Testimony by Dr. Wizdom Powell, PhD, MPH
Committee on Ways and Means
Hearing on "America's Mental Health Crisis"
February 2, 2022

Good Morning Chairman and Members of the Committee:

It is an honor to be invited to testify today about America's Mental Health Crisis. I am deeply troubled by the scientific evidence base documenting upticks in mental health conditions among U.S. adults in the aftermath of COVID-19. Even more troubling than the distal data points are proximal insights from mental health providers across our nation who are telling us that our current mental health delivery systems, which were fledging at best before the pandemic, are veritably collapsing in its presence. As a trained clinical psychologist and population health scientist, I am bearing witness to this crisis in my day-to-day community-based advocacy and policy work. But, like many Americans, this crisis has also found its way to my family's doorsteps.

My 14-year-old niece is agentic, savantishly brilliant, and in the developmental throws of adolescence. I will be using the pseudonym Tasha when referring to her throughout. She also has a history of mental health obstacles that sometimes overshadow her grit and numerous strengths. When she is thriving, she lights up the room with her cerebral humor. However, when she is having emotional struggles, she is defiant and self-destructive. One evening, roughly 6 months ago, I received a frantic call from my sister telling me that my niece was having a violent emotional episode. We, as a resourceful family launched into problem-solving mode. We attempted to locate a crisis center or other emergency psychiatric support services in her geographic area. I called colleagues to see if they could make a personal referral. None of these efforts produced a solution. The only option we had for rapid mental health support in 2020, during a period of intense tension between law enforcement and communities of color, was to call a police officer to the scene. For my 14-year-old niece. There were no adequate systems in place for her and despite the compassion and warmth of the arriving officer, he was ill-equipped to manage her acute psychotic break. He had no formal mental health training. He interpreted her symptoms through a law and order lens because that is what his training taught him to do. So, I am here today also because we are failing Tasha and so many other children like her who have significant promise to contribute to a nation's economic vitality and competitiveness.

My niece Tasha's story illustrates **four few key points** about America's mental health crisis that I would like to use the balance of my testimony to highlight. I will end my testimony with some suggested courses of positive action.

Key Point 1: A Shadow Mental Health Pandemic is Raging in Our Nation and Youth are at the Epicenter

As we are painfully aware, COVID-19, its accompanying physical distancing requirements, and our nation's racial reckoning converged to produce what we refer to in the social sciences as a mental health *syndemic*.[i, ii,iii] That is the overlap of two or more epidemics or disease clusters over time, space, and geography.

For instance, among US adults, we are observing pandemic period elevations in symptoms like feelings of isolation and clinically relevant posttraumatic stress disorder (PTSD), other generalized anxiety, and depression. Generally speaking, depression is a mood disorder characterized by the lack of interest or pleasure in most activities and can include a variety of symptoms that are not limited to, changes in appetite, physical pain, feelings of hopelessness and helplessness. And so that we are crystal clear, the broader, population-level impacts of depression were quite significant before COVID-19. In fact, 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 cited. These estimates are largely from 2010.[iv] 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. The recent high-profile suicides of MARTA CEO and General Manager, Jeffrey Parker and Hyattsville, MD, Mayor, Kevin Ward, Actress Regina King’s son, Ian Alexander, Jr., and former Miss USA Cheslie Kryst's are just a few tragic reminders that suicide knows no demographic boundaries.

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.[v] However, in comparison, many more Americans appear to be self-medicating their ways right now through pandemic fatigue.

However, if we think these data on the mental health crisis in adult populations are alarming, then we should all be kept awake at night by the state of mental health among American youth. In a recent US Surgeon General’s Advisory, it was reported that up to 1 in 5 children ages 3 to 17 in the US reported having a mental, emotional, developmental, or behavioral disorder.[vi] This same advisory noted that in 2016, half of the 7.7 million children with treatable mental health disorder, did not receive adequate mental health treatment.[vii] It is further apparent from national data that after a year of lockdowns and remote schooling and the disruption of social norms, teens and young adults are reporting growing levels of depression, stress, anxiety, and suicidal behavior.[viii]

According to a recent national study published by the Centers for Disease Control and Prevention, the proportion of mental health–related emergency department (ED) visits among adolescents aged 12–17 years increased 31% in 2020 compared with visits

documented during 2019. And this apparent increase in suicide was higher among girls like my niece Tasha between the ages of 12 and 17. Statistics like these documenting increased youth suicide are especially alarming for Black youth, who recorded the largest increase in suicidal attempts (80%) from 1991-2019 – findings that ignited the establishment of the Congressional Black Caucus Emergency Task Force on Black Youth Suicide and Mental Health.[ix]

We are also learning from national-level claims data that youth experiencing COVID-19 related events (COVID-19 diagnoses, negative COVID-19 tests, or COVID-19 symptoms only) are even more vulnerable to mental health challenges and conditions.[x] The vulnerability to mental health challenges among youth with COVID-19 related events is even more enhanced among those with intellectual/developmental disabilities and adverse childhood experiences. Taken together, these findings mean that we are likely only seeing the tip of the iceberg for these more vulnerable youth.

> As Seth Lavin, Principal at Brentano Elementary Math & Science Academy in Chicago, Illinois noted, *"Children suffered in this pandemic. … There is no way to unbreak everything the pandemic broke….Our job is to be what children need. Their needs are different now. We have to be different too."*

Future generations depend on us holding space for and speaking to the cumulative emotional wounds being metabolized by our youth in this moment. Teachers, who are desperately burned out and in need of their own radical healing, cannot shoulder this caretaking burden alone. We will not train our way out of this crisis. If we are to be what our children truly need, then youth mental health has to be a priority for every decisionmaker and system that routinely touches them. And we have to fight for them as if our lives and future at stake because they are.

Key Point 2: Our Current Mental Health Labor force is Inadequately Supplied to Effectively Serve Our Nation's Evolving Demographics

On the night my niece Tasha had her mental health emergency, we learned a tough lesson about our nation's inadequate mental health labor force supply chain. I wish that I could say that this lesson was anomalous. But unfortunately, our family is not the only ones in this classroom of lived experience.

Before the COVID-19 pandemic took hold of our globe, the US was already struggling to build and sustain a viable mental health labor force. Looking ahead and anticipating our future supply and demand is critical to ensuring readiness. To be certain, the precision of future mental health workforce projections is contingent on a number of factors like population growth, socioeconomic conditions, geographic concentration of providers, training rates, insurance coverage stability, and others. Most projections suggest a decrease in the number of adult psychiatrists by 2030 and an overall increase in the

supply of other workers across the mental health ecosystem.[xi] Yet, many models simulating these estimates were analyzed before the COVID-19 pandemic.[xii]

Further, even if we could accept these estimates as accurate projections, they would significantly underestimate labor force supply chain inputs and outputs for Black, Indigenous, and People of Color, as well as other historically excluded subpopulations (e.g., LGBTQ+, individuals with intellectual/developmental disabilities, and those whose primary language is not English). Because we have not systematically disaggregated, measured, or monitored mental health workforce data for historically excluded populations, less is known about trends and what we can expect in the future. Data analyzed by the American Psychological Association's Center for Workforce Studies[xiii] in 2018 indicate the following:

- "In 2015, 86 percent of psychologists in the U.S. workforce were white, 5 percent were Asian, 5 percent were Hispanic, 4 percent were black/African-American and 1 percent were multiracial or from other racial/ethnic groups. This is less diverse than the U.S. population as a whole, which is 62 percent white and 38 percent racial/ethnic minority."

Demographers estimate that we are on track to become a majority Black/African American and Hispanic/Latino nation by 2040. These shifting population s represent an opportunity for us to live the principles set forth in many of the founding documents of our nation. Moreover, while social identity concordance between mental health providers and patients is not the only important factor in establishing a fortified therapeutic alliance, data suggests that it can often improve outcomes (e.g., patient satisfaction and retention). At the same time, it is crucially important that we train all mental health practitioners in culturally centered treatment delivery as the burden to meet the unmet needs of overlooked populations cannot and should not be carried solely by individuals with shared social identities. To meet the demand produced by this impending demographic transition, we need to renew federal commitments to fueling and retaining a diverse, equitable, and inclusive pipeline to mental health careers.

Key Point 3: Mental Health Delivery Systems are Outdated, Fragmented and Need to Be Radically Reimagined to Meet Present and Future Demand

When faced with an outdated and fragmented mental health delivery systems, families and individuals have to make tough and unsatisfying choices about where to seek care. Yet, it is important to acknowledge, as outlined by the Congressional Research Service, the fragmentation we are often forced to navigate contemporarily is a historical artifact of US mental health delivery systems.[xiv] History reminds us that even as treatment advances are occurring, the growth in our reimbursement models and processes of care has been comparatively stagnant. Our way of organizing medical care into the treatment of the body as disparate organ parts, also limits our radical imagination for systems transformation including aligning incentives for treatment of the whole patient. Our

patients feel this fragmentation viscerally when they enter mental health delivery systems.

In CT, where I live, work, play, and pray, it is also not uncommon for me to hear from less connected community members that they do not know where to go for support with mental health crises. Pathways into the mental health delivery system are obscure for far too many Americans, who when compared to other nations are the most open to the receipt of mental health services.[xv] Psychiatric emergency rooms (ERs) are one of the most frequently used pathways into mental health delivery systems. Typically, non-institutionalized individuals in crisis enter the mental health delivery system through psychiatric ERs rooms.[xvi] But, these care delivery sites are also becoming overburdened during the pandemic. For example, a recent investigation published in the Journal of the American Medical Association (JAMA) Psychiatry documented an increase in the average mental health-related ER visitation rate from 2019 to 2020.[xvii] Even if families or individuals muster up the courage and conviction to seek care in the ER for mental health, the wait times are often prohibitively longer than visits for physical health problems.[xviii]

The limited number of available psychiatric beds in our nation for adults and youth means also that many patients are boarding in ERs for extended periods.[xix] This practice reduces the overall capacity of ERs to serve other patients. But it also could mean critical delays in treatment planning and diminished patient motivation to seek help. This is what we faced as a family when my willful adolescent niece 'decided' and then managed to convince her exasperated single mom that she would be fine to go home after boarding in the ER for nearly 24 hours. She needed more intensive treatment.

Those of us working in mental health care ecosystems, know that the lack of efficiency and clarified pathways to care come at a high cost to patients, providers, and payers. According to recent estimates, patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions cost 2-3 times more as those without.[xx] We also know that effectively integrating medical and behavioral (mental health and substance use) healthcare is a true north goal that can rarely be effectively achieved because of structural barriers.

While we passed the 2008 Mental Health Parity and Addiction Equity Act, there are still a number of existing insurance and policy-level loop holes that compromise patient's ability to secure affordable care. Then there are lifetime maximums on the receipt of mental health care that mean many more patients leave treatment without having their mental health challenges remedied or mitigated. There are also score of uninsured patients who are unable to pay the high costs of mental healthcare even when it is available.

A bright spot during the pandemic was the expansion of telemedicine services, which included mental health care that can now be delivered by providers across state lines.

However, the future of those expansions is hanging in the balance as we wait to learn if they will be retained post-pandemic.

And expanded telemedicine services are not a magic bullet for America's mental health crisis. For a number of reasons, we need to consider telemedicine as one of many tools in our overall mental healthcare delivery toolkit. First, taking full advantage of telemedicine for mental healthcare requires internet *and* reliable broadband access. Many individuals living below poverty lines and lacking a thrivable wage reside in broadband desserts. Second, crowded, multigenerational homes present other challenges to privacy that may limit telemedicine uptake. Third, for populations with high-levels of cultural stigma and rational mistrust of medical organizations, the lack of face-to-face contact may produce other relationship-building barriers. Lastly, rural populations are especially edged out of a variety of telemedicine services because of more limited broadband capacity. Thus, we may bear witness to an exacerbation of mental health disparities in these populations even with and oxymoronically because of expanded telemedicine services.

Each of the features of our mental healthcare delivery system lifted up in this section are untenable and yet solvable for a highly industrialized nation.

Key Point 4: Unmet Mental Health Needs Will Further Exacerbate Long Standing Racial/Ethnic Health Disparities and Inequities

While every population group has children like my niece Tasha and adults with mental health challenges, there is subpopulation variation in the frequency of and subsequent impacts of their occurrence.

In our nation, there is a longstanding and documented history of unequal treatment of Black, Indigenous, and People of Color by healthcare providers. Those of us in partnership with medically underserved communities, know that it is enough to reduce mental health disparities defined as preventable differences in health outcomes among population groups. We have the tacit wisdom to know that what's needed most now is a focus on creating mental and/or behavioral health equity or the circumstance where every American has a fair and just opportunity to live a life full of complete emotional wellness. While most contemporary instances of unequal treatment are the consequence of unconscious biases, there are bones in our basements, examples of fully conscious bias and systematic exclusion requiring deep excavation to produce mental health equity.

For a longtime, the narrative in our nation has been that Black, Indigenous, and People of Color suffer less from mental health disorders and conditions. Evidence affirms that relative to non-Hispanic White populations, Black/African Americans have been less likely to be clinically diagnosed with some mental health disorders. However, a deeper exploration by the Office of Minority Health[xxi] reveals:

- "Black/African American adults in the U.S. are more likely than white adults to report persistent symptoms of emotional distress, such as sadness, hopelessness and feeling like everything is an effort.
- Black/African American adults living below the poverty line are more than twice as likely to report serious psychological distress than those with more financial security."

Even when the need for mental health care is identified and accepted, treatment gaps for Black/African Americans and Hispanic/Latinos persist. An equally troubling fact is that the social consequences of unmet mental health needs in these historically excluded populations are most severe with many un-and-under individuals becoming disabled or justice-involved.

There are a number of factors contributing to poor mental health outcomes in historically excluded populations. However, the factor receiving the most scientific attention is racism. Racism is a biopsychosocial stressor that impacts the physiology, psychology, physicality, and behavioral coping responses of exposed individuals. Numerous studies conducted at one slice in time and longitudinally affirm that racism contributes to depression, anxiety, posttraumatic stress disorder, and substance misuse/abuse in Black, Indigenous, and People of Color. After the past two years of reckoning with racialized violence, I am sure that I do not need to remind this body of its socioemotional consequences. However, it is important to point out that our current mental health diagnostic and clinical assessment tools do not formally acknowledge this racism as potentially stress inducing and traumatogenic. This lack of formal acknowledgment also means that future providers do not receive training in the treatment of race-related stress or trauma, which results in patient harm, clinical error, and deepening lack of faith in mental health providers. It means that we may be building mental health delivery systems but Black, Indigenous, and People of Color will never come.

We should also be bearing in mind that many more Black, Indigenous, and Pacific Islanders perished from, lost loved ones to, and shouldered a significant burden of the economic fallout from COVID-19. Mental health conditions and the higher comorbid physical chronic disease burden among historically excluded populations represent a tremendous threat to our economic security as a nation. Mental health disparities are effectively hemorrhaging talent of American citizens vital to our progress. Remedying this particular dimension of America's mental health crisis is not about displaying political correctness or demonstrating structural wokeness. Rather, it is about ensuring that we will not be as philosopher Kwame Appiah suggests, condemned by future generations for engaging in "strategic ignorance' and avoiding the kinds of truths that might force us to face the failures of our mental health delivery systems in which we are complicit.[xxii]

Potential Solutions and Promising Practices

My role today was to set the stage and provide a contextual view of America’s mental health crisis. There are other experts that will testify to potential policy and practice transformation recommendations. However, I would like to highlight a few potential promising practices to each of the key points lifted up in today’s testimony.

1. **Deliver, support, and incentivize social emotional learning** (SEL) curriculum delivery in educational and community-based settings. SEL is a recognized and critical component of positive youth development that focuses on the skills provision like managing and understanding behaviors and emotions, problem solving, building healthy coping strategies, enhancing self-esteem and confidence, building positive relationships, and increasing resilience so that youth are better equipped with navigating adversities.

2. **Stop focusing purely on the top of the labor force supply chain funnel**. While PhD and MD-level providers are indispensable to mental healthcare delivery, they require lengthy training timetables. Also, such providers bill at higher rates and are often less accessible to un- and underinsured populations. We have tremendous opportunities to build a complimentary paraprofessional mental health labor force by harnessing the power, reach, and boots-on-the ground influence of community health workers (CHWs). Enlist, train, and design payment reimbursement models CHWs to provide rapid mental health assessments, brief crisis interventions, navigation support, and rapid referrals. CHWs are poised to be trained in conducting assessments and providing Mental Health First Aid. We need to **realign reimbursement models and insurance systems** to ensure that CHWs are reimbursed and fully integrated into the mental health care delivery team.

3. **Reaffirm investments in training programs for students from Black, Indigenous and People of Color, first-generation graduate student, and other historically excluded populations**. Despite public perceptions that the need for such programs has passed, it is notable that the percentage of providers from these populations are inconsistent with their representation across our nation. For many individuals having a provider who looks like you and perhaps also shares your same values could make a huge difference in mental health treatment uptake and adherence.

4. **Support and lead efforts to democratize mental health treatment**. It is painfully obvious that our demand is outpacing our labor force supply. Our current models of treatment delivery are quickly becoming obsolete. At the same time, we are bearing witness to an explosion in digital mental health solutions that have promise to mind some of the treatment gaps. Like any other rapidly scaling innovations, digital mental health solutions also might benefit from the development and adoption of National Digital Mental Health Safety and Quality Standards.

5. **Focus on building structural competencies among mental health providers to address unmet social, physical, and mental health needs among historically excluded populations**. According to Dr. Jonathan Metzl and colleagues, structural competencies are defined as "trained abilities 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."(p. 6)[xxiii] Such competencies are essential to advancing health equity in our nation.

Conclusions

In closing, I want to underscore that neither our emergent adult nor youth mental health crises in America are a consequence of individual failings. My niece Tasha is not doing anything to 'deserve' the mental health cards she was dealt. She is just an American girl daring greatly at becoming during a period of great social uncertainty. Youth and adults across our nation who are suicidal or suffering in silence from depression, anxiety, or other serious mental illness are not doing anything to 'deserve' the mental health cards they were dealt. America's mental health crisis is a 'wicked problem' that have roots in structural disadvantage, environmental adversities, and barriers to high quality mental health care. Thus, the solutions we offer should address these root causes head-on and as an integrated component of mental health care delivery. Americans deserve better mental health care coordination, integrated delivery systems (specifically those that combine primary and mental healthcare), and policies designed to not simply help them cope with mental health challenges…but to radically heal, grow, and thrive in their aftermath. That is my hope and prayer for my niece and every citizen, and I am optimistic that there is both political will and a legislative way to do so.

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

---

[i] Singer, M. (2009). *Introduction to syndemics: A critical systems approach to public and community health*. John Wiley & Sons.
[ii] https://onlinelibrary.wiley.com/doi/10.1002/jcop.22747
[iii] https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.202000725
[iv] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007565/
[v] https://www.jec.senate.gov/public/_cache/files/0f2d3dba-9fdc-41e5-9bd1-9c13f4204e35/jec-report-deaths-of-despair.pdf
[vi] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf
[vii] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[viii] https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w
[ix] https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf
[x] https://aspe.hhs.gov/sites/default/files/documents/0bcc372f4755cca29ebc80a47cfe300e/child-adolescent-mh-covid.pdf.
[xi] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf
[xii] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf
[xiii] https://www.apa.org/monitor/2018/02/datapoint
[xiv] https://sgp.fas.org/crs/misc/R40536.pdf
[xv] https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries
[xvi] file:///Users/wizdompowell/Downloads/RAND_RBA889-1.pdf
[xvii] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780949
[xviii] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0344
[xix] https://khn.org/news/article/children-teens-emergency-room-boarding-mental-health/
[xx]https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx
[xxi] https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American
[xxii] https://www.washingtonpost.com/wp-dyn/content/article/2010/09/24/AR2010092404113.html?hpid=opinionsbox1
[xxiii] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf