American Foundation for Suicide Prevention

Written Testimony of Robert Gebbia

Chief Executive Officer, American Foundation for Suicide Prevention

House of Representatives, Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Mental Health Emergencies: Building a Robust Crisis Response System

May 13, 2021

Chairwoman DeLauro, Ranking Member Cole, and members of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, thank you for the opportunity to testify today on the vital topic of crisis response services. I am Bob Gebbia, Chief Executive Officer of the American Foundation for Suicide Prevention (AFSP). AFSP is the nation's largest non-profit dedicated to saving lives and bringing hope to those affected by suicide. AFSP was established in 1987 and gives those affected by suicide a nationwide community empowered by research, education and advocacy to take action against this leading cause of death. 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 hundreds of suicide researchers who are advancing the science of suicide prevention.

With over ten million Americans[1] living with serious thoughts of suicide, over one million[2] suicide attempts annually, and as a leading cause of death in the country, suicide is a national public health crisis that requires robust investment and response that is commensurate with the scope of the problem. We have seen a 35% increase in the national suicide rate from 1999 through 2018[3] (and fortunately two years of declining numbers of suicides, 2% decrease in 2019 and preliminary numbers showing a 5% decrease in 2020). 1 in 4 Americans will have a diagnosable mental health condition in their lifetime[4] - 1 in 5 each year - and the World Health Organization[5] has declared depression a leading cause of medical disability globally. Other conditions such as substance use disorders are on the rise

[1] Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic (CDC, 2020): https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm?s_cid=mm6932a1_w
[2] NIMH Suicide Statistics Webpage (NIMH, 2021): https://www.nimh.nih.gov/health/statistics/suicide#:~:text=During%20that%2020%2Dyear%20period,females%20(6.2%20per%20100%2C000).
[3] Increase in Suicide Mortality in the United States, 1999-2018 (CDC National Center for Health Statistics, 2020): https://www.cdc.gov/nchs/products/databriefs/db362.htm
[4] Mental Health By the Numbers (NAMI): https://www.nami.org/mhstats
[5] Depression Fact Sheet (WHO, 2020): https://www.who.int/news-room/fact-sheets/detail/depression

with an unprecedented number of opioid overdose deaths in 2020. And yet less than half of Americans with mental health conditions are receiving care. This begs the question, how do we ensure that people can be connected to care, and why are we unable to adequately respond to mental health and suicidal crises?

Today, I am here to speak about a crisis response system that is holistic, responsive, and able to mitigate suicidal and mental health crises. The COVID-19 pandemic greatly increased depression, anxiety, substance use, and other well recognized risk factors for suicide. As the viral component of the pandemic becomes more manageable, it will be incumbent on us to adequately address the often-overlooked mental health needs of the country, especially as communities continue to experience the health, economic, and social challenges wrought by the pandemic.

Though great strides have been made by the country and by Congress to support the mental health needs of the public, much more work must be done to tackle these complex and overlapping challenges. We must aggressively pursue scientific research on mental health and suicide prevention. We must implement national suicide prevention strategies. And we must advance policies that can fill the gaps in our public health and safety systems.

That is why AFSP applauds the Subcommittee for hosting this hearing on mental health crisis response. Our national inefficiencies in responding to mental health needs is no more evident than in the crisis service space. Too many communities do not have the capacity to respond to individuals in emotional distress or in a mental health crisis. Too often, emergency medical or law enforcement personnel are the only interventions available – and more often than not, these responders are not trained to respond to these types of emergencies.[6]

Ineffective responses to mental health crises yield negative personal and systemic consequences. An average of 10% of law enforcement agencies' total budgets is spent responding to and transporting persons with mental illness. Nationwide, an estimated $918 million was spent by law enforcement on transporting people with severe mental illness. Research also shows that 21% of total law enforcement staff time is spent responding to and transporting people with mental illness.[7] Members of law enforcement do not serve as treatment providers for any other illness, yet they are de facto first

[6] Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters (Treatment Advocacy Center, 2015): https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted
[7] Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness (Treatment Advocacy Center, 2019): https://www.treatmentadvocacycenter.org/road-runners

responders for individuals experiencing complex crises that warrant specially trained responders as 1-in-10 police responses involve someone with a mental health condition.

What does this massive misallocation of emergency response resources yield? Individuals in emotional distress or experiencing a suicidal crisis waiting in emergency rooms and jail cells for treatment, or worse – 1-in-5 incarcerated individuals lives with a mental health condition and 1-in-4 individuals killed by law enforcement officers had a mental health condition. Unnecessary admission to emergency departments, which often include extended waiting times (ranging from hours to days) without receiving mental healthcare, can be dangerous; 8 in 10 emergency department doctors reported that the mental health system is not working for patients.[8]

When an individual is experiencing a mental health crisis, they need to be quickly connected to suitable resources and services, depending on their need – the Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized that crisis call centers and hotlines, mobile crisis intervention teams, and stabilization facilities and services are the core components of an effective crisis response system.[9]

And right now, in this moment, we are at an inflection point to determine how our country chooses to respond to these instances of acute mental distress. In October 2019, Congress unanimously passed the *National Suicide Hotline Designation Act*, to establish the "988" crisis number and support the implementation of an easily accessible mental health and suicide crisis response system.[10] The 988 number will connect callers to the National Suicide Prevention Lifeline, the 24/7 free and confidential support system for individuals in need, funded through SAMHSA.[11] The Lifeline consists of an expansive network of over 170 local- and state-funded crisis centers located across the United States. The counselors at these local crisis centers answer the millions calls and chats from people in distress that the Lifeline receives every year. The Lifeline's crisis centers provide the specialized care and resource referrals in the local community with the support of a national network. We must recognize that the Lifeline is a key component of crisis response, but there is a need to go beyond this.

[8] Survey: 8 in 10 ER Docs Say Mental Health System is Not Working for Patients (ACEP, 2015): https://www.prnewswire.com/news-releases/survey-8-in-10-er-docs-say-mental-health-system-is-not-working-for-patients-300193187.html
[9] National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (SAMHSA, 2020): https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[10] National Suicide Hotline Designation Act (116th U.S. Congress, 2020): https://www.congress.gov/bill/116th-congress/senate-bill/2661
[11] National Suicide Prevention Lifeline: https://suicidepreventionlifeline.org/

The Lifeline currently receives several million calls and chats every year but has seen steady volume increases annually. When the 988 crisis line becomes nationally available on July 2022 Americans will have a number as recognizable as 911 to reach the services that they desperately need. It is imperative that as this system goes live, local crisis centers who answer the calls and the national network that administers the service and provides quality assurance, the back-up call centers, and training are prepared. This is where crisis services can go from a rebranding to a reimagination, as we transfer to a more effective response for those in crisis who are too often met with ineffective interventions. This includes expanding the current capacity of local centers to not only answer the National Suicide Prevention Lifeline calls to deescalate suicidal or mental health crises, but to include a continuum of care that can send mobile crisis outreach when needed, provide follow-up to callers, and divert from current emergency response efforts that too often lead to poor outcomes for individuals in need. Current investments and support for crisis response services cannot meet the existing demand, let alone the projected increase in demand that will undoubtedly be the consequence of this increased access as a result of 988.[12]

Many states do not have the capacity to effectively respond to crisis callers in need, let alone deploy necessary mobile crisis outreach. In Chairwoman DeLauro's and Ranking Member Cole's home states of Connecticut and Oklahoma, over 1-in-4 calls made to their Lifeline network centers are not able to be answered in-state today, and this is prior to the availability of 988. Supporting crisis call center capacity to answer incoming calls will be crucial for the rollout of 988, but without also supporting the continuum of crisis response, including mobile crisis outreach and stabilization services, the promise of 988 as a robust, comprehensive alternative to 911 emergency services will not be actualized.

Not only are crisis response services necessary – they are effective. The mental health community recognizes that active engagement, active rescue, and collaboration between crisis and emergency services can save lives.[13] Specialized responses to mental health crisis share the common goal of diverting people with mental health crises from criminal justice settings into mental health treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs

[12] Our Network (National Suicide Prevention Lifeline): https://suicidepreventionlifeline.org/our-network/
[13] Helping callers to the National Suicide Prevention Lifeline who are at imminent risk of suicide (National Library of Medicine, 2015): https://pubmed.ncbi.nlm.nih.gov/25270689/

of persons in crisis.[14] Of the millions of calls made to the National Suicide Prevention Lifeline each year, 98% of crises are successfully deescalated over the phone and through referral and additional service connection.

But mental health crises are variable, and when additional intervention and support is necessary, mobile crisis outreach and stabilization abilities have been shown to be valuable and lifesaving. In Eugene, OR the CAHOOTS[15] program provides mobile crisis interventions with medical and mental health personnel that rarely require police involvement, correspond with much lower incidences of untoward outcomes against individuals with mental health conditions, and saves millions of dollars a year. Ensuring that callers in every community have access to all the facets of crisis response will be crucial for developing a culture of crisis response in the United States – because when some individuals and communities fall through the cracks it weakens public perception of these nascent services.

We cannot let 988 just be a rebrand of our current crisis response system – we must reimagine how communities respond to and support mental health crises in any community, anytime, anywhere. Our local crisis center infrastructure must be strengthened to address the needs of millions of people in emotional distress every year. Building this capacity within states is critical, or calls will go unanswered, wait times will increase, and people will not receive the help they need.

Conservative estimates of call volume to the 988 system indicate a doubling of call volume – with other projections showing even greater increases in crisis service demand.[16] The easily accessible dialing code, coupled with promotional campaigns to encourage help-seeking, is expected to dramatically increase call volume to the national suicide and mental health crisis hotline. This at a time when the public's mental health is of high concern. Recent reporting[17] from the Centers for Disease Control and Prevention indicate that mental health and suicidal ideation has worsened since the onset of COVID-19; approximately twice as many respondents reported serious thoughts of suicide and 40% of U.S. adults reported struggling with mental health or substance use. Present-day stressors can be

[14] Crisis Now: Transforming Services is Within Our Reach (National Action Alliance for Suicide Prevention, 2016): https://theactionalliance.org/sites/default/files/crisisnow.pdf
[15] What is CAHOOTS (White Bird Clinic, 2020): https://whitebirdclinic.org/what-is-cahoots/
[16] 988 Serviceable Populations and Contact Volume Projections (Vibrant Emotional Health, 2020): https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443
[17] Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic (CDC, 2020): https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm?s_cid=mm6932a1_w

particularly challenging for at-risk communities, with nearly 1-in-4 young people reporting suicidal thoughts.

The potential for 988 to build a foundation where the default mental health providers are not police, depends on proper implementation, policy support, and robust funding. In many communities 988 will be the most immediate (and in some, the only) easily accessible crisis service resource available. Few communities have access to the excellent crisis service models outlined by my fellow panelists. This much change, all Americans should have access to the best crisis care possible.

A robust crisis service infrastructure will be a safety net for the general public, where mental health crises affect all communities, but these systems will also support our most vulnerable. The Veterans Crisis Line will become accessible through the 988 crisis hotline and specialized services for particularly at-risk populations, including LGBTQ youth and people in rural communities, will also be paramount in this new system.[18]

In a cross-sectional before-and-after observational study, on the suicide rates in England and Wales between 1997-2006[19] on the implementation of mental health service provisions, one of the main recommendations was the provision of 24 hour crisis care, as it was associated with the largest decrease in suicide rates, along with policies for dual diagnosis patients and multidisciplinary review and information sharing with families. There has been a major shift in attitudes around opening up around one's mental health as a legitimate and critical part of human health.

The United States has a *National Strategy for Suicide Prevention*[20] that was last updated in 2012 and more recently the U.S. Surgeon General and the National Action Alliance for Suicide Prevention released *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*[21] in January 2021. We agree with these findings but recognize that it will take a significant federal investment in order to implement these recommendations. In particular, the recent Call to Action notes that while the US has a solid foundation, there is much work to be done and outlines six key actions. One of those six actions is, Enhance Crisis Care and care Transitions to ensure that crisis

[18] FAQ for Understanding 988 and How It Can Help with Behavioral Health Crises (MHA, 2020): https://mhanational.org/sites/default/files/FAQ%20with%20vibrant%20FINAL%20COPY.pdf
[19] Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and after observational study (The Lancet, 2012): https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961712-1/fulltext
[20] National Strategy for Suicide Prevention (Action Alliance, 2012): https://theactionalliance.org/our-strategy/national-strategy-suicide-prevention
[21] The Surgeon General Releases Call to Action to Implement the National Strategy for Suicide Prevention (HHS< 2021): https://www.hhs.gov/about/news/2021/01/19/the-surgeon-general-releases-call-to-action-to-implement-the-national-strategy-for-suicide-prevention.html

services are available to anyone, anywhere, at any time, as the current option in many states for an individual who is in suicidal crisis is to call 911 or visit the Emergency Department. In many cases after the call or visit, an individual doesn't receive mental health treatment, loses contact with their health care system, and resurfaces again during the next crisis. As a result, the current approach to crisis care is insufficient, and dangerous as it does not ensure safety or treat underlying mental health conditions or suicidality. Other individuals continue to be readmitted to a hospital multiple times for expensive and restrictive care that may not meet their needs. SAMHSA's recently released *National Guidelines for Behavioral Health Crisis Care*[22] shares that the long-term consequences of inadequate crisis care can include homelessness, involvement with the criminal justice system, and premature death.

In a joint report, the National Association of State Mental Health Program Directors[23] and SAMHSA found that "by enhancing crisis response, community needs can be met, and lives can be saved with services that reduce suicides and opioid-related deaths, divert individuals from incarceration and unnecessary hospitalization and accurately assess and stabilize and refer individuals with mental health, substance use and other behavioral health challenges." These are the outcomes we hope to achieve.

We appreciate the work the Subcommittee has done to increase federal funding for crisis response programs, including the National Suicide Prevention Lifeline and the Mental Health Block Grant's Crisis Set-Aside. The broader mental health community is requesting the Subcommittee to build upon these developments and continue to support additional funding measures that will advance our national crisis response capacity. The Subcommittee will soon receive a report from the Substance Abuse and Mental Health Services Administration and the Veterans Health Administration detailing the opportunities and challenges facing our current crisis response system – we urge you to consider the funding necessary to truly make the future 988 system operational and effective.

Ultimately, you get the system you invest in. Our public investments directly translate to calls answered, services provided, and outcomes achieved. Today, we have call centers that are not adequately funded to answer incoming calls. We have emergency medical and law enforcement personnel responding to crises that they are not adequately trained to address. We have individuals in

[22] National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (SAMHSA, 2020): https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[23] Crisis Services: Meeting Needs and Saving Lives (NASMPHD, 2020): https://www.nasmhpd.org/sites/default/files/2020paper1.pdf

mental health crises waiting in emergency departments and jail cells before they can receive treatment. Our system is wasteful, can increase trauma, and often have negative outcomes for individuals in need. This is the system that our current level of investment yields. We must use the launch of 988 as an opportunity to reimagine crisis response and to make the necessary financial investments to do so.

Again, the American Foundation for Suicide Prevention thanks Chairwoman DeLauro, Ranking Member Cole, and the Labor, Health and Human Services, Education, and Related Agencies Appropriations Subcommittee for spotlighting these urgent issues. We look forward to working with you, crisis service stakeholders, and the broader mental health community to enact the policies and secure the investments to establish a 21st century crisis response system.

Sincerely,

Robert Gebbia
Chief Executive Officer
American Foundation for Suicide Prevention