Testimony by Jonathan M. Metzl, MD, PhD
Director, Department of Medicine, Health, and Society
Professor of Sociology and Psychiatry
Vanderbilt University
Nashville, TN

Committee on Ways and Means Hearing on "Substance Use, Suicide Risk, and the American Health System," March 2, 2022

Chair Neal, Ranking Member Brady, and Members of the Ways and Means Committee,

It is an honor to be invited to testify today about Substance Use, Suicide Risk, and the American Health System, and about broader questions of what Congress can do to improve access to mental health treatment in our nation during a time of urgent need. I come to these topics as a result of my research and training. I am dually trained as an MD psychiatrist and a PhD sociologist, and my research explores the social, political, and economic determinants of mental illness as a way of better understanding the highly individual ones. I've written books that study gender and prescription psychiatric medications[i], the over-diagnosis of schizophrenia in Black men[ii], and gun suicide in White rural America.[iii] I also spent many years working as an academic psychiatrist—at Stanford University and then at the University of Michigan---and as a program administrator. I now direct a large department at Vanderbilt University, The Department of Medicine, Health, and Society, that trains the healthcare leaders of tomorrow to better understand and reimagine American health and healthcare.

Over the course of my career I've seen how issues like addiction, depression, and suicidality do not discriminate. I've witnessed their pernicious effects in Blue states and Red ones, in dense urban areas and in rural settings, among students at colleges and in some of the poorest parts of the United States. Each locale is different, but the cross-cutting nature of mental illness highlights a national crisis that demands a unified national response, and particularly so as COVID-19 overlapped with our nation's racial reckoning. As Powell rightly put it in prior testimony, "A Shadow Mental Health Pandemic is Raging in Our Nation":

- Major depression is a leading cause of disability worldwide, and there are additional health outcomes associated with depression, resulting in high rates of medical and psychiatric comorbidity. Depression is also a major risk factor for suicide. Approximately 6-7% of full-time US adult workers reported experiencing major depression within the last year. And when we look at data estimating the economic burden of depression, astonishing figures that are well over $200 billion a year are

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> cited. These estimates are largely from 2010. Undoubtedly, we will observe increases in the economic cost of untreated depression in our nation when the proverbial COVID-19 smoke disappears. And the economic costs pale in comparison to the socioemotional costs to our families and communities when those we love find themselves standing at an emotional cliff and see suicide as the only way to end mental health suffering…Coincident with upticks in adult suicides are rises in other, so-called "deaths of despair" like substance use, misuse, and addiction. Admittedly, deaths of despair were already outpacing other serious chronic conditions (e.g., lung cancer) and unintentional injuries (e.g., car crashes) in 2017. However, in comparison, many more Americans appear to be self-medicating their ways right now through pandemic fatigue.[iv]

My research as an interdisciplinary scholar and administrator who joins psychiatry and social science informs the key points I wish to make before you today:

1. **There is no magic cure**. As a psychiatrist it is my deepest wish that I and others in my field might identify some core finding based in genetics or biology that singularly explains depression, suicidality, addiction, and other conditions, and then prescribes a magic treatment. Mental health expertise has come a very long way over the past decades, in no small part as a direct result of the opportunities provided by government funding. The therapies we offer become ever-more advanced and effective, and should be supported—as should access to mental health treatment more broadly.

But it becomes ever-increasingly clear that mental illness does not have a single determining cause and is instead the result of intersecting stressors and variables linked to biology, development, environment, society, economy, history, and other confounders.[v] Suicide is often linked to mental illness, but it can also be an impulsive act in response to an overwhelming stressor attempted by persons with no history of psychiatric diagnosis or treatment.[vi] Substance use can descend into addiction because of external triggers as much as because of a person's biological or genetic predisposition. As such, much current research highlights the importance of understanding mental illness in the context of larger social structures and systems, and of creating healthy environments and mental-health-informed infrastructures as a way of supporting healthy minds, in addition to providing evidence-supported treatments like therapy and medication.

2. **The pandemic is a stress accelerator on a historic scale.** Perhaps before the pandemic, many of us could allow the fantasy that persons with depression or addiction represented distinct diagnosable categories given to a group of people who were "mentally ill" –and that these DSM diagnoses separated "them" from "us." But the pandemic, and our fractured national response to it, highlights how mental wellness and mental illness represent points

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along the human continuum. In part, that's because the pandemic exacerbated many of the very stressors that lead to mental illness (see below). More broadly, the specific nature of COVID-19 transmission and infection led to profound social division and isolation. No matter a person's position regarding masks, vaccines, or other public health measures, the nature of the virus itself changed social interaction, and led to fear, isolation and mistrust – in as much as talking to another person suddenly became laden with risk. The air we share itself became a pathogen, and everyone who breathed was vulnerable. Within that complex and once unimaginable world, we collectively and individually asked, whose air do you trust? What is the best way to protect myself and my family? What will be the impact on socializing, schooling, work, and other pillars of human development and interaction? What knowledge do we respect, and what forms of expertise do we reject? As a society, we have not fully reckoned with the effects of these complex questions and their implications in communal, honest, and productive ways.

3. **The pandemic highlighted and exacerbated structural inequities that underlie mental illness.** COVID seemed an equalizer. No one was safe until everyone was safe. Infection anywhere was a threat to people everywhere. Yet it quickly became clear that the pandemic exacerbated long standing health disparities and inequities. As the virus traveled through towns and communities, illness and death mapped onto existing, mutually reinforcing systems of discriminatory housing, education, employment, earnings, health care, and criminal justice. Paths of COVID suffering and loss illuminated centuries of support systems that America did not build, investments it did not make, opportunities it did not allow. As but one example, it was quickly evident that early rates of COVID death in many communities mapped onto socioeconomic neighborhoods, leaving populations with higher-income and wealth relatively unscathed while decimating populations with low income and wealth. As such, though we were all vulnerable to COVID-19 by nature of being human, different communities experienced risk, anxiety, and susceptibility in different ways. Overt and implicit racism and xenophobia also played out in ways that shaped rates for mental illness. For instance, Asian-Americans experienced an 18.7% higher prevalence of depression symptoms during the pandemic than they did before. So too did economic insecurity: persons with lower incomes were 2.4 times more likely than their peers to report depression symptoms during the pandemic, while those with less than $5,000 in savings were 1.5 more likely, and those with higher numbers of stressors were 3.1 times more likely.[vii]

4. **The pandemic and our response to it also propagated specific risk factors for depression, addiction, and suicide**. Economic inequity rose in many locales. The rich got richer—a report by the Swiss bank UBS found, the world's billionaires' wealth soared to upward of ten trillion dollars during the pandemic[viii]—while persons of lower means were cast into what Thrasher calls a "viral underclass," a state defined by precariousness and instability.[ix] The pandemic also highlighted the effects of what Pirtle calls racial capitalism, a

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system that constructs the harmful social conditions that fundamentally shape biologies, diseases, and pandemic patterns.[x] Meanwhile, in a time of extreme isolation, many people drank alone rather than in social settings. While drinking alone isn't necessarily bad if done responsibly, many people may drink alone because of alcohol addiction, and doing so can lead to an impaired ability to stop or control alcohol intake.[xi] So too, the availability of a firearm during a moment of crisis is a key risk factor for gun suicide. Early in the pandemic, sales of civilian owned semi-automatic weapons surged by 800% in some locales. While the vast majority of guns are never fired, the surge in gun sales meant many more guns in many more homes—including homes with little history of gun ownership or training, uneven risk assessment, and again in a moment of higher personal and interpersonal stress.[xii] These are but a few examples of the perfect storm of heightened tension and risk that help explain current trends and should help frame our response to them.

5. Interdisciplinary frameworks for addressing mental health in moments such as the one in which we now find ourselves **emphasize the importance of communal infrastructure for mental and biological wellbeing**. We've learned, time and again, that rates of mental illness rise during and after largescale traumatic events (i.e., depression rates more than doubled after the Sep 11, 2001, terrorist attacks[xiii]). The pandemic represents an even greater risk to mental health because of its ongoing nature, and because symptoms of COVID infection can themselves be long-lasting.

Research suggests that, beyond access to individual treatment, societies that respond to moments of peril by building social cohesion and communal infrastructure—bolstering actual support along with the notion that "we're all in this together"—come out ahead in the long run. Sen describes "better societies" that can emerge from moments of crisis—ones in which moments of peril spark appreciation of shared humanity and renewed drive toward building shared and mutually beneficial infrastructures that persist well after the crisis has subsided. He highlights the importance of expanding access to healthcare and information, and addressing food an economic insecurity, to building health as well as national unity.[xiv]

Ettman and colleagues link the prevalence of depression during the pandemic with economic insecurity—after adjusting for all other demographics, the researchers found that, during COVID, someone with less than $5,000 in savings was 50% more likely to have depression symptoms than someone with more than $5,000. The analysis found that persons who were already at risk before COVID-19, with fewer social and economic resources, were more likely to report probable depression. "We would hope that these findings promote creating a society where a robust safety net exists, where people have fair wages, where equitable policies and practices exist, and where families can not only live on their income but can also save money towards the future," Ettman argues.[xv] [xvi]

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Jewett and colleagues, as well as other scholars, detail the importance of social cohesion for pandemic response. Social cohesion refers to the degree of social connectedness and solidarity between different community groups within a society, as well as the level of trust and connectedness between individuals and across community groups. It exists on multiple levels of organization, from the household level through international relations, all of which are intertwined and interact with one another. The relationships among individuals and communities and their local, regional, and national levels of government are affected by social cohesion. In their analysis,

> Government funding and programs are often forced to respond to priorities that are shared across entire nations or large geographies at the expense of addressing the needs of vulnerable and marginalized groups. The gap between the needs of local municipalities and the responses and actions of government during a disaster can often drive public mistrust, especially in communities without strong social cohesion and community resilience. Community engagement and strong social networks are instrumental for identifying priorities and solutions that are more likely to be appropriate, lasting, and supported by the affected community.[1] Moreover, enabling civic participation allows communities to generate the financial and human capital to identify and prioritize their own goals, which can sometimes be beyond the scope of government intervention.

Makardis and Wu similarly emphasize the importance of "social capital" (community attachment, social trust, family bond, and security). Their research analyzes the heath effects of features of social organization, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit, as defined by Putnam. In communities with large reserves of social capital, people trust their institutions and their neighbors. These communities with high amounts of interconnectedness and communal trust experienced less severe coronavirus outbreaks. Conversely, in places with low social capital, people tend to be distrustful of the government, which can create a type of vicious cycle: Lack of compliance with public health directives led to more severe outbreaks, which causes trust in government to erode further.[xvii] [xviii]

Potential Solutions and Promising Practices

American mental health expertise has historically emphasized treating individual patients and individual brains. Doing so remains vital, and particularly so during our current epidemic of mental illness, addiction, suicide, and despair. At the same time, growing bodies of research highlight the importance of rebuilding social structures as a way of promoting individual and communal wellbeing. Key points in that regard include:

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1. **Address polarization as a national health crisis.** The American political system is often a zero-sum, winner-take-all proposition. Yet the growing bodies of research like that cited above, and much more not cited here, suggests that divisiveness itself is a vector that weakens our nation in moments of crisis. What can we do to promote common cause? How can eminent bodies like Congress change the algorithms and structures that foment divisiveness and replace them with structures that model unity and value cooperation over competition? How are rising rates of mental illness also a collective crisis that demands a collective response? How can we reach across the many divisive aisles of everyday life?

2. **Hold a national referendum on mental illness and mental health that models and promotes social cohesion.** How can we build trust in one another and in our institutions? A number of groups currently address polarization itself as an urgent threat to American mental and national health. As one example, Tennessee-based Millions of Conversations brings Americans together "to transcend critical divides" and promote "public space where all Americans experience a productive sense of belonging."[xix] In a moment of profound division, we must ask, how can we listen to one another? Can we promote trusted sources of health information? Where are the forums where we can disagree without pathologizing one another? These questions seem almost impossible to address—but it was not always so. In the present day United States, we've developed expert methods for expressing (and monetizing) discord, but have few processes for safely disagreeing with one another in productive ways. Make mental health a site of common cause.

3. **Build structures and infrastructures that connect people and communities and address disparities.** Much attention goes toward repairing America's roads, bridges, and aqueducts, and rightly so. But in the urgency of fixing physical structures we sometimes lose the larger picture of what roads and bridges *do*—namely, connect people and communities. Investment in infrastructure builds social capital and cohesion in lasting ways. We need to think about/plan infrastructure in terms of its social functions in addition to its material ones.

Healthcare infrastructure is a key example. Beyond hospitals, clinics, or coverage networks, research repeatedly shows that healthcare coverage promotes social cohesion. Key findings from this research by McKay, Timmermans, Sohn, and others:

- Inclusive healthcare policies, systems, and infrastructure matter for more than just the individuals who get health coverage. Inclusive healthcare promotes feelings of belonging, social/civic engagement, and health in communities.
- Lack of access to healthcare exacerbates social and economic inequality in communities
- Social and economic inequality in communities and neighborhoods erodes trust and civic engagement and contributes to population health inequalities.

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- Changes in levels of insurance in a neighborhood are directly linked to changes in feelings of belong, trust, and civic participation: When marginalized and excluded populations are explicitly included in healthcare policies and infrastructure development, belonging, trust, collaboration, and engagement increase.

For instance, Sohn and Timmermans show how states that expanded Medicaid saw more civic engagement (measured as volunteerism) in the immediate years following passage of ACA.[xx] Conversely, McKay and colleagues show how individuals living in communities with higher levels of uninsurance report lower social cohesion net of other individual and neighborhood factors. In their analysis, uninsurance carries "social consequences" in addition to health ones. [xxi]

4. Promote Structural Competency. This term, developed by myself and Hansen[xxii], promotes awareness of ways that symptoms of mental and physical illness, as well as stigma against these illnesses, and shaped by larger upstream economic and political conditions. We theorize a five-step conceptual model meant to promote awareness of forces that influence health outcomes at levels above individual interactions. As we write in our seminal paper on the topic, [xxiii]

- We define structural competency as the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health….

  Promoting awareness of structural forces serves as a first step toward promoting recognition of the web of interpersonal networks, environmental factors and political/socioeconomic forces that surround clinical encounters and of better understanding the conversations that take place there within.

In the years since the 2014 publication of this paper, Structural Competency has become the foundation for a number of interventions broadly relevant to the topics we address today.[xxiv]

For instance, in a 2020 paper joined by Maybank and De Maio of the American Medical Association, "Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System," we detail four domains of intervention emerge from a structural competency analysis[xxv]

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- **Promote Truth and Reconciliation**. The US health care system needs to form far-ranging commissions that take full account of the systems exposed and strained by the pandemic and that show why, despite heroic efforts by clinicians, those systems failed people and communities in their time of greatest need. A national "structural vulnerability" analysis, based on a framework that operationalizes the negative health outcomes imposed by poverty, inequality, racism, and discrimination, could highlight weakened structures that contribute to devastating outcomes in vulnerable populations.[2] The analysis should also consider the full breadth of communities made vulnerable by inadequate infrastructures and policies, from first responders endangered by inadequate production and supply chains for personal protective equipment or coronavirus tests, to rural communities put at higher risk of medical bankruptcies…Such analysis also needs to include self-reflection regarding the structural disparities created and sustained by the US health care system.

- **Reimagine Infrastructure**: The US health care system needs to build more structurally competent community health centers and hospitals that address patients' social needs in addition to their medical ones. Such rethinking has long been part of medical attempts to address inequities, from Geiger's Mississippi clinics that wrote prescriptions for food in the 1960s, to numerous community health centers around the US, and Health Leads, which provides access to essential resources alongside medical care today. Such efforts need to be built out systemwide, substantially expanded in collaboration with communities, and funded and reimbursed through vast new public-private partnerships that can support a diverse array of potential commitments and collaborations. Structurally competent health centers could, for instance, ensure internet access (for expanded telemedicine), provide food and housing assistance (in cases of food or housing insecurity), deliver resources (protective equipment), and create new medical-financial-legal partnerships (helping people with rental issues, labor concerns, immigration). Ongoing, community- and meta-level assessment could then coordinate and evaluate services, track potential overlap, and innovate and develop future partnerships.

- **Democratize Information**. It is essential that the US health care system build and sustain robust channels of communication with affected communities, ultimately valuing community-level intelligence to inform health system strategies for emergency preparedness and response. Doing so means markedly expanding the public voice of the medical and health care professions more broadly, such as by partnering with media, social media, and other platforms and with communities to co-create health messaging and response strategies that are antiracist, relevant, and rooted in science. Such platforms could promote structurally competent information about systemic inequities and ways to mobilize responses to them. These networks

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also could provide powerful channels to help counteract the misinformation and extremism that have been promulgated on social media during the pandemic.

- **Educate**. The US health care system needs a new, structurally competent Flexner Report, a new Hippocratic Oath, and a new set of board examinations. Health equity could be promoted by educating physicians about social inequality, training more clinicians to consider and treat the upstream structural, social, and environmental conditions that often underlie disease. This also means training a workforce of public health–qualified clinicians who understand the social, structural, and political basis of disease, and embrace joining medical care with public health in ways that facilitate system redesign that aligns the two fields instead of segregates them.

Clark applies a somewhat similar framework to address upstream risk of gun violence and suicide among LGBTQ populations generally.[xxvi] And our group at Vanderbilt published an analysis, "Structural competency and the future of firearm research," which develops a structural framework around research into US gun violence and addresses the risks, traumas, meanings, and consequences that firearms represent for all communities—and highlights the importance of a renewed focus on mental health and safety for communities of color. Speaking of the risks of gun suicide and partner violence during the pandemic, the paper specifically calls for,[xxvii]

- …sustained collaborations between researchers, victims, survivors, communities, funders, politicians, and others. Indeed, the pandemic exposed the almost complete absence of trusted voices that…warned credibly of the dangers of growing numbers of guns kept in homes where, for instance, children were home-schooled. Mental health experts can develop better messaging through partnerships with faith and community organizations, technology platforms, and services that reach at-risk individuals. Mental health knowledge about the co-morbidity of conditions that preempt both inter- and intra-personal firearm violence might be adapted by social media companies, first responders, employment boards, or delivery services.

Conclusions:

As a psychiatrist and a sociologist, I see America's mental health crisis jointly as a series of individual level tragedies that urgently need to be addressed, and as a challenge to our nation to reimagine and build anew the structural fault lines that rising rates of depression, addiction, and suicide expose. The pandemic, and our national reckoning with racism and inequity, have thrown into stark relief the need for structures that promote social capital and

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that mitigate the burden of existing mental-health inequities to promote healing from the past three years—and indeed to better prepare the US for future pandemics.

Rising rates of mental illness during the pandemic are also a clear reminder that the US cannot treat its way out of mental health problems with therapeutic methods alone. COVID-19 is a disease of communities and networks, a pathogen that floats along the infrastructures of human relations. Only by better strengthening networks and supporting the mental health of all communities will we fully return to well-being.

Thank you again for the opportunity to address this esteemed body.

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