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A CRISIS IN MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE: CLOSING GAPS IN ACCESS BY BRINGING CARE AND PREVENTION TO COMMUNITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND RETIREMENT SECURITY

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING A CRISIS IN MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE, FOCUSING ON CLOSING GAPS IN ACCESS BY BRINGING CARE AND PREVENTION TO COMMUNITIES

MAY 17, 2023

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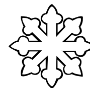

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A CRISIS IN MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE: CLOSING GAPS IN ACCESS BY BRINGING CARE AND PREVENTION TO COMMUNITIES

Wednesday, May 17, 2023

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

The Subcommittee met, pursuant to notice, at 10 a.m., in room 430, Dirksen Senate Office Building, Hon. Edward Markey, Chairman of the Subcommittee, presiding.

Present: Senators Markey [presiding], Baldwin, Hickenlooper, Marshall, Murkowski, and Tuberville.

OPENING STATEMENT OF SENATOR MARKEY

Senator MARKEY. Thank you all for joining us today for the first Primary Health and Retirement Subcommittee hearing on mental health and behavioral health for the 118th Congress.

Thank you to Senator Marshall for your shared commitment to addressing the mental health and substance use crisis in the United States. There are many people at home who will watch this hearing and recognize the realities they face every day.

They call for help and are met with long wait times or an hour-long commute to care. They have lost a friend, or a loved one, to mental illness or a substance use disorder. But support and services aren't accessible. They know when they need help, but they don't know where to go to get it.

Let me start by saying, you are not alone. The reason we are here today is to identify those challenges and chart a path toward a future where help is there when you need it. On health—Senate Health, Education, Labor, and Pensions Committee it is our responsibility to take up the fight for a better mental health and substance use disorder care system that meets people where they are with dignity.

But today we are losing that fight. Last year, over 106,000 people died from an overdose. The CDC reported just last week that overdose deaths involving fentanyl had more than tripled in the last 5 years. Emergency department visits for opioid related overdoses increased by 41 percent for boys, and 10 percent for girls age 12 to 17 in the fall of 2022, compared to the year before.

Yet, 94 percent of people age 12 and older with substance use disorders did not receive treatment. The prospects for people facing mental health challenges are equally distressing. More than one in five adults in the United States has a mental health disability, yet over 10 million people report an unmet need for mental health services.

One in five highschoolers have seriously considered attempting suicide. For LGBTQ youth, the number was closer to one in two. Yet over 2 million adolescents who needed care did not receive it.

The cause is complex. Pharmaceutical companies supercharged an opioid pandemic by overprescribing oxycodone, ultimately hooking people on heroin and fentanyl. Big tech serves toxic content that grabs young people's attention, and fuels depression, anxiety, and eating disorders.

Childhood trauma and toxic stress linked to violence, poverty, racism, and housing instability create invisible scars that weigh heavily on caregivers' children and seniors. And as a growing number experience mental health conditions, our health system has not been able to keep up. People are looking for an open door to care, and instead they are locked out.

But these invisible scars continue to grow, and thousands of people find themselves in the emergency departments hoping for placement in treatment programs, or they leave, and without anywhere to go, we lose them to suicide and overdose.

Yes, the challenges are complex, but the solution is simple, affordable, accessible, mental and substance use care for any and all that need it, when they need it, and where they need it. This is easier said than done, but there is hope to be found in the everyday heroes who have rolled up their sleeves, looked into people's eyes, and offered a helping hand.

A few of those people are with us today, addiction medicine physicians, child psychiatrists, and providers from community health centers and certified community behavioral health clinics. They are the better angels of our health care system, and right now we need an army of angels.

We can build a system that treats people with dignity and doesn't price patients out of the care. We can invest in community health providers. We can pass legislation to break down antiquated barriers to medication, treatment for opioid use disorder.

We can support local communities, public health response to rising overdoses and mental health needs. And we can make sure that big pharma doesn't charge big bucks for life saving prescriptions. We can create a system that puts patients over profits.

I am proud that so many of our fiercest advocates for these efforts are in this room today, and we thank you for all of your work. And with that, I turn to the Ranking Member, Senator Marshall, for his opening statement.

OPENING STATEMENT OF SENATOR MARSHALL

Senator MARSHALL. Well, thank you, Mr. Chairman. I also want to appreciate your dedication to addressing the mental health crisis and for holding our first Subcommittee hearing. I know our col-

leagues on both sides of the aisle interested in reauthorizing several expiring programs.

We also want to look for new ways to tackle this crisis. Our witnesses today will show us how they are using existing Federal programs and their own ingenuity to reshape their communities. It has been 5 years since Congress passed the Support for Patients and Community Act, the largest, most comprehensive legislative package that directs Federal resources and statutory changes toward prevention, treatment, and recovery.

The Support Act encourages payers and providers to utilize alternative treatments for pain. It increased patient education and awareness across many markets. Modernizing prescribing to detect and prevent fraudulent prescriptions.

The expanded safe disposal of unused prescription drugs, including at home deactivation packets. And finally, it helped people get on the road to recovery through various inpatient and outpatient services.

Let's talk about prevention first, where we are seeing great progress. Notably, substance use disorder related deaths as a result of prescription opioids are decreasing because physicians and nurses are increasing patient awareness and utilizing other treatments for pain. However, Chairman Markey and I in this Committee, our aim is to prevent addiction by moving away from addictive medicines.

The Support Act required the FDA to help address biopharmaceutical challenges in developing non-addictive pain therapies, but the agency has not successfully carried this out. We will hold the FDA accountable so patients can one day have access to innovative, non-addictive prescription drugs.

On treatment, we will hear from our witnesses on the successes of expanded access to medication assisted treatment, telehealth, and novel coordinated care models, including certified community behavioral health clinics, or CCBHCs, which I am a very strong advocate for. We have all witnessed too many people experiencing mental health crises in the wrong setting and receiving the wrong type of care.

While still new, the data looks promising. People who receive care at a CCBHC spend 60 less—60 percent less time in jail, 70 percent less time in the hospital, and are much likely—much more likely to have access to a primary care provider.

CCBHCs also contributed to a 41 percent reduction in homelessness. Congratulations, and I will look forward to Mr. Denny's testimony to share some more of those stats again. For all the good the witnesses are providing,

Congress must work to ensure that they can deliver timely access to care by addressing mental health parity issues. They need our help to eliminate unnecessary delays and denials from prior authorization, the No. 1 administrative burden across all clinicians and other health care providers.

On recovery, the Support Act provided peer recovery support services and other programs that are helping people help themselves become independent, stable, and healthy. In addition to the

Support Act, I hope this Committee will work with us on developing solutions to address some of the root causes of the mental health crises in America's youth. Do the lockdowns result in isolation?

Kids increase their reliance on social media, shifting their habits beyond a casual pastime. In fact, experts have found that overuse of social media rewires their brains to constantly seek out immediate gratification. This leads to obsessive, compulsive, and addictive behaviors. Studies have linked heavy social media use increased risk for depression, anxiety, loneliness, self-harm, and even suicide ideation.

This year, the CDC released a new survey finding that nearly 60 percent of young girls reported a mental health issue, with 30 percent seriously considering suicide, double the rate there was among boys and up to almost 60 percent from a decade ago. We know social media companies are aware of this based upon their own similar findings. There is no silver bullet in solving the mental crisis.

We must continue to bolster efforts on prevention, treatment, and recovery. In doing so, we should value what we measure and measure what we value. As we consider reauthorizing expiring programs and exploring new ideas, they should be patient centered, outcome driven, cost effective.

They must be backed by data. Mr. Chairman, thank you again for calling this hearing, and I yield back.

Senator MARKEY. Thank you, Senator, so much. And we will turn to our first witness, Dr. Maria Celli, a Psychologist and Deputy CEO of Brockton Neighborhood Health Center in Brockton, Massachusetts.

She has worked at the Brockton Neighborhood Health Center since 2016 and has worked in community health centers since 2010. Dr. Celli launched the Brockton Behavioral Health Task Force to promote collaboration between behavioral health providers across the city's behavioral health and substance use services ecosystem.

Welcome, doctor, whenever you are ready, please begin.

STATEMENT OF MARIA CELLI, DEPUTY CEO, BROCKTON NEIGHBORHOOD HEALTH CENTER, BROCKTON, MA

Dr. CELLI. Good morning, Chairman Markey, Ranking Member Marshall, and Members of the Committee. Thank you for the opportunity to testify on the critical topic of mental health and substance use disorders and access to community-based prevention and services.

As Senator Markey noted, my name is Maria Celli, and I am a Psychologist and the Deputy CEO at Brockton Neighborhood Health Center, a federally qualified health center located in Brockton, Massachusetts.

In my role, I have witnessed the negative impact that the pandemic has had on the mental health of our patients and the community. The demand for behavioral health services is enormous, outstripping our community wide supply of resources. This morning, I am coming on behalf of our providers and patients I have the

privilege to serve to propose four opportunities for support to improve community level access to behavioral health and substance use disorder services.

Those four are, increasing support for integrated care team models, leveraging mobile medical units and continued use of telehealth services, including audio only services when appropriate, prioritizing pediatrics, and workforce development and wellness.

Like many other community health centers across the country, Brockton Neighborhood Health Center employs integrated, multidisciplinary teams to serve patients holistically. That means we address everything from food insecurity and housing insecurity to disease management.

Our patients are universally screened for health-related social needs, depression, and risky substance use. We make screening for mental health and substance use disorder a standard part of primary care.

By doing so, we reduce stigma and create easy and seamless access to mental health and addiction services. Additionally, we have found that primary care behavioral health integrated teams can reduce costs to the medical system, and I will give one example.

Recently, we had a 21-year-old male who was new to our adult medical department. This individual had significant medical complications and was in and out of the hospital frequently, very frequently, like seven times in a couple of weeks.

Concerned about his mental status, the primary care provider at the NHC engaged one of the integrated behavioral health clinicians who was able to meet with this individual and begin to build trust.

Since the team of the integrated primary care—the integrated clinician and the primary care provider has started to work with this patient, he has significantly reduced his emergency room visits and has begun to make good progress with his medical care addition.

Additionally, in addition to primary care, behavioral health integrated models of care, I propose increasing access through mobile units and telehealth services. We have found at Brockton Neighborhood Health Center through our first mobile unit that this is an effective way to reach vulnerable populations, and I will highlight three in particular.

In 2020, Brockton Neighborhood Health Center leveraged grant funding to launch our first mobile unit, which provides services specifically to those experiencing homelessness and people who use drugs. We have observed that overdose deaths have increased significantly in our town, and nationally that is the same.

The services on this mobile unit have undoubtedly saved lives. However, we have also observed a rise in mental health needs in both pediatrics and seniors within our community. That is why Brockton Neighborhood Health Center is working hard to acquire mobile units that can be deployed to provide integrated care at schools, at senior housing sites, etcetera, to meet our patients in the community that has the need where they are.

I am so appreciative that last year this Committee recognized the value of mobile care units when it passed the Mobile Health Care

Act by unanimous consent to make it easier for health centers to finance mobile health units.

Additional new access point funding will help health centers like ours take advantage of this opportunity to create easier access to patients who need it. In addition to launching the mobile clinical unit, leveraging strategic use of telehealth is essential to address this crisis, and I strongly support permanently extending the telehealth flexibilities implemented during the COVID–19 public health emergency.

Of course, none of our work in addressing this crisis is possible without robust and well staffing. The NHC has designed and launched a number of grants funded professional pipeline projects, including one designed for the training, recruitment, and retention of behavioral health clinicians.

We would love for this Committee to provide more flexible funding to support projects like ours. Another priority for our workforce is wellness programing to mitigate employment related stress. I appreciate that last year the HELP Committee passed the Lorna Breen Act, which authorized funding for provider burnout, and we genuinely appreciate any support that our staff can receive to remain well in these roles as they continue to work daily to save lives.

Health centers like Brockton Neighborhood Health Center need long term, sustainable, and predictable funding to continue to address this behavioral health and substance use disorder crisis.

Chairman Markey, Ranking Member Marshall, and Members of the Committee, thank you for allowing me to share some of the great work that my team at the NHC is doing to fight the mental health and substance use disorder crisis in this country.

With this Committee's support, we will continue to find new ways to provide affordable, accessible, and high-quality care to the communities we serve. I look forward to your questions.

[The prepared statement of Dr. Celli follows:]

PREPARED STATEMENT OF MARIA CELLI

Chairman Markey, Ranking Member Marshall, and Members of the Committee, thank you for the opportunity to testify on the critical topic of mental health and substance use disorders. My name is Maria Celli, and I am a psychologist and the Deputy CEO at Brockton Neighborhood Health Center, a federally qualified health center located in Brockton, MA, a city 24 miles south of Boston. BNHC serves over 37,000 unique patients and conducted over 200,000 visits in 2022.

While I am currently the Deputy CEO of BNHC, I have previously served as a COO and Director of Behavioral Health and Social Services at BNHC and as a Director of Behavioral Health at a Boston-based FQHC. As a psychologist, my areas of clinical work have focused on behavioral health-primary care integration and working with individuals who have experienced trauma. I have trained in early childhood mental health and perinatal care, and I continue to be attentive to the needs of our youngest patients because they are our future, and I am aware that the ills I see in our adult patients were, in many ways, impacted by their experiences as young children. I am eager to promote the well-being of children to reduce their risk of developing pathologies later in life.

From my clinical care and administrative perspectives, I have observed the current state of behavioral health and substance use needs and care access from the patient level through to systems level. In Massachusetts, we are fortunate that the state's Executive Office of Health and Human Services has committed to improving access to behavioral health and substance use disorder services, through the development of a Behavioral Health Roadmap, which is a blueprint for creating accessible

and equitable access to behavioral health and substance use disorder services across the state. Introduced in 2021 and implemented in 2023, this roadmap included the design and launch of 24 Community Behavioral Health Centers across the commonwealth. We, at BNHC, are thankful that one of the 24 CBHC's is located within the city of Brockton; and we leverage this and every other resource in Brockton's behavioral health ecosystem to try to address our patients' and community's needs. Despite these improvements in access, we are still witnessing a demand for services that exceed our supply of resources. We were concerned about our staff and community's mental health and wellness prior to COVID. However, the needs have risen throughout the pandemic and remain high.

I have professionally witnessed the negative impact that the pandemic had on the mental health and well-being of our patient population. More specifically, the trauma of COVID has triggered exacerbations of what were once subthreshold mental health conditions. The demand for behavioral health services is enormous—outstripping our community-wide supply of resources. Unfortunately, the acuity of patient needs is also worse, meaning that patients who might have once sufficed with outpatient therapy, are now reporting symptoms requiring more intensive or even inpatient care due to imminent risk concerns.

From my own professional experience, and as the representative on behalf of providers and patients whose voices are not here, I propose four opportunities for continued or additional support to improve community-level access to behavioral health and substance use disorder services:

1. **Increasing support for integrated care team models:** Integrated primary care team models co-locate and integrate licensed behavioral health clinicians, Community Health Workers, Peer Recovery Coaches, and sometimes other disciplines to work alongside primary care providers so that health-related social needs and behavioral health screenings and treatment are universally available to any patient as part of their general medical care. This model of care is foundational to how FQHCs' practice and its expansion is essential to improving access.

2. **Leveraging Mobile Medical Units and continued use of Telehealth Services:** I propose support for care for hard-to-reach patients through support for unique and flexible models of care, including mobile medical units that can strategically deliver integrated primary care services to vulnerable individuals who are not engaging in their primary health care such as those struggling with homelessness, seniors and individuals with transportation or mobility barriers. Similarly, it is essential to continue to strategically use telehealth services for otherwise hard-to-reach populations.

3. **Prioritizing Pediatrics:** We must ensure that all pediatric patients have universal access to behavioral health screenings, assessments, and treatments throughout their development, especially in their first 5 years of life.

4. **Workforce Development:** Finally, we must continue to invest in developing the healthcare workforce to serve these behavioral health and substance use disorder needs, through support for existing professional pipeline projects.

Increasing Community Access through Primary Care-Behavioral Health Integration

BNHC operates four clinical sites (including one in a homeless shelter and one mobile unit). BNHC provides the full spectrum of primary care services including adult medical, behavioral health, OB/GYN, pediatrics, nutrition, oral health, optometry, cancer screenings, onsite pharmacy, radiology, diagnostic laboratory, infectious disease screening and care, substance use disorder screening and treatment. We serve patients with extraordinarily complex medical and social needs, including poverty, food insecurity, homelessness, trauma, and difficulty accessing transportation and employment. We serve all people regardless of their insurance status or ability to pay.

Like many other Community Health Centers across the country, we serve our patients holistically, meaning that we provide healthcare that pays attention to and aims to address all aspects of a person's life, as they all impact their health. We screen, assess and address their care across multiple levels and domains of need addressing everything from food access to disease management. We practice this way because it is our mission to do so, and it is a way to promote wellness for individ-

uals who might not otherwise engage in preventative services. This strategy is beneficial to the patients and restrains costs to the medical system, as the patient's engagement in our integrated primary care teams can reduce unnecessary utilization of higher levels of care.

One recent example of this is the case of a 21-year-old male with multiple medical conditions, including seizure disorder, who was in and out of the hospital due to seizures. Unfortunately, he was not engaging in his medical treatment due to undiagnosed severe depression. After becoming aware of his medical disengagement and his frequent trips to the hospital, his primary care provider at BNHC engaged the integrated behavioral health clinician, who was able to begin to build trust with this traumatized young individual. Together, the primary care provider, behavioral health clinician, and patient began to make slow but steady progress in his participation with his healthcare. The patient has not visited the emergency room since the holistic treatment team has collectively engaged him. Now that he has built trust with this team, he is willing to meet with specialists who can stabilize his medical condition. Given his many needs, the behavioral health team is also working with his family and friends to know how to support his health and wellness. This is a person who was in a revolving door pattern of medical exacerbation to the emergency department—until he was engaged by his primary care provider and an integrated behavioral health clinician. Now, he is stabilized and moving toward illness management and an improved quality of life.

At BNHC, like many other health centers, the integrated model of care is foundational to how we provide primary care services. Our patients are universally screened for health-related social needs (i.e. social drivers of health), as well as risky substance use and depression. Just as we measure vital signs such as blood pressure, temperature, and weight, we ask them about the social conditions that impact their health and wellness; and we have staff on the team who assist with addressing the issues that patients report. This universal screening and team-based approach to access is crucial because it communicates that health-related social needs, substance use and behavioral health concerns are all part of their primary care. It destigmatizes these issues and creates easy access to needed services that improve their health, well-being, and effective participation in their own treatment, in their own lives and in their communities.

Another illustrative example of the benefits of Primary Care-Behavioral Health Integration and universal screening for BH and SUD conditions is the story of Gloria, a 73-year-old woman who had recently moved to our service area and was a newer patient. She completed our standard, universal screening process and was found to have an elevated score on the depression screening tool. Her response on the screening indicated suicidal ideation, and the PCP was planning to complete a Section 12 for the patient, meaning sending her to the hospital for inpatient hospitalization. However, because of the integrated model of care, the PCP reported the result to the integrated BH clinician, who met with the patient and carefully assessed the patient's risk. Rather than hospitalizing the patient, the integrated clinician was able to make a referral to one of our in-house psychiatric providers, who consulted with the PCP to start psychotropic medications. The BHI clinician helped the patient to connect with other resources in the community because the patient had acknowledged that the primary drivers for her current state were loneliness and hopelessness due to multiple losses, including loss of employment.

This patient did not need a hospital. She needed connection. The integrated care team model, which is a cornerstone for how BNHC and so many other CHCs around the country operate, made those connections possible. We strive, train, practice, commit and recommit to seeing the whole person. And in doing so, we are privileged to know the patients and support them through accessing what they need to cope more effectively with the many stressors associated with their lives. Access to effective behavioral health and substance use disorder screening and treatment within the community and through the primary care doorway is an essential strategy for maximizing access in this time of tremendous need.

Increasing Access through Mobile Units and Telehealth Services

Another fundamental way that Community Health Centers operate is that we are innovative and driven to meet the needs of our community. Additionally, we are committed to our communities' health and our patients' care, whether the patient is attending visits or not. We continuously track population health level data to monitor who is in or out of care, whose healthcare metrics (such as blood pressures or A1c's are out of control or have not been checked recently enough) etc. We launch population health text and mail campaigns to outreach and engage patients who are

out of care. We mobilize community health and outreach workers to locate and reconnect these patients to their trusted medical home. However, many individuals remain disconnected, and it has worsened throughout the pandemic. We have observed that this has been particularly true for certain vulnerable populations, such as those experiencing homelessness, children, and seniors.

BNHC was fortunate to be awarded a grant in 2020 that yielded our first mobile health unit. The "Community Care in Reach" mobile unit provides services specifically to those experiencing homelessness, as well as people who use drugs. Started in 2021, this mobile unit can provide primary care, some acute care services, peer recovery coaching, and referrals to specialty services—all occurring where the patients are located. According to the CDC, there were over 100,000 drug-related overdose deaths in 2021 alone, which has steadily increased over the last 5 years. The screening, education and interventions provided on this mobile unit have undoubtedly saved lives! Additionally, it offers a patient-centered approach to high-quality, evidence-based care while also serving to contain costs through the reduction of ED utilization for services that are offered on the unit.

In addition to a mental health and substance use crisis in those who use drugs and in individuals experiencing homelessness, we have observed and measured an incredible increase in the behavioral health needs of our pediatric patients during and coming out of the pandemic. BNHC is actively seeking funding to acquire another mobile unit serve the pediatric populations of the city as a school-based service site. The integrated care team would include a full-time Nurse Practitioner, as well as a Behavioral Health Clinician, community health workers and Peer Recovery Coach. While not yet operational, this model (across any willing school system) can bring necessary and easily accessible resources to kids who are falling through the cracks, despite the school, parents' and health centers' best efforts.

On the other end of the age spectrum, I have also professionally observed and have been informed by behavioral health providers across the city of Brockton and the state that there is great concern for the mental health and well-being of many seniors. Having been more socially isolated during COVID (in order to protect themselves), they are now struggling to re-emerge, including struggling to re-engage with their health care providers.

I am privileged to treat a senior struggling with depression, who has said to me that she is deeply lonely, but is scared to leave her home without certain trusted individuals (her adult children). Despite the best efforts to coordinate transportation and engage her family, there are times when she simply does not feel well enough to leave the street on which she lives. She has missed appointments as a result. And like her, there are many others! BNHC is hoping to acquire a mobile unit that can visit senior centers, senior housing sites, the council on aging and potentially other locations (as determined by data) to bring integrated care, including screening and treatment for behavioral health and substance use disorder to their living space. Making care accessible reduces inefficiencies in the system, is cost-effective, and, most importantly, promotes patients' health and well-being.

I am so appreciative that last year this Committee recognized the value of mobile care units when it passed the MOBILE Health Care Act by unanimous consent to make it easier for health centers to finance mobile health units. These mobile units can offer primary or dental care or provide behavioral health services to sparsely populated rural areas or underserved urban populations. While the MOBILE Health Care Act provided the necessary flexibility to health centers to use Federal funding for mobile units, it did not provide any additional New Access Point dollars to take advantage of this flexibility. Additional New Access Point funding is necessary for health centers to take advantage of this unique opportunity. With this funding, health centers, like BNHC, can provide easier access to patients who are not engaging in their integrated primary care homes. This prevents the worsening of their conditions, thus improving their health and well-being while being cost-effective.

In addition to launching mobile clinical units to provide integrated care services to the homeless, at schools, and for seniors, I strongly support permanently extending the telehealth flexibilities, including audio only telehealth care, implemented during the COVID–19 public health emergency. Telehealth has been particularly effective in creating and maintaining access to behavioral health and substance use disorder treatment. This should remain an option to maximize access to services so critically needed by so many. We are experiencing a mental health crisis, and our providers feel it. When 1 in 5 adults and 1 in 2 adolescents live with a mental health illness, these nimble and flexible strategies can save lives, prevent the need for higher levels of care and promote well-being.

Prioritizing Pediatrics

While I spoke about children generally, I would like to call out the critical importance of early childhood mental health. At BNHC, our experienced pediatric providers are deeply disturbed and overwhelmed by the number of children with symptoms of psychological distress. Senior pediatricians who have worked with our patient population for decades, are reporting a particular concern about seeing young children (0–5 years old) exhibiting symptoms that are consistent with Autism Spectrum Disorder but having difficulty accessing diagnostic evaluations due to a limited supply of professionals (psychologists and psychiatrists) trained in these assessment protocols, particularly to serve patients who are uninsured or underinsured.

Fortunately, at BNHC, we have had a robust primary care-behavioral health integration program for years, but we expanded in 2019 with the help of a private grant through the Transforming and Expanding Access to Mental Health Care in Urban Pediatrics (TEAM UP for children) program. TEAM UP is an initiative to build the capacity of 7 Community Health Centers in MA to deliver high-quality, evidence-based, integrated behavioral health care to children and families. The TEAM UP transformation model is rooted in three principles: transforming care, strengthening foundations, and creating a learning community. BNHC has been implementing the TEAM UP model since 2019 and continues to transform to meet the behavioral health needs of its early childhood, pediatric population through integration of behavioral health and social services into primary care. A study of the utilization of services for children who have engaged with TEAM UP sites showed an increase in access to behavioral health services for Medicaid-enrolled children.[1] The mental health needs of our pediatric patients are enormous, and Community Health Centers have innovative and proven strategies to increase access to mental health services. I strongly support investments in health center service expansions, as health centers are well-positioned to meet the needs of our children, who continue to demonstrate the repercussions of the traumatic effects of the last 3 years.

Workforce Development

Nationally and locally, workforce recruitment and retention pose major barriers to maximizing access to services that can address this mental health crisis we are experiencing. According to HRSA estimates based on national benchmarks, nearly one-third of Americans live in a federally designated Mental Health Professional Shortage Area, 7.7 million health center patients are currently going without needed mental health care, and 4.9 million health center patients are going without needed substance use disorder treatment. The models of care to maximize access exist and can be leveraged to meet these needs. However, staffing is critical to addressing this mental health crisis.

In full awareness of our challenge, BNHC has designed and launched a number of grant-funded professional pipeline projects, including one designed for the training, recruitment, and retention of behavioral health clinicians. In this program, BNHC commits to accepting, training, supervising and paying stipends to a cohort of behavioral health students completing their Masters degrees. Additionally, BNHC will pay a recruitment bonus to new hires, and a retention bonus to Behavioral Health Clinicians who have been with the organization for 2 years or more. Our intention is to incentivize training at and hopefully also working at BNHC, or another Community Health Center. We would love for this Committee to provide more flexible funding to support a project like ours. These projects encourage training and working at community health centers, thus increasing the supply of trained behavioral health clinicians to meet the needs of this mental health crisis.

According to a survey by the National Association of Community Health Centers, behavioral health staff are in the top three categories for the highest rate of job loss for health centers. Competition from other employers and burnout from the pandemic are the most common reasons for staff departure. Additional Federal funding would help recruitment and retention. Another top priority impacting retention of staff are wellness programs and other interventions for employees to mitigate employment-related stress. I appreciate that last year, the HELP Committee passed the Lorna Breen Act by unanimous consent, which authorized funding for provider burnout. These programs are valuable because our staff are extraordinarily burnt out. As the Deputy CEO of BNHC, and a psychologist, I have the privilege and re-

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[1] Association of Integrating Mental Health into Pediatric Primary Care at federally Qualified Health Centers with Utilization and Follow-Up Care. Jihye Kim, PhD1; R. Christopher Sheldrick, PhD2; Kerrin Gallagher, MPH2; et al

sponsibility of listening to a lot of staff, and many of them have reported that they have "never felt worse".

We genuinely appreciate any support that our staff can receive to remain well in their roles as they continue to work daily to save lives and serve as the healthcare heroes who have been heralded throughout the pandemic. While not fighting COVID, they are fighting to address the effects of COVID including increased overdose deaths and substance use as well as serious mental health concerns.

Conclusion

Health centers like Brockton Neighborhood Health Center need long-term, sustainable, and predictable funding to meet our patients' behavioral health and substance use disorder needs. I recognize the difficult decisions Congress must make to balance funding levels with the need to maintain our Nation's fiscal health. Still, medical inflation has outpaced health centers' funding increases since 2015, leading to a 9.3 percent decrease in actual funding levels. Decades of research show that Federal investments in health centers reduce overall health spending by expanding access to efficient and effective primary care. Patients who access primary care at health centers show positive health outcomes and reduced use of emergency departments and hospital stays.

I appreciate that this budget environment makes additional investments challenging. Still, millions of patients could benefit by expanding access to mental health and substance use disorder care at the health centers where they are already receiving primary care. For example, the National Association of Community Health Centers estimates that an additional investment of $500 million over 5 years would allow health centers to hire more than 2,500 behavioral health specialists and reach more than 5 million additional patients. This level of commitment by Congress would leverage the existing network of care and build on a proven model that saves the health system billions of dollars.

Chairman Markey, Ranking Member Marshall, and Members of the Committee, thank you for allowing me to share the great work my team at BNHC is doing to fight the mental health and substance use disorder crisis in our Country. With this Committee's support, we will continue to find new ways to provide affordable, accessible, and high-quality care to the communities we serve. I look forward to your questions.

Senator MARKEY. Thank you, Dr. Celli, so much. Now, Senator Marshall will introduce our next witness.

Senator MARSHALL. Well, thank you, Mr. Chairman. I am certainly honored to introduce our second witness, Mr. Steven Denny, a fellow Jayhawk and a multi-generational Kansan. Mr. Denny is the deputy director of the Four County Mental Health Center. Their main office is in Independence, Kansas, and they proudly serve five counties now across Southeastern Kansas, including Montgomery County, Wilson, Elk, and Chautauqua.

As I think about that, that is probably an area of about 100 miles by 70 miles, very sparsely populated, and probably—it is the most economically challenged portion of Kansas. In addition to serving the mental health center, Mr. Denny is also the project director of Four Counties Certified Community Behavioral Health Clinic Expansion Grant, provided by the U.S. Substance Abuse and Mental Health Services Administration.

Under this role, Mr. Denny oversees clinical crises and substance use treatment services, as well as seeing patients every day. Thank you so much for agreeing to testify in person to discuss the work being done at Four County.

Mr. Denny, the floor is yours, thank you.

STATEMENT OF STEVEN DENNY, DEPUTY DIRECTOR, FOUR COUNTY MENTAL HEALTH CENTER, INDEPENDENCE, KS

Mr. DENNY. Chairman Markey and Senator Marshall, thank you so much for this opportunity to testify before the Senate HELP Committee this morning. As I mentioned, my name is Steve Denny.

I serve as Deputy Director at Four County Mental Health Center, serving five counties in Southeast Kansas. You will hear me refer to our organization as Four County throughout this testimony. As I mentioned, I am also the Certified Community Behavioral Health Clinic Project Director, also known as CCBHC.

We were the first Kansas organization awarded a SAMHSA CCBHC expansion grant in May 2020. Since then, six additional centers have followed suit in 2021, and by July 1st of 2024, all Kansas community mental health centers will have the same opportunity to become CCBHCs after the passage of Kansas House Bill 2208.

It is a true honor today to speak to you about this exciting opportunity and what it has done for our state and our Nation. The second C in CCBHC stands for community. My community is Montgomery County, Kansas. It is a rural Kansas county located on the Oklahoma border. It contains both industry and agriculture.

My hometown is a place that I swore I would never return to when I went away to college, and I have been back now for 18 years. My father was a lifelong rancher. My children are the sixth generation to live on our family property, our small farm. My community matters to me.

The CCBHC model requires nine core services that are oriented around the unique needs of each community served by CCBHCs. Those nine services are included in my written testimony for further review. This community focus, combined with the comprehensive care, data driven measures, and a continuous focus on quality improvement, is what makes the CCBHC model such a game changer.

I have worked in this field since 2002 as a therapist and a supervisor of multiple populations. During this time, our field has experienced funding cuts, reduction of inpatient resources, and a state hospital crisis that has brought our system to a breaking point.

Many of my colleagues have left the field for less demanding jobs that often pay more. Meanwhile, the needs of our communities continue to grow, leading to this crisis. CCBHCs have served as a lifeline for our system.

Kansas House Bill 2208 provided foundation for our state to apply for the recent CCBHC planning grant to expand this model, with the support of Senator Marshall, for which we are immensely thankful. One shining example of an expanded program into our model is our Veterans Services Program. This provides specialized care coordination for veterans, service members, and their families.

We have seen a 51 percent increase from baseline of veterans served each quarter since project implementation. This crisis also involves our youth. The pandemic was mentioned as a creator of isolation. We found that 36 percent of our adolescent admissions are identified as at risk for suicide or self-harm. 35 percent from

the same demographic report that social media is a negative factor in relationship to their mental wellness.

In response, we have started a robust school-based program that serves ten different districts in our area so that we can move our staff beyond the walls of our clinic. We anticipate continued growth in our youth services. In addition, we have created a special program targeting at risk adults for both legal place or legal issues and homelessness.

This program is known as the ACT, or a sort of community treatment program. It provided a crucial relief valve to law enforcement and emergency services. Initial outcome shows that 80 percent of the population has avoided homelessness and 76 percent have avoided new legal incidents based on quarterly tracking data.

In addition, we have developed a special program in partnership with law enforcement. We have four co-responders and 25 iPad devices deployed to our law enforcement partners to increase connection to law enforcement and emergency services. The CCBHC model increases access to care.

Since implementation, our Four County provides 70 percent of the admissions on the same day that individuals seek services. For those who elect to wait, the average wait time is 3 days compared to the national average of 48 days.

They also receive enhanced care coordination and involvement with primary care. If they don't have a primary care provider, we work hard to get them connected. The next big thing in our field is mobile crisis services, which we will need to develop in partnership with a new 9–8–8 crisis hotline.

National data indicates that this CCBHC model reduces ER visits by 68 percent. It also emphasizes care coordination and improved partnership with our local emergency hospitals. In conclusion, I just want to express my sincere support that we should move this model beyond a demonstration project and have it become a staple of our health care system.

Thank you for the opportunity to testify here today on behalf of the people we serve, and for the incredible workforce. Senator Markey, you said, heroes will go—there are so many unsung heroes that do this work, and I am thankful to be in this field. Thank you.

[The prepared statement of Mr. Denny follows:]

PREPARED STATEMENT OF STEVEN DENNY

Chairman Markey and Senator Marshall, thank you for the opportunity to testify before the Senate HELP Committee this morning. My name is Steve Denny, and I serve as Deputy Director of Four County Mental Health Center, Inc. (FCMHC) located in Southeast Kansas, where I also serve as the Certified Community Behavioral Health Clinic (CCBHC) project director. FCMHC was the first Kansas organization awarded a SAMHSA CCBHC expansion grant in May •20. Six additional Community Mental Health Centers followed suit and were awarded expansion grants in 2021. I have had the privilege of bearing witness to the milestones that created the rapid development of CCBHCs in Kansas. These milestones include the passage of the Kansas House Bill 2208 which established CCBHCs in Kansas and led to the eventual development of a State Plan Amendment to fund these clinics. By July 1st, 2024, our goal is to have all Kansas Community Mental Health Centers become CCBHCs. It is my honor today to speak to the exciting opportunity that the CCBHC model has brought to Kansas and to our Nation.

The second "C" in "CCBHC" represents the word "community." My community is Montgomery County, Kansas. It is a rural Kansas county located on the Oklahoma border that contains both industry and agriculture and where CCBHCs have saved lives. The CCBHC model requires 9 core services based on the unique needs assessment of the communities served by each clinic. These services include **(1) crisis services, screening, (2) diagnosis and risk assessment, (3) psychiatric rehabilitation services, (4) outpatient primary care screening and monitoring, (5) targeted case management, (6) outpatient mental health and substance use services, (7) person and family centered treatment planning, (8) community based mental health care for veterans and (9) peer and family support services.** This community focus combined with comprehensive care, data-driven approaches, and a continuous focus on quality is what makes the CCBHC model such a game changer.

I have worked in the field of behavioral health since 2002 as a therapist and supervisor for services to adults diagnosed with severe mental illness, crisis services, substance use treatment services, and adult and child outpatient therapy services. During this time, our field has experienced funding cuts, reduction of inpatient resources that brought us to the breaking point. Many colleagues have left the field for less demanding jobs that pay more. Meanwhile, the behavioral health needs of our communities continue to rise, leading us to a mental health and substance use crisis. Both personally and professionally, I've experienced the impact of suicide involving a variety of demographics, including adults, older adults, veterans and adolescents. One out of every five of FCMHC's crisis assessments are in response to a suicide attempt. In addition, we are facing an unparalleled mental health and substance use provider workforce shortage that has been growing for years and now is at a tipping point.

CCBHCs serve as a lifeline to the people of Kansas. Legislative efforts in Kansas established CCBHCs and provided the foundation for us to apply for the recent CCBHC planning grant to expand this model, with the tremendous support from Senator Marshall, for which we are immensely thankful. CCBHC implementation meant our organization could start and bolster mental health and substance use services based on the community needs. One shining example is FCMHC's Veterans Services program, which provides specialized care coordination for Veterans, service members, and their families. As a result, our organization serves an average of 140 unduplicated veterans each quarter which is a 51 percent increase from baseline all while improving our working relationship with two Veterans Administration facilities with the support of Senator Moran.

Part of the nationwide mental health and substance uses crisis involves our youth. Our children have been isolated with nothing but screens and devices, left alone at times to try and survive without the support of a community that teaches them to not just survive but to thrive. Youth suicide rates in Kansas increased by 63.8 percent in the most recent 15 year period (Kansas Health Institute) Outpacing the national

average, which is also rising.. 36 percent of adolescent admissions at FCMHC are identified as at risk for suicide or self-harm and 35 percent of the same demographic report that social media is a negative factor in relationship to their mental wellness. In response, we started a robust school-based program along with long standing programs that offer rehabilitation services to youth with more intensive needs. We are currently serving 9 school districts with CCBHC staff embedded in schools. We anticipate that opportunities to serve our youth will increase under the CCBHC model.

In addition, we have created special programs to work with the most "at risk" adults who have been diagnosed with mental health and substance use challenges and are often homeless and/or involved with the legal system. This program is known as the Assertive Community Treatment (ACT) model and has provided a crucial relief valve to law enforcement. The initial outcome data shows 80 percent of the population has avoided homeless incidents and 76 percent have avoided new legal incidents. Nationally, 96 percent of CCBHCs are actively engaged in one or more innovative activities in partnership with criminal justice agencies, including 77 percent who—like us—have used their CCBHC status to launch intensive outreach and engagement services to divert people at high risk from further involvement with the criminal justice system.

Of equal importance is the increased access to services in a timely manner while improving care coordination. Since CCBHC implementation, our organization provides 70 percent of admissions on the same day that they seek services. For those who do have to wait, the average wait time is 3 days compared to the national average of 48 days. Individuals in our care receive enhanced care coordination with pri-

mary care. 74 percent of our active population has an active primary care provider. When individuals do not have a primary care provider or require additional referrals, care coordinators work hard to close the referral loop. Through data collection, we identified the need to develop a tobacco cessation program. FCMHC currently provides tobacco cessation services to 72 individuals with 47 percent successfully quitting or reducing usage by more than half after starting the program. This is especially encouraging for the long-term cost implications for populations that have co-occurring chronic health conditions.

As we look ahead to CCBHC implementation in Kansas, we need to develop more mobile crisis services in partnership with the national 988 crisis hotline. Mobile crisis services reduce the number of emergency room visits. National data indicates that the CCBHC model reduces emergency room admission percentages by 68 percent. In addition, the CCBHC model emphasizes care coordination agreements between the CCBHC and the hospital. This improves partnerships and helps individuals from falling through the cracks upon discharge to the community.

In conclusion, I wish to express my support that the CCBHC model should move beyond "demonstration" status and become a staple of our healthcare system. As Daniel Tsai, the Director of Center for Medicaid and CHIP services at the Center for Medicare and Medicaid Services (CMS) and past Medicaid Director for the State of Massachusetts articulated during the national meeting for the National Council for Mental Well-being just a few weeks ago, the CCBHC model represents a crucial part to the pyramid of health care that we need to ensure high quality access to care for all people across our Nation. We have clearly seen this to be true for Kansas. Thank you for the opportunity to testify on behalf of the countless individuals that the CCBHC system serves and the incredible workforce that provides this care.

Senator MARKEY. Thank you, Mr. Denny, so much. I am going to recognize Senator Tuberville for an introduction of Dr. Taylor. Dr. Taylor is President Elect of the American Society of Addiction Medicine, a triple board certified in general child, adolescent addiction and sports psychiatry. Dr. Taylor also serves as the Medical Director of the NBA.

Senator Tuberville.

Senator TUBERVILLE. Thank you. Thank you, Senator Markey and Senator Marshall, for having this. Just a quick statement, and I note, I am not a Member of this Committee, but I will say this is—the importance of this Committee. I dealt with hundreds of families every year in my former job, and there weren't many families that I would ever run into that didn't have some type of mental health problem in their family.

This is not a crisis. This is a national emergency. I don't think we really understand the problems that we have now. We are going to continue to have it. It is going to get worse if we don't address it, and it is by having hearings like this. I tell people all the time, they say, wait, we can't afford to attack mental health problems. It is too big.

My comment to that is we can't afford not to fund mental health in this country. We have to attack mental health in this country, and we have got to fund it no matter what it takes. So, tough times requires tough leaders. Dr. Taylor, it is my privilege to introduce Stephen Taylor from Birmingham, Alabama.

He is completing his 13th season as the Medical Director of the Player Assistance Anti-Drug Program with the NBA, the National Basketball Players Association. He also serves as the Chief Medical Officer of the Behavioral Health Division of Pathway Health Care, a company that operates 17 outpatient addiction treatment offices

spread throughout the South. Additionally, Dr. Taylor is President Elect of the American Society of Addiction Medicine.

Dr. Taylor is uniquely positioned to understand the scope and the extent of the mental health crisis and emergency we are experiencing in this country. This crisis affects children and adults of all ages and all walks of life. He is a perfect witness for today's hearing, a crisis in mental health and emergency substance use disorder care.

He will discuss the work that needs to be done to fix our broken mental health care infrastructure in this country. I am incredibly proud to have someone like Dr. Taylor working on these issues in the great State of Alabama, and I look forward to partnering with him, moving forward, to help keep up these efforts. I am also pleased that this Subcommittee is focusing on this today and hope that the entire HELP Committee can understand the importance of this.

Dr. Taylor, welcome and thank you, Mr. Chair.

Senator MARKEY. Thank you, Senator. You are recognized, whenever you are comfortable, Dr. Taylor. Please begin.

STATEMENT OF STEPHEN TAYLOR, PRESIDENT ELECT, AMERICAN SOCIETY OF ADDICTION MEDICINE, BIRMINGHAM, AL

Dr. TAYLOR. Thank you for that kind introduction, Senator Tuberville. Chairman Markey, Ranking Member Marshall, and esteemed Members of this Subcommittee, thank you for inviting me to participate in today's hearing on closing gaps in access to mental health and substance use disorder care by bringing that care into communities across this Nation.

Today, I am testifying in my capacity as President elect of the American Society of Addiction Medicine, known as ASAM. ASAM is a National Medical Society representing over 7,000 physicians and other clinicians who specialize in the prevention and treatment of addiction and co-occurring conditions.

I would like to begin by recognizing the bipartisan work that Congress has done over the years to help address what is turning out to be the deadliest addiction and overdose crisis in American history. Thank you for your efforts.

Still, at a time of elevated death rates and medical complications associated with synthetic opioids like fentanyl, psycho stimulants like methamphetamine, and the non-opioid veterinary tranquilizer Xylazine, much more work needs to be done to create a sustainable and robust addiction care infrastructure, one that addresses addiction as a preventable and treatable chronic medical disease.

Accordingly, ASAM asks this Subcommittee to focus on three areas that are ripe for policy intervention. First, the addiction specialist physician workforce. ASAM estimates that there are only about 7,000 addiction specialist physicians defined as physicians who are board certified in addiction medicine or addiction psychiatry in this country.

While addiction treatment in the United States is often delivered to patients by multidisciplinary health care teams that work to address patients bio-psychosocial needs, the distinct clinical knowl-

edge and skill set of addiction specialist physicians best situates us to lead those teams.

Addiction specialist physicians can increase our health care team's capacity to prevent and treat more complicated medical cases involving substance use disorder. Addiction specialist led care teams also lead to the greater integration of addiction care into general medical and mental health treatment settings.

Even more importantly, such care models can enable our health care system to increase its capacity to provide addiction treatment in primary care settings, which is especially important in areas where there is a dearth of specialty addiction treatment facilities.

For this and other reasons, Congress created the groundbreaking Substance Use Disorder Treatment and Recovery Loan Repayment Program, or STAR-LRP, in the Support Act of 2018. When individuals pursue a full-time job to provide addiction treatment in high need geographic areas, HRSA's STAR-LRP can help them repay up to $250,000 in their student loans. Demand for this program has been overwhelming.

Therefore, ASAM strongly supports the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization Act of 2023, which was introduced yesterday in the House on a bipartisan basis and would further strengthen the program while preserving its focus on addiction care workforce.

Additionally, ASAM urges this Congress to pass legislation to encourage teaching health center graduate medical education program applicants to sponsor addiction medicine fellowship programs, and to require all HRSA funded health centers to offer addiction and mental health services.

Second, decriminalization of the prescribing of methadone for the treatment of OUD by addiction specialist physicians for dispensing at pharmacies. While ASAM is grateful for SAMHSA's ongoing efforts to update Federal regulations governing opioid treatment programs known as OTPs, continuing to restrict patient access to methadone for OUD to OTP settings is a public health threat that unnecessarily limits access to this lifesaving medication for those who need it.

Therefore, ASAM strongly supports passage of the bipartisan, bicameral, Modernizing Opioid Treatment Access Act, which would responsibly expand access to methadone treatment for all OUDs by decriminalizing its prescribing by addiction specialist physicians for dispensing at pharmacies.

Third, enforcement of Federal mental health and addiction parity law. It has been well documented that we need better enforcement of Federal mental health and addiction parity law in this country. Under current law, the U.S. Department of Labor lacks the authority to assess civil monetary penalties for violations of Federal parity law already on the books.

This prevents DOL from effectively ending parity violations with respect to group health plans. That is why ASAM strongly supports the soon to be introduced Parity Enforcement Act, which would finally add civil monetary penalty authority to the DOL's oversight.

In conclusion, these policies and resources are imperative to bringing addiction care into communities across this Nation and to saving more lives. Thank you, and I look forward to answering your questions.

[The prepared statement of Dr. Taylor follows:]

PREPARED STATEMENT OF STEPHEN TAYLOR

Chairman Markey, Ranking Member Marshall, and esteemed Members of this Subcommittee, thank you for inviting me to participate in today's critically important hearing on closing gaps in access to mental health and substance use disorder (SUD) care by bringing that care into communities across this Nation. My name is Dr. Stephen Taylor. I am board-certified in addiction medicine, addiction psychiatry, child and adolescent psychiatry, and general psychiatry. I take care of patients with addiction and co-occurring conditions in Birmingham, Alabama where I serve as the Chief Medical Officer of Pathway Healthcare—a company operating 17 outpatient mental health and addiction treatment offices in five southern states. I am also the Medical Director of the Player Assistance and Anti-Drug Program of the National Basketball Association (NBA) and the National Basketball Players Association (NBPA) . Today, I am testifying in my capacity as President-Elect of the American Society of Addiction Medicine, known as ASAM. ASAM is a national medical society representing over 7,000 physicians and other clinicians who specialize in the prevention and treatment of addiction and co-occurring conditions.

I would like to begin by recognizing the bipartisan work that Congress has done over the years to help address—what is turning out to be—the deadliest addiction and overdose crisis in American history. Your efforts have made a positive difference. Thank you.

Still, at a time of elevated death rates and medical complications associated with synthetic opioids like fentanyl, psychostimulants like methamphetamine, and the non-opioid veterinary tranquilizer xylazine, **much more work needs to be done to create a sustainable and robust addiction care infrastructure—one that addresses addiction as a preventable and treatable chronic medical disease.**

Accordingly, ASAM asks this Subcommittee to focus on the following three areas that are ripe for policy intervention:

1. Prioritization of the recruitment, training, and retention of addiction specialist physicians—defined as physicians who are board certified in addiction medicine or addiction psychiatry; [1]

2. Decriminalization of the prescribing of methadone for the treatment of opioid use disorder (OUD) by addiction specialist physicians (and OTP (defined below) clinicians) for dispensing at pharmacies; methadone is the only full opioid agonist medication that is approved by the Food and Drug Administration (FDA) for the treatment of OUD; and

3. Enforcement of Federal mental health and addiction parity law that is already on the books.

Prioritization of the Addiction Specialist Physician Workforce

Addiction is a chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. A lack of knowledge and misinformation about addiction within the medical community has been a longstanding problem. Therefore, the fact that there remains far too few physicians and other clinicians who specialize in the assessment of substance use disorder (SUD) and the prevention and treatment of the disease of addiction is of grave concern. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2021,

[1] ASAM. Public Policy Statement on Recognition and Role of Addiction Specialist Physicians in Health Care in the United States. *https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/01/28/public-policy-statement-on-the-recognition-and-role-of-addiction-specialist-physicians-in-health-care-in-the-united-states* (describing the four medical subspecialty certifications that demonstrate and define physician expertise in addiction treatment).

well over 40 million Americans had SUD in the past year.[2] For purposes of comparison, the State of California has nearly 40 million residents. At the same time, deaths continue to persist at record levels from drug overdoses, according to the Centers for Disease Control and Prevention.[3]

Shortfalls exist at all levels of the addiction care workforce, but one of the most grievous is among addiction specialist physicians. ASAM estimates that there are only about 7,000[4] of said physicians in this country—defined as physicians holding board certification in the medical subspecialty of addiction medicine or addiction psychiatry. As of March 2023, there were only 96 ACGME-accredited addiction medicine fellowship programs in the nation[5]5—far below the recommended goal of 125 fellowships by 2022 set by the President's Commission on Combating Drug Abuse and the Opioid Epidemic over 5 years ago.[6] Our failure to meet this goal should be unacceptable.

While addiction treatment in the U.S. is often delivered to patients by multidisciplinary healthcare teams that work to address patients' biopsychosocial needs,[7] the distinct clinical knowledge and skill set of addiction specialist physicians best situate them to lead those teams. Addiction specialist physicians can increase a healthcare team's capacity to prevent and treat more complex medical cases involving substance use disorder. Addiction specialist-led care teams can also lead to the greater integration of addiction care into general medical and mental health treatment settings. Even more importantly, such care models can enable our healthcare system to increase its capacity to provide addiction treatment in primary care settings—which is especially important in areas where there is a dearth of specialty addiction treatment facilities.

Indeed, Congress acknowledged just how severe the overall SUD workforce shortage is—including its addiction specialist shortage—when it created a groundbreaking loan repayment program, known as the Substance Use Disorder Treatment and Recovery Loan Repayment Program, or STAR-LRP, in the SUPPORT for Patients and Communities Act of 2018. When individuals pursue a full-time job to provide SUD treatment in high-need geographic areas, the Health Resources and Services Administration (HRSA)'s STAR-LRP can help them repay up to $250,000 in their student loans. Unsurprisingly, demand for this program has been overwhelming. In Fiscal Year 2021, alone, over 3,000 people applied for the program, but HRSA only had enough funding to serve 8 percent—or 255 of them—at an average award amount of a little over $100,000, which is far below the maximum award amount allowed. Reauthorizing and strengthening STAR-LRP this year, while retaining its laser focus on the SUD workforce, is a top priority for ASAM. **That is why ASAM strongly supports passage of the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthoriza-**

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[2] Substance Abuse and Mental Health Administration. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health." U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, Populations Survey Branch, no. PEP22–07–01–005 (December 2022). *https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.*

[3] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2023. Designed by LM Rossen, A Lipphardt, FB Ahmad, JM Keralis, and Y Chong: National Center for Health Statistics.

[4] According to an email that ASAM received from the Executive Director of the American Board of Preventive Medicine (ABPM), as of January 2023, there were 4,347 Addiction Medicine Diplomates through ABPM with active status. According to an email that ASAM received from the Executive Director of the American College of Academic Addiction Medicine (ACAAM), as of January 2023, there were 1,312 addiction medicine physicians through the American Board of Addiction Medicine (ABAM). (According to ACAAM's Executive Director, there may be small overlap of people who remain both certified by ABAM and ABPM, but it would not be a significant number.) According to the 2021—2022 ABMS Board Certification Report, as of June 30, 2022, there were 1,398 board-certified addiction psychiatrists in the U.S. (some of whom may be retired). ASAM was unable to confirm the number of AOA board-certified addiction medicine physicians as of the date of this hearing, but estimates a few hundred physicians holding such board certification.

[5] American College of Academic Addiction Medicine. *https://www.acaam.org/fellowship-training*

[6] THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS. *https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final—Report—Draft—11-15-2017.pdf*

[7] Examples of multidisciplinary team models include specialized addiction treatment programs, the Patient Centered Medical Home (PCMH), the "hub-and-spoke" model, the nurse care management model, and the Collaborative Care Model, which exist on a spectrum of integration with general medical treatment.

tion Act of 2023, which is bipartisan legislation in the House that would further strengthen the program while preserving its focus on the addiction care workforce.

In addition, while **ASAM urges Congress to ensure that addiction specialist physicians are included across all HRSA Behavioral Health Workforce Development Programs, I also want to highlight that addiction specialist physicians often hold primary board certifications in the primary care specialties recognized by HRSA's Teaching Health Center Graduate Medical Education (THCGME) program. Those primary care specialties include family medicine, internal medicine, pediatrics, and general psychiatry. This multispecialty characteristic of addiction medicine is, therefore, why ASAM recommends that Congress pass legislation that would prioritize (or otherwise incentivize) THCGME program applicants that sponsor addiction medicine fellowship programs. ASAM also strongly supports the President's Budget proposals to (1) make additional investments in addiction and mental health services at health centers and (2) amend section 330 of the Public Health Service Act to require all HRSA-funded health centers to offer addiction and mental health services.** [8]

Decriminalization of the Prescribing of Methadone for OUD by Addiction Specialist Physicians for Pharmacy Dispensing

Second, we all know that the long U.S. history of treating addiction in siloed settings separate from the rest of medicine exacerbates the addiction care workforce shortage. SAMHSA estimates that less than four in ten patients with OUD—who are primarily admitted for OUD to publicly funded SUD treatment—receive treatment with medications for OUD. [9] Other studies have shown even worse rates of appropriate medication usage for alcohol use disorder. [10, 11] We no longer accept this in other parts of American medicine, and it is not acceptable for caring individuals with addiction.

In 2019, a national report noted that the fragmentation that has occurred as a result of separating OUD treatment settings from other medical care not only creates significant access barriers, but is not supported by evidence. [12] More specifically, while models of integrated methadone treatment of OUD with primary and other medical care sometimes exist in the U.S., they are much more common internationally. A 2017 international meta-analysis showed a significant reduction in all-cause mortality among people treated with methadone for OUD, both by general practitioners and specialty clinics. [13, 14] Randomized controlled trials—the gold standard—have demonstrated the safety and efficacy of methadone treatment of sta-

[8] Johnson, Carole. HRSA Administrator. Testimony before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health on "Examining Existing Federal Programs to Build a Stronger Health Workforce and Improve Primary Care." *https://d1dth6e84htgma.cloudfront.net/Witness—Testimony—Carole—Johnson—HE—Hearing—04—19—23—e3abe98943.pdf?updated—at=2023—04—17T20:18:01.021Z*. Published April 19, 2023. Accessed April 24, 2023.

[9] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2020. Admissions to and Discharges from Publicly Funded Substance Use Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022.

[10] Arms L, Johl H, DeMartini J. Improving the utilization of medication-assisted treatment for alcohol use disorder at discharge. BMJ Open Quality 2022;11:e001899. doi: 10.1136/bmjoq—2022—001899

[11] Policymaker Summary: Pharmacotherapy for Adults With Alcohol Use Disorder in Outpatient Settings. Content last reviewed January 2021. Effective Health Care Program, Agency for Healthcare Research and Quality, Rockville, MD. *https://effectivehealthcare.ahrq.gov/products/alcohol-misuse-drug-therapy/policymaker*

[12] National Academies of Sciences, Engineering, and Medicine. 2019. Medications for opioid use disorder save lives. Washington, DC: The National Academies Press. doi: *https://doi.org/10.17226/25310*.

[13] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357:j1550

[14] Samet JH, Botticelli M, Bharel M. Methadone in Primary Care—One Small Step for Congress, One Giant Leap for Addiction Treatment. N Engl J Med. 2018;379(1):7–8. doi:10.1056/NEJMp1803982

ble patients in primary care.[15, 16] Safety has also been shown in multiple non-randomized studies, some with 9 to 15 years of follow-up.[17, 18, 19] Methadone has been available by prescription in Australia since 1970, and in Great Britain since 1968.[20] Moreover, office-based prescribing and pharmacy dispensing of methadone increase the number of individuals with OUD with access to methadone treatment, as occurred in Canada following its 1996 implementation of such practices.[21]

Here, in the U.S., methadone was first used for OUD treatment in the 1960's under Investigational New Drug applications issued by the FDA, at a time when providing opioid medications for OUD remained illegal otherwise.[22] In 1972, the FDA determined and approved methadone as safe and effective for treatment of OUD.[23] At the same time, erroneous beliefs that methadone replaced one addiction for another, reports of methadone-related deaths and diversion,[24] and concerns over increasing crime rates[25] created a climate of skepticism and hostility toward methadone-based OUD care. In 1974, Congress granted additional jurisdiction over methadone to the Drug Enforcement Administration (DEA).[26] Both FDA, and subsequently SAMHSA, replaced the usual practice of physician autonomy with strict rules governing the provision of methadone for OUD treatment that—to this day-do not apply when methadone is prescribed for pain and dispensed from a community pharmacy.

These exceptional Federal regulations specified criteria on eligibility, initial methadone dosages, required counseling services, supervised dosing, and restricted methadone treatment to provision within a closed system of regulated clinics, then known as narcotic treatment programs, now known as opioid treatment programs or OTPs.[27] Such detailed regulations surrounding a specific medical practice have led into an orientation toward regulatory compliance, to the detriment of incentivizing innovation, quality, or individualized patient care. The detailed regulations also have carried along with them a misguided conception of abstinence de-

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[15] Fiellin DA, O'Connor PG, Chawarski M, Pakes JP, Pantalon MV, Schottenfeld RS. Methadone maintenance in primary care: a randomized controlled trial. JAMA. 2001 Oct 10;286(14):1724–31. doi: 10.1001/jama.286.14.1724. PMID: 11594897.

[16] Carrieri PM, Michel L, Lions C, et al. Methadone induction in primary care for opioid dependence: a pragmatic randomized trial (ANRS Methaville). PLoS One. 2014;9(11):e112328. Published 2014 Nov 13. doi:10.1371/journal.pone.0112328.

[17] Novick DM, Joseph H, Salsitz EA, et al. Outcomes of treatment of socially rehabilitated methadone maintenance patients in physicians' offices (medical maintenance): follow-up at three and a half to nine and a fourth years. J Gen Intern Med. 1994;9(3):127–130. doi:10.1007/BF02600025.

[18] Salsitz EA, Joseph H, Frank B, et al. Methadone medical maintenance (MMM): treating chronic opioid dependence in private medical practice—a summary report (1983–1998). Mt Sinai J Med. 2000;67(5–6):388–397.

[19] Schwartz RP, Brooner RK, Montoya ID, Currens M, Hayes M. A 12-year follow-up of a methadone medical maintenance program. Am J Addict. 1999;8(4):293–299. doi:10.1080/105504999305695.

[20] Samet JH, Botticelli M, Bharel M. Methadone in Primary Care—One Small Step for Congress, One Giant Leap for Addiction Treatment. N Engl J Med. 2018;379(1):7–8. doi:10.1056/NEJMp1803982

[21] Nosyk B, Anglin MD, Brissette S, et al. A Call For Evidence-Based Medical Treatment Of Opioid Dependence In The United States And Canada. Health Affairs. 2013;32(8): 1462—1469. *https://doi.org/10.1377/hlthaff.2012.0846*

[22] Jaffe JH, O'Keeffe C. From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. Drug Alcohol Depend. 2003 May 21;70(2 Suppl):S3–11. doi: 10.1016/s0376–8716(03)00055–3. PMID: 12738346.

[23] Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment; Rettig RA, Yarmolinsky A, editors. Federal Regulation of Methadone Treatment. Washington (DC): National Academies Press (US); 1995. Executive Summary. Available from: *https://www.ncbi.nlm.nih.gov/books/NBK232111/*.

[24] Jaffe JH, O'Keeffe C. From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. Drug Alcohol Depend. 2003 May 21;70(2 Suppl):S3–11. doi: 10.1016/s0376–8716(03)00055–3. PMID: 12738346.

[25] Kleber, Herbert D. Methadone Maintenance 4 Decades Later. JAMA. 2008;300(19):2303–2305. free: *https://jamanetwork.com/journals/jama/fullarticle/182898.*

[26] Jaffe JH, O'Keeffe C. From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. Drug Alcohol Depend. 2003 May 21;70(2 Suppl):S3–11. doi: 10.1016/s0376–8716(03)00055–3. PMID: 12738346.

[27] Jaffe JH, O'Keeffe C. From morphine clinics to buprenorphine: regulating opioid agonist treatment of addiction in the United States. Drug Alcohol Depend. 2003 May 21;70(2 Suppl):S3–11. doi: 10.1016/s0376–8716(03)00055–3. PMID: 12738346.

fined as cessation of methadone pharmacotherapy.[28] Experts have written about how such a highly regulated system of methadone-specific clinics in the U.S. reflects structural racism and contributes to health disparities among people with OUD.[29]

It is progress and good news that outdated Federal OTP regulations will be updated soon to address OUD treatment standards in that setting. Drawing on research, evidence, and experience from the past two decades, thankfully, SAMHSA has indicated forthcoming regulatory updates when it issued a notice of proposed rulemaking in December 2022.[30] However, by continuing to largely restrict access to methadone for OUD to OTPs, the potential for expanded access to methadone treatment for OUD remains severely limited. Despite an expansion of OTPs in the U.S. in certain sectors in recent years, the prevalence of OUD has grown more quickly.[31] Most U.S. counties do not even have an OTP.[32] OTPs have established only a limited number of "mobile components," known as medication vans,[33] and a limited number of satellite medication units in locations such as pharmacies, jails, prisons, federally qualified health centers (FQHCs), and residential treatment facilities, resulting in limited geographic reach,[34] and complex demographic inequities in access to treatment.[35]

For these reasons, ASAM strongly supports passage of the bipartisan and bicameral Modernizing Opioid Treatment Access Act (M-OTAA) (S. 644/H.R. 1359). M-OTAA would responsibly expand the capacity for lifesaving methadone treatment for individuals with OUD through our existing medical infrastructure. Specifically, it would decriminalize[36] OTP clinicians and addiction specialist physicians—the latter representing some of the most educated and experienced physicians using pharmacotherapies for OUD in the nation[37]—who prescribe methadone

[28] White WL, Mojer-Torres L. Recovery-Oriented Methadone Maintenance. 2010. *http://www.williamwhitepapers.com/pr/dlm—uploads/2010Recovery—orientedMethadoneMaintenance.pdf.* Accessed April 22, 2023.

[29] Miller, NS. Racial disparities in opioid addiction treatment: a primer and research roundup. The Journalist's Resource. 2021. *https://journalistsresource.org/home/systemic-racism-opioid-addiction-treatment/*. Accessed April 22, 2023.

[30] SAMHSA. SAMHSA Proposes Update to Federal Rules to Expand Access to Opioid Use Disorder Treatment and Help Close Gap in Care. *https://www.samhsa.gov/newsroom/press-announcements/20221213/update-Federal-rules-expand-access-opioid-use-disorder-treatment*. Published December 13, 2023. Accessed April 24, 2023. In addition, in April 2023, SAMHSA issued newly revised April 2023 Guidance extending methadone take-home flexibilities—effective upon the expiration of the COVID–19 public health emergency and remaining in effect for the period of 1 year from the end of the COVID–19 public health emergency, or until such time that the final rules revising 42 CFR part 8 are published. *https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance*.

[31] Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

[32] Joudrey PJ, Chadi N, Roy P, Morford KL, Bach P, Kimmel S, Wang EA, Calcaterra SL. Pharmacy-based methadone dispensing and drive time to methadone treatment in five states within the United States: A cross-sectional study. Drug Alcohol Depend. 2020 Mar 27;211:107968. doi: 10.1016/j.drugalcdep.2020.107968. Epub ahead of print. PMID: 32268248; PMCID: PMC7529685.

[33] Biden-Harris Administration Expands Treatment to Underserved Communities with Mobile Methadone Van Rule. *https://www.whitehouse.gov/ondcp/briefing-room/2021/06/29/biden-harris-administration-expands-treatmentto-underserved-communities-with-mobile-methadone-van-rule—2021/*. Published June 29, 2021. Accessed April 22, 2023.

[34] "Methadone Barriers Persist, Despite Decades Of Evidence, " Health Affairs Blog, September 23, 2019. DOI: 10.1377/hblog20190920.981503.

[35] Joudrey, Paul, Gavin Bart, Robert Brooner, Lawrence Brown, Julia Dickson-Gomez, Adam Gordon, Sarah Kawasaki, et al. "Research Priorities for Expanding Access to Methadone Treatment for Opioid Use Disorder in the United States: A National Institute on Drug Abuse Center for Clinical Trials Network Task Force Report." Substance Abuse 42 (July 3, 2021): 245—54. *https://doi.org/10.1080/08897077.2021.1975344*.

[36] Lampe, J.R. (2023). The Controlled Substances Act (CSA): A legal overview for the 118th Congress (CRS Report No. R45948). Congressional Research Service, 9. *https://crsreports.Congress.gov/product/pdf/R/R45948* (stating that a violation of the Controlled Substances Act's registration requirements is a criminal offense if the violation is committed knowingly, and the Department of Justice may bring criminal charges against individual registrants; for example, a first criminal violation of the registration requirements by an individual is punishable by a fine or up to a year in prison).

[37] The American College of Graduate Medical Education (ACGME) sets the program requirements for graduate medical education in addiction medicine and addiction psychiatry. ACGME common core program requirements for addiction medicine fellowships include: pharmacotherapy and psychosocial interventions for SUDs across the age spectrum, (IV.B.1.c.).(1).(k)); the mechanisms of action and effects of use and abuse of alcohol, sedatives, opioids, and other drugs, and the pharmacotherapies and other modalities used to treat these (IV.B.1.c).(1).(m)); the safe prescribing and monitoring of controlled medications to patients with

for OUD that can be dispensed from a community pharmacy. Among other safeguards contained in M-OTAA, these separately registered prescribers would remain subject to SAMHSA's continued regulation and guidance on supply of methadone for unsupervised use.

While it is true there is widespread stakeholder support for SAMHSA's proposals for greater OTP clinician discretion in determining take-home methadone doses for OUD,[38] certain OTP stakeholders have expressed concerns with M-OTAA's provisions that would allow addiction specialist physicians practicing outside of OTPs to prescribe methadone for OUD. These critics often cite the risks of methadone overdose and diversion as the primary reasons for this concern. However, when more closely examined, the totality of that opposition puts more patients with OUD at risk for overdose in a time of an alarming death toll.

For starters, any analysis of M-OTAA must be situated in a contemporary framework for the current crisis. The adulteration of the illegal drug supply with illicitly manufactured fentanyl, fentanyl analogs, and xylazine has created an unprecedented and catastrophic moment in U.S. history. Today, it is a more dangerous time than it has ever been to be an American with OUD. However, patients with OUD who are engaged in addiction treatment are less likely to die than those who remain untreated, and for some patients, methadone is essential to a successful recovery.[39] Methadone can facilitate abstinence from illegal substance use, support recovery, and prevent overdose deaths.[40] Thus, restrictions that continue to limit methadone treatment for OUD to OTPs are a well-recognized vulnerability in the response to the nation's addiction and overdose crisis.[41]

Furthermore, there are underlying complexities in the early trends of diversion of methadone and related overdoses, which were, in large part, associated with historical trends in the acceleration of prescribing opioids for chronic, non-cancer

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or without SUDs (IV.B.1.c).(1).(n)); at least 3 months of structured inpatient rotations, including inpatient addiction treatment programs, hospital-based rehabilitation programs, medically managed residential programs where the fellow is directly involved with patient assessment and treatment planning, and/or general medical facilities or teaching hospitals where the fellow provides consultation services to other physicians in the Emergency Department for patients admitted with a primary medical, surgical, obstetrical, or psychiatric diagnosis; (IV.C.3.a).(1)); at least 3 months of outpatient experience, including intensive outpatient treatment or "day treatment" programs, addiction medicine consult services in an ambulatory care setting, pharmacotherapy, and/or other medical services where the fellow is directly involved with patient assessment, counseling, treatment planning, and coordination with outpatient services (IV.C.3.a).(2)). *https://www.acgme.org/globalassets/pfassets/programrequirements/404—addictionmedicine—2022—tcc.pdf*

[38] Two studies published in January 2023 raise questions about the role of Federal regulatory OTP flexibilities during the COVID public health emergency in increases in methadone-involved overdoses deaths. However, both studies' authors identify significant limitations of their study in demonstrating direct causality. While there remains no direct evidence of causality, ASAM recognizes that granting more flexibilities within the OTP setting must be carried out with caution and with Federal agencies' continual, longitudinal regulations and monitoring for unintended consequences, notwithstanding the widespread support of making such Federal take home policy changes permanent, including among OTP stakeholders. OTP medical directors are not required to be addiction specialist physicians, and not all OTP clinicians are physicians. See Kleinman, Robert A., and Marcos Sanches. "Methadone-Involved Overdose Deaths in the United States before and during the COVID–19 Pandemic." Drug and Alcohol Dependence 242 (January 1, 2023): 109703. *https://doi.org/10.1016/j.drugalcdep.2022.109703*. See also Kaufman, Daniel E., Amy L. Kennalley, Kenneth L. McCall, and Brian J. Piper. "Examination of Methadone Involved Overdoses during the COVID–19 Pandemic." Forensic Science International 344 (January 31, 2023): 111579. *https://doi.org/10.1016/j.forsciint.2023.111579*.

[39] National Academies of Sciences, Board on Health Sciences Policy, Committee on Medication Assisted Treatment for Opioid Use Disorder. The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. National Academies Press (US); 2019. Accessed March 31, 2022. *http://www.ncbi.nlm.nih.gov/books/NBK541393/*

[40] Stone AC, Carroll JJ, Rich JD, Green TC. Methadone maintenance treatment among patients exposed to illicit fentanyl in Rhode Island: Safety, dose, retention, and relapse at 6 months. Drug Alcohol Depend. 2018;192:94–97. doi:10.1016/j.drugalcdep.2018.07.019

[41] NASEM. Methadone Treatment for Opioid Use Disorder Examining Federal Regulations and Laws A Workshop National Academies. Published 2021. Accessed December 6, 2021. *https://www.nationalacademies.org/event/03—03—2022/methadone-treatment-for-opioid-usedisorder-examining-Federal-regulations-and-laws-a-workshop*

pain.[42], 1A[43], [44] Methadone is unusual among opioid agonists in that the slow accumulation of serum levels during initial dose adjustment may contribute to the risk of fatal methadone overdose,[45] especially if healthcare professionals overestimate a patient's degree of opioid tolerance.[46] And, when methadone is used to treat chronic pain—especially by prescribers lacking training in pain medicine, the frequent dosing regimens tend to play into methadone's pharmacological risks.[47] M-OTAA, however, does not increase methadone prescribing for chronic pain (which happens to remain available through prescription and pharmacy dispensing today). Indeed, historical and contemporary research support a responsible expansion in access to methadone treatment for OUD, including through office-based practices.[48], 1A[49], [50]

To be clear, M-OTAA is not methadone for everyone, prescribed by anyone. It represents a responsible expansion in methadone access for OUD, including through a highly trained, modern-day workforce of expert physicians who can manage this essential treatment for Americans who need it. Inaction on M-OTAA is the risk that this country cannot continue to take.

Enforcement of Existing Federal Mental Health and Addiction Parity Law

Last, despite over a decade since the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, such parity of coverage for care remains elusive for millions of Americans suffering with mental health and substance use disorders. A wide disparity in network use and provider payment rates between mental health and addiction treatment, on the one hand, and general medical care on the other, have been well-documented.[51] A recent report to Congress, issued by the U.S. Departments of Labor, Health and Human Services, and the Treasury, suggests that health plans and issuers are not always delivering parity for mental health and substance use disorder benefits to their beneficiaries.[52]

While the reasons for parity elusiveness are many, one sits squarely within your jurisdiction. Under current law, the U.S. Department of Labor (DOL) lacks the authority to assess civil monetary penalties for violations of Federal parity law already on the books. Without this power, DOL cannot effectively end parity violations with respect to group health plans. That is why **ASAM strongly supports passage of the Parity Enforcement Act,[53] which would finally add civil monetary pen-**

[42] Paulozzi L, Mack K, Jones CM. Vital Signs: Risk for Overdose from Methadone Used for Pain Relief—United States, 1999—2010. Published July 6, 2012. Accessed December 11, 2021. *https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm*

[43] Jones CM. Trends in Methadone Distribution for Pain Treatment, Methadone Diversion, and Overdose Deaths—United States, 2002—2014. MMWR Morb Mortal Wkly Rep. 2016;65. doi:10.15585/mmwr.mm6526a2

[44] DEA. Methadone Diversion, Abuse, and Misuse: Deaths Increasing at Alarming Rate. Published October 16, 2007. Accessed April 22, 2023. *https://www.justice.gov/archive/ndic/pubs25/25930/index.htm—Diversion*

[45] Clark JD; Understanding Methadone Metabolism: A Foundation for Safer Use. Anesthesiology 2008; 108:351— 352 doi: *https://doi.org/10.1097/ALN.0b013e318164937c*

[46] Center for Substance Abuse Treatment, Methadone-Associated Mortality: Report of a National Assessment, May 8–9, 2003. SAMHSA Publication No. 04–3904. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2004.

[47] FDA. Highlights of Prescribing Information—Methadone

[48] Salsitz EA, Joseph H, Frank B, et al. Methadone medical maintenance (MMM): treating chronic opioid dependence in private medical practice—a summary report (1983–1998). Mt Sinai J Med N Y. 2000;67(5–6):388–397.

[49] McCarty D, Bougatsos C, Chan B, et al. Office-Based Methadone Treatment for Opioid Use Disorder and Pharmacy Dispensing: A Scoping Review. Am J Psychiatry. 2021;178(9):804–817. doi:10.1176/appi.ajp.2021.20101548

[50] Novick DM, Salsitz EA, Joseph H, Kreek MJ. Methadone Medical Maintenance: An Early 21stCentury Perspective. J Addict Dis. 2015;34(2–3):226–237. doi:10.1080/10550887.2015.1059225

[51] Davenport S, Gray T, Melek SP. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. *https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p*. Published November 20, 2019. Accessed May 14, 2023.

[52] USDOL. US DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, TREASURY ISSUE 2022 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT REPORT TO CONGRESS. *https://www.dol.gov/newsroom/releases/ebsa/ebsa20220125*. Published January 25, 2022. Accessed May 6, 2023.

[53] The Parity Enforcement Act was introduced by Senator Christopher Murphy during the 117th Congress. *https://www.Congress.gov/bill/117th-congress/senate-bill/4804—qpercent7B percent22search percent22 percent3A percent5B percent22parity+enforcement+act percent22 percent5D—percent7D&s=1&r=41*. It is expected to be reintroduced during the 118th Congress.

alty authority to the DOL's oversight, by amending the Employee Retirement Income Security Act (ERISA) to allow the DOL to levy Federal parity violation penalties against covered health insurance issuers, plan sponsors, and plan administrators. According to the same report to Congress noted above, the Employee Benefits Security Administration (EBSA) "believes that authority for DOL to assess civil monetary penalties for parity violations has the potential to greatly strengthen the protections of MHPAEA [the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008]." [54]

Conclusion

In conclusion, ASAM is actively designing, implementing, and advocating for the policies and resources that will secure a stronger foundation for addiction prevention, treatment, harm reduction, and recovery in this country. The policies and resources I have mentioned today are not inconsequential; they are imperative to saving lives.

We know what to do to treat addiction. We also know that systemic change—a disruption of the status quo, which is currently falling short of our Country's full potential—is exceptionally difficult. But, working together, we must effect change, nonetheless. It is a matter of life or death.

Thank you, and I look forward to answering your questions.

Senator MARKEY. Thank you, doctor, so much. And our final witness is Dr. Warren Ng. Dr. Ng is the President of the American Academy of Child and Adolescent Psychiatry, and a Professor of Psychiatry at Columbia University Medical Center in New York City.

At the American Psychiatric Association, he served on the Council for Children, Adolescents and their Families. Dr. Ng, welcome. Whenever you are ready, please begin.

STATEMENT OF WARREN NG, PRESIDENT, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, NEW YORK, NY

Dr. NG. Good morning. Thank you, Chairman Markey and Ranking Member Marshall, as well as Members of the Senate HELP Subcommittee.

The members of the American Academy of Child and Adolescent Psychiatry, or AACAP, thanks you for hosting this hearing, as well as your opportunity to share our thoughts on how to bridge the gap to access to care, particularly for the pediatric mental health and substance use treatment.

AACAP represents over 10,000 child and adolescent psychiatrist and trainees, all of whom grasp the gravity of the current situation in the pediatric mental health crisis. Our members work in every child facing system of care in rural and urban communities, as well as hospitals, schools, to families and communities across our Country.

No one in our Nation has been spared the impact of the COVID–19 pandemic. Child and adolescent psychiatrists with their teams have been on the front lines. That is the reason why in October 2021, the American Academy of Child Analysis and Psychiatry with the American Academy of Pediatrics and the Children's Hos-

[54] USDOL. US DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, TREASURY ISSUE 2022 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT REPORT TO CONGRESS. *https://www.dol.gov/newsroom/releases/ebsa/ebsa20220125*. Published January 25, 2022. Accessed May 6, 2023.

pital Association officially declared a national state of emergency for children's mental health.

While there are many factors that contribute to poor access to pediatric mental health care, my testimony today will focus on the impact of the insufficient behavioral health workforce on access to care, as well as some potential solutions.

There has been a silent pandemic of pediatric mental health building for decades. This has largely impacted minoritized groups, including racial, ethnic, as well as gender diverse youth, as well as those who are still living in poverty.

The social disruptions, fear and grief caused by COVID–19 has turned the world upside down for all children, especially those most vulnerable. The escalating rates of pediatric suicide, as well as mental illnesses, compounded by the chronic workforce shortages are well-documented.

We, in collaboration with the Federal and state policymakers, must support immediate, short, and long term strategies. In the short term, to increase access. We can extend the reach of child and adolescent psychiatry workforce by supporting primary care and school-based providers in their settings.

Pediatric mental health care access programs, as well as school based mental health programs, integrated behavioral health, as well as primary care partnership, and tele-psychiatry have all increased access to care.

AACAP is grateful for the recent congressional investments in these models and urges Congress to promote state financing innovations, provider adoption to ensure these models are sustainable. We must meet children where they are at and reduce the barriers to care.

We can also supplement our physician supply by recognizing the invaluable contributions of our international medical graduates. These American trained physician experts are an important part of the mental health care teams, particularly in underserved areas.

Long term strategies to address access counts must include building a strong pipeline of pediatric mental health providers. There are significant workforce shortages even before the pandemic. This was especially true for child and adolescent psychiatrists, whose educational requirements as physician subspecialists are expensive and costly.

Targeted student loan repayment programs and programs set to first student loan payments interest free while training make a difference. Research has shown that these solutions directly influence physician practice choices. The good behavioral health will not attract qualified, highly trained providers, reduce stigma, nor accommodate the growing demand until it is on equal footing with physical health and surgical care.

Poor reimbursement is a disincentive to recruiting medical students into psychiatry and building robust behavioral health services. This contributes to limited in-network psychiatry access, longer wait times, higher expenses for patients who are forced to go out of network to find any care.

Full parity for insurance coverage and reimbursement rates for mental health substance use treatment are critical. AACAP also recommends the Centers for Medicare and Medicaid Services, and other insurance regulators require health plans to use nationally recognized service intensity tools to making medical necessity determinations.

These standardized assessment tools determine the appropriate level of service intensity needed for a particular patient and could assist payers in making appropriate coverage determinations.

Last, we must acknowledge that America is becoming more racially and ethnically diverse and requires a pediatric mental health care system that reflects the communities being served.

The COVID–19 pandemic and preexisting disparities for minoritized youth, including gaps in access to high quality care, truly to bridge this gap in all access to care, we need a workforce that reflects the patients' experiences, language, and background. This leads to better outcomes overcoming stigma, as well as addressing inequities.

We can do this by investing in recruitment, training, and broader distribution of a more diverse representative workforce. AACAP encourages Congress to support programs and improve health equity by providing support for training to racially, ethnically diverse pediatric behavioral health professionals, to scholarship tuition assistance, as well as professional development opportunities.

Thank you again for this opportunity to testify. AACAP is grateful for this opportunity give input into closing the gap in access for lifesaving behavioral health care for children and all Americans. Thank you for taking care of our—being our heroes, as well as our angels in terms of taking care of our children. Thank you.

[The prepared statement of Dr. Ng follows:]

PREPARED STATEMENT OF WARREN NG

Chairman Markey, Ranking Member Marshall, and Members of the Senate HELP Subcommittee on Primary Health and Retirement Security, the members of the American Academy of Child and Adolescent Psychiatry, AACAP, thank you for hosting this hearing and for the opportunity to share our thoughts on how to bridge the gap in access to pediatric mental health and substance use disorder care. I am Warren Ng, AACAP President, and Director of Outpatient Behavioral Health for New York Presbyterian Hospital in New York City.

AACAP represents over 10,000 child and adolescent psychiatrists and trainees all of whom grasp the gravity of our Nation's pediatric mental health crisis and have been responding. Our members work in every child-facing system of care, in urban and rural communities, from hospitals to schools, and across the lifespan. No one in our Nation has been spared the impact of the COVID–19 pandemic, and child and adolescent psychiatrists and their teams have been on the frontlines. In fact, in October 2021, AACAP along with the American Academy of Pediatrics and the Childrens' Hospital Association, declared a national state of emergency in children's mental health.[1]1 While there are many factors that contribute to poor access to pediatric behavioral health care, my testimony today will focus on the impact the insufficient behavioral health workforce has on access to care and potential solutions.

There has been a silent pediatric mental health pandemic building for decades, disproportionately impacting minoritized groups including racial, ethnic, and gender diverse youth, and those living in poverty. The social disruptions, fear and grief caused by the COVID–19 pandemic turned the world upside down for all children, especially those vulnerable to mental illness and substance use disorders. The esca-

[1] Pediatricians, CAPs, and Children's Hospitals Declare National Emergency (aacap.org)

lating rates of suicide and mental illness-related morbidity and mortality are well documented. Behavioral health workforce shortages are also chronic and well documented, especially for children. We, in collaboration with our Federal and state policymakers, must support immediate short and long-term strategies.

In the short-term to increase access, we can extend the reach of the child and adolescent psychiatry workforce by supporting primary care and school-based providers in identifying, assessing, and stabilizing pediatric behavioral health disorders and in escalating to specialty behavioral healthcare when the patient's needs require a higher level of care. Pediatric Mental Healthcare Access (PMHCA) consultation programs, school based mental health care, integrated behavioral health and primary care models, and telepsychiatry have all proven to be effective means of connecting patients to behavioral health care. AACAP is grateful for recent congressional investments in these models and urges Congress to promote state financing innovation and provider adoption to ensure these models are sustainable. We must meet children where they are and eliminate additional barriers.

We can also supplement our physician supply by recognizing the invaluable contributions of our international medical graduate (IMG) colleagues. These American trained physician experts are an important part of our mental health care teams, particularly in rural and underserved areas. In fact, recent data shows that 31 percent of child and adolescent psychiatrists are IMGs.[2] We encourage Congress to reauthorize the Conrad 30 Waiver and extend for another 3 years.

Long-term strategies to address access gaps must include building a strong pipeline of pediatric mental health providers, including child and adolescent psychiatrists. Long before the COVID–19 pandemic, the workforce shortages of pediatric mental health providers were significant. This is especially true for child and adolescent psychiatrists, whose educational requirements as physician subspecialists are extensive and costly. Targeted student loan repayment programs that support pediatric mental health professionals and programs that defer student loan payments, interest-free, while training, help mitigate the barrier of student debt. Research has shown that these solutions directly influence physician practice choices.

The field of behavioral health care will not attract qualified, highly trained providers, reduce stigma, nor accommodate the growing demand for such services until it is on equal footing with physical health and surgical care. In addition to extensive time in training and student debt, poor reimbursement is a disincentive to recruiting medical students into psychiatry and building robust psychiatric services. This contributes to limited in-network psychiatry access, longer wait times, and higher expenses for patients—who are often forced to go out of their insurance networks to find any care. Full parity in insurance coverage and reimbursement rates for mental health and substance use treatment in Medicare and Medicaid would support children's access to high quality and timely mental health care by covering the full range of evidence-based behavioral health care services.

AACAP recommends that the Centers for Medicare & Medicaid Services (CMS) and other insurance regulators require health plans to use nationally recognized service intensity tools developed by professional organizations in making medical necessity determinations. These standardized assessment tools provide determinations of the appropriate level of service intensity needed by a particular patient and could assist payers in making appropriate coverage determinations relating to mental health and substance use services.

Last, we must acknowledge that America is becoming more racially and ethnically diverse and that the current pediatric mental health care system does not sufficiently serve the needs of our communities. The COVID–19 pandemic amplified preexisting mental health disparities in minoritized children and adolescents, including gaps in access to high quality mental health care. To truly bridge the gap in all children's access to mental health and substance use disorder care, we need a behavioral health workforce that understands and identifies with their patient's experiences, language, and background. We can do this by investing in the recruitment, training, and broader distribution of a more diverse and representative workforce. Physicians who understand, speak the language, and identify with their patient's life experiences lead to better outcomes and are better equipped to overcome stigma and address inequities. AACAP encourage Congress to support programs that improve health equity by supporting the training of racial and ethnically diverse pediatric behavioral health professionals through scholarship, tuition assistance, and professional development opportunities.

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[2] Active Physicians Who Are International Medical Graduates (IMGs) by Specialty, 2021—AAMC

Thank you, again, for the opportunity to testify on this important topic. AACAP appreciates the opportunity to provide input as the Senate HELP Subcommittee on Primary Health and Retirement Security works to close gaps in access to life-saving behavioral healthcare for all Americans who need it, including those who hold our promise for the future, our children.

Senator MARKEY. Thank you. Thank you, Dr. Ng, very much. Now we will turn to questions from the Senators. Dr. Taylor, thank you for raising the Modernizing Opioid Treatment Access Act. Methadone for chronic pain can be prescribed by doctors and picked up at a pharmacy.

But methadone for opioid use disorder, it has a stigma. It is restricted. You talked about SAMHSA and ensuring that we decriminalize methadone as a treatment. Can you talk about why that is such an important step for our Country to take?

Dr. TAYLOR. Absolutely, Senator. As you know that methadone is the only full agonist opioid treatment for opioid medication that is FDA approved for treatment of patients with opioid use disorder.

It seems strange, to say the least, to put it mildly, that I, as an addiction specialist physician, board certified in addiction medicine and addiction psychiatry, would be committing a crime to prescribe a patient methadone in my office who needs methadone for treatment and stabilization of their opioid use disorder.

But someone who has no training in addiction treatment, a doctor who is maybe a general family medicine physician or someone in some other specialty, as long as they have a DEA registration, can prescribe methadone in their office for pain, and can do so and have that patient go pick up that medication in a pharmacy.

That does not make sense, to be honest. And that is a remnant of a really stigmatizing approach to the treatment of people with opioid use disorder. That is really the only way to understand how that came about.

What we are trying to advocate for, and what we hope Congress will pass with the Modernizing Opioid Treatment Access Act, is to make it so that we can be very thoughtful and very careful in our approach to prescribing methadone for treatment of patients with OUD.

That it is addiction specialist physicians, defined as someone who is board certified in addiction medicine or addiction psychiatry, who can prescribe the medication in a patient, in our office, or in one of the other various settings in which addiction specialist physicians work.

Some of those settings are actually even more carefully monitored than OTPs, so called methadone clinics. But can prescribe it to patients and then have those patients pick up that medication in a pharmacy.

It just increases access to care at a time when, as was mentioned, 106,000 patients died, people died last year from overdoses. We have to increase access to care.

Senator MARKEY. Thank you, Dr. Taylor. I wanted unanimous consent to enter into the record two letters from 94 supporting organizations and other clinicians supporting expanding access to

methadone and to pass the Modernizing Opioid Treatment Access Act.

Without objection, so ordered.

[The following information can be found on page 42 in Additional Material.]

Senator MARKEY. Social media, its role in creating this teenage, young people mental health crisis in our Country. I would love to hear any of you step up and speak about this, and what you believe the correlation is. Dr. Celli, would you like to take that on?

Dr. CELLI. Sure. This one hits close to home as I have two teenagers and a preteen at home. But I think what we have observed is that social media is—distracts children. It is extraordinarily appealing and gives instant gratification for the desire to connect with somebody.

Now, this was happening prior to the pandemic, but of course, during the pandemic, in a time where children were isolated, had to remain at home in many cases, were not in their school settings, they were not practicing social skills.

It is much the anecdotes that I will hear in the office or from behavioral health clinicians who are seeing teens where I work is that it takes 1 second for a child to put in a friend into some sort of a platform where they can connect with other peers, and instantly your friends come up and they begin to connect.

But these are not actual practiced social skills sort of relationships. And what I think is appealing is that it is so instant, and it can be very engrossing. What is—as a result, the adolescents and children are feeling more isolated.

In fact, I mean, we call these social skills because they are skills they need to be practiced. I think this is impacting how our children are—whether or not they are connecting with their peers and how they are feeling about themselves.

Senator MARKEY. Thank you, doctor, so much. It is unbelievable. One in three teenage girls contemplated suicide last year. One in ten teenage girls attempted suicide last year. One in five LGBTQ youth attempted suicide last year.

Social media is implicated. It is an accessory to this tragedy that we are seeing in our Country, and we have to do something. We need a teenage privacy bill of rights online. We just have to pass one this year. It is urgent. Thank you.

Senator Marshall.

Senator MARSHALL. Thank you again, Chairman. Mr. Denny, I want you to talk just a second about your mobile crisis center. As I travel around the State of Kansas, I think I have been in every hospital, the emergency room is the epicenter of the crisis, and the mental health epidemic has definitely impacted that.

The National Nurses Organization in my office 2 weeks ago, concerned about the violence in the emergency room. There is a right place, there is a tough place to take care of folks with mental health crisis going on, but it is tough in the emergency room.

ER docs are leaving the field. We are not getting new year docs to go into to the field. How have you interacted with your emergency room, and what does your mobile crisis center do?

Mr. DENNY. Well, our mobile crisis services to degree have always been mobile. We are now taking it to 2.0 in terms of being able to respond to anywhere in the community. One strategy is to divert crisis in someone's home or a school or another location, so they do not end up in the emergency room.

That is one of the big strategies that we will employ. Stabilization during a wait for a placement in inpatient hospitalization is an adaptive challenge. And what I mean by that is that there is no technical fix that is going to immediately resolve this issue.

But what we have found, first of all, is partnership on the front end with our emergency rooms, and we serve rural areas, so getting to know and having plans on how we deal with emergency situations are important.

Training for emergency room staff is important, at least some base level behavioral health response training. There are different options out there. And last, one of the things we have developed in Kansas, or are still developing, are the regional crisis centers, which would provide an alternative for someone to go and wait, and be assessed and stabilized, versus an emergency room.

Anytime we can find a different setting to accomplish that purpose that is not as triggering or as difficult as an emergency room, I think the more of that we can do, that is a state program with Federal support, but the more of that we can do, the less of those incidents we will see over time.

But it is a challenge. It is a frustration. It takes partnership between both of our systems to work through those issues.

Senator MARSHALL. Certainly, a patient waiting days in an isolated room in the emergency room is not the solution. And it takes one on one nursing staff, so it takes away resources.

We literally just have a shortage of those inpatient opportunities. Maybe, kind of turn to Dr. Ng, tell us, what is working and what is not working out there in your world? Just take like 1 minute to tell me what you think is cutting edge, and what do you think we have been doing that is not working?

Dr. NG. Thank you very much, Senator Marshall. I think that what is working and what is not working is also acknowledging, I think what Mr. Denny mentioned, is really creating that better continuum of care that goes from community to more intensive treatment, whether or not that is emergency department or inpatient psychiatric units.

I think what is really important to hold center is the fact that person who is experiencing that mental health or emotional crisis is probably scared and frightened and overwhelmed as well.

Being able to center our experience with that person is also understanding that emergency departments are never the place to be when you are in that situation. And how do we humanize that environment, whether or not this an adult or as a child, or a family member.

I think that creating that continuum of care, of escalating intensity of outpatient and community services, that are embedded within communities, partnering with communities to provide the most culturally competent, as well as responsive care is really important.

I think that means that we have to create some innovative programs that are funded and sustainable so that we can provide wraparound care for young people, and their families, and adults within communities.

I think that we are thinking about these intensive outpatient programs, partial hospitalization, wraparound, as well as some of the critical time intervention programs that can sometimes be helpful, but I think the important thing is that they are networked toward a system of care that is a continuum, so that people who are experiencing that care don't have to jump through hoops, but experience it as being surrounded by people who can provide the care they need.

Senator MARSHALL. Yes. Thank you so much. Mr. Chairman, I yield back and maybe we can get some follow-up questions after our colleagues finish.

Senator MARKEY. Absolutely.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman, Ranking Member, for holding this important Subcommittee hearing, and thank you to all of our witnesses today. I will never forget meeting with three moms in my office who all lost their children to fentanyl overdoses.

Poisonings is the word they used, I think, in part because they believe their children perhaps didn't know that there was fentanyl lacing the illegal pill that they had taken. It is so clear that we have to do more to stop fentanyl from coming into our Country and our communities, and increase prevention and treatment efforts, and make overdose reversal drugs much more widely available.

To do so, we have to use every tool we have to combat this epidemic. I know as Chair of the LHHS Subcommittee of Appropriations, I am committed to fighting for sufficient resources. I am also proud to co-sponsor Bruce's law with my colleague, Senator Murkowski, who has led that important measure.

It would bolster Federal prevention and education efforts surrounding fentanyl. I look at how the opioid epidemic has changed and evolved, if that is the word you want to use, but changed fundamentally just in the last decade or so.

Dr. Taylor, maybe you can describe why the fentanyl phase of this crisis has proven to be so especially challenging for health care providers. How have you experienced this transformation or evolution in our opioid epidemic and in the country?

Dr. TAYLOR. Thank you for that question, Senator Baldwin. So, you hit something right on the head, which is fentanyl represents a third phase of this opioid crisis. Sort of the first phase was the prescription opioid proliferation and the overdose—the overdose death and the addiction epidemic that resulted from that.

Second phase being heroin, as prescription opioids were made more difficult to access and much more expensive, and heroin came

in and was much cheaper and much more readily accessible. One of the challenges is that fentanyl is even cheaper than heroin.

As people developed ongoing addiction, marked, of course, with particularly with opioids, with the development of tolerance to whatever dose of drug that they were taking, and withdrawal, which is incredibly unpleasant when someone attempts to abruptly stop using opioids, then the person is driven to find something else that they can take.

Of course, with fentanyl being less expensive and more readily available, it was predictable, if you think about it, that people would then turn to fentanyl. The problem is that it wasn't just pharmaceutical fentanyl.

When you think of fentanyl, it is important to recognize there is pharmaceutical fentanyl, and then there is the illicitly manufactured synthetic product. And then beyond that, there is a number of different synthetic fentanyl analogs that are even more potent than fentanyl.

People are familiar with the word carfentanyl, which is an analog, a synthetic analog of fentanyl that is—has been used to put down elephants. And that is how potent that drug is, and that is the drug that you hear people first responders showing up in situations and just by casual contact with it, ending up with significant levels of it in their system.

Part of the challenge is that as people have continued on with addiction, that may have started from the time they were on prescription opioids, they now are at a point where they are addicted to fentanyl. The other part of the challenge for us as addiction treatment professionals is that because fentanyl and its analogs are so incredibly potent, it is actually much harder to provide treatment for someone who is addicted to fentanyl.

We literally now are scrambling. ASAM just had our annual meeting a couple of weeks back, actually about a month ago in—right here in the D.C. area. And we literally had several conferences with people on the front lines sharing with our general membership what are the strategies for taking someone who is addicted to fentanyl, or even one of the more potent fentanyl analogs, and trying to get that person inducted on to buprenorphine or even methadone.

Because the challenge is that the withdrawal syndrome is so severe when we try to transition a person, that very often people end up not continuing with the treatment and going back out to use fentanyl. And so, we have had to figure out, and we are actively working on, strategies that work to address the severe withdrawal that people go through long enough so that they can transition smoothly to a medication like buprenorphine or methadone.

Which is why we are pushing to make it possible for us to be able to prescribe methadone and have people get it from pharmacies, because for many patients, buprenorphine isn't the medicine that they are going to need for that transition—it is methadone.

That is—and we need to have every tool available in the toolbox to be able to take care of people, particularly because of this ex-

tremely complicated, potent drug to which so many people are addicted.

Senator BALDWIN. Thank you.

Senator MARKEY. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. I want to thank my colleague for your support on Bruce's law. I think, Dr. Taylor, this goes exactly to what you are talking about is the intensity of the addiction for those that have been using, whether it was prescription drugs or heroin.

The intensity of the addiction is such that I think people need to understand that we are dealing—we are dealing with something at a higher, more intense level, and what that actually means. And the intensity of fentanyl itself and the lethality.

As we work to educate people, to try to explain that this is not something that you can engage in lightly—you will be poisoned, and you will die. And part of what I am hearing with fentanyl is that the treatment, as you have indicated, is very, very challenged. But, that the likelihood of being poisoned as Sandy Snodgrass' son Bruce was, is out there as a very real reality.

The lethality of fentanyl is something that scares the living daylights out of me. I want to ask, and I am not entirely sure who to address this to, but this week in our largest newspaper in the state was a front-page article about traumatic brain injury and how Alaska has the highest rates of TBI deaths, related deaths in the country.

One out of every four deaths in Alaska under the age of 30 is related to TBI. So, we know that we do a lot of rock climbing and some things that are inherently dangerous, four-wheeling, snow machining. We get all that.

But the reality is, of those deaths, 43 percent were due to suicide. Suicide attempts are more common in individuals that have sustained a brain injury. Almost half of brain injury survivors reporting symptoms of depression.

The question to you all is, what protocols are in place to ensure that those who have sustained a TBI get the mental health that they need, that they get it on the front end? We recognize that this is—this is a pretty tight correlation here.

Are we doing anything with regards to that? If you have got—if you have had a traumatic brain injury, is there follow-up then to help on the mental health side? Dr. Ng.

Dr. NG. Thank you, Senator Murkowski. I think that this is a really incredibly important question to ask around how are we integrating mental health, and behavioral health, and suicide screening throughout all of our health care systems.

It is really understanding that there is no health without mental health, and it is being able to ask those questions, but also work collaboratively with teams.

When we integrate mental health and behavioral health services within medical settings and primary care settings, in specialty pediatric settings, it is really important. It allows us to have that conversation, to ask those questions.

But also, when there are issues related to suicide, that we are able to address it directly and we are not having to refer to someone else. But when you are talking within your trusted medical care team and you are able to provide that level of identification, screening assessment, and referral to treatment, I think that is really key.

Senator MURKOWSKI. Dr. Ng, let me ask about that, because part of our big challenge in Alaska is lack of access to the providers, and particularly pediatric health providers who would be encouraged to practice in rural and medically underserved communities.

Senator Smith and I have a bill, the Mental Health Professionals Workforce Shortage Loan Repayment Act, again, designed to get professionals out into rural areas. But it is a challenge for us in Alaska, I know, but I know that it is also equally challenging in other parts of rural America.

I don't know that we can do enough fast enough, and particularly when we are looking at suicide statistics for young people who are struggling and are just simply not able to get the mental health treatment that they need.

In Alaska, unfortunately, if a young person has been told that we don't have any services that we can provide to you, the care that they receive is outside. And when I say outside, it is not outside of a building, it is outside of the State of Alaska. So, they have to fly to Seattle, if they are lucky. A lot of times the medical help is available in Utah. You are separated from your family, from your support systems. This is not a tenable situation.

I look at what we need to do to grow this workforce, but I also think that—Dr. Ng, you talk about this continuum of care and wraparound services, what more we can do to help parents and families and educators and local community leaders to help be that support in these smaller communities until you can get to the medical professional. I don't know if there is a question in there, but we are really struggling with this at home. Dr. Ng.

Dr. NG. Thank you, Senator. I think that—thank you very much for your leadership and support for S. 462, because I think the workforce shortage issues are really key. But also, being able to fund and support providers to be able to provide those mental health services within the medical setting and within communities is also really key.

Being able to finance some of those strategies, the pediatric mental health care access programs that provides consultation to medical providers, particularly pediatric providers in urgent settings. The other thing is tele-psychiatry has been really important to be able to bridge some of those gaps.

I think that partnership with families within communities is key so that we can also encourage tele-psychiatry to be able to be helpful, to bring in key members of the community, as well as family members, to be a partner to that care.

I totally agree that there isn't a quick fix to this because this problem existed well before, but at the same time, the loan repayment, as well as trying to finance integrated behavioral health interventions, as well as leveraging tele-psychiatry and continuing

to fund those innovations that have been helpful during the pandemic would be key.

Senator MARKEY. Thank you. Thank you.

Senator from Colorado.

Senator HICKENLOOPER. Thank you, Mr. Chair. And thank all of you for being here today, but also for your ongoing work. Clearly, very, very important time to address some of these issues. Peer to peer mental health programs are taking off across school districts around the country.

These programs where trained students offer a listening ear to their peers, they look for concerning signs, help connect students with professional resources appear to add real value. Students often feel more comfortable asking for help from a peer than from an adult, and this step alone can help break the stigma, especially for young people, around going forward and seeking care.

Dr. Ng, why don't I start with you and just say, why do you think so many schools are gravitating—I mean, beyond that trying to work around the stigma, why are they gravitating toward these peer-to-peer programs, and what more can we do to support them?

Dr. NG. Thank you, Senator Hickenlooper. I think that is really a key perspective, is really bringing in the youth voice, as well as the youth involvement, and the youth solutions.

I think that they are incredibly creative, and they are also an incredible resourced for us to continue to partner with, and that is partnering with them at a level that respects the information that they are giving us.

I think it is really important that we honor that and also the diversity among the youth perspectives. And as you heard, the number of adolescent females that are experiencing helplessness and the rates of suicide with regards to the LGBTQ and gender diverse youth, as well as racial or ethnic diversity youth as well.

I think that having the youth voice, and the youth is definitely—they will connect with each other in a way that we are not easily connected to them, and we can also gain from them that wisdom. But the important thing is, is that is not where we stop, that is where we start.

Where we need to end up is actually connecting those youth peers, as well as support services, with other additional help and services along a larger continuum. So being able to reinforce the school based mental health programs embedded within those, as well as crisis response, so that those young people who need more urgent and critical care can be coordinated through that system, through their youth advocates.

Senator HICKENLOOPER. Great. Appreciate it. Mr. Denny, you are from—your approach is from a different ecosystem. Would you agree with that?

Mr. DENNY. Yes, especially in relation to the development of peer services. That is one of the nine required services under CCBHC, person, peer and family support services organization. We have hired our first peer services supervisor and our hope is to continue to develop those services.

One of the exciting things in Kansas too is we have just recently passed a code that would allow us to provide parent peer support services for parents of youth in our services, and I am really excited to see those develop. But it is as it was addressed earlier, there is not always a provider nearby.

Our need to identify across multiple areas, whether it be schools, hospitals, there is a lot of different community-based trainings to help identify people in need and not always rely on a service provider to be there. Because a lot of times when the crisis happens, a behavioral health professional is right around the corner.

Programs for us, such as mental health first aid, psychological first aid, question—for QPR training. There is a lot of different models that help train the community and engage around suicide, particularly in rural areas where we don't always have someone readily available.

We don't have to go to Seattle, but we are two and a half hours away sometimes from a hospital. I totally get the isolation. And what do we do when we are here—kind of out here on our own.

Senator HICKENLOOPER. Great. Thank you. Dr. Celli, I was going to—Colorado hospitals often don't have the resources to provide the care for kids, just as Mr. Denny was describing. Hospital staff are trying to do too much with too little, and again, especially in rural areas.

Your testimony highlighted the outsized importance of community health centers, I think, in this community health programs, but not just—centers and programs.

What do community health centers and certified community behavioral health clinics do to help address these gaps in the behavioral health care system? And how do we—how can we do more, since there are still so many people struggling to access care?

Dr. CELLI. Thank you so much, Senator Hickenlooper, for the question. So, one of the cornerstones of community health centers is that all of the service—all of the services are within the same team.

That team can be very large thousands of staff, but they are all within the same team. And that makes coordination of care, as Dr. Ng was referring to, much easier. You don't have to go through—to another institution. It is one of your colleagues.

That makes access to care much faster, more seamless, and feel like a standard part of your health care, once again, reducing stigma. So, addiction services, mental health services, help for health-related social needs.

Many times, a person is subthreshold diagnostic depression, but then food insecurity or housing insecurity is that one stressor that takes them to a level of being quiet quite ill.

I think that is one of—again, one of the cornerstones of community health centers, that integrated model, and the ability to have all of those services within the same system helps with coordination of care. I did want to highlight for a moment around pediatrics, in particular.

At Brockton Neighborhood Health Center, we have the good fortune of having a program that is called—a grant funded initiative that trains not only the behavioral health providers.

You could have a behavioral health provider who maybe had worked more with adults but is able to get trained in working with children because there is such a gap in services for pediatrics of trained professionals.

This program trains providers on the medical side, medical assistance, nurses, behavioral health clinicians, clinical secretaries, everybody who is on the team, on how to create that space that really engages both the child and the family, and in some cases, other community members as well.

Senator HICKENLOOPER. Yes, I love that approach. I think that is very useful. Thank you all. Dr. Taylor, I have got questions for you as well, and we will put them into the written. I am out of time. I apologize. I yield back to the Chair.

Senator MARKEY. Thank you, Senator, so much. I would just like to follow-up, if I could, on Senator Murkowski's line of questioning of, with so few practitioners, how can telehealth help deliver services?

What is necessary to be able to bridge this gap between Anchorage and Seattle, or Salt Lake City? What are the reimbursement issues? What are the licensing issues so that people can practice across state lines virtually?

What are those new licensing opportunities that are going to have to be put in place if we are going to ensure that we get the resources to where the problem is? Yes, Dr. Ng.

Dr. NG. I will give it a try. I think that there are multiple strategies. I think one of that is the state compacts and being able to provide regional support.

I think that familiarity for the child and adolescent psychiatrist consultant, to know that system of care, to understand that community being served is really key, until the time that you can develop in resources. So, specialists who are actually embedded within, for Senator Murkowski, within the State of Alaska.

Really being able to partner with the local resources, with the community health centers, with the CCBHCs, with that network of care and the educational system is key. Also being able to finance appropriate consultation.

When we are providing that expertise, as child and adolescent psychiatrists and physician experts in mental health, one of the things that we do, we are able to integrate is the health, as well as the mental health, as well as the psychosocial issues.

Being able to integrate all of those in terms a comprehensive treatment plan involving all members, as well as the youth, the family, the community, and the school resources, is really key.

Senator MARKEY. How will that help Senator Murkowski's problem in Alaska? Do you have a recommendation in terms of ensuring that somebody doesn't have to leave Anchorage, can get a top-notch psychiatrist in another state online, so that it can be integrated with perhaps the physical care in Anchorage? What is your recommendation?

Dr. NG. Those wonderful programs, the pediatric mental health care access programs, which really helps to partner child and adolescent psychiatrists with pediatricians, if we are talking about that population.

It is really helping them talk through the care of that young person to develop and acquire some of the skills and the tools necessary to providing that care onsite. And it is really building that capacity for the care.

There are other models, such as the Echo models, that can help extend the clinical expertise locally, whether or not it is with a primary care provider or if it is a provider within the CCBHC, or a community health center, or a private practice provider as well. I think that is the most rapid way of expanding your current short-term strategy, in addition to building some long-term strategies.

Senator MARKEY. Dr. Taylor, I would like to come back to you one more time, and that is on this suboxone, methadone issue, in terms of the help which people need. Can you just put an exclamation point on the need for that law to change?

Dr. TAYLOR. Senator, I have—about a few months ago, I got a message on LinkedIn from a gentleman who was the father of a young man who had been a patient of mine.

The message was thanking me for helping his son and letting me know that his son was just about to graduate from law school. His son had been a patient of mine with a severe opioid use disorder, and I took care of him in my office for several years when he had flunked out of college and was—had gone through the progression, very much like I described previously, of addiction to prescription opioids, and then had moved on to snorting heroin and then injecting heroin, and had really severe addiction to opioids.

I worked with him in the office, and I treated him with buprenorphine, and he did well for periods of time, and then would have a recurrence of his illness. And then I, at one point, had to refer him to a methadone program, an OTP, because I was not able to provide that for him in my office.

During that period of time, I stayed in touch with him, and I tried to liaison with the doctor at the methadone program, who was not necessarily an addiction specialist, but we made the best of it. And then at other periods of time, we then transitioned him back to buprenorphine and I was able to then be the one prescribing and monitoring his medication.

It was a torturous process taking care of that young man because of the fact that he wasn't able to just have me work with him on a consistent basis, prescribing whatever it was that he needed, that I, as an addiction specialist, was more than qualified to prescribe him.

The bottom line—and so he had to come and see me for a while, and then go to the OTP for a while, and then come back into my office for a while, and it was a very difficult treatment course.

I can't guarantee that he would have had a shorter or easier time of it if we had been—if I had been able to prescribe him the methadone the same way I was able to prescribe him buprenorphine, but

it certainly would have made more sense for him, and it would have been more convenient for his family.

Thankfully, he is in recovery now. He is doing great. He just graduated from law school. But it shouldn't be necessary for him to go through all of that, and not everyone has the kind of outcome he had.

Senator MARKEY. Senator Marshall.

Senator MARSHALL. Thank you again, Mr. Chairman. Mr. Denny, you have led this prototype of the Certified Community Behavioral Health Clinics. What are the three most important lessons that you would pass on, if we are going to set up something like this up in Alaska or other parts of Kansas? What is the secret recipe, in your opinion—lessons learned?

Mr. DENNY. From the National Council was just letting me know there are two clinics being piloted in Alaska currently, two CCBHC clinics. So that is—the model is off the ground there.

Senator MARSHALL. That is great. And we should ask the Senator Murkowski's staff to follow-up with you and the clinics, and share some lessons learned.

Mr. DENNY. Yes. In terms of setting, it up, it is so important to have an effective community needs assessment and make sure that you are really assessing the needs of each community served. You know, the accessibility conversation, particularly as it relates to telehealth, I always think about rural frontier areas, right.

A lot of our areas that we serve don't necessarily have connectivity. So, making sure that whenever—wherever we offer, those services have the tools and resources, that the right people are at the table. So, an effective needs assessment that truly identifies the unique needs of each community.

The second thing is really developing providers' skill sets and practices that are going to have outcomes. So, the models you choose need to be applicable to the populations you are serving. I think Kansas has done a really good job of choosing evidence-based practices that are really relevant to the needs of Kansans we are serving.

The third thing is, and this is a practical thing, but there is a lot of talented CCBHC clinics throughout our Country. When we were starting, I had people from all over the country reaching out to me saying, try this, try that, consider this, consider that. Here is how you get started on your data.

But the thinking of a data collection strategy that is practical, meaning that you can get started with meaningful outcomes that are going to tell your story, but at the same time, having a plan to how to build and grow that.

You know, in Kansas, in the next 6 months to a year, we will have a data warehouse that will allow us to track outcomes across our entire state population. That will be a really unique opportunity just to begin observing how we are using these clinics to truly impact change.

Senator MARSHALL. Thank you. Dr. Taylor, I know you are a treatment specialist, but I want to go to the prevention side for a second. You know, as a physician, we take family histories.

You say, oh, my goodness, you are at risk for colon cancer, so therefore you need to start your screening at an earlier age. Or you are at risk for diabetes, and your weight is up a little bit this year, and your blood pressure is up we have—how are we doing identifying at risk people, and what other ounces of prevention would you be recommending out there from your experiences?

Dr. TAYLOR. Thanks for that question, Senator Marshall. I am actually also a big-time prevention hawk. Our organization, ASAM, is very much concerned about prevention as well as treatment. We know what the risk factors are for a young person to develop an addiction disorder. We know that addiction is a disease of pediatric onset, in fact.

We know that effective interventions—and when I say—just want to say pediatric onset, we know most of the time when someone develops an addiction disorder, the onset of use and the onset of the disorder is actually in adolescence. So that is what I mean by pediatric onset.

But we know that there are effective evidence-based interventions, prevention and prevention interventions that work at the community-based level. They often involve building social skills, teaching adolescents social skills, and many of these are school based programs. We know that if—the No. 1 risk factor for a young person to develop an addiction is to have a parent who has or has had an addiction disorder.

One of the most effective things you can do is to provide effective treatment for parents who have an addiction disorder, get them stabilized, so that their children are not subject to the ACES, the adverse childhood experiences, that a child of a person with an addiction is at risk for, and then target those young people, knowing that they are at increased risk, with early intervention.

I have done that on the individual level in my office, but also organizations can do that. And I am involved in community-based organizations in Birmingham, one specifically called the Addiction Prevention Coalition that actually does a lot of programing in and around Birmingham, specifically designed to target young people in schools with mental health first aid, with peer programs like Senator Hickenlooper had described.

That is something that is doable. We at ASAM support the implementation of those programs. The key is to fund ones that are evidence based and to actually de-emphasize and not continue to fund those that have been shown to not be effective.

Senator MARSHALL. Well, thanks so much. Again, I want to thank all the witnesses. I think you can tell this is a very thoughtful Subcommittee, and your testimony is very valuable, and we hope that there is follow-up at the staff level. And you all certainly made us think about several issues, and I appreciate you being here. Thank you.

Senator MARKEY. Thank you, Senator Marshall. Thanks to our great panel here today. This is obviously a period where there is a devastating behavioral health crisis that threatens every community in this country, and disproportionately impact communities of color and low income and other marginalized communities.

Thanks to these experts here today and so many people across the country, we have the opportunity to build on what has already been done to create a society where everyone has a fair and just opportunity to attain their highest level of health, and I look forward to continuing to work with each of you to do that.

We have to discuss how we can get more resources into the hands of all of the practitioners, all the families out there. A vision without funding is a hallucination. You need—if you get the tools, you will be able to help families.

I ask unanimous consent to enter into the record statements from various stakeholders outlining priorities for closing the gaps in access to mental health and substance use disorder care.

[The following information can be found on pages 64 through 77 in Additional Material.]

Senator MARKEY. For any Senators who wish to ask additional questions for the record, they will be due in 10 business days, on June 1st at 5.00 p.m.

The Committee stands adjourned.

ADDITIONAL MATERIAL

May 16, 2023

Hon. KEVIN MCCARTHY, Speaker,
Hon. HAKEEM JEFFRIES, Minority Leader
Hon. CHUCK SCHUMER, Majority Leader,
Hon. MITCH MCCONNELL, Minority Leader,
Hon. MCMORRIS RODGERS, Chair,
Hon. FRANK PALLONE, Ranking Member,
Hon. JIM JORDAN, Chair,
Hon. JERROLD NADLER, Ranking Member,
U.S. House of Representatives House of Representative
Washington, D.C. 20515.

Hon. BERNIE SANDERS, Chair,
Hon. BILL CASSIDY, Ranking Member,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC. 20510.

Dear SPEAKER MCCARTHY, MAJORITY LEADER SCHUMER, MINORITY LEADER JEFFRIES, MINORITY LEADER MCCONNELL, CHAIR MCMORRIS RODGERS, RANKING MEMBER PALLONE, CHAIR JORDAN, RANKING MEMBER NADLER, CHAIR SANDERS, AND RANKING MEMBER CASSIDY:

The undersigned organizations, representing a broad base of stakeholders, write today to endorse **S. 644/H.R. 1359—the Modernizing Opioid Treatment Access Act (the "M-OTAA").** This bipartisan, bicameral legislation would responsibly expand access to methadone treatment for opioid use disorder (OUD) in medical settings and areas where it is not available now. There is a shortage of methadone treatment for OUD that contributes to racial, gender, and geographic inequities in access to such treatment in the U.S.—especially in rural areas—despite an increasing number of opioid treatment programs (OTPs) in the for-profit sector in recent years. [1] Therefore, imminent passage of the M-OTAA is critical to saving lives, helping families, and strengthening American communities.

Only three medications have been approved by the Food and Drug Administration to treat OUD: methadone, buprenorphine, and naltrexone. OUD is associated with a 20fold greater risk of early death due to overdose, infectious disease, trauma, and

[1] Joudrey, Paul, Gavin Bart, Robert Brooner, Lawrence Brown, Julia Dickson-Gomez, Adam Gordon, Sarah Kawasaki, et al. "Research Priorities for Expanding Access to Methadone Treatment for Opioid Use Disorder in the United States: A National Institute on Drug Abuse Center for Clinical Trials Network Task Force Report." Substance Abuse 42 (July 3, 2021): 245—54. *https://doi.org/10.1080/08897077.2021.1975344.*

suicide.[2] Methadone is the most well-studied pharmacotherapy for OUD, with the longest track record.[3] According to myriad experts, methadone is safe and effective for patients when indicated, dispensed, and consumed properly.[4] But federal law largely limits its availability for OUD to OTPs and prevents the broader use of this medication to address fentanyl's deadly role in driving the rise of, and disparities in, drug overdose deaths in America.

The M-OTAA would allow OTP clinicians and board-certified physicians in addiction medicine or addiction psychiatry to prescribe methadone for OUD treatment that can be picked up from pharmacies, subject to the Substance Abuse and Mental Health Services Administration rules or guidance on supply of methadone for unsupervised use. This legislation would capitalize on the existing addiction expert workforce and pharmacy infrastructure to integrate methadone treatment for OUD with the rest of general healthcare. In doing so, the M-OTAA would help increase innovation in the OTP industry and narrow gaps in access to methadone for OUD for those who need it.

[2] Schuckit MA. Treatment of Opioid-Use Disorders. N Engl J Med. 2016;375(4):357–368. doi:10.1056/NEJMra1604339

[3] Substance Abuse and Mental Health Administration. Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families. Treatment Improvement Protocol (TIP) Series, No. 63. Chapter 3B: Methadone.; 2018. Accessed March 31, 2022. *http://www.ncbi.nlm.nih.gov/books/NBK535269/*

[4] Baxter LES, Campbell A, DeShields M, et al. Safe Methadone Induction and Stabilization: Report of an Expert Panel. J Addict Med. 2013;7(6):377–386. doi:10.1097/01.ADM.0000435321.39251.d7

Our organizations are unified in our support of the M-OTAA and our strong belief that it will help turn the tide on the addiction crisis facing our Nation.

Sincerely,

1. American Society of Addiction Medicine
2. American Association of Psychiatric Pharmacists
3. American College of Academic Addiction Medicine
4. American College of Osteopathic Emergency Physicians
5. American College of Medical Toxicology
6. American College of Physicians
7. American for Multidisciplinary Education and Research in Substance Use and Addiction, Inc. (AMERSA)
8. American Medical Association
9. American Osteopathic Academy of Addiction Medicine
10. American Pharmacists Association
11. American Psychological Association
12. AIDS Foundation Chicago (AFC)
13. AIDS United
14. Alabama Society of Addiction Medicine
15. A New PATH (Parents for Addiction Treatment & Healing)
16. Anxiety and Depression Association of America
17. Any Positive Change, Inc.
18. Arkansas Society of Addiction Medicine
19. Association for Behavioral Health and Wellness
20. Being Alive
21. Big Cities Health Coalition
22. Broken No More
23. CADA of Northwest Louisiana
24. California Society of Addiction Medicine
25. Center for Adolescent Behavioral Health Research, Boston Children's Hospital
26. Center for Housing & Health
27. Clinical Social Work Association
28. Collaborative Family Healthcare Association
29. Community Outreach Prevention and Education Network
30. Coolidge Consulting
31. DAP Health
32. Drug Policy Alliance
33. Faces & Voices of Recovery
34. Florida Society of Addiction Medicine
35. The Grand Rapids Red Project
36. Grayken Center for Addiction at Boston Medical Center
37. Harm Reduction Action Center
38. Hawai'i Health & Harm Reduction Center
39. Hawai'i Society of Addiction Medicine
40. Hep Free Hawai'i
41. Honoring Individual Power and Strength (HIPS)
42. Illinois Society of Addiction Medicine
43. Indiana Recovery Alliance
44. Inseparable
45. International Society for Psychiatric Nurses
46. The Kennedy Forum
47. Landmark Recovery
48. Legal Action Center
49. Louisiana Society of Addiction Medicine

50. Massachusetts Association of Behavioral Health Systems
51. Massachusetts Association for Mental Health, Inc.
52. Massachusetts Society of Addiction Medicine
53. Mental Health America
54. Michigan Society of Addiction Medicine
55. Midwest Society of Addiction Medicine
56. Minnesota Society of Addiction Medicine
57. National Alliance for Medication Assisted Recovery (NAMA Recovery)
58. National Association of Pediatric Nurse Practitioners
59. National Alliance on Mental Illness
60. National Association of Addiction Treatment Providers
61. National Association of Social Workers
62. National Board for Certified Counselors
63. National Council on Alcoholism and Drug Dependence
64. National Harm Reduction Coalition
65. National Health Care for the Homeless Council
66. National League for Nursing
67. National Safety Council (NSC)
68. National Survivors Union
69. New Bedford Community Health
70. New York Society of Addiction Medicine
71. Northern New England Society of Addiction Medicine
72. Oklahoma Society of Addiction Medicine
73. Oregon Society of Addiction Medicine
74. Overdose Crisis Response Fund
75. Partnership to End Addiction
76. Pennsylvania Harm Reduction Network
77. The Porchlight Collective SAP
78. Public Justice Center
79. RI International
80. Rural Organizing
81. San Francisco AIDS Foundation
82. Shatterproof
83. The Sheet Metal and Air Conditioning Contractors National Association (SMACNA)
84. SMART Recovery
85. South Shore Health
86. Southwest Recovery Alliance
87. Students for Sensible Drug Policy
88. Tennessee Justice Center
89. Tennessee Society of Addiction Medicine
90. Today I Matter, Inc.
91. Vital Strategies
92. Washington Society of Addiction Medicine
93. Wisconsin Society of Addiction Medicine
94. Young People in Recovery

March 30, 2023

U.S. Committee on Energy and Commerce,
2125 Rayburn House Office Building,
Washington, DC 20515.
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Subcommittee on Primary Health and Retirement Security,
428 Dirksen Senate Office Building,
Washington, DC. 20510.

Dear United States Senators and Representatives:

We write from the frontlines of our Nation's addiction and overdose crisis, as board-certified physicians in addiction medicine or addiction psychiatry, some of whom work in opioid treatment programs (OTPs). As you help lead us out of this public health emergency, we humbly ask that you consider this message with the seriousness it deserves. Our aim is to inform recent discourse on the delivery of high-quality and effective treatment for people with opioid use disorder (OUD) with methadone, and provide critical clarifications to complex issues that have arisen in the context of that discussion on Capitol Hill.

Currently, Federal law limits the availability of methadone for OUD to heavily regulated OTPs at both the Federal and state level, a structure that has implications for access to, and quality of, care. During the COVID–19 pandemic, public health recommendations for social distancing compelled the Federal Government to reform Federal regulations governing methadone treatment for OUD at OTPs. As a result, a natural experiment occurred,[1] and our Nation learned that the Federal Government could move quickly and responsibly to protect patients' health and safety, while ensuring that they receive the addiction care they need. Thus, as you consider next steps to tackle our Nation's addiction and overdose crisis, we urge you to support swift passage of the bipartisan and bicameral Modernizing Opioid Treatment Access Act (S. 644/H.R. 1359) (the "M-OTAA").

The Modernizing Opioid Treatment Access Act

The M-OTAA would modernize Federal law governing the delivery of OUD treatment with methadone—law which has largely remained unchanged since 1974, despite the scientific and medical consensus, dating as far back as 1995, calling for the Federal Government to regulate methadone for OUD more in alignment with other Schedule II Food and Drug Administration (FDA)-approved medications.[2] Notably, existing Federal law predates the establishment and recognition by the American Board of Medical Specialties of the medical subspecialties of addiction medicine and addiction psychiatry. This explains one reason for the prescriptive Federal laws enacted in the 1970's that were to govern methadone treatment for OUD in a practice environment without recognized addiction specialist physicians. In brief, the M-OTAA would authorize the Drug Enforcement Administration (DEA) to issue special registrations for physicians who are board-certified in addiction medicine and/or addiction psychiatry, as well as OTP prescribing clinicians, who could then use their clinical expertise in prescribing methadone for OUD treatment that could be dispensed by community pharmacies, subject to SAMHSA rules or guidance on supply of methadone for unsupervised use.

Areas of Concern: Patient and Public Safety, the Current Quandary in Outpatient Treatment with Buprenorphine, and High-Quality and Effective OUD Treatment and Persistent Stigma

Methadone is a lifesaving medication that also has risks that we take very seriously. It can be a challenge to balance the risk of adverse individual and community-related impacts associated with the inappropriate provision, and diversion, of the medication against the well-established individual and public health benefits of properly treating certain patients with OUD with methadone. Our aim with this letter is to provide salient information on three relevant areas of concern: 1) the safety of patients with OUD who may be treated with methadone, and more broadly, of the public, 2) the current quandary in outpatient treatment with buprenorphine (a partial agonist) for patients with OUD who are increasingly using fentanyl or other high potency synthetic opioids, and 3) what constitutes high-quality and effective treatment for patients with OUD and the persistent stigma that surrounds those patients.

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[1] Krawczyk, Noa, Bianca D. Rivera, Emily Levin, and Bridget C. E. Dooling. "Synthesising Evidence of the Effects of COVID–19 Regulatory Changes on Methadone Treatment for Opioid Use Disorder: Implications for Policy." The Lancet Public Health 8, no. 3 (March 1, 2023): e238—46. *https://doi.org/10.1016/S2468–2667(23)00023–3.*

[2] In 1995, experts at the Institute of Medicine (IOM) wrote, "In light of these considerations, the committee urges reassessment of the appropriate balance between the risks of methadone and its benefits. The current regulations foster situations where addicts cannot obtain a treatment program tailored to their individual circumstances, physicians are unable to exercise professional judgment in treating individual patients, programs are isolated from mainstream medical care (thus depriving patients of important ancillary services), and significant economic costs are incurred in assuring compliance with regulatory requirements—costs that are shared by programs, insurers, patients, and taxpayers. We have concluded that there is no compelling medical reason for regulating methadone differently from all other medications approved by FDA, including schedule II controlled substances. Nevertheless, the committee is not recommending abolition of the methadone regulations. The regulations serve important functions, not the least of which is to maintain community support for methadone treatment programs by assuring that the programs maintain standards and are subject to outside review." See Institute of Medicine (US) Committee on Federal Regulation of Methadone Treatment; Rettig RA, Yarmolinsky A, editors. Federal Regulation of Methadone Treatment. Washington (DC): National Academies Press (US); 1995. Available from: *https://www.ncbi.nlm.nih.gov/books/NBK232108/—doi—10.17226/4899.*

Patient and Public Safety

Evidence gathered over the last several decades illustrates that, for many people with OUD, treatment with methadone is critical to preventing overdose and promoting remission and recovery.[3] In addition, because methadone is also a very effective analgesic and has a long half-life, it is also sometimes used to treat chronic pain in pain management practice.

Decades Ago, Methadone-Involved Overdoses Correlated With Its Use in the Treatment of Pain

As an opioid analgesic for pain, methadone was swept up in the confluence of factors that lead to the inappropriate prescribing of opioids for pain treatment in the 1990's and 2000's.[4] The scientific and medical consensus after examining these trends concluded that there was a strong, positive correlation between rates of methadone prescription for use in pain treatment and methadone diversion and overdose deaths.[5] Methadone for use in pain treatment and its involvement in overdoses, however, drastically declined as public health and law enforcement agencies took measured steps to limit its injudicious use for pain, while still making it available via prescription and pharmacy dispensing when clinically appropriate for pain treatment.[6]

New Studies Have Been Used Opportunistically, And Their Nuances Have Not Been Explained

With that said, we share concerns expressed by others of methadone becoming a potential contributor of more overdoses and deaths if careful policy changes are not enacted. For example, there was an increase in methadone-involved overdose deaths in 2020; however, evidence shows such increase was likely associated with the synthetic opioid-driven spike in drug overdose deaths that year.[7] Unfortunately, some advocates use that increase opportunistically to convey a fatalistic approach that risks paralyzing lawmakers and preventing any progress. Further, those same advocates may even mention two other studies published in January 2023 that raise questions about the role of Federal regulatory OTP flexibilities during the COVID PHE—which allowed for more unsupervised use of methadone in the treatment of OUD within OTP settings—to increases in methadone-involved overdoses deaths. Specifically, one such study found an increase in methadone-involved overdose deaths in the year after March 2020 compared with prior trends, both with and without co-involvement of synthetic opioids;[8] the other found an increase of methadone-involved overdose deaths by 48.1 percent in 2020 relative to 2019.[9]

Neither of those two studies, however, includes or examines additional, provisional overdose death data after March 2021, when the rate of methadone-involved

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[3] National Academies of Sciences, Engineering, Health and Medicine Division, Board on Health Sciences Policy, Committee on Medication-Assisted Treatment for Opioid Use Disorder, Michelle Mancher, and Alan I. Leshner. The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Medications for Opioid Use Disorder Save Lives. National Academies Press (US), 2019. *https://www.ncbi.nlm.nih.gov/books/NBK541393/*.

[4] Paulozzi, Leonard, Karen Mack, and Christopher M. Jones. "Vital Signs: Risk for Overdose from Methadone Used for Pain Relief—United States, 1999—2010," July 6, 2012. *https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm.*

[5] Jones, Christopher M., Grant T. Baldwin, Teresa Manocchio, Jessica O. White, and Karin A. Mack. "Trends in Methadone Distribution for Pain Treatment, Methadone Diversion, and Overdose Deaths—United States, 2002—2014." Morbidity and Mortality Weekly Report 65, no. 26 (2016): 667—71.

[6] Id.

[7] Jones, Christopher M., Wilson M. Compton, Beth Han, Grant Baldwin, and Nora D. Volkow. "Methadone-Involved Overdose Deaths in the US Before and After Federal Policy Changes Expanding Take-Home Methadone Doses From Opioid Treatment Programs." JAMA Psychiatry 79, no. 9 (September 1, 2022): 932—34. *https://doi.org/10.1001/jamapsychiatry.2022.1776.*

[8] This study examines absolute counts rather than relative rate increases in methadone-involved overdose deaths. Relative rates are in proportion to the whole, while absolute counts are not, and the use of absolute counts rather than relative rates limits the usefulness of this analysis. See Kleinman, Robert A., and Marcos Sanches. "Methadone-Involved Overdose Deaths in the United States before and during the COVID–19 Pandemic." Drug and Alcohol Dependence 242 (January 1, 2023): 109703. *https://doi.org/10.1016/j.drugalcdep.2022.109703*

[9] This study points out that the rate of methadone-involved overdose deaths in 2020 was much lower than its peak in 2006–2008, and that these methadone-involved overdose deaths have been largely attributed to methadone prescribed for pain. See Kaufman, Daniel E., Amy L. Kennalley, Kenneth L. McCall, and Brian J. Piper. "Examination of Methadone Involved Overdoses during the COVID–19 Pandemic." Forensic Science International 344 (January 31, 2023): 111579. *https://doi.org/10.1016/j.forsciint.2023.111579*

overdose deaths stabilized and declined. The authors' failure to include this data may bias the models in their studies. Indeed, the relative rate of methadone-involved overdose deaths has declined by 9.5 percent between August 2021 and August 2022,[10] while overdose deaths related to a lack of access to medications for OUD increased in the same period.[11]

In addition, there is no direct evidence of causality that links any change in Federal OTP take-home policies to an increase in methadone-involved overdose deaths, as is noted in one study.[12] Nor do the authors in the other study wish to add to misconceptions about the safety of methadone for OUD, as stated by those authors themselves.[13] If anything, these two studies demonstrate that modernizing treatment with methadone for OUD—within the OTP setting—must be carried out with caution and with Federal agencies' continual, longitudinal regulations and monitoring for unintended consequences, notwithstanding the widespread support of making such Federal take home policy changes permanent by OTP organizations and associations. By way of contrast, our experience and training as addiction specialist physicians, coupled with the thoughtful guardrails in the M-OTAA, enables us to lead models of methadone treatment for OUD responsibly and safely, while we manage risks to patient and public health. In the absence of continued DEA and SAMHSA Federal regulations, oversight, and monitoring of OTPs on several fronts, however, these two studies do illustrate why we cannot say the same yet for all clinicians within the OTP setting. While some OTP medical directors are board-certified addiction specialist physicians, the Federal Government does not require them to be so credentialed; thus, some are not.

Recently Published Systematic Review Finds No Increased Risk of Methadone Overdose From Federal Regulatory Flexibilities That Allowed For More Unsupervised Use of Methadone

We also draw your attention to a review that synthesized peer-reviewed research between March 2020 and September 2022 on the effect of the Federal regulatory flexibilities on OTPs' operations, the perspectives of patients and providers, and health outcomes of patients at OTPs, including for methadone-involved overdoses, which found no evidence of increased risk of methadone overdose.[14] We do understand from this review, on the other hand, that many OTPs limited their uptake of the Federal regulatory flexibilities and did not universally provide the maximum ceiling of doses allowed for take home methadone, driven in part due potential consequences to patients, concerns about reduced OTP revenue, and uncertainty about when this temporary regulatory flexibility would end.[15]

One Explanation for the Spike in Methadone-Involved Overdoses Is The Increase of Synthetic Opioids in the Non-Pharmaceutical Drug Supply

As previously noted, a plausible explanation for changes in trends in methadone-involved overdose deaths in 2020 is the dominating role that fentanyl and other high potency synthetic opioids have been playing in our non-pharmaceutical drug

[10] See statistical examination of provisional overdose death data from the CDC's National Center for Health Statistics Vital Statistics System. Volkow, Nora, D. Presentation to the American Society of Addiction Medicine Advocacy Conference, "National Institute of Drug Abuse: What Radical Change Means," March 6, 2023.

[11] Kariisa, Mbabazi. "Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics—25 States and the District of Columbia, 2019—2020." MMWR. Morbidity and Mortality Weekly Report 71 (2022). *https://doi.org/10.15585/mmwr.mm7129e2.*

[12] "This study is observational and does not allow for a causal attribution of the increase in methadone-involved overdose deaths to any specific factor," and "this study cannot distinguish whether individuals who die from methadone-involved overdoses receive methadone through OTPs, as prescriptions for pain, or through other sources, including diverted methadone." See Kaufman, et al., (2023).

[13] "We hope that these findings will not add to further misconceptions about the safety of methadone relative to other less widely prescribed Schedule II opioids," see Kleinman, et al., (2023).

[14] The systematic review of 29 peer-reviewed studies published between March 1, 2020, and September 6, 2022, includes six studies that assessed the association between pandemic flexibilities and overdose risk, which used OTP records or state-level mortality data, national poison-control or mortality data, or qualitative data. See Krawczyk, Noa,

[15] Findings include three studies of OTP providers, three surveys of OTP patients, and one multi-State survey of 170 OTP providers. Krawczyk, Noa, Bianca D. Rivera, Emily Levin, and Bridget C. E. Dooling. "Synthesising Evidence of the Effects of COVID–19 Regulatory Changes on Methadone Treatment for Opioid Use Disorder: Implications for Policy." The Lancet Public Health 8, no. 3 (March 1, 2023): e238—46. *https://doi.org/10.1016/S2468–2667(23)00023–3.*

supply. For example, another recent analysis found an increase in overdose deaths, with and without methadone, in March 2020. Then, overdose deaths not involving methadone continued to increase by approximately 69 deaths per month, while methadone-involved overdose deaths remained stable. In terms of the implementation of the Federal regulatory flexibilities for unsupervised use of methadone at OTPs, in the period before this policy change, and after it, there were similar rates of decline in the percentage of methadone-involved overdose deaths.[16] This study therefore suggests, in light of this data, that in the early months of the COVID–19 pandemic, the spike in drug overdose deaths overall in March 2020 was associated with the increase in synthetic opioids in the drug supply among people who were being treated with methadone from an OTP, not due to methadone risks associated with Federal regulatory flexibilities for OTPs.

Multiple Factors Explain Methadone Being Preferentially Listed on Overdose Death Certificates

Finally, it is important for lawmakers to understand that methadone's long half-life is an additional, confounding variable that can result in the preferential listing of methadone on death certificates, during a period when overdose deaths frequently involve multiple substances. Novel psychoactive substances permeate the non-pharmaceutical drug supply as well, for which drug overdose deaths are not routinely assessed. Moreover, the decentralization of authority in death certification policy and procedure also creates substantial differences in how overdose deaths are characterized and reported, and there is a high error rate in death certificates for overdose deaths.[17]

The Current Quandary in Outpatient Treatment with Buprenorphine for Patients with OUD Involving Fentanyl or Other High Potency Synthetic Opioids

Under the Code of Federal Regulations Title 21 1306.07(b), the DEA permits an exception to methadone dispensing requirements for DEA-registered physicians outside of OTPs to provide emergency treatment for patients with methadone for OUD for 1 day, and to carry out such treatment for no more than 3 days, while planning for the patients' referral to treatment.[18] Last March 2022, the DEA started allowing certain DEA-registered physicians to dispense a 3-day supply of methadone at one time, so long as the exception is requested.[19] While this change is theoretically helpful, it does not help us face a terrible quandary when we attempt to initiate buprenorphine treatment with patients with OUD involving illegal fentanyl or other high potency synthetic opioids.

Federal Law Currently Prevents the Use of Methadone for the Treatment of Patients Via a "Low Dose Buprenorphine with Opioid Continuation" Initiation Process

Patients who use fentanyl in the unregulated drug supply, which increasingly has unpredictable and hazardous novel contaminants, have significant challenges with initiation of buprenorphine (a partial agonist), another highly effective medication for OUD treatment. Under current law, however, it is illegal to prescribe full opioid agonists such as hydromorphone, oxycodone, or morphine for OUD during buprenorphine initiation and titration. Thus, we are sometimes left with a dangerous alternative, which is to advise patients that use of opioids from the unregulated supply should be continued while undergoing buprenorphine initiation via a low dose buprenorphine with opioid continuation initiation process. Access to methadone would be a safe full agonist alternative to use for individuals who are undergoing a low dose buprenorphine with opioid continuation initiation process, and the M-OTAA could allow this to be safely done under expert physician guidance.

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[16] In January 2019, 4.5 percent of overdose deaths involved methadone, and 3.2 percent of overdose deaths involved methadone by August 2021. See Jones, et al., (2023).

[17] Peppin, John F., John J. Coleman, Antonella Paladini, Giustino Varrassi, John F. Peppin, John J. Coleman, Antonella Paladini, and Giustino Varrassi. "What Your Death Certificate Says About You May Be Wrong: A Narrative Review on CDC's Efforts to Quantify Prescription Opioid Overdose Deaths." Cureus 13, no. 9 (September 16, 2021). *https://doi.org/10.7759/cureus.18012.*

[18] "21 CFR 1306.07—Administering or Dispensing of Narcotic Drugs." Accessed March 16, 2023. *https://www.ecfr.gov/current/title–21/chapter-II/part–1306/subject-group-ECFR1eb5bb3a23fddd0/section–1306.07.*

[19] "DEA's Commitment to Expanding Access to Medication-Assisted Treatment." Accessed March 16, 2023. *https://www.dea.gov/press-releases/2022/03/23/deas-commitment-expanding-access-medication-assisted-treatment.*

Restrictions on Methadone for OUD Limit Treatment Options for Patients with OUD Who Do Not Stabilize on Buprenorphine

In addition, methadone is an excellent alternative medication treatment recommended for patients with OUD who do not stabilize on buprenorphine. However, unless it's being dispensed from an OTP, we can only dispense methadone to those patients for up to 3 days. This limitation restricts our being able to offer this critically important medication to those patients, even when they face insurmountable geographical, financial, transportation, or other barriers to continue their treatment at OTPs. In these medical scenarios, the absurdity of antiquated Federal laws that govern methadone for OUD treatment is extremely clear. When the laws are applied to an ever and rapidly changing unregulated drug supply, the laws' out-of-date nature is obvious and distressing.

High-Quality and Effective OUD Treatment and Persistent Stigma

High-Quality and Effective Treatment for OUD Does Not Make Engagement in Psychosocial Counseling a Condition of Receiving Medication

Patients with OUD who are treated with medications for OUD have over 50 percent lower overdose rates.[20] For this reason and to fulfill our medical mission to save lives, our first, most immediate goal is to reach more people with moderate to severe OUD with this life-saving medication.[21] Patients who receive medication for OUD, including methadone, have better rates of retention in treatment; behavioral therapies, alone, do not increase patient retention in treatment.[22] While psychosocial treatment and other services are an important component of quality care and beneficial to many people with OUD,[23] the scientific and medical consensus is that psychosocial treatment should be made available to patients in treatment for OUD, but a patient's willingness to engage in such treatment should not be a condition of the patient receiving medication.[24]

High-Quality and Effective Treatment for OUD Is Patient-Centered

In an office-based practice of addiction medicine or addiction psychiatry, an expert physician may counsel patients with OUD who are willing to engage in psychosocial treatment as part of the physician's medical management; a multidisciplinary team member in the practice may provide more intensive counseling for patients with OUD, or the practice may refer some of those patients to another practice for even more psychosocial treatment. While we are grateful for SAMHSA's recently proposed modifications to 42 CFR Part 8 which, if finalized, should significantly improve the quality of treatment services at OTPs, by making it less "program centered" and more "patient centered"—like expert-led office-based practices—patients with OUD need more options for their care, and more OTPs need to face high-quality competition as an incentive to continue to improve their services.

[20] National Academies of Sciences, Engineering, Health and Medicine Division, Board on Health Sciences Policy, Committee on Medication-Assisted Treatment for Opioid Use Disorder, Michelle Mancher, and Alan I. Leshner. The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Medications for Opioid Use Disorder Save Lives. National Academies Press (US), 2019. *https://www.ncbi.nlm.nih.gov/books/NBK541393/*.

[21] NYU Langone News. "Almost 90 Percent of People with Opioid Use Disorder Not Receiving Lifesaving Medication." Accessed March 10, 2023. *https://nyulangone.org/news/almost–90-percent-people-opioid-use-disorder-not-receiving-lifesaving-medication.*

[22] Timko, Christine, Nicole R Schultz, Michael A Cucciare, Lisa Vittorio, and Christina Garrison-Diehn. "Retention in Medication-Assisted Treatment for Opiate Dependence: A Systematic Review." Journal of Addictive Diseases 35, no. 1 (2016): 22—35. *https://doi.org/10.1080/10550887.2016.1100960.*

[23] Dugosh, Karen, Amanda Abraham, Brittany Seymour, Keli McLoyd, Mady Chalk, and David Festinger. "A Systematic Review on the Use of Psychosocial Interventions in Conjunction With Medications for the Treatment of Opioid Addiction." Journal of Addiction Medicine 10, no. 2 (March 2016): 91—101. *https://doi.org/10.1097/ADM.0000000000000193.*

[24] See National Academies of Sciences, Engineering, Health and Medicine Division, Board on Health Sciences Policy, Committee on Medication-Assisted Treatment for Opioid Use Disorder, Michelle Mancher, and Alan I. Leshner. The Effectiveness of Medication-Based Treatment for Opioid Use Disorder. Medications for Opioid Use Disorder Save Lives. National Academies Press (US), 2019. *https://www.ncbi.nlm.nih.gov/books/NBK541393/,* and see American Society of Addiction Medicine. "National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update," 2020. *https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2—2.*

Existing Stereotypes Lend Themselves to Prescriptive, Rigid Models of Methadone Treatment for OUD

Finally, we know that patients with OUD face persistent stigma, including stereotypes that they are non-compliant, out-of-control, unwilling to change risk behaviors, and do not have strong communities.[25] We are extremely concerned that these stereotypes lend themselves to prescriptive, rigid approaches to methadone treatment for OUD. The existing, siloed infrastructure for methadone treatment for OUD in the U.S. has compounded such stigma, and despite methadone's strong evidence as a life-saving medication, there is neither broad acceptance of methadone as a treatment intervention by the public, nor by healthcare providers, including some addiction providers.[26]

The Integration of Methadone Treatment with Other Medical Care Will Improve the Quality of OUD Care

The separateness of methadone treatment for OUD—which results in methadone dispensed from OTPs, rather than pharmacies, being nearly universally excluded from prescription drug monitoring programs—has rather served to focus OTP services on the administration of one medication for one medical indication.[27] In contrast, the modernization of methadone treatment for OUD, as contemplated by the M-OTAA, will give Americans with addiction involving polysubstance use more conveniently located, comprehensive treatment options that can treat and manage their uncontrolled use of any substance, as well as other chronic, often comorbid diseases with OUD, such as depression, diabetes, bipolar disorder, and hypertension.[28] These additional options are urgently needed, so that we may safely integrate treatment with methadone for OUD with the rest of general healthcare, and continue to improve the treatment of OUD with methadone in this country.

We stand ready to discuss this information further with you at any time. We are hopeful that we can work together to save as many lives as possible. We look forward to hearing from you.

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The views expressed are those of the authors and do not necessarily represent the views of their institutions.

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[26] Madden, Erin Fanning. "Intervention Stigma: How Medication-Assisted Treatment Marginalizes Patients and Providers." Social Science & Medicine (1982) 232 (July 2019): 324—31. *https://doi.org/10.1016/j.socscimed.2019.05.027.*

[27] See Olsen, Yngvild, and Joshua M. Sharfstein. "Confronting the Stigma of Opioid Use Disorder—and Its Treatment." JAMA 311, no. 14 (April 9, 2014): 1393—94. *https://doi.org/10.1001/jama.2014.2147,* and National Association of State Alcohol and Drug Abuse Directors, and American Association for the Treatment of Opioid Dependence. "TECHNICAL BRIEF: CENSUS OF OPIOID TREATMENT PROGRAMS—NASADAD," December 5, 2022. *ttps://nasadad.org/2022/12/technical-brief-census-of-opioid-treatment-programs/.*

[28] Olsen, Yngvild, and Joshua M. Sharfstein. "Confronting the Stigma of Opioid Use Disorder—and Its Treatment." JAMA 311, no. 14 (April 9, 2014): 1393—94. *https://doi.org/10.1001/jama.2014.2147.*

One asterisk (*) indicates an individual has past work experience at an opioid treatment program (OTP); two asterisks (**) indicates the individual currently works at an OTP.

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AMERICAN ACADEMY OF FAMILY PHYSICIANS,
May 17, 2023.

Senator ED MARKEY, Chairman
Senator ROGER MARSHALL, Ranking Member
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Subcommittee on Primary Health and Retirement Security,
428 Dirksen Senate Office Building,
Washington, DC. 20510.

DEAR CHAIRMAN MARKEY AND RANKING MEMBER MARSHALL:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to applaud the Subcommittee's focus on mental health and substance use disorder with today's hearing titled "A Crisis in Mental Health and Substance Use Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities."

Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. Nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physi-

cians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.[1] Family physicians also play a crucial role in safe pain management prescribing practices, screening patients for opioid use disorder (OUD), and prescribing and maintaining treatment of medications for OUD (MOUD). Primary care physicians are often the first point of care for patients and can provide necessary referrals or coordinate care with psychiatric and other mental health professionals when needed.

Unfortunately, access to mental health care and substance use disorder (SUD) treatment remains a significant challenge for many patients across the country, particularly those from underserved communities or marginalized populations. A study published this month found that Black patients lacked equal access to OUD treatment and were far less likely to be prescribed buprenorphine, to live near a prescriber, and to remain in treatment 6 months after first being prescribed it when compared to white patients.[2]

The AAFP shares your commitment to advancing policies that will improve access to mental health and SUD care for all communities across the country. We long advocated for elimination of the X-waiver and applaud Congress for doing so as part of the Consolidated Appropriations Act of 2023. Removing these burdensome requirements for physicians to prescribe MOUD will greatly improve patient access to evidence-based, lifesaving treatment. To build upon this momentum, we urge Congress to consider the following policy recommendations.

Support Integration of Behavioral Health and Primary Care

Given the dire shortage of behavioral health clinicians, especially in many rural and underserved communities, equipping primary care clinicians to provide frontline mental health and substance abuse disorder treatment is essential for ensuring patients have timely access to care. Integrated behavioral health has shown significant cost-savings for payers and physicians, as well as more equitable access to mental health services for traditionally underserved populations.[3] Unfortunately, while many primary care physicians want to integrate behavioral health services in their practices, they face burdensome startup costs and payment and reporting challenges that prevent integration.

The AAFP has continuously advocated for additional Federal investments to initiate and sustain BHI in primary care practices. We applaud Congress for including a provision in the most recent year-end omnibus to authorize grants to support the uptake and adoption of integrated care services, including the Collaborative Care Model (CoCM). We strongly encourage Congress to build upon this by implementing additional legislation to support BHI.

Specifically, the AAFP urges the reintroduction and passage of the bipartisan Improving Access to Behavioral Health Integration Act. This bill makes necessary changes to existing Federal programs to ensure primary care practices can integrate behavioral health care services by providing grant funding that covers the steep startup costs. This initial financial support is critical to improving access to integrated services and ensuring patients and payers can achieve the long-term cost savings that behavioral health integration often provides.

We also urge Congress to pass the Better Mental Health Care for Americans Act (S. 923), which would establish a Medicare add-on code for office visits provided by primary care physicians who have integrated behavioral health into their practice. This enhanced payment recognizes the unaccounted resources required to provide integrated behavioral health care and ensures that primary care practices can sustain it. Additionally, it would establish a Medicaid demonstration program to ensure that all children covered by Medicaid have access to integrated behavioral health care in primary care, schools, or other critical settings. This program would provide infrastructure, technical assistance, and sustainable financing to support expanding access to integrated mental health care for children.

Additionally, to improve access to integrated tele-mental and behavioral health care in primary care settings, **the AAFP encourages Congress to establish a**

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[1] Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey: *https://Doi.Org/10.1177/21501327211023871*

[2] Black patients with opioid addiction lack equal access to treatment (statnews.com)

[3] SY, L.-T., J, E., D, C., & PY, C. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. Psychiatric Services (Washington, DC.), 69(6), 628—647. *https://doi.org/10.1176/APPI.PS.—201700382*

new program for adults that mirrors HRSA's Pediatric Mental Health Care Access Program (PMHCA). This program, recently reauthorized in 2022, promotes behavioral health integration into pediatric primary care by using telehealth, and has a proven track record of increasing mental and behavioral health needs despite ongoing workforce shortages by meeting children and adolescents where they are. Given the well-documented shortage of mental and behavioral health clinicians and the growing demand for specialized care, a HRSA-funded program that provides primary care clinicians with virtual access to specialists could increase timely access to care for adult patients.

Telehealth

The COVID–19 public health emergency (PHE) transformed access to mental and behavioral health care via telehealth, making it possible for many patients to be connected to appropriate clinicians and treatment that had otherwise been unavailable to them due to financial, geographic, coverage, or other barriers. As PHE flexibilities end, we strongly urge that Congress implements policies to minimize disruptions in access to tele-mental and behavioral health care.

The AAFP has consistently advocated to Congress to permanently remove the in-person requirement for tele-mental health services for Medicare beneficiaries. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[4] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients. Arbitrarily requiring an in-person visit prior to coverage of tele-mental health services will unnecessarily restrict access to behavioral health care.

As acknowledged in the AAFP's recent comments to the Drug Enforcement Administration (DEA), the in-person connection between a physician and patient can provide a valuable touchpoint for patients receiving MOUD and other OUD treatment services. However, existing shortages of clinicians prescribing buprenorphine for OUD, as well as numerous other barriers faced by patients with OUD, will prevent many patients from being able to obtain an in-person visit, particularly within the DEA's proposed 30-day timeframe. **To that end, we strongly urge against requiring an in-person exam for prescribers of buprenorphine for treatment of OUD,** given evidence in support of telehealth, limited access to OUD treatment prescribers, and relatively lower rates of buprenorphine diversion.

While an in-person evaluation may be necessary for other primary care treatment, data shows that buprenorphine prescribing is particularly well-suited for virtual-only visits. Telehealth initiation of and continued treatment with buprenorphine has shown greater treatment retention, reduced illicit opioid use, improved access to treatment, greater patient satisfaction, and reduced healthcare costs.[5]

Nearly 160 million individuals live in a mental health professional shortage area, and many more have mental health professionals in their area that do not accept the patient's insurance or require unfeasible cost sharing.[6] Nearly 99 million individuals live in a primary care health professional shortage area and would be unable or challenged to receive MOUD without telehealth and audio-only visits.[7] This difficulty in access to care for patients is compounded by transportation, time, and child-care challenges, as well as trauma and stigmatization from past experiences with the health care system. All of which makes virtual visits critically important for initiating and maintaining OUD treatment.

Close the Medicaid Coverage Gap

The AAFP *supports* efforts to provide coverage for low-income individuals in states that decided to forgo the Affordable Care Act's Medicaid Expansion. Closing

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[4] Pew Trust. (2021, December 14). State Policy Changes Could Increase Access to Opioid Treatment via Telehealth—The Pew Charitable Trusts. *https://www.pewtrusts.org/en/research-andanalysis/issuebriefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth*

[5] Vakkalanka, J.P., Lund, B.C., Ward, M.M. et al. Telehealth Utilization Is Associated with Lower Risk of Discontinuation of Buprenorphine: a Retrospective Cohort Study of US Veterans. J GEN INTERN MED 37, 1610—1618 (2022). *https://doi.org/10.1007/s11606—021—06969—1*

[6] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022 available at *https://data.hrsa.gov/topics/healthworkforce/shortage-areas.*

[7] Ibid.

the Medicaid expansion coverage gap would grant over 2 million uninsured Americans access to health coverage and would be a critical step in improving access to mental and behavioral health care, as well as addressing existing disparities in access. Data has shown that 60 percent of those in the Medicaid coverage gap are people of color, and more than 1 in 4 are estimated to have a behavioral health condition.[8] Family physicians have repeatedly called upon states to expand Medicaid to avoid coverage gaps, and in the absence of state action, we support alternative options to cover individuals who would otherwise be eligible.

Improved Access for Justice-Involved Populations

Individuals who have been incarcerated have significant health care needs and face multiple barriers to obtaining health insurance and access to care. These challenges affect not only the formerly incarcerated individuals, but also their families and communities, many of which are disadvantaged, and experience health inequities born out of complex social determinants of health.

It is estimated that nearly half (47 percent) of individuals who are incarcerated meet the Diagnostic and Statistical Manual (DSM)-IV criteria for substance use disorder in the 12 months prior to admission to prison.[9] Unfortunately, only 12 to 15 percent of individuals who have a substance use disorder receive drug treatment while incarcerated.[10] For this reason, individuals who have chronic addictions have a higher risk of going through withdrawal while in custody and then overdosing when they return to the community.[11], [12]

The AAFP *advocates* for individuals who are incarcerated or detained to have access to comprehensive medical services, including mental health care and substance use disorder treatment. We support the funding and implementation of successful re-entry models and other evidence-based programs to assist those who have recently been incarcerated. Access to evidence-based treatments for SUD should be provided by correctional health facilities while individuals are still incarcerated, and connections to housing, employment, comprehensive primary care, and substance use and mental health support should be made to best support their health outcomes and transition back into the community.

To that end, the AAFP urges Congress to pass the Reentry Act (S. 1165 / H.R. 2400), which allows Medicaid coverage for incarcerated individuals to automatically begin 30 days prior to their release. This will facilitate better care continuity as part of community reentry, including for those with SUD and mental health needs.

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with you to advance policies that improve patient access to mental health and substance use disorder care. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at *nwilliams2@aafp.org*.

Sincerely,

STERLING N. RANSONE, JR.,
Board Chair,
American Academy of Family Physicians.

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[8] Sullivan J, Pearsall M, and A Bailey. "To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap," Center on Budget and Policy Priorities. October 4, 2021. Accessed online: *https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-Medicaid-coverage-gap#—ftn3*

[9] Maruschak L, Bronson J, and M Apler. "Survey of Prison Inmates, 2016: Alcohol and Drug Use and Treatment Reported by Prisoners," U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. July 2021. Accessed online: *https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/adutrpspi16st.pdf*

[10] Ibid.

[11] Fu JJ, Zaller ND, Yokell MA, et al. Forced withdrawal from methadone maintenance therapy in criminal justice settings: a critical treatment barrier in the United States. J Subst Abuse Treat. 2013;44(5):502–505.

[12] Magura S, Lee JD, Hershberger J, et al. Buprenorphine and methadone maintenance in jail and post-release: a randomized clinical trial. Drug Alcohol Depend. 2009;99(1–3):222–230.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
May 17, 2023.

Senator ED MARKEY, Chairman
Senator ROGER MARSHALL, Ranking Member
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Subcommittee on Primary Health and Retirement Security,
428 Dirksen Senate Office Building,
Washington, DC. 20510.

DEAR CHAIRMAN MARKEY AND RANKING MEMBER MARSHALL:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for holding today's hearing, entitled, "A Crisis in Mental Health and Substance Use Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities." We appreciate the opportunity to share some of our experiences on the frontlines of our Nation's mental health and substance use disorder (SUD) crises, and we look forward to continuing to work with you to improve access to the lifesaving care and treatment that our patients need and deserve.

As the health care safety net, the emergency department (ED) is often the first—and sometimes only—point of contact for individuals experiencing mental health crises or other behavioral health challenges, such as substance use disorder (SUD) or overdose. While the ED is the critical frontline safety net and the most appropriate setting for acute unscheduled care for individuals suffering from a mental health crisis, it is not ideal for long-term treatment of mental and behavioral health needs. However, due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges contribute to long ED wait times and aggravate "boarding" issues, a scenario where patients are kept in the ED for extended periods of time due to a lack of available inpatient beds or space in other facilities where they could be transferred. **Overcrowding and boarding are not failures of the ED; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net.**

Once again, ACEP is grateful for the Committee's attention to the mental and behavioral health challenges affecting millions of Americans. As you continue to examine this pressing public health issue, we urge you to consider several key issues. These include strengthening the mental/behavioral health workforce; increasing integration, coordination, and access to care; ensuring parity; furthering the use of telehealth; and improving access to behavioral health care for children and young people. We also continue strongly urge the Committee to include physician and provider mental health and burnout as necessary considerations in comprehensive mental health policy initiatives, especially in light of the significant mental health toll the COVID–19 pandemic and its lingering effects have taken on frontline health care providers. Improving and providing for the mental health and well-being of the health care workforce is a unique challenge, but one that is absolutely essential to ensure that patients have access to the full continuum of high-quality health care. Additionally, we hope you will examine the many innovative solutions that emergency physicians throughout the country have developed and successfully implemented to reduce emergency psychiatric patient boarding.

Emergency Department Boarding

Patient "boarding" occurs when a patient continues to occupy an ED bed even after being seen and treated by a physician, while waiting to be admitted to an inpatient bed in the hospital, or transferred to psychiatric, skilled nursing, or other specialty facility. As our health care system becomes increasingly strained, these patients must stay in the ED for days or even weeks on end waiting for a bed to become available so they can be admitted or transferred. Patients being boarded in the ED limits the ability of ED staff to provide timely and quality care to all patients, forcing other newly arriving patients with equally important emergency conditions to wait in the ED waiting room for care, with wait times as long as eight or even 12 hours rapidly becoming a new norm, and patients even dying during these waits as staff struggle to keep up with an unsupportable volume of sick patients to care for.

Boarding has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting—waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities that have little to no available beds, or, waiting to simply return to their nursing home. And this breaking point is entirely outside of the control of highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. But boarding does not just affect those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician.

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have include last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room. In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of COVID as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."——anonymous emergency physician*

To illustrate the stark reality of this crisis, ACEP asked its members to share *examples of the life-threatening* impacts of ED boarding. The stories paint a picture of an emergency care system already near collapse. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, paramedics, and other health care professionals.

We need a health care system that can accurately track available beds and other relevant data in real-time, appropriate metrics to measure ED throughput and boarding, contingency plans and "load balancing" plans for boarding/crowding scenarios, and fewer regulatory or other "red tape" burdens that delay necessary care. Recognizing all EDs are different and there is no one-size-fits-all solution to this multifactorial problem, ACEP is in the process of developing a broad range of potential legislative and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. As we finalize these recommendations and policy solutions, we will share more broadly with you and your staff in the coming weeks. Further, we strongly urge Congress to direct its attention to this critical issue and work with us and other stakeholders through roundtables, hearings, and legislation to provide both short-and long-term solutions to this public health crisis.

Violence Against Emergency Physicians and Health Care Workers

Violence in the emergency department is a serious and growing concern, causing significant stress to emergency department staff and to patients who seek treatment in the emergency department (ED). *According to a survey conducted by ACEP in 2022,* two-thirds of emergency physicians report being assaulted in the past year alone, while more than one-third of respondents say they have been assaulted more than once. Nearly 85 percent of emergency physicians say the rate of ED violence has increased within the last year.

Beyond the immediate physical impacts and injuries, the risk of violence increases the difficulty of recruiting and retaining qualified health care professionals and contributes to greater levels of physician burnout. In fact, 87 percent of emergency physicians report a loss of productivity from the physician or staff as a result, and 85 percent of emergency physicians report emotional trauma and an increase in anxiety because of ED violence. Most importantly, patients with medical emergencies deserve high-quality care in a place free of physical dangers from other patients or individuals, and care from staff that is not distracted by individuals with behavioral or substance-induced violent behavior.

And unlike the significantly more visible violence against airline employees and other travelers that has become more ubiquitous over the last several years, vio-

lence against health care workers often is not seen or addressed because of inadequate reporting and tracking of violent incidents, and other systemic barriers that do not hold violent individuals accountable for their actions. As a result of the inability to prosecute those who are arrested, many health care workers are discouraged from even pressing charges and being forced to accept that it's "just part of the job." Violence is not accepted in any other workplace, and it must not be accepted especially in a setting focused on improving the health and well-being of individuals.

There are many factors contributing to the increase in ED and hospital violence, we recognize there is no one-size-fits-all solution to this issue either. In fact, one of the challenges is that the types of violence one ED typically experiences can be significantly different from another ED, even in the same town. Therefore, ensuring there are adequate resources to help identify best practices and outfitting facilities with resources appropriate to their specific needs is imperative. Overall, employers and hospitals should develop workplace violence prevention and response procedures that address the needs of their particular facilities, staff, contractors, and communities, as those needs and resources may vary significantly.

ACEP supports multi-pronged legislative efforts to address various aspects of health care workplace violence prevention, including the *"Workplace Violence Prevention for Health Care and Social Service Workers Act,"* (H.R. 2663/S. 1176), introduced by Sen. Tammy Baldwin (D-WI) (and by Reps. Joe Courtney (D-CT), Don Bacon (R-NE), and others in the House); as well as the *"Safety From Violence for Healthcare Employees (SAVE) Act,"* (H.R. 2584) introduced by Reps. Larry Bucshon (R-IN) and Madeline Dean (D-PA). The Workplace Violence Prevention for Health Care and Social Service Workers Act would ensure that health care workplaces implement violence prevention plans and techniques and are prepared to respond to acts of violence, while the SAVE Act would establish Federal legal penalties for individuals who knowingly and intentionally assault or intimidate health care workers and provide grants to help hospitals and medical facilities establish and improve workplace safety, security, and violence prevention efforts.

Access to Mental Health Care

The emergency department is not only a safety net for those with physical care needs, but also for individuals suffering from a mental health crisis or acute psychiatric emergency. However, it is not ideal for long-term treatment of mental and behavioral health needs. Due to the fragmented nature of the mental health care infrastructure in the U.S., persistent lack of sufficient resources, and longstanding shortages of mental and behavioral health professionals, far too many Americans have limited options for the longer-term follow-up treatment they need and deserve. These challenges also contribute to the long ED wait times and aggravate ED boarding issues detailed above. In fact, ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system.

Improving coordination of care across the health care continuum must be one of the highest priorities for any mental health reform effort. The ED serves as the critical health care safety net not only for acute injuries, but for psychiatric emergencies as well. However, most EDs are not ideal facilities to provide longer-term care for patients experiencing a mental health crisis—they are often hectic, noisy, and particularly disruptive for behavioral health patients.

Across the country, communities have adopted innovative alternative models to improve emergency psychiatric care and reduce psychiatric patient boarding. These include Behavioral Health Emergency Rooms (BHERs), separate areas of the ED that specialize in caring for patients experiencing a behavioral health crisis; Emergency Psychiatric Assessment Treatment and Healing (EmPath) Units, a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic but with the ED's ability to care for any patient presenting for treatment; and Psychiatric Emergency Service (PES) models, a "hub-and-spoke" model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services.

- **Behavioral Health Emergency Rooms (BHERs).** BHERs are separate areas of the ED that specialize in proactive rapid-assessment, stabilization, and treatment of patients in experiencing a behavioral health crisis. Care is delivered via a multidisciplinary team of emergency physicians, psychiatrists, psychiatric nurses, and social workers. This service is operational 24 hours a day, 7 days a week, 365 days a year. These dedicated

spaces provide patients with a safer, private, and more peaceful setting in which to deescalate and receive specialized care.

By initiating proactive assessments in a BHER, 40–50 percent of patients can be safely discharged home, reducing ED boarding time. Additionally, optimizing transition of care through Integrated Outpatient Care clinics ensures ongoing high-quality medical and behavioral health care follow-up with convenient and comprehensive treatment options for patients.

- **EmPath (Emergency Psychiatric Assessment Treatment and Healing) Units.** The EmPath unit is a separate, hospital-based setting solely for psychiatric emergencies with the safe, calming, homelike environment of a community mental health crisis clinic with the ED's ability to take care of any patient who presents for treatment. This unit accepts all suitable patients regardless of the severity of their illness, legal status, dangerousness, substance use intoxication or withdrawal, or co-morbid medical problems, as these patients are typically excluded from community programs and thus would likely experience boarding in an ED in the traditional medical system.

EmPath units provide immediate access to individualized care from a comprehensive mental health care team of psychiatrists, psychologists, mental health nurses, social workers, and other licensed mental health care professionals. This team partners directly with patients and their families to address the immediate mental crisis and to develop a longer-term care plan through appropriate follow-up services. In some instances, EmPath Units have reduced regional ED boarding by 80 percent, and have also reduced the need for—and incidence of—coercive measures (such as physical restraints), episodes of agitation, and psychiatric hospitalization.

- **Psychiatric Emergency Service (PES). The PES model is a multipronged approach for emergency psychiatric patients treated in the ED based on increased availability of psychiatrists and dedicated case managers who focus on psychiatric patients.** This model is referred to as a "hub-and-spoke" model with a dedicated psychiatric ED serving as a central hub with bidirectional spokes going out to a wide variety of mental, behavioral, and physical care, as well as social services. Recognizing that psychiatric patients have vastly different needs and circumstances affecting their overall health, this model helps address the patient's immediate mental health needs and swiftly directs them to the most appropriate follow-up services, which helps alleviate the overall load on the mental health care system. These two-way spokes may also serve to reconnect patients with the psychiatric ED should they require acute stabilization while receiving follow-up services, potentially avoiding an inpatient hospitalization and ensuring the patient receives the most appropriate care and treatment throughout the mental health care continuum.

These innovative approaches have helped communities improve coordination of emergency psychiatric care and they can serve as models for other communities to implement and build upon. *However, what is clear from experience is that the ultimate success of any model hinges on the availability of resources, whether monetary, staffing, or access to follow-up services and patient access to long-term mental and behavioral health care.* One of the persistent challenges in emergency medicine is that "one emergency department is one emergency department"—i.e., the needs of each community and the resources available to local EDs, hospitals, and other facilities vary widely, and a model that is successful in one community may not be the best fit for another community.

For example, in 2017, Oregon implemented a dedicated psychiatric ED model in Portland based closely on the Alameda Model (California), but the transition has been marked by challenges for both the dedicated psychiatric ED and surrounding facilities. The dedicated psychiatric ED that was intended to reduce the burden on individual EDs is frequently at capacity or overcrowded, but emergency physicians at other facilities have noted that they are still seeing the same number of acute psychiatric patients in their own EDs. Additionally, the dedicated psychiatric ED has struggled to transfer patients to long-term follow-up treatment at Oregon State Hospital, contributing to long wait times, crowding, and poor outcomes for patients. Despite these challenges, stakeholders have been working to address the shortcomings of the system and adapt the model to better meet the needs of the Portland community, but the experience has highlighted that new care models are not necessarily "plug-and-play" and do not guarantee immediate results.

To ensure that communities can implement models that best fit their needs, ACEP supports the bipartisan *"Improving Mental Health Access from the Emergency Department Act"* (S. 1346), led by Senators Shelley Moore Capito (R-WV) and Maggie Hassan (D-NH). This legislation would provide critical funding to help communities implement and expand programs to expedite transition to post-emergency care through expanded coordination with regional service providers, assessment, peer navigators, bed availability tracking and management, transfer protocol development, networking infrastructure development, and transportation services; increase the supply of inpatient psychiatric beds and alternative care settings; and, expand approaches to providing psychiatric care in the ED, including telepsychiatry, peak period crisis clinics, or dedicated psychiatric emergency service units. During the 117th Congress, this legislation (H.R. 1205) was passed by the House of Representatives in a voice vote but was not considered by the Senate. We urge Congress to consider and pass this important legislation.

Another longstanding barrier to providing adequate mental health treatment services is the Medicaid Institutions for Mental Disease (IMD) exclusion that prohibits the Federal Government from providing Medicaid reimbursement to states for care provided to most patients in an inpatient psychiatric or SUD facility with more than 16 beds. Though this longstanding policy was intended to reduce the number of people committed to long-term psychiatric treatment facilities without receiving appropriate care, it has perpetuated the problem of disparate treatment of mental health and has stood as a major barrier in the effort to provide necessary non-hospital inpatient psychiatric care options.

As a limited workaround, states have been able to apply for Section 1115 Medicaid waivers to receive matching Federal funds for short-term residential treatment services in an IMD. Congress also recently took steps to address some of the challenges posed by the IMD exclusion in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (P.L. 115–271), creating a limited new exception to allow states to provide Medicaid coverage for beneficiaries with at least one SUD in certain IMDs.

The IMD exclusion may also threaten the ability of communities to provide a continuum of crisis stabilization services that includes call centers, mobile crisis units, and crisis stabilization programs. Crisis stabilization programs are a resource distinct from traditional residential treatment facilities for mental health and SUD treatment. These provide individuals with additional immediate-access treatment options, helping them avoid settings detrimental to their condition such as jails, homeless shelters, or the streets. Unfortunately, the IMD exclusion was established before crisis stabilization beds were developed, and the 16-bed limitation for facilities severely restricts the ability of these services to meet the needs of communities with vulnerable Medicaid populations and high demand for such services. We agree with legislators' *bipartisan efforts* urging CMS to ensure Medicaid reimbursement for crisis stabilization beds and to ensure these programs are not adversely affected by the IMD exclusion.

ACEP has long advocated for full repeal of the IMD exclusion and strongly urges Congress to rescind this harmful policy either as a standalone effort or as a cornerstone of any comprehensive mental health reform legislation.

Ensuring Parity Between Behavioral and Physical Health Care

Limited access to appropriate coverage, narrow provider networks, lack of Federal enforcement mechanisms for parity law violations, and low reimbursement for mental health services remain barriers to achieving parity between mental and physical health care.

In recent years, Congress has taken important steps to improve parity between mental and physical health care by requiring insurers to provide the same level of coverage for mental health and substance use disorder treatment as they do for physical care. **But despite Federal law, there is no mechanism for the Federal Government to enforce compliance against plans that continue to violate parity requirements and discriminate against patients with mental health conditions or SUD.** ACEP supports providing the Department of Labor (DOL) with the ability to issue civil monetary penalties (CMPs) for violations of the "Mental Health Parity and Addiction Equity Act" (MHPAEA; P.L. 110–343) by group health plan sponsors, plan administrators, or issuers. ACEP supports legislative efforts to give the DOL the authority to issue CMPs.

Without enforcement penalties and more explicit parity requirements, we will continue to see insurers attempting to find their way around the law and limit the cov-

erage available to beneficiaries experiencing mental health crisis. As a recent example, Optum in Maryland issued a policy several years ago establishing that only certain provider types (specialty mental health providers) are eligible to bill when the only diagnosis is a psychiatric issue, including homicidal ideation and suicidal ideation, precluding payment for an ED physician's evaluation and management services. This policy ignores the significant challenges emergency physicians are experiencing in seeing and treating mental health needs in the ED and has disproportionate impacts on hospitals with high Medicaid populations. Though Optum ultimately issued an updated provider alert that resolved this matter, it was not without significant confusion and substantial delays that affected patient care.

We also believe this is yet another example of insurers attempting to disregard the Prudent Layperson Standard (PLP), a longstanding and critical policy that protects patients from retroactive denials of insurance coverage for emergency department visits that are ultimately determined to be non-emergent. Patients who believe they are experiencing a medical emergency should not be discouraged from seeking treatment out of fear that their ED visit will not be covered by their insurer.

Ensuring parity for behavioral health care also requires appropriate treatment of substance use and opioid use disorders (SUD/OUD). Individuals with SUD/OUD often seek care in the emergency department, and one of the most effective means emergency physicians have to aid these patients is by using buprenorphine as part of a medications for opioid use disorder (MOUD) protocol. As one of three drugs approved by the U.S. Food & Drug Administration (FDA) for the treatment of opioid dependence, buprenorphine is a very safe and efficacious medication. Strong enough to reduce withdrawal symptoms and cravings but not enough to cause euphoria, it can allow individuals with OUD to more effectively engage in treatment as they pursue recovery. But despite the passage of the MAT Act and subsequent removal of the X-waiver, significant barriers to the use of buprenorphine persist, including limited access to the treatment due to Drug Enforcement Administration (DEA) set quantity limits, which flag pharmacy and hospital purchases of these required SUD/OUD treatments as suspicious orders. In fact, both prescribers and patients across the Nation are still experiencing difficulty in obtaining buprenorphine prescriptions. According to a recent study that surveyed more than 5,000 pharmacies, less than half stocked buprenorphine.[1] Additionally, a separate survey found that one-fifth of pharmacies were not willing to fill buprenorphine prescriptions.[2] A survey of addiction treatment providers also revealed that 84 percent of their patients experienced a delay in accessing their buprenorphine, which can be life-threatening for those undergoing treatment for opioid use disorder.[3] We urge Congress to ensure that health insurance plans appropriately cover SUD/OUD treatments, and further to ensure that patients are not are not hindered by unnecessary Federal barriers on their path to recovery through arbitrary limitations on the medications they need.

Improving Access to Behavioral Health Care for Children and Young People

The full effects of the COVID–19 pandemic are not limited to the staggering toll on American lives or the long-term physical health challenges from which many recovering patients still suffer. We are still collectively struggling to comprehend the true scope of the pandemic's impact on the mental health and well-being of millions of Americans, particularly on children and younger Americans.

As the recent U.S. Department of Education report, *"Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs"* notes, children have experienced isolation, bereavement, depression, worry, and other issues throughout the pandemic, leading to reports of anxiety, mood, and eating disorders, as well as increased self-harm behavior and suicidal ideation at nearly twice the rate of adults.

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[1] Hill, L. G., Loera, L. J., Torrez, S. B., Puzantian, T., Evoy, K. E., Ventricelli, D. J., Eukel, H. N., Peckham, A. M., Chen, C., Ganetsky, V. S., Yeung, M. S., Zagorski, C. M., & Reveles, K. R. (2022). Availability of buprenorphine/naloxone films and naloxone nasal spray in community pharmacies in 11 U.S. states. Drug and alcohol dependence, 237, 109518. *https://doi.org/10.1016/j.drugalcdep.2022.109518*

[2] Kazerouni, N. J., Irwin, A. N., Levander, X. A., Geddes, J., Johnston, K., Gostanian, C. J., Mayfield, B. S., Montgomery, B. T., Graalum, D. C., &; Hartung, D. M. (2021). Pharmacy-related buprenorphine access barriers: An audit of pharmacies in counties with a high opioid overdose burden. Drug and Alcohol Dependence, 224. *https://doi.org/10.1016/j.drugalcdep.2021.108729*

[3] American Society of Addiction Medicine. (2022).Reducing Barriers to Lifesaving Treatment: Report on the Findings from ASAM's Pharmacy Access Survey. *https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/advocacy/reports/asam-pharmacy-access-survey-report-final 11.7.22.pdf sfvrsn=6da97680—3*

Pediatric ED visits related to mental health significantly increased during the pandemic—a 24 percent increase for children 5–11 years of age, and 31 percent for children 12–17. These stressors affect children's development and ability to learn in both the immediate and long-term with lasting consequences should their mental health needs not be adequately addressed.

Adding to these long-term considerations are the mental health stresses associated with the loss of a caregiver. According to a recent pre-publication study in the October 2021 issue of the American Academy of Pediatrics journal, Pediatrics, more than 140,000 U.S. children under the age of 18 lost a primary or secondary caregiver due to COVID–19 between April 1, 2020 and June 30, 2021.[4] The consequences of the pandemic's disproportionate impact on racial and ethnic minorities, exacerbated by longstanding systemic inequalities, manifest here as well given that children of racial and ethnic minorities account for 65 percent of children who lost a primary caregiver (compared to 39 percent of the total population). The authors note the significant long-term impacts that orphanhood and caregiver loss have on the health and well-being of children, ranging from mental health problems and increased risks of suicide violence, sexual abuse, and exploitation, to disruptions in family circumstances such as housing instability and lack of nurturing support. Especially given the Committee's considerable attention to gaps in equity and longstanding disparities in health care, we urge you to examine the far-reaching effects of pandemic on historically underserved populations and we stand ready to work with you to provide the perspective and experience of emergency physicians to help develop effective and durable policy solutions.

Our health care system is not currently well-equipped to address the long-term effects of the significant trauma so many young Americans have experienced over the course of the last year. **Given the substantial strains on the health care and social safety nets that existed long before the pandemic hit, it is clear that EDs, child welfare systems, the child and adolescent mental health workforce, and other related services will need considerable investments and significantly expanded resources in order to appropriately address this unprecedented challenge.** As policymakers and stakeholders evaluate suggestions to improve mental and behavioral health access, these proposals and any new treatment models must be considered through the lens of pediatric care in order to prioritize the most vulnerable of the vulnerable.

Once again, thank you for the opportunity to provide our comments and suggestions on how to improve access to mental health and substance use disorder care for our patients and their families. We look forward to working with you on these important efforts. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP's Congressional Affairs Director, at *rmcbride@acep.org.*

Sincerely,

CHRISTOPHER S. KANG,
M.D., FACEP,
ACEP President.

AMERICAN THERAPEUTIC RECREATION ASSOCIATION,
May 17, 2023.

Senator ED MARKEY, Chairman,
Senator ROGER MARSHALL, Ranking Member,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Subcommittee on Primary Health and Retirement Security,
428 Dirksen Senate Office Building,
Washington, DC. 20510.

DEAR CHAIRMAN MARKEY AND RANKING MEMBER MARSHALL:

On behalf of the American Therapeutic Recreation Association (ATRA), we appreciate the opportunity to submit this testimony for the record regarding the Committee's hearing on *A Crisis in Mental Health and Substance Use Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities.* As providers that comprise a part of the mental healthcare workforce with a particular focus on community response, we look forward to working with you to develop solutions to address America's mental health and substance use crisis.

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[4] COVID–19-Associated Orphanhood and Caregiver Death in the United States *(aappublications.org)*

ATRA is committed to advancing access to recreational therapy and ensuring that individuals are able to receive care that suits their interests and needs and supports the development of functional skills for daily living and stress release. ATRA is the largest professional association representing recreational therapy. Recreational therapists are nationally certified, and where applicable, state-licensed to provide evidence-based treatment services for individuals with a range of disabling conditions across the lifespan. Recreational therapy is active treatment, medically necessary, and can be prescribed by a physician as part of a client's plan of care.[1]

ATRA has watched with interest and concern as new data has highlighted the mental health crisis that America is currently experiencing. As recreational therapists, we are trained to use a variety of interventions to help clients address mental health challenges, as well as other areas like physical health and emotional/social well-being. Therefore, we recognize the critical need to ensure that resources are in place to address this mental health emergency to ensure that people are able to successfully manage the stress and anxiety of everyday life.

In mental health care, recreational therapists support clients with cognitive, social, leisure, and physical interventions, as well as stress management techniques, to improve a client's overall health. Recreation therapy (RT) for mental health incorporates activities including music, sports, dance, art, and outdoor activities to help a client find strategies that work for them to manage stress and ensure they have a healthy outcome for managing their mental health. RT also uses meaningful engagement in life activities or leisure as a means to increase coping and therefore reduce depression and anxiety. This type of therapy can be particularly helpful and attractive to individuals, including adolescents, as an alternative, non-pharmacological outlet.

RT's focus their work on community engagement and specifically work with individuals in their communities and homes to provide opportunities to participate in life activities including leisure, recreation, and play. The primary purpose of recreational therapy is to establish and maintain tools and skills to be successful in their community and home environment.

The Important Role that Recreational Therapists Play

Recreational Therapy (RT) embraces a definition of "health" which includes not only the absence of "illness," but extends to the enhancement of physical, cognitive, emotional, social, and leisure development so individuals may participate fully and independently in chosen life pursuits. Recreational therapists address assessed client needs related to behavior, cognition, function, pain management, physical activity level, socialization, recreation, and leisure.[2] Recreational therapists have the competencies to assess and implement interventions necessary to promote improved mental health, quality of life, and prevent secondary conditions[3,4] by reducing depression, stress, and anxiety in their clients and helping build confidence to socialize in their community. Recreational therapists work in a variety of settings that promote youth and adolescent mental health including community mental health centers, public and alternative schools, co-occurring disorder programs, day hospitals for outpatient treatment, inpatient psychiatric hospitals, inclusive recreation programs, residential living facilities, nature-based recreation programs, and addiction recovery centers.

In the United States, recreational therapists at a minimum must have a bachelor's degree in recreational therapy or a related field.[5] Anatomy and physiology, assessment, salient characteristics of illness and disabilities, medical terminology, the therapeutic process, and 560 hours of fieldwork are required courses.[6] The Certified Therapeutic Recreation Specialist (CTRS) is the required certification for recreational therapists by NCTRC and shows that the recreational therapist has

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[1] Kemeny B, Fawber H, Finegan J, Marcinko D. Recreational therapy: Implications for life care planning. J life care Plan. 2020;18(4):35–58.

[2] Commission on Accreditation of Rehabilitation Facilities. 2020 Medical Rehabilitation Standards Manual. 2020.

[3] Hawkins B, Kemeny B, Porter H. Recreational therapy competencies, Part 2: Findings from the ATRA competencies study. Ther Recreation J. 2020;54(4). doi:10.18666/trj–2020-v54-i4–10238

[4] Kinney J. Analysis of services performed by recreational therapists. Ther Recreation J. 2020;54(3):227–243. doi:10.18666/trj–2020-v54-i3–10248

[5] National Council for Therapeutic Recreation Certification. The CTRS is the qualified provider of Recreational Therapy Services. 2020.

[6] Bureau of Labor Statistics U.S. Department of Labor. Occupational Outlook Handbook, Recreational Therapists. 2020.

passed an all-encompassing national certification exam demonstrating extensive knowledge and skill-based training in core therapy skills (assessment, planning, implementation, documentation, and evaluation), a team-oriented approach to care delivery, and training in group processes.5 The CTRS credential is required for practice as a recreational therapist in Veterans Affairs[7] and designated as the accepted certification for recreational therapists by the Centers for Medicare and Medicaid Services Federal guidelines for skilled nursing facilities. Ethical conduct is mandated by the professional organization, the American Therapeutic Recreation Association (ATRA)'s code of ethics, and quality indicators of RT practice are supported by the ATRA Standards of Practice.

Research has shown the effectiveness of recreational therapy services for mental health outcomes. Through recreational therapy interventions, youth with mental health challenges saw increases in health-related quality of life[8], positive changes in their perceived self-esteem[9], and decreases in feelings of social isolation and loneliness.[10] Through outdoor adventure interventions, recreational therapists also helped some young people with substance abuse disorder and post-traumatic stress disorder to learn effective strategies for their personal recovery.[11]

To better explain the role of RT, we have provided some examples of recreational therapy services specific to adolescents with mental health conditions:

- A recreational therapist in Virginia works at a residential treatment center for adolescents with mental health diagnoses. Utilizing stress management interventions like guided imagery, progressive muscle relaxation, Tai Chi, and yoga, recreational therapy services help adolescents reach goals like decreasing symptoms of depression and anxiety while increasing self-confidence and personal grounding.
- Another recreational therapist works in a school in New Mexico with high school students with intellectual and developmental disabilities (IDD) who are experiencing increased anxiety during COVID–19. Recreational therapy services help the students cope with feelings of fear, worry, and hopelessness through after-school, group therapy sessions for teaching emotional identification, coping skills, and adjustment strategies to navigate their ever-changing daily schedules.
- Last, a recreation therapist in Colorado utilizes nature-based, adventure therapy interventions for adolescents with mental health diagnoses. Goals of improving adolescents' self-confidence, problem-solving skills, and sense of community are achieved through outcomes-based, recreational therapy modalities that include kayaking, rock climbing, high and low ropes courses, and wilderness hiking.

Conclusion

ATRA is supportive of Congress' work to address the mental health crisis and appreciates the opportunity to provide written testimony. **As Congress continues to consider legislative opportunities to address the mental health crisis, we ask that recreational therapists be included in any legislative language to support efforts to reduce stress, anxiety, and depression among youth, adolescents and adults.** We welcome the opportunity to speak with you more about what RT is, and how it can help in responding to the mental health emergency.

[7] U.S. Department of Veterans Affairs. VA Handbook 5005, Part II, Appendix G60. The Recreation and Creative Arts Therapist.

[8] Bennett JR, Negley SK, Wells MS, Connolly P. Addressing well-being in early and middle childhood: recreation therapy interventions aimed to develop skills that create a healthy life. Spec Issue Strengths-based Pract—Part 1. 2016;50(1):unpaginated. *http://js.sagamorepub.com/trj/article/view/6782.*

[9] Concepcion H. Video game therapy as an intervention for children With disabilities. Ther Recreation J. 2017;(3):221–228.

[10] Luchies LB, Barbour AL, Anderson SR. Children's Healing Center involvement reduces social isolation and loneliness among immunocompromised children and their family members. Am J Recreat Ther. 2019;18(3):37–47.

[11] Leighton J, Lopez KJ, Johnson CW. " There is Always Progress to Be Made": Reflective Narratives on Outdoor Therapeutic Recreation for Mental Health Support. Ther Recreation J. 2021;55(2):185–203.

Please do not hesitate to contact the American Therapeutic Recreation Association (ATRA) directly Brent Wolfe, ATRA Executive Director, at *brent@atra-online.com*.

Sincerely,

BRENT WOLFE,
on behalf of ATRA.

CHILDREN'S HOSPITAL ASSOCIATION,
May 17, 2023.

Senator ED MARKEY, Chairman,
Senator ROGER MARSHALL, Ranking Member,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Subcommittee on Primary Health and Retirement Security,
428 Dirksen Senate Office Building,
Washington, DC. 20510.

DEAR CHAIRMAN MARKEY AND RANKING MEMBER MARSHALL:

On behalf of the nation's children's hospitals and the children and families we serve, thank you for holding this hearing, "A Crisis in Mental Health and Substance Abuse Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities." We appreciate your leadership on this issue and look forward to working together to ensure that Federal programs are tailored to meet the unique needs of children, adolescents and the pediatric provider community proudly committed to serving them. We appreciate the work Congress has done to date to address the national children's mental health crisis; however, more Federal support and attention is urgently needed to meaningfully impact the troubling trajectory for our Nation's children.

Children's Hospital Association represents more than 220 children's hospitals nationwide, dedicated to the health and well-being of our Nation's children through innovations in the quality, cost, and delivery of care. Children's hospitals serve as a vital safety net for all children across the country regardless of insurance status, including those that are uninsured, underinsured and enrolled in Medicaid, the single largest payer of mental health services for children. As essential providers dedicated to providing the highest quality pediatric care, children's hospitals look forward to working with you to address the crisis in mental health facing America's children.

Prior to the pandemic, trends in child and adolescent mental health were worrying, as mental health symptoms increased among children, and many did not receive needed care. The stressors of the pandemic on families and children have worsened these trends significantly. Concerning evidence of the crisis:

- 1 in 5 children and adolescents experience a mental health condition in a given year. [1]
- In 2021, 29 percent of teens reported experiencing poor mental health, while 4 in 10 reported feeling persistent sadness or hopelessness. Teen girls were twice as likely (57 percent) to report persistent sadness. [2]
- 1 in 5 high school students contemplated suicide and 1 in 10 attempted suicide one or more times. [3]
- Suicide is the second leading cause of death for youth and young adults between the ages of 10 and 24. [4]

An increased demand for mental health services across the continuum of care for children, but particularly for children in crisis, has stressed already inadequate and under-resourced systems, leaving far too many children waiting for needed mental and behavioral health care, frequently "boarding" in emergency departments until an appropriate placement becomes available. As compared to pre-pandemic, 84 percent of hospitals report boarding more children and youth and 75 percent report

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[1] *"What is Children's Mental Health?,"* Centers for Disease Control and Prevention, April 2019

[2] *"Youth Risk Behavior Survey Data Summary & Trends Report,"* Centers for Disease Control and Prevention, February 2023.

[3] *"Youth Risk Behavior Survey Data Summary & Trends Report,"* Centers for Disease Control and Prevention, February 2023.

[4] *"Facts about Suicide,"* Centers for Disease Control and Prevention

longer boarding stays.[5] As we emerge from the public health emergency, the troubling trends continue with large numbers of children and youth languishing in hospital emergency departments waiting for access to needed care.

This crisis in boarding is also reflection of inadequacies within our Nation's pediatric mental health system, which is fragmented and insufficiently supported, too often resulting in delayed care. For many children, their mental health conditions can be managed with less intensive treatment, such as outpatient therapy and medication management through primary care, yet children's mental health conditions often go unidentified and untreated. Nearly 60 percent of children and youth with major depression are not receiving care and it is common for several years to pass between when symptoms first appear and treatment begins.[6] To prevent the children's mental health crisis from continuing we need to do a better job of providing access to needed services across the continuum of care, beginning as early as possible and ideally before children reach a point of crisis.

As you consider changes to existing programs and contemplate new initiatives, it is critical to examine how these changes affect the pediatric population. The importance of investing in services and supports that promote timely access to necessary pediatric mental health care cannot be overstated. Current Federal programs are essential and yet remain insufficient to meet the severity of this compounding national crisis in children's mental health. We look forward to partnering with you as you work to implement programmatic improvements and address the continued mental, emotional, and behavioral health needs of children across the country.

As the Senate HELP Committee moves forward, we urge you to prioritize:

- Creating new programs and investments meeting the needs of children and youth.
- Refining existing programs and increasing support to ensure that they are intentionally designed to meet the unique needs of children and adolescents and ensure access to services as early as possible.
- Increasing and targeting investments to support the recruitment, training, retention, and professional development of a diverse clinical and non-clinical pediatric workforce.

New Tailored Investments to Meaningfully Address the Crisis

Within HHS, there are several programs that focus on mental health broadly and some that focus on children specifically. These are important programs that play a role in meeting children's needs, but more is desperately needed. There are a number of programs that aim to improve children's access to evidence-based treatment for mental health conditions, yet they do not go far enough to address the widespread and unmet needs of children. Both the creation of new initiatives and enhancements to existing programs will be needed to adequately address the growing crisis in child and adolescent mental health.

At the core of a strong pediatric mental health care delivery system is a strong, interconnected network of pediatric health providers and supportive services that are available to deliver high-quality, developmentally appropriate mental and behavioral health care. Building a strong system of care starts with ensuring that children are able to access services in the settings where they are such as: early learning and childcare settings, schools, their pediatrician's office, community settings and emergency departments. A truly comprehensive approach must include the full continuum of clinical and non-clinical health services and supports that encompass promotion and prevention, early intervention and treatment. In too many communities, there are few local options for children in need of mental health treatment and investment is urgently needed to scale up services and support for the pediatric population.

Given the workforce shortages within pediatric mental health professions, the importance of innovative approaches to utilizing our current workforce, such as through integrated care, and support for enhanced care coordination are paramount. When children's and adolescents' mental health needs are significant enough to require services outside of schools and community-based outpatient settings, it is critical that they are delivered in appropriate settings designed for them and staffed

[5] Leyenaar J, Freyleue S, Bordonga A, et al., "Frequency and Duration of Boarding for Pediatric Mental Health Conditions at Acute Care Hospitals in the US," JAMA: Vol 326, No. 22, 2021.

[6] *"The State of Mental Health In America,"* Mental Health America, 2023.

by professionals with pediatric expertise. Children's hospitals have seen a growing demand for inpatient psychiatric care, as well as step down levels of care including partial hospitalization, day hospitals and intensive outpatient services. Unfortunately, there are too few of these services designed specifically for children, adolescents, and young adults, which results in significant delays in care and contributes to mental health boarding.

While investing in upstream mental health promotion, prevention, early identification and intervention for children is critical, including to prevent conditions from worsening to the point of crisis, we also need to ensure that there are appropriate treatment options across the full continuum of care for children and adolescents who need them. We urge Congress to provide resources to support efforts to scale up inpatient care capacity, including costs associated with the conversion of general beds to accommodate mental health patients, as well as to support the development of intermediate levels of care such as partial hospitalization, day programs, intensive outpatient services and crisis response and stabilization services which are designed to support families and divert children from emergency departments.

To better support the continuum of care, we strongly support legislation introduced last year by Sens. Casey and Cassidy entitled, Health Care Capacity for Pediatric Mental Health Act of 2022. The bill focused on children and would improve access to community-based services and supports, support training to enhance the workforce and invest in mental health infrastructure. Similar bipartisan legislation has been introduced in the House this year, H.R. 2412, the Helping Children Cope Act, which would provide grants to children's hospitals and other providers to increase their capacity to provide pediatric mental health services such as those described above. We would like to see policies like these enacted this year to address the serious gaps children and youth experience when attempting to access mental health services. We understand it is challenging to create new programs and dedicate spending but the level of the crisis and longstanding impacts for children and families and our Nation warrant the new dedicated investments.

Refining Existing Programs to Better Work for Children and Youth

The Community Mental Health Services Block Grant. The Community Mental Health Services Block Grant, frequently called the Mental Health Block Grant, supports state mental health agencies to provide comprehensive community mental health services and investments in evidence-based prevention for adults with severe mental illness or children with serious emotional disturbances (SED). The parameters of the funding as currently written focus on children with SED, making it difficult to spread funds to broader activities, such as evidence-based prevention efforts or mental health services for children whose needs do not reach the threshold of a serious emotional disturbance or have not yet been diagnosed. We strongly support a set-aside within this block grant for prevention and early intervention, to ensure that these Federal dollars can be used by states to expand early intervention and prevention services, especially with children and teens. A similar provision was included in the Mental Health Reform Reauthorization Act of 2022, led by Senators Cassidy and Murphy last Congress, and received bipartisan support.

Support for Children's Mental Health Workforce. Congress must address the urgent need to relieve pressure on the existing pediatric mental health workforce, as well as invest in its long-term expansion across disciplines to meet the ongoing and growing mental health needs of our children. Pediatric mental health workforce shortages are persistent and projected to increase over time. Nationally, there are approximately 10,500[7] practicing child and adolescent psychiatrists and only 5.4 clinical child and adolescent psychologists per 100,000 children 18 years of age and younger, far fewer than needed to meet the existing and increasing demand.[8] Shortages also exist for other vital pediatric mental health specialties critical to improving early identification and intervention for children with mental health needs. Additionally, racial and ethnic minority providers are under-represented across many mental health professions, which can be an added burden on racial and ethnic minority communities who already face inequitable access to care. More dedicated support for a larger and more diverse pediatric workforce is critical to addressing children's mental health needs now and into the future.

[7] Workforce Maps by State (aacap.org), American Academy of Child and Adolescent Psychiatry.

[8] "Supply of Child and Adolescent Behavioral Health Providers." University of Michigan Behavioral Health Workforce Research Center. July, 2020.

Congress can take several immediate steps to address the current and ongoing mental health workforce shortage.

Loan forgiveness for pediatric mental health providers. Existing loan forgiveness programs can be difficult for pediatric specialty providers to access. We support robust funding for the Pediatric Subspecialty Loan Repayment Program, which would provide loan forgiveness for pediatric subspecialists, including mental health providers practicing in underserved areas. While we were glad to see the program received increased funding in fiscal year 2023, we strongly encourage a larger investment of at least $30 million, to support the pediatric subspecialty workforce and improve longstanding shortages. Additionally, we support S. 462, the Mental Health Professionals Workforce Shortage Loan Repayment Program Act, a bipartisan bill which would extend loan repayment to mental health providers across a wider array of mental health professional fields, who serve in areas with shortages of mental health professionals. We look forward to working with you to identify realistic and effective immediate solutions to support and retain a diverse national pediatric mental health workforce.

Children's Hospitals Graduate Medical Education (CHGME) program. Pediatricians build strong relationships with families and can play a critical role in identifying children with mental and behavioral health needs earlier, before more serious issues emerge. The CHGME program supports the training of more than half of the nation's pediatric physician workforce and is essential to the continued access of children to needed pediatric specialists, including developmental pediatricians and child adolescent psychiatrists. However, CHGME represents only 2 percent of the total Federal spending on GME. These funding shortfalls must be financed by children's hospitals' child-patient care operations and are a key contributor to the overall pediatric workforce shortage. We appreciated the fiscal year 2023 funding level but would encourage Congress to consider a higher overall appropriations level for fiscal year 2024 to reduce the growing and unsustainable gap between other federally funded training programs and CHGME and a bipartisan reauthorization of the program this year supporting the existing goals to secure the future pediatric physician workforce.

Project AWARE. SAMHSA's Project AWARE—Advancing Wellness and Resiliency in Education, supports partnerships between State Mental Health Agencies and State Educational Agencies to expand programs which improve mental wellness and mental health awareness in schools. The program provides funding to develop school-based mental health programs and training for school-based professionals. Given the increased need for early intervention services, and the effectiveness of the existing program we support the Mental Health Services for Students Act, led by Senator Tina Smith and Rep. Grace Napolitano in the 117th Congress. This legislation would provide competitive grants for local education agencies to bring in onsite mental health professionals, improving children's access to mental health services at schools across the country. School partnerships with local mental health providers, including children's hospitals, facilitate early identification and intervention to improve mental health outcomes for school-aged children and teens.

Pediatric Mental Health Care Access Grants. The Pediatric Mental Health Care Access program is administered through HRSA with the goal of improving access to quality health care services through supporting the development of pediatric mental health care telehealth access programs or support existing programs. We were pleased to see the program reauthorized in the Bipartisan Safer Communities Act last year and we look forward to seeing how the program's expansion into more sites, including emergency departments and schools, progresses. Integrated care, including through telehealth consultation supported by this program, can improve identification of mental and behavioral health needs in children and streamline connections to care. While this program provides critical support to pediatricians, enabling them to treat some mental health conditions within primary care, we know that greater investment is needed in pediatric care integration. Integrating mental health with primary care, including through colocation of mental health providers, has been shown to substantially expand access to mental health professionals and increase children's utilization of behavioral health services.

Thank you again for your commitment to improving the mental and behavioral health care delivery system for children and adults. Children's hospitals and their affiliated providers stand ready to partner with you as you continue your work. Children need your help now.

With questions or for more information on Children's Hospital Association's mental health policy recommendations, please contact Vice President of Policy, Aimee Ossman, or Director of Federal Affairs, Cynthia Whitney.

[Whereupon, at 11:17 a.m., the hearing was adjourned.]

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