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WHY ARE SO MANY AMERICAN YOUTH IN A MENTAL HEALTH CRISIS? EXPLORING CAUSES AND SOLUTIONS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE AMERICAN YOUTH MENTAL HEALTH CRISIS, FOCUSING ON CAUSES AND SOLUTIONS

JUNE 8, 2023

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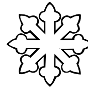

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WHY ARE SO MANY AMERICAN YOUTH IN A MENTAL HEALTH CRISIS? EXPLORING CAUSES AND SOLUTIONS

Thursday, June 8, 2023

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

The Committee met, pursuant to notice, at 10:01 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Smith, Markey, Cassidy, Murkowski, Braun, Marshall, Romney, Tuberville, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Senate Committee on Health, Education, Labor, and Pensions will come to order. And we are delighted to welcome our panelists that we are going to hear from in a few minutes.

But let me begin by telling everybody what they already know, and that is it is no great secret that in America today we have a mental health crisis, and the crisis has been exacerbated by the horrific COVID pandemic which we have experienced.

This is a crisis that has hit all of us, but I think especially the younger generation. In America today, 40 percent of parents report being either very or extremely worried that their child is struggling with anxiety or depression.

According to a recent survey by the Centers for Disease Control, nearly one out of every three teenagers in America reported that the state of their mental health was poor. Two out of every five teenagers felt persistently sad or hopeless, and tragically, one out of every five teenagers in our Country has seriously considered suicide.

How frightening is that? Tragically, suicide was the second leading cause of death for young people between the ages of 10 and 14, and it was the third leading cause of death among teenagers. All of us understand that the pandemic has had a huge and lasting impact on the mental health and well-being of our Country and our young people.

Let us never forget, and sometimes it is easy to forget, we remember the million people who died during the pandemic. But over 200,000 children, often children of color by the way, lost one or both of their parents to COVID.

Think about the impact that had on their lives. Further, and I think we are going to hear more about this later, our kids have become less connected humanly to each other, and this is kind of a new phenomenon.

Dr. Murthy has written about this, and I am sure will be speaking about it this morning. Instead of building trusting healthy, and strong relationships with their friends, their teachers, their mentors, an increasing number of kids are turning to their phones and social media to feel connected.

What type of impact does social media have on the mental health of our Nation's youth? That is an issue that we have got to really explore at great length as a Nation. According to a recent study, 32 percent of teen girls said that when they felt bad about their bodies, Instagram made them feel worse.

More than 40 percent of Instagram users who reported feeling unattractive said the feeling began on Instagram. About 25 percent of teenagers who reported feeling not good enough, inadequate, said it started on Instagram. But we are not here to single out Instagram alone, certainly, and I am sure that the same can be said about other social media platforms.

Let's be clear, and something I think this Committee in the months ahead will get into, we are up against some of the best minds in the world who keep coming up with new ways to get teenagers addicted, addicted to their websites in order to sell them more products and make more money, and that is what we are going to have to address.

But it is not just social media, as dangerous as that may be. Kids in Vermont, and I have been around to a lot of high schools and some community colleges in my state, but around this country as well, worry about the kind of future that awaits them.

They wonder if their political leaders in this country and around the world will address climate change, or whether the world that they and their kids will grow up in will be increasingly unhealthy and uninhabitable.

I really do wonder, walking here today through the smog and the smoke that Washington, DC. is experiencing right now, the horror in New York City, yes, it is a bad day, but you wonder what impact it has on the kids who wonder, is this the future—and what that does to them psychologically.

Yesterday on another issue, I had the occasion to meet with people who came to the Capitol who lost loved ones as a result of gun violence in schools. And I was stunned, in Vermont, where kids worry, when we were young, you went to school. It was a safe haven.

Now they really wonder that some terrible thing might happen. And when we talk about the anxieties facing young people, we can't ignore economics. Everything being equal, if we don't get our act together, the young people will have a lower standard of living than their parents.

Right now, some 60 percent of our people are struggling paycheck to paycheck. So, all I would say is the pandemic has exacer-

bated a bad situation. It is there. As political leaders in this country, it is our job to address it. Senator Cassidy, the mic is yours.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Mr. Chairman. Everybody here knows a fellow American struggling with mental health issues. Everybody watching knows, school closures, isolation from the COVID–19 pandemic exacerbated, almost concentrated this among those who are younger.

According to the CDC, from 2021 to 2022, the percent of teenagers feeling sad or hopeless increased from 37 percent to 42 percent. Those seriously considering suicide, seriously considered suicide, goes from 19 percent to 22. To say it is troubling is to kind of not have an adequate adjective.

This is terrible. The goal of this hearing is how do we improve access to quality mental health care for young people? Now, we must highlight that Congress has done a lot in recent years to improve mental health care and access for children and all Americans. We have walked this ground.

We need to see what our recent work has accomplished, need to measure its effectiveness, and then to figure out what gaps remain. Now, just for context, we have know this for decades, the Nation's mental health system was dysfunctional, under-resourced, not getting crucial services to Americans facing mental health issues, especially those in underserved areas. I worked in a hospital for the uninsured and the under-insured for 25 years.

I worked with this. Now, before I go on, let me give a shout out to Senator Chris Murphy. He and I in 2015 led the Mental Health Reform Act, an historic bill that overhauled our mental health system to increase access to quality mental health care for all Americans.

I remember Chris at that time saying, Bill, there are some things we agree on, a lot of them, and a few that we disagree. Let's focus on that which we agree and leave the other for another day.

By that, we did something which Lamar Alexander, then the Chair of this Committee, said he didn't think two freshmen Senators could do. There is both an insult and a praise in there.

[Laughter.]

Senator CASSIDY. But we accomplished it. And Lamar went on to say it was the most profound—the most profound reform of mental health law in the previous 30 years. He and I were both honored. Now, we teamed up again this past year to reauthorize this and to reform it to better address the needs of Americans.

We increased funding for mental health block grants to better serve children at risk for serious mental illness, expanded telemental health care, and promoted the integration of mental health providers into primary care, increased mental health workforce programs, focusing on treating children and underserved populations, and I could go on.

Now, additionally, and again I am going to give a shout out to Murphy once more, in response to the tragedy in Uvalde, Congress passed the bipartisan Safer Community Act, which invested bil-

lions of dollars so that every child and every American had access to mental health care no matter whether they are in a pediatrician's office, their school, an emergency room, or a community health center.

Chris was the lead on that, I had the privilege to work with them, but Congress passed it. The legislation invested $8.6 billion to expand certified community behavioral health clinics to all 50 states, offering 24/7 crisis intervention services, outpatient mental health, and substance abuse services, case management, increasing access to primary care for Americans, especially those who are lower income and uninsured.

It provided $2 billion for school based mental health treatment, to train school personnel to better help students through a crisis, to increase care for children suffering from trauma, to fund prevention programs, to decrease bullying and violence in schools, and much more.

Additionally, the Safer Communities Act instructing the Department of Education and the Department of Health and Human Services, both represented here today, to improve guidance to schools, particularly those in local—excuse me, in small or rural communities, to more easily build Medicaid for school based mental health services. And we will talk and hear more about that during the first panel.

I am proud of the work that Congress put into this legislation and signed into law, and these achievements show that there is a strong bipartisan support for addressing youth mental health issues.

But, and I say this all the time at home, these grants and programs only make a difference if state and local Government are aware of them, and apply, and show local leadership in order to participate. We need this local leadership to use these resources to make sure the assistance reaches those who need it most.

What we can't do is pretend that Congress hasn't done anything and that we must start anew. That, sweeping the debt clean, so to speak, in our minds, not acknowledging the basis upon which we build will create duplicate, inefficient programs, wasting dollars and wasting effort.

By the way, the Chair, just echoing the Chair, made the point, and I agree wholeheartedly, as you might guess, that the resources Congress appropriates should not be wasted. Now, Congress can't solve this on its own. Throwing money at an issue without accountability is not the solution.

There has to be complete buy in from the executive, from states, local Government, tribal leaders, and community organizations, among others, to make sure these programs work as Congress intended. There is, however, existing legislation up for reauthorization that requires attention.

As I mentioned in last week's hearing, the Committee has nine health care reauthorizations are waiting for programs that expire in September. One of these is the Support Act which helps individuals dealing with substance abuse disorder and increases support services for children suffering from trauma.

There are more than 50 individual provisions in the Support Act that fall in this Committee's jurisdiction. The fact that the Committee has 2 months left to reauthorize the programs and we have not formally considered bipartisan text, let alone marked them up, is concerning. I reiterate that reauthorizing the Support Act and these eight other health related bills on time, bipartisan must be the Committee's top priority.

As Ranking Member of the Committee, improving our Federal programs so they are more effective and having greater reach is crucial. So let me finish by saying I look forward to hearing from our witnesses as to how we can better address the mental health crisis to make sure that more young people have access to quality mental health and that the resources already allocated are used effectively.

Thank you, I yield.

The CHAIR. Thank you, Senator Cassidy. Now we are going to hear from our witnesses. And our first witness will be Vice-Admiral Vivek Murthy, who is the Surgeon General of the United States of America.

In my view, Dr. Vivek has done an extraordinary job in talking about the mental health crisis and the crisis of loneliness and many, many other issues. Dr. Vivek, thanks very much for being with us.

STATEMENT OF VICE ADMIRAL VIVEK H. MURTHY, U.S. SURGEON GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Admiral MURTHY. Thank you so much, Chairman Sanders. And thank you so much, Ranking Member Cassidy, for your leadership as well on issues related to mental health. To all the Members of the Committee who are here today, I am Dr. Vivek Murthy.

I have the privilege of serving as Surgeon General and as Vice Admiral of the U.S. Public Health Service Commission Corps, but I am most importantly here, as a father of two young children who is concerned about their future and the future of kids across America.

I am here to speak about what I believe is the defining public health issue of our time, and that is a youth mental health crisis. It now threatens the foundation for health and well-being for millions of our children.

In 2021, more than two in five high school students, including almost 60 percent of girls and 70 percent of LGBTQ youth, reported feeling persistently sad or hopeless. Nearly one in five high school students reported making a suicide plan, and this followed a 57 percent increase in the suicide rate among young people in the decade prior to the pandemic.

In response to this crisis, in December 2021, I issued a Surgeon General's advisory on protecting youth mental health, and I did this to call our Nation's attention to this urgent issue and to the need to act.

Over the last 2 years, I am grateful that Congress, on a bipartisan basis, and the Biden administration have made unprece-

dented investments to strengthen the mental health care system and to connect more youth to care.

These investments have already started to help children and families. But as all of you know, we have much more to do. Last month, my office released two new Surgeon General's advisories, and one on our epidemic of loneliness and isolation, and the other on social media and youth mental health.

Together, they explore two important drivers of the youth mental health crisis. Regarding loneliness and isolation, we now understand that social disconnection is both exceedingly common and profoundly consequential.

About one in two adults are reporting measurable levels of loneliness, and social disconnection is associated with an increased risk of not only depression, anxiety, and suicide, but also heart disease, dementia, stroke, and premature death.

The loneliness epidemic has hit young people particularly hard, and they have the highest rates of loneliness across age groups. The time young people, ages 15 through 24, spend in-person with friends declined by more than 50 percent from 2003 to 2019.

Furthermore, there has been a decline in participation over the last half century in community organizations that have traditionally brought us together, including faith organizations and recreational leagues.

Second though, I am increasingly concerned about the harmful impact that social media is having on youth mental health. Despite near universal users' inadequate evidence to conclude that social media is sufficiently safe for our kids, and while social media may provide some benefits for some children, there is a growing body of research associating social media use with potential harms.

This is especially concerning during adolescence, which is a highly sensitive period of brain development for kids and when they are particularly susceptible to peer comparison. The data show that youth who spend more than 3 hours a day on social media face double the risk of experiencing symptoms of depression and anxiety.

This is deeply worrisome because on average, teenagers are spending 3.5 hours a day on social media. And excessive social media use can also disrupt activities that are essential for healthy development, like physical activity, sleep, and in-person interactions. For example, a third of adolescents are telling us that they stay up until midnight or later on weeknights in front of their screens, and much of that is, in fact, social media use.

In addition, too often kids on social media are exposed to extreme, inappropriate, and harmful content. Indeed, nearly half of adolescents are saying that social media now makes them feel worse about their bodies. Now, two other drivers of youth mental health crisis that I just want to note briefly.

One is trauma, which has become all too common in young people's lives, particularly from violence and abuse, and the loss of loved ones to incarceration, addiction, and death. When young people go through such adverse childhood experiences, we know it has a negative impact on their mental and physical health.

Additionally, for many young people, their confidence in the future has been undermined by the serious challenges they are set to inherit, from economic inequality, and climate change, to racism, and gun violence.

This is what they say to me time and time again when I meet with young people around the country. The bottom line is our kids can't afford to wait longer for us to address the youth mental health crisis.

We have to expand our efforts to ensure every child has access to high quality, affordable, culturally competent mental health care. But we also must tackle the root causes by addressing the potential harms of social media through age appropriate health and safety standards and data transparency requirements, by investing in school based programs that equip children with the tools to manage their emotions, adversity, and their mental health, by addressing trauma, particularly violence, and by embarking on a generational effort to rebuild social connection and community in America.

Finally, we can all play a role in addressing the ongoing shame and stigma that still surround mental health and prevent young people for asking from help. Now, our obligation, finally to act is not just medical, it is moral.

It is about fulfilling our most sacred responsibility to care for our children and to secure a better future for them. I thank you for giving this critical issue the attention and the action it deserves, and I look forward to your questions.

[The prepared statement of Mr. Murthy follows:]

PREPARED STATEMENT OF VIVEK H. MURTHY

Chairman Sanders, Ranking Member Cassidy, Members of the Committee. I'm Dr. Vivek Murthy, and I have the privilege of serving as Surgeon General of the United States; as Vice Admiral in the United States Public Health Service Commissioned Corps; and, most importantly, as the father of two young children, a 5-year-old girl and a 6-year-old boy. They are the primary reason I am grateful for this opportunity to speak with you today.

Over the next few years, both of my children will enter an important stage of their education and development, where they'll learn how to build friendships, deal with adversity, and develop the values that will guide them throughout their lives. They and millions of their peers will start down the path to adulthood. Each path will be different. All will be filled with challenges along the way.

It's these challenges that I want to talk about today. I'm deeply concerned, as a parent and as a doctor, that many of the obstacles that this generation of young people face are unprecedented, and uniquely hard to navigate. The resulting impact on the mental health of millions of our children has been devastating.

In 2021, more than 2 in 5 high school students reported feeling persistently sad or hopeless almost every day for at least 2 weeks in a row—so much so that they stopped their regular activities.[1] This is an increase of 14 percent from 2019 and 50 percent from the previous decade. We also know that, in 2021, nearly 1 in 5 high school students reported making a suicide plan, a 13 percent increase from 2019.[2] And, within these numbers, we know that disparities exist. For example, nearly 60 percent of high school girls reported persistent feelings of sadness or hopelessness—

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[1] Centers for Disease Control and Prevention. (2023). Youth Risk Behavior Surveillance Data Summary and Trends Report: 2011–2021. Retrieved from *https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS-Data-Summary-Trends-Report2023-508.pdf*.

[2] *Id.*

a figure that was double the share of boys and the highest in a decade.[3] Students who identified as lesbian, gay, bisexual, questioning, or another non-heterosexual identity were approximately two times more likely than their heterosexual peers to experience persistent feelings of sadness or hopelessness too (69 percent vs 35 percent).[4] And also, in 2021, 3.7 percent of youth ages 12–17 had both a Major Depressive Episode (MDE) and a substance use disorder (SUD).[5]

The pandemic exacerbated this problem, but these challenges started well before the pandemic began and have many other contributing factors. From 2011 to 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28 percent.[6] And between 2007 and 2018, suicide rates among youth ages 10–24 increased by 57%—a total of 65,026 young people lost.[7]

Many mental health challenges first emerge early in life—half of all lifetime mental health issues begin by age 14, and 75 percent begin by age 24.[8] We need to do more to give young people and their families the tools to prevent and treat these mental health challenges. The average delay between the onset of mental health symptoms and treatment is 11 years—11 long, isolating, confusing, and painful years.[9]

We have the opportunity, the responsibility, and—as evidenced through my travels across the country and my conversations with many of you—the desire to address the youth mental health crisis in America. In 2021, I released The Surgeon General's Advisory on Protecting Youth Mental Health, which outlines the policy, institutional, and individual changes it will take to treat and prevent mental health challenges. Just last month, my office released two new advisories. First on Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community. And second, The U.S. Surgeon General's Advisory on Social Media and Youth Mental Health. Together, these Advisories explore what's contributing to the mental health crisis among youth and how to address it.

One of the key barriers to addressing mental health is the stubborn and pervasive stigmatization of mental health that tells people they should be ashamed if they are struggling with depression, anxiety, stress, or loneliness. It's isolating and further separates people experiencing mental health challenges from their loved ones and from sources of support. This stigmatization prevents kids from seeking help and receiving the long-term recovery supports they need.

I felt that stigma myself, growing up in Miami as a child who didn't look the same as the other kids, and who too often was bullied and called racial slurs by classmates who told me I didn't belong. Not surprisingly, that left me feeling lonely and anxious about going to school—and I felt a deep sense of shame as well. Like it was somehow entirely my fault that I was hurting. Even though I knew my family loved me unconditionally, the embarrassment I felt prevented me from asking them for help.

Even when children are able to summon the courage to ask for help, we do not always have sufficient resources to meet their needs. I am grateful that, in recent years, Congress and the Biden administration have made unprecedented investments in expanding access to mental health care and treatment for kids. In 2022, President Biden announced his Unity Agenda for the Nation—calling on us all to

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[3] *Id*. at 1.

[4] *Id*. at 1.

[5] Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22–07–01–005, NSDUH Series H–57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. *https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report*.

[6] Kalb, L. G., Stapp, E. K., Ballard, E. D., Holingue, C., Keefer, A., & Riley, A. (2019). Trends in Psychiatric Emergency Department Visits Among Youth and Young Adults in the US. Pediatrics, 143(4), e20182192. *https://doi.org/10.1542/peds.2018-2192*.

[7] Curtin, S. C. (2020). State suicide rates among adolescents and young adults aged 10–24: United States, 2000–2018. National Vital Statistics Reports; 69:11. Hyattsville, MD: National Center for Health Statistics.

[8] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of general psychiatry, 62(6), 593–602. *https://doi.org/10.1001/archpsyc.62.6.593*.

[9] Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. Health services research, 39(2), 393–415. *https://doi.org/10.1111/j.1475-6773.2004.00234.x*.

work together to tackle the mental health crisis, particularly for our youth. He released a comprehensive strategy to transform how we understand, treat and integrate mental health in America. And, already several actions have been taken to strengthen system capacity and connect more youth to care, including unprecedented investments to increase access to school-based mental health services with a focus on high-need school districts; to harness technology to bring virtual mental health services to where young people are; and to increase the number of peer support workers across the country. And historic investments have been made to enhance crisis response through the 988 Suicide and Crisis Lifeline to ensure that anyone experiencing a mental health crisis receives faster access to mental health services and trained mental health professionals. Significant investments have also been made to expand proven models of care like Certified Community Behavioral Health Centers (CCBHC) to provide comprehensive behavioral health care—including crisis care—to the most vulnerable Americans regardless of their ability to pay.

These are tremendous steps and many children now have access to care that they didn't previously have. However, more action is needed to help the millions who still lack adequate access. This means training providers, expanding peer support programs, enabling widespread use of technology to provide remote care, integrating behavioral health care with primary care and other settings, and strengthening and enforcing health insurance parity laws to ensure that insurers do their part to provide fair, equitable access to mental health services.

In addition to investment in treatment, it's crucial we do more to address the root causes of the youth mental health crisis. Today, I'd like to highlight three drivers that impact the mental health of today's kids and that I am particularly concerned about: loneliness, the impact of social media, and profound concerns about the state of the world.

First, increasing rates of loneliness. Across many measures, Americans appear to be becoming less socially connected over time. This is a problem that preceded the COVID–19 pandemic, though it certainly worsened for many people over the last 3 years. Social networks have been getting smaller, and levels of social participation have been declining. For example, objective measures of social exposure obtained from 2003–2020 find that social isolation, measured by the average time spent alone, increased from 2003 (285-minutes/day, 142.5-hours/month) to 2019 (309-minutes/day, 154.5-hours/month) and continued to increase in 2020 (333-minutes/day, 166.5-hours/month).[10] This represents an increase of 24 hours per month spent alone. At the same time, social participation across several types of relationships has steadily declined. For instance, the amount of time respondents engaged with friends socially in—person decreased from 2003 (60-minutes/day, 30-hours/month) to 2020 (20-minutes/day, 10-hours/month).[11] This represents a decrease of 20 hours per month spent engaging with friends. This decline in total time spent in-person with friends was starkest for young people ages 15 to 24. For this age group, time spent in-person with friends has declined by nearly 50% over the last two decades, from roughly 150 minutes per day in 2003 to less than 70 minutes per day in 2019.[12] This is concerning because, for children and adolescents, loneliness and social isolation in childhood increases the risk of depression and anxiety both in the short-term and well into the future (up to 9 years later).[13]

Second, as discussed in the recent U.S. Surgeon General's Advisory on Social Media and Youth Mental Health, we have reason to be concerned about the impact of social media[14] use on youth mental health. Social media use by youth is nearly

[10] Kannan, V. D., & Veazie, P. J. (2022). US trends in social isolation, social engagement, and companionship—nationally and by age, sex, race/ethnicity, family income, and work hours, 2003–2020. SSM—population health, 21, 101331. *https://doi.org/10.1016/j.ssmph.2022.101331*.

[11] *Id*.

[12] *Id*. at 9.

[13] Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID–19. Journal of the American Academy of Child and Adolescent Psychiatry, 59(11), 1218–1239.e3. *https://doi.org/10.1016/j.jaac.2020.05.009*.

[14] The definition of social media has been highly debated over the past few decades. As a result, there isn't a single, widely accepted scholarly definition of social media. (Aichner et al., 2021) The definition may vary from the cited research in this document based on the methods used in each study. In making conclusions and recommendations, this document regards social media as "internet-based channels that allow users to opportunistically interact and selectively self-present, either in real-time or asynchronously, with both broad and narrow audiences who derive value from user-generated content and the perception of interaction with others." (Carr

Continued

universal. Up to 95 percent of youth ages 13–17 report using a social media platform, with more than a third saying they use social media "almost constantly."[15] Although age 13 is commonly the required minimum age used by social media platforms in the U.S., nearly 40 percent of children ages 8–12 use social media.[16] Despite this widespread use among children and adolescents, there is insufficient evidence to conclude that social media is sufficiently safe for kids. Instead, there is a growing body of data associating social media use with potential harms to kids. There are also widespread concerns among parents and caregivers, young people, health care experts, and others about the impact of social media on youth mental health.

While social media may have benefits for some children and adolescents, such as serving as a source of connection, information, and support, especially for youth who are often marginalized, we must acknowledge and better understand the growing body of research about potential harms associated with social media use and urgently take action to create safe and healthy digital environments—ones that minimize harm and safeguard children's and adolescents' mental health and well-being while also maximizing the potential benefits of social media on health and well-being.

We are especially concerned about social media use among children because adolescence represents a highly sensitive period of brain development that can make young people more vulnerable to harms from social media. During this period, we know that young people are more prone to engage in risk-taking behaviors, their overall well-being (in terms of mood, physical health, etc.) fluctuates the most, and mental health challenges begin to emerge. We also know that, in early adolescence, when identities and sense of self-worth are forming, brain development is especially susceptible to social pressures, peer opinions, and peer comparison. As such, adolescents may experience heightened emotional sensitivity to the communicative and interactive nature of social media.

Social media platforms may contribute to youth mental health concerns in a number of ways. Excessive social media use can disrupt activities that are essential for healthy youth development like physical activity and sleep and reduce time for positive in-person activities. The content on social media platforms can reinforce negative behaviors like online harassment, abuse, exploitation, and exclusion, perpetuate body dissatisfaction and social comparison, and undermine the safe and supportive environments kids need to thrive. Research suggests that social media use can be excessive and problematic for some kids; that children and adolescents on social media are commonly exposed to extreme, inappropriate, and harmful content. The research also shows that those who spend more than 3 hours a day on social media face double the risk of experiencing poor mental health outcomes, such as symptoms of depression and anxiety.[17] This is deeply concerning as a survey of teenagers showed that, on average, they spend 3.5 hours a day on social media, with one in four spending 5 or more hours per day and one in seven spending 7 or more hours per day on social media.[18] Over half of teenagers report that it would be hard to

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& Hayes, 2015). For the purposes of this product, we did not include studies specific to online gaming or e-sports. Aichner, T., Grunfelder, M., Maurer, O., & Jegeni, D. (2021). Twenty-Five Years of Social Media: A Review of Social Media Applications and Definitions from 1994 to 2019. Cyberpsychology, Behavior And Social Networking, 24(4), 215–222. *https://doi.org/10.1089/cyber.2020.0134*; Carr, C. T., & Hayes, R. A. (2015). Social Media: Defining, Developing, and Divining. Atlantic Journal of Communication, 23:1, 46–65. *https://doi.org/10.1080/15456870.2015.972282*.

[15] Vogels, E., Gelles-Watnick, R. & Massarat, N. (2022). Teens, Social Media and Technology 2022. Pew Research Center: Internet, Science & Tech. United States of America. Retrieved from *https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology2022/*.

[16] Rideout, V., Peebles, A., Mann, S., & Robb, M. B. (2022). Common Sense Census: Media use by tweens and teens, 2021. San Francisco, CA: Common Sense. Retrieved from *https://www.commonsensemedia.org/sites/default/files/research/report/8-18-census-integrated-report-final-web-0.pdf*.

[17] Riehm, K. E., Feder, K. A., Tormohlen, K. N., Crum, R. M., Young, A. S., Green, K. M., Pacek, L. R., La Flair, L. N., & Mojtabai, R. (2019). Associations Between Time Spent Using Social Media and Internalizing and Externalizing Problems Among US Youth. JAMA psychiatry, 76(12), 1266–1273. *https://doi.org/10.1001/jamapsychiatry.2019.2325*.

[18] Miech, R. A., Johnston, L. D., Bachman, J. G., O'Malley, P. M., Schulenberg, J. E., and Patrick, M. E. (2022). Monitoring the Future: A Continuing Study of American Youth (8th-and 10th-Grade Surveys), 2021. Inter-university Consortium for Political and Social Research [distributor]. *https://doi.org/10.3886/ICPSR38502.v1*

give up social media, and on a typical weekday, nearly one in three adolescents report using screens (most commonly social media) until midnight or later.[19,20]

When asked about the impact of social media on their body image, nearly half (46 percent) of adolescents ages 13–17 said social media makes them feel worse, 40 percent said it makes them feel neither better nor worse, and 14 percent said it makes them feel better.[21]

This increase in social media use may also contribute to the bombardment of messages that undermine this generation's sense of self-worth—messages that tell our kids with greater frequency and volume than ever before that they're not good-looking enough, not popular enough, not smart enough, not rich enough.

Third, many young people are grappling with challenges that impact their present-day experience and the world they'll inherit, including economic inequality, climate change, racial injustice, discrimination against individuals who identify as LGBTQI+, the opioid epidemic, and gun violence. And they feel progress is too slow. The COVID–19 pandemic further exacerbated the stresses young people already faced. As of December 2022, more than 275,000 children lost a primary or secondary caregiver due to COVID–19 and many more worried about losing loved ones who fell sick.[22] With the support of Congress, the Administration has taken actions to support this population of youth who have been affected by COVID–19 and other disasters, such as the Children and Youth Resilience Prize Challenge which will fund innovative community-led solutions to promote resilience in children and adolescents. Millions of children experienced increased food insecurity, instability, and economic stress at home, and were isolated from friends and family during an extraordinarily stressful period. The collective impact of these challenges and the absence of a clear, unified path to progress has undermined young people's confidence in the future that awaits them.

It is imperative that we act now. Our children do not have the luxury of time—their childhoods and developments are happening now.

Out of the many recommendations in the recent Surgeon General's Advisories, I'd like to highlight four overarching recommendations today:

First, ensuring that every child has access to high-quality, affordable, and culturally competent mental health care. To do this, we must make sure that children are enrolled in health coverage—far too many children in our Country are eligible for coverage under Medicaid and the Children's Health Insurance Program, but aren't enrolled. We need to do better here, especially as pandemic-era provisions to support coverage have come to an end, which could leave gaps in coverage for countless families and children.[23] We also need to expand our mental health workforce, from clinical psychologists, school counselors, and psychiatrists, to recovery coaches and peer specialists—and that includes making sure these professionals can serve in, and provide services at, schools. We have too few providers to meet the growing demand. And we need to make sure that care is delivered at the right place and time, whether that's in health care settings like primary care practices, or community-based settings like schools, and whether it's in person or through telehealth. The Departments of Education and Health and Human Services are collaborating to help make it easier for schools to file Medicaid claims for crucial mental and physical school-based health services, with potential to unlock additional supports for millions more students nation-wide. This is on top of the from the American Rescue Plan Elementary and Secondary School Emergency Relief Fund and the Bipartisan Safer Communities Act that we know states and schools districts are already using to provide more counselors, other mental health providers, and nurses in schools. More than 14,000 new mental health professionals—including school psychologists, counselors, and social workers—are projected to be placed in U.S.

[19] *Id*. at 14.

[20] Bickham, D.S., Hunt, E., Bediou, B., & Rich, M. (2022). Adolescent Media Use: Attitudes, Effects, and Online Experiences. Boston, MA: Boston Children's Hospital Digital Wellness Lab. Retrieved from *https://digitalwellnesslab.org/wp-content/uploads/Pulse-Survey-Adolescent-Attitudes-Effects-and-Experiences.pdf*.

[21] *Id*.

[22] Imperial College London. (14 February, 2022). Global Orphanhood estimates real time calculator. Imperial College London. Retrieved from *https://imperialcollegelondon.github.io/orphanhood-calculator/#/country/United%20States%20of%20America*.

[23] Centers for Medicare & Medicaid Services. (n.d.). Unwinding and Returning to Regular Operations after COVID–19. Retrieved from *https://www.Medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html*.

schools.[24] Those funds, coupled with Medicaid funding, are available now to help meet our young peoples' critical mental health needs.

Second, focusing on prevention, by investing in school-and community-based prevention, promotion, and early intervention programs that have been shown to improve the mental health and emotional well-being of children at low cost and high benefit. Every dollar we spend on prevention represents multiple dollars we won't have to spend on treatment—in fact, one study estimated that investment in early prevention offered a fourfold return down the line.[25] We've seen the extraordinary potential of certain strategies and programs—Project AWARE and What Works in Schools, for example, which help communities develop a sustainable infrastructure for school-based mental health programs and services. The recent Surgeon General's Advisory on Our Epidemic of Loneliness and Isolation lays out a set of recommendations for schools, including developing a strategic plan for school connectedness, building social connection into health curricula, implementing socially based educational techniques such as cooperative learning projects, and creating supportive school environments that foster belonging.

These programs support families, teaching parents how to recognize challenges as they emerge, find available resources, and offer support and care. They also give kids tools to manage their emotions in healthy ways, build supportive relationships, and get help when they need it. We need to invest in scaling these programs, and programs like them, across the country. And that must go hand-in-hand with continuing to advance comprehensive public health approaches such as preventing adverse childhood experiences, promoting positive childhood experiences, and addressing the systemic economic and social barriers, like safety, housing, food, and economic insecurity, that contribute to and create the conditions for poor mental health for young people, families, and caregivers.[26]

Third, we need to take action now to protect children against the potential harms of social media. The recent Surgeon General's Advisory on Social Media and Youth Mental Health describes the current evidence on the impacts of social media on the mental health of children and adolescents. It details how there are critical gaps to understanding the full extent of mental health risks posed by social media—including a lack of evidence that social media is sufficiently safe for children and adolescents. There are critical steps policymakers can take to address the complex issues related to social media use and protect youth from the risk of harm, including by strengthening safety protections, developing age-appropriate health and safety standards, limiting access in ways that make social media safer for children of all ages, requiring platforms to better protect children's privacy, supporting digital and media literacy curricula within schools and in academic standards, and supporting research on both the benefits and harms of social media use. The Administration has taken actions to help us fill critical knowledge gaps such as the establishment of the National Center of Excellence on Social Media and Mental Wellness, which will develop and disseminate information, guidance, and training on the impact—including risks and benefits—of social media use on children and young people and examine clinical and social interventions that can be used to prevent and mitigate the risks. It's crucial that these platforms are designed to maximize the benefits and minimize the harms to the mental health of our youth and with the health and well-being of all users, especially children, in mind.

The final recommendation I will highlight today concerns individual and community engagement to cultivate a culture of connection—a culture in which we prioritize cultivating healthy relationships with family, friends, neighbors, coworkers, and community members. A strong culture of connection shapes not only our individual experience but also how we design our school and work environments and the investments we make in community organizations that bring us together. Such a culture rests on core values of kindness, respect, service, and commitment to one another. As leaders, parents, friends, and fellow Americans, it is up to us to build

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[24] U.S. Department of Education. (15, May 2023). Press Release: Biden-Harris Administration Announces Nearly $100 Million in Continued Support for Mental Health and Student Wellness Through Bipartisan Safer Communities Act. Retrieved from *https://www.ed.gov/news/press-releases/today-biden-harris-administration-announcing-more-95-million-awards-across-35-states-increase-access-school-based-mental-health-services-and-strengthen-pipeline-mental-health-professionals-high-needs-school-districts-t*.

[25] Karoly, L.A., Greenwood, P.W., Everingham, S.S., Houb́, J.S., Kilburn, M.R., Rydell, C.P., Sanders, M.R., & Chiesa, J. (1998). Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions.

[26] Centers for Disease Control and Prevention. (22 September, 2022). Preventing Adverse Childhood Experiences: Data to Action (PACE:D2A). Retrieved from *https://www.cdc.gov/violenceprevention/aces/preventingace-datatoaction.html*.

this culture by reflecting these core values through our actions, our words, and our example. We can do it by investing in local-level programs, policies, and physical elements of a community that facilitate bringing people together, by reaching out to people in our lives who are having a hard time to offer our support, by choosing to understand someone's intention and choosing not to demonize them because of our differences, and by sharing our own stories and struggles with mental health, recognizing that there is great power in our authenticity and vulnerability.

A nation with a strong culture of connection is one where people feel a sense of community and belonging, where people recognize that we are defined not by our differences and disagreements but by the hopes we share for our kids, our community, and our Country.

I look forward to discussing these recommendations and possibilities with you today. Mitigating this crisis is urgent, but it will take a bipartisan, all-of-society coalition of governments, community organizations, employers, technology and social companies, schools and health care systems, and young people and their families alike. I thank you for recognizing this, and for your shared commitment to action.

Our obligation to act is not just medical—it's moral. It's not only about saving lives. It's about fulfilling our sacred obligation—to care for our children and secure a better future for them. Throughout our history, progress has been born in the wake of tragedy. I'm eager to partner with you to make it happen again.

Thank you for having me, and for giving this critical issue the attention it needs and deserves.

The CHAIR. Let me turn to Senator Cassidy, who will introduce our next witness.

Senator CASSIDY. It is an honor to introduce Mrs. Katherine Neas, Deputy Assistant Secretary of the Office of Special Education and Rehabilitative Services at the U.S. Department of Education.

In her role, Mrs. Neas works to improve the educational and employment outcomes for students with disabilities. Today, she will discuss the Department's broader work to support the mental wellbeing of all students. Mrs. Neas.

STATEMENT OF KATHERINE NEAS, DEPUTY ASSISTANT SECRETARY, OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, DC

Ms. NEAS. Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee, thank you for the opportunity to share the Department of Education's work on youth mental health and promising interventions.

The Youth Risks Behavioral Survey, released this past February by the Centers for Disease Control and Prevention, conveyed alarming findings of the prevalence of mental health or substance use disorder among our Nation's youth.

The report advances the critical need for schools to expand school based services and to connect youth and families to community based sources of care. Simply put, schools are a gateway to needed services that otherwise might be inaccessible to many young people. The report also emphasizes the responsibility of schools to ensure that all learning occurs in a safe and supportive environment.

The Department's work is focused on three top priorities, increasing the skill and knowledge of existing school personnel to support the mental health needs of students, increasing the supply of mental health professionals who can work with students, and increas-

ing funding through the Medicaid program to support school health services, including mental health services.

One year ago, Congress provided new funding under the bipartisan Safer Communities Act that significantly bolstered Federal, state, and local efforts to address student mental health needs. I am pleased to provide you with an update of our work to implement this law.

Last September, the Department awarded $1 billion to state educational agencies to competitively award sub-grants to high needs school districts for activities to support safe and healthy students. This Stronger Connections Grant Program will support school districts to develop, implement, and evaluate comprehensive programs and activities that foster safe, healthy, supportive, and drug free environments that support student academic achievement.

The bipartisan Safer Communities Act also provided $1 billion over 5 years to be equally divided across two programs to increase the supply of school based mental health service providers. The response to these two grants has been enthusiastic. Under the school based mental health services grant, 12 states and the District of Columbia and 229 school districts across 41 states submitted applications.

The Department was able to fund nine states, the District of Columbia, and 94 school districts across 31 states. Under the Mental Health Services Professional Demonstration Grant Program, 266 school districts applied, and the Department was able to find 160 grants.

To support this $280 million of Federal support across 264 grantees that will train 14,000, sorry, school based mental health professionals, the Department will fund a mental Health Personnel Technical Assistance Center later this year.

This past January, the Department awarded $86 million in grants to local communities through the Promise Neighborhood and the Full Service Community Schools Program. The bipartisan Safer Communities Act also directed the Departments of Health and Human Services in collaboration with the Department of Education to issue guidance to increase access to school based health services to children enrolled in Medicaid and the Children's Health Insurance Program.

This guidance was released on May 18th of this year. Medicaid and CHIP provide health coverage to more than half of America's children, roughly 41 million children. These programs are administered by state according to Federal requirements.

Children are eligible based on family income or unique health care needs, such as having a disability or a serious mental illness, or if they are in foster care. Under Medicaid's Early Periodic Screening Diagnostics and Treatment Program, eligible children can receive comprehensive primary health, mental health, and behavioral health services.

Medicaid enrolled children who need services in school can fall into two categories, eligible children who need general health care services and students with disabilities who receive services under the Individuals with Disabilities Education Act.

In 2021, schools receive nearly $6 billion in total payments for school based health care to Medicaid students. Schools also received about $14 billion in Federal IDEA funding. In 2014, the Centers for Medicare and Medicaid Services issued a letter to state Medicaid directors clarifying reimbursable services in a school based setting.

The CMS letter explained that schools can seek payment for all Medicare covered services provided to all students enrolled in Medicaid, not just for students with disabilities. As of May 2023, 21 states have used this policy to expand their school based Medicaid programs. Most states use these funds to hire and sustain essential personnel who can deliver or facilitate the delivery of health and mental health services.

As you can see, the Department is actively engaging in efforts to address the mental health crisis facing our Nation's youth. We are committed to ensuring that students' needs are met, that they are ready to learn, and that they have the full access to learning opportunities. Thank you for the opportunity to be here, and I look forward to answer your questions.

[The prepared statement of Ms. Neas follows:]

PREPARED STATEMENT OF KATHERINE NEAS

Chairman Sanders, Ranking Member Cassidy, and distinguished Members of the Committee, thank you for the opportunity to share the Department of Education's (Department's) work to meet the needs of the 49.5 million students enrolled in public schools across the country and the 25.3 million students enrolled in colleges and universities.

While I serve as the Department's Deputy Assistant Secretary for the Office of Special Education and Rehabilitative Services, mental health is a deep personal and professional area of interest to me, and a priority issue across the Department. Mental health affects the well-being of every student, educator, school, and community in America; and the Department is committed to creating the conditions for all students to thrive academically and personally.

The *National Survey on Drug Use and Health* released in January by the Substance Abuse and Mental Health Services Administration and the *Youth Risk Behavioral Survey* released this past February by the Centers for Disease Control and Prevention (CDC) conveyed alarming findings of the prevalence of mental health or substance use disorders, or co-occurrence of both among our Nation's youth. [1] The *Youth Risk Behavioral Survey* also included recommendations on how schools can be part of the solution. The report advances the critical need for schools to expand school-based services and to connect youth and families to community-based sources of care. Simply put, schools are a gateway to needed services for many young people. As trusted community partners, schools can provide critical behavioral and mental health services directly or establish referral systems to connect those in need to community sources of care that might otherwise be inaccessible. The report also emphasized the responsibility of schools to ensure that all learning occurs in a safe and supportive environment.

The Kaiser Family Foundation highlights several factors that limit schools' current ability to effectively provide mental health services to students. [2] These factors include insufficient mental health professional staff coverage; inadequate access to licensed mental health professionals; inadequate funding; concerns about reactions from parents; requirements that schools pay for the services, and a lack of community support for providing services.

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[1] Centers for Disease Control and Prevention, *Youth Risk Behavior Survey: Data Summary and Trends Report 2011–2021*, *https://www.cdc.gov/healthyyouth/data/yrbs/yrbs-data-summary-and-trends.htm*.

[2] Nirmita Panchal, Cynthia Cox, Robin Rudowitz, "The Landscape of School-Based Mental Health Services," Kaiser family Foundation, September 6, 2022, *https://www.kff.org/other/issue-brief/the-landscape-of-school-based-mental-health-services/*.

We know the COVID–19 pandemic exacerbated certain pre-existing challenges to student wellness and academic success, and the ongoing impacts of the pandemic continue to hinder some state and local recovery efforts.[3] Moreover, suicide was the second leading cause of death among people age 20–34.[4] Additionally, college students who experience basic needs insecurity experience significantly higher rates of depression, anxiety, and suicidal ideation, planning, or attempt.[5] The Department embraces the opportunity to reflect on what we have learned and move forward with a renewed energy to support the field in accelerating learning and supporting the mental health of preschool to postsecondary students and school personnel.

The Department is actively engaged in efforts to accelerate recovery. These efforts have been supported by historic investments that continue to raise the bar so students can recover academically and access critical supports for their mental health and well-being. Raising the bar means recognizing that our Nation already has what it takes to continue leading the world—if we deliver a comprehensive, rigorous education for every student; boldly improve conditions for learning; and ensure every student has a pathway to multilingualism and to college and careers. When the bar is raised in education, all our Nation's students will build the skills to succeed inside and outside of school. Our students will reach new heights in the classroom, in their careers, and in their enriched lives and communities, making a positive difference in the world, for generations to come.

While the work is far from over, I am pleased to share what is underway.

Department of Education Priorities

The Department's work aligns with the President's Unity Agenda, the CDC and the Kaiser Family Foundation findings and is focused on three top priorities: (1) increasing the skills and knowledge of existing school personnel to support the mental health needs of students; (2) increasing the supply of mental health professionals who can work with students; and (3) increasing funding through the Medicaid program to support school health services, including mental health services.

One year ago, Congress provided new funding under the Bipartisan Safer Communities Act (BSCA) that significantly bolstered Federal, state, and local efforts to address student mental health needs. I am pleased to provide you with an update on our work to implement this legislation.

Funding of School Based Mental Health Services

Through BSCA, the Department received four categories of funding, reflecting a comprehensive approach to supporting States, Local Educational Agencies (LEAs), and schools in creating safe and healthy learning environments.

This includes:

- $1 billion through Title IV, Part A of the Elementary and Secondary Education Act of 1965 (ESEA) to enable State Educational Agencies (SEAs) to competitively award subgrants to high-need LEAs for activities to support safe and healthy students under ESEA section 4108. The Department has designated this component of BSCA the *Stronger Connections Grant Program*. States are in the process of running Stronger Connections grant competitions. ESEA section 4108 allows funds to be used to "develop, implement, and evaluate comprehensive programs and activities" that foster safe, healthy, supportive, and drug-free environments that support student academic achievement. Therefore, Stronger Connections funds may be used to hire professionals who are necessary to implementing such programs.
- An additional $50 million in formula funding for the 21st Century Community Learning Centers, which provides academic enrichment opportunities to students during non-school hours.
- $500 million for competitively awarded School-Based Mental Health (SBMH) Services Grants designed to increase the number of credentialed

[3] U.S. Department of Education. "Education in a Pandemic: Disparate Impacts of COVID–19 on America's Students." Retrieved from: *https://www..ed.gov/about/offices/list/ocr/docs/20210608-impacts-of-covid19.pdf*.

[4] Centers for Disease Control and Prevention. Facts About Suicide. *https://www.cdc.gov/suicide/facts/index.html*.

[5] Katharine M. Broton, Milad Mohebali, Mitchell D. Lingo. *Basic Needs Insecurity and Mental Health: Community College Students' Dual Challenges and Use of Social Support*. 2022. *https://journals.sagepub.com/doi/abs/10.1177/00915521221111460*.

school-based mental health services providers delivering school-based mental health services to students.

- $500 million for competitively awarded Mental Health Services Professionals (MHSP) Demonstration Grants to support innovative partnerships involving states, school districts, and institutions of higher education (IHEs) to train and increase the number and diversity of high-quality school-based mental health services providers available to address shortages of such providers in schools within high-need districts. Nearly half of the new MHSP awardees included a partnership with a Minority Serving Institution, Historically Black Colleges or Universities or Tribal Colleges.
- $280 million across 264 projects projected to train approximately 14,000 school-based mental health professionals.
- $86 million in grants to local communities awarded in December 2022. Under the Promise Neighborhood Grants, six communities received $23 million to provide coordinated support services and programs to students from low-income backgrounds at every stage of their education from early childhood through their careers. These grants will also focus on preventing and reducing community violence that too often impacts low-income communities. Under the Full-Service Community Schools program, $63 million in new awards went to 42 LEAs, non-profits, and IHEs across 18 states, the District of Columbia, and Puerto Rico.

To support grantees funded under the SBMH and MHSP grant programs, later this year, the Department will fund a first of its kind school-based mental health professional development technical assistance center. This center will provide support and resources to grantees, help ensure accurate data-collection and reporting to gauge progress, and disseminate best practices in credentialing, recruiting, training and developing, and retaining school-based mental health services providers. This will include best practices for establishing and sustaining partnerships with IHEs to create and provide innovative high-quality training and credentialing options and maintain a robust pipeline of school-based mental health services providers.

IHEs have also worked creatively on the ground to utilize funding from the Higher Education Emergency Relief Fund to address mental health at colleges and universities around the country. [6]

Some examples include:

- North Carolina Central University created a suicide prevention coordinating committee. The committee has worked to develop on-campus resources and a suicide response plan.
- The University System of Georgia created a system-wide task force to develop a comprehensive plan for long-term solutions to address mental health challenges and provide mental health services at their institutions.
- The University of Alabama provided centers for students from underserved or marginalized groups and communities, open for all students, including a Safe Zone for LGBTQ+ students, a Collegiate Recovery and Intervention Services Center for students with substance use disorders, and a Women and Gender Resource Center for students who are survivors of violence.
- Lac Courte Oreilles Ojibwe College in Wisconsin partnered with a mental health platform to allow all students and faculty on-demand, 24/7 access to counselors.

Interagency Collaboration and Capacity Expansion Through Medicaid

BSCA also directed the Department of Health and Human Services, in collaboration with the Department of Education to issue guidance to state Medicaid agencies, LEAs, and school-based entities to support the delivery of medical assistance to Medicaid and the Children's Health Insurance Program (CHIP) beneficiaries in school-based settings. This guidance, *Delivering Services in School-Based Settings:*

[6] U.S. Department of Education. *Using Higher Education Emergency Relief Fund (HEERF) Institutional. Portion Grant Funds to Meet the Mental Health and Substance Use Disorder Needs of Students*. May 19, 2022. *https://www..ed.gov/about/offices/list/ope/heerfmentalhealthfaqs.pdf*.

A Comprehensive Guide to Medicaid Services and Administrative Claiming was released on May 18, 2023.[7]

Medicaid and CHIP provide health coverage to millions of people living with disabilities and low-income families, children, pregnant individuals, adults, and seniors, including over half of American children (57 percent = 41.9 million children enrolled in Medicaid and CHIP / 73.1 million children in the U.S.).[8] These programs are administered by states, according to Federal requirements. Children are eligible based on their family income or unique health care needs (such as a disability or serious mental illness), or if they are in foster care. Under Medicaid's Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, eligible children under age 21 should receive comprehensive physical health, mental health and behavioral health services.[9]

Medicaid-enrolled children who need services in school can fall into two categories: eligible students who need general health care services and students with disabilities who receive special education services under the Individuals with Disabilities Education Act (IDEA). School-based services delivered to children with disabilities are at no cost to their families. The Medicaid Budget and Expenditure System (MBES) expenditures reports for 2021 show more than $5.98 billion in total computable payments for school-based health care services to Medicaid students. Schools also received $14.1 billion in Federal IDEA funding in 2023.[10]

Medicaid can support schools to sustain essential services for eligible students.[11] In 2014, the Centers for Medicare & Medicaid Services (CMS) issued a letter to State Medicaid Directors clarifying reimbursable services in a school-based setting. The CMS letter explained that schools can seek payment for all Medicaid-covered services provided to all students enrolled in Medicaid.[12] As of May 2023, 214 states have used this policy to expand their school-based Medicaid programs. Most states use these funds to hire and sustain essential personnel who can delivery or facilitate the delivery of health and mental health services. The actual amount of additional Medicaid funding varies across school districts based on a wide variety of factors, including: (1) the number of students who are eligible for Medicaid in a district; (2) the unique needs of each child with a disability; and (3) State Medicaid payment rates;

Here are a few examples of how states have leveraged this opportunity to date to leverage Medicaid payments to hire key staff to provide essential health and mental health services to youth:

- Louisiana was the first state to expand its program, focusing solely on school nursing services. The State's financial analysis showed a 35 percent increase in Federal revenue. The program was such a success that the State did a second school Medicaid expansion to include all eligible providers and services.[13]
- Colorado ran a pilot project to better understand the financial impact of expanding its program. The state began by examining the impact of adding additional Medicaid eligible providers and, with the inclusion of additional school behavioral providers, estimated an increase of around $8 million, Michigan expanded its program to allow claiming for all Medicaid-enrolled students and added a number of additional providers, including masters-level school psychologists and behavioral health analysts.

[7] **The Centers for Medicare and Medicaid Services**, *Delivering Services in School-Based* Settings, 2023, *https://www.Medicaid.gov/Medicaid/financial-management/downloads/sbs-guide-Medicaid-services-administrative-claiming.pdf.*

[8] **The Centers for Medicare and Medicaid Services**, *Delivering Services in School-Based Settings*, 2023, *https://www.Medicaid.gov/Medicaid/financial-management/downloads/sbs-guide-Medicaid-services-administrative-claiming.pdf.*

[9] **The Centers for Medicare & Medicaid Services**, *CMCS Informational Bulletin: Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services*, August 18, 2022, *https://www.Medicaid.gov/Federal-policy-guidance/downloads/sbscib081820222.pdf.*

[10] **The Centers for Medicare and Medicaid Services**, *Delivering Services in School-Based Settings*, 2023, *https://www.Medicaid.gov/Medicaid/financial-management/downloads/sbs-guide-Medicaid-services-administrative-claiming.pdf.*

[11] **Healthy Schools Campaign, "State Data on Medicaid-Eligible School Health Services and Providers,"** *https://healthystudentspromisingfutures.org/map-school-Medicaid-programs/.*

[12] **Centers for Medicare & Medicaid Services**, *SMD# 14–006 Medicaid Payment for Services Provided without Charge (Free Care) https://www.Medicaid.gov/Federal-policy-guidance/downloads/smd-Medicaid-payment-for-services-provided-without-charge-free-care.pdf.*

[13] *https://healthystudentspromisingfutures.org/state-successes/examples/.*

Billing for masters-level school psychologists alone is projected to lead to an increase of $14 million to the school system.

- Voices for Georgia's Children estimates that Georgia's pending expansion to allow claiming and payment for school nurses would bring in an additional $48.6 million in Federal revenue to the school-based Medicaid program.

Conclusion

The Department's mission is "to promote student achievement and preparation for global competitiveness by fostering educational excellence and ensuring equal access." This mission is urgent now more than ever as members of the educational community work together to address the learning gaps and increased mental health needs, fueled by the pandemic, that affected all students, particularly students from historically underserved groups.

As described above, we are actively engaging in efforts to accelerate recovery. We note throughout this testimony how the Department prioritizes work to address the mental health crisis facing our Nation's youth. We are committed to ensuring that students' needs are met, that they are ready to learn, and that they have full access to learning opportunities.

Thank you, I look forward to answering your questions.

[SUMMARY STATEMENT OF KATHERINE NEAS]

Mental health affects the well-being of every student, educator, school, and community in America; and the Department is committed to creating the conditions for all students to thrive academically and personally. The Department's work is focused on three top priorities: (1) increasing the skills and knowledge of existing school personnel to support the mental health needs of students; (2) increasing the supply of mental health professionals who can work with students; and (3) increasing funding through the Medicaid program to support school health services, including mental health services. The Department also is engaged in robust delivery of technical assistance through funded technical assistance centers.

One year ago, Congress provided new funding under the Bipartisan Safer Communities Act (BSCA) that significantly bolstered Federal, state, and local efforts to address student mental health needs. Here is an update on our work to implement this legislation.

- $1 billion through Title IV, Part A of the Elementary and Secondary Education Act of 1965 (ESEA) to enable State Educational Agencies (SEAs) to competitively award subgrants to high-need LEAs for activities to support safe and healthy students under ESEA section 4108. The Department has designated this component of BSCA the *Stronger Connections Grant Program*. States are in the process of running Stronger Connections grant competitions. ESEA section 4108 allows funds to be used to "develop, implement, and evaluate comprehensive programs and activities" that foster safe, healthy, supportive, and drug-free environments that support student academic achievement.
- $280 million across 264 projects projected to train approximately 13,500 school-based mental health professionals and hire approximately 14,000 more under the School-Based Mental Health Services Grant and the Mental Health Services Professionals Grants.
- $86 million in grants to local communities under the Promise Neighborhood Grants and the Full-Service Community Schools program.
- A new competition for a mental health professional development technical assistance center is underway. services providers.
- BSCA also directed the Department of Health and Human Services, in collaboration with the Department of Education to issue guidance to State Medicaid agencies, LEAs, and school-based entities to support the delivery of medical assistance to Medicaid and the Children's Health Insurance Program beneficiaries in school-based settings. This guidance, *Delivering Services in School-Based Settings: A Comprehensive Guide to*

Medicaid Services and Administrative Claiming was released on May 18, 2023. [1]

Additional Resources from the US Department of Education

Bipartisan Safer Communities Act—Office of Elementary and Secondary Education

Safe and Supportive Schools—Office of Elementary and Secondary Education

Center to Improve Social and Emotional Learning and School Safety—Office of Elementary and Secondary Education

Supporting Child and Student Social Emotional Behavioral and Mental Health

Medicaid School Based Services information

www.ed.gov/raisethebar

The CHAIR. Mrs. Neas, thank you very much. Let me start off with Dr. Murthy. Senator Cassidy mentioned what is true, that the Congress has taken some action. But I will tell you, as I go around Vermont and talk to teachers and principals, they tell me they need more help.

In your judgment, do we have at this moment the kind of mental health infrastructure, from psychiatrists, the social workers, the counselors that this country needs?

Admiral MURTHY. Well, thank you, Senator. And I do appreciate the significant historic investments that have been made over the last few years. I think they have helped, but we do need more to help build the infrastructure.

When we think about care, for example, mental health care, there are several pieces of the infrastructure that still need to be expanded. No. 1 is the mental health workforce itself.

I am talking here not only about psychologists and psychiatrists and others in the traditional mental health delivery model, but I am also thinking about peer support models and others, which we know can help kids, and we need to think more broadly about that workforce.

The CHAIR. Let me ask you this, we have talked a lot about the problems. Talk about some of the solutions. Are there communities or schools in America that are doing something that is effective in addressing the crisis we are talking about?

Admiral MURTHY. The good news is that there are successful models around the country. Many of them do not know about each other and hence are not learning from each other, and we have to invest in studying and scaling them.

But a few that I will mention. One is the Becoming a Man Program, which has been a very powerful program, started in Chicago and now spread to some other cities, which has worked in high schools with helping young people, essentially be sources of support to one another, and it has been able to demonstrate actual benefits in trials that were run by the University of Chicago.

We also know the Afterschool Matters Program has been another one, which has brought community organizations together to be

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[1] Medicaid, *Medicaid and School Based Services: Overview of Medicaid and School-Based Services*, May 18, 2023, *https://www.Medicaid.gov/resources-for-states/Medicaid-state-technical-assistance/Medicaid-and-school-based-services/index.html*.

with kids and provide the mentorship, support, and safe spaces to play and learn after school. And that has also demonstrated positive benefits.

The CHAIR. Let me ask you this, because you have written about this. What is—you write about loneliness, and yet people spend half their lives on these things. What is the difference, in your judgment, between human interactivity and activity on social media, and how does that impact the well-being of Americans?

Admiral MURTHY. Well, Senator, this has been an important point of concern for me. There is no substitute for in-person interaction. As human beings, we evolved over thousands of years to perceive not just the content of what someone says, but also interpret their body language, to sense nonverbal cues.

We take all of that in, and that contributes to a rich human interaction. When you strip a lot of that away, you lose richness, you lose quality of connection. That is not to say there is never a place for texting or for online connection.

But what I worry about is that the balance has shifted dramatically toward online connection and away from in-person connection, particularly for our kids. But the other concern, Senator, is not only what kids are missing out on as a result of social media, but what they are being exposed to on social media.

We—I talk to parents all over the country who—and to kids as well, who say that they are exposed to content that is violent and sexual in nature, that they are often bullied and harassed online. Six out of ten adolescent girls are telling us that they have been approached by strangers on social media in ways that have made them feel uncomfortable.

These are—I am concerned both about what is not happening as a result of social media in our kids' lives, but also about some of the toxic effects of what they are being exposed to.

The CHAIR. Mrs. Neas, you spoke about the impact that Medicaid is having on providing services to kids who desperately need it. We are now, as a result of the end of the pandemic and the cessation of the funding,—the many billions of dollars we put into funds and increasing Medicaid,—what impact will hundreds of thousands of millions of people losing their Medicaid have on mental health in this country?

Ms. NEAS. Senator, thank you for that question. The work that we have done with the Department of Health and Human Services to make it easier for schools to access the Medicaid program for school based services is one that we are very proud of because we think it is going to make it easier for schools to hire and sustain necessary people.

At the same time, we have been working hand in glove with the Department to get word out to our school leaders about this time of re-enrollment and hoping that those children who have to re-enroll in Medicaid are found eligible.

That those that are found not eligible can be directed to another source of insurance. But it is something that I think the Administration is very concerned about and wanting to do everything we

can to make sure that children who are eligible can stay on the program.

The CHAIR. But is it a concern that if hundreds of thousands of millions of families lose their Medicaid, it is going to make it harder for people to get the mental health services they need?

Ms. NEAS. Without question, sir.

The CHAIR. Senator Cassidy.

Senator CASSIDY. Although I am tempted not to because my fellow Southerner did not wear a seersucker today, I am going to defer to Senator Tuberville.

[Laughter.]

Senator TUBERVILLE. I have got two suits, I just forgot.

[Laughter.]

Senator TUBERVILLE. Thank you, Mr. Chairman, for having this hearing. I spent 35 years with the youth of this country as a coach, educator, and this is not just a crisis that we have, mental health, it is an emergency. We got huge problems. This is probably the biggest problem we have in this country. It is getting worse every day.

I saw it change in just a short period of time. The No. 1 commodity that we have in this country is not gold and silver, it is our young people, and we are destroying them, and we are sitting back and watching it happen. I have seen prescription drugs take over our youth, especially a lot of kids that I work with.

We have ruined the nuclear family, and that is where a lot of this has got to come from. I counted up yesterday 32 mental health programs that we have in this country—32. We spend tens of billions of dollars. We are not making any progress. We are going the opposite way. We have all kinds of addiction.

I talked to a sheriff last week in Montgomery, Alabama, and he said, coach, I had never heard the word fentanyl till 2 years ago. Now, that is 95 percent of the drugs that we have in our schools and on the streets. The biggest drug we got is this right here. We all got it. There is not a person in here that doesn't have one of these.

I am guilty like everybody else, and I stay on it. I think everything on it is true, but it is not. But our young kids think that it is. That is the problem, and we have got to get control of that. And a lot of it, that is what we are talking about here today, is loneliness. And we can agree on some of that.

We have a program in Alabama that is called Harsha that our state mental health Department is running through our children's hospital. It works to connect interested primary providers with mental health specialists across the state and operates a sort of a command center at the hospital in Birmingham. Kids experiencing these—all the issues that they have, they are connected with providers that are close to them, whether it is rural or inner city.

Money for this particular program has tripled in the last year in the bipartisan Safer Communities Act. Now, I will tell you this. We can afford a lot of things around here, but we cannot not afford to fund mental health.

We can't. We have to be able to afford it and through situations like this. So, Dr. Murphy, are we tracking the successes and failures of the rest of the billions of dollars that we spend, or we track?

Are we tracking that, where it is working? Have you got people that are doing that in your line of work, that is helping us track the money going in? Is that money helping to the degree where we can see success?

Admiral MURTHY. Well, thanks, Senator, and I wish I could circle, underscore, star so much of what you just said, because you are right on and you are right that the most important task that we have is our kids, and we have got to do more to protect them.

I also agree with you that when we do put funds toward a cause, it is important to know, is it actually working? Is it delivering the benefit? And, while our office, the Surgeon General does not conduct evaluation trials, that is not what we are a resourced to do, we do have colleagues across the Department of Health and Human Services, at NIH and at SAMHSA, who do conduct evaluations of programs so that we understand what is working, who it is working for, and what more—what is missing.

But I think, Senator, to pick up on something else you said here as well. I think—and I like the program you mentioned in Alabama in terms of the concept of building a network and an infrastructure so that primary care doctors in particular and others aren't trying to manage all this on their own.

Programs like the Pediatric Mental Health Access Program, for example, have been very helpful in making sure that those primary care doctors can get expertise, mental health expertise, into the clinic when a patient is there, and we do need more programs like that.

But I don't think that we will be able to keep up with the sheer disturbing trends that we are seeing in terms of increased mental health concerns unless we simultaneously attack some of these root causes.

You mentioned our devices, and particular for young people, social media has become, I worry for too many of them, a contributor, an important contributor to their mental health strains. I also spent a lot of time with student athletes when I travel around the country, do roundtables specifically with student athletes.

Many of them tell me that not only are they having a hard time sometimes getting help, some of them have incredibly supportive coaches and administrations. Others do not. I had one football player who told me that after having serious thoughts of taking his own life, he approached his coach and said—and it took a lot of courage for him when he admitted to his coach what was going on and asked for help.

But as a response from the coach as well if that is how you are feeling, maybe this program is not for you. You should consider going to another university. And he was heartbroken. Now, thankfully, that is not the response that most kids get, but we still have more to do in terms of making sure kids get the help they need.

But if we can focus on making social media safer for our kids, if we can focus on rebuilding the social connection and community

that our kids need, families are a key part of that, faith institutions are a key part of that, other community organizations like YMCA, boys and girls clubs, these are all play vital roles in helping connect kids to each other, families to each other, but participation in them, Senator, has been declining for a half a century, and it is leaving people lonely, isolated, and in greater risk for mental illness.

Senator TUBERVILLE. Thank you. And one thing I would like to say, I know we are over a little bit here, Mr. Chairman, but we have, unfortunately, people in this country that are born with a mental health problem, and we are trying to treat them with a lot of prescription drugs. And I think that is fine to a certain degree.

Sometimes we are overprescribing. But the problem is we are creating more mental health problems now than we are having young people born with mental health problems. And I think we all have to understand that. If we will start understanding that I think we can understand the problems that we have to overcome.

Because if we don't do this now, we are going to lose the country that we all grew up in, because mental health is the No. 1 problem in this country, the No. 1 problem, and we have to—because it leads to everything else. Leads to so many things in this country that are negative. So, thank you. Thank you for your answer. Thank you. Mr. Chairman.

The CHAIR. Senator Casey.

Senator CASEY. Mr. Chairman, thanks for having this hearing. I want to thank you and the Ranking Member for convening us. And I want to thank both of our witnesses for their testimony and their public service.

I wanted to start with Deputy Assistant Secretary Neas to talk about bullying and harassment, one aspect of this larger challenge. I think we can all agree that children deserve to go to school without any fear or intimidation.

But as we know, far too often bullying and harassment affects so many children and can have very serious consequences for the mental health that stay with them for the rest of their lives, and it undermines their ability to achieve academically.

We know that these issues are especially prevalent among students with disabilities, LGBTQ+ students, students of color, and students who are either in high school or elementary school, girls and young women.

To support the well-being of all students, I have introduced multiple times now the Safe Schools Improvement Act, which would require school districts to adopt codes of conduct that explicitly and transparently prohibit bullying and harassment based upon race, color, national origin, sex, disability, sexual orientation, gender identity, and religion, very much consistent with our civil rights statutes.

The bill would ensure that school districts take proactive action to support the safety and inclusion of all children. And Deputy Assistant Secretary, what is the value of universal prevention strategies such as legislation like I just outlined, in supporting mental health and academic achievement of every student?

[Technical problems.]

Ms. NEAS. Is that better? Here we go, sorry. Thank you for that question. The Department has partnered with the Department of Health and Human Services on a website called *stopbullying.gov*, which includes resources for schools to do exactly what you are saying.

I think one of the reasons we are so proud of the bipartisan Safer Communities Act and the work we are doing to increase the supply of mental health professionals who are in school is to make those things real. It is important to have the culture of a school be conducive to learning and safe for everyone.

We want to have those resources in schools and available to schools so that they can actually act on it. So, I couldn't agree with you more. The need for us to address the bullying, particularly of vulnerable kids, kids with disabilities, kids who may have uncertainty at home. We want school to be that safe place where they always know that there is somebody there who has their back.

Senator CASEY. Thank you. I wanted to move to a question for Dr. Murthy. One of the many pieces of data that you cite in your testimony—and I am looking at page one of your written testimony, it just kind of leaps off the page, and I am just reading a pertinent part here, "in 2021, nearly one in five high school students reported making a suicide plan."

Hard to comprehend those numbers, one in five high school students. And I wanted to not just focus on those high school years, but what happens afterwards as well. And because if that is the circumstance in high school, we can only imagine what that means down the road.

This challenge that we are all talking about here today predated obviously the pandemic but was made much worse by it. I am citing here the Kaiser Family Foundation, showing that half of young adults, ages 18 to 24, reported anxiety and depression symptoms this year, 2023—half of young adults.

Despite these rising needs, many institutions of higher education are poorly equipped to handle the mental health needs of students. I have introduced the Higher Education Mental Health Act, along with Senator Kaine.

The legislation promotes collaboration among educators, students, parents, advocates, and communities to study the mental health concerns facing college students. How can institutions of higher education better support students who are struggling with mental health today?

Admiral MURTHY. Well, thank you, Senator. And I appreciate your leadership on this issue, and with your proposed legislation. I think higher—institutions of higher learning have a huge role to play.

First of all, they are aware a lot of young people are, and we better bring the care to where people are. They can help to change culture by starting conversation addressing stigma. They can increase access to mental health services on campus and through telehealth to make it easy for kids to get care. But they can also invest in

building the kind of connection and community that we know is vital to the mental health of children.

It doesn't just happen by throwing kids in a room and saying, hey, mingle and build connection. It turns out a little bit of structure, along with a little bit of time, can help kids actually build the relationships that they want. And finally, let's just keep in mind, many kids don't have what we might assume are just basic tools for managing emotions, building strong, healthy relationships.

Many of them may not have gotten that. And so, we have got to recognize that. And it is why I think programs that focus on building social skills and an emotional development so kids can manage their emotions and understand the emotions of others are really vital. That is a life skill. That, to me, is just as important as learning how to read or write.

Senator CASEY. Thanks very much.

The CHAIR. Senator Cassidy.

Senator CASSIDY. I defer to Senator Budd.

Senator BUDD. Thank you, Senator. And thank you, Chair. And thank you both for being here today. So, I sent a letter to NIH back on May 9th asking why taxpayer dollars were spent on a study entitled, Psychological Functioning in Transgender Youth After Two Years on Hormones, in which two participants tragically committed suicide. So, I am still waiting for a response from NIH on that letter, and I, Chairman, I ask for unanimous consent that I can submit my letter for the record.

The CHAIR. Without objection——

[The following information can be found on page 90 in Additional Material:]

Senator BUDD. Thank you. Now, the researchers, they concluded that the study was a success, but they admitted also that they couldn't show that cross-sex hormones improved the psychosocial functioning for minors. So clearly, it looks like this was a real waste of taxpayer dollars.

Even worse than that, it led or contributed to the suicide of two youth. So, Dr. Murthy, considering what I understand is your past support for providing cross-sex hormones to children, can you explain whether you think spending more taxpayer dollars on research into transgender procedures on minors will actually help children with the mental issues that we are discussing today?

Admiral MURTHY. Well, thanks, Senator Budd, for that question. While I was not directly involved in this study, and I am not familiar with it——

Senator BUDD. I understand——

Admiral MURTHY [continuing]. What I will say is that it is important for us to study what measures may help improve the mental health and well-being of transgender youth, because what we see clearly in the data is that as disturbing as these rates of anxiety, depression, and suicide are, they are actually disproportionately higher among LGBTQ youth, particularly transgender youth.

Studies that look to understand what interventions that work to address those psychosocial concerns I do think are important because this is a community that is struggling.

Senator BUDD. Thank you. A follow-up to that. Are you concerned about causing sterility and infertility in children who receive these cross-sex hormones, and about the negative long term impacts of these medical interventions on their mental health?

Admiral MURTHY. Well, Senator, I think whenever you have a medical intervention, it is vital to study both the short and long term impacts on physical and mental health. And I think that is where an investment of resources is needed.

Senator BUDD. Just to clarify, you said you would be concerned about the long term and short term impacts of these medical interventions on their health, their mental health?

Admiral MURTHY. Well, I think it is important for us to understand what those are through research, sir. So that is what I am saying. And I think that this is a space where, this is obviously a very complex area, and what we need to do here is what we do in other areas of medicine, which is to look to experts who have expertise in this area to put together the kind of guidelines that clinicians can then look at, and then make the best decision for patients based on that, or individual circumstance, just like we do in other areas of medicine.

Senator BUDD. Thank you. And I would just hope that the medical community and their research would be very cautious here. I mean, we have seen an NIH study which contributed to the suicide of two individuals, so please be careful, is the message. I want to shift gears just a little bit back to social media.

We know that children are being bombarded every day by unhealthy information on social media. Millions of children are suffering, as we have talked about, from anxiety and depression, and loneliness, because of the addictive content on social media.

There is an advisory, I think, that you issued on social media and youth mental health, and it discussed the increased use of social media by kids. So, to what extent, Dr. Murthy, do you agree that social media is damaging to the mental well-being of children? And how do you believe that we should address this?

Admiral MURTHY. Well, thanks for that, Senator. And my concern here is not just the Surgeon General, sir, it is as a doctor and as a parent. I have a five and 6 year old child—children, and my daughter is five. She is in preschool. And she came home a couple of weeks ago and asked my wife and me if she could post a picture on social media. She didn't have a social media account.

We have never talked to her about social media, yet all of her friends are talking about this. And I do believe that while there are some kids who get benefits from their use of social media in terms of opportunities to interact with others, in terms of the opportunity to find a community online, whereas they may not have one in person, I do worry that for many children the effects are in fact harmful and are contributing to the depression and the anxiety that we see among many young people, as well as issues with body image. In terms of what we can do, I think there is a lot we can do.

Ultimately, this isn't all about what Government can do. I think there is an important role, a critical role for parents here and for kids themselves. But I think what parents need is some support and help. And by establishing safety standards for social media that help protect kids from exposure to harmful content, and from harassment and bullying, and from features that seek to manipulate them into excessive use, I do think that we can help parents.

We also need, as policymakers, I think there is also a role to require data transparency here. And researchers around the country, Senator, tell me that they have had a hard time getting the data from companies to fully understand the extent of the impact of social media.

I will just say this, Senator, when our child—when our children get old enough to drive a car, or when they are small like mine were a few years ago and we needed to get a car seat for them, we don't tell parents, go inspect the tires yourself, check out the engine, make sure the frame is adequately strong, because we know that not all parents have the expertise to do this.

They rely on us establishing standards and then enforcing those with manufacturers. These are incredibly complex platforms that are rapidly evolving, fundamentally changing how our kids see themselves and interact with the world, and parents need help here to interpret and understand their safety.

Senator BUDD. Good. Thank you both.

The CHAIR. Thank you.

Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman. Thank you for holding this very important hearing. I am so proud of this Congress and many on this Committee for passing the bipartisan Safer Communities Act, and I am glad to get an update today on how that money is being impactful to help our kids. It is part of a trend. We are spending more money today on mental health than ever before.

We have gone from about $155 billion in 2010 to $238 billion in 2020, and it is still not enough. But I think this hearing is so important because I think we have come to the conclusion that unless you get at the root causes of unhappiness and isolation and loneliness, there is almost no amount of money that can make up for that inattention.

Dr. Murthy, I wanted to continue this conversation about social media, in part because I think it is the most immediate public policy concern that this Congress can tackle, and because I think there is easy agreement between Republicans and Democrats, but not because I think it is the whole story.

I think, frankly, we probably spend more time than we should talking about this narrow but very important problem that our kids are facing. But I think we can do something about it, so let's not lose the opportunity. I know the Administration hasn't endorsed any specific policy proposals, but just give us your take on which direction we should head.

Senator Schatz, and Cotton, and Britt, and I have a piece of legislation that says, you have got to do age verification and make

sure that you can't get on before you are 13. You can't use algorithm boosting on younger kids, and parents have to have a say.

Other legislation says you should have a standard that applies to social media companies so that they are only putting healthy content online. As you look at the sort of cornucopia of policy options that Congress is looking at here, what direction would you point us in to best protect our kids?

What are the tactics that the social media companies are using that are most disturbing to you? And I will just give you maybe the statistic that is most worrying to me. There is a recent study that shows within 2 minutes of establishing a TikTok account, a teenager can be fed information glorifying suicide.

Within 4 minutes of establishing a TikTok account, a teenager can be sent content celebrating eating disorders. That is how quickly really damaging, really dangerous content can get to kids who are in crisis, who are in trouble. And it just compels us, in this Congress, to do something about it. So, give us a little bit of advice.

Admiral MURTHY. Well, thanks, Senator. And I just want to also appreciate your leadership on the issue of loneliness and isolation. It has been an honor to work together with you on addressing this. And I agree with you that there are multiple drivers of the mental health crisis. Social media is one of them, and I agree it is an important one for us to address.

A few things I would say in terms of avenues of focus on, recognizing that social media has been around for almost two decades. During that time, there has been a lot of evolution in the platforms, a lot of different ways in which it is affecting our kids' lives. And so there is actually a lot to do here if we truly want to make them safe.

I think one certainly is around enforcement concerning age. Many platforms established 13 as the age at which kids can use social media. By the way, that is not based on health grounds, the age of 13.

Although many people think it is. But it—40 percent of kids 8 through 12 are on social media. So whatever rules the platforms have in place are very poorly enforced. I think the second area is we need to protect the privacy, data privacy of kids. Kids at this point do not have sufficient control over their data, neither do their parents.

This data is often used in direct ads to them, and other content is driven by the algorithms. We need to give kids and parents control over that data. The third is actually around data transparency. Companies are not fully disclosing the data they have about the health impacts of their platforms to our kids, to kids, to parents, to researchers, and to the public at large.

This is what researchers tell us all the time. And without that transparency, we don't even know the full extent of the problem and which kids are more most affected, and so it is hard to target interventions. But finally, I would say when it comes to safety standards, this is a place where I do think we can build models off of other products where we establish safety standards.

Whether it is for cars, car seats, medication, baby formula, whatever you want to consider as a parallel, but the bottom line is, we need to have standards that push companies to assure us and to be able to demonstrate through data that they are not exposing our kids to harmful content, that they are not in fact allowing kids to be bullied and harassed online, particularly by strangers, and also that they are not promoting the use of features that lead to excessive use.

We know that kids are in a vulnerable stage here of development and they are particularly susceptible to some of these features. We can't have companies taking advantage of those. So, these are some areas that I think are essential for.

I would be happy to work with you and other Members of this Committee as you develop legislation around this, because I think this can't come soon enough.

Senator MURPHY. I appreciate our partnership. I appreciate your guidance to this Committee. The only thing we cannot afford to do is to stand pat. There is a consensus here that we can find with your help. Thank you very much, Mr. Chairman.

The CHAIR. Thank you.

Senator Cassidy.

Senator CASSIDY. I defer to the sartorially splendid, Dr. Marshall.

Senator MARSHALL. Well, thank you, Senator Cassidy. And thank you, Chairman Sanders. We have to stop the hemorrhaging. We have to stop the hemorrhaging. When a patient comes to the emergency room when they are bleeding out, we don't start pumping blood into them. The first thing we have to do is stop the bleeding. Most of our solutions today seem to be pumping more blood into people.

We got to go back and start over. The greatest health care mistake the NIH and CDC ever did was locking our youth out of schools, and that has launched this mental health epidemic that we have. Irrefutable damage to our children's mental health, and I hope the CDC will own that someday.

Instead of our children talking to their friends, their colleagues, their teachers, their coaches, they talk to social media. That became their best friend. So how do we stop that hemorrhaging? I think we have to go back and think about, I look at social media today it is worse than pornography.

My young sons were exposed to pornography when they were very young because of social media, and I think the addictive pressures coming from social media today are worse than pornography. And just like we had to set parameters around pornography, we need to do the same thing with social media.

I wish we didn't have to. I think we need to start over on what the solutions are. Dr. Murthy, would you support some type of an electronic Surgeon General's warning on a statement on mental health and the impact of social media?

Admiral MURTHY. Well, thank you, Senator Marshall. And it is always good to be here with a fellow clinician as well. I know you have seen this from different angles.

I do worry about social media, as you do, and what I have tried to actually do in the advisory we just issued 2 weeks ago was to put in writing clear as day what our concerning was. Our concern was about social media, and to issue that warning to the American public.

I don't think it is the last thing, though, that we need to do. I think it is a start.

Senator MARSHALL. Much like when I was growing up, we put a Surgeon General's warning on tobacco. And it had an impact. I think, when we put a Surgeon General's warning on alcohol for pregnant women, it has an impact. Are you willing to use your bully pulpit and say, we need a Surgeon General's warning on what is the biggest threat to our youth right now when it comes to their health.

This is the No. 1 threat to our children's health right now. It is not cancer. It is not osteoporosis. It is not a whole lot of things. This is the No. 1 threat. Are you willing to use your pulpit and put your reputation on the line and say, we need a Surgeon General's warning on social media for youth?

Admiral MURTHY. Well, Senator, I do think it would be appropriate to have a warning on social media to warn parents and kids. And if Congress is willing to provide the legislative or regulatory authority to put that label on, then I would certainly be willing to partner.

Senator MARSHALL. Does it take legislation for you to put that label on? I don't know the answer to that.

Admiral MURTHY. Yes, it takes either a legislative or regulatory authority to do that.

Senator MARSHALL. Okay. Another issue I want to talk about are—is fentanyl or drug cartels, that they are selling fake Adderall. This, of course, laced with fentanyl. You are well aware of this. And they are using social media.

Of course, the top buyers are children. Senator Shaheen and I wrote legislation with leaders on the Judiciary Committee to hold social media companies accountable for illegal drug sales happening on their platforms.

Does this have the support—it does have the support of the White House and the DOJ and would love to add your continued efforts with this. Any comments on that?

Admiral MURTHY. I want to highlight the word you use, accountability, because there has been an utter lack of that when it comes to how we have been addressing the impact of social media on our kids.

What you mentioned, which is the use—the platform is being used to expose our kids to drugs and other harmful content is one example of that. So yes, I would support measures to ensure there was more accountability for the platforms.

Senator MARSHALL. Okay. The last thing we need to do is go back and study this and form committees and pray about this. We know social media is preying on our youth. We know it as surely as alcohol causes infant problems for moms as well. We know it. We don't need to study this more.

As black and white as you can make this, what would be your recommendations to stop this from happening? What—if you were—if you owned the social media company, why wouldn't you take the responsibility yourselves? Why does it take an act of Congress to do the right damn thing? What would you recommend that they do?

Admiral MURTHY. Well, do you mean this company specifically?

Senator MARSHALL. Yes.

Admiral MURTHY. Yes. So, what I laid out on the advisory is a series of checks for the tech companies specifically. One is to apply age appropriate design to their platform, so they are not exposing young kids to harmful content.

Second is to be transparent with their health impacts and the data that they are collecting that—so everybody can see how these platforms are impacting our kids' health. But the truth is, Senator, these social media platforms have been around for nearly 20 years. If we are going to just rely on them to fix this problem, I think we are waiting for something that is not going to happen.

Because while they have made some efforts to put safety measures in place, it is not nearly enough, and it is not happening nearly fast enough.

Senator MARSHALL. Greed is a horrible thing. Using greed to take advantage of our youth is a horrible thing. I just call on the social media companies to take self-accountability and to do something about this. Don't wait for Congress to do it. They know what the right thing is to do. They are taking advantage of our youth. They are poisoning our youth. They are killing our youth.

Admiral MURTHY. Senator, I would just say, when you and I have practiced medicine and we have prescribed medicines to people, to patients, we have been able to generally tell them what the evidence is if something works or doesn't work, and what the evidence is around safety.

I think it is very reasonable for us to expect a company to demonstrate similar data to us, so that parents like we can take that into account as we make decisions for our kids on when to start using social media and whether or not to even use it.

The CHAIR. Senator Kaine.

Senator KAINE. Thank you, Mr. Chair. And to our witnesses, what an important hearing. And my colleagues have asked a lot of good questions that I was thinking about asking, but I have decided I would like to just take my time to speak to any young person that is watching this hearing, here in the room, or watching it live, or maybe watching it streamed.

Young people feeling depressed about the future of the world, feeling hopeless has many causes, but to some degree you probably feel that way because you think adults have let you down, climate change, gun violence—a couple people were killed in my hometown at a high school graduation the other day.

Both my kids graduated from that building. My wife and I both spoke in that building. That is where we do all the graduations in Richmond. So, I think young people's part of this sense of hopelessness is this feeling that adults have let us down, whether it is on

climate, or guns, or political polarization, or kids getting kicked around by adults for political purposes if they are marginalized.

I look in my own life, I have a Social Security card now, but I look at my own life to can I even remember what it was like to be a 5 to 18 year old? And I want to tell you, I had the same feeling when I was 5 to 18, that the adults in the world were letting us down. I came home from kindergarten in November 1963.

I saw my mother crying for the first time in front of the television because JFK had been assassinated. I picked up the newspaper in April 1968 and the news of RFK—of MLK being assassinated. And then in June of 1968, RFK being assassinated. You saw protests about the Vietnam War.

You saw protests about civil rights issues. I was 16 when our President was forced to resign because of corruption. So, my formative life from 5 to 16 was a time of chaos. War, nuclear weapons, drills in the classroom.

It was a time of chaos and there was a palpable feeling that I had, and that a lot of my friends had, that the adults in the world were letting us down. And that was a creator of confusion and anxiety and even depression.

We weren't so open about talking about mental health and mental health stresses then, but I could just remember that feeling. But what I want to say to young people watching, and Dr. Murthy, your focus on loneliness and isolation really gets at something really important, young people have the power—young people have the power to change the reality if you link arms and band together, and to reduce some of the things that might make you feel hopeless or depressed right now.

Because in all of that confusion, I saw young people a little older than me, I wasn't into it, but I saw young people protesting against the war and helping lead to its end. I saw young people in the civil rights movement helping battle to get voting rights done and civil rights laws passed.

I saw young people who are now eligible to vote at age 18, becoming deeply engaged in events that led to improvements, that led to a Congress willing to hold the President accountable for impeachable behavior, forcing his resignation.

The lesson that I learned from 5 to 16 was the adults were screwing a lot of things up, and if we waited for adults to solve those things, we would wait for a very long time. But when the young high schoolers and college kids that I was looking up to as a younger person linked arms and said, well, we are not going to just wait for adults to fix it, we are going to get engaged, when young people do that, young people change the direction of the country.

I guess what I would just like to say to any young person watching this is you might not think you have the power to change the conditions that you find depressing. I think an awful lot of young—well, I am not even on up to vote yet, or what does one vote matter the system is rigged so that we don't matter.

Our history shows the opposite. Things get worse when young people don't engage. Things get better when young people do en-

gage. And not only do they get better in society, but the therapeutic value of linking arms with colleagues to battle for improvements in climate or reductions in gun violence, that very act of forming community among young people has a positive impact not only on society but on one's sense of well-being. You have a purpose on the table right before you.

If you look at us and you think we are not responsive to you, you can link arms and you can change the world and feel a lot better about the world that you are living in. So, with that, Mr. Chair, I yield back.

The CHAIR. Thank you, Senator Kaine.

Senator Cassidy.

Senator CASSIDY. Thank you, Mr. Chair. In Senator Sanders, opening questions of Dr. Murthy, he suggested, yes, we have done a lot, but we need to do more. But Mrs. Neas, you made it clear that we were actually on a trajectory to do more. Yes, we have put in these programs. For example, you mentioned in your testimony a school in Louisiana that has very successfully instituted a Medicaid based clinic for those with mental health.

Now there is another one opening. And presumably there will be another, and another, and another. So sometimes it is the potential of that which is being realized, which is more important to allowed to be realized, than creating a whole new program.

I say that, though, my question is, are my assumptions correct, that the programs that we put in place, for example, to help schools use Medicaid to pay for services, is that increasing in terms of its implementation, and do you suspect that it will continue to increase?

Ms. NEAS. Senator, thank you so much for that question. And we certainly hope that with this Medicaid guide and a new technical assistance center that will be announced shortly, that we are going to make it easier for more and more school districts to figure out how to access Medicaid so they can, in fact, do just the things that you are talking about. We have seen a number of great examples across the country of partnerships. We were just in Delaware——

Senator CASSIDY. Let me stop, because I understand you have got these examples, but are you getting—what I am really asking is, do you have the interest being shown to expand upon these examples to make this even more widely used?

Ms. NEAS. Absolutely.

Senator CASSIDY. The potential is being realized. And I think that is the point I want to emphasize.

Ms. NEAS. Yes, sir.

Senator CASSIDY. Now, let me speak to something which perhaps is not being realized, and maybe you can speak to it directly. But in the bipartisan Safer Communities Act passing because of Republican support, there was $1 billion for funding physical safety of schools. In one says we are trying to address the front end.

How do we keep kids from having a problem? But we are also trying to address the back end. If a kid does have a problem and comes in and tries to commit violence or someone else does. And

as far as I know, the rules to tell schools districts how to implement physical hardening of their schools has only been promulgated into three different states.

Why have those rules not been promulgated? Okay, this is what is allowed to physically harden your school in case there is somebody who attempts to commit violence. Why have those not been promulgated to all 50 states?

Ms. NEAS. Senator, thank you for that question. The Stronger Connections Grant that we released the funds to states last September and states are—we are doing listening sessions with key stakeholders on what kinds of things they wanted to use those funds for.

Our guidance that was put out in November, and again revised this past March, does help schools understand what are allowable activities. What we are hearing from——

Senator CASSIDY. Let me stop you, again to being specific with my question——

Ms. NEAS. Yes, sir.

Senator CASSIDY. I was called by my state Superintendent that they were being told that they could not use the money to physically harden the school. I spoke with the Secretary, and he said he would correct that. But I am told, maybe I am wrong, that the correction that says that schools may use the money, as is Congress intended by the way——

Ms. NEAS. Correct.

Senator CASSIDY [continuing]. To physically harden was only promulgated with three states, Louisiana being one of them. Is that—am I correct in that or am I wrong?

Ms. NEAS. Senator, I am not aware of—my understanding is, from what we have heard from states, that they have used these funds for things to increase the physical security of schools.

Senator CASSIDY. Now, that is different from hardening. So, if I can ask, can you get back with me on the particulars of that most updated information?

Ms. NEAS. Yes, sir, I would be happy to do that.

Senator CASSIDY. Next. It has been suggested several times that there are things which subject children to ridicule that can otherwise make them prone to these episodes of depression, etcetera. I am very concerned about the issue of dyslexia.

I think anyone that as a child stands up that can't read in front of a class and is ridiculed because she can't read understands that pain. Now, there is a lot of money put out in these bills to help school districts do catch up learning. And I mentioned dyslexics because they are particularly vulnerable.

Here is an article, though, from The Times from 3 days ago. Schools receive billions in stimulus funds that may not be doing enough. Pandemic aid was supposed to help students recover from learning loss, but results have been mixed. And it points out that there was little guidance given to schools beyond, you shall spend 20 percent of it.

There are some schools that have put in very good programs, small, focused learning, and others that apparently have not. Any comments on that? And specifically, what can Congress—knowing the money is about to run out, but what can we do now to try and get schools to use best practices as opposed to just frittering dollars away?

Ms. NEAS. Right. Senator, one of the key elements of the Federal special education law is child find. And one of the things that states have struggled with that we are working very closely with them on to address is making sure they are identifying and serving any eligible child. And certainly, students who have dyslexia are among those kids that we want——

Senator CASSIDY. I get that but there are best practices. It does not appear as if they are universally adopted.

Ms. NEAS. That is correct, sir. We are—and we are working on specific guidance on these specific issues so that states can fully understand what their responsibilities are, so they can make, so that we can have a different situation.

Senator CASSIDY. Okay.

The CHAIR. Senator Hassan.

Senator HASSAN. Thank you very much, Mr. Chairman, Ranking Member for this hearing. Thanks to our witnesses not only for being here today, but for the work that you do. And I just want to start by following-up a little bit on what Senator Kaine was talking about.

I think we all have been hearing from constituents about concerns about mental health, in particular children's mental health. I will tell you that in the spring of 2021, when schools in New Hampshire began to reopen more fully, I went and visited in one of my local school districts with a mix of students, and teachers, and administrators. Students from first grade all the way through high school.

I was struck toward the end of the discussion when we had been talking about how kids were doing, how their families were doing, what the schedule in school felt like. Did they feel that they were keeping up with their learning?

How the year had been, when a girl who must have been about ten turned to me and said, so, Senator, what are you doing about mental health? And I had been kind of dancing around it. I am from a generation where we didn't talk about mental health in the same way we talked about so-called physical health.

Then recently, another one of my constituents, Loreley, who is 18 years old, raised awareness about mental health because she was driving with a friend 1 day and the friend had a panic attack, and Loreley didn't know what to do.

Now Loreley is working to help students get that kind of understanding for mental health first aid—what can kids do to help each other in these moments where they need to be supported and until they can get professional help.

I also want to encourage young people to know that when you speak up, your representatives hear it, and we are doing our best to listen, and we are trying to make progress. And I want to ask

a couple of questions to our witnesses about some of the progress we have made.

Sometimes it doesn't seem enough, fast enough, but it is really important to understand the building blocks that maybe are in place. So let me start with a question to Dr. Murthy. I really enjoyed our discussion, doctor, in my office yesterday, and my team appreciated it very much, too.

Last year, my colleague, Senator Ernst and I, led something called the Stand Up Act, which was passed into law. And it is a law that helps ensure that schools are using suicide prevention policies that are actually evidence based. So, Dr. Murthy, why is it important for schools to adopt policies that are evidence based?

Senator Cassidy was just talking about our schools using the resources we are giving them in the right way. Why is it important that they are evidence-based, especially given the increased mental health risks that our youth face from social media?

Admiral MURTHY. Well, thank you, Senator. And Loreley's story will remain with me, and I have something I want to say about that at the end. But specifically, to your question, having evidence based practices is important because sometimes, even with the best of intentions, our programs may not have the desired effect, either in terms of the extent of impact, or in terms of who they are impacting.

They may leave certain people behind. The only way we really know that is to study them. The other piece is that sometimes when we study programs well, we realize that there may be unintended consequences of those programs. They may help in some areas and actually harm in others.

That is the whole point of studying these programs and then making sure that people know what the evidence tells us so that the program, when they do finally invest resources, time, and effort, they can do it in programs that we have greater confidence will actually help.

Senator HASSAN. Yes. Good. So let me then ask a question to you, Mrs. Neas. This is another example coming out of New Hampshire. Our University of New Hampshire and Manchester School District, which is our biggest school district in New Hampshire, they are leveraging funds from the bipartisan Safer Communities Act to train and place 80 graduate students studying social work in high school—in high needs schools—high schools, and elementary, and middle schools.

These graduate students will benefit from a yearlong internship with on the job training while public school students receive needed services. So, Mrs. Neas, in addition to this innovative example from my state, what other innovative local solutions are you seeing school districts deploy to address the school mental health personnel shortage?

Ms. NEAS. Senator, one of my favorite questions. We have seen some really innovative things across the country. We were just in a school in Delaware where the children's hospital runs a clinic that is on the campus of the school.

The majority of these children in this elementary school are homeless and live in nearby shelters. The year before the clinic was on staff, they had more than 1,000 instances of this disruptive behavior that resulted in suspensions. The first year of the center, that 1,000 number went down to 100, and now there are virtually none.

It is a great partnership. The children's hospital staffs it, does all the billing, and the school provides the physical space. What the principal said to me, I said, what keeps you up at night? And he said, learning loss. He said, we have got the support for kids and the teachers don't have to be both therapist and teacher.

Senator HASSAN. Right.

Ms. NEAS. That the staff there help teachers figure out how to get through the day to support kids so that they are emotionally Okay and learning. And I think that is one of the greatest things that we are seeing, is that partnership between educators and mental health providers on behalf of children, where children are.

Senator HASSAN. Well, thank you very much. Thank you, Mr. Chair, for your indulgence. I have some other questions, too, including the importance of providing services in summer programs and summer camps, which is something I think I will follow-up with our witnesses on.

Last, again, to the young people watching, this hearing probably wouldn't be happening if young people hadn't been speaking up, so thank you all very much for that.

The CHAIR. Senator Smith.

Senator SMITH. Thank you, Chairman Sanders and Ranking Member Cassidy. And thanks so much to both of you for being here. So, when I was in—a sophomore in college, I was really struggling.

I, thanks to my roommate who recognized some of the signals and signs of somebody who is dealing with depression, she suggested that I go to a school counselor at my university. And man, that made a huge difference.

I don't think I would have done that on my own, and I can see now that I was struggling also in high school, but having access to that care in my school setting made a huge difference because the barriers and the stigma that I would have experienced were sort of stripped away.

I share this story often, especially with young people, because I can see them kind of go, finally somebody is being real about this with me. This is one of the reasons why I have been so focused on expanding access to school based care.

Ms. Neas, I am really excited about the support that we have put behind school based services. I have heard from places in Minnesota where we are doing this, especially in places, this is something I have been working on, helping schools partner with community based organizations to get those services in schools.

It makes a huge difference. But here is the thing. In Minnesota—and Minnesotans we are go getters. All of this money. Three higher education institutions focus on training. That is fantastic. One school district has pursued this so far. So can you talk to us just

a little bit about—because I have this feeling that we are sort of constantly putting grant opportunities in front of school districts.

Some of them, especially rural districts, just do not have the capacity to even know about these opportunities, let alone act on them. Could you talk a little bit about that issue, and how we are putting resources out there that is actually not that accessible to a lot of schools?

Ms. NEAS. Absolutely. And thank you very much for that question. And we hear that all the time about capacities, especially small districts not able to write for these opportunities. It is one of the many motivators to our Medicaid work.

Senator SMITH. Right.

Ms. NEAS. Where we are really trying hard to make it possible for people that are in schools to work with their Medicaid agencies so that—we know we have got lots of kids.

Half the kids in our public schools——

Senator SMITH. Right.

Ms. NEAS. Are eligible for Medicaid. If we can help schools figure out how to recoup some of those payments——

Senator SMITH. Exactly.

Ms. NEAS. They can sustain things. They don't have to write a grant.

Again, we know that with the 21 states that have access to free care rule, that they are—that is resulting in an almost $6 billion of revenue to schools for services they want to provide. And that is to me, how do—we need the more people, and the people—we need to train more people.

Senator SMITH. Yes.

Ms. NEAS. We need to train more people. And that is something that you can do with grants. But I want this to be sustainable for the long term——

Senator SMITH [continuing]. They need sustainable funding. Yes, exactly——

Ms. NEAS. For small school districts to not be left out of that. That is really what we hope TA center and the guidance and in our efforts to shine a light on this opportunity, that we can have more of that happen.

Senator SMITH. Let me just ask for clarification. How many states did you say are participating in this right now?

Ms. NEAS. 21.

Senator SMITH. 21. So only—less than half of the states are participating. And that is a decision essentially of the Governor and the legislature. So, this is another problem we have, Mr. Chairman, is that in some places there is opportunity, in some places there are not based on the calculations that state leaders have. Vice Admiral Murthy—I am used to calling you Vivek, so——

[Laughter.]

Senator SMITH. You and I have had some really terrific conversations. I am so grateful for your leadership on issues of social isolation, both for our elders, as well as for young people.

Now, I have had people say to me, Tina, like, you can't legislate away loneliness, but you have done research that really shows how we can think about this as a social determinant of people's health, and that can make a huge difference. Could you just speak briefly to that, because I think it is really important.

Admiral MURTHY. Absolutely. And I think, I agree that you can't legislate away loneliness, but I don't think that is the solution here.

Senator SMITH. Right.

Admiral MURTHY. But I think there are steps Government can take to help support community organizations, to invest in research, to understand more deeply the drivers and solutions of loneliness.

But we also need community organizations, families, individuals to recognize that this is an important priority for all of us. I worry that we have become a lonely and disconnected nation, and that has massive consequences for our mental health, for our physical health, for economic prosperity, for our ability to pull together in the face of adversity, whether that is a pandemic or another hardship.

For all of those reasons, I believe that addressing loneliness is a strategic and critical priority for our Country. It is something I think we can do, and the people who give me the most faith that we can do that are young people.

Because when I talk to them around the country, they are not waiting for others to step in, they are building programs at their schools to help connect one another. They are reaching out to support each other.

They are talking more openly about mental health and issues like loneliness than any prior generation. And I think their leadership is going to be vital in us addressing this challenge.

Senator SMITH. Thank you. Thank you so much, Mr. Chair.

The CHAIR. Thank you.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. And thank you for the hearing this morning. I think it is somewhat telling that with everything that is happening this morning, there is a significant overflow room just down the hall.

I have been back and forth between a couple of different committee hearings this morning and there continues to be a line of young people, of young people trying to get into this Committee hearing. And so, I stopped and talked to them. Why are you standing in this line today? Why is it important to you?

One of the young men said, it is personally important to me. I am curious to know, as a—apparently as a young immigrant, the intersection, the services that are available for those in—from other areas. Another one indicated that she was interested in education, but she wanted to understand more how people who had adverse incidents in their lives as young kids as she had, what more support could be provided in schools? Young people are paying attention to this as an issue.

They are paying attention to what we as legislators do. And I have listened to some of my colleagues, and yes, we can't legislate loneliness going away. It is hard enough to; how do you legislate against bullying? How do we do the reach out? I appreciated your comments to Senator Tuberville when he mentioned that as a coach he interacted directly with these young people.

Your comment that you sat down at roundtables with students, particularly student athletes. What more are we doing to ask young people what the solutions are? We had a hearing in this—in the HELP Committee last year on youth mental health. We invited an extraordinary young Alaskan by the name of Claire Rainier.

I think Claire at the time was 19. She gave testimony and presented the youth perspective and what she had done as one individual that had gone through real crisis, what she had done within her school community to engage more.

I remember Claire's story and how strong she was in sharing that with us. But what are we doing to ask the young people what we can do to help? And I will throw that out to you, Surgeon General.

Admiral MURTHY. Well, thanks so much, Senator——

Senator MURKOWSKI. I understand you are coming to Alaska soon, and I hope those conversations are going to take place.

Admiral MURTHY. I am. Thank you. Yes, I am really looking forward to it. And it is actually relevant, like when I first came to Alaska, when you and I met there in 2016, that was an opportunity.

We did a lot of roundtables, including with young people. And the goal there was to really understand how they are being impacted by substance use disorders, and more broadly by behavioral health concerns.

To involve young people, to answer your question, I think there are a few things we have to do and that we are doing more and more. No. 1 is we have got to bring young people to the table to understand and hear their concerns and go to where they are.

That is part of what my office has been doing, is having roundtables with young people in communities across the country. The second thing we have to do——

Senator MURKOWSKI. Can I just stop you there?

Admiral MURTHY. Of course.

Senator MURKOWSKI. Because it takes extraordinary strength for a young person to say, no, I am going—I want to be part of this public dialog and engagement.

The ones that are really hurting are the ones that are just struggling to get up out of bed that morning, much less go to a roundtable. How do we get them?

Admiral MURTHY. That is exactly right. And that is why what we are also doing is recognizing that it is not easy for everyone to come to those tables, to be open. It is easier often when they are doing that with folks they know with trusted institutions, trusted organizations.

We are also working with faith organizations, with universities, and others to help them pull roundtables and other such listening sessions together with young people to create opportunities for them to give input that don't necessarily involve showing up at a roundtable—that may involve more commenting on a survey or share their input anonymously.

We want to create as many channels as possible for young people to be heard on this. And then using that input, we are encouraging mayors as well as the institutions I mentioned to then formulate their plans.

My belief is that if we want to do something that is going to help young people here, we need them at the table throughout the process, before we developed a solution, as we work on execution, and when we do evaluation to understand whether it is working or not. And that is what we are encouraging localities to do, from Mayors to non-Governmental organizations like YMCAs, educational institutions, and others.

But, Senator, it is not—I will just say this, it is not easy to do this, right. It takes time, effort, and focus, and continued attention. The easiest thing is just to go into a closed room and come up with your own solutions and try to implement them, but I just don't think that is what is going to get us the best result here.

Senator MURKOWSKI. Agreed. Recognize that we just need to be doing more to be inclusive of these young people. I am going to have a question for the record for you, Mrs. Neas.

This is relating to the fact that of the bipartisan Safer Communities Act funding through the mental health services grant, professional demonstration grant programs, apparently only 17 percent of these grants were awarded to rural districts.

I am trying to understand what more we can be doing to make sure that these grant resources are going out to all areas of the country, including rural. Thank you, Mr. Chairman.

The CHAIR. Thank you very much.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. In June, we celebrate pride. It is a time for folks to gather and lift up and celebrate LGBTQ Americans, the movement for the fight for equality. And we also reflect upon the challenges.

There is an intersection of our conversation here. It has already come up a little bit that with the mental health crisis that kids are facing, from data last year, 45 percent of LGBTQ youth reported that they had considered attempting suicide—45 percent. Youth who live in communities that are not particularly accepting or families that aren't particularly accepting report higher rates of attempting suicide.

I am just going to note, and maybe we can introduce it for the record, there was an article last weekend in the New York Times about death investigations and the fact that we don't have complete—after suicides, we don't have complete information, because oftentimes they don't ask the question about sexual orientation or gender identity.

But in Utah, they are. And it was a fascinating piece that we should have as a part of the record, because that is data that we are lacking. But at the same time, we are celebrating pride month, we are witnessing in America a staggering number of pieces of legislation at the state level that are described as anti-LGBTQ bills. I—491 reported so far this year. At the state and local level, school board level, we see a lot of additional activity.

I don't have any numbers on that. I don't know who is aggregating those. But it is rampant. And I wonder, again, what the impact of that is on mental health of members of the LGBTQ community. Now, I want to get to a question.

We are talking about offering support in schools, but I want to also think of other gateways where people come in and get help. I was proud to co-sponsor the bill that brought us the 9–8–8 suicide prevention hotline, and it was made—it was—became operational last summer.

There is the ability with that technology to provide more customized service. I know the first thing people are asked, are you a veteran? And if so, you will get your mental health services, if you choose, from the VA.

But we, along with Susan Collins, we have provided funding for a pilot program in 9–8–8 for offering specialized support for people who call, text, or chat on 9–8–8 who are identifying as LGBTQ. So, how do we use we have school board—or sorry, school based mental health in some cases, but how do we use a gateway like 9–8–8 to provide better support for, in particular, our LGBTQ population?

Admiral MURTHY. Senator, first, just thank you for your leadership on 9–8–8. As it is a topic that I talk about often when I travel around the country, and I can't tell you how many faces I have seen turn from worry to look of relief when they know that there is some help actually available immediately when they or their child have a crisis. So, thank you for that. It is already making a difference.

I do want to say, specifically with LGBTQ youth, I agree with you that we need to look for more ways to ensure that they know help is available for them. I think schools are a natural place. I think 9–8–8 is a place where early on, if we can signal to young people that this is a place where you can get assistance, where people will understand your unique circumstance and your background, I do think that is essential.

I also think that, and I say this just as a doctor and as a father, I believe that every child deserves to know they matter, regardless of what their background is. The reason my parents came to America many years ago was because they wanted my sister and me to grow up in a country where we knew that just because we had a different color of our skin or our name sounded funny or a background was different, it didn't mean that we mattered any less than any other child. And that is a value we aspire to as a country.

We may not always have gotten there, but I think that is a place where we need to do more when it comes to making LGBTQ youth feel that they do matter, that they are valued. And too many of

them tell me often that they don't feel that way. They often feel left out or bullied or attacked.

Finally, I would just urge leaders, whether they are elected leaders, whether they are leaders in the community, to include LGBTQ youth at the table when they are listening to what communities have to say, and to specifically reach out to them to understand their perspective and their life experience.

I have just learned as a doctor over the years who has had the privilege of sitting with patients and with very different backgrounds, and listening and learning to them, that there is nothing that replaces face to face contact with people, listening to someone's story, and it shifts how we think about issues.

I think that could not be more important now because too many of our LGBTQ youth are struggling, and you see it in the suicide rates. And to me, that is in—a five alarm fire that we are dealing with.

Senator BALDWIN. Yes. Thank you. Mr. Chairman, I have several questions for the record, since I have run out of time, but I thank our witnesses.

The CHAIR. Thank you very much, Senator Baldwin. And let me thank the panelists for what I think is an extraordinarily interesting hearing on a subject that I think everybody here recognizes is of enormous consequences to this country.

I just want to take a few seconds to make this point. I think we are all proud of the accomplishments that we have made, and we wanted to help them. But there is another reality, and I want you to tell me what I am missing here, if I am missing anything.

If 85 million Americans are uninsured or underinsured, and if we have a scarcity of mental health providers in this country, am I missing something in suggesting that for tens of millions of people—I know people call my office.

I am sure they call other offices. My husband is in desperate shape. I can't find the help. We can't afford the help. And on top of that, correct me if I am wrong, but I think it as a result of the ending of the public health emergency, some 17 million people are going to be dropped from the Medicaid rolls. Is that correct, Mrs. Neas? Is that correct?

Ms. NEAS. I am not—I know that it is a large number, sir. I am not exactly——

The CHAIR. The point is, yes, we want to take pride in what we have accomplished, but let's not kid ourselves. We have got to move dramatically if we are serious about protecting the mental health and helping people in this country. There is a lot of work that has to be done. So, with—Okay. Yes, Senator Cassidy. Well, let me just, with that—all right, give the mic to Senator Cassidy.

Senator CASSIDY. A lot of great things said today. In my closing, 30 seconds, I want to emphasize three things. Senator Kaine is speaking about how young people can be the drivers of change. Senator Murkowski is speaking about how folks are lined up and they are all young.

Looking at the audience here, you are young, and I suspect those watching on TV are young. And Dr. Murthy saying that we can't

leave it up to Government, but we also have to have individual action.

I guess my appeal is all the young people who rightly have a concern about this, you are the ones who can introduce people to this hotline set up by Senator Baldwin. You are the ones that can advise, as Senator Smith was advised, to go seek help.

We can only do so much. You are going to do a heck of a lot more than we. So, I just finish by echoing wonderful comments from my colleagues.

The CHAIR. All right. To the witnesses, thank you very, very much. This is the end of our first panel. We are going to be going to our second panel in a moment. Thank you. Thank you all very much for being here, and we are going to continue this discussion on this issue of enormous concern to the American people.

I—Senator Murphy was going to introduce Charlene Russell-Tucker, but unfortunately, he is detained. So let me begin by introducing her. And that is, Mrs. Russell-Tucker was appointed Commissioner of the Connecticut Department of Education in 2021.

Previously, she served as Chief Operating Officer and Division Chief for the Department's Office of Student Supports and Organizational Effectiveness. Mrs. Russell-Tucker, thank so much for being with us.

STATEMENT OF CHARLENE M. RUSSELL-TUCKER, COMMISSIONER, CONNECTICUT STATE DEPARTMENT OF EDUCATION, HARTFORD, CT

Ms. RUSSELL-TUCKER. Thank you. Good morning, Chairman Sanders, Ranking Member Cassidy, and Members of the Senate Committee on Health, Education, Labor, and Pensions. I am Charlene Russell-Tucker, Commissioner of Education in Connecticut. I am honored to share critical information regarding the youth mental health crisis and Connecticut's response to support the needs of our students.

My big audacious goal is to ensure every Connecticut school has a coordinated and sustainable system of care to provide comprehensive behavioral and mental health support and services to all students and school staff. As Surgeon General Murthy mentioned and a survey of Connecticut high school students confirms, our students face unprecedented mental health challenges.

Too many of our students reported having felt sad or hopeless, and that their mental health was not good most or all of the time. Most concerning is that 14 percent said they had seriously considered suicide, and 6 percent actually attempted suicide. These data highlight the immense need to address student wellness and underscore the urgency for action at Federal, state, and local levels.

Effective solutions require teams of stakeholders, including policymakers, community leaders, parents and families, educators and students. I like to say, it can't be about them without them.

The Commissioners Roundtable for Family and Community Engagement and Education is a diverse constituent group of stakeholders, representing school staff, advocates, parents and guard-

ians, community leaders, and students to advise me on policy and programmatic priorities.

Connecticut's Student Voice for Change Program allows high school students to propose projects utilizing state ESSER funds. Notably, 80 percent of student proposals focused on mental health, using their voice to advocate for mental health supports for their peers. They spoke and we are listening.

Our ESSER funded behavioral health pilot established a system of coordinated care for schools in seven districts. One pilot school district identified 250 students at risk of suicide and was able to provide critical and immediate responses. Our state's mobile crisis intervention services deliver a range of crisis response and stabilization services to youth and families.

Simply call in 2–1–1, or now 9–8–8, immediately dispatches clinicians to schools or anywhere a child is in crisis. The Surgeon General report on the epidemic of loneliness reinforces the importance of school attendance and engagement.

Our Governor's Learner Engagement and Attendance Program is a research based home visit initiative that improves attendance, feelings of belonging, and family, school relationships. Additionally, we invested $33 million in ESSER and ARP funding in a multiyear summer enrichment grant program, prioritizing communities disproportionately impacted by the pandemic.

Programs place a strong focus on peer relationships, wellness, and academic acceleration during the summer. In the first year, this program connected more than 108,000 students with enrichment opportunities. The Department invested $2.2 million in ESSER funds for innovation grants to support new partners in underserved communities in designing innovative, high quality afterschool programs to address students' academic and mental health needs.

Mental health is a bipartisan state priority, including addressing workforce shortages. Governor Lamont and our General Assembly directed $100 million for multi-agency mental health initiatives, including $28 million for mental health professionals in schools. Multi-state agencies are working together to expand the ranks of clinicians to meet increasing mental health needs.

Additionally, the school districts are leveraging over $183 million of local ESSER funds for student and staff well-being. We are committed to funding and sustaining what works. We also invested ESSER funds to establish a groundbreaking collaborative that brings together teams of university researchers to conduct rigorous evaluations of the many new programs and initiatives that are underway in our state to ensure programs and investments are achieving results.

Thank you for modeling bipartisan national discourse that will lead to enhanced access to needed services, and ultimately, improve academic access, supports, and outcomes for young people. Thank you very much. I am happy to take your questions.

[The prepared statement of Ms. Russell-Tucker follows:]

PREPARED STATEMENT OF CHARLENE M. RUSSELL-TUCKER

Good morning. Chair Sanders, Ranking Member Cassidy, Committee Members, thank you for having me here today.

My name is Charlene Russell-Tucker, and I am the Commissioner of Education in Connecticut. I am honored to appear before you all today to represent our great state and share critical information regarding the youth mental health crisis, its impact on learning, and the interventions, policies and initiatives Connecticut implemented before, during and after the pandemic to support the emotional, mental, physical, and behavioral health needs of our students. Many of the interventions that I am discussing today align with what I call my "Big Audacious Goal," which is to ensure every Connecticut school has a coordinated and sustainable system of care for all K–12 schools to provide comprehensive behavioral and mental health supports and services to students and staff.

As mentioned by Surgeon General Murthy earlier today, Connecticut, like the rest of the country, is experiencing an unprecedented need for mental, physical, and behavioral health supports among young adults and adolescents—likely stemming from and exacerbated by isolation and loneliness caused by the pandemic and its after-effects, as well as a lack of meaningful connection due to this isolation. Concurrently, consistent with national trends, Connecticut is experiencing a shortage of mental health professionals. Despite these challenges, Connecticut is leveraging substantial Federal and state resources to build a scalable system of supports to address our students' mental, physical, and emotional health through prevention and early intervention services, as well as just-in-time crisis support. Sound mental health is foundational to learning and ultimately all aspects of human development; therefore, we must continue to develop, evaluate, and provide resources to support these efforts.

Connecticut prioritized student mental health alongside academic recovery when investing the more than $1.7 billion that has been allocated to our state under the Elementary and Secondary Schools Emergency Relief (ESSER) Fund. On behalf of the State of Connecticut, we are very appreciative for Congress's critical support. The priorities we established for these funds at both the state and district levels included supporting learning acceleration and academic renewal, ensuring safe and healthy schools during and post pandemic, technology enhancements, and family and community engagement. We knew, however, that none of these investments would be successful if we did not first implement a system of supports for students' physical, social, emotional, and mental wellness, which is why we included this funding priority as well. Districts responded by earmarking over $183 million for supporting student and staff wellness through hiring additional staff, providing professional learning and technical assistance, and partnering with external partners for the provision of referral services, enhanced counseling, and care coordination. Additionally, this is also why the Connecticut General Assembly and Gov. Ned Lamont, in a bipartisan effort, allocated over $100 million in the 2022 legislative session to support mental health statewide, of which $28 million was earmarked for the Connecticut State Department of Education (CSDE) to create grant programs to support the hiring of school mental health professionals.

The Connecticut Landscape

Connecticut has a beautifully diverse student body of more than half a million students. Across 205 districts, we have over 1,500 schools and more than 110,000 school staff devoted to helping our students thrive.

Looking more closely at our student population, more than half of students identify as nonwhite; 42.4 percent are eligible for free or reduced-price meals, 17.1 percent are students with disabilities, and 9.7 percent are English/multilingual learners with more than 145 spoken languages.

Results from the Connecticut School Health Survey, modeled after the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey, indicated that feelings of sadness and hopelessness in high school students have increased steadily over time, reaching a new high during the COVID–19 pandemic. In the 2021 survey, 35.6 percent of Connecticut high school students reported having felt sad or hopeless, 28.5 percent reported that their mental health was not good most or all the time. Most concerning in the survey results, is that 14.1 percent said they had seriously considered attempting suicide and 5.9 percent had actually attempted suicide.

The survey found that mental health issues are more common among female students, with 47.6 percent of female students reporting feelings of sadness or hopelessness compared to 24.2 percent of male students and 40.5 percent of female students

saying their mental health was not good most or all of the time compared to 16.4 percent of male students. Suicidality in females was also much more pronounced, with 19.8 percent of female students verses 8.7 percent of male students seriously considering attempting suicide and 8.8 percent of female students verses 3.3 percent of male students actually attempting suicide. These data highlight the immense need to address student wellness and underscore the need for action at all levels—Federal, state, and local—to protect our students' mental health.

Stakeholder Involvement and Collaboration

I want to lead with what makes Connecticut unique—what in Connecticut is referred to as "The Connecticut Difference." This is our longstanding focus on *best-in-class* collaboration, working together, and listening to one another, in search of common ground for the sake of our students.

With almost every policy or initiative, including supporting the mental, physical, and behavioral health needs of our students, Connecticut prioritizes engagement with our various partners and stakeholders—the Office of the Governor, the State Board of Education, state agencies, educators and administrators, families, students, advocates, policymakers, local health officials, and more—as often as possible to develop and implement our policies. Policies designed without hearing different perspectives, and without our constituents' input and feedback, are not likely to produce the intended and needed results.

We are staunchly committed to ensuring that family, student, and community voices are included in our decision-making processes. I like to say, "It can't be about them without them." We cannot actively gauge the impacts of isolation and the pandemic on our students' mental health without understanding their perspectives.

In Connecticut, we strongly affirm these voices, particularly when they indicate severe mental health concerns, suicidality, or other harmful thoughts because these challenges negatively impact students' overall well-being and, therefore, their ability to learn. We believe that part of addressing student learning and academic needs is the provision of mental and behavioral supports. A quote from yesteryear still rings true today—there is no curriculum brilliant enough to compensate for a hungry stomach or a distracted mind.

Listed below are structures that the CSDE has in place that are foundational to engaging stakeholders in driving our mental and behavioral health policies, practices, and initiatives.

1. Commissioner's Roundtable on Family and Community Engagement

In 2017, recognizing the critical importance of family and community voice, I developed and implemented the Commissioner's Roundtable for Family and Community Engagement in Education, which is a diverse constituent group of education stakeholders representing school and district staff, advocacy organizations, parents and guardians, community members, and students, who advise the Commissioner of Education regarding policy and programmatic priorities. The Roundtable meets quarterly to bring authentic parent and community voice to CSDE products and initiatives; communicate state-level initiatives with families and communities; recommend effective practices to increase successful school and district engagement with families; and provide strategies to empower families in supporting their children's education. The Roundtable has informed many of our mental, physical, and behavioral health initiatives through active deliberation and discussions. This group developed the Connecticut Framework for Family and Community Engagement, which defined family engagement as "*a full, equal, and equitable partnership among families, educators, and community partners to promote children's learning and development form birth through college and career*."

2. AccelerateCT Taskforce

AccelerateCT Education Taskforce was launched to develop a statewide education recovery and acceleration framework and programming for students across the state beginning with enhanced learning and enrichment opportunities. The Taskforce is made up of over 30 members representing every aspect of education and focuses on six key areas: learning acceleration; academic renewal and student enrichment; family and community connections; social, emotional, and mental health of students and school staff;

leveraging technology to accelerate student learning; building safe and healthy schools; and summer enrichment. As noted, mental health is a core component of the Taskforce's priorities, consistent with our statewide approach.

3. School Discipline Collaborative

Understanding that students sometimes do not feel welcomed and valued in school and that exclusion from school impacts students' overall behavioral health and learning, I formed the Connecticut School Discipline Collaborative. The Collaborative advises the Commissioner of Education and State Board of Education on strategies for transforming school discipline to reduce the overall and disproportionate use of exclusionary discipline. Members reflect a diverse range of expertise in the fields of school administration, teaching and learning, public policy and legislation, education law, youth development and children's advocacy, family and student engagement, and community leadership.

4. Voice4Change Initiative

In November 2021, the CSDE launched Voice4Change, the first statewide student participatory budgeting initiative in the country, to give students a direct say in how a portion of the $1.5 million of ESSER funding should be spent across Connecticut schools. Using the same five investment priorities set forth for districts, students crafted and voted on proposals for projects or supports they desired in their school community. More than 80 percent of winning proposals addressed the need for more supports for student social, emotional, and mental health. Students also saw what worked during the pandemic—best practices they wanted to make permanent in their school going forward like a mental health first aid team available to students, peer mediation, afterschool programming focused on stress reduction, and creative and innovative learning environments such as outdoor classrooms.

In addition to the structures described above, the CSDE works closely with our member associations in Connecticut to gain feedback from the field, drive policy development and implementation, discuss resource access and allocation, and receive advice on how the CSDE can support our schools. These organizations include the Connecticut Association of Public School Superintendents, the Connecticut Association of Boards of Education, and the Connecticut Association of Schools, which represents school principals and vice principals. The CSDE also routinely engages with our teachers' unions as well as associations representing school nurses, counselors, social workers, and psychologists, paraeducators, and child nutrition program directors. This collaborative approach is necessary in building effective policy and positively supports the whole child.

Initiatives and Programs Supporting the Social, Emotional, and Mental Health Needs of Students and Staff:

I am privileged to live in a state where education receives robust bipartisan support from the legislature. Last session, Connecticut lawmakers passed the most comprehensive mental health bills in the state's history—including grants for schools to hire staff to support student well-being, bolstering the Governor's home-visiting initiative, increasing summer programs' capacity to support the mental health of their campers, and more.

The pandemic brought keen attention to the necessity of addressing the social, emotional, and mental health needs of our students and school staff. While Connecticut has a longstanding history with this work, COVID–19 significantly increased the demand for mental health services and supports—both in the number of students needing support as well as the severity and complexity of those needs.

Connecticut has prioritized the allocation of human and financial resources toward addressing the comprehensive health needs of our students, encompassing their emotional, mental, physical, and behavioral well-being. Throughout the pandemic, the state implemented a range of interventions and policies that not only catered to immediate challenges but also considered prevention strategies and long-term support. By prioritizing the whole child, Connecticut has paved the way for promising practices that can serve as valuable examples for other regions across the Nation seeking to enhance their educational systems and ensure the overall well-

being of their student populations. The following outline some of our most impactful initiatives and programs:

1. Statewide Behavioral Health Landscape Scan

The CSDE commenced a statewide behavioral health landscape scan in September 2020 to provide insight into emerging concerns and trends related to the well-being of students in K–12 schools across Connecticut. This was the first step in providing a systematic collection of data to identify needs and enhance existing efforts related to supporting the mental health and well-being of our students.

2. Connecticut Behavioral Health Pilot

State level ESSER funding has afforded the CSDE the opportunity to support resources to fully fund the Connecticut Behavioral Health Pilot. Currently, our Behavioral Health Pilot is underway in seven districts in partnership with community-based behavioral health partners to assess their mental health support needs.

The CSDE identified districts of various demographics—from large urban districts, medium sized suburban districts and small rural districts—to participate in the pilot program to implement targeted supports based on needs identified from the landscape scan and focus group discussions. The specific needs and gaps in service will drive the development and implementation of these systems of care. The pilots will then inform plans to scale these systems statewide for implementation in similarly situated Connecticut districts. Robust needs assessments are being conducted in each district to document the mental health system components that exist within each district and assess the comprehensiveness of those systems. These data are driving the prioritization of quality improvement efforts and will set into motion systems to track improvements throughout implementation.

Specifically, the district-level assessments examined the efficacy of districts' behavioral and mental health systems by analyzing current and existing programming, as well as human and fiscal capital. This process will help to determine the appropriate, scalable interventions, which will depend on the capacity and resources—both internal and community-based—in each community. Solutions may include increased staffing and service provision; opportunities for training, professional development, technical assistance, and coaching; external referral systems of care through partnerships with mental health providers and primary care facilities; and streamlined and shortened referral processes. These combined efforts will ensure students' emotional well-being, which can support consistent school attendance, engagement, and academic success. All relevant school district staff will then receive adequate trainings and demonstrate increased knowledge in both content and referral processes and systems, which will help to reduce both the total number of student visits to local emergency departments for behavioral health crises and reduce the rates of exclusionary discipline and absenteeism.

The early results of the pilot are already evident. Districts have established priorities and identified community partners to support them. One district realized that it needed more universal mental health assessment capacity. They have subsequently created a liaison position between the school and the community provider to identify students needing a higher level of support. Through their assessment, one of our larger districts identified that over 250 out of their 4,000 students reported having attempted suicide. The district quickly developed partnerships with community providers and created a student response team to address pressing mental health needs.

3. Grants to Support Mental Health Professionals

In a bipartisan effort, the Connecticut General Assembly directed $28 million in American Rescue Plan Act (ARPA) funding across three different grants to support mental health professionals in schools. The legislature directed $5 million toward a School Mental Health Workers grant program to assist Connecticut local and regional school districts in hiring and retaining additional school social workers, school psychologists, school counselors, school nurses, and licensed marriage and family therapists. An additional $15 million was directed to support a School Mental Health Specialist grant

program to assist school districts in hiring and retaining additional school social workers, school psychologists, trauma specialists, behavior technicians, board certified behavior analysts, school counselors, licensed professional counselors, and licensed marriage and family therapists. Over 70 clinicians have been or will be hired through these grants to support students through three school years. Last, the legislature directed $8 million to a Summer Mental Health grant program to support the delivery of mental health services for students when school is not in session. Funding is available to school districts, operators of youth camps and other summer programs.

These grants, funded entirely through Federal ARPA dollars, are essential for local efforts to adequately address the needs of children and youth. The CSDE understands the critical need to maintain these positions and the vital services they provide for our students, and districts will require new mechanisms and resources to retain these essential staff when the ARPA funding expires. The CSDE is looking at opportunities under Medicaid to sustain this critical investment.

4. Summer Enrichment Grant Program

Connecticut has invested $33 million in ESSER and ARPA funding toward a multi-year Summer Enrichment Grant program, initiated in summer 2021. The program was created in an effort to connect K–12 students whose education may have been negatively impacted by the pandemic with low or no-cost, high-quality enrichment opportunities when they are out of school during the summer months, including at summer camps, childcare centers, and other similar programs, with a priority for those in communities that were disproportionately impacted by the pandemic.

Programs place a strong focus on social-emotional, physical, and mental health; academic acceleration, intellectual growth, and exploration; and student-peer relationships during the summer months. This investment also enables summer camps to hire additional staff such as behavioral specialists or other personnel to serve more students. An evaluation of the 2021 program concluded that the initiative successfully connected more than 108,000 Connecticut students with summertime enrichment opportunities that year. An evaluation of the 2022 program will be released soon.

5. After-School Grants

In 2022, the CSDE released $2.2 million in ESSER funding to support after-school Innovation Grants for underserved communities to address the academic, social, emotional, and mental health needs of students, especially for those who have been disproportionately affected by COVID–19. Innovation Grants enabled smaller towns, districts, and non-profit organizations to create innovative after-school programs. This was an addition to $8.7 million used to expand and enhance Connecticut's existing after-school programs, for a total combined funding of $10.9 million.

The Innovation Grants focused on creating new after-school programs to reach underserved target populations while building districts' capacity through the assistance of local and community partnerships. This grant provided successful applicants with the necessary funding to design and implement new, high-quality after-school programs that address the academic, social, emotional, and mental health needs of students across the state.

6. Deveraux Student Strengths Assessment System (DESSA)

Through ESSER funding, the CSDE implemented the DESSA System. The DESSA is a strength-based observation tool that teachers use to capture how frequently they have observed a student demonstrating positive behaviors (e.g., getting along with others, taking turns, considering different opinions, active listening, etc.) rather than inappropriate behaviors. Focusing on strengths can build students' self-efficacy and help them persevere when they face difficulties and challenges in the classroom and the school environment. This helps teachers better support their students in feeling, confident, successful, engaged in learning and connected to school. Close to half of Connecticut school districts are participating in the DESSA System.

Following the first year of implementation, half of students were already demonstrating positive growth in pro-social competence and behavior. Our

high school students are invited to participate in the DESSA Student Self-Report (SSR), which engages students in reflecting on their own strengths and empowers them to steer their learning in a way that aligns with their needs. The SSR is a student self-rating that delivers real-time results and immediate strategies to incorporate student voice and choice in learning, which has a significant impact on learner engagement, motivation, and achievement.

Supporting the well-being of our K–12 administrators, educators and staff is also vital for them to be able to ensure student growth and success. This initiative is a pilot program designed to help educators give their best to students while also caring for themselves. It includes a comprehensive set of research-based resources that provide educators with professional development tools, self-assessments, personal development plans, self-directed strategies, and teaching practices.

7. Components of Social, Emotional, and Intellectual Habits for Grades K–12

The CSDE has developed the Components of Social, Emotional, and Intellectual Habits for Grades K–12. This guidance represents the knowledge, skills, and habits that form an essential blueprint for students' well-being and equip every student with the knowledge and skills necessary to succeed in college, careers, and civic life. While attention to core academic subjects remains important, positive habits set the stage for all future learning, promoting intrapersonal, interpersonal, and cognitive competence. This guidance provides grade-specific competencies for districts and schools to integrate into academic content areas so that students will learn and model essential life habits. Some examples of the competencies include: (1) *Acknowledging and welcoming constructive feedback from others that challenges and builds resilience and identifies strengths and areas for growth and* (2) *demonstrating critical thinking skills when solving problems or making decisions, recognizing there may be more than one perspective or solution to the problem*.

8. Leveraging Medicaid Reimbursement

The CSDE's partnership and collaboration regarding leveraging Medicaid reimbursement began with the Connecticut Department of Social Services (CTDSS) prior to the pandemic due to the existing challenges of providing healthcare supports to all students in Connecticut. The current patchwork of Medicaid, private coverage, SAMHSA, local and state educational authority funding makes it very challenging to implement consistent, evidence-based, sustainable and comprehensive systems within schools. Current medical models in which reimbursement is provided based on individual student clinical services do not allow for a systems approach to meeting the needs of all students. Schools and school districts do not have the capacity or expertise to bill as medical providers or manage complex grants, and districts with the greatest needs often have the least capacity in this regard. Eligible students currently receive coverage and care through Medicaid via the Medicaid School Based Child Health Program (administered by the CT DSS). This program allows school districts to seek federal Medicaid reimbursement for many Medicaid-covered services, such as assessment, audiology, clinical diagnostic laboratory, medical, mentalhealth, nursing, occupational therapy, physical therapy, respiratory care, speech/language, and optometric services. Districts may also pursue federal reimbursement for administrative activities which support provided Medicaid health services. Currently 118 of Connecticut's 205 school districts are enrolled in the Medicaid School Based Health Program. Medicaid covers roughly 250,000 young people (ages 5-17) in the state of Connecticut. Prior to the pandemic, the CSDE was in active communication with the CTDSS on how to leverage Medicaid reimbursement for students. With the new Centers for Medicare and Medicaid Services guidelines, CT DSS is actively looking into two options to streamline Medicaid coverage and reimbursement. These are (1) School Based Child Health (the district is the provider and biller) and (2) School Based Health Center (private health care provider embedded in the school). The partnership between the CSDE and CT DSS will actively work to ensure that schools and school districts can leverage these added resources and that a robust plan is in place to ensure the greatest number

of students possible are eligible for Medicaid. In addition, the sustainability of funding a robust professional mental health work force within schools is tied to our ability to leverage Medicaid funds for students. As mentioned above, we also see Medicaid as a tool to sustain some of the impactful work enabled by ESSER funds once those funds are no longer available.

9. Bipartisan Safer Communities Act (BSCA)

Connecticut received $9.12 million in federal BSCA funding to create a Stronger Connections Grant. These grants are competitive subgrants that SEAs can provide to high-needs LEAs to fund a broad range of activities including school-based mental health services, early identification of mental health issues, substance use prevention, trauma-informed care, and appropriate referrals to support services, which may be provided by school-based mental health service providers or in partnership with a public or private mental and behavioral health providers.

Our Request for Proposals (RFP) will be released this month and will reflect feedback provided from our many stakeholders. It must be noted that this timeline to release the Bipartisan Safer Communities Act RFP is purposeful following the awarding of the robust $28 million in School Mental Health Grants mentioned above. This allows for the CSDE, as well as school districts, to be strategic in first planning for the use of existing ESSER funding to support student mental health and then determining the gaps in resources that can be supported by the School Mental Health Grants. This will ensure that BSCA funds will be strategically utilized to support the most pressing needs.

10. School Based Health Centers

Connecticut's School-Based Health Centers (SBHCs) are comprehensive primary health care facilities licensed as outpatient clinics or hospital satellites. SBHCs are intentionally located in schools where students have historically experienced health care access disparities and are often publicly insured, underinsured, or uninsured. Multi-disciplinary teams of pediatric and adolescent health specialists staff the health centers, including nurse practitioners, physician assistants, social workers, physicians and in some cases, dentists and dental hygienists. SBHCs provide all levels of care for students including medical services and mental health services. Connecticut currently funds 90 SBHCs and efforts are underway to expand that number in areas and schools not currently served by an existing SBHC or other health care center.

11. Mobile Crisis Intervention Services

Mobile Crisis Intervention Services is an initiative developed and administered by the Connecticut Department of Children and Families (CT DCF), the state's child welfare and behavioral health agency. Accessible by simply calling 2–1–1, or 9–8–8, Mobile Crisis providers deliver a range of crisis response and stabilization services to children, youth, their families and caregivers. Mobile Crisis providers are experts in meeting the complex needs of students experiencing psychological or behavioral issues. Districts in Connecticut are required to contract with community-based Mobile Crisis providers to respond to schools and families when students are in crisis. As a result of the pandemic, Connecticut invested an additional $8.6 million in ARPA funding for an annual total of $19 million to ensure access 24 hours per day, 7 days per week, 365 days per year. In the event of a psychiatric emergency, a trained screener will, within 15 minutes, facilitate direct contact with a licensed Mobile Crisis staff member or other emergency service as necessary. The trained screener will connect the caller real-time with a clinician during the call and the clinician can respond in person to the caller's location within 45 minutes if needed.

Initiatives to Support Healthcare Workforce Development

As stated, Connecticut is not immune to shortages of mental and behavioral health staff. As a result, a concerted cross-agency effort to recruit and retain a quality behavioral and mental health workforce is underway in Connecticut.

1. Connecticut Office of Workforce Strategies (CT OWS) Initiatives

The Connecticut Office of Workforce Strategy (CT OWS) has several workforce initiatives related to healthcare career pathways. While these programs are not focused specifically on school-based practitioners, they are geared toward increasing the number of clinical workers in the state. The education and training provided these programs will increase the supply of clinical healthcare workers entering schools as school-based practitioners. Many of these projects have stemmed from inter-agency collaborative efforts, including between the CSDE, CT State Colleges and Universities (CSCU), and CT OWS.

(a) One such program is the CT Health Horizons, which CT OWS launched with $35 million in state ARPA funds. The goal of this program is to increase the number of graduates from the nursing and social work program (prioritizing the MSW degree, which is the precursor to becoming a Licensed Clinical Social Worker, the most in-demand position in behavioral health), with a focus on diversifying the workforce. Grants will soon be available to address three areas: (1) Tuition Support to incentivize low-income and minority students to enter accelerated and cost-effective nursing and social work programs, (2) Increase faculty to expand seat capacity and train an influx of nursing and social work students, and (3) Promote employer-driven innovation programs to support entrance into high-demand careers in nursing and social work. Grants were provided to independent colleges and universities that coordinated efforts to increase access to accelerated nursing and mental health programs. Students are enrolling in programs that start fall semester 2023.

(b) In addition, CT OWS has invested $11.6 million in two CareerConneCT grants focusing on health care training. The Academy for Human Service Training (AHST) is a 15-week comprehensive classroom and hands-on training opportunity for roles in Community and Social Services/Human Services; Case Managers, Direct Support Professionals, Psychiatric Aides, Recovery Assistants, etc. The Health CareerX Academy is designed to support the scaling of the Southwest Healthcare Career Academy statewide to train individuals in entry-level healthcare roles.

(c) An OWS legislatively mandated report is recommending a plan to work with high schools across the state to develop and strengthen pathways that encourage students to pursue careers in healthcare.

2. Connecticut Department of Public Health (CT DPH) Initiatives

Similar to the CT OWS, the CT DPH has recognized the pressing need to bolster its mental health workforce to effectively address the growing demand for mental health services. In response to this imperative, the state has embarked on a series of robust public health initiatives aimed at increasing the number of mental health professionals.

(a) In 2022, CT DPH joined the Psychology Interjurisdictional Compact (PSYPACT®) designed to facilitate the practice of tele-psychology and the temporary in-person, face-to-face practice of psychology across state boundaries. The Interstate Medical Licensure Compact is an agreement among participating U.S. states and territories to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify.

(b) In 2022, the Connecticut General Assembly passed two public acts providing DPH resources to strengthen the mental and behavioral healthcare workforce in Connecticut, to include:

(i) PA 22–81 encourages pediatric offices to integrate behavioral health into their practices. This is accomplished through a new grant program to provide pediatric offices with a 50 percent match for costs associated with paying the salaries of licensed social workers providing counseling and other services to children receiving primary health care from such providers.

(ii) PA 22–47 increases the number of child and adolescent psychiatrists available in the state to provide services to school-aged children. This is accomplished by the establishment of child and adolescent psy-

chiatrist grant program to provide incentive grants to employers for recruiting, hiring, and retaining child and adolescent psychiatrists.

Focus on Attendance and Engagement

With any discussion on mental and behavioral health supports, it is critical to include the importance of student attendance and engagement in school. Attendance is a precursor to engagement which is a precursor to learning. When students regularly attend school, they have access to not only in-person relationships with their peers but also to critical social and emotional supports. Therefore, the CSDE has placed a significant focus on improving attendance. Two practices the CSDE implemented to decrease chronic absenteeism include:

1. Increased Data Collection

Beginning with the 2020–21 school year, the CSDE rolled out two new data collections—weekly collection of learning models (e.g., in-person, hybrid, or remote) and enrollment, as well as expanding the collection of student attendance from yearly to monthly, to allow us to make data-informed decisions in real time to focus resources on student engagement and participation.

2. The Learner Engagement and Attendance Program (LEAP)

The state's response to this data collection was the Governor's Learner Engagement and Attendance Program, or LEAP, which was announced in April 2021. Underway in 15 high-needs districts, LEAP is the CSDE's research-based, relational home visiting model proven to increase student attendance and family engagement. Home visitors establish relationships with families and students and connect them with school and community resources, including behavioral health resources as needed.

As of December 2021, nearly 7,000 students across the 15 LEAP school districts had received more than 12,000 contacts from home visitor staff to encourage and support increased student attendance in school. Thanks to financial commitments of our legislature, this program will continue.

LEAP, by design, is supportive and creates trusting, relationship-based partnerships with parents. This helps parents resolve barriers to attendance and other life stressors. The Center for Connecticut Education Research Collaboration's (CCERC) evaluation of the LEAP program found that home visitors and families noted eight main benefits of LEAP including:

- Improved family school relationships
- Increased student attendance
- Increased student achievement
- Increased feelings of belonging
- Increased access to resources for families
- Increased expectations of accountability
- Greater gratitude and appreciation

CCERC conducted the largest, most robust study ever completed of a home visit program. The research shows that when implemented with fidelity, the LEAP model has a positive impact on students and families.

The results of the quantitative analysis indicated the following findings:

- Visits that were made in-person had more impact than virtual visits or phone calls.
- One month after the initial home visit, participating students showed a 4 percentage point increase in attendance.
- Six months after the visit showed a 10 percentage point increase in attendance among pre-K to grade 5.
- Six months after the visit showed a 20 percentage point increase in attendance among grades 6–12.

Evaluating Effectiveness and Sustainability

Scientifically researching and evaluating the effectiveness of the referenced initiatives, programs and investments is at the heart of our strategy in Connecticut. ESSER funds were used to establish the first-of-its-kind research collaborative we

call the Connecticut COVID–19 Education Research Collaborative (CCERC). CCERC is a research partnership between the CSDE and public and private institutions of higher education across Connecticut that works collaboratively on program evaluations. Given the value of the research collaboration beyond COVID–19 research efforts, it was recently rebranded as the Center for Connecticut Education Research Collaboration (CCERC), keeping the same acronym, and continuing this partnership well after the COVID–19 pandemic.

The rebranded CCERC's mission is to address pressing issues in the state's public schools through high quality evaluation and research that leverages the expertise of researchers from different institutions possessing varied methodological expertise and content knowledge. District and school leaders across our state are critical partners in this work. Many of the projects require an in-depth review of local policies and practices, especially when there have been large investments in the area of study. These important evaluation studies require district cooperation with researchers.

In addition to evaluation studies released on LEAP, summer enrichment, and remote learning, nine additional projects are underway and include the behavioral health pilot, identifying effective and equitable socio-emotional supports for students and educators, equity in academic recovery, and more.

CCERC demonstrates the CSDE's commitment to programmatic accountability and sustainability, building evidence on the effectiveness of its interventions and knowing what works. As the end of the ESSER funding approaches, Connecticut will have the strength of results to fund and sustain what works.

Policy Recommendations:

As we gather here today to address pressing youth mental health challenges, I would like to draw your attention to a set of policy recommendations below that I believe warrants your consideration.

1. Allocate Resources for State and Local Evidence-Based Program Evaluation

Program evaluation initiatives such as CCERC provide an objective and evidence-based assessment of the efficacy of educational programs, allowing policymakers, educators, and administrators to make informed decisions. These evaluations help identify strengths and weaknesses in funded programs/initiatives, measure impact on student outcomes, and pinpoint areas for improvement. By understanding what works and what does not, states and school districts can better direct resources to strategies that have a proven track record of success, ultimately benefiting students, educators and communities. As Congress considers reauthorizing the Education Sciences Reform Act, I encourage you to help states build capacity to evaluate program effectiveness and support effective uses of limited resources.

2. Provide Funding for the Continuation of Prevention and Intervention Initiatives

By the end of 2024, states and school districts will have fully invested the Federal education funding that Congress provided under three relief packages to mitigate COVID–19 and address its lasting impacts upon student achievement and well-being. In 2024, the end of this funding will significantly limit schools' ability to access the resources and supports students and communities need to recover from the ongoing effects of the pandemic. Moving forward, we are committed to effective uses of more limited funds but also encourage Congress to make additional investments in K–12 education to ensure that we can continue to meet the needs of students and families.

3. Support Educators' Focus on Student Physical Health

Student physical health is a critical factor in youth development and overall health and needs to be part of the package of supports for students. Childhood obesity is again on the rise along with increased sedentary habits in our Nation's youth. Diminished physical health, especially in underserved populations is a doorway to other issues and concerns, including mental and behavioral health, potentially leading to negative impacts on overall health and well-being. Programs and services to support physical fitness

and wellness, as well as expansion of the Federal child nutrition programs for all students, are foundational to lifelong health and success.

4. Incentivize Collaboration Between Federal Agencies [

Federal agencies need to coordinate to leverage different entry points to mental health support so that, regardless of the agency that has a high touch with a family, any one of them are able to provide entry into supports for children and students experiencing trauma and struggling with access to services and care. Such collaboration is critical to address the Social Determinants of Mental Health. Augmenting traditional behavioral health services with additional health-enhancing supports and positive youth development opportunities has the power to develop well-rounded students with the knowledge, skills and confidence to support their lifelong wellness and success. Such opportunities include: focused investments targeting protective factors; providing for basic needs such as stable housing; supporting comprehensive wraparound supports for emerging adults; providing innovative education opportunities outside of school that focus on building skills and confidence; providing opportunities for employment or training; and, providing access to mentors with lived experience in behavioral health, juvenile justice, and child welfare systems.

As Connecticut's Commissioner of Education, I am greatly appreciative for the invitation to be part of this national discourse to share what Connecticut has done to support youth mental health and to describe potentially scalable initiatives to inform Federal investments and policies. Addressing non-academic barriers to learning will serve to improve educational attainment. Your willingness to model transparent bipartisan national discourse such as this will lead to enhanced access to needed services and ultimately improved academic supports and outcomes for our young people, and I appreciate these efforts. I am part of a strong, nationwide network of state commissioners working together with the Council of Chief State School Officers, and I can guarantee you no two stories are alike. What I can surely guarantee you is that we all collectively wake up every morning with our students and their families, educators, and school staff at the forefront of our minds, because it is when our schools are supported our students achieve more, our communities achieve more, and together—we all achieve more.

We must use this moment to think holistically across all levels of government about the continuum of supports necessary for our students and nation to thrive.

Finally, none of the practices and initiatives that I bring from our great state would be possible without the leadership of our Governor, our sister agencies, the excellent staff at the CSDE, our State Board of Education, our school district superintendents, administrators, educators and staff, our policymakers, and the many education partners in our state. That truly is the Connecticut Difference!

Chair Sanders, Ranking Member Cassidy, and HELP Committee Members, thank you once again for the opportunity to share Connecticut's story with you today.

[SUMMARY STATEMENT OF CHARLENE M. RUSSELL-TUCKER]

The social isolation and stress of the COVID–19 Pandemic exacerbated existing mental health challenges facing our youth and also exposed gaps in the behavioral and mental health care system. This is evident from the results of the Connecticut School Health Survey, which indicated that feelings of sadness and hopelessness in high school students reached a new high in the fall of 2021. The Connecticut Department of Education (CSDE) built on existing systems and leveraged new funding to address this critical need in our students.

Stakeholder Involvement and Collaboration

Stakeholder engagement is a pillar of Connecticut's response to addressing mental health concerns in students. The Commissioner's Roundtable for Family and Community Engagement in Education represents a diverse constituent group of education stakeholders representing school and district staff, advocacy organizations, parents and guardians, community members, and students, to advise the Commissioner of Education regarding policy and programmatic priorities. Voice4Change, the first statewide student participatory budgeting initiative in the country, gave students a direct say in how a small portion of state set-aside ESSER funding should be spent across Connecticut schools. Students overwhelmingly voted for projects that supported student and staff mental health. The AccelerateCT Education Taskforce

was launched in 2021 to develop a statewide education recovery and acceleration framework and programming for students across the state beginning with enhanced learning and enrichment opportunities, which included a focus on social, emotional, and mental well-being. Engaging associations representing school superintendents, principals, teachers, nurses, counselors, social workers and others are also part of Connecticut's play book for success.

Supporting the Social, Emotional, and Mental Health Needs of Students and Staff

Connecticut created programs and rolled out grants to strategically build the infrastructure to support schools and students. Efforts include: $183 million district ESSER funding prioritized for mental health; $28 million in school mental health personnel grants; $35 million after-school and summer enrichment grants; the school behavioral health pilot program; expansion of Mobile Crisis Intervention Services; School Based Health Center expansion plans; guidance and systems to support positive growth in pro-social competence and behavior in students.

Initiatives to Support Healthcare Workforce Development

Key initiatives spearheaded by the CSDE's partnerships with other state agencies include workforce grants and training programs for mental health professionals to increasing the number of social workers and psychologists for school-aged children including $35 million to support students in nursing and social work programs, and funding incentive programs for employers of clinicians to strengthen the mental and behavioral healthcare workforce.

Focus on Attendance and Engagement

The CSDE understands the power and importance of real-time evaluation data. Increasing the collection of attendance data from yearly to monthly allowed the CSDE to address root causes of chronic absence and disengagement in real time. These data points led to the development of the Governor's Learner Engagement and Attendance Program (LEAP). LEAP is the CSDE's research-based, relational home visiting model proven to significantly increase student attendance and family engagement.

Evaluating Effectiveness and Sustainability

A commitment to evaluation is at the heart of our strategy in Connecticut. Data-driven decisionmaking is key to informed and effective policymaking. To that end, the CSDE invested a portion of our ESSER funds to establish the first-of-its-kind, research collaborative called the Connecticut COVID–19 Education Research Collaborative (CCERC). Recently rebranded as the Center for Connecticut Education Research Collaboration, CCERC is a research partnership between the CSDE and institutions of higher education across Connecticut. This research center allows the CSDE to leverage the strong collaboration that exists in our state to scientifically research and evaluate the effectiveness of our initiatives and investments.

Policy Recommendations

The policy recommendations in this testimony for consideration to support youth mental health include: allocate resources for state and local evidence-based program evaluation; provide funding for the continuation of prevention and intervention initiatives; support a focus on student physical health; and incentivize collaboration between Federal agencies.

The CHAIR. Thank you very much. We are going to jump over Dr. Garcia for a second. We are to go to Dr. Joy Osofsky, who will be introduced by Senator Cassidy.

Senator CASSIDY. It is a joy to introduce Dr. Joy Osofsky. She is the head of pediatric mental health at LSU Medical School, a developmental psychologist, and a national leader in early childhood development. I have learned a lot from Dr. Osofsky.

She is who taught me that you can actually begin picking up separation disorder from day zero. It was just amazing to me. And she

was very influential in what Chris Murphy and I did, at least my part of the mental health reform bill of 2016, so I owe a lot to her.

She has expertise in trauma informed care, helped many Louisiana families recover from Hurricane Katrina, and apply that expertise during the COVID–19 pandemic. She received numerous awards and recognition for her work. Dr. Osofsky, thank you for being here.

STATEMENT OF JOY OSOFSKY, PROFESSOR OF PEDIATRICS, PSYCHIATRY, AND PUBLIC HEALTH, HEAD OF DIVISION OF PEDIATRIC MENTAL HEALTH, LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER, NEW ORLEANS, LA

Dr. OSOFSKY. Thank you very much, Senator Cassidy, for the invitation, and Senator Sanders. I very much appreciate being here.

One of the things that I want to say in introducing my testimony is how important the opportunity has been for me, actually together with my husband who is a psychiatrist, to be able to consult with Senator Cassidy on mental health issues, to identify and support community and state agencies that work individually and collaboratively in supporting the mental health needs of children and families, including cross-state efforts.

We started this in 2016. We have been pleased to support his efforts to increase mental health support in schools and in communities. And we didn't talk earlier as much about communities, and I think we need to integrate that in the conversation we have now.

Bipartisan Safer Communities Act and Support Act would expand community based behavioral health services and access to mental health care services in schools and communities in both rural and urban areas. And we know in rural areas, it is much harder to access mental health services in general.

The Act would provide funding also for the National Child Traumatic Stress Network to improve trauma informed training, treatment, and services for children, adolescents, and families who have experienced trauma. I have been fortunate enough to work with the National Child Traumatic Stress Network being funded since 2003, to develop mental health collaboration with schools and communities.

Our latest effort, and I think one that is really very much reflective of the direction of the National Child Traumatic Stress Network is going, has been to not just work in one community, but develop regional coalitions so that we spread the work that we do and the efforts that each of us make in working with children who have been traumatized in different ways and experienced trauma, to be able to share that knowledge with other communities.

For example, and I actually happened to be quite fortunate during the COVID pandemic, we had a center within the National Child Traumatic Stress Network that just ended, a terrorism and disaster coalition for child and family resilience.

Through that coalition, we built regional relationships across states, one in the Gulf South, where we already had relationships due to the disasters, Hurricane Katrina and the Gulf oil spill, but

then in the Northeast region of the United States, across five states.

The regional coalitions are composed of people from all different backgrounds, state agencies, education agencies, stakeholders in the community, people who are involved in policy, we have some politicians involved, so that we were able to share information across the different groups for much better preparedness, as we share information, response, and then recovery when a disaster of any type occurs.

Not just a natural or technological disaster, but also a terrorist attack or a shooting that has occurred in a community, or a shooting that has occurred in schools, that we can share information and have immediate response to those situations. I really feel about the work of the National Child Traumatic Stress Network speaks to some of the issues that have already come up in terms of integrating across community innovative ways to provide mental health services in ways that would be quite acceptable.

The other thing that I want to bring up that has not been discussed is the importance of how to support resilience—how to support resilience in children, and how to support resilience in families. Certainly, we have seen families being pressed immeasurably during the COVID pandemic. What I call it is an indefinite information.

Everything changed all the time, indefinite uncertainty. We didn't know what was going to happen from 1 day to the next. How can a family come together and how can a school system or a community come together when you don't know how things are going to change from day to day? And the issue came off of how to communicate, and I think that is why there has been so much excess use of social media as a way to connect.

We were told we couldn't be around people, so how can children relate to their friends? And how can one have a sense of family, if you can't see people and relate to them? So, I think that it is really very important for us to think about how to establish connections across families and connections across communities.

One of them, I will give you—I see I am just about out of time. I was going to give you a brief example how we brought together families and children after Hurricane Katrina on some of the cruise ships that housed people who did not have housing. And how we work together, including mental health, as a way of just being there.

That is something that we have to think about. Also, it is supporting parents to be able just be there and listen to their children and give support to parents to be able to do that. Thank you very much.

[The prepared statement of Dr. Osofsky follows:]

PREPARED STATEMENT OF JOY OSOFSKY

Since 2016, we have had the opportunity to work with Senator Cassidy to identify and support community and state agencies that can work individually and collaboratively in supporting the mental health needs of children and families including cross-state efforts. We have been pleased to support his efforts to increase mental health support in schools and communities. The Bipartisan Safe Communities Act and SUPPORT Act would expand community based behavioral health services and

access to mental health care services in schools and communities in both rural and urban areas. This Act would also provide funding for the National Child Traumatic Stress Network to improve trauma informed training, treatment, and services for children, adolescents, and families who have experienced trauma.

Effects of Trauma on Youth

Youth are exposed to trauma in many ways, for example, experiencing abuse and neglect, exposure to domestic violence, substance use, and community violence. Youth are also exposed to natural and technological disasters and, in the past 3 years, to the COVID–19 pandemic with its many effects on children and families, including parental and caregiver loss. There is much evidence that exposure to trauma affects development in different ways. For very young children, exposure to abuse and neglect can impact on their brain development. For all children, their cognitive, social, and emotional development can be affected by abuse and neglect (Center for the Developing Child at Harvard, 2023). Many studies have shown that children who are exposed to adverse life experiences (ACEs) early in their lives are at significant risk for developing serious and long-term problems, both medical and psychological, later in development. Trauma-informed and trauma-responsive interventions and evidence-based mental health treatments have been developed to help youth who have been exposed to trauma. It is crucial to recognize that recovery from trauma and development of resilience with meaningful, consistent relationships which means that parent and caregiver availability and support, in addition to mental health services, will help children and adolescents recovery from trauma exposure and also support resilience (Masten, 2021). The COVID–19 pandemic has contributed to increased risk of mental health problems for several reasons. Children of all ages, including adolescents, are likely to develop well with consistency in their schedules, positive relationships with a parent or caregiver in a supportive environment, and, as they grow older, consistent peer relationships. Few of these positive supports for youth development were in place during the COVID –19 pandemic.

The Mental Health Impact of Natural and Technological Disasters on Youth Compared to the COVID–19 Pandemic

While the psychological and social impact of the COVID–19 pandemic shares some similarities to natural and technological disasters, there are also major differences that need to be considered related to the mental health impact on youth, having contributed significantly to the increase in anxiety, depression, and other mental health disorders. Unlike the COVID–19 pandemic, natural disasters commonly impact on designated regions of a city, community, state, or country, allowing those not impacted to be available to help with recovery. A second difference is that it is often possible to predict, with some variations, the duration of natural and technological disasters; however, with the COVID–19 pandemic, there has been much uncertainty about the duration and, therefore, the recovery process. Third, and perhaps most important, is that recovery from natural and technological disasters is helped to a great extent by supportive in-person relationships that have been unavailable during COVID–19. Psychological and social well-being has been affected significantly by "stay at home" orders, social distancing, and other safety precautions needed to contain the pandemic that preclude social relationships. Further, the psychological and social impact is influenced by fears of becoming sick as well as having to cope with friends and family being sick and dying mostly alone from COVID–19. Youth have reported that they often worried about going to school when they opened being fearful of bringing COVID back to a parent or other caregiver in the family. Recent data has shown that intrafamilial spread is often due to apparently well children. The number of fatalities from COVID–19 also has taken a toll on psychological well-being. Following Hurricane Katrina, Louisiana experienced an estimated 1,700–2,200 fatalities. In contrast, as of May 2020, there were already more than 2,281 fatalities in Louisiana from COVID–19 (NOLA.com, 2020) and in 2023, a total of 18,835 deaths which was 1 in 247 residents. The death rate for the African American population is 2.65 times the rate for all other groups. As with many major disasters, socioeconomic difficulties and preexisting health conditions are contributing to racial disparities in COVID–19. The mental health repercussions following disasters like Hurricane Katrina have been significant with both adults and children reporting high incidences of depression, anxiety, posttraumatic stress disorder, and substance abuse that went down slowly over time with growing family and community stability. This outcome has not been the case with COVID–19. Rather there have been reports of increases in anxiety, depression, substance use, and an exacerbation of previous mental health problems. Early in the pandemic, crisis counseling (Psychological First Aid), as is offered with disasters, was provided re-

motely. However, generally, there were limited clinical services and outreach support for individuals and families dealing with the stresses of temporary or permanent layoffs, decline in income, having to provide remote learning for children, and worries about illness and possible death. Mental health support also emphasizes the importance of establishing new routines and schedules for daily life including a schedule for youth to get up in the morning, have breakfast and go to school. During COVID, both youth and families experienced continual uncertainty about school, work, virtual schooling, homework, meals, self-care for parents, and time with children not only for virtual schoolwork, but also for positive play or conversation. The new routines also needed to include virtual ways to maintain friendships and family relationships using telephone or social media if available. While systematic reporting has been hampered with Stay-at-Home orders, concerns were raised, but not fully substantiated, about possible increases in child abuse and domestic violence with perpetrators and victims living in close quarters. Additional stress was contributed by family members becoming ill with COVID and not being able to be with loved ones when they were severely ill or dying from the virus. Further, youth experienced death of a parent, grandparent, or caregiver being taken to the hospital or leaving in an ambulance when sick with COVID never to return. For all children, this experience has been traumatic and, for younger children, confusing and difficult for them to understand. Clinically, we have heard many reports of young children continuing to stand at the window of their homes waiting for a parent to return. And with such losses, the remaining caregivers have had to find ways to support the children while also grieving themselves. The issue of inequities with COVID–19 is striking. In Louisiana, African Americans represent 32.7 percent of the population but account for 70 percent of the deaths from COVID–19. These figures for Louisiana have been repeated across the United States with a much higher incidence of illness and death from COVID for Black/African Americans, Latino, Native Americans, Alaska Natives, Pacific Islanders among the many groups heavily impacted. This figure and inequities are likely related to having less access to care. Further, limited health care, which has contributed to a higher percentage of underlying conditions such as heart disease, hypertension, diabetes, and respiratory problems, places these individuals at higher risk if they become sick with COVID–19. The only conclusion to be drawn is that the COVID–19 pandemic is an unmitigated disaster in many ways comparable but worse than traditionally defined disasters such as hurricanes, earthquakes, tornadoes, and fires. Natural and technological disasters disrupt the essential consistencies in children's environments that are important for positive development. However, in most cases, substitute support can be established relatively quickly. However, the COVID–19 pandemic was different requiring a prolonged lockdown and social distancing requirements that should have been called physical distancing for safety so that social interactions that are so important for youth development would continue to occur, even if done virtually. Many young children could not really understand what happened and why their lives had changed from going to day care, preschool, or school to being isolated at home. For youth and adolescents of health care providers, they were often confused about why could they not see or hug their mother or father when they came home from work. Why could they not see or visit their grandparents who played such an important part in their lives? Also, the role of parents and caregivers in supporting their children is very important. If a parent is available to listen to their child, it can be extremely helpful even before mental health support may be available. A study done by Sesame Workshop during the pandemic that asked children to answer questions about their experiences during COVID, found that most children said that their parents would take care of them and keep them safe and secure.

Youth and parents were continually living with "indefinite uncertainty" with schools, including preschools, being closed and then opened and closed again if there was spread of COVID. Further, the pandemic exposed inequities as for many families, virtual schooling was not possible with parents needing to work and limited access to internet and the technology needed for virtual schooling. This constantly changing environment interfered for children and adolescents with many of the important components for positive development including consistent peer relationships. The Rapid Assessment of Pandemic Impact on Development Early Childhood Survey, that was designed to collect essential information from households and families of young children during COVID, indicated that the level of emotional distress in households for both parents and children was related to the number of material hardships encountered. Further, they found that financial and material hardships contribute to caregiver distress that impacts on child distress. Virtual schooling with little support may have added to the stress for both youth and parents contributing to mental health symptoms.

Youth mental health has been impacted by the "indefinite uncertainty" as a result of the pandemic with inconsistencies in schedules, feelings of isolation and anxiety with schools being closed, and an inability to be with friends. While virtual communication was possible for many youth, having to depend totally on this type of interaction may have also contributed to feelings of isolation and anxiety. Given that ideally for positive youth development, the use of social media, both content shared with friends and time spent, should be monitored by parents. During the pandemic, both children and parents depended more on virtual communication to interact with friends and family members. While some use of social media is reasonable for development. Unfortunately many youth and also their parents became more dependent on this method of communication and sharing during the pandemic. On the one hand, youth likely felt less isolated using social media; however, it could also have led to their feeling more isolated if they saw others interacting more with peers than they were doing. The main point is that use of social media for youth of any age should be monitored carefully by parents or caregivers which was made more difficult during COVID when this became a main way for youth to communicate and to receive education.

Integrating Mental Health Support in School and Community Settings

Following Hurricane Katrina, we had the opportunity to develop an innovative community-academic partnership program in a temporary building with school personnel, all of whom had lost their homes and now their schools, the former principals and teachers collaborated with our mental health team to encourage high school students to take a leadership role in recovery by helping older citizens and younger children come back to school and the community. The youth in the "Young Leadership Program" who were mainly higher risk adolescents felt responsibility for leadership in the recovery giving them a sense of purpose and also helped other students and their community—giving them a sense of purpose. Other youth leadership programs were being planned for high-risk students when the COVID–19 pandemic closed schools.

From extensive school and community-based experiences in providing mental health supports following Hurricane Katrina and the Deepwater Horizon Oil Spill, our team learned about the importance of delivering mental health supports and services in collaboration with schools and community groups. In several of the rural parishes where few mental health supports are available, we also collaborated with community clinics to bring more mental health support for youth. Further, and not unexpectedly, we also learned about the importance of providing trauma-informed training for school personnel including teachers, counselors, nurses, other school staff, and administrators most of whom were also impacted personally by the disasters. To be supportive of students who experience trauma, it is important for school personnel to understand the impact of trauma and how it may be affecting the students. In this relationship-based approach, the students can feel understood and heal from trauma. The training and support for schools also includes information about vicarious traumatization and compassion fatigue in trying to support children who have also experienced trauma. The situation has been similar with the COVID–19 pandemic from survey research with teachers, childcare providers, and administrators who have experienced due to illness and loss in their families, the pressures of doing virtual schooling, and their concerns related to re-opening schools and possible illness. Many of the teachers reported being concerned that it would be difficult for them to provide the support that the youth needed while also teaching them. Emphasis on these recommendations also comes from a recent experience shared by a psychologist who worked closely with us during our NCTSN grants supporting students in school settings. He shared with me that he walked into the school where he provides services and learned that two students had been shot and killed they day before. There was no supportive work done for the students or the teachers whether or not they knew the boys as all attended the same school. There are strategies that have been established to support schools, students, teachers, and staff when a student has been traumatically injured. It was hard for us to imagine the feelings at the school with no intervention and supportive work being done. Trauma-informed interventions and support should be in place for all students, teachers, staff, and families when needed.

To deliver mental health services most effectively in school settings, collaboration with school personnel is important especially with counselors and nurses whom the youth see if they are having problems. Unfortunately, there are many schools across the country that have no school counselors. In the work of our team after natural disasters, we learned the importance of school personnel being "trauma-informed," in order to recognize that behaviors like anxiety, irritability, or symptoms like stom-

ach aches may reflect the child or adolescent's anxiety related to exposure to trauma. After Hurricane Katrina and the Deepwater Horizon Oil Spill, our team worked collaboratively with schools to obtain parental consent, which is required for mental health services for youth, to provide services at the school setting. It also provides an opportunity to also meet and work with the parents.

Providing Mental Health Support in Collaboration with Community Groups

Not only partnering with schools in delivery of mental health services, but also collaborating with community groups where children may come for recreation or after school activities may be a place to identify increased anxiety or depression in youth and provide support. Trauma-informed community programs can play an important role in identifying and helping with mental health and substance use problems earlier. We have had experience with a successful community program in New Orleans, Son of a Saint, started 11 years ago by an innovative young man who lost his father, a New Orleans Saints player, due to natural causes when he was 3 years old. While his mother was very devoted, he found the teenage years difficult without having a father and was determined after he finished his education to start a program for adolescents. Boys ages 10–12, who had lost their fathers to violence or incarceration. Ninety percent of the youth are minorities and 80 percent are Black. While there are some mental health services provided for the program, most of the support is done by mentors who are well trained to provide ongoing support for the youth and adolescents, including the important encouragement of a consistent relationship. Since the beginning of the program, all have graduated high school, many have gone on to college, and none have had problems with the law.

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[SUMMARY STATEMENT OF JOY OSOFSKY]

Since 2016, we have had the opportunity to work with Senator Cassidy to identify and support community and state agencies that can work individually and collaboratively in supporting the mental health needs of children and families including cross-state efforts. We have been pleased to continue to support his efforts to increase mental health support in schools and communities in urban and rural areas to help youth and families.

In my written testimony, I review and provide some important references for this work:

1. The Effects of Trauma on Youth including ways to support resilience following trauma exposure. Children of all ages, including those exposed to trauma, are likely to develop well with consistency in their schedules, positive relationships with a parent or caregiver in a supportive environment.
2. Mental health impact of natural and technological disasters on youth compared to the COVID–19 pandemic.

Natural disasters are often more predictable and are time limited. The COVID–19 pandemic has been marked by indefinite uncertainty. Recovery

from disasters is helped by supportive in-person relationships. Mental health support following natural disasters is helped by supportive in-person relationships. Mental health support following natural disasters can be provided in schools and community settings.

With COVID–19, in order to limit spread of the virus, lockdowns and social distancing was imposed with no in-person contact. Schools that are important for recovery following disasters were closed during the pandemic with much stress imposed on families, particularly those with fewer resources having to work and do virtual schooling. Family stress after natural disasters is helped with community support. With COVID–19, increased financial and other family stress due to lockdown contributed to child stress. Both parents and youth depend on social media to maintain contact with family, friends and peers. Difficult to set suggested limits on use of social media with COVID–19. Inequities were apparent with both natural disasters and the pandemic. Inequities were even more pronounced with serious illness from COVID–19

3. Integrating Mental Health Support in Schools and Community Settings.

Mental health services in collaboration with schools worked well in providing support for youth of all ages. Trauma-informed training and support in preparation for or following disasters for teachers, administrators, and other school staff to help them be more sensitive to students, especially given vicarious trauma and compassion fatigue.

4. Providing mental health collaboration with community groups and school collaborations will be very helpful in supporting youth mental health following the COVID–19 pandemic. Additional initiatives in school and community settings following disasters were helpful for high-risk youth with an illustrative example provided.

The CHAIR. Thank you. Our next witness is Dr. Joshua Garcia. Dr. Garcia is the Superintendent of the Tacoma, Washington School District. He previously served as Deputy Superintendent, Assistant Superintendent, High School Principal, Assistant Principal, Athletic Director, and Teacher. Other than that, not much. All right.

[Laughter.]

The CHAIR. Thanks very much for being with us, Dr. Garcia.

STATEMENT OF JOSHUA GARCIA, SUPERINTENDENT, TACOMA PUBLIC SCHOOLS, TACOMA, WA

Dr. GARCIA. Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, I am a proud Superintendent of the Tacoma school district and honored to share the viewpoint of superintendents for this important hearing focused on mental health of our Nation's youth, and to speak with you about what we have observed, what we have been doing, and what we might do together to curb the youth mental health crisis in America.

Tacoma is fully committed to each of our students being safe, engaged, supported, healthy, and challenged. We recognize mental health impacts us all. Mental health includes our emotional, psychological, and social well-being. It affects how we think and act. It helps us determine how we handle stress, relate to others, and make healthy choices.

During a highly critical phase of development, the lack of support and comprehensive approaches are significantly impacting our students' ability to grow socially, emotionally, and their academic development. Tacoma Public Schools, more than 28,000 students represent 170 tribes and ethnicities.

Over 2,000 of our students qualify as homeless. Over 55 percent of our students qualify as low income. And over 15 percent qualify for special education students. In the 2011 and 2012 school year, each of our high schools was labeled as a dropout factory. We were in a dire state, and we needed a new approach.

We started the Tacoma Whole Child Initiative, an intentional action plan that recognizes students are learning 24 hours a day, 7 days a week. Fast forward to 2022, 90.2 percent of our students graduate in 4 years. 86.7 percent of our high schools take college level classes. This year alone, over 12,000 participants in kindergarten through eighth grade have engaged in after school activity, and a record number of high school students are participating in paid job experience.

Tacoma has been able to make big strides to improve outcomes, but we know the challenges our students are facing are only growing. In the last year, our students, Tony, Angel, Brielle, Isiah, Marco, DJ, Wyatt, Xavier, Larry, and Iyana have been shot in our community. Our students have to survive human trafficking, battle homelessness, drug abuse, physical and mental abuse, and social media harassment and bullying.

Although these may not be new challenges to us as a nation, the speed of the incidences and the traumatic stress are only increasing. Like you and I, students are being bombarded with images, news events, daily experiences of trauma, and hate and stress.

Unlike us, they are doing this without fully developed brains, coping skills, or access to preventative and therapeutic services. In 2021, 13,239 of our 10th graders in our states made a plan for suicide. As you heard, Washington State is not unique. Our students are facing tremendous challenges and schools can't do this work alone.

Through the Tacoma Whole Child Initiative, we have moved away from episodic events to sustainable practices across our buildings and our community. They are focused on three elements, prevention strategies, response strategies, and therapeutic services. Our prevention strategies.

Each of our schools develop an intentional plan to support social emotional learning. They contextualize each plan at each school site. Our students are engaged in physical and mental wellness supports during the day and in the afterschool ecosystem. We do this with the Beyond the Bell and Club B, which uses a shared business model, common mental health supports, community assets, and align funding with over 70 partners.

Our system of positive behavioral supports ensure students understand schoolwide expectation, fostering stability and reinforcing healthy mental health habits. We also provide a safe space for our students to build belonging during evening and non-school hours. Our responsive strategies.

We have invested in professional development focused on trauma sensitive practice. We support and train facilitate restorative practice that bring voice with intentional healing and understanding. And we also provide tiered supports, focusing on target intensive support for students at risk. Using ESSER and U.S. Department

of Education grants, we were able to invest in therapeutic supports.

During a robust prevention and strategy, TPS is not able to alone meet the needs. To meet this challenge, we are implementing an ambitious plan to increase the ratio of students to mental health providers. Here are a few things I encourage us to think about doing together. Expand on the bipartisan Safe Communities Act. I know budget decisions are tough, but with the message students are telling us, we just—we have to listen to.

Pay for health care services with health care dollars to ensure Medicaid access. Incentivize the health care industry to formalize partners with schools, prioritizing youth first. Build on categorical funding opportunities.

Increase flexibility with the support for the Carl Perkins and Department of Labor grants to build hope. Require states to match your investment. Has Tacoma done everything we could? Not yet. Tacoma is learning, responding, and making a difference.

We have evidence. We know that through engagement, tiered supports, and shared strategies, our students are being more successful dealing with their individual emotions and stresses, developing their social awareness, and working academically at all times.

Finally, America's schools and individual communities can't do this alone. We must work in partnership, and we know that it is not easy. There are egos, turf battles, and frustrations. However, we are truly better together.

We may not be united on everything, but our future is with us now, and we must be united in our commitment to serving youth first. Thank you.

[The prepared statement of Dr. Garcia follows:]

PREPARED STATEMENT OF JOSHUA GARCIA

Good morning, Chairman Sanders, Ranking Member Cassidy and Members of the Committee.

My name is Josh Garcia, and I am the proud Superintendent of the Tacoma School District. I am honored to share the viewpoint of school superintendents for this important hearing focused on the mental health of our Nation's youth and to speak with you today what we have observed, what we have been doing in Tacoma Public Schools and what we might do together to support the youth mental health crisis in America.

What do we want for every child in America? A simple question that has a complex and nuanced response. As one school district, we're thinking and working to take action every day. We are fully committed to each of our kids being safe, engaged, supported, healthy and challenged. We recognize mental health impacts us all, students, staff, and community. Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. The need for this hearing is more critical than ever.

As we know, the human brain is developing during the K–12 experience. At the most impactful phase in human development, the lack of support and comprehensive approaches are significantly impacting our students' ability to grow their social, emotional, and academic development.

1. Tacoma—

For those that don't know our beautiful community, Tacoma WA is an urban port city that is diverse. Our Tacoma Public Schools represent more than 28,000 students representing over 170 tribes and ethnicities. Over 2,000 of our students qual-

ify as homeless, over 55 percent qualify as low income, and over 15 percent receive special education services.

In the 2011–2012 school year, each of our high schools was labeled as drop out factory by *U.S. News and World Report*. We were in a dire state, and we needed a new approach. We started the Tacoma Whole Child Initiative, which is an intentional action plan that recognizes that students are learning 24 hours a day, 7 days a week. It's a recognition that focusing all our community energy on solely transforming the student experience during schools is a bad model, when schools only have students one-third of the time. We knew we had to transform schools and leverage the other two-thirds of the time to truly make gains and provide the supports necessary to reach our desired academic and mental health goals.

Fast Forward to 2022, 90.2 percent of our students graduate in 4 years. 86.7 percent of high school students take college level classes. We have record numbers of students engaged in extra-curricular activities and athletics. This year alone over 12,000 participants in K–8 have been engaged in after school activities, STEM, fitness, arts and more. A record number of High School students are participating in paid job experiences through work-based learning and Jobs 253. Tacoma has been able to make big strides to improve student outcomes. But we know that the challenges our students are facing are only growing. Our kids are in pain—in our own homes, neighborhoods, cities, states and in our own Nation. We need a united response.

2. Mental Health Youth Crisis

Everyday our students face the challenges that are ripping our great nation apart. In the last year, 10 of our students—Tony, Angel, Brielle, Isiah, Marco, DJ, Wyatt, Xavier, Larry, and Iyana—have been shot, our students have had to attempt to survive human trafficking, battle homelessness, drug abuse, physical and mental abuse, and social media harassment and bullying. If we pause and read the news, we will see that our students are like many American youth in the trauma they face daily. Although these may not be new challenges for us as a Nation, the speed of the incidents and the traumatic stress are more intense than ever.

Like you and I, our students are relentlessly being bombarded with images, news events and daily experiences of trauma and stress. Unlike you and I, they are doing this without fully developed brains, coping skills and access to preventive and therapeutic services. This repeated attack on the human brain is putting our youth on high alert, which brings us all here today.

In 2021, 72 percent of our 10th graders reported feeling anxious, nervous or on edge regularly (68 percent across the state) and 60 percent reported not being able to stop worrying (55 percent across the state).

17 percent of our 10th graders made a suicide plan in the last year compared to 15.6 percent across the state. This translates into 13,239 students in our state making a plan to commit suicide.

Unfortunately, it is hard to imagine that 10th grade kids in Washington are unique. That same data would show the number is higher in 8th grade (16.2 percent of 85, 819) = 13,902.

3. How Tacoma Faces These Challenges Head On

The challenges our students and schools face are tremendous, and schools can't do this work alone! Communities, states, and our great nation need sustainable action plans that are functional, continuous, and comprehensive. We must all acknowledge our responsibility without blame. Through the Tacoma Whole Child Initiative, we have moved away from episodic events to sustainable practices across our school buildings. Our sustainable practices related to supporting whole child to improve student outcomes are focused on three elements: prevention strategies, response strategies, and therapeutic supports.

Prevention Strategies:

In Tacoma we have an intentional plan to support social emotional learning defined at the local level: each of our schools has developed their own social emotional learning plan and publishes it annually to ensure feedback from families and community stakeholders.

We also make sure our students are engaged in solid physical and mental wellness supports during the school day as well as in the afterschool ecosystem. Locally we do this with Beyond the Bell and Club Beyond which serves over 12,000 participants using a shared business model, common mental health supports, accessing community assets and aligned funding with over 70 partners. Through our shared signature strategies, we make sure students are greeted warmly, which builds a sense of belonging, and we focus on relationship building through strategies

like, “circles” (building community, empathy and equitable story telling) and “emotion checks” (fostering self-regulation and understanding of others).

Our system of positive behavioral supports ensures students understand—school wide expectations to foster stability, encourage positive expectations and outcomes and reinforce healthy mental health habits.

We also provide a safe place for students to build belonging during the evening; Tacoma has launched 12 summer sites across town where teens can belong, break bread, and have equitable access to safe environments.

Responsive Strategies:

We have invested in professional development focused on trauma sensitive practices.

We support, train, and facilitate restorative practices that bring voice with the intention of healing and understanding for all participants.

We also provide tiered supports—focusing on targeted support for some students (check in, check out) and intensive supports (students at risk of harming self or others).

Therapeutic Supports:

Using Federal ESSER funding and U.S. Department of Education grants we were able to invest in therapeutic supports. We have learned that we must build partnerships and be honest about what our schools can and can’t do for our students. We have 10 healthcare partners that are providing site based mental health supports to our students to keep them engaged in school and learning alongside their peers.

How can we move forward together:

Expanding on the lessons we have learned and successes we have had in Tacoma to date, I would encourage Congress to do the following:

(1) Continue to expand on your work with Bipartisan Safer Communities Act. I know that budget decisions are difficult and there is never enough. However, it would be foolish for us all to ignore the signs are youth are sending us. If we don’t invest now, our costs will be 10 times what they are now in the future. In particular, the School-Based Mental Health Services Grant and the Mental Health Service Professional Demonstration (MHSP) grants will help districts train and retain desperately needed school mental health professionals.

(2) Pay for healthcare services with healthcare dollars by ensuring every district can bill Medicaid for the healthcare services delivered to Medicaid eligible students, so we can focus our local education funding on other supportive programs and services.

(3) Incentivize the Health Care Industry to have formalized partnership with public schools to serve youth with Mental Health Supports. We need to bring therapeutic services to our youth and continue to find ways to support growth in the workforce.

(4) Build on categorical funding opportunities like Title IV of ESEA and consider new targeted support specifically for mental health programs and services and require states to match Federal investments. This will allow smaller communities to have sustainable resources for their students.

(5) Provide flexibility through the Carl Perkins Grant and Department of Labor Grants to support paid youth job experiences and required financial literacy, building a sense a hope for the future.

Gratitude

Has Tacoma done everything we could, far from it! Tacoma is trying, learning, responding, and making a difference, we have evidence. We know that through engagement, tiered supports, and shared strategies, our students are being more successful dealing with their individual emotions and stresses, developing their social awareness and its impact on others. They are making responsible decisions for their future and building relationship skills. We are seeing students give back, feel seen, fostering their own sense of belonging, and working academically at all time high levels.

America’s public schools and our beautifully unique communities can’t respond to the mental health needs in isolation. In Tacoma, we work in partnership and that is not easy, there are egos, turf battles and frustrations. However, we recognize that we are better together, that we may not be united on everything, but our future is with us now and we must be united in our commitment to serving youth first. Personally, and professionally, I am grateful for your willingness to do more and

better. I know that out of the 27,141 Washington students who reported the made a plan to commit suicide, 751 of those students are in our city. I challenge us all to know how many youth are in crisis in our own communities.

Thank you!

References:

Data Dashboard—Healthy Youth Survey (askhys.net)

Report Card—Washington State Report Card (ospi.k12.wa.us)

[SUMMARY STATEMENT OF JOSHUA GARCIA]

Tacoma is an urban port city that is diverse, with more than 28,000 students representing over 170 tribes and ethnicities. Over 2,000 of our students qualify as homeless, over 55 percent qualify as low income, and over 15 percent receive special education services. In the 2011–2012 school year, each of our high schools was labeled as drop out factory by *U.S. News and World Report*. We were in a dire state, and we needed a new approach. We started the Tacoma Whole Child Initiative, an intentional action plan that recognizes that students are learning 24 hours a day, 7 days a week. Fast Forward to 2022, 90 percent of our students graduate in 4 years and 87 percent of high school students take college level classes. But we know that the challenges our students are facing are only growing. Our kids are in pain and we need a united response. Everyday our students face the challenges that are ripping our great nation apart. In the last year, 10 of our students have been shot, our students have had to attempt to survive human trafficking, battle homelessness, drug, physical, and mental abuse, and social media harassment and bullying. In 2021, 72 percent of our 10th graders reported feeling anxious, nervous or on edge regularly and 60 percent reported not being able to stop worrying. 17 percent of our 10th graders made a suicide plan in the last year. This translates into 13,239 students in our State making a plan to commit suicide.

Our sustainable practices related to supporting whole child to improve student outcomes are focused on three elements: prevention strategies, response strategies, and therapeutic supports. In Tacoma each of our schools has developed their own social emotional learning plan and publishes it annually to ensure feedback from families and community stakeholders. Our system of positive behavioral supports ensures students understand—school wide expectations to foster stability, encourage positive expectations and outcomes and reinforce healthy mental health habits. We also provide a safe place for students to build belonging during the evening with 12 summer sites where teens can belong, break bread, and have equitable access to safe environments. We have invested in professional development focused on trauma sensitive and restorative practices that bring voice with the intention of healing and understanding.

Expanding on the lessons we have learned and successes we have had in Tacoma to date, I would encourage Congress to (1) continue to expand on your work with Bipartisan Safer Communities Act. In particular, the School-Based Mental Health Services Grant and the Mental Health Service Professional Demonstration grants; (2) ensure every district can bill Medicaid for the healthcare services delivered; (3) incentivize the Health Care Industry to have formalized partnership with public schools to serve youth; (4) increase funding for Title IV of ESEA; and (5) Provide flexibility through the Carl Perkins Grant and Department of Labor Grants to support paid youth job experiences and required financial literacy.

We know that through engagement, tiered supports, and shared strategies, our students are being more successful dealing with their individual emotions and stresses, developing their social awareness and its impact on others. They are making responsible decisions for their future and building relationship skills. We are seeing students give back, feel seen, fostering their own sense of belonging, and working academically at all time high levels. America's public schools and our beautifully unique communities can't respond to the mental health needs in isolation. In Tacoma, we work in partnership and that is not easy. However, we recognize that we are better together, that we may not be united on everything, but our future is with us now and we must be united in our commitment to serving youth first.

The CHAIR. Thank you very much. Let me begin the questioning. Mrs. Russell-Tucker, you mentioned the importance of afterschool and summer programs.

I think one of the things we all agree on is that we are going to have to do a lot of treatment, but on the other hand, we are going to have to give young people a lot of positive community based activity.

Can you talk a little bit about the impact that increased funding for summer and afterschool programs has had in Connecticut?

Ms. RUSSELL-TUCKER. Thank you, Senator. Really important for—I appreciate that question, because it is such an important piece of the work that we have been doing. Under ARP ESSER fund, or ESSER funding, that we received $11 million for some enrichment, and we immediately put that to work. And our state stepped up and added more funding for the subsequent summers.

We are now up to $33 million of state investment around summer enrichment. We are able, in that space—the first summer was to really try to get students back together, back with their peers, back in that environment, allowing them to work with sometimes behavioral—behavior therapists in that space while they are having a really good time with each other, right.

It is enrichment, which is so important. And so, we have been able now, we have also evaluated the impact of that reimbursement. As I mentioned in my testimony of our 108,000 students we served that first summer, we are now into summer No. 3, and we are evaluating it rigorously to make sure we know what is happening and so that we can——

The CHAIR. Let me guess that you would like Congress to continue that kind of funding. Is that a good guess?

Ms. RUSSELL-TUCKER. [continuing]. Exactly. Fund what works, right. That is one way of thinking about sustainability. Same is true for our after school program that we also we see funding to support.

The CHAIR. We significantly expanded those programs in the American Rescue Plan.

Ms. RUSSELL-TUCKER. Yes, absolutely. And so, it is important that we are funding what works, and that is why I am so proud that we are evaluating the impact of those investments.

The CHAIR. Okay. Dr. Garcia, I want you to pick up on that. Again, we want to treat the millions of young people who are struggling, but we also want to challenge them. We want to bring them together.

We want to have proactive activities. It sounds to me like in Tacoma, you are challenging young people. You are trying to provide job opportunities, among other things. Talk about the importance of treating young people with respect and allowing them to use their energies in productive ways.

Dr. GARCIA. Thank you, Senator. I think it is important that each community has the opportunity to define what respect, responsible, and safe looks like, and that is what our social emotional learning plans do. They bring voice, student voice to that conversation. They bring staff voice to that conversation. And they bring family voice. Each of our plans is published, so——

The CHAIR. Young people are involved in the development of those plans?

Dr. GARCIA. Absolutely. Absolutely. And they define what it looks like in each location, right. Respect looks a little differently in a classroom than it does in a lunchroom, right. There are different settings. It looks different than in your neighborhood.

We have to build community through a common language, and that is important. We bring respect, and how does that look in the afterschool world? How do we hear their voice and what are the activities that they want to participate in?

It is very much an intentional effort to bring community together to define that, but those common words are across all the town.

The CHAIR. I am gathering that the empowerment of young people, giving them a voice in the community, has a positive impact on mental health, among other things.

Dr. GARCIA. We bring voices in several ways, and we also hear from students. Students have asked me, they have said, Josh, stop asking us our opinions and bringing others to ask our opinions if the adults aren't going to do anything.

That is a really important message. So, we bring voice through empathy interviews. We bring data around positive interactions. We have student voice at our board meetings. We—students will vote with their feet, if you will.

The increased activities in extracurricular activities, not what the adults want to offer, but what do they want to participate in. They have also told us they don't want to be engaged in the business model. They want to know the activity of that. We survey their interest regularly.

The CHAIR. Okay. Let me ask Dr. Osofsky a question. You use the term indefinite uncertainty. What impact you walk through the streets of Washington this morning, you breathe the air, which is a result of terrible fires in Canada. Young people worry about climate change.

We have heard discussions, Senator Kaine mentioned, on school, gun violence in the school. Kids worry about gun violence. Families all over the country are struggling economically. Louisiana, Vermont.

What impact does all of that and more have in indefinite uncertainty about worrying what the future is going to look for these young people, whether there will be a decent future, from an environmental point of view, from an economic point of view, from a violence free point of view? What impact is that having on the lives of young people?

Dr. OSOFSKY. I really appreciate you are asking that question because this is something that I struggle with and a lot of us struggle with, us in the mental health world. What children need, of all ages growing up, is they need to have schedules. They need to have routines. They need to know what is expected.

For example, having a schedule of knowing they get up in the morning and they go to school, and who is going to pick them up at school, or where they are going to go and what their activity might be. And what happened, unfortunately, with the COVID pandemic is that changed continually.

One of the things that we recommended is set a new schedule, have the children involved with setting the schedule so there is something predictable for them. But it went on for a very long time in that way. We also tried to support the parents, too, because parents were having—didn't have a schedule either.

Instead of getting up, and if they went to work, going to work and doing whatever, they were having to balance that with educating their children virtually, if they were fortunate to have the internet and the equipment that is needed to do that. And every day that changed as well for them.

The other thing that is very important for the young people is their peers at every age. For the younger children, being able to play with them and get to know them. For the older children, we know that it gets more complicated in adolescence and that kind of thing, which as I mentioned, contributes to some of the extensive use of social media.

It is very, very important now that schools are open again for there to be that kind of schedule and things that parents can count on and children can count on to be able to move forward. I also wanted to make a comment on the involvement of youth.

We found that to be extremely helpful after there was so much destruction with Hurricane Katrina, that there were a lot of teenagers who were on the streets because there was nothing there for them to do with themselves. They couldn't—there were no activities. So, we involved them with recovery.

The teachers, who also didn't have classrooms and schools, they involved with recovery, so that the teenagers, instead of being in trouble, were able to contribute in positive ways.

The CHAIR. Thank you very much. My time is long expired. Senator Braun, or Senator Cassidy? Senator Cassidy.

Senator CASSIDY. Dr. Osofsky, in some schools, they are limiting information sharing between parents and teachers, effectively cutting parents out of their child's life. What does your research say about the role of parents when students are going through traumatic experiences?

Dr. OSOFSKY. That is such an important issue that you bring up, Senator Cassidy, because we know the important role that parents play for children, to be there, for them to listen, to advise them, and to be very much a part of their life.

One of the studies that was done during COVID by Sesame Workshop sent out information to families, different backgrounds, racial groups, and asked them to have their children talk about what is important to them during COVID and what is going to help them. And the No. 1 issue was their parents.

Their parents were the hero. The parent was going to keep them safe, and that was so important to them. And also, from a mental health point of view, if parents are available, can be emotionally available, like say to not just be there and listen to the children, and be involved with their activities, that is going to be very important.

They will know when things are happening sometimes before the school will know, but obviously that collaboration is very impor-

tant. But parents play a key role in mental health, in supporting the mental health of their children.

Senator CASSIDY. In the bipartisan Safer Communities Act, there are significant dollars put forward for tele-mental health. Does that work equally well for adolescents? Is there a role for that to be used in school health settings?

Dr. OSOFSKY. We found tele-mental health to be very helpful and it does work well generally for adolescents. They kind of like that. They are more used to being on the screen than others are, and it is a way to stay in contact.

We are very pleased that they allowed a lot of mental health work to be done using telehealth during the pandemic because it was a way that we were able to stay in touch and help people. For younger children, it can be a little bit challenging.

They may want to go press a button or something like that, but we found it to be very successful in working with teenagers related to telehealth, and I hope that opportunity will continue as a way to reach them.

Senator CASSIDY. I keep asking questions I don't know the answer to, but hearing you speak today, it suddenly occurred to me that the people that decided to lock down our economy, who had the noble goal of limiting death but of course ended up increasing isolation, did they actually have children, psychiatrists, psychologists involved in their deliberations to do a cost benefit ratio, if you will, a risk benefit ratio of if we lock down, we are going to have X amount happen because of isolation, as much as that was foreseeable? Do you know that process? I don't, I am asking.

Dr. OSOFSKY. Yes. I don't know for sure about that process either. Certainly, we were communicating, a number of us, and talking about it. And I recall almost every time I did an interview, I specifically recall an interview with an NPR reporter who had two children at home, and he took 15 minutes before he did the interview to talk to me about how can I support my children under the circumstance.

They can't see their grandparents. The holiday was coming. It was a very important part of their lives. So, the tele—telecommunication was really helpful. But I am not sure, Senator Cassidy, whether they did consult——

Senator CASSIDY. But what I am hearing from you is actually, it wasn't an imponderable. It was actually predictable that when the children were isolated, that they would have some of the problems that we now see. Is that a fair statement?

Dr. OSOFSKY. I think it is. I think in families, it is very clear in families where they have more resources, for example, where they could work remotely, where they could get help, where they could set up separate learning areas for a few kids. Where they consist in kids that wouldn't have to be afraid of COVID.

I know many families with resources who were able to do that. But for families with fewer resources, it was going to set up an ongoing problem, including learning over time and catching up where many of these children had problems to begin with.

Senator CASSIDY. Last, when I FaceTime with my 8 year old grandson, almost nine, he has got like 3 minutes for me, then he's gone. I say that because you mentioning that tele-mental health actually works.

But as the younger child, they want to hit a button. At what point does it begin to work? Because we will be asked to support these programs in schools of various ages. At what point does it begin to work, and at what point—or is it just a little boy who has got ADD? Like a squirrel, squirrel, squirrel.

Dr. OSOFSKY. Yes, I think certainly with what we call latency in children. Children about 8 years old and older, as we found with the earlier—that they were able to pay attention better when we did something——

Senator CASSIDY. Boys, girls difference or the same?

Dr. OSOFSKY. Sorry—?

Senator CASSIDY. Boy and girl——

Dr. OSOFSKY. Oh, I didn't—we didn't see differences between boys and girls, but we found the earlier work, at that age and older, seemed to be going pretty well. But on the other hand, we provided mental health services for younger children, but again, that was in person. I think it is the really little ones.

As you know, we work with very young children like under the age of five that may have more difficulty with that. But again, if the parent is with them and working with them, and it is really a combination. It is not just the mental health person dealing with a three or 4 year old, it is working with the parent together.

A dyadic work, and then the parent learns how to support the child. We are finding now in mental health in general, even in person, but certainly virtual, that involving parents, even with teenagers, with older children, is very important as a way to support them.

Senator CASSIDY. Thank you.

The CHAIR. Thank you.

Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman, before I begin my questions, I want to address and make a comment about the health of trans youth, reiterating some of what Senator Baldwin mentioned earlier.

In the past 6 months, state legislators have passed 75 bills discriminating against LGBTQ Americans and blocking access to gender affirming care. Drag shows have been attacked, hospitals providing gender affirming care are receiving bomb threats, and local clinics are installing security systems.

Human Rights Campaign declared a national state of emergency for LGBTQ Americans, and the discriminatory actions and statements by elected officials at every level of Government are fueling the fire and making the youth mental health crisis worse. Passing bills into law is a tough process.

What is easy is giving people the freedom to be themselves. What is easy is not using hate fueled rhetoric on trans kids to score cheap political points. And we need to do this, especially during

pride week, to identify this as a huge problem in our Country. So, I want to turn to other issues that obviously the Surgeon General was addressing. But you are on the front lines. 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—one in five LGBTQ youth attempted suicide last year. So, this is a real crisis, and we know that it is totally exacerbated by big tech and the role that they are playing in the lives of these children in our Country, because it is just unregulated in terms of what it can do to teenagers in our society. No protections, no safeguards.

They collect an avalanche of personal information, and they use it up to send back an endless stream of toxic content into the minds of young people in our society. And the results are clear. More money for big tech, more pain for kids and teenagers in our Country. And we know that it is Instagram. We know that it is—we know that it is Facebook. We know that it is TikTok.

We have to take action to pass a comprehensive law. We know that it is Disney. We know that it is Paramount. They are collecting information and sending it right back in a form that advances the financial interests of these companies. So, my question to you is, Ranking Member Cassidy and I have introduced a piece of legislation that would create an online privacy bill of rights for teenagers in America.

There is a law on the books right now for 12 and under, but there is no law for a 13 year old girl with bulimia or anorexia from being targeted by these companies with information that actually worsen the situation. So here is what the legislation would do. Just would love to get your comments on it.

One, the bill would ban targeted ads to children and teens. Two, it would establish a youth marketing and privacy division at the Federal Trade Commission. And three, it would limit the collection of children and teens' personal information.

It would actually say to parents, you have a right to say to the companies, erase this stuff that you have gathered about my child. Do you think that is necessary? Would you support legislation to accomplish that goal, so that the parents and the kids have protections against big tech?

Ms. RUSSELL-TUCKER. Well, thank you, Senator, for the background and information that you have just shared. And it is so important, I think, critically, recognizing the impacts of all of this on our youth, that we are really paying close attention.

I really believe hearing the voices, so having youth voices as a part of what is proposed, which is what we try to do in Connecticut. Hear from all the voices, including our families. Inform ultimately the impact, right, of the proposal being made. And so, we will really be looking at that very closely to get a sense of all that is being proposed, but anything that we can do——

Senator MARKEY. But in general, do you believe that teens and children need an online privacy bill of rights?

Ms. RUSSELL-TUCKER. No, I believe that.

Senator MARKEY. Thank you. Yes, sir.

Dr. GARCIA. Thank you, Senator. Yes, I do. I also was struck by the comments earlier this morning, and I don't know if we are using the tools to our advantage. The data would tell us that when kids are talking about suicide, that we could inform them right there online and require companies to give them suicide information. If they are struggling with food, we could require those companies to push that information to them as well to curb that support as well.

Senator MARKEY. What about upfront just putting the preventative action in place?

Dr. GARCIA. Yes, Senator.

Senator MARKEY. That way the kids and the parents have a bill of rights so that the kid isn't targeted, that exacerbates the situation, so that they do become excessively depressed and contemplate suicide. Do we need those protections put in place?

Dr. GARCIA. I have three teenagers and I would say yes, please.

Senator MARKEY. Okay, yes. And doctor?

Dr. OSOFSKY. Yes, I would agree with my with two other panelists here. One of the things I was thinking about, but it doesn't in any way negate what I just said that I agree with that. We also know that for many of these youth, that is how they make relationships, too. And so, if there was a way that we would be able to help support them in some way, at the same time that we are protecting them, I think it would be very important.

Senator MARKEY. Yes, I would say that we are in a crisis. We hear it today, we know that big tech plays a big role in creating this amongst kids. So, we are urgently in need of passing comprehensive legislation in my opinion.

AI that we are discussing right now is just algorithms on steroids. But we already have algorithms on steroids by big companies who target children in our Country. We have to put the protections in place.

If we can't do that, we are never going to be able to deal with the consequences for AI on steroids. If we can't protect children, we are not going to be able to protect our society. Thank you, Mr. Chairman.

The CHAIR. Thank you.

Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. Senator Kaine asked Dr. Osofsky about parents' role. I am going to turn to Mrs. Russell Tucker. I served on a school board many years ago, didn't have the issues I think that we now contend with. It is a lot different now than then. Parents were always the primary stakeholder on almost any issue.

Generally, it ended up being a disciplinary one, not what we deal with currently. In your testimony, you list in terms of on the mental health issue, the stakeholders, the Office of the Governor, and the State Board of Education, state agencies, educators, administrators, families, students, advocates, policymakers, local health officials, and more.

I tried to tease out of Secretary Cardona on who the main stakeholders should be in our own kids' education and could not get parents out of his mouth the first time. After the Virginia election and it was made an issue there, he did begrudgingly say that parents should be a stakeholder, not the primary.

When we are talking about mental health, there is a list of a lot of, and I believe sometimes that village doesn't need to be consulted, but I would think that in any of these issues, the parents ought to be the primary and everything else ancillary.

By the way, you stated that. Would you agree with parents being the primary, all these other ancillary, or do you have a different way of saying what you are meaning what you said there?

Ms. RUSSELL-TUCKER. Thank you, Senator. And I have long, if you saw from my testimony, as you mentioned, recognized the value and importance of parent voice in everything that we do in education. It is really important that they are at the table.

They are a stakeholder. And the family engagement roundtable that I mentioned is doing just that. As a matter of fact, they have worked together through their voices to define what family engagement means in Connecticut.

They truly are very important. And every time we have a chance to do any program, any policy, that their voices are actually are there at the table so we can understand, hear from them, and hear their perspectives. Because it really—so they are key stakeholders——

Senator BRAUN. Are they consulted first in any navigation through a mental health issue in terms of getting with them first, are they just part of the group?

Ms. RUSSELL-TUCKER. They are very much important about the health of their children. And so, I know for a lot of the initiatives that we have in the state, they are consulted and provide consent for services that is being provided. And so, in that case of health, I think it is very important that they are very much key and there to make decisions, to help to make decisions around their children.

Senator BRAUN. Thank you. And Dr. Garcia, briefly on that topic.

Dr. GARCIA. Yes. They are very much a part of the process. At certain ages in Washington State, students can access services without family consent.

Senator BRAUN. Would you say they are the primary, not just part of it?

Dr. GARCIA. I don't think it is a simple answer because I have experiences as families are in different spots. And so there is a recognition that I have, is that some families are not in a place where they are able to be at the table for work, social issues, a variety of things. And so, as a school system, it is not a luxury of one——

Senator BRAUN. But whenever possible and able to, you would probably consider them the primary.

Dr. GARCIA. We engage them. Yes.

Senator BRAUN. Another question, over the years, we have spent billions on the issue, and I would like each panelist, we have got about a minute and a half left here, do you think we have imple-

mented what we have already put in the law and the money that we have devoted to it properly?

Do you think that has been done in a way that would justify more? Do we need to do better at that? And where does the state fit in terms of maybe being able to do that better? We will start with Mrs. Russell Tucker. Give it about 30, 40 seconds, and move on down the panel.

Ms. RUSSELL-TUCKER. Really important that we are continually evaluating so we know what works. We implement, but we must know the results and the impact. And so, at the state level, we have done that. You can see that in my testimony in making sure that we are indeed doing that. So, we can tell you what works, so we can actually talk about sustainability.

Senator BRAUN. Yes or no, have the Federal programs and everything we have sent your way, do you think we have implemented that as good as it needs to be?

Ms. RUSSELL-TUCKER. I think there is always room for improvement.

Senator BRAUN. Thank you. And Dr. Garcia.

Dr. GARCIA. In my testimony, I ask that you work with states to require them to match your investments. My rural colleagues—let me know that categorical funding, direct streams are important, and competing for grants are oftentimes problematic alone. And so, I would encourage us to think about how we can do direct spend through categorical investments to build on sustainability.

Dr. OSOFSKY. Yes, I believe very strongly that the investment, at least one program that I am involved with, and that is the National Child Traumatic Stress Network, has been extremely helpful because we focus on trauma.

We have been talking about trauma. How to help children. And there has also been creative ways to spread what we have learned and also address the issues that we are concerned about with children. So that money has been very well spent.

Senator BRAUN. Thank you.

The CHAIR. Thank you, Senator Braun. That concludes our hearing today. And I want to thank all three of our witnesses for their excellent presentations. For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, June 23rd at 5.00 p.m.

Finally, I ask unanimous consent to enter into the record five statements from stakeholders outlining their youth mental health priorities, and that will take place.

[The following information can be found on page 80 in Additional Material:]

The CHAIR. The Committee stands adjourned. Thanks.

ADDITIONAL MATERIAL

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION,
AOTA.ORG.
June 8, 2023,

Hon. BERNIE SANDERS, *Chairman*,
Hon. BILL CASSIDY, *Ranking Member*,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC.

RE: Why Are So Many American Youth in a Mental Health Crisis? Exploring Causes and Solutions

DEAR CHAIRMAN SANDERS and RANKING MEMBER CASSIDY:

The American Occupational Therapy Association (AOTA) greatly appreciates the Senate Health, Education, Labor, and Pensions Committee's hearing on the youth mental health crisis. We are pleased to provide testimony and resources in support of this hearing.

Background

AOTA is the national professional association representing the interests of more than 244,500 occupational therapists, occupational therapy assistants, and students of occupational therapy across the Nation. The practice of occupational therapy is science-driven, evidence-based, and enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability.

Occupational therapy (OT) is a vital component of a complete mental health team to address the youth mental health crisis. Roughly one third of the profession are already working with children in a range of settings, such as schools, pediatric outpatient clinics, and hospitals. OT practitioners focus on an individual's ability to engage in day-to-day activities to maximize independence, function, and performance. They are trained to identify how factors such as the environment, cognition, and sensory processing support or hinder recovery and participation.

A History and Scope in Mental Health

The profession was founded in public psychiatric hospitals over a century ago, based on the observation that a person's ability to engage in their desired roles, routines, and activities, could dramatically affect their mental health and overall wellbeing. Today, occupational therapy practitioners still focus on an individual's ability to engage in day-to-day activities.

For decades, OT was a core part of the interdisciplinary mental health services. With the call for deinstitutionalization of individuals with mental illness, which culminated in the 1963 Community Mental Health Act, occupational therapists and occupational therapy assistants began working in community mental health. However, the role of occupational therapy in working with those with behavioral health disorders has declined, despite OT's focus on the promotion of functional skills and independence.

One of the barriers to providing the services they are trained to provide, is a lack of clear and complete understanding of the profession and what they are allowed to provide by law. This barrier has created the misconception OT mental health services aren't eligible for reimbursement. However, statute in all 50 states and the District of Columbia, the explicitly allows OT practitioners to provide interventions and procedures for the development, remediation, or compensation of cognitive, psychosocial, or psychological deficits.

Occupational therapists have been included in imperative legislation to combat workforce shortages in mental and behavioral health, addressing chronic pain, and expansion of community mental health services. The Federal Government recognizes occupational therapy as a valued part of the behavioral health workforce. Occupational therapy services provided to a beneficiary with a mental health diagnosis have long been reimbursable under Medicare.

Occupational therapy is included under the staffing suggestions for Certified Community Behavioral Health Centers, a Medicaid demonstration program. In 2016 occupational therapy education programs were made eligible to receive Behavioral Health Workforce Educations Training Grants, and since 2018, the Health Re-

sources Service Administration (HRSA) has included occupational therapy among the professions making up the behavioral health workforce.

School and Community-Based Settings

AOTA believes the schools are the most effective setting to provide basic and universal mental health support. Children spend a vast majority of their time outside of the home in schools, where they have access to a range of specialized instructional support personnel (SISP) who work in mental health, such as occupational therapists, psychologists, social workers, and counselors.

Academic success is critical, but schools must be equipped to address children's social, emotional, and behavioral needs in order to make it possible for them to learn in the classroom. These needs and their educational progress cannot be minimized or separated. This emphasized by research that demonstrates the relationship between improved mental health and improved outcomes for students. Occupational therapy uses activity or occupation-based interventions to enable students to achieve their potential by increasing their functional skills for better participation in school and later in adult life, as well as to minimize the effects of disabilities.

As part of a larger treatment plan, occupational therapy practitioners help persons with schizophrenia, bipolar disorder, and major clinical depression, regain, build, or maintain skills that are essential to independent functioning, health, and well-being. In particular, occupational therapy practitioners are able to assist individuals with the cognitive impairments commonly associated with serious mental disorders that impact independent function, and compromise speech, memory, attention, and executive decision-making of all kinds.

Indiana: The National Model

The State of Indiana should be the national model for coverage of mental health OT services. In September 2021, the Indiana Health Coverage Programs (IHCP) issued a *bulletin* clarifying coverage of occupational therapy services for eligible IHCP persons. The IHCP supported including occupational therapists on a substance use disorder (SUD) or behavioral health treatment team when the occupational therapists provide services within their scope of state licensure.

In addition, the IHCP guidance specifies that when occupational therapy is delivered to patients with mental illnesses or addiction treatment disorders, the scope of occupational therapy includes "services that are provided to promote health and wellness, prevent disability, preserve functional capabilities, prevent barriers for occupational performance from occurring, and enable or improve performance in everyday activities." The agency noted that the scope of occupational therapy practice allows for the provision of psychosocial interventions, and the IHCP supported including occupational therapy in the treatment plan of members receiving mental health care and addiction treatment services.

Conclusion

As is well known, there is a documented shortage of mental health professionals in America with at least 152 million Americans living in a mental health professional shortage area. While occupational therapy practitioners continue to provide services in multiple mental and behavioral health settings, such as acute care hospitals and Certified Community Behavioral Health Centers, they remain an underutilized part of this workforce. The profession is already well positioned to support efforts to address the youth mental health crisis. In early 2023, two occupational therapy programs received funding to strengthen the mental health workforce pipeline from the Department of Education's Mental Health Service Professional Grant Program.

AOTA strongly urges the Committee to build on past successes broadening OT's visibility with regards to mental health services and prioritize methods to promote the inclusion of occupational therapy in future policy discussions.

Thank you for the opportunity to provide these comments. AOTA stands ready to provide any additional information you need and to collaborate on any efforts in this area. Please contact Abe Saffer if you have questions or need additional information.

Sincerely,

ABE SAFFER,
MPM American Occupational Therapy Association.

PREPARED STATEMENT OF THE CHILD AND ADOLESCENT MENTAL HEALTH COALITION

On behalf of our organizations, which are leading members of the Child and Adolescent Mental Health Coalition (CAMH),[1] we commend the Senate Health, Education, Labor, and Pensions Committee for holding a hearing on youth mental health. We thank you for your bipartisan commitment to addressing the youth mental health crisis and look forward to working with you to ensure that Congress crafts legislation that addresses the full continuum of child and adolescent mental health needs.

In October 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a *national emergency* in child and adolescent mental health. Since then, important work has been done to address the mental and behavioral health needs of the Nation's youth, but it is not enough. Suicide is the second leading cause of death for youth ages 10–18 in the United States.[2] In 2021, 42 percent of high school students reported feeling persistently sad or hopeless, and 29 percent reported experiencing poor mental health.[3] Additionally, 20.1 percent of youth ages 12–17 had a major depressive episode in the past year, compared to only 15.7 percent of youth in 2019.[4] We urge Congress to make new dedicated investments that are designed to support a full range pediatric mental and behavioral health services and to grow the pediatric mental health workforce to deliver this essential care, across settings.

The experiences and needs of children and adolescents are different from those of adults, and the system and funding must be designed to address their needs across the continuum of mental health care services, from promotion and prevention to early identification, intervention and treatment, to care for children and youth in crisis. To support this continuum of care, new dedicated investments in pediatric health care services and infrastructure are vital, including to grow the pediatric behavioral health workforce. It is clear that current Federal programs and investments are not sufficient, as currently structured and funded, to alleviate the national emergency in children's mental health and to ensure that children's mental health needs are prioritized, identified, and addressed with timely, high-quality care.

By some estimates, as many as 19 percent of children have mental health symptoms that impair their functioning without meeting criteria for a disorder. Programs and funding that are limited to children with serious emotional disturbance (SED) miss a key opportunity to support early prevention and early intervention. Our organizations were pleased to see a prevention set-aside within the Community Mental Health Services Block Grant for early identification and early intervention in the *Mental Health Reform Authorization Act of 2022*. A similar provision to allow Community Mental Health Services Block Grant funds to be used for prevention and early intervention passed the House in H.R. 7666, Restoring Hope for Mental Health and Well-Being Act of 2022. We were disappointed that these provisions which would enable the Community Mental Health Services Block Grant to better meet children's needs did not become law last Congress. Children urgently need access to prevention and early intervention services to improve outcomes and prevent worsening conditions.

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[1] CAMH is a coalition of organizations dedicated to promoting the mental health and well-being of infants, children, adolescents, and young adults. Our organizations reflect a diversity of viewpoints and expertise, ranging from clinical providers to school-based services to suicide prevention organizations and others. As a coalition, we seek to advance a robust mental health safety net, inclusive of programs, supportive payment models, and infrastructure, that provide the full continuum of mental health care, in a manner that facilitates easy and prompt access to services. Our coalition has prepared a set of core principles, *available here*. Our full coalition consists of over 30 organizations; entities specifically endorsing this statement are specified at the conclusion of this statement.

[2] National Vital Statistics System. Leading Causes of Death, United States. Centers for Disease Control and Prevention; 2020 *https://wisqars.cdc.gov/data/lcd/home*.

[3] Youth Risk Behavior Survey Data Summary & Trends Report, 2011–2021. Centers for Disease Control and Prevention; 2023. *https://www.cdc.gov/healthyyouth/data/yrbs/yrbs-data-summary-and-trends.htm*.

[4] Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. US Department of Health and Human Services; 2020. *https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report*; Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. US Department of Health and Human Services; 2023. *https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report*.

The Community Mental Health Services Block Grant is SAMHSA's primary investment in community mental health services, yet children's mental health needs continue to be insufficiently met by this program. A set aside for prevention and early intervention would allow states to fund programs that provide help upstream to people who have not been diagnosed with SED or Serious Mental Illness (SMI). Research shows that early intervention and prevention activities can mitigate, or in some cases, prevent the incidence of mental health conditions. With a prevention and early intervention set-aside in place, the block grant would allow flexibility for states to determine what prevention and early intervention programs are needed in their communities and fund those initiatives. This can include mental health literacy programs, outreach programs, and integrated services in primary care and school settings that reach underserved communities.

We strongly support a 5 percent set aside for the Community Mental Health Services Block Grant targeted for prevention and early intervention to begin addressing these needs not currently met with these funds. We encourage a greater emphasis on addressing the mental health needs of children, including young children and children who do not have a diagnosis or who have a mental health condition that is not considered an SED. Congress must make targeted investments in expanding the availability of a full spectrum of mental health care for children and the critical infrastructure to support these services. While this set aside is a good first step, it is unlikely to be enough to facilitate the expansion needed to meet children's mental health needs across settings and across the continuum of mental health service levels.

CAMH has identified nine priority areas and offers the following policy solutions that, if enacted, will help to increase access to quality pediatric mental health care. For more information, please see the *CAMH Principles*:

Prevention, Early Identification, and Early Intervention

- Roughly half of lifetime cases of mental illness begin by age 14 and almost three-quarters begin by age 24. [5]
- Congress should ensure new and existing Federal investments in mental health are tailored to include prevention and early intervention services.

School-Based Mental Health

- School-based mental health services help ensure children receive screenings and care.
- Congress should increase resources and financing mechanisms available to schools for mental health services.

Integration of Mental and Behavioral Health into Pediatric Primary Care

- Primary care is where most families access care and where identification, initial assessment, and care of mental health conditions in children often occur.
- Congress should support models of co-location or integration of mental health providers in all pediatric primary care settings.

Child and Adolescent Mental and Behavioral Health Workforce

- There is a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults.
- A nationwide cross-sector strategy to expand the supply, diversity, and distribution of the behavioral health workforce, along with appropriate payment for pediatric mental health services, must be developed and implemented.

Insurance Coverage and Payment

- Even when covered by Medicaid, CHIP, or private insurance, children's access to timely, quality mental health care is often limited by high costs.
- Barriers to care like carve-outs, same day billing restrictions, inadequate payment rates for mental and behavioral health services, and lack of payment for emerging conditions that do not yet have a diagnosis should be addressed.

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[5] Kessler RC, Berglund P, Demler O et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry; 2005; 62(6):593–602. Doi:10.1001/archpsyc.62.6.593.

Mental Health Parity

- There is a persistent need to improve oversight and compliance with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).
- Congress should expand MHPAEA to children in Medicaid fee-for-service arrangements and ensure meaningful compliance and enforcement.

Telehealth

- Telehealth utilization has surged in the past few years, offering an efficient way to support youth in rural, underserved, and low-income communities who continue to face the most barriers to care.
- Congress should ensure that telehealth continues to be a part of a comprehensive set of care options available to children with mental and behavioral health needs.

Infants, Children, and Adolescents in Crisis

- Providers are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm.
  - Congress should designate funding specifically intended to target youth crisis care needs, including consistent and sufficient funding for 988 and to support access to step-down programs.

Justice-Involved Youth

- The prevalence of mental health disorders among justice-involved youth ranges from 50 percent–75 percent.
- Congress should invest in incarceration diversion programs, including specialized mental health and substance use programs.

We thank the Senate Health, Education, Labor, and Pensions Committee for your continued attention to child and adolescent mental health and the critical roles of child serving professionals within both education and health care. More action is needed now to end the national emergency in child and adolescent mental health and ensure children and families can access the mental health services and support they need.

American Academy of Pediatrics. American Academy of Child and Adolesecent Psichiatry. American Foundation for Suicide Prevention. Children's Hospital Association.

NATIONAL EDUCATION ASSOCIATION,
WASHINGTON, DC,
June 7, 2023.

U.S. Senate,
Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR:

On behalf of our 3 million members and the 50 million students they serve, we would like to submit the following comments for the record of tomorrow's hearing, "Why Are So Many American Youth in a Mental Health Crisis? Exploring Causes and Solutions." This is a vital topic as students and families emerge from the COVID–19 pandemic. We embrace public dialog on mental healthcare for our Nation's students.

Our youth are in crisis. According to the Centers for Disease Control and Prevention (CDC), more than a third (37 percent) of high school students reported experiencing poor mental health during the pandemic, and 44 percent reported feeling persistently sad or hopeless during the past year. In addition, more than 1 in 5 students (22 percent) seriously considered attempting suicide and 1 in 10 (10 percent) attempted suicide. Suicide attempts occurred more often among Black students than students from other groups, and increased among Black and White students from 2011 to 2021.

We are pleased that Congress responded to this crisis through the Bipartisan Safer Communities Act, creating and funding two programs that begin to address these needs. We urge continued support for the:

- **Mental Health Service Professional Demonstration Grant Program** that provides competitive grants to support a strong pipeline into the mental health profession, including innovative partnerships to prepare qualified school-based mental health service providers for employment in schools.
- **School-Based Mental Health (SBMH) Services Grant Program** that provides competitive grants to states and school districts to increase the number of qualified mental health service providers delivering school-based mental health services to students in local educational agencies with demonstrated need.

In addition, we urge continued support for the **Full-Service Community Schools Program** that meets the unique needs of the locations they serve by engaging with parents, students, and the community. Through this grant program, student and family needs are assessed, and programs developed and opportunities created in partnership with students, families, and community members to meet those needs. A critical aspect of these opportunities is the ability to help youth and their families access mental health services and supports.

We know that the programs cited above are not the only programs to address the mental health and overall health of students, and that we must continue to partner to address the crisis facing young people today. NEA and its members stand ready to work with you to do so.

We thank you for holding this hearing and giving us the opportunity to submit these comments.

Sincerely,

MARC EGAN,
Director of Government Relations.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF CHILD AND ADOLESCENT PSYCHIATRY

On behalf of the American Association of Child and Adolescent Psychiatry (AACAP), we thank the Committee for hosting this hearing and for the opportunity to submit testimony on why so many American youth are in a mental health crisis and to offer AACAP's recommendations on causes we should consider and solutions that can make a difference.

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 continue to respond to it. Our members work in every child-facing system of care: in urban and rural communities and from hospitals to schools.

AACAP, along with the American Academy of Pediatrics and the Children's Hospital Association, have declared a national state of emergency in children's mental health. [1] While there are many factors that contribute to poor access to pediatric behavioral health care, we emphasize the impact the insufficient behavioral health workforce has had and continues to have on access to care and note the importance of ensuring equity, diversity, and inclusion. Along these lines, we recommend policy solutions toward addressing this crisis.

Background

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 and 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.

Rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018, suicide was the second leading cause of death for youth ages 10–24. The pandemic intensified this crisis: across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies, including suspected suicide attempts.

The pandemic struck at the safety and stability of families. According to the National Institutes of Health, more than 140,000 children in the United States lost a primary and/or secondary caregiver, with youth of color disproportionately impacted.

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

Child and adolescent psychiatrists are caring for young people with soaring rates of depression, anxiety, trauma, loneliness, and suicidality. We must identify strategies to meet these challenges through state, local and national approaches to improve access to care. We must work as a community to address mental health awareness, prevention, and treatment.

The Declaration of a National State of Emergency in Children's Mental Health outlined the following shared recommendations for how we address the crisis we face (in no order of priority):

- Increase Federal funding dedicated to ensuring all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment to appropriately address their mental health needs, with particular emphasis on meeting the needs of under-resourced populations.
- Address regulatory challenges to improve access to technology to assure continued availability of telemedicine to provide mental health care to all populations.
- Increase implementation and sustainable funding of effective models of school-based mental health care, including clinical strategies and models for payment.
- Accelerate adoption of effective and financially sustainable models of integrated mental health care in primary care pediatrics, including clinical strategies and models for payment.
- Strengthen emerging efforts to reduce the risk of suicide in children and adolescents through prevention programs in schools, primary care, and community settings.
- Address the ongoing challenges of the acute care needs of children and adolescents, including shortage of beds and emergency room boarding by expanding access to step-down programs from inpatient units, short-stay stabilization units, and community-based response teams.
- Fully fund comprehensive, community-based systems of care that connect families in need of behavioral health services and support for their child with evidence-based interventions in their home, community, or school.
- Promote and pay for trauma-informed care services that support relational health and family resilience.
- Accelerate strategies to address longstanding workforce challenges in child mental health, including innovative training programs, loan repayment, and intensified efforts to recruit underrepresented populations into mental health professions as well as attention to the impact that the public health crisis has had on the well-being of health professionals.
- Advance policies that ensure compliance with and enforcement of mental health parity laws.

Policy Actions for Committee Consideration

Access to Specialty Care and the Child and Adolescent Psychiatry Workforce

To increase access, we can extend the reach of the child and adolescent psychiatry workforce by supporting primary care providers and school-based providers in identifying, assessing, and stabilizing children with pediatric behavioral health disorders and then escalating to specialty behavioral healthcare when a patient's needs require a higher level of care.

1. Support child psychiatry consultation programs

Pediatric Mental Healthcare Access (PMHCA) consultation programs, run through the Maternal and Child Health Bureau (MCHB) at the Health Resources and Services Administration (HRSA), school-based mental health care, and integrated behavioral health and primary care models, connect patients to behavioral health care.

These consultation programs, commonly called child psychiatry access programs (CPAPs), have been implemented in most states across the country, and are funded through HRSA grants, state funding, or institutional funding, or a combination of these funding resources, yet some states with large rural and underserved areas

have not yet developed such programs.[2] Pediatricians utilize CPAPs in their state to consult with child and adolescent psychiatrists about treatment options for the children and youth they see who may need mental and behavioral health care. Research has shown that the use of CPAPs significantly improves outcomes for the patients who receive integrated medical and behavioral health care through this model compared to treatment as usual.[3] AACAP encourages the Committee to support replication of the CPAP program in every state.

AACAP is grateful for recent congressional investments in these programs and urges the Committee to continue to support these resources and promote state and provider adoption to ensure these models are sustainable. We must meet children where they are and eliminate additional barriers.

2. Support integrated care arrangements

Integrating behavioral healthcare, including child and adolescent psychiatry, into primary care practices facilitates primary care provider's in accessing real time, immediate support for behavioral and mental health issues that present during patient visits. AACAP encourages the Committee to support integrated care arrangements, like the collaborative care model, that support pediatric practice engagement with child and adolescent psychiatrists.

3. Build a pipeline of child and adolescent psychiatrists

Before the COVID–19 pandemic, the workforce shortage of child and adolescent psychiatrists was significant, and this shortage continues. As physician subspecialists who conduct 4 years of medical school, complete a medical residency in psychiatry and complete a residency fellowship in child and adolescent psychiatry, the training is extensive and costly. AACAP recommends the following strategies for supporting a pipeline of child and adolescent psychiatrists:

- Support targeted student loan repayment programs—S. 462, the "Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023," sponsored by Committee Members Senators Tina Smith, Lisa Murkowski, and Maggie Hassan, would repay up to $250,000 in eligible student loan debt for mental health professionals who work in mental health professional shortage areas.
- Support efforts to defer student loan payments on an interest-free basis during training—S. 704, the "Resident Education Deferred Interest (REDI) Act," would allow borrowers to qualify for interest-free deferment on their student loans while serving in a medical residency program.

4. Advocate for mental health parity—coverage and payment

We must support mental health parity to ensure mental health is on equal footing with physical health and surgical care. Lack of medical coverage and poor reimbursement for mental health care are disincentives to recruiting medical students into child and adolescent psychiatry and building robust psychiatric services for children. Lack of parity contributes to limited in-network psychiatry access, longer wait times for children and youth, 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 across insurance plans would support children's access to high quality and timely mental health care.

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) aims to ensure that insurance coverage for mental health and addiction treatment is no more restrictive than insurance coverage for other medical care. This goal needs to be realized to tackle mental health access issues. AACAP appreciates the authorization of state parity assistance grants in the *2023 Consolidated Appropriations Act*, as well as the sunsetting of the non-government health plan opt-out of MHPAEA. AACAP respectfully asks Congress to fund the state parity assistance grants.

AACAP urges the Committee to support granting the Department of Labor authority to levy civil monetary penalties on ERISA plans found out of compliance with MHPAEA. In addition, the Committee should encourage more technical assistance to state regulators to ensure health plans are complying with MHPAEA.

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[2] Map—NNCPAP National Network of Child Psychiatry Access Programs.

[3] Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis—PubMed (*nih.gov*).

AACAP also recommends that insurance regulators require health plans to use nationally recognized service intensity technological tools developed by professional medical organizations in making medical necessity determinations. With respect to children and adolescents, service intensity instruments such as the Child and Adolescent Service Intensity Instrument [4] and the Early Childhood Service Intensity Instrument, [5] are standardized assessment tools that provide determinations of the appropriate level of mental, behavioral, substance use, or other service needed by a particular child or adolescent and his or her family.

5. Build a behavioral health workforce that represents communities being served

The current pediatric mental health care system does not sufficiently serve the needs of all of our communities. The COVID–19 pandemic amplified pre-existing 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 through the workforce programs supported by HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA). Physicians who speak the same language as their patients and can identify with their patient's life experiences are best equipped to overcome stigma and gain the trust of their providers. AACAP encourage Congress to support programs that improve health equity by training a racially and ethnically diverse pediatric behavioral health workforce through scholarship, tuition assistance, and professional development opportunities.

We hope to work with the Committee to advance these priorities to improve existing programs and create new models to address the series crisis in children's mental health care.

[4] CASII (aacap.org)
[5] ECSII (aacap.org)

Key Findings

41% of LGBTQ young people seriously considered attempting suicide in the past year — and young people who are transgender, nonbinary, and/or people of color reported higher rates than their peers.

41%

56% of LGBTQ young people who wanted mental health care in the past year **were not able to get it.**

56%

Transgender and nonbinary young people who reported that all of the people they live with **respect their pronouns reported lower rates of attempting suicide.**

Fewer than 40% of LGBTQ young people found their home to be LGBTQ-affirming.

38%

Roughly half of transgender and nonbinary young people found their school to be gender-affirming, and those who did reported lower rates of attempting suicide.

A majority of LGBTQ young people reported being verbally harassed at school because people thought they were LGBTQ.

Nearly 1 in 3 LGBTQ young people said their **mental health was poor** most of the time or always **due to anti-LGBTQ policies and legislation.**

Nearly 2 in 3 LGBTQ young people said that hearing about **potential state or local laws banning people from discussing LGBTQ people at school** made their mental health a lot worse.

2023 U.S. National Survey on the Mental Health of LGBTQ Young People

THE TREVOR PROJECT

CONGRESS OF THE UNITED STATES,
WASHINGTON, DC,
May 9, 2023.

The Hon. Lawrence Tabak,
Acting Director, National Institutes of Health,
9000 Rockville Pike,
Bethesda, MD.

DEAR DR. TABAK:

We write today with grave concerns regarding a study funded by the National Institutes of Health (NIH) in which two young people tragically died by suicide.

The study, titled "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones," evaluated the psychosocial effects of cross-sex hormones on "transgender and nonbinary youth."[1] In this study, researchers examined young people between the ages of 12 and 20 who identify as transgender and were given cross-sex hormones. Of the 315 subjects, 240 were minors.[2]

Notably, the four clinics and some of the researchers who conducted this experiment are outspoken advocates for conducting gender transition interventions on children. In a video it later removed from its YouTube channel, Boston Children's Hospital, one of the clinics involved, went as far as to claim that children can know their gender identity "from the womb."[3] Johanna Olson, a co-author of this paper, told CNN in 2014, "We're definitely in the middle of a gender revolution and it's exciting."[4] This same researcher later received a Federal grant for a study in which she altered protocol to allow children as young as 8 years old to receive cross-sex hormones.[5]

During this study, two young people died by suicide and 11 reported suicidal ideation.[6] Rather than shutting the study down after such serious adverse events, the researchers published their paper, concluding that the study was a success because cross-sex hormones had altered subjects' physical appearance and improved psychosocial functioning.[7] However, the researchers admitted that they were not able to properly establish causality between the administration of cross-sex hormones and improved psychosocial functioning because their study lacked a control group.[8]

Despite glaring shortfalls, this government-funded research is already being used to further the fallacy that chemically transitioning children is safe and effective.[9] It is alarming that vulnerable young people died by suicide while participating in a taxpayer-funded study that will almost certainly inflict devastating physical harm on those who participated. Twenty-four participants in this study received cross-sex hormones after puberty suppression or "in early puberty" and are likely sterile as a result.[10] Further, participants are now at increased risk for cardiovascular disease, blood clotting, and a host of other complications.[11]

Research shows that gender dysphoria in minors often resolves as they progress through puberty—completely undermining the idea that children should have their bodies permanently altered to match their changing identities.[12] Despite overwhelming evidence that chemically transitioning children is not safe, the NIH plans to give more than $10.6 million to experiment on children and adolescents through 2026.[13] We are deeply concerned about your agency's use of taxpayer dollars to advance experiments on children who will be irreversibly harmed by radical gender ideology.

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[1] *https://doi.org/10.1056/nejmoa2206297.*
[2] Ibid.
[3] *https://first-heritage-foundation.s3.amazonaws.com/live-files/2023/01/230130-DNH-NEJM-Response.pdf.*
[4] *https://www.cnn.com/2014/06/27/living/transgender-youth-pride-march/index.html.*
[5] *https://docs.wixstatic.com/ugd/3f4f51-a929d049f7fb46c7a72c4c86ba43869a.pdf.*
[6] *https://doi.org/10.1056/nejmoa2206297.*
[7] Ibid.
[8] Ibid.
[9] *https://www.nbcnews.com/nbc-out/out-health-and-wellness/hormone-therapy-improves-mental-health-transgender-youths-new-study-fi-rcna66306*; *https://abcnews.go.com/Health/gender-affirming-care-trans-youth-improves-mental-health/story?id=96510337*; *https://www.washingtonpost.com/business/trans-teens-benefit-from-gender-affirming-care/2023/01/20/955f807c-98bd-11ed-a173-61e055ec24ef-story.html.*
[10] *https://doi.org/10.2147/AHMT.S110859.*
[11] *https://pubmed.ncbi.nlm.nih.gov/36238954/.*
[12] *https://www.dovepress.com/getfile.php?fileID=40774.*
[13] *http://gendersanity.org/documents/NIH-funding-from-progress-report-12-15-21.pdf.*

We request your full and complete response to each question below no later than June 9, 2023. Please provide a separate response to each question, rather than a narrative response.

1. Were the individuals who tragically died by suicide while participating in this study minors?

2. At which study sites did the two participants who died by suicide receive treatment? On what date did the researchers from these sites inform researchers at other participating sites that a study participant had died by suicide?

3. Please list the steps that were taken to halt and review the study after the first and second deaths and the dates on which these actions occurred.

   a. If a review took place, please provide the outcome of that review.

4. Were the other participants, as well as their parents, notified that two participants died by suicide? If so, who provided this notification?

5. Were participants and their parents given the opportunity to reconsider their consent and withdraw from this research in light of the suicides?

6. What steps were taken to provide ongoing monitoring of other children participating in the study to ensure they were not at risk for suicidal ideation?

7. Have study participants been evaluated to assess sterility or impaired fertility as a result of receiving cross-sex hormones? If so, how many participants are now sterile or suffering from impaired fertility?

8. Will a follow-up occur to evaluate the long-term physiological state of the subjects? If so, please provide an expected date for this follow-up.

9. The study notes that "6 participants withdrew from the study." Please provide the ages and Tanner stages at which these participants withdrew and their reasons for withdrawing.

10. Please provide all closed-meeting minutes from the NIH regarding the approval of funding for this study.

11. Please provide all closed-meeting minutes from the NIH, researcher Johanna L. Olson, the Children's Hospital of Los Angeles, and any relevant review boards regarding the approval of children as young as 8 years old to receive cross-sex hormones in the study titled "The Impact of Early Medical Treatment in Transgender Youth," redacting any information that personally identifies study participants if applicable.

12. Please provide all information that participants and their parents received specifically regarding sterility or risks of impaired fertility resulting from the use of cross-sex hormones, redacting any information that personally identifies study participants if applicable.

13. Does the NIH still commit to funding Project Number R01 HD082554 through 2026? If so, please provide justification for continuing this funding and detail what additional steps will be taken to prevent such serious adverse events going forward.

14. Please detail any ongoing or proposed NIH funding for studies involving transgender or nonbinary identified minors.

Thank you for your attention to this important matter.

Sincerely,

JOSH BRECHEEN
Member of Congress

TED BUDD
U.S. Senator

MARCO RUBIO
U.S. Senator

RAND PAUL, M.D.
U.S. Senator

JAMES LANKFORD
U.S. Senator

MICHAEL S. LEE
U.S. Senator

MARY MILLER
Member of Congress

RANDY WEBER
Member of Congress

LAUREN BOEBERT
Member of Congress

CHIP ROY
Member of Congress

ANDY BIGGS
Member of Congress

RONNY L. JACKSON, M.D.
Member of Congress

ELI CRANE
Member of Congress

JEFF DUNCAN
Member of Congress

MICHAEL CLOUD
Member of Congress

The New York Times

No One Knows How Many L.G.B.T.Q. Americans Die by Suicide

Death investigators in Utah are among a handful of groups trying to learn how many gay and transgender people die by suicide in the United States.

By Azeen Ghorayshi

June 1, 2023

Cory Russo, the chief death investigator in Utah, is used to asking strangers questions at the most excruciating moments of their lives. When she shows up at the scene of a suicide, a homicide or another type of unexpected death, her job is to interview the grievers about how the deceased had lived.

How old were they? What was their race? Did they have a job? Had they ever been hospitalized for psychiatric issues? How had they been feeling that morning?

Over the past couple of years, she has added new questions to the list: What was their sexual orientation? What was their gender identity?

Ms. Russo, who works in the Office of the Medical Examiner in Salt Lake City, is one of the relative few death investigators across the country who are routinely collecting such data, even though sexuality or gender identity can be relevant to the circumstances surrounding a person's death.

She recalled the recent suicide of a young man who died in the house of older adults. During her interviews, Ms. Russo learned that the man had been living with them for a year, ever since his family had kicked him out of their house because he was gay. He had struggled with emotional upheaval and addiction.

"It was heartbreaking to hear," said Ms. Russo, a lesbian who has lost loved ones to suicide. "In that case, it was very relevant to understand that piece."

Studies of L.G.B.T.Q. people show they have high rates of suicidal thoughts and suicide attempts, factors that greatly increase the risk of suicide.

But because most death investigators do not collect data on sexuality or gender identity, no one knows how many gay and transgender people die by suicide each year in the United States. The information vacuum makes it difficult to tailor suicide prevention efforts to meet the needs of the people most at risk, and to measure how well the programs work, researchers said.

The absence of data is especially unfortunate now, they said, when assumptions about suicide rates among L.G.B.T.Q. groups are frequently thrust into high-stakes political debates. Some L.G.B.T.Q. advocates have warned that bans on gender-affirming care for transgender minors will lead to more suicides, for example, while some Republican lawmakers have claimed that deaths by suicide are rare.

Utah, which like many mountain states has a high rate of suicide mortality, has been at the forefront of efforts to collect such data since 2017, when its State Legislature passed a law mandating detailed investigations of suicides.

The lawmakers were "frustrated with being asked to respond to the suicide crisis in our state with a blindfold on," said Michael Staley, a sociologist who was hired to lead the data-collection effort in the Utah medical examiner's office. "It's a five-alarm fire."

Michael Staley, a sociologist who works in the Salt Lake City Medical Examiner's Office, conducts "psychological autopsies" in the months after a death by suicide or drug overdose. Kim Raff for The New York Times

In the months after investigators like Ms. Russo show up at the scene of a death, Dr. Staley's team of six people conducts "psychological autopsies," contacting family members of everyone in the state who dies by suicide or drug overdose for detailed information about the lives of the deceased.

Such data — which includes information on sexual relationships and gender, as well as housing, mental health, drug problems and social media use — can be used to help understand the complex array of factors that contribute to people's decisions to end their lives, Dr. Staley said. He plans to release a report later this year describing interviews with the families of those who died by suicide in Utah over the last five years.

For children and adolescents who die by suicide, the team interviews not just parents and guardians, but also several close friends. In some cases, Dr. Staley recalled, friends knew about the deceased's struggles with sexuality, gender or drug use that the parents did not.

These conversations can be exceedingly difficult. John Blosnich, head of a research initiative called the L.G.B.T. Mortality Project at the University of Southern California, has done ride-alongs to observe and train death investigators on the importance of collecting data on gender and sexuality. His training also helps investigators navigate distress or stigma about the questions from the deceased's friends and relatives.

"They're talking with families who are in shock, who are infuriated, who at times are catatonic because of their loss," Dr. Blosnich said.

So far, Dr. Blosnich has trained investigators in Utah, Nevada, Colorado, New York and California, where a 2021 state law started a pilot program to collect data on sexual orientation and gender identity. In a recent study of 114 investigators in three states, Dr. Blosnich reported that only about 41 percent had directly asked about a deceased person's sexual orientation, and just 25 percent had asked about gender identity, before going through the training.

Medical examiners send reports of homicides and suicides to the Centers for Disease Control and Prevention, which maintains a database of violent deaths with extensive demographic, medical and social information, including toxicology tests, mental health diagnoses and even stories of financial and family hardships. But a study of more than 10,000 suicides among young adults reported to the C.D.C. database found that only 20 percent included information on the deceased's sexuality or gender identity.

Another agency in the health department, the Office of the National Coordinator for Health Information Technology, is trying to set new standards that would require any hospital that receives federal money to ask its patients about their sexuality and gender identity.

Death investigators are "limited by the fact that they can't ask the person the question," said John Auerbach, who worked on standardizing questions about sexuality and gender at the C.D.C. from 2021 to 2022. If doctors were routinely talking to their patients about sexuality and gender identity, that information could help answer other public health questions as well, such as those regarding the relative risk of cancer or diabetes in the L.G.B.T.Q. community, Dr. Auerbach said.

But that approach has its limits. Patients may not feel comfortable disclosing that information to their doctors. And those who don't interact with the health care system may be at especially high risk of suicide.

“Lacking in data, it is all too easy to dismiss us,” said Casey Pick, director of law and policy at the Trevor Project. Shuran Huang for The New York Times

L.G.B.T.Q. advocates said that obtaining that data had become more urgent in the past couple of years, as states across the country have imposed restrictions on many aspects of life for gay and transgender people.

“Lacking in data, it is all too easy to dismiss us,” said Casey Pick, director of law and policy at the Trevor Project, a nonprofit organization focused on suicide prevention among L.G.B.T.Q. young people that has lobbied at the state and federal levels to begin collecting that data.

“I have heard it too many times: Lawmakers and public witnesses in hearings suggest that the L.G.B.T.Q. community is crying wolf on suicide because we don’t have this data to point to,” Ms. Pick said.

It’s also important to acknowledge the unknowns, Dr. Staley said. Although studies have reported a high rate of suicidal thoughts and suicide attempts among lesbian, gay and transgender people, that doesn’t necessarily mean a high rate of suicides. He noted that although women have a higher rate of suicide attempts than men do, men have a much higher rate of dying by suicide, partly because they have more access to guns.

And Dr. Staley, who is gay, cautioned against political narratives that “normalize suicide as part of the queer experience.”

“I would argue that if anything, this life experience sets us up to be resilient,” he said. “Our fate is not sealed. Our story is not written.”

If you are having thoughts of suicide, call or text 988 to reach the 988 Suicide and Crisis Lifeline or go to SpeakingOfSuicide.com/resources for a list of additional resources.

Azeen Ghorayshi covers the intersection of sex, gender and science for The Times.

A version of this article appears in print on , Section A, Page 16 of the New York edition with the headline: Utah Is Driving Push to Fill Void on L.G.B.T.Q. Suicide Data

[Whereupon, at 12:26 p.m., the hearing was adjourned.]

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