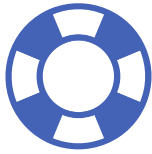



April 11, 2021

Testimony: Dr. Christine Moutier, Chief Medical Officer, American Foundation for Suicide Prevention

House Education and Labor Committee, Subcommittee on Health, Employment, Labor, and Pensions

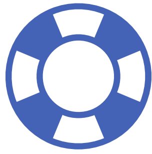
Hearing: Meeting the Moment: Improving Access to Behavioral and Mental Health Care

I am the Chief Medical Officer for the American Foundation for Suicide Prevention, the nation's largest non-profit dedicated to saving lives and bringing hope to those affected by suicide. Today I am here representing the hundreds of thousands of people walking in our Out of the Darkness Walks, participating in International Survivors of Suicide Loss Day events, our dedicated volunteers and field advocates from all 50 states and Washington, D.C., as well as several hundred suicide researchers who are advancing the science of suicide prevention. I am a psychiatrist, a medical educator, and someone who has addressed mental health conditions in my patients, medical trainees, my family, and my own life. My message today about the growing gap between mental health needs and the support that is critically serious, but hopeful and actionable. Thank you Chair DeSaulnier, Ranking Member Allen, and Members of the Subcommittee for your time today.

## The Mental Health Crisis in Our Nation

The pandemic has clearly been a time of increased attention to mental health and very real heightened mental health distress for the nation. However, even pre-pandemic, we have seen changes in the landscape around mental health. For example, there has been a major shift in attitudes opening up around mental health as a legitimate and critical part of human health. There has been a rise in prevalence of mental health conditions in youth and young adults over the past decade. We have seen a 35% increase in the national suicide rate from 1999 through 2018 (and fortunately two years of declining numbers of suicides in 2019 and 2020). One in four Americans will have a diagnosable mental health condition in their lifetime - 1 in 5 each year - and the World Health Organization has declared depression a leading cause of medical disability globally. Other conditions such as substance use disorders are on the rise with an unprecedented number of opioid overdose deaths in 2020. And yet less than half of Americans with mental health conditions are receiving care. The degree of suffering experienced by millions of Americans and families is enormous, with barriers still impeding mental health being approached on par with physical health - in workplaces, schools and in healthcare delivery systems.

For those who do seek care, there's often a long delay between the onset of symptoms and the healthcare they receive - in many cases months to years. There is an alarming gap between the number of people who experience mental illness and those who receive care. And especially troubling is the fact that some populations have additional layers of inequity that pile on top of the health disparity that exists for people just due to mental illness alone.




Research shows people with mental illness have a higher relative risk of death than the general population and die 15 to 20 years younger than their counterparts. Most die of the same natural causes that are leading causes of death nationwide, including heart disease, cancer, and cerebrovascular, respiratory, and lung diseases. For people with mental illness, the risk of dying by suicide is also much higher (as much as 30 times higher) than the general population. A lion's share of these terrible outcomes can be mitigated with early recognition and treatment, and even prevention of mental health conditions.

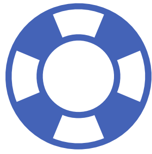
Health system delivery in the US was designed without mental health in mind. Most health professionals do not receive education in mental health, and even among mental health professionals, training in effective suicide prevention practices is at an early stage of implementation. The public, including people with Lived Experiences of mental health conditions and suicide loss survivors have been making change at the grassroots community level, implementing education programs in schools and workplaces, campaigns to reduce stigma, and have successfully advocated for increasing legislative changes at the state and federal levels. Celebrities across all fields are speaking out, a recent example being Meghan Markle in her interview with Oprah Winfrey, when she shared her experience with suicidal crisis. But until the *health system* including system leaders, payers, training programs and accrediting bodies, improves and makes mental health a real priority, the gap between the demand for quality, timely, culturally competent treatment and the ability to access those mental health services will only grow larger. Stigma is going down, more people are speaking out, families are desperate, but what are they encountering when they do come for help in primary care, emergency departments, substance use treatment or mental health care settings?

Research shows that when primary care and health systems embrace mental health and substance use disorders as integral components of primary care and healthcare delivery, many health outcomes improve. Individual suffering and disability improve, and families, schools and workplaces are benefited when individuals can live and function to their healthiest potential. There are enormous economic benefits for societies that prioritize mental health and an economic return on investment for each dollar spent on mental health promotion and prevention – in many ways, we cannot afford inaction.

To put it succinctly, with all of our advances in science, systems design, and technology, in the USA in 2021, we can, and we must, reconcile the growing mismatch in the mental health needs of our nation with the ability to access services and support.

## The Impact of COVID-19 on Mental Health

During the COVID-19 pandemic, data show 50-70% of the population report elevations in experiences of depression, anxiety, loneliness, trauma, loss, grief and increased substance use. Numerous studies have kept abreast of the nation's mental health experiences and suffering during the pandemic through various mechanisms such as the CDC Household Pulse Survey during COVID which has been surveying 60-90,000 Americans adults every 3-5 weeks during the pandemic.



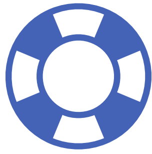

The portion of the American public experiencing anxiety, isolation, symptoms of depression, insomnia and increased substance use has been rising. Suicidal thoughts are much more prevalent during this time especially among young people with 25% of young adults reporting suicidal ideation in the past 30 days, an increase of 2-3 times usual baseline rates. As the pandemic progressed during 2020, the proportion of respondents who reported detrimental effects on their mental health continued to rise—39% in May 2020 and 53% in July 2020 and just recently in March 2021, we are seeing the first decreases in distress by 8-10 percentage points for depression and anxiety across age and demographic groups.

Fortunately, preliminary suicide data in the US in 2020 find suicide deaths have actually decreased by 5.6% year over year.

There are reasons to be especially concerned about particular populations: marginalized communities, essential and frontline health workers, caregivers, youth, rural residents and LGBTQ people. For example, in CDC surveys, Hispanic and Black Americans have shown the highest rates of distress of all racial groups with 19% of Hispanic Americans reporting suicidal ideation and 15% of Black Americans, which was more than twice the rate of suicidal ideation in the general population. Additionally, while the overall suicide mortality is showing decreases, some states have begun analyzing their mortality data by groups and find that suicide rates went down in White residents (of MD and CT) but went up in Black and other non-white groups in those same states.

In my JAMA Psychiatry article, which was released April 8, 2021, on Suicide Threats and Opportunities during COVID-19, I outline the ways the pandemic is pressing on known risk factors. The pandemic affects people differently: we are all in this pandemic together, however we are not all having the same experiences. Many groups may be hit harder, either for reasons of pandemic-specific impacts such as the impact on essential workers and frontline health workers, groups experiencing greater economic strain, vulnerable youth, people in unsafe homes, people with pre-existing disabilities, and other groups who have long had the experience of discrimination and inequities which are being accentuated by the pandemic - these include LGBTQ people, women, and other potentially marginalized groups.

Some good news: help seeking is on the rise during the pandemic and conversations about mental health are at an all-time high with all our lives turned upside down in one way or another. One in four Americans are currently in mental health treatment per both CDC and our Harris poll. Calls to the National Suicide Prevention Lifeline and its subnetwork, the Disaster Distress Helpline (1-800-985-5990) have increased since the onset of the pandemic, with significantly higher increases to the Disaster Distress Helpline. Implementation of 988 will likely dramatically increase calls to the Lifeline network as that number goes live nationwide in July 2022 and efforts begin to promote the new number. Texts to the Crisis Text Line (text TALK to 741-741) have risen 40% during the pandemic.




Health Disparities

The pandemic and recent events have laid bare the health, social and economic disparities leading to disproportionate trauma, suffering, and loss of life for certain groups. In the March 31 JAMA report of 2020 mortality, we see that overall mortality as well as COVID-19 deaths were disproportionately higher in American Indian, Hispanic and Black Americans than the general population. In fact, health disparities have been well studied and documented long before COVID-19, e.g., by the National Academy of Sciences (Institute of Medicine) in their landmark 2003 report.

Studies of implicit bias among health care providers reflect the general population biases related to women, LGBT people and people from minoritized race/ethnicities. These biases of physicians feed into clinical decision making, leading to worse outcomes for diagnosing and/or appropriately treating cardiovascular disease, cancer, HIV, diabetes, kidney problems, mental health conditions and pregnancy related health issues. Black adolescents are significantly less likely to receive care for depression, with experts identifying pervasive structural inequities even when socioeconomic status is controlled for. Other factors that lead to health inequities include generational trauma, workforce issues with lack of access to culturally competent providers, and mistrust of healthcare providers creating daunting barriers to treatment.

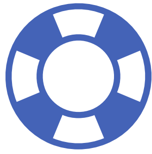
Pre-existing disparities in health, access to care, economic/job type disparities and education are showing up in these mental health experiences. For example, regarding educational background and the likelihood of having suicidal thoughts during the pandemic, education had a protective effect. Respondents with who did not complete high school are having the highest rates of suicidal thoughts (30%, more than 3 times greater than all other education levels).

The American Psychiatric Association reports that racial/ethnic minority communities are less likely to receive mental health care. In 2015, among adults with any mental health condition, 48% of white individuals received mental health services compared with 31% of Black and Hispanic individuals and 22% of Asian individuals. Lack of access, stigma, lack of providers, and inadequate support for mental health service safety nets are all barriers for marginalized communities.

AFSP applauds the work already undertaken by Congress to address longstanding disparities in mental health and suicide prevention support for all communities. The Congressional Black Caucus's Emergency Task Force's Report on Black Youth Suicide & Mental Health, new legislative efforts addressing mental health disparities in diverse communities, and conversations like these are moving policy in a positive direction, to ensure that the mental health of all people is prioritized, and so one day no one, in any community, will die by suicide.

Access to Mental Health Care and Need for Parity

The Education and Labor Committee is well positioned to address many of the critical challenges facing mental health care. I urge the Subcommittee to consider strategies to increase access to




mental health resources, support a robust mental health workforce, integrate suicide prevention in clinical and professional settings, and enforce mental health parity.

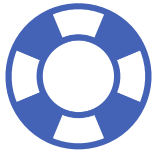
Despite the evident need for broad and equitable access to mental health care, many are having trouble accessing care. In 2019 a CDC survey found 4.3% of American adults had tried to access mental health services but were not able to. These challenges have worsened during the pandemic, despite the greater access via teleservices. The demand is still outweighing the available services as the demand has grown. Compared with 4% in 2019, in Aug 2020, 9.2% of adults said they needed therapy but could not access it. In December 2020 that rose to 12.4%.

The Subcommittee should consider efforts that would support enhanced mental health parity enforcement, to ensure that coverage for mental health care is no less restrictive than medical or surgical care. A Milliman Research Report from November 2019, analyzing network use and provider reimbursement for 37 million employees and dependents indicates that despite the Mental Health Parity and Addiction Equity Act being enacted over a decade ago, disparities in mental health coverage have continued to increase.

- From 2013 to 2017, the disparity between how often behavioral inpatient facilities were utilized out of network relative to medical/surgical inpatient facilities increased 85%.
- From 2013 to 2017, the disparity for out-of-network use of behavioral outpatient facilities relative to medical/surgical outpatient facilities increased 90%.
- From 2013 to 2017, the disparity for behavioral health office visits relative to medical/surgical primary care office visits increased from 500% to 540%.
- In 2017, 17.2% of behavioral office visits were to an out-of-network provider compared to 3.2% for primary care providers and 4.3% for medical/surgical specialists. In 2017, primary care reimbursements were 23.8% higher than behavioral reimbursements.
- In 2017, a behavioral healthcare office visit for a child was 10 times more likely to be an out-of-network provider than a primary care office visit – this was more than twice the disparity seen for adults.

The report concludes that while "disparate results are not in and of themselves definitive evidence of noncompliance, significant disparities, such as high out-of-network use of behavioral health providers and/or lower reimbursement for behavioral health providers, could point to compliance problems." There must be much more accountability and oversight of parity plans to ensure that mental health conditions are not being discriminated against.

Furthermore, the Subcommittee should consider the positive benefits of an enhanced mental health workforce and integrated suicide prevention services in workplaces and educational settings. The supply of practicing psychiatrists and psychologists is expected to decrease significantly over the next decade and projected demand for mental health services will demand a much larger workforce across the continuum of care. It would also be incumbent to consider how representative the mental health workforce is of the communities they serve – a more diverse workforce will be essential for increasing access, combatting stigma, and encouraging help seeking in every community.



American Foundation *for* Suicide Prevention

**Conclusion**

In conclusion, the time to make mental health a priority in our nation is now. Specifically, COVID-19 is presenting a new and urgent opportunity to double down and focus on federal investments and policies that can improve the nation's mental health infrastructure and resources. We can do that by working together to speak out, notice when a colleague or loved one is struggling and learn how to have caring conversations, and by making the science that shows mental health is as impactful and critical to our lives as any other aspect of health. Parity must be enforced, and disparities must be addressed to ensure equitable access and care for those in need.

We have seen the entire healthcare apparatus of the United States dramatically respond to the threat of COVID-19. Now, we must do the same for mental healthcare. As the viral component of the pandemic gets more and more manageable it is crucial that we turn our attention to the mental health needs that the nation is already experiencing.

We must aggressively increase access to mental health care, through effective mental health parity enforcement and telehealth coverage. We must lead the world in mental health and suicide prevention research. We must ensure that no community impacted by these issues is disregarded. We as a country are beginning to take mental health seriously – we must ensure that our healthcare systems, our schools, and our workplaces do so as well to ensure equitable and affordable care.

I urge the subcommittee to consider legislation and policies to:

1. Ensure the effective enforcement of mental health parity and broaden access to mental health care generally.
2. Support a robust, diverse mental health workforce.
3. Integrate mental health and suicide prevention in health systems, workplaces and schools, as critical touchpoints that can establish a professional culture that is responsive to mental health needs.

The steps we take in the aftermath of the pandemic will set the trajectory for the Nation's mental health for years to come. I thank the subcommittee for appreciating the gravity of the situation and look forward to hearing your comments and answering your questions.

Thank you.

Christine Moutier, MD
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American Foundation for Suicide Prevention