Answer 1. Untreated trauma can result in an individual or a community experiencing emotional challenges including suicidal ideation, depression, anxiety, increased substance use, an inability to thrive in interpersonal relationships and more The impact of

trauma can be subtle, insidious, and destructive[4] There is, unfortunately, an inaccurate perception that mental illness is a cause of violent crime, wherein actuality, people with mental illness are more likely to be victims of violent crime than perpetrators[5] Data implies there is a benefit of trauma informed care regardless of an individual's mental health status

HRSA is working to increase not only the pipeline of mental and behavioral health care professionals but also to increase the access and touch points for mental and behavioral health services in the community through community health workers, and other professionals.

Question 2. Federal data shows that 37 percent of people sentenced to prison, and 44 percent of people arrested and jailed, have experienced a mental health issue At the same time, we know that an estimated 1 in 10 police service calls are responding to an untreated mental health issue Across the country, we've seen community-based programs that seek to divert individuals experiencing mental health issues, direct individuals to treatment and resources, and do so in a way so the police department does not have to be involved.

Question 2(a). What is the Federal Government doing to ensure that mental health emergencies are being responded to appropriately, early on, before a treatable illness becomes a safety issue?

Answer 2. The HRSA Health Center Program supports mental health and substance use disorder services in primary care settings These investments support health centers to integrate mental health/substance use disorder services into the primary care setting to better address the significant unmet need for these services in their communities.

RESPONSE BY JOSHUA A. GORDON TO QUESTIONS FROM SENATOR CASEY, SENATOR ROSEN, SENATOR HICKENLOOPER, SENATOR MURKOWSKI, SENATOR SCOTT, AND SENATOR TUBERVILLE

SENATOR CASEY

Question 1. Postsecondary age youth are often in need of greater access to mental health resources than the general population With 2 years of the pandemic causing social isolation and greater levels of stress and anxiety, their needs are likely even greater Prior to the pandemic, the number of postsecondary students using their college counseling centers increased by 30–40 percent, whereas enrollment had only increased by 5 percent How the pandemic has affected the need for additional mental health services has yet to be determined as we do not yet have systematic, quality data on the mental health impacts of the pandemic on postsecondary students My Higher Education Mental Health Act would establish a national Commission to study the mental health concerns facing

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[4] Understanding the Impact of Trauma—Trauma-Informed Care in Behavioral Health Services—NCBI Bookshelf (nihgov)

[5] Desmarais SL, Van Dorn RA, Johnson KL, Grimm KJ, Douglas KS, Swartz MS Community violence perpetration and victimization among adults with mental illnesses Am J Public Health 2014 Dec;104(12):2342–9 doi: 102105/AJPH2013301680 Epub 2014 Feb 13 PMID: 24524530; PMCID: PMC4133297.

students at institutes of higher education and report on services available to students with mental health disabilities The bill also charges the Commission to provide detailed recommendations to improve the mental health services available to students at institutes of higher education.

Question 1(a). If passed, what data would you recommend be collected by the Commission and do you have preliminary recommendations the Commission should consider to assist institutes of higher education to better serve the mental health needs of young adults entering postsecondary education?

Answer 1. The National Institute of Mental Health (NIMH) supports research aiming to develop and test sustainable approaches to college-based mental health interventions and services NIMH-supported researchers are evaluating the use of a mobile prevention and intervention platform that includes population-level screening for college students and tailored services to address common mental disorders (clinical anxiety, depression, eating disorders) Additional NIMH-funded investigators are testing the effectiveness and implementation of two separate prevention and early intervention strategies for eating disorders among college populations, and other NIMH-funded researchers are aiming to test the effectiveness of sequential suicide prevention interventions for college students Another team of NIMH-supported researchers are examining changes in mental health over the course of the undergraduate experience through a longitudinal study.

The neurodiversity of young adults entering postsecondary education, including the diversity of needs experienced by adolescents and young adults with autism spectrum disorder (ASD), is also important to consider NIMH recently supported researchers examining the Stepped Transition in Education Program for Students with ASD (STEPS), a multipronged approach to prepare students with autism for the transition to post-secondary education The study demonstrated that STEPS helped to increase participants' college readiness and decrease depressive symptoms over the transition period. [1], [2]

Youth mental health is a priority for the National Institutes of Health (NIH) Both NIMH and the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) prioritize research focused on social determinants of health and the impact of health disparities on intervention efforts during adolescence NIMH prioritizes research to understand the mechanisms by which social determinants of health drive risk of, and resilience to, the development of mental illnesses NICHD supports research to determine how exposure to social and environmental factors such as diet and nutrition, technology and digital media use, sleep habits, and physical activity affect neurodevelopment and health outcomes Advances in our understanding of the mechanisms by which these social and environmental factors impact mental health could lead to improved interventions for youth with, or at high risk for, mental illnesses—including interventions delivered through non-specialty settings such as colleges and universities.

[1] White et al (2021), *pubmedncbinlmnihgov/31609666/*
[2] Capriola-Hall et al (2021), *pubmedncbinlmnihgov/32468396/*.

SENATOR ROSEN

Question 1. Over the last 2 years, we saw the devastating impact of social isolation on seniors' mental health As we look back at measures taken to protect the physical health of the most vulnerable during the pandemic, we also must take to heart the lessons learned for how to do better in the future One area of particular concern is how many seniors were not allowed a family member or caregiver to be with them during inpatient hospital stays—even when dealing with anxiety, depression, temporary psychosis, or delirium—regardless of whether their caregiver was vaccinated or willing to use protective gear AARP also has noted how critical it is to find a balance between protecting patient health and how the absence of caregivers puts additional pressure on clinical staff.

Question 1(a). Dr. Gordon, how would you recommend Federal guidance be adjusted in the future to best protect both the physical and mental health of seniors, especially when they are particularly vulnerable during hospital stays?

Answer 1. NIH continuously strives to build a strong foundation of evidence to inform Federal guidance, including through research on evidence-based practices to optimally protect the physical and mental health of older adults across multiple care settings To this end, the NIMH supports interdisciplinary research to improve diagnosis, treatment, and prevention of mental illnesses in older adults NIMH recognizes the ongoing need for research to develop and test strategies that speed dissemination, adoption, and implementation of evidence-based interventions, and the importance of sustaining these practices over time For example, universal screening for suicidal thoughts and behaviors in older adults is shown to double the rate of suicide risk detection [3] While effective evidence-based practices like these could improve diagnosis, treatment, and prevention of mental illnesses in older adults, more NIH research is needed to inform broader Federal guidance.

NIMH supports the Partnership for the Implementation Science in Geriatric Mental Health (PRISM) Hub, which aims to establish a collaborative network of institutions and individuals to carry out and utilize research that answers policy-relevant questions related to reducing the treatment gap for older adults with mental health problems Recently, and historically, NIMH has supported studies related to reducing suicidal ideation in older adults with depression, including research on person-centered approaches for understanding suicidal ideation and behaviors among nursing home residents and research on reducing suicidal ideation and depressive symptoms in depressed older primary care patients [4, 5, 6]

NIMH Director Dr. Joshua Gordon has highlighted the need to further examine the impact of social isolation and loneliness among older adults and the impact the COVID–19 pandemic might have on this vulnerable population [7] NIMH also encourages research that examines novel treatment delivery paradigms that might

[3] Betz et al (2016), *pubmedncbinlmnihgov/27596110/*.
[4] *reporternihgov/project-details/10163269*
[5] Bruce et al (2004), *pubmedncbinlmnihgov/14996777/*
[6] Untzer et al (2006), *pubmedncbinlmnihgov/17038073/*.
[7] Gordon and Evans (2021), *pubmedncbinlmnihgov/35132392/*

reach underserved populations, more innovative approaches to the ways in which care is delivered, and improved understanding of the negative impact of social isolation and loneliness on the mental health of older adults relatedly, in December 2021, NIMH issued a pair of calls for applications to examine the role of social disconnection and risk of suicide in late life. [8], [9]

NIMH has also supported research to examine the impact of telehealth approaches to the provision of treatment for isolated and homebound elders Further, NIMH highlights a commentary discussing potential mechanisms of risk and resilience among older adults at risk for the development of prolonged grief disorder. [10]

In addition, other NIH Institutes and Centers, including the National Institute on Aging (NIA), directly support research which informs policies related to older adults' health and well-being, particularly in the context of the COVID–19 pandemic and associated social isolation and loneliness NIA has a robust history of promoting research to help understand how we can reduce loneliness and enhance social connection among older adults to improve physical and mental health outcomes The pandemic underscored that rigorous research on the health effects of social isolation and loneliness—and the development of interventions to prevent or address these conditions—are needed now more than ever [11] To this end, NIA supports the following:

- Studies examining how COVID–19-associated social isolation and loneliness impact the health and well-being of midlife and older adult populations. [12]
- Research on the biopsychosocial aspects of social connectedness and isolation and their association with health, well-being, illness, and recovery, via two funding opportunity announcements. [13], [14]
- Observational studies as well as intervention research to identify quality of life and health outcomes for people with dementia, with particular interest in those who are socially isolated. [15]
- An NIA-hosted Facebook Live Q&A event on social isolation and loneliness, [16] in which NIA experts shared insights on how social isolation and loneliness affect health, and how to stay connected during and after the COVID–19 pandemic.
- A Focus on Aging: Federal Partners' Webinar on social isolation and loneliness, [17] conducted by NIA in partnership with the Administration for Community Living, the

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[8] *grantsnihgov/grants/guide/rfa-files/RFA-MH–22–135html*
[9] *grantsnihgov/grants/guide/rfa-files/RFA-MH–22–136html.*
[10] Goveas and Shear (2020), *pubmedncbinlmnihgov/32709542/.*
[11] Necka (2021), *wwwnianihgov/research/blog/2021/06/after-covid-research-social-isolation-and-loneliness-needed-more-ever*
[12] *grantsnihgov/grants/guide/notice-files/NOT-AG–21–015html.*
[13] *grantsnihgov/grants/guide/pa-files/PAR–21–144html*
[14] *grantsnihgov/grants/guide/pa-files/PAR–21–145html.*
[15] *grantsnihgov/grants/guide/notice-files/NOT-AG–18–056html.*
[16] *youtube/WBJclABlg—U.*
[17] *youtube/tKOAO09PsFU*

Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

In concert with the efforts above, NIA supports research to understand the effect of the COVID–19 pandemic on older adults' health and well-being, particularly as a result of shifting patterns of social contact Researchers found that greater levels of concern about becoming infected with SARS-CoV–2, the virus which causes COVID–19, were associated with greater loneliness in older adults [18] Researchers showed that weekly in-person contact fell substantially during the pandemic among older adults in both residential care and community settings This effect was particularly pronounced among older adults living in residential care facilities and was not counterbalanced by an increase in video contact for these individuals [19] In addition, older adults with cognitive impairment living alone during the pandemic reported significant distress, including isolation, fear, confusion, and variable access to essential services [20] In addition to experiencing these effects, older adults may also be relatively resilient to the negative psychosocial effects of the COVID–19 pandemic, showing lower levels of stress, better psychosocial functioning, and more effective coping behavior than younger adults. [21]

Question 1(b). Dr. Gordon, can you please speak to how the presence of a trusted caregiver impacts the well-being of vulnerable seniors when they are in an unfamiliar setting?

Answer 1(b). NIA conducts research to better understand the pivotal role that caregivers play in providing support to older adults Older adults, particularly those living with chronic disease, disability, or cognitive impairment or dementia, may be vulnerable in unfamiliar settings and especially reliant upon a caregiver Below are several examples of NIA-and other NIH-supported research which indicate the potential significance of these trusted caregivers.

In the context of COVID–19, the presence of a trusted caregiver may be indispensable given what is known about the presentation of COVID–19 in older adults For example, NIA-funded researchers showed that older adults may present with COVID–19 in an atypical manner, showing altered mental status or functional decline, and that an atypical presentation may lead to less aggressive care [22] Similarly, NIA-funded researchers showed that 28 percent of older adults with COVID–19 present with delirium, and 37 percent of these older adults with delirium did not show typical COVID–19 symptoms, such as fever or cough [23] Delirium in this context was also associated with an increased risk of death In such situations, the presence of a trusted caregiver might enhance recognition of these atypical COVID–19 symptoms (eg, altered mental status/delirium, functional decline) in an older patient, particularly in an emergency room, hospital, or other potentially novel and un-

[18] Polenick et al (2021), *pubmedncbinlmnihgov/33641513/*
[19] Freedman et al (2021), *pubmedncbinlmnihgov/34529083/*
[20] Portacolone et al (2021), *pubmedncbinlmnihgov/33404634/*
[21] Minahan et al (2021), *pubmedncbinlmnihgov/33320191/*.
[22] Marziliano et al (2022), *pubmedncbinlmnihgov/34279628/*
[23] Kennedy et al (2020), *pubmedncbinlmnihgov/33211114/*.

familiar setting, and could enhance the likelihood of appropriate intervention.

In addition, the COVID–19 pandemic led to restrictions regarding in-person visits in residential care settings, thereby limiting interactions between older adults and their families and trusted caregivers NIA-supported researchers examined communication methods which replaced face-to-face visits with the onset of the COVID–19 crisis and their impact on the emotional well-being of long-term care residents These researchers showed that the ability to communicate through familiar and synchronous modes of communication (eg, phone calls, email) improved residents' emotional well-being, whereas less familiar and asynchronous methods of communication (eg, letters delivered by a staff member) negatively affected their emotional well-being. [24]

NIH's Inclusion Across the Lifespan initiative, [25] which seeks to increase the recruitment and retention of older adults and children in NIH research, has identified a need to engage caregivers in older adults' care and well-being This recommendation stems from the NIA-supported "5Ts" framework, [26] in which a team-based approach, incorporating geriatric care professionals, as well as family members, caregivers, and community partners, is posited to support the needs and well-being of older adults in clinical research settings, including those related to studies of COVID–19.

SENATOR HICKENLOOPER

Across the Nation, suicide is the second leading cause of death for children and young adults In Colorado, it is number 1.

The pandemic has exacerbated mental health challenges for kids, including increased isolation and distance from social and emotional support.

I was proud to vote for the Omnibus bill, which included more than $100 million for the Department of Education to increase mental health services in schools.

Question 1. What does the data indicate about the benefit of school interventions and support for students struggling with mental health needs?

Answer 1. Youth have been disproportionately impacted by the pandemic; globally, in the first year of the pandemic one in four children reported elevated depression and one in five reported elevated anxiety [27] Numerous causes likely contributed to these mental health impacts, including loss of caregivers and family members, fear of being infected, loss of family income, and social isolation.

For more than one in three adolescents, schools provide their primary access to mental health care [28] School-based health centers (SBHCs) have been recommended by the American Academy of Pediatrics as a safety net care delivery model for youth who do not

[24] Monin et al (2020), *pubmedncbinlmnihgov/33004262/*.
[25] *grantsnihgov/policy/inclusion/lifespanhtm*
[26] Bowling et al (2019), *pubmedncbinlmnihgov/30693952/*
[27] Racine et al (2021), *pubmedncbinlmnihgov/34369987/*.
[28] Hertz and Barrios (2021), *pubmedncbinlmnihgov/33172840/*

have access to a consistent source of health care [29] However, more research is needed to investigate the effectiveness of SBHCs To this end, NIMH issued a funding opportunity announcement to support research on the delivery, implementation, and sustainability of evidence-based mental health interventions provided by SBHCs that also addresses health disparities and advances health equity among underserved populations. [30]

School settings also present a critical opportunity for identifying risk and preventing youth suicide NIMH recently hosted a webinar, titled "School-based Suicide Prevention: Promising Approaches and Opportunities for Research," in which presenters discussed preliminary research efforts and challenges, as well as ways to overcome common barriers to implementing suicide prevention in schools, including data collection and evaluation [31] NIMH-supported investigators are testing a universal school-based suicide prevention program, and other NIMH-supported researchers are examining school-based interventions to prevent depression in adolescents with attention-deficit hyperactivity disorder (ADHD).

SENATOR MURKOWSKI

Medication Assisted Treatment

Question 1. The Anchorage Daily News reported recently that the U.S. has passed a "never-before-seen milestone" in losing more than 100,000 Americans to drug overdoses in a year Sadly, the CDC reports that the number of drug overdoses in Alaska rose by more than 45 percent as of June 2021 That's more than double the rate of increase for the United States.

One treatment that we know is critical to stemming the overdose crisis is medication that prevent withdrawal symptoms and stem opioid cravings These medications, like buprenorphine, can cut the risk of overdose death in half when a person starts taking them But, outdated Federal laws and stigma are restricting access to these life-saving medications I have introduced the Mainstreaming Addiction Treatment Act with my colleague, Senator Hassan, to help more Americans have access to life-saving medication and eliminate burdensome Federal red tape.

Question 1(a). How is the administration supporting expanding access to medications to treat substance use disorder so they reach all communities in need?

Answer 1(a). Methadone, buprenorphine, and naltrexone are effective for the treatment of opioid use disorder (OUD) and the prevention of overdose deaths, but they are highly underutilized The Department of Health and Human Services (HHS) released the Overdose Prevention Strategy (OPS) in October 2021 to expand access to substance use prevention, treatment, harm reduction, and recovery support services. [32]

To identify best approaches to expand access to and speed the uptake of medications for OUD (MOUD) in diverse settings and di-

[29] Kjolhede et al (2021), *pubmedncbinlmnihgov/34544844/*
[30] *grantsnihgov/grants/guide/pa-files/PAR–21–287html*.
[31] *wwwnimhnihgov/news/events/2022/school-based-suicide-prevention-promising-approaches-and-opportunities-for-research*
[32] *wwwhhsgov/overdose-prevention/*.

verse populations, the National Institute on Drug Abuse (NIDA) funds implementation research in healthcare settings, justice settings, and community settings through the Clinical Trials Network,[33] the Justice Community Opioid Innovation Network (JCOIN),[34] and the HEALing Communities StudySM[35] These studies are evaluating strategies for expanding OUD screening and treatment into emergency departments, primary care clinics, infectious disease programs, rural and American Indian/Alaska Native communities, and criminal justice settings.

NIDA also funds research on the provider-and systems-level barriers and facilitators to adoption of MOUD, particularly among people experiencing homelessness, women, and racial/ethnic minority groups, as well as testing new strategies to expand MOUD access to pregnant people, rural areas, and justice-involved populations.

During the COVID–19 pandemic, people with OUD can now obtain a 14–28 days' take-home supply of methadone, which may particularly benefit people who live in rural areas or who otherwise have had trouble accessing treatment in the past NIDA-funded research is examining clinicians' and patients' experiences with telehealth services for the treatment of OUD and studying the implementation and outcomes of changes in OUD health services delivery policies This research will be critical for determining how to optimize access to effective MOUD through flexibilities in the provision of MOUD.

Question 2. Infant and Early Childhood Mental Health: The first years of life are an incredible opportunity to promote positive mental health for babies, and health and well-being during this time period affects future learning, behavior and health.

Question 2(a). Have you seen a marked impact by Federal investment in infant and early childhood mental health (IECMH)?

Answer 2. NIMH supports biomedical research to understand the mechanisms that underlie neurodevelopment, and how typical and atypical development affects future learning, behavior, and mental health Novel biomarkers and behavioral indicators hold promise for identifying at the earliest possible point who is at risk, when development or aging is going off course, or which preventive and treatment interventions will produce the best outcomes for which individuals To identify promising targets for new interventions, studies of risk factors—including those related to genetics, experience, and the environment—help provide clues to how mental disorders and developmental disorders emerge.

NIMH-supported investigators found that early life stress, for example, can cause alterations in neural circuitry and impair social interactions later in life[36] Other NIH-funded studies are examining measurements of sleep and brain activity related to mental health in children In addition, as a result of the growing focus on mental health during the COVID–19 pandemic, NIMH is supporting research on COVID–19 mother and baby outcomes for brain and behavior function, as well as neurobehavioral consequences of

[33] *nidanihgov/about-nida/organization/cctn/clinical-trials-network-ctn*
[34] *healnihgov/research/research-to-practice/jcoin*
[35] *healnihgov/research/research-to-practice/healing-communities*.
[36] Opendak et al (2021), *pubmedncbinlmnihgov/34706218/*

COVID–19-related stressors on maternal mental health and infant and child neurodevelopment [37, 38]

NIMH is committed to supporting research to identify autism spectrum disorder (ASD) at the earliest age possible to enable early intervention and better long-term outcomes NIMH-funded researchers have demonstrated that differences in brain development and function (eg, eye gaze patterns, brain growth, and how different parts of the brain develop connections), as well as some subtle behavioral differences, emerge in the first months of life, before ASD symptoms begin to appear [39, 40] Building on these findings, NIMH is partnering with other NIH Institutes to support researchers developing and validating new screening methods for ASD that can be used in the first year of life [41] For example, NIMH and the NICHD supported researchers developed an eye-tracking app that successfully distinguished toddlers diagnosed with ASD from typically developing toddlers [42] Study results indicate that an app-based approach could be used to screen infants and toddlers for ASD and refer them for early intervention when likelihood for treatment success is greatest (ie, at younger ages) In addition, a network of NIMH-funded researchers has tested different models of service engagement and coordination to determine how best to eliminate disparities in diagnosis, and how to diagnose children within underserved populations at earlier ages [43, 44]

In addition, NICHD is committed to supporting research to identify and examine the psychological and behavioral factors and processes that influence social/emotional development and expression in individuals with intellectual and developmental disabilities NICHD-funded researchers recently examined the role of behavioral and mindfulness-based interventions in promoting parent and child well-being in families with children demonstrating intellectual and developmental disabilities. [45]

Question 3. Suicide Screening in the Emergency Department: A recent CDC report on emergency department visits for people age 12–25 found an over 50 percent increase visits for suspected suicide attempts during early 2021 This underscores the devastating mental health impact of the pandemic on our youth and highlights yet another way that COVID–19 has strained our hospitals and medical staff.

I introduced a bill, the Effective Suicide Screening and Assessment in the Emergency Department Act, to improve the screening and treatment of patients in hospital emergency departments who are at high risk for suicide It will make sure that we can better identify our most vulnerable mental health patients so they do not slip through the cracks when they are treated in hospitals, and

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[37] Shuffrey et al (2022), *pubmedncbinlmnihgov/34982107/*
[38] *reporternihgov/project-details/10414939*.
[39] Hazlett et al (2017), *pubmedncbinlmnihgov/28202961/*
[40] Stallworthy et al (2022), *pubmedncbinlmnihgov/33965519/*
[41] *wwwnimhnihgov/news/science-news/2019/nih-awards-funding-for-early autism-screening*
[42] *wwwnimhnihgov/news/science-news/2021/media-advisory-prototype-app-for-mobile-devices-could-screen-children-at-risk-for-autism-spectrum-disorder*
[43] Sheldrick et al (2022), *pubmedncbinlmnihgov/34982099/*
[44] Pierce et al (2019), *pubmedncbinlmnihgov/31034004/*.
[45] McIntyre (2020), *pubmedncbinlmnihgov/32936889/*.

make sure hospitals have the resources they need to provide these critical services.

Question 3(a). What is the need for improved suicide screening protocols in the Nation's emergency rooms?

Answer 3. Developing suicide risk screening tools and testing their effectiveness in real-world settings such as emergency departments (EDs) remains a high-priority research area for NIMH Approximately 80 percent of U.S. suicide decedents accessed health care services in the 12 months preceding their death, and nearly 30 percent had a health care visit in the week before suicide, demonstrating that health care systems can play a vital role in identifying individuals at risk and preventing suicide attempts. [46]

NIMH-funded researchers demonstrated that the use of brief screening tools in EDs can improve providers' ability to identify individuals at risk for suicidal behavior and refer them to treatment [47] As one example, the NIMH-funded ED Safety Assessment & Follow-up Evaluation (ED-SAFE) study found that universal screening of ED patients doubled the rate of risk detection (from 3 percent to 6 percent), and that ED-initiated interventions reduced subsequent suicidal behavior by 30 percent [48] Additionally, NIMH-funded researchers developed the Ask Suicide-Screening Questions tool—a very brief (four-question) screening instrument that was shown to identify risk for suicide in pediatric emergency departments and has now been adapted for use across multiple other settings and populations. [49], [50]

Question 3(b). Do you support efforts to bolster the resources available to emergency rooms so they can enhance their screening for high-risk suicide patients?

Answer 3(b). Since emergency departments and other health care settings have a critical role in identifying and providing preventive interventions for individuals at risk of suicide, it is important that these settings have the resources they need to implement effective screening tools and evidence-based preventive interventions NIMH remains committed to supporting research on developing and validating tools and interventions for use in such settings, and also on identifying innovative and sustainable service delivery models to ensure that such tools and interventions are widely available.

Question 4. FASD: During COVID, we have seen a sharp rise in substance misuse specifically alcohol, the most widely used and misused substance Unfortunately, a landmark NIH study in 2018 established that 1 in 20 school-aged children are affected by fetal alcohol spectrum disorders—FASD Due to its significance and status as an overlooked disability that includes debilitating stigma, I introduced S 2238, the FASD Respect Act My legislation establishes common standards of care and increases the capacity to manage FASD in medical and mental health settings.

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[46] Gordon, Avenevoli, and Pearson (2020), *pubmedncbinlmnihgov/32432690/*.

[47] *wwwnimhnihgov/news/science-news/2021/adaptive-screener-may-help-identify-youth-at-risk-of-suicide*

[48] Boudreaux et al (2016), *pubmedncbinlmnihgov/26654691/*

[49] Horowitz et al (2012), *pubmedncbinlmnihgov/23027429/*

[50] *wwwnimhnihgov/research/research-conducted-at-nimh/asq-toolkit-materials*.

Question 4(a). How can we address the social and environmental factors that contribute to prenatal alcohol exposure and reduce the traumas FASD creates for individuals and families?

Answer 4. The risk for use of alcohol during pregnancy is influenced by a range of environmental and social factors such as social isolation, living in environments where alcohol misuse is common and accepted, and having limited resources for prenatal care Stigma can serve as a barrier to pursuing and receiving care for alcohol misuse or an alcohol use disorder as part of prenatal care This is particularly concerning given recent research indicating that during 2018—2020, 135 percent of pregnant adults in the United States reported current drinking, 52 percent reported binge drinking, and those with no routine health care provider or with frequent mental distress were more likely to consume alcohol The risk of an individual being born with a fetal alcohol spectrum disorder (FASD) is influenced by factors such as the level and frequency of alcohol exposure during prenatal development and when during prenatal development alcohol exposure occurs Maternal factors that can also influence this risk include inadequate nutrition and smoking or other substance use, among other factors In addition to the physical, cognitive, and other challenges individuals with FASD may face, stigma can be a barrier to seeking and receiving the health, educational, and professional care and support they need.

Evidence-based prevention and treatment interventions, improved access to care, and substance misuse and mental health services integrated into routine health care are among the strategies needed to prevent and reduce prenatal alcohol exposure For children who are prenatally exposed to alcohol, widespread screening (including when screening for developmental disabilities), accurate diagnosis, early intervention, and access to support services are needed to improve the health and quality of life for individuals with FASD and their families.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the NIH, supports a broad research portfolio on the etiology, prevention, diagnosis, and treatment of FASD A major research program funded by NIAAA is the Collaborative Initiative on Fetal Alcohol Spectrum Disorders (CIFASD) with the goal to improve prevention of FASD, diagnosis of the full range of birth defects associated with prenatal alcohol exposure, and interventions for affected individuals One recent study includes the development and evaluation of mobile apps to give caregivers of children with FASD to help them learn new skills to manage their children's behavior and to provide adults with FASD tools to promote their own self-management and health advocacy goals.

To facilitate widespread screening and early diagnosis of FASD, CIFASD researchers have developed three-dimensional photography and computerized image analysis that can enhance the detection of a broad range of alcohol-induced facial characteristics in children with prenatal alcohol exposure This approach is being refined and could improve access to FASD diagnosis in underserved regions Other projects are developing screening tools that distinguish neurobehavioral features associated with FASD from other neurodevelopmental conditions NIAAA-supported studies also focus

on the use of novel methodologies such as 3D fetal ultrasound, blood-based biomarkers, and physiological measures to improve earlier identification of prenatal alcohol exposure and risk of neurodevelopmental delay among neonates, infants, or young children.

Developing culturally appropriate approaches for the prevention of alcohol-exposed pregnancies also continues to be an important focus of NIAAA research For example, an ongoing study is conducting a randomized clinical trial of a culturally appropriate prevention program delivered via a smartphone app for urban American Indian and Alaska Native women ages 16–20 This study is also examining the impact of the COVID–19 pandemic on risk of alcohol-exposed pregnancy NIAAA-supported research is also evaluating the effectiveness of nutritional supplementation, administered prenatally and during childhood, to mitigate the adverse impact of prenatal alcohol exposure Studies have shown that screening, brief intervention, and referral to treatment (SBIRT) approaches are a significant tool for addressing alcohol and other substance use in primary and prenatal care settings NIAAA will continue to encourage alcohol SBIRT in these settings and provide resources to assist health care providers in improving care for patients with alcohol misuse, such as our Alcohol Treatment Navigator and soon-to-be launched Healthcare Professional's Core Resource on Alcohol.

Moving forward, NIAAA will continue to encourage research on prevention and intervention approaches for FASD through funding opportunities [51], [52] Among the research topics of interest is advancing strategies to reduce stigmatization of biological mothers of children with FASD and individuals with FASD NIAAA will continue its overall effort in reducing alcohol-related stigma by promoting the use of non-stigmatizing language when describing alcohol-related issues and the people who experience them. [53]

Question 4(b). What steps are being taken by the administration to provide more education and training on FASD? How can stigma be lessened for individuals living with behavioral health conditions, like FASD?

Answer 4(b). NIAAA sponsors and chairs the Interagency Coordinating Committee on FASD (ICCFASD) to foster improved communication, cooperation, and collaboration among Federal agencies that address issues related to prenatal alcohol exposure [54] Several member agencies of ICCFASD have ongoing efforts aimed at improving education and training on FASD and reducing stigma for people living with FASD These agencies can be contacted for more information Examples of their educational efforts are:

- Through its Collaborative for Alcohol-Free Pregnancy, the Centers for Disease Control and Prevention (CDC) works with multiple partner organizations to educate healthcare professionals on the risks of alcohol use during pregnancy and to equip them to help their patients

[51] *grantsnihgov/grants/guide/pa-files/PAR–21–097html*
[52] *grantsnihgov/grants/guide/pa-files/PAR–21–098html*
[53] *wwwniaaanihgov/alcohols-effects-health/reducing-alcohol-related-stigma.*
[54] *wwwniaaanihgov/interagency-coordinating-committee-fetal-alcohol-spectrum-disorders*

in preventing prenatal alcohol use and identifying and caring for individuals and families living with FASDs Disciplines represented are family medicine, medical assisting, nursing, obstetrics-gynecology, pediatrics, and social work CDC and partners involved in the Collaborative have developed and disseminated a wide range of online courses on alcohol use during pregnancy and FASDs for healthcare providers These free courses offer continuing education and are available at *wwwcdcgov/FASDtraining*[55]

- The Administration for Children and Families Children's Bureau in collaboration with the CDC support the Prenatal Alcohol and Other Drug Exposures in Child Welfare Study which explores the current knowledge, attitudes, policies, practices, and needs of child welfare agencies for identifying and caring for children who were exposed to alcohol and other drugs during pregnancy Findings from this study can be found at *https://wwwacfhhsgov/cb/report/prenatal-alcohol-drug-exposures-final-report* and are being used to inform the development of resources and tools for professionals serving child welfare populations.[56]
- CDC, in collaboration with March of Dimes, developed the Beyond Labels Stigma Reduction interactive website Designed for people who work in health-related fields, this site helps users learn how stigma can impact the healthcare and support women need, seek, and receive during pregnancy The site provides information on why stigma happens, stories about the impact of stigma, and specific ways users can become a change agent to reduce stigma in their workplace or community This resource also offers a specific module on stigma around substance use during pregnancy.
- The Health Resources and Services Administration's Maternal and Child Health Bureau established the SAFEST Choice Learning Collaborative, a primary care provider education and practice improvement effort to reduce prenatal alcohol exposure and improve outcomes in children with suspected or diagnosed FASD.[57]

SENATOR SCOTT

School closures have failed America's children, particularly students in marginalized communities whose families are living paycheck-to-paycheck From learning loss to mental health crises, the damaging effects of school closures on our Nation's children are undeniable.

Because of this, I introduced the Kids in Classes Act, which would allow families with children in Title I schools to put unused Federal education funds toward in-person education, should their school close due to COVID–19 or a teachers union strike.

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[55] *nccdcdcgov/FASD/*.
[56] *wwwacfhhsgov/cb/report/prenatal-alcohol-drug-exposures-final-report*.
[57] *wwwbmcorg/addiction/training-education/safest-choice*

You noted yourself in your testimony before this Committee that "the effects on our youth, though still not full quantified, are substantial" Based on your remarks, I think you would agree with me when I say that if we want to move forward, we must examine the long-term repercussions of COVID–19 on students' academic and health outcomes.

As such, I joined my colleagues on both sides of the aisle to introduce the Assessing Children's Academic Development and the Emotional and Mental Health Implications of COVID–19 (ACADEMIC Act), which would help to better assess the impact of the pandemic on student outcomes and well-being I am hopeful this legislation will pass and am eager to see the results, but I am also interested in what the National Institute of Mental Health has found in its preliminary research.

Question 1. Dr. Gordon, what impact do you think school closures have had on the youth mental health crisis we are facing?

Answer 1. The COVID–19 pandemic has been challenging for many children, due to the fear of being infected, loss of economic, food, caregiver, or housing security, in addition to over 140,000 children losing at least one parent or caregiver to COVID–19 as of June 2021[58] Children are also facing challenges due to the cumulative social effects of hybrid and remote schooling and the need for physical distancing, which may leave some feeling less connected with their peers and teachers While early data indicate that school closures and other mitigation efforts were effective at significantly reducing the spread and mortality of COVID–19,[59],[60] school closures have also been associated with increased mental health symptoms among children[61] It is currently unknown whether the benefits of school closures outweigh the drawbacks,[62] and it will likely take years to fully understand the long-term effects of the COVID–19 pandemic and mitigation efforts.

For more than one in three adolescents, schools provide primary access to mental health care[63] Pandemic-related school closures and remote schooling may cutoff or limit access to these resources, leaving many youths disconnected from their primary sources of social support and mental health treatment As schools continue to navigate in-person and remote schooling, it will be important to consider ways to ensure that youth with or at risk for mental illnesses have access to the supports they need.

NIH is funding research investigating evidence-based approaches for children to safely remain in school during the COVID–19 pandemic For example, NICHD manages the Safe Return to School Diagnostic Testing Initiative, launched in 2021 as part of the NIH Rapid Acceleration of Diagnostics-Underserved Populations (RADxSM-UP) program[64] This initiative addresses the needs of children with unequal access to COVID–19 testing and who face barriers to attending school remotely, including those who do not

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[58] Hillis et al (2021), *pubmedncbinlmnihgov/34620728/*
[59] Liu et al (2021), *pubmedncbinlmnihgov/34020613/*
[60] Liyaghatdar et al (2021), *pubmedncbinlmnihgov/34849394/*
[61] Verlenden et al (2021), *pubmedncbinlmnihgov/33735164/*
[62] Mulligan (2021), *pubmedncbinlmnihgov/34334835/*.
[63] Ali et al (2019), *pubmedncbinlmnihgov/30883761/*.
[64] *wwwnihgov/research-training/medical-research-initiatives/radx/funding—radx-up-funded*

have adequate equipment, internet access, or adult supervision at home The RADx-UP Return to School projects combine frequent COVID–19 testing with evidence-based safety measures to reduce the spread of SARS-CoV–2[65] Early results indicate that COVID–19 testing is feasible and acceptable in the school setting across a range of populations Furthermore, these community-engaged projects will aid in our understanding of the social, behavioral, and ethical implications of COVID–19 testing implementation within underserved and vulnerable school communities.

Findings from a nationwide study of 1,290 parents of children aged 5–12 years conducted during October and November 2020, suggest children not receiving full-time, in-person instruction and their parents "might experience increased risk for negative mental/emotional and physical health outcomes"[66] Specifically——

- Parents of children receiving virtual-only or combined instruction more frequently reported that their child's mental/emotional health worsened during the pandemic and that their time outside, time in-person with friends, and physical activity decreased.
- Parents of children receiving virtual-only instruction more frequently reported their own distress, difficulty sleeping, loss of work, concern about job stability, conflict between work and providing childcare, and childcare challenges than did parents whose children were receiving in-person only instruction.
- Children receiving in-person instruction and their parents reported the lowest prevalence of negative indicators of child and parent well-being.
- Parents whose children attended school in-person only were less likely to report challenges with employment and childcare.

Moreover, findings from a similar nationwide survey of 567 adolescents aged 13–19 years, conducted during October—November 2020, suggested similar results:[67]

- Students attending school virtually reported poorer mental health than students attending in-person.
- Racial/ethnic disparities related to mode of school instruction were noted, with virtual instruction only more prevalent among Black (68 percent) and Hispanic students (69 percent) compared to White students (48 percent).
- Adolescents receiving virtual instruction reported more mentally unhealthy days, more persistent symptoms of depression, and a greater likelihood of seriously considering attempting suicide than students in other modes (in-person or hybrid) of instruction.
- After demographic adjustments, school and family connectedness each reduced the strength of the association

[65] D'Agostino et al (2022), *pubmedncbinlmnihgov/34737180/*.
[66] Verlenden et al (2021), *https://pubmedncbinlmnihgov/33735164/*
[67] Hertz et al (2022), *https://pubmedncbinlmnihgov/34930571/*

between virtual versus in-person instruction for all of the examined mental health indicators

SENATOR TUBERVILLE

Question 1. we know that one in four Americans reports having been a victim of crime in the past 10 years, and half of those were victims of a violent crime Most report receiving no help in the aftermath Police, corrections leaders, and the courts agree that untreated mental health or co-occurring substance abuse disorders are core drivers of the cycle of crime and that they lack the infrastructure to respond appropriately.

Question 1(a). What do you see as the individual and societal impacts of untreated trauma as it relates to mental health and substance use disorder?

Answer 1. Traumatic events include any shocking, scary, or dangerous event in which someone experienced, or was threatened with, death or serious injury, or witnessed the death or threat to the physical safety of others Without professional intervention, trauma is likely to result in negative mental and behavioral health consequences, including post-traumatic stress disorder, substance use, and substance use disorders (SUDs).

Among people diagnosed with SUDs, a history of exposure to violence or other traumatic experiences is common, as are experiences of mental illnesses such as post-traumatic stress disorder SUDs also exacerbate the impacts of trauma exposure, with downstream effects on individuals, families, and society, including job loss, housing instability, fractured relationships, and legal system involvement Despite the known bidirectional, deleterious relationship between trauma and SUDs, a major gap exists in understanding how trauma history affects treatment seeking, treatment retention, and recovery from SUDs.

NIMH supports clinical research focused on developing a deeper, more complete understanding of how exposure to traumatic stress affects individuals' mental health, with particular emphasis on youth and U.S. military service members, as these groups are disproportionately impacted by trauma As an example of NIMH-supported research in this area, a study of over 9,000 youths between the ages of 8 and 21 found that low socioeconomic status and the experience of traumatic stressful events were associated with alterations in neurodevelopment and cognition, as well as greater severity of psychiatric symptoms such as anxiety, depression, fear, externalizing behavior, and psychosis. [68]

Similarly, NIDA continues to support studies at the intersection of substance use and trauma Current studies aim to adapt evidence-based interventions and test novel approaches tailored to individuals at the highest risk for comorbid SUDs and trauma-related stress, including people who have experienced interpersonal violence, multiple adverse childhood experiences, or racial trauma In addition, the HEALthy Brain and Child Development Study and the Adolescent Brain Cognitive Development (ABCD) Study, which NIDA respectively leads and co-leads with other NIH Institutes,

[68] Gur et al (2019), *pubmedncbinlmnihgov/31141099/*.

will substantially contribute to our understanding of healthy development and the impact of adverse childhood experiences on outcomes like substance use and post-traumatic stress, paving the way for new prevention and treatment interventions.

Question 2. Federal data shows that 37 percent of people sentenced to prison, and 44 percent of people arrested and jailed, have experienced a mental health issue At the same time, we know that an estimated 1 in 10 police service calls are responding to an untreated mental health issue Across the country, we've seen community-based programs that seek to divert individuals experiencing mental health issues, direct individuals to treatment and resources, and do so in a way so the police department does not have to be involved.

Question 2(a). What is the Federal Government doing to ensure that mental health emergencies are being responded to appropriately, early on, before a treatable illness becomes a safety issue?

Answer 2. As noted by the Substance Abuse and Mental Health Services Administration, "preventing mental and substance use disorders or co-occurring disorders and related problems is critical to behavioral and physical health"[69] NIMH shares this sense of urgency for ensuring that individuals experiencing or at high risk for a mental health emergency are able to receive effective, evidence-based interventions as early as possible NIMH aims to build the evidence base for effective interventions through research For example, NIMH recently supported a study designed to examine the effectiveness of a new police-to-mental-health linkage system that would provide opportunities for officers to involve a mental health professional immediately and directly during encounters with individuals with serious mental illness NIMH also supported a study aiming to evaluate alternative mental health crisis services that seek to reduce the incarceration of individuals with serious mental illnesses and provide alternatives to law enforcement in responding to mental health crises.

As well, NIMH supports research focused on identifying individuals and populations most at risk for suicide, understanding the causes of suicide risk, developing suicide prevention interventions, and testing the effectiveness of these interventions and services in real-world settings Because many suicide decedents in the United States access health care services in the 12 months before their death by suicide,[70] NIMH is prioritizing research on practices within health care settings that may identify individuals at risk for suicide.[71]

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[69] *wwwsamhsagov/find-help/prevention*.
[70] Hedegaard et al (2021), *wwwcdcgov/nchs/products/databriefs/db398htm*.
[71] *wwwnimhnihgov/news/science-news/2020/nimh-leadership-describes-suicide-prevention-research-priorities*.

RESPONSE BY NORA D. VOLKOW TO QUESTIONS FROM SENATOR CASEY, SENATOR MURKOWSKI, AND SENATOR TUBERVILLE

SENATE CASEY

Without a robust mental health and substance use disorder system of care, we are unfortunately asking law enforcement officers to be on the frontlines of addressing mental health and substance use crises In response, some communities have been developing programs like Crisis Assistance Helping Out on the Streets (or CAHOOTS) that divert mental health calls to mobile crisis teams staffed by a mental health professional along with an EMT or nurse.

Question 1. What models of non-law enforcement mental health and substance use crisis interventions are effective and which would you want to see made available to communities across the country?

Answer 1. When someone with a substance use disorder (SUD) or other mental health condition is in crisis—potentially at risk of suicide or overdose—and does not pose a threat to public safety, a response aimed at connecting the person to treatment should be available CAHOOTS and similar programs deploy mental health crisis teams to redirect the person toward essential healthcare and away from law enforcement resources in appropriate circumstances Given promising results to date, the White House Office of National Drug Control Policy has commissioned a model law, the Law Enforcement and Other First Responder Deflection Act,[1] to make it easier for states to establish deflection programs Existing legislation in this area includes the National Suicide Hotline Designation Act of 2020 which designates "9–8–8" as the universal telephone number in the United States for the national suicide prevention and mental health and substance use crisis hotline system; and new funding authorized under President Biden's American Rescue Plan to support community-based mobile crisis intervention services for persons with Medicaid[2] In February 2020, NIH issued a Notice of Special Interest encouraging research on the full continuum of crisis service systems.

In addition to crisis response, it is important to invest in preventive health programs to reduce the risk of crisis from occurring in the first place For this reason, NIH funds research to develop and test methods of delivering preventive care to people at high risk from substance use and other mental health issues For example, to reduce the risk of opioid overdose, the HEALing Communities StudySM aims to integrate SUD prevention and treatment across primary care, behavioral health, justice, and other community-based settings in communities hit hard by the opioid overdose epidemic This study is part of the NIH Helping to End Addiction Long-term (HEAL) Initiative and is funded by the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

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[1] *legislativeanalysisorg/model-law-enforcement-and-other-first-responder-deflection-act/*
[2] *https://wwwCongressgov/bill/116th-congress/senate-bill/2661/text—overview—closed.*

Because individuals involved in the justice system are at particularly high risk of suicide and overdose, NIH supports research into interventions to reduce these risks For example, NIDA's Justice Community Opioid Innovation Network (JCOIN), funded by the HEAL Initiative, is testing strategies to expand treatment for opioid use disorder (OUD) in justice settings The National Institute of Mental Health (NIMH) is supporting research on interventions to reduce suicide risk among incarcerated youth as they transition to residential placement and probation, and among incarcerated adults as they re-enter their communities NIMH, the NIH Office of Behavioral and Social Sciences Research (OBSSR), and the National Institute of Justice (NIJ) are also funding a study to test whether a safety plan developed for and by at-risk adults during jail detention can reduce their suicide risk after release from jail.

In addition to efforts to prevent and reduce drug use, NIDA supports research into harm reduction, which involves strategies to prevent overdose and infectious disease among people who use drugs One such strategy is to increase availability and use of naloxone, a medication that can rapidly reverse opioid overdose Through funds from the HEAL Initiative, NIDA plans to establish a Harm Reduction Network that aims to increase our understanding of the effectiveness, implementation, and impact of existing and new harm reduction strategies Projects are expected to begin as early as September 2022.

SENATOR MURKOWSKI

Fentanyl Overdose Deaths

Question 1. Overdose deaths from fentanyl are on the rise, including in Alaska, which saw deaths triple from 2019 to 2020 The loss of a loved one impacts friends, families, and communities who continue to bear the trauma of addiction long after someone passes I have heard directly from Alaskans who have lost their children and are now dedicating their lives to prevent future overdose deaths from fentanyl.

Unfortunately, this drug has a high lethality that can harm both the user and responder I was horrified to learn about five young men and women who overdosed on fentanyl-laced cocaine a couple weeks ago while on spring break in Florida What is particularly distributing, is that two of these young men didn't consume the substance, but were performing CPR on their friends when they went into respiratory arrest They were exposed to fentanyl while they were performing mouth-to-mouth resuscitation.

Congress needs to take action before fentanyl claims one more American we need to start by educating people about the lethality of fentanyl and the risk of contaminated drugs.

Question 1(a). Dr. Volkow, how can we raise awareness to ensure no good Samaritans are harmed when responding to a fentanyl overdose?

Answer 1. Despite media reports alleging first responder exposures to fentanyl, the risks for secondhand fentanyl toxicity when rendering aid to a person who is experiencing overdose are very low Unfortunately, research shows that misinformation about risk from accidentally coming in contact with fentanyl is abundant

among first responders The good news is that this study also shows that education shows greats promise in correcting these false beliefs[3] "Second-hand" fentanyl exposure—eg, through mouth-to-mouth cardiopulmonary resuscitation (CPR)—has not been documented and is unlikely, given that once consumed, fentanyl is rapidly absorbed across mucous membranes into the blood[4] Common preparations of fentanyl include liquid, pills, and powder that can be injected, ingested, or inhaled Inadvertent consumption of fentanyl by these routes, at a dose required for toxicity, would occur only in exceptional cases where a significant volume of drug powder, liquid, or aerosol becomes airborne[5] For example, a 2010 medical report describes a veterinarian who became drowsy after accidentally splashing himself in the mouth and eyes with an animal tranquilizer that contained fentanyl[6] and in 2017, the American College of Medical Toxicology (ACMT) and the American Academy of Clinical Toxicology (AACT) concluded that a person would have to breathe fentanyl at its highest airborne concentrations for 200 minutes to ingest a therapeutic does, which still would not be potentially fatal.

Transdermal patches have become a familiar means of fentanyl delivery and unfortunately have been linked to accidental poisonings Yet these patches are designed to be firmly pressed to the skin and worn for many hours, with the fentanyl contained in a liquid or gel that aids absorption By contrast, accidental skin contact with fentanyl pills or powder is exceedingly unlikely to cause harm For instance, a study demonstrated that an extreme example of covering both palms of a person with fentanyl patches, each specifically designed to transmit high doses through skin (unlike powders or tablets), would take 14 minutes to reach clinically significant levels,[7] leading the ACMT and AACT to conclude that it "is very unlikely that small, unintentional skin exposures to tablets or powder would cause significant opioid toxicity, and if toxicity were to occur, it would not develop rapidly, allowing time for removal".

Despite the low probability of actual opioid toxicity, there are other reasons that responders at the scene of an overdose might report symptoms of possible exposure Responding to an overdose can be a stressful experience, even for emergency personnel, and observing known or suspected opioids at the scene can cause anxiety about exposure Indeed, analyses of responders who report potential exposure to opioids typically find no conclusive route of exposure and symptoms that are more consistent with anxiety (eg, dizziness,

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[3] del Pozo, et al Can touch this: training to correct police officer beliefs about overdose from incidental contact with fentanyl Health Justice 9, 34 (2021) *https://doiorg/101186/s40352–021–00163–5*

[4] Lŏtsch, Walter, Parnham, et al (2012) Pharmacokinetics of Non-Intravenous Formulations of Fentanyl Clin Pharmacokinet 52, 23—36

[5] Moss, Warrick, Nelson, et al (2017) ACMT and AACT Position Statement: Preventing Occupational Fentanyl and Fentanyl Analog Exposure to Emergency Responders J Med Toxicol 13(4): 347—351

[6] George, Lu, Pisano, et al (2010) Carfentanil—an ultra potent opioid Am J Emerg Med 28(4):530–532.

[7] Rhodes & Phillips (2013) The surface area of the hand and the palm for estimating percentage of total body surface area: results of a meta-analysis Br J Dermatol 169(1):76–84.

nausea, palpitations) than with opioid toxicity (eg, slowed breathing). [8]

Given the potency of synthetic opioids such as fentanyl and their increasing presence in the illicit drug supply, concerns about accidental exposure are understandable However, a person rendering standard aid to an overdose victim—including CPR or naloxone—has little danger of opioid toxicity More dangerous is the possibility that the person might decline to render aid based on fears about fentanyl exposure.

Medication Assisted Treatment

Question 2. The Anchorage Daily News reported recently that the U.S. has passed a "never-before-seen milestone" in losing more than 100,000 Americans to drug overdoses in a year Sadly, the CDC reports that the number of drug overdoses in Alaska rose by more than 45 percent as of June 2021 That's more than double the rate of increase for the United States.

One treatment that we know is critical to stemming the overdose crisis is medication that prevent withdrawal symptoms and stem opioid cravings These medications, like buprenorphine, can cut the risk of overdose death in half when a person starts taking them But, outdated Federal laws and stigma are restricting access to these life-saving medications I have introduced the Mainstreaming Addiction Treatment Act with my colleague, Senator Hassan, to help more Americans have access to life-saving medication and eliminate burdensome Federal red tape.

Question 2(a). How is the administration supporting expanding access to medications to treat substance use disorder so they reach all communities in need?

Answer 2. Methadone, buprenorphine, and naltrexone are effective for the treatment of OUD and the prevention of overdose deaths, but they are highly underutilized The Department of Health and Human Services (HHS) released the Overdose Prevention Strategy (OPS) in October 2021 to expand access to substance use prevention, treatment, harm reduction, and recovery support services.

To identify best approaches to expand access to and speed the uptake of medications for OUD (MOUD) in diverse settings and diverse populations, NIDA funds implementation research in healthcare settings, justice settings, and community settings through the JCOIN, and the HEALing Communities Study These studies are evaluating strategies for expanding OUD screening and treatment into emergency departments, primary care clinics, infectious disease programs, rural and American Indian/Alaska Native communities, and criminal justice settings.

NIDA also funds research on the provider-and systems-level barriers and facilitators to adoption of MOUD, particularly among people experiencing homelessness, women, and racial/ethnic minority groups, as well as testing new strategies to expand MOUD access to pregnant people, rural areas, and justice-involved populations.

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[8] *https://wwwcdcgov/niosh/topics/opioids/fieldinvestigationshtml*.

Policy changes made at the beginning of the COVID–19 pandemic have allowed people with OUD to obtain a 14–28 days' take-home supply of methadone, which particularly benefits people in rural areas or those who otherwise had trouble accessing treatment in the past NIDA-funded research is examining clinicians' and patients' experiences with telehealth services for the treatment of OUD and studying the implementation and outcomes of changes in OUD health services delivery policies This research will be critical for determining how to optimize access to effective MOUD through flexibilities in the provision of MOUD.

Question 3. Infant and Early Childhood Mental Health: The first years of life are an incredible opportunity to promote positive mental health for babies, and health and well-being during this time period affects future learning, behavior and health.

Question 3(a). Have you seen a marked impact by Federal investment in infant and early childhood mental health (IECMH)?

Answer 3. NIMH supports biomedical research to understand the mechanisms that underlie neurodevelopment, and how typical and atypical development affects future learning, behavior, and mental health Novel biomarkers and behavioral indicators hold promise for identifying at the earliest possible point who is at risk, when development or aging is going off course, or which preventive and treatment interventions will produce the best outcomes for which individuals To identify promising targets for new interventions, studies of risk factors—including those related to genetics, experience, and the environment—help provide clues to how mental disorders and developmental disorders emerge.

NIMH-supported investigators found that early life stress, for example, can cause alterations in neural circuitry and impair social interactions later in life Other NIH-funded studies are examining measurements of sleep and brain activity related to mental health in children In addition, as a result of the growing focus on mental health during the COVID–19 pandemic, NIMH is supporting research on COVID–19 mother and baby outcomes for brain and behavior function, as well as neurobehavioral consequences of COVID–19-related stressors on maternal mental health and infant and child neurodevelopment.

NIMH is committed to supporting research to identify autism spectrum disorder (ASD) at the earliest age possible to enable early intervention and better long-term outcomes NIMH-funded researchers have demonstrated that differences in brain development and function (eg, eye gaze patterns, brain growth, and how different parts of the brain develop connections), as well as some subtle behavioral differences, emerge in the first months of life, before ASD symptoms begin to appear Building on these findings, NIMH is partnering with other NIH Institutes to support researchers developing and validating new screening methods for ASD that can be used in the first year of life For example, NIMH and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) supported researchers developed an eye-tracking app that successfully distinguished toddlers diagnosed with ASD from typically developing toddlers Study results indicate that an app-based approach could be used to screen infants and

toddlers for ASD and refer them for early intervention when likelihood for treatment success is greatest (ie, at younger ages) In addition, a network of NIMH-funded researchers has tested different models of service engagement and coordination to determine how best to eliminate disparities in diagnosis, and how to diagnose children within underserved populations at earlier ages.

In addition, NICHD is committed to supporting research to identify and examine the psychological and behavioral factors and processes that influence social/emotional development and expression in individuals with intellectual and developmental disabilities NICHD-funded researchers recently examined the role of behavioral and mindfulness-based interventions in promoting parent and child well-being in families with children demonstrating intellectual and developmental disabilities.

Question 4. Suicide Screening in the Emergency Department: A recent CDC report on emergency department visits for people age 12–25 found an over 50 percent increase visits for suspected suicide attempts during early 2021 This underscores the devastating mental health impact of the pandemic on our youth and highlights yet another way that COVID–19 has strained our hospitals and medical staff.

I introduced a bill, the Effective Suicide Screening and Assessment in the Emergency Department Act, to improve the screening and treatment of patients in hospital emergency departments who are at high risk for suicide It will make sure that we can better identify our most vulnerable mental health patients so they do not slip through the cracks when they are treated in hospitals, and make sure hospitals have the resources they need to provide these critical services.

Question 4(a). What is the need for improved suicide screening protocols in the Nation's emergency rooms?

Answer 4. Developing suicide risk screening tools and testing their effectiveness in real-world settings such as emergency departments (EDs) remains a high-priority research area for NIMH Approximately 80 percent of U.S. suicide decedents accessed health care services in the 12 months preceding their death, and nearly 30 percent had a health care visit in the week before suicide, demonstrating that health care systems can play a vital role in identifying individuals at risk and preventing suicide attempts. [9]

NIMH-funded researchers demonstrated that the use of brief screening tools in EDs can improve providers' ability to identify individuals at risk for suicidal behavior and refer them to treatment As one example, the NIMH-funded ED Safety Assessment & Follow-up Evaluation (ED-SAFE) study found that universal screening of ED patients doubled the rate of risk detection (from 3 percent to 6 percent), and that ED-initiated interventions reduced subsequent suicidal behavior by 30 percent Additionally, NIMH-funded researchers developed the Ask Suicide-Screening Questions tool—a very brief (four-question) screening instrument that was shown to identify risk for suicide in pediatric emergency departments and

[9] Gordon, Avenevoli, and Pearson (2020) Suicide Prevention Research Priorities in Health Care JAMA Psychiatry 1;77(9):885–886.

has now been adapted for use across multiple other settings and populations.

Question 4(b). Do you support efforts to bolster the resources available to emergency rooms so they can enhance their screening for high-risk suicide patients?

Answer 4(b). Since emergency departments and other health care settings have a critical role in identifying and providing preventive interventions for individuals at risk of suicide, it is important that these settings have the resources they need to implement effective screening tools and evidence-based preventive interventions NIMH remains committed to supporting research on developing and validating tools and interventions for use in such settings, and also on identifying innovative and sustainable service delivery models to ensure that such tools and interventions are widely available.

Question 5. FASD: During COVID, we have seen a sharp rise in substance misuse specifically alcohol, the most widely used and misused substance Unfortunately, a landmark NIH study in 2018 established that 1 in 20 school-aged children are affected by fetal alcohol spectrum disorders—FASD Due to its significance and status as an overlooked disability that includes debilitating stigma, I introduced S 2238, the FASD Respect Act My legislation establishes common standards of care and increases the capacity to manage FASD in medical and mental health settings.

Question 5(a). How can we address the social and environmental factors that contribute to prenatal alcohol exposure and reduce the traumas FASD creates for individuals and families?

Answer 5. The risk for use of alcohol during pregnancy is influenced by a range of environmental and social factors such as social isolation, living in environments where alcohol misuse is common and accepted, and having limited resources for prenatal care Stigma can serve as a barrier to pursuing and receiving care for alcohol misuse or an alcohol use disorder as part of prenatal care This is particularly concerning given recent research indicating that during 2018—2020, 135 percent of pregnant adults in the United States reported current drinking, 52 percent reported binge drinking, and those with no routine health care provider or with frequent mental distress were more likely to consume alcohol The risk of an individual being born with a fetal alcohol spectrum disorder (FASD) is influenced by factors such as the level and frequency of alcohol exposure during prenatal development and when during prenatal development alcohol exposure occurs Maternal factors that can also influence this risk include inadequate nutrition and smoking or other substance use, among other factors In addition to the physical, cognitive, and other challenges individuals with FASD may face, stigma can be a barrier to seeking and receiving the health, educational, and professional care and support they need.

Evidence-based prevention and treatment interventions, improved access to care, and substance misuse and mental health services integrated into routine health care are among the strategies needed to prevent and reduce prenatal alcohol exposure For children who are prenatally exposed to alcohol, widespread screening (including when screening for developmental disabilities), accurate diagnosis, early intervention, and access to support services

are needed to improve the health and quality of life for individuals with FASD and their families.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the NIH, supports a broad research portfolio on the etiology, prevention, diagnosis, and treatment of FASD A major research program funded by NIAAA is the Collaborative Initiative on Fetal Alcohol Spectrum Disorders (CIFASD) with the goal to improve prevention of FASD, diagnosis of the full range of birth defects associated with prenatal alcohol exposure, and interventions for affected individuals One recent study includes the development and evaluation of mobile apps to give caregivers of children with FASD to help them learn new skills to manage their children's behavior and to provide adults with FASD tools to promote their own self-management and health advocacy goals.

To facilitate widespread screening and early diagnosis of FASD, CIFASD researchers have developed three-dimensional photography and computerized image analysis that can enhance the detection of a broad range of alcohol-induced facial characteristics in children with prenatal alcohol exposure This approach is being refined and could improve access to FASD diagnosis in underserved regions Other projects are developing screening tools that distinguish neurobehavioral features associated with FASD from other neurodevelopmental conditions NIAAA-supported studies also focus on the use of novel methodologies such as 3D fetal ultrasound, blood-based biomarkers, and physiological measures to improve earlier identification of prenatal alcohol exposure and risk of neurodevelopmental delay among neonates, infants, or young children.

Developing culturally appropriate approaches for the prevention of alcohol-exposed pregnancies also continues to be an important focus of NIAAA research For example, an ongoing study is conducting a randomized clinical trial of a culturally appropriate prevention program delivered via a smartphone app for urban American Indian and Alaska Native women ages 16–20 This study is also examining the impact of the COVID–19 pandemic on risk of alcohol-exposed pregnancy NIAAA-supported research is also evaluating the effectiveness of nutritional supplementation, administered prenatally and during childhood, to mitigate the adverse impact of prenatal alcohol exposure Studies have shown that screening, brief intervention, and referral to treatment (SBIRT) approaches are a significant tool for addressing alcohol and other substance use in primary and prenatal care settings NIAAA will continue to encourage alcohol SBIRT in these settings and provide resources to assist health care providers in improving care for patients with alcohol misuse, such as our Alcohol Treatment Navigator and soon-to-be launched Healthcare Professional's Core Resource on Alcohol.

Moving forward, NIAAA will continue to encourage research on prevention and intervention approaches for FASD through funding opportunities Among the research topics of interest is advancing strategies to reduce stigmatization of biological mothers of children with FASD and individuals with FASD NIAAA will continue its overall effort in reducing alcohol-related stigma by promoting the

use of non-stigmatizing language when describing alcohol-related issues and the people who experience them.

Question 5(b). What steps are being taken by the administration to provide more education and training on FASD? How can stigma be lessened for individuals living with behavioral health conditions, like FASD?

Answer 5(b). NIAAA sponsors and chairs the Interagency Coordinating Committee on FASD (ICCFASD) to foster improved communication, cooperation, and collaboration among Federal agencies that address issues related to prenatal alcohol exposure Several member agencies of ICCFASD have ongoing efforts aimed at improving education and training on FASD and reducing stigma for people living with FASD These agencies can be contacted for more information Examples of their educational efforts are:

- Through its Collaborative for Alcohol-Free Pregnancy, the Centers for Disease Control and Prevention (CDC) works with multiple partner organizations to educate healthcare professionals on the risks of alcohol use during pregnancy and to equip them to help their patients in preventing prenatal alcohol use and identifying and caring for individuals and families living with FASDs Disciplines represented are family medicine, medical assisting, nursing, obstetrics-gynecology, pediatrics, and social work CDC and partners involved in the Collaborative have developed and disseminated a wide range of online courses on alcohol use during pregnancy and FASDs for healthcare providers These free courses offer continuing education and are available at *wwwcdcgov/FASDtraining*.
- The Administration for Children and Families Children's Bureau in collaboration with the CDC support the Prenatal Alcohol and Other Drug Exposures in Child Welfare Study which explores the current knowledge, attitudes, policies, practices, and needs of child welfare agencies for identifying and caring for children who were exposed to alcohol and other drugs during pregnancy Findings from this study can be found at *https://wwwacfhhsgov/cb/report/prenatal-alcohol-drug-exposures-final-report* and are being used to inform the development of resources and tools for professionals serving child welfare populations.
- CDC, in collaboration with March of Dimes, developed the Beyond Labels Stigma Reduction interactive website Designed for people who work in health-related fields, this site helps users learn how stigma can impact the healthcare and support women need, seek, and receive during pregnancy The site provides information on why stigma happens, stories about the impact of stigma, and specific ways users can become a change agent to reduce stigma in their workplace or community This resource also offers a specific module on stigma around substance use during pregnancy.

- The Health Resources and Services Administration's Maternal and Child Health Bureau established the SAFEST Choice Learning Collaborative, a primary care provider education and practice improvement effort to reduce prenatal alcohol exposure and improve outcomes in children with suspected or diagnosed FASD.

SENATOR TUBERVILLE

Question 1. In July 2017, you and Dr. Collins co-authored a paper entitled: "The Role of Science in Addressing the Opioid Crisis" That report states, "The NIH will now work with private partners to develop stronger, longer-acting formulations of antagonists, including naloxone, to counteract the very-high-potency synthetic opioids that are now claiming thousands of lives each year".

Question 1(a). What innovation is still needed regarding these lifesaving medications given that at present, over 80 percent of opioid overdose deaths have been linked to synthetics?

Answer 1. Deaths involving synthetic opioids (like illicitly manufactured fentanyl), cocaine, and methamphetamine—as well as combinations of these drugs—have increased sharply in recent years Opioid overdose reversal agents may not be as effective when opioids, stimulants, alcohol or other substances are used in combination NIH and NIDA are supporting numerous studies across the therapeutics development pipeline to advance treatments for OUD and stimulant use disorder, and to develop novel therapeutics to treat co-intoxication with stimulants and opioids.

The opioid overdose reversal medication, naloxone, still remains the most effective available agent to save the life of someone who is overdosing on opioids, but a recent study found that naloxone was not administered in 77 percent of 33,084 opioid-involved overdose deaths in 2019[10] NIDA funds research to identify innovative ways to expand access to naloxone and promote its use, for example by identifying barriers and facilitators to naloxone access through pharmacies by testing the effectiveness of overdose education and naloxone distribution through churches in Black communities, and using simulation models to determine the best local strategies to distribute naloxone.

Fifty-six percent of individuals who died from a fentanyl-involved overdose had no pulse when first responders arrived[11] Timely naloxone administration is critical, particularly for overdoses involving highly potent synthetic opioids, and because of naloxone's short duration of action, repeat doses may need to be administered in some cases NIDA-supported research led to FDA approval of KLOXXADO, a higher dose naloxone nasal spray formulation NIDA funds research on longer-acting reversal agents, including methocinnamox (MCAM) and implants and injections containing nalmefene, which prevents opioid overdose during relapse Other

[10] Quinn, Kumar, Hunter et al (2022) Naloxone administration among opioid-involved overdose deaths in 38 United States jurisdictions in the State Unintentional Drug Overdose Reporting System, 2019 Drug and Alcohol Dependence Volume 235, 1 June 2022, 109467.

[11] O'Donnell, Tanz, Gladden, et al Trends in and Characteristics of Drug Overdose Deaths Involving Illicitly Manufactured Fentanyls—United States, 2019—2020 MMWR Morb Mortal Wkly Rep 2021;70:1740–1746.

NIDA-funded researchers have developed a small molecule intended to act like a sponge and clear drugs from the body; they are testing its ability to clear either fentanyl or methamphetamine NIDA is also funding research to develop antibodies against fentanyl that could be used to treat and prevent overdoses.

One-third of fentanyl-involved overdose deaths occurred when a potential bystander was present who did not respond to the overdose (eg, person who overdosed was in a separate room of the same house, underscoring the need for innovative overdose reversal agents that can detect overdose and quickly administer reversal medication when individuals are alone or friends and family are unaware NIDA is funding the development of wearable devices and smartphone sensors that detect opioid-induced respiratory depression and administer naloxone or summon help.

NIDA plans to fund more research to develop new medications to prevent and treat OUD and opioid overdose, elucidate mechanisms of action of synthetic opioids, and understand the complexities, public health impacts, clinical characteristics, and treatment of opioid and polydrug use disorders involving fentanyl.

Question 2. we know that one in four Americans reports having been a victim of crime in the past 10 years, and half of those were victims of a violent crime Most report receiving no help in the aftermath Police, corrections leaders, and the courts agree that untreated mental health or co-occurring substance abuse disorders are core drivers of the cycle of crime and that they lack the infrastructure to respond appropriately.

Question 2(a). What do you see as the individual and societal impacts of untreated trauma as it relates to mental health and substance use disorder?

Answer 2. Traumatic events include any shocking, scary, or dangerous event in which someone experienced, or was threatened with, death or serious injury, or witnessed death or a threat to the physical safety of others Without professional intervention, trauma is likely to result in negative behavioral health consequences, including post-traumatic stress disorder, substance use, and SUDs.

Among people diagnosed with SUDs, a history of exposure to violence or other traumatic experiences is common, as are experiences of mental illnesses such as post-traumatic stress disorder SUDs also exacerbate the impacts of trauma exposure, with downstream effects on individuals, families, and society, including job loss, housing instability, fractured relationships, and legal system involvement Despite the known bidirectional, deleterious relationship between trauma and SUDs, a major gap exists in understanding how trauma history affects treatment seeking, treatment retention, and recovery from SUDs.

NIMH supports clinical research focused on developing a deeper, more complete understanding of how exposure to traumatic stress affects individuals' mental health, with particular emphasis on youth and U.S. military service members, as these groups are disproportionately impacted by trauma As an example of NIMH-supported research in this area, a study of over 9,000 youths between the ages of 8 and 21 found that low socioeconomic status and the experience of traumatic stressful events were associated with alter-

ations in neurodevelopment and cognition, as well as greater severity of psychiatric symptoms such as anxiety, depression, fear, externalizing behavior, and psychosis.

Similarly, NIDA continues to support studies at the intersection of substance use and trauma Current studies aim to adapt evidence-based interventions and test novel approaches tailored to individuals at the highest risk for comorbid SUDs and trauma-related stress, including people who have experienced interpersonal violence, multiple adverse childhood experiences, or racial trauma In addition, the HEALthy Brain and Child Development Study and the Adolescent Brain Cognitive Development (ABCD) Study, which NIDA respectively leads and co-leads with other NIH Institutes, will substantially contribute to our understanding of healthy development and the impact of adverse childhood experiences on outcomes like substance use and post-traumatic stress, paving the way for new prevention and treatment interventions.

Question 3. Federal data shows that 37 percent of people sentenced to prison, and 44 percent of people arrested and jailed, have experienced a mental health issue At the same time, we know that an estimated 1 in 10 police service calls are responding to an untreated mental health issue Across the country, we've seen community-based programs that seek to divert individuals experiencing mental health issues, direct individuals to treatment and resources, and do so in a way so the police department does not have to be involved.

Question 3(a). What is the Federal Government doing to ensure that mental health emergencies are being responded to appropriately, early on, before a treatable illness becomes a safety issue?

Answer 3. As noted by the Substance Abuse and Mental Health Services Administration, "preventing mental and/or substance use disorders or co-occurring disorders and related problems is critical to behavioral and physical health" NIMH shares this sense of urgency for ensuring that individuals experiencing or at high risk for a mental health emergency are able to receive effective, evidence-based interventions as early as possible NIMH aims to build the evidence base for effective interventions through research For example, NIMH recently supported a study designed to examine the effectiveness of a new police-to-mental-health linkage system that would provide opportunities for officers to involve a mental health professional immediately and directly during encounters with individuals with serious mental illness in appropriate circumstances NIMH also supported a study aiming to evaluate alternative mental health crisis services that seek to reduce the incarceration of individuals with serious mental illnesses and provide alternatives to law enforcement when appropriate in responding to mental health crises.

As well, NIMH supports research focused on identifying individuals and populations most at risk for suicide, understanding the causes of suicide risk, developing suicide prevention interventions, and testing the effectiveness of these interventions and services in real-world settings Because many suicide decedents in the United States access health care services in the 12 months before their death by suicide, NIMH is prioritizing research on practices within

health care settings that may identify individuals at risk for suicide.

[Whereupon, at 11:50 am, the hearing was adjourned].

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