THE community foundation FOR NORTHERN VIRGINIA

FINDING OUR WAY BACK TO

mental health

The need for accessible, affordable treatment in the midst of collective trauma

FINDING OUR WAY BACK TO

mental health

A SHAPE OF THE REGION™ SPECIAL REPORT

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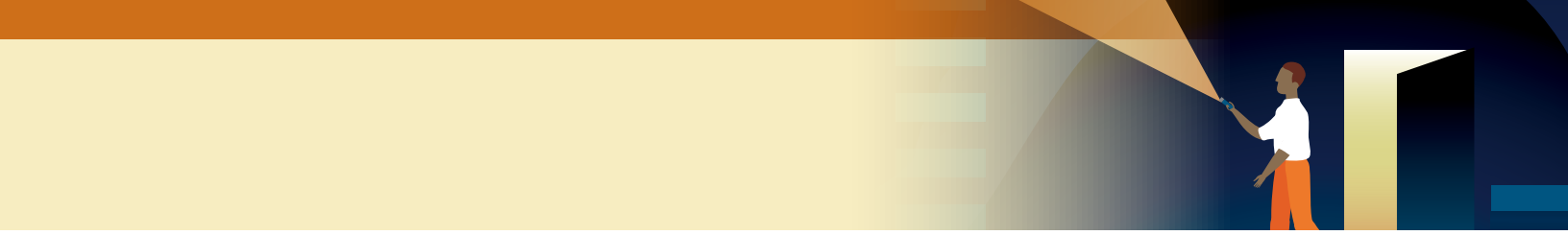
The Community Foundation for Northern Virginia

LIST OF FIGURES



executive summary

The past two years have not been kind to Northern Virginia's collective psyche.

In 2019, about eight percent of the adult population was dealing with active symptoms of anxiety and/or depression. Today, that rate is 28 percent, a nearly four-fold increase, and impacts nearly 550,000 adults in the region. An additional 200,000 adult residents are asymptomatic consumers of mental health services—that is, while their levels of anxiety and depression are not frequent, they are receiving (or want to receive) medication and/or talk therapy. *All told, over 750,000 adults in Northern Virginia (39 percent) have mental health needs.*

An estimated 370,000 of these adults specifically want therapy or counseling. Unfortunately, of those who want it, 39 percent have not been able to get it. This report explores four systemic barriers driving unmet treatment needs in Northern Virginia, including:

PEOPLE STRUGGLE TO ASK FOR HELP

The risk associated with having a mental illness—stigma—has likely lifted somewhat since the pandemic, but remains present in certain communities and professions. People who are unable or unwilling to label their symptoms as part of a mental illness, or who simply do not know where to go, will often look to wayfinders outside of the mental health system for guidance and support.

PEOPLE STRUGGLE TO FIND A PROVIDER

The region is home to approximately 5,100 mental health professionals, who can provide an estimated 127,000 sessions of therapy per week and 6.4 million sessions per year. Because therapy is on a first-come basis, individuals seeking immediate care may face long wait times and delayed care (over the course of a year, everyone will likely be able to find help, a small concession for those who need support now). Limited availability means limited options, and some individuals may find that the therapists who are accepting patients do not have experience treating their specific condition or sub-population.

PEOPLE STRUGGLE TO MANAGE THE COST AND LOGISTICS

Nationally, the main reason that people do not get help for their mental health needs is due to cost, around $215 per session for self-pay in Northern Virginia; out-of-pocket expenses with insurance are lower, at $70 per session, but only half of the region's therapists accept any kind of insurance. Three months of therapy will cost around $2,800 without insurance; a year of therapy will cost $11,000. There are limited low-cost options for those who are not seriously mentally ill or experiencing a crisis.

PEOPLE STRUGGLE TO SEE RESULTS

Treatment effectiveness—that is, the temporary reduction in symptoms of anxiety and/or depression—depends on a host of factors related to the diagnosis, treatment, patient, and therapist; it also assumes that individuals will complete the recommended course of treatment (patient adherence) and that providers will monitor symptoms to adjust their approach and track progress toward recovery (provider adequacy). When these perquisites are not in place, many will struggle to see symptoms improve; others are likely to recover without any intervention.

Recommendations follow on how Northern Virginia can work to support the substantial share of its population with mental health needs by addressing these four systemic barriers to treatment.

quantifying need
IN NORTHERN VIRGINIA

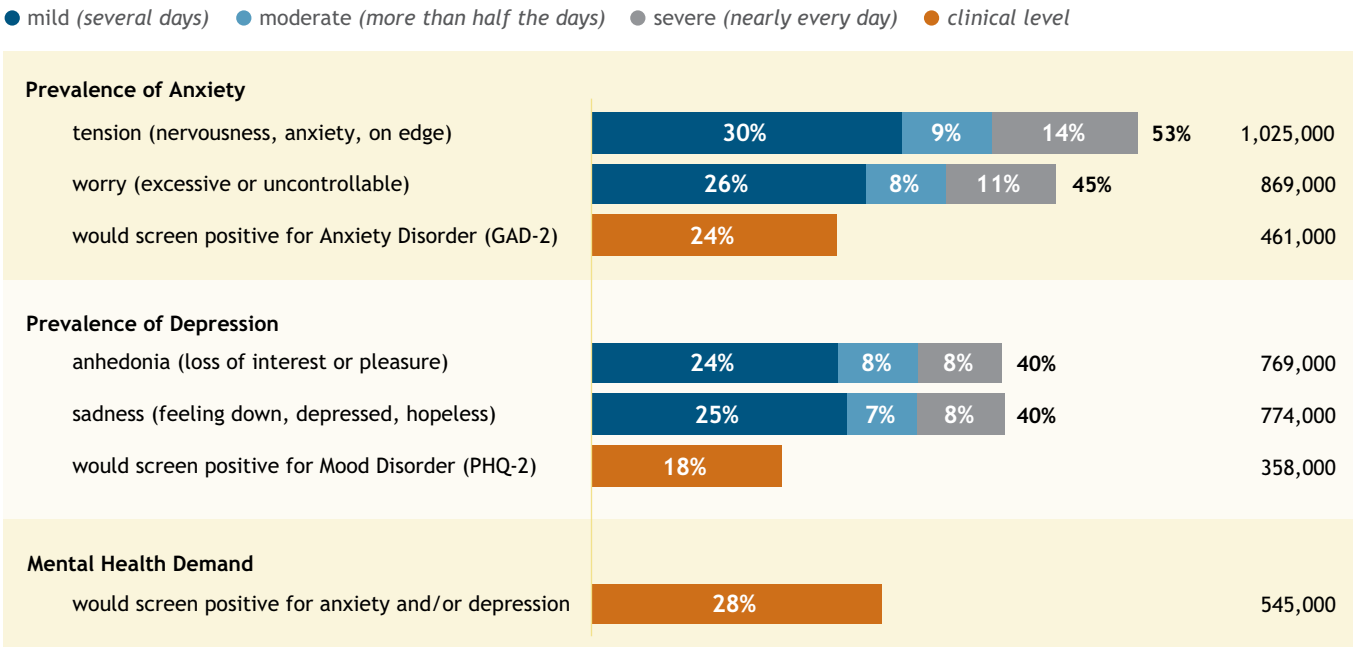
Two years ago, one in twelve adults in Northern Virginia had active symptoms of a mental health disorder. Today, that number is one in four. Nearly 550,000 adult residents across the region are experiencing clinical levels of anxiety and depression, and an additional 200,000 are asymptomatic consumers of mental health services.

SADNESS, APATHY, WORRY, FEAR.

Negative emotions are part of everyday existence, often in rational response to chronic, multiple, and/or acute stressors. They are also extraordinarily common throughout Northern Virginia. Based on responses to the U.S. Census Bureau's Household Pulse Survey from Fall 2021 (September-October), more than half of adults in the region—nearly one million residents—reported feeling nervous or anxious for at least a few days over the past two weeks.[1] Around 40 percent also reported excessive worry, feeling down or hopeless, and/or reduced interest or pleasure in daily activities. Ten percent felt this way *every single day.* See **Figure 1**.

Figure 1.

Mental health needs of adults in Northern Virginia in Fall 2021



Source: Insight Region™ analysis of U.S. Census Household Pulse Survey ("Pulse Survey") for September-October, 2021 for Virginia portion of DC metro ("Northern Virginia").

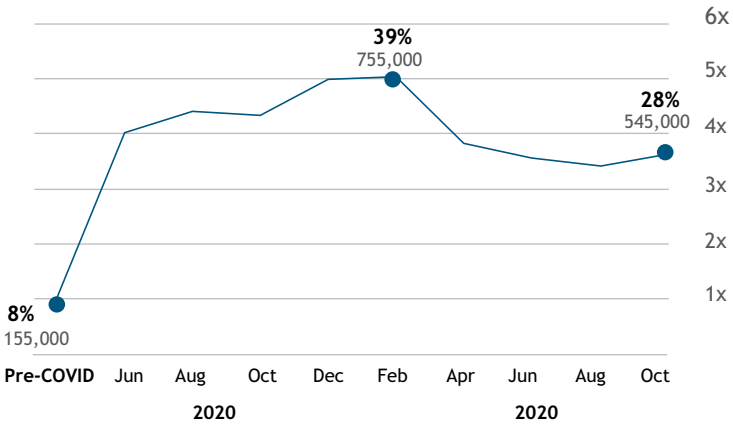
When feelings of anxiety and depression become frequent (more than half of the time), they are considered symptomatic of a *mental health disorder*. An estimated 28 percent of adults in Northern Virginia (545,000 residents) would screen positive for generalized anxiety (using the GAD-2) and/or major depression (using the PHQ-2).[2] In addition to this population with presenting symptoms of a clinical disorder, an estimated 217,000 Northern Virginians with mild or no symptoms are receiving therapy/psychotropic medications or would like to receive such services.

All told, 762,000 adults in Northern Virginia (38 percent of the population) are experiencing active symptoms of a mental health disorder and/or desire mental health services.

Rates of adult anxiety and/or depression have increased dramatically since the beginning of the Covid-19 pandemic. In 2019, an estimated 155,000 adults in Northern Virginia (8 percent) had active symptoms of a mental health disorder, compared to 755,000 individuals (39 percent) at the beginning of 2021. While rates have declined from that peak, they remain nearly four times higher than prior to the pandemic.[3] See **Figure 2.**

Figure 2.

Percent of adults in Northern Virginia with active symptoms of clinical anxiety/depression



Source: Insight Region™ analysis of data from Pulse Survey for Northern Virginia and data from the National Health Interview Survey (2019) for Virginia, adjusted down based on historic prevalence of "frequent mental distress" in Northern Virginia compared to the state.

WHAT DOES IT MEAN TO HAVE A MENTAL HEALTH NEED?

For the purposes of this report, the population with a "mental health need" includes the weighted number of adults in Northern Virginia (the Virginia portion of the DC metro, an area slightly larger than the Community Foundation's service area) who reported any of the following on the U.S. Census Household Pulse Survey:

(a) tension or excessive worry more than half of the time in the past two weeks (clinical anxiety),

(b) sadness or loss of interest more than half of the time in the past two weeks (clinical depression),

(c) consumption of therapy and/or psychotropic medication (e.g., anti-depressants, anxiolytics, and anti-psychotics) in the past four weeks, and/or

(d) an unmet desire for therapy in the past four weeks.

It is important to recognize that:

- **Responses to the first two items constitute a positive screen for anxiety and depression, not diagnosis.**
- **Data are self-reported, and individuals vary in their ability and willingness to recall, label, and quantify their degree of emotional health or desire for specific forms of treatment.[4]**
- **Estimates likely undercount populations who are homeless, hospitalized, or incarcerated; who cannot complete an online survey; and who are asymptomatic but have been diagnosed with a mental illness.**
- **Estimates exclude children and youth, who have historically had rates of depression that were double that of adults and who have also suffered an emotional toll from the COVID-19 pandemic.**

prevalence of need
IN DIFFERENT POPULATIONS

Mental health needs are elevated and widespread across Northern Virginia. However, certain groups are experiencing exceptionally high levels of anxiety and depression and/or demand for treatment. See Figure 3.

AGE: *Children & Young Adults*

Recent data on the mental health needs and service consumption of children in Northern Virginia are not readily available. Historically, we know that about 14 percent of Virginia's youth (ages 12-17) experienced a major depressive episode in 2017-18, more than twice the rate of adults during the same time period, and 10 percent had a severe episode.[5] Since the pandemic, the mental health needs of children and youth have become acute. For example, one study of adolescents' mental health-related insurance claims found that claims were 100 percent higher in April 2020 than a year prior and still 20 percent higher by year end 2020.[6] Similarly, another study found that 22 percent of parents reported overall worsened mental or emotional health for their school-age children.[7] Globally, rates of depression and anxiety for children and youth have doubled from their pre-pandemic levels.[8]

Young adults have also experienced elevated rates of anxiety and depression. As shown in **Figure 3**, in 2021, 60 percent of adults in their twenties and half of adults in their thirties reported clinical levels of anxiety and depression and/or were active consumers of mental health treatment. These rates fall steadily with age, with 27 percent of residents over the age of 70 reporting clinical anxiety/depression and/or demand for services.

GENDER AND SEXUAL ORIENTATION: *Individuals who identify as LGBTQ+*

Over two-thirds (71 percent) of adults who identify as LGTBQ+ reported frequent symptoms of anxiety and depression and/or needing mental health treatment in 2021. In contrast, 43 percent of heterosexual, cisgender women reported symptoms and/or service needs, and just 30 percent of men reported such needs. It is important to note that in the latter two groups, the rates of mental health disorder are similar (28 percent of women and 22 percent of men), but women have much higher rates of asymptomatic treatment.

RACE-ETHNICITY: *Similar levels of need*

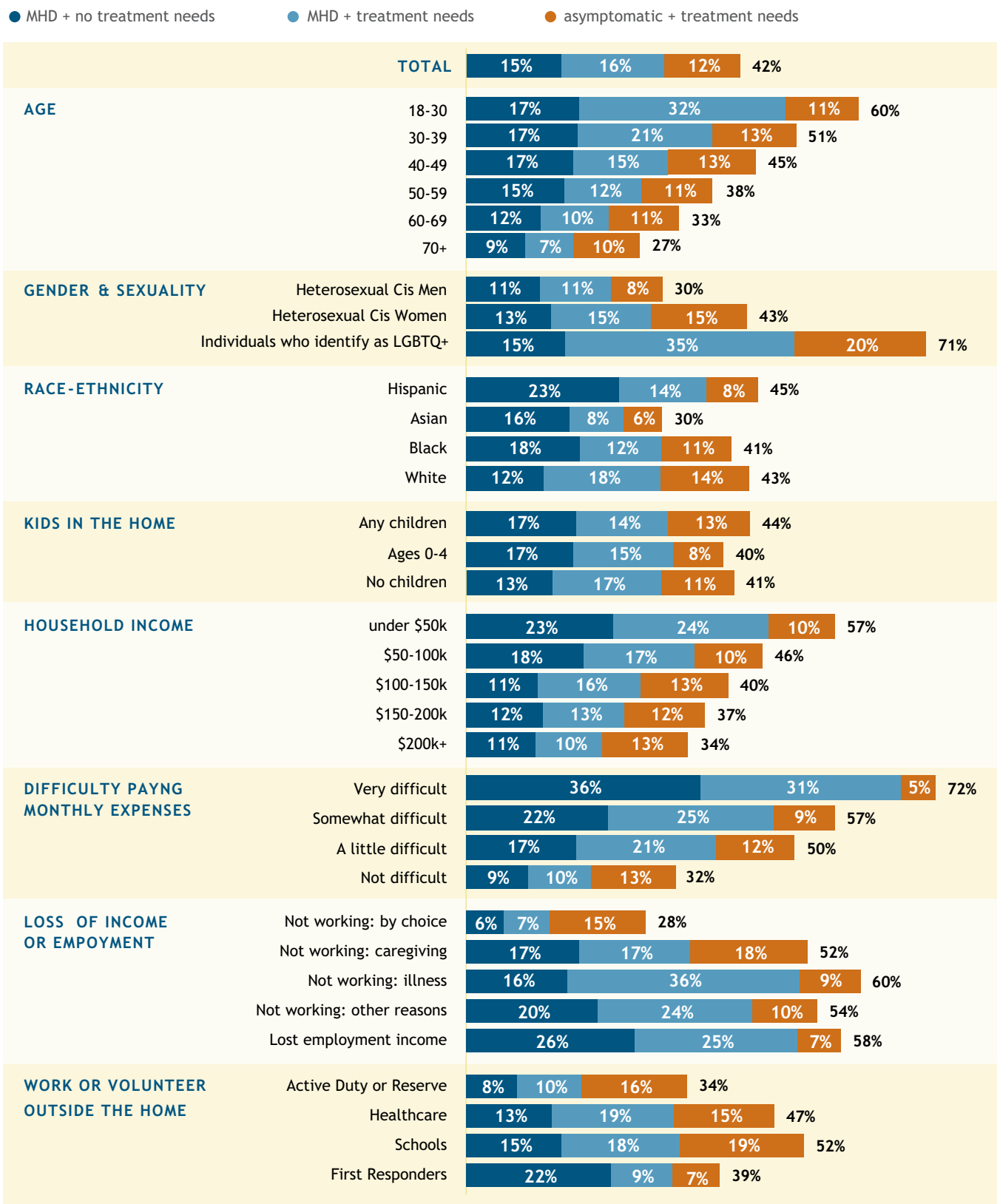
Hispanic, White, and Black populations reported similar levels of mental health need, with Hispanic residents reporting the highest level of overall need (45 percent) and the highest rate of mental health disorder (37 percent, slightly higher than Black and White populations at 30 percent). Asian residents reported far lower levels of disorder and service consumption, with just 24 percent experiencing symptoms of clinical anxiety/depression and 6 percent asymptomatic consumers of services. Data do not allow for further disaggregation by race-ethnicity-nativity.

INCOME AND EMPLOYMENT: *Households experiencing financial hardship*

Those with a household income below $50,000 (the federal standard for "low-income" at 200 percent of federal poverty), those who report difficulty with monthly expenses, and those who cannot work or lost employment income recently are also experiencing very high mental health needs. In particular, 72 percent of individuals who reported that it was "very difficult" to pay for usual monthly expenses evidenced mental health needs.

Figure 3

Percent of adults in Northern Virginia with mental health needs in 2021



Source: Insight Region™ analysis of data from Pulse Survey, calendar year 2021, Northern Virginia

EXPLORING THE REGION'S

unmet treatment needs

Elevated anxiety and depression across the region have been accompanied by an increased demand for services and high levels of unmet need. Of those who want therapy, 39 percent did not get it.

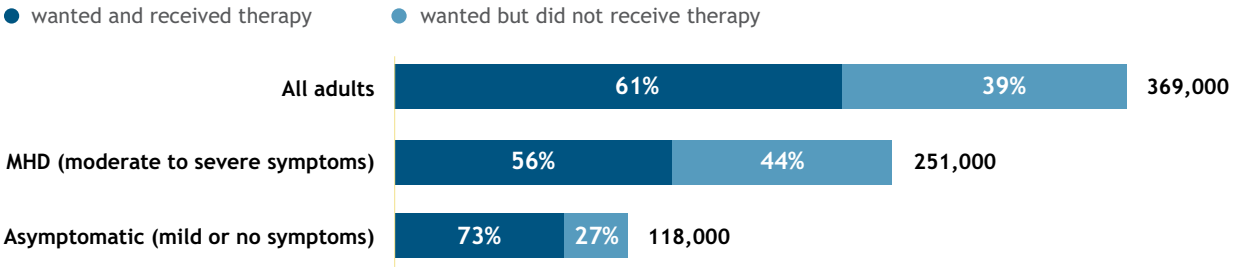
Most adults in Northern Virginia who are experiencing clinical levels of anxiety and depression want help. Of the 545,000 residents with active symptoms of a mental health disorder, 61 percent were either receiving or wanted to receive treatment in the form of psychotropic medication and/or therapy, and 46 percent (251,000) specifically wanted therapy. An additional 118,000 adults with mild to no symptoms of a disorder wanted therapy. See **Figure 4.**

All told, 369,000 Northern Virginians (19 percent of the adult population) were actively consuming therapy or wanted to consume therapy in Fall 2021. Nearly forty percent will not get the help that they want, including 44 percent of those with presenting symptoms of a mental health disorder.[9]

These rates do not include the demand for mental health services among children and teenagers, which historically have been very high. In 2016, for example, 78 percent of U.S. children with depression and 59 percent of those with anxiety received treatment for their condition. However, among teenagers, treatment rates are much lower; for example, in 2018, just 44% of youth (ages 12-17) in Virginia with depression received care.[10] Data on the population who want therapy but have not been able to obtain it are not available.

Figure 4.

Demand for therapy in Northern Virginia, by severity of symptoms and receipt of services



Source: Insight Region™ analysis of data from Pulse Survey, September-October 2021 for Northern Virginia. Note that individuals who did not receive therapy may have still received other forms of treatment, such as medication.

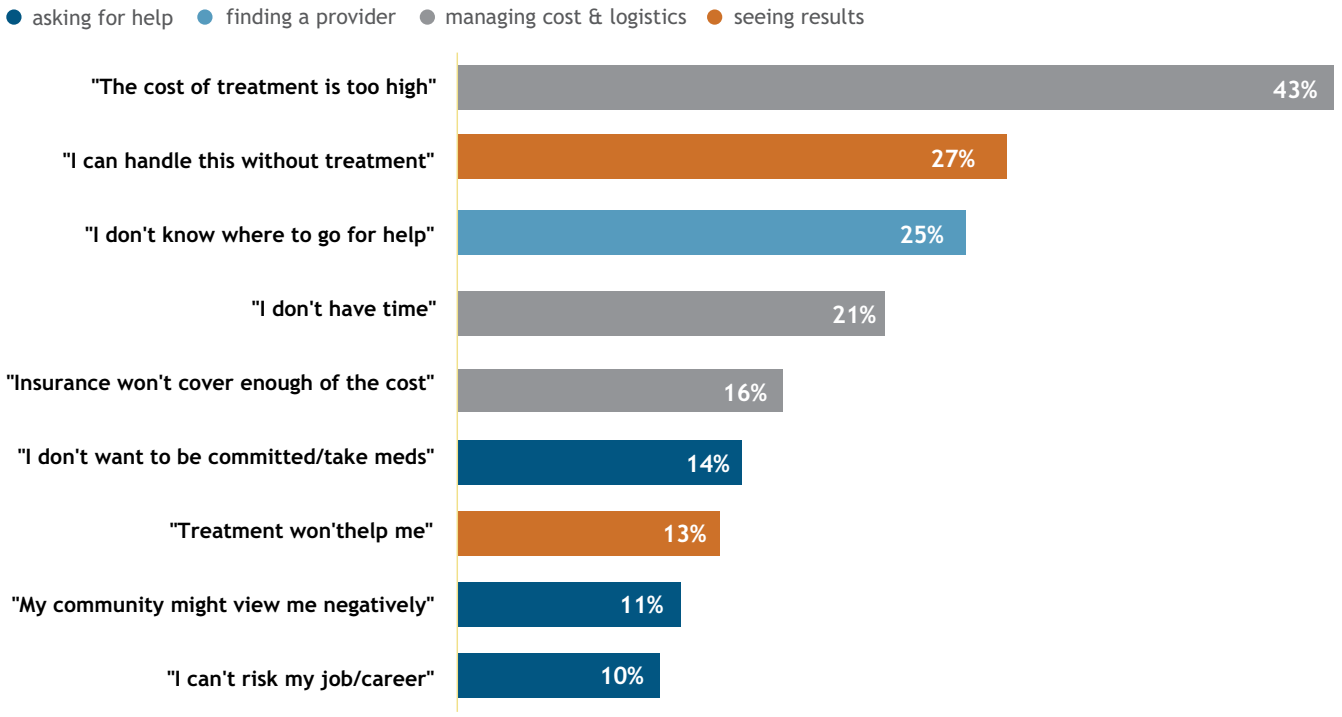
What is driving this unmet demand? The 2019 National Survey of Drug Use and Health (NSDUH) asks this very question of a nationally-representative sample of adults who report having a diagnosed mental illness and an unmet need for services, including therapy or medication. Consistently, the cost of services topped the list for drivers of unmet need (43 percent), followed by a belief that the problem can be handled without treatment (27 percent) and not knowing where to go for help (25 percent).[11] See **Figure 5**. Although the survey does not ask about challenges with provider availability, well-documented supply shortages exist across the country and likely represent an additional barrier to treatment receipt.[12]

Together, these barriers to receiving treatment can be grouped into four major categories:

1. Asking for Help
2. Finding a Provider
3. Managing cost and logistics
4. Seeing Results

Figure 5.

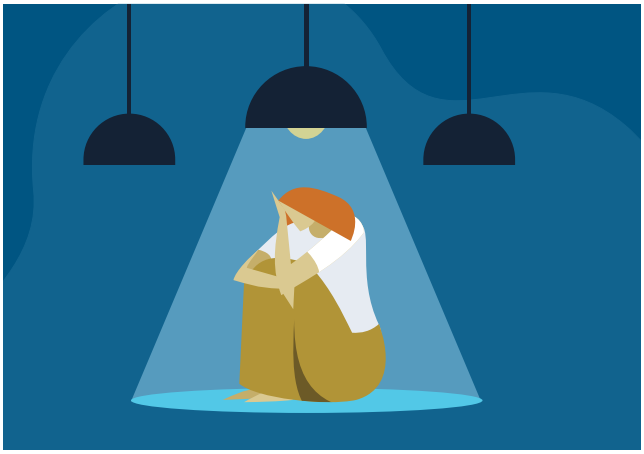
Barriers to receiving mental health services in the United States, 2019



Source: SAMHSA. (2020). National Survey of Drug Use and Health, 2019, page B-21.

1 BARRIERS RELATED TO *asking for help*

For individuals dealing with any form of anxiety and depression, it can be difficult to determine when symptoms have risen to the level of a disorder that requires professional help, particularly if those feelings are in response to known stressors (e.g., "Of course I feel sad—I just lost a loved one."). In a nationally representative sample of U.S. adults, 93 percent of respondents who met the clinical criteria for depression or anxiety did not associate their symptoms with a formal disorder, even though half acknowledged that their symptoms prohibited them from leading normal lives.[13]



Deliberate aversion to recognizing a disorder may be particularly salient when an individual faces stigma associated with seeking professional help—about one in ten people with unmet mental health needs cite *personal and/or professional risk* as a barrier to care.

PERSONAL RISK. While stigmatizing views about individuals with mental health concerns may have abated since the pandemic, historically, they were quite common. A 2013 meta-analysis found, for example, that adults and children tend to hold stigmatizing beliefs about those with mental illness—especially concerns that such individuals are dangerous, prone to violence, and/or lack competence—and respond with social avoidance.[14]

PROFESSIONAL RISK. Occupations that face professional risk are typically those where a lapse in attention or judgement poses an increased safety risk to others. Medical, defense, public safety, and aviation all have regulations in place governing the mental health of professionals licensed to practice/serve in a given state. See **Figure 6**.

Figure 6.

Professional risk in seeking mental health services

Industry	Barriers To Asking For Help
MEDICAL	Forty-four states and the District of Columbia ask about mental health when a physician applies for a license through the state medical board.[15] In Virginia, applicants are asked if they have "mental disorder… which could affect [their] performance of professional duties."
DEFENSE	An individual can be disqualified from receiving clearance due to: (a) instability, irresponsibility, violence, paranoia; (b) a diagnosed condition that impairs judgment, reliability, or trustworthiness; or (c) failure to follow treatment advice or take medication.[16] Individuals must disclose treatment receipt when applying for clearance.
PUBLIC SAFETY	Many first responders are mandated to maintain good mental health and undergo fit-for-duty evaluations that include psychological testing. Failure may result in job loss or suspension.
AVIATION	Pilots are restricted by the FAA from taking certain medications or receiving certain forms of therapy.

Source: Insight Region™

Because people may be unable or unwilling to label their symptoms as part of a mental illness, mental health journeys frequently begin with wayfinders, including religious leaders, confidential resource centers, primary care physicians (PCPs), and personal confidants. These wayfinders can provide support to those struggling with a mental health issue but may lack the training and expertise needed to adequately screen and refer those seeking help to the right resources.

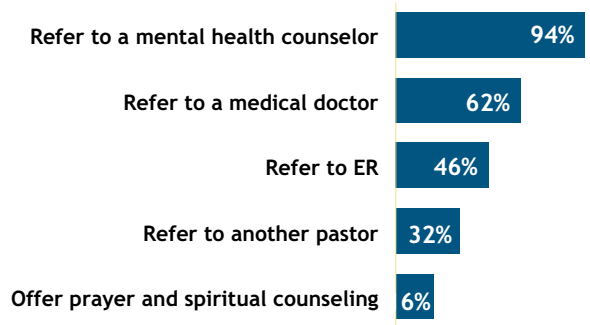
Religious leaders are the first point of contact for an estimated 25 percent of those seeking treatment for a mental disorder, including a substantial portion with a serious mental illness.[17] One study of Christian clergy found that 31 percent encounter individuals with mental health challenges (church members or others in the community) at least once a week.[18]

While faith leaders may have differing beliefs about the underlying causes of mental illness,[19] they are generally willing to refer those suffering from apparent depression (83 percent) or anxiety (58 percent) to mental health specialists,[20] particularly if the specialists are ones whom they trust[21] and who share the parishioner's religious beliefs.[22]

When asked how they would respond if a parishioner was experiencing a serious mental health challenge, the vast majority of clergy (94 percent) report that they would refer that person to a mental health counselor and/or to a medical doctor (62 percent).

Figure 7.

If a parishioner is experiencing a serious mental health challenge, members of the clergy tend to…



Source: VanderWaal, Hernandez, & Sandman, 2012

About half would refer to an emergency department (46 percent)[23] and just 16 percent would treat with spiritual counseling. See **Figure 7**.

In practice, rates of referral might be much lower[24], particularly if the individual has more subtle signs of mental health disorder. Research finds that the majority of individuals who seek help through these channels do not go on to receive treatment from a physician or therapist.[25] Faith-based care, however, may be perfectly adequate for those who receive it; one study found that 92 percent of people who sought help from the clergy with their mental health issue were satisfied with the care they received.[26]

Confidential resource centers like national crisis hotlines, help lines (like those offered through insurance companies, behavioral health services, NAMI, and Employee Assistance Programs), and informational websites can serve as the first point of contact for those with a mental health issue, and may or may not result in a referral to external services.

Research is limited on the outcomes of help lines or the follow through with referrals obtained through these resources, particularly for individuals with mild to moderate disorders who are not experiencing a crisis. Over the next few years, Virginia will roll out a regional call center, aligned with the national 988 help line, to provide individuals with access and referrals to mental health services.[27] The quality of the information available online will depend on the extent to which the site (and those supplying the information) has been vetted by a mental health professional.

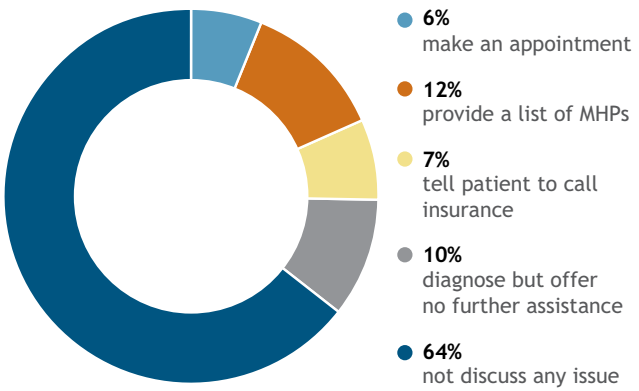
Primary Care Physicians (PCPs) are a common first step for those seeking mental health services. Among adults with no existing mental health concerns, 32 percent would seek help from a general practitioner if they ever had a mental health issue, compared to just 4 percent who would seek out a psychiatrist or therapist.[28]

Referrals to mental health professionals are not common among doctors. In one study of first-time patients who presented with depression (actors portraying symptoms of clinical depression or adjustment disorder), just 36 percent of PCPs told the patient to see a mental health professional, and only 18 percent made a specific referral (either by the office scheduling an appointment, or more commonly, providing a list of therapists to call).[29] See **Figure 8**. Just one percent of doctors referred patients to a psychiatrist. Low referrals rates may be associated with supply issues,[30] patient preferences,[31] and reluctance to diagnose.[32]

Doctors who proactively screen for a mental health disorder are slightly more likely to refer patients to a therapist. The PHQ-9 and GAD-7 (see **Figure 9**) can be used to detect clinical levels of depression and anxiety, respectively, and to refer patients for further evaluation. Screeners are administered infrequently by PCPs—in 2016, just 8.5 percent of primary care visits included a depression screening[33]—and tend to be used to *confirm* a disorder rather than to proactively screen for it.[34] Similarly, among children, research finds that pediatricians tend to under-detect mental health issues if they rely on clinical judgement in lieu of standard screeners, such as the Pediatric Symptom Checklist (**Figure 9**).[35] In one study, pediatricians who relied solely on clinical judgment positively identified just 30 percent of clinical patients, compared to 70 percent when using a validated screener.[36]

Figure 8.

When a new patient presents with depression, primary care physicians tend to…



Source: Kravitz et al, 2006

Family, friends, coworkers, teachers, and other confidants are another first point of contact for many seeking help. In addition to being reactive wayfinders—that is, responding when someone presents with a need—these community members can also serve proactively by observing issues and helping connect individuals to resources.

These wayfinders will vary considerably in their willingness and ability to respond to a mental health need. Some may recognize that an individual is struggling or exhibiting unusual behavior but fail to recognize these changes as symptoms of a mental illness. Those who correctly identify that a problem has become serious may be reluctant to label or "escalate" the issue due to their relationship with the individual. Others will simply not know where to go for help. Initiatives like Mental Health First Aid and the American Psychiatric Association's Notice. Talk.Act.® campaign (see **Figure 9** for example) focus on increasing symptom recognition and equipping community members to take action. These tools are often targeted at particular stakeholder groups and wayfinders, including those referenced above, but contain principles that could be used by anyone who observes a need and wants to respond.

Figure 9
Sample mental health screeners

Adults /Teens select how frequently they experience select feelings *(edited for space)*

PHQ-9 (DEPRESSION)	GAD-7 (ANXIETY)
☐ Little interest or pleasure in doing things	☐ Feeling nervous, anxious, or on edge
☐ Feeling down, depressed, or hopeless	☐ Not being able to stop or control worrying
☐ Trouble falling or staying asleep, or sleeping too much	☐ Worrying too much about different things
☐ Feeling tired or having little energy	☐ Trouble relaxing
☐ Poor appetite or overeating	☐ Being so restless that it is hard to sit still
☐ Feeling bad about yourself or that you are a failure	☐ Becoming easily annoyed or irritable
☐ Trouble concentrating on things, such as watching tv	☐ Feeling afraid, as if something awful might happen
☐ Moving /speaking slowly or being fidgety / restless	
☐ Thinking of self-harm or that being better off dead	

Parents select how frequently their child experiences select feelings

PEDIATRIC SYMPTOM CHECKLIST	
☐ Complains of aches/pains	☐ Is down on him or herself
☐ Spends more time alone	☐ Visits doctor with doctor finding nothing wrong
☐ Tires easily, has little energy	☐ Has trouble sleeping
☐ Fidgety, unable to sit still	☐ Worries a lot
☐ Has trouble with a teacher	☐ Wants to be with you more than before
☐ Less interested in school	☐ Feels he or she is bad
☐ Acts as if driven by a motor	☐ Takes unnecessary risks
☐ Daydreams too much	☐ Gets hurt frequently
☐ Distracted easily	☐ Seems to be having less fun
☐ Is afraid of new situations	☐ Acts younger than children his or her age
☐ Feels sad, unhappy	☐ Does not listen to rules
☐ Is irritable, angry	☐ Does not show feelings
☐ Feels hopeless	☐ Does not understand other people's feelings
☐ Has trouble concentrating	☐ Teases others
☐ Less interest in friends	☐ Blames others for his or her troubles
☐ Fights with others	☐ Takes things that do not belong to him or her
☐ Absent from school	☐ Refuses to share
☐ School grades dropping	

Community members note the following changes in co-workers, friends, family, etc. *(edited for space)*

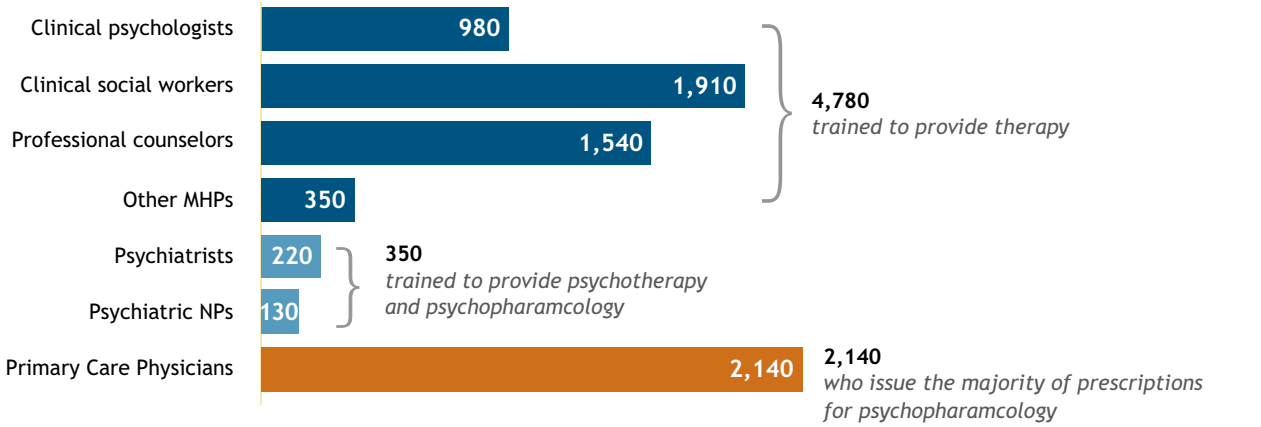
APA NOTICE.TALK.ACT.® CHECKLIST *(American Psychiatric Association Foundation, Notice.Talk.Act.® Justice: During and Beyond COVID-19)*	
☐ Excessively sleepy, low energy, or fatigued	☐ Disappearing for breaks for an extended period
☐ Flat affect, not expressing emotion	☐ Physical health issues without a clear cause
☐ Excessive weight gain or loss	☐ Constant, intrusive thoughts
☐ Poor personal hygiene or overly casual	☐ Difficulty concentrating and confused thinking
☐ Fidgety or nervous movements	☐ Persistent negative thoughts and beliefs
☐ More withdrawn and avoiding social situations	☐ Personalizing situations
☐ Uncharacteristically interactive or demanding	☐ Irritability with personal conflicts, aggressiveness
☐ Not enjoying usual activities	☐ Excessive worrying and feeling anxious
☐ Misuse of alcohol and/or drugs	☐ Extremely high and low moods
☐ Issues with deadlines, work quality, accountability	☐ Easily overwhelmed and unable to manage tasks
☐ Showing up late or at odd hours	☐ Hopelessness

2 BARRIERS RELATED TO *finding a provider*

Northern Virginia is home to around 5,100 licensed mental health providers (MHPs), including nearly 4,800 who are trained to provide *psychotherapy*[37] and 350 who are also trained in *psychopharmacology* (psychiatrists and psychiatric nurse practitioners).[38] See **Figure 10**. While this latter group can technically provide therapy, research suggests that just 30 percent of psychiatric visits include therapy, with the remainder focused on prescribing and managing medications.[39] The region also has over 2,000 primary care physicians (PCPs), who are unlikely to have received extensive training in mental health treatment but are responsible for approximately 60 percent of mental health treatment[40] and 79 percent of psychotropic prescriptions in the United States.[41]

Figure 10.

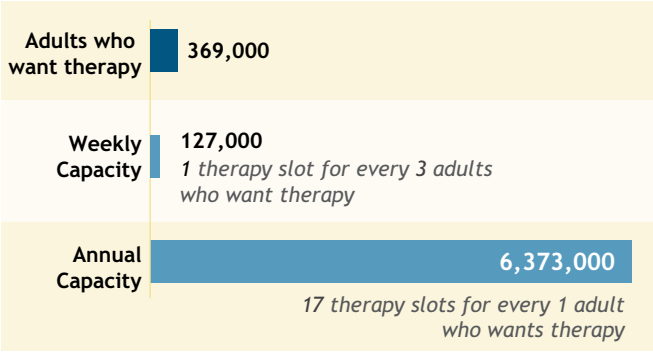
Supply of licensed mental health providers and primary care physicians in Northern Virginia



Source: Insight Region™ analysis of workforce data from the Virginia Department of Health Professions (2020-2021), U.S. Bureau of Labor Statistics (2020), and Virginia Health Care Foundation (2021).

Figure 11.

Number of clients that Northern Virginia's therapists could serve

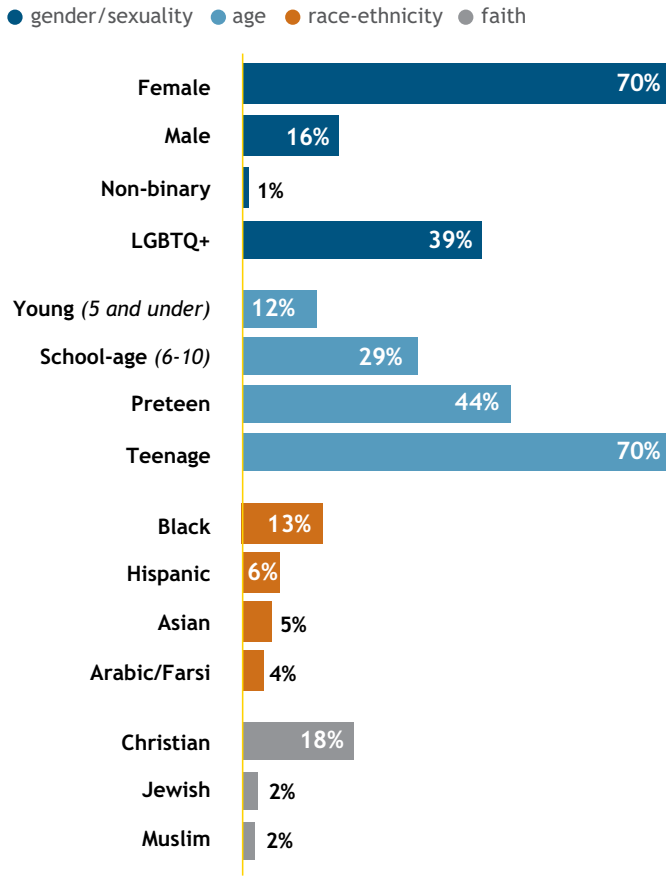


Source: Insight Region™ analysis, assuming 26.6 sessions/week for 50 weeks per year across 4,780 therapists

If we assume that a single therapist could see just under 27 patients in a given week (with some able to see more or less depending on the administrative demands on their time), then the region's the 4,780 MHPs that primarily provide therapy could offer 127,000 sessions in a single week. See **Figure 11**. This weekly capacity is about a *third* of the level of current demand for therapy. Over the course of a year, however, therapeutic capacity increases to approximately 6 million sessions, or about 17 sessions per adult currently in need of therapy. These findings suggest that Northern Virginia may have a *short-term shortage* of mental health professionals to handle current levels of demand with sufficient supply to handle these patients in the long-term.

Figure 12.

Percent of therapists in Northern Virginia on Psychology Today who identify as/focus on clients who are …



Source: Insight Region™ analysis of search results from Psychology Today (accessed January 4, 2022). Most attributes are not mutually exclusive.

For children and youth, the supply of mental health providers is much more limited, particularly psychiatrists who are often the only professional who will prescribe medication (unlike PCPs serving adults, *pediatricians* prefer to send their young patients to a psychiatrist in lieu of issuing a prescription[42]). According to the CDC, there are 5.5 child and adolescent psychiatrists in Northern Virginia for every 10,000 residents under the age of 18, a supply gap driven primarily by a dearth of availability in Prince William and Loudoun counties.[43] Further, while most therapists in Northern Virginia serve teenagers, finding those that serve younger clients may be increasingly difficult. See **Figure 12**.

When it comes to therapy, finding a provider is not just a matter of locating a therapist who is accepting new patients; for many, there is a question of "fit" between practitioner and client, which includes the therapist's experience treating specific conditions or types of patients. Such traits are searchable on many provider directories, such as the online platform Psychology Today, but reveal limited choices in the area. Among therapists in Northern Virginia registered on Psychology Today, just 5 percent focused on Asian clients and 6 percent focused on Hispanic clients—populations that represent 16 and 18 percent of Northern Virginia, respectively. Clients looking for a male therapist or one who specializes in a specific religion will also have limited choices—for example, 40 percent of Fairfax County residents are Christian and 5 percent are Muslim[44], rates that are double the percent of therapists serving these populations. See **Figure 12**.

Websites like ZocDoc have fewer filters available to search for therapist attributes, but will show therapists' real-time availability and allow individuals to schedule an appointment at a time (and location, if virtual) that works for them. This feature eliminates the need to "call around" and determine if a therapist is accepting new patients and has availability that works with the patient's schedule. Historically, this process was very time consuming, particularly for persons who may be deprioritized for treatment; research suggests that a middle-class white woman can find a therapist in five attempts, while a working-class black man would need to call 80 times.[45]

3 BARRIERS RELATED TO *managing the cost and logistics*

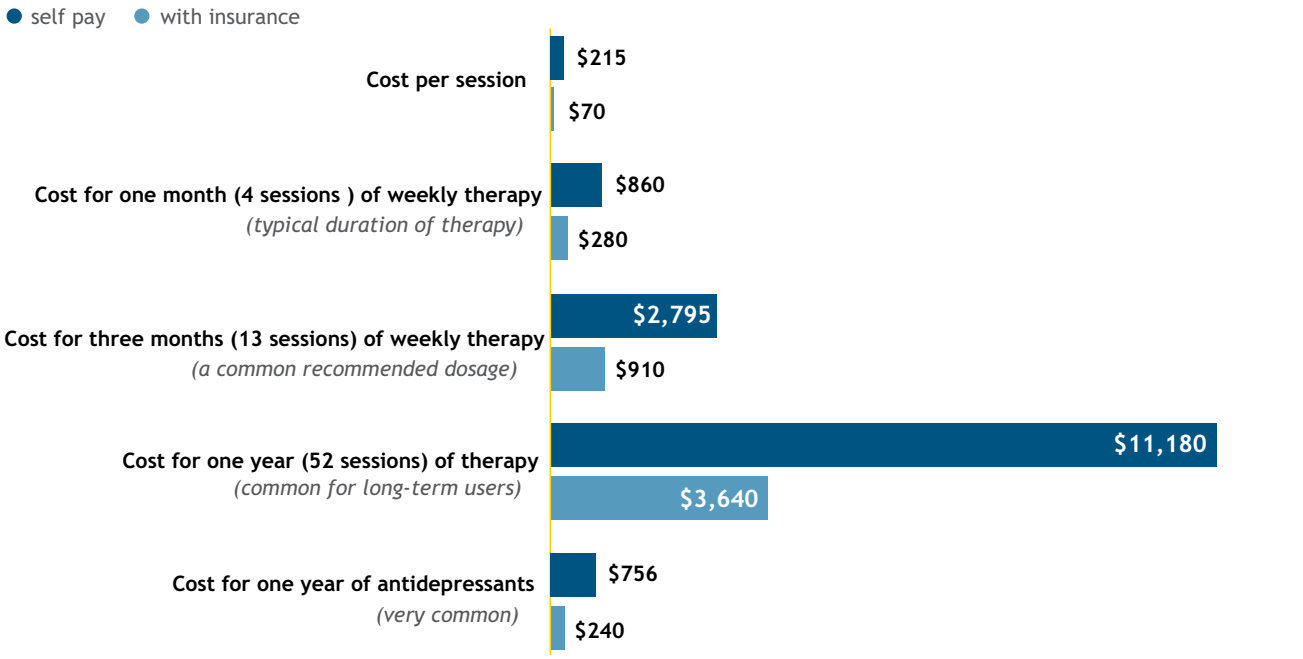
The financial cost of treatment remains the single largest driver of unmet mental health needs in America. Among adults with a mental illness who reported an unmet need for treatment on the 2019 NSDUH, 43 percent did not receive services due to the cost; the rate was slightly higher among individuals experiencing serious mental illness, particularly those who had not received treatment in the past year (52 percent).[46] Nationally, one in four Americans report having had to choose between getting mental health treatment and paying for daily necessities, and one in five have had to choose between getting treatment for a *physical health* condition and a *mental health* condition due to cost. In Virginia, 35 percent of adults with a cognitive disability reported not being able to see a doctor due to cost,[47] the fifth highest rate in the country.[48]

In 2021, Northern Virginians paying out of pocket for therapy would typically be charged around $215 for a 45-minute session of therapy;[49] those covered by insurance might pay around $70 per session.[50] Nationally, the typical duration of treatment is just 4 sessions—about a month of therapy, assuming weekly visits—which would amount to $280 with insurance and $860 without insurance. Most patients, however, need more than four visits to see a reduction in symptoms; three months of therapy (a common dosage level)[51] would total $2,800 for individuals without insurance and $900 for an individual with insurance. A year of treatment (52 weeks) would amount to over $3,600 in out-of-pocket expenses with insurance and over $11,000 without insurance. See **Figure 13**.

The majority of patients (75 percent in Northern Virginia) receiving therapy also receive psychotropic medication, where prices vary widely by type and insurance coverage. At minimum, the average monthly cost for generic antidepressants is around $63 without insurance and $20 with insurance;[52] a year of use would total $240 and $750, respectively. For many patients, prescriptions for psychotropics are issued indefinitely—an astounding 12 percent of the U.S. adult population has been taking antidepressants for 2 years or more.[53]

Figure 13.

Estimated costs for one month, three months, and one year of therapy + medication



Source: Insight Region™ analysis of data from Slobin (2021) and Simple Practice (2018)

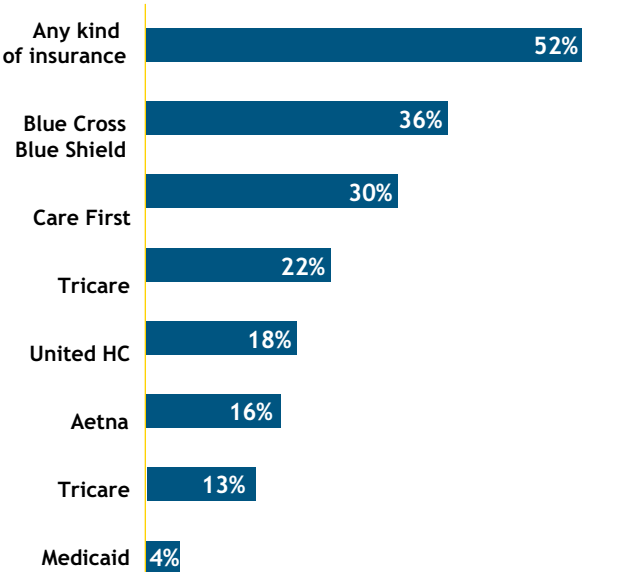
Many people who see a therapist will likely need to pay out of pocket, as only half of therapists in Northern Virginia accept any kind of insurance, based on an Insight Region™ sampling of therapists from the website Psychology Today.[54]

Just four percent of therapists accept Medicaid. See **Figure 14**. Lower-income, working age Northern Virginians are even more likely to pay full price for therapy, as half (47 percent) do not have insurance.[55] Individuals who want to receive therapy from a psychiatrist are also likely to be paying for treatment out-of-pocket, with research suggesting that psychiatrists prioritize psychotherapy for those who are "self pay".[56] Sessions with a psychiatrist typically cost substantially more than those provided by other mental health professionals.

Some non-profit organizations offer help locating non-crisis, low cost mental health services (such as the Open Path Psychotherapy Collective, Open Counseling, NAMI peer support groups), but such resources are limited, competitive, and may be hard to find. Data do not exist on how many individuals receiving mental health care get their services through these more affordable options.

Figure 14.

What percent of therapists in Northern Virginia accept insurance?



Source: Insight Region™ analysis of search results from Psychology Today (December 10, 2021)

Individuals with Medicaid may be able to attain services free of charge, if they can find a therapist who accepts Medicaid. The region lacks a robust safety net of publicly-funded mental health services, and local behavioral health authorities (such as Community Service Boards) prioritize services for people with serious mental illness and/or who are in crisis.

For many individuals, the "cost" of treatment is not just about the *financial* resources necessary to purchase therapy and/or medication; costs also include opportunity costs associated with attaining treatment. Around one in five individuals with unmet mental health needs cite the time commitment associated with treatment, which individuals with flexible employment, paid time off, retirement, child care, and higher incomes will not feel as acutely. Those with heavy constraints -on how long and where they can attend a therapy session may face the greatest barriers to receiving care. The emergence of telehealth and virtual therapy may address the time constraints associated with *commuting* to a session, while introducing new issues around privacy (does the individual have a space where they can be alone?) and connectivity (can the individual access and afford high-speed internet?).

4 BARRIERS RELATED TO *seeing results*

Most individuals who reported unmet treatment needs (56 percent) on the 2019 NSDUH actually received some level of mental health service in the past year,[57] pointing to broader, inter-related issues with treatment compatibility, patient adherence, and provider adequacy.

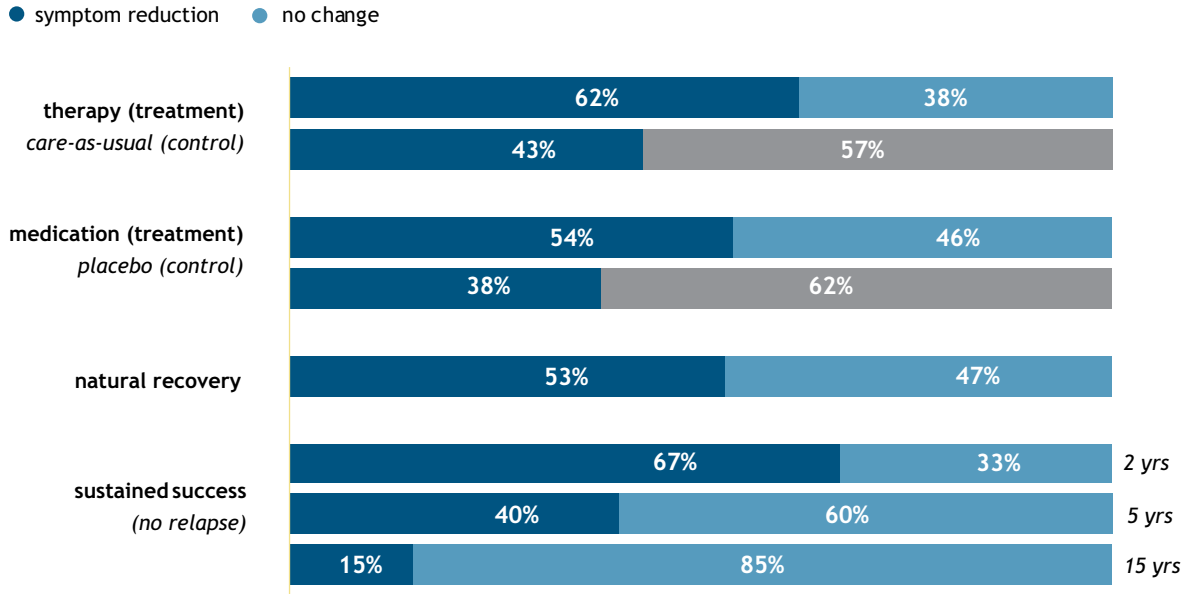
TREATMENT COMPATIBILITY

While the general public has high confidence in therapy,[58] those with impaired mental health tend to be more skeptical—27 percent of U.S. adults with unmet mental health needs feel they can handle their condition without professional help and 13 percent feel that treatment will not help.[59] Such beliefs are present and consistent regardless of the severity of an individual's mental illness or on their receipt of treatment in the past year.[60]

Although individuals are not necessarily equipped to determine whether and what type of treatment will help them, research suggest that many individuals will improve without formal intervention as others will struggle to see change this latter group—those for whom therapy does not work—are referred to as "treatment resistant" or "treatment refractory"). For example, **Figure 15** summarizes the literature on the effectiveness of therapy and medication for those struggling with major depression.[61] The body of evidence suggests that, in clinical trials, while treatment works for most people, it does not work for everyone—62 percent of patients improved when given a full course of psychotherapy (but 38 percent did not) and 54 percent improved with medication (and 46 percent did not). While not as effective, care-as-usual and placebos work for around 40 percent of patients, and rates of *natural recovery* are especially high, with the majority of individuals with untreated depression seeing symptoms improve within the year.

Figure 15.

Percent of individuals with major depression who see a reduction in symptoms



Source: Unless otherwise noted, all data from Cuijpers, Stringaris, & Wolpert, 2020

Research is emergent but still limited on how these outcomes vary by treatment modality, setting, diagnosis, patient characteristics, and provider characteristics.[62] For example, the effectiveness for *youth* is unclear; a comprehensive meta-analysis conducted by the U.S. Department of Health and Human Services found, for adolescents with major depression (MDD), that cognitive-behavioral therapy and/or certain medications reduce short-term symptoms while "long-term outcomes remain largely unknown." Researchers detected little evidence of treatment effectiveness for children and for those with non-MDD depression, and cautioned that certain medications are associated with a higher risk of suicide ideation and "serious adverse events" (such as death and hospitalization).[63]

PATIENT ADHERENCE

Attrition is the early termination of treatment and is a common outcome in therapy—for example, a large meta-analysis on the subject found that between 18 and 40 percent of patients do not complete their full course of therapy, with rates especially high when based on clinician assessment.[64] On the medication side, an estimated one third of mental health prescriptions are never filled.[65] Even when patients are still technically receiving treatment, there may be problems with compliance: one survey of health care providers found that 52 percent felt that their patients had difficulty adhering to their therapy regimens, and 40 percent struggled with medication adherence.[66] Certain demographic groups—including younger clients, those with less education, and those with less income—may be at heightened risk of not adhering to treatment.[67]

Attrition and non-compliance increase the likelihood that treatment will not work. For example, one study found that while "there is general consensus that between 13 and 18 sessions … are required for 50 percent of patients to improve," most patients receive fewer than 5 sessions, where success rates plummeted to 20 percent.[68] The authors note that these results suggest that the typical patient (that is, who is receiving services in the real world, and not in a clinical trial) will not receive adequate exposure to therapy or see the rates of recovery/symptom abatement observed in more controlled environments.

PROVIDER ADEQUACY

Getting the right treatment also means finding a practitioner who monitors and adjusts their approach based on continuous feedback, known as *measurement-based care*. In reality, this data-driven approach to mental health treatment is somewhat rare in the delivery of both therapy and medication:

Therapy. Collecting standardized data on patient progress, such as through routine outcome monitoring practices like OQ-System and PCOMS, has been shown to "reduce deterioration and improve outcomes, particularly among clients at risk for treatment failure."[69] However, just 14 percent of therapists use such metrics to monitor progress and adjust therapy, the majority expressing limited faith in the ability of these tools to provide useful feedback.[70]

Medication. Research suggests that about half of patients treated for depression in a primary care setting do not receive "adequate" care, typically due to lapses in medication management. For example, an estimated half of patients end up needing at least one medication adjustment and about a third require multiple medications concurrently. Both circumstances require frequent monitoring and assessment to adjust treatment, yet only a fraction of primary care clinics practice this type of measurement-based care.[71]

A data-driven approach to care can also help with issues around treatment compatibility and attrition. For example, one study found that machine learning could be used to better match individuals experiencing depression to effective anti-depressants (technology-enabled prescribing),[72] and the same techniques could likely be used to better match patients to mental health providers and therapies.

coming together

AROUND SOLUTIONS

Clinical anxiety and depression are not "normal" in a historical sense—just two years ago, only 8 percent of the population experienced such symptoms—but are certainly common throughout the region today. For many, these needs are a perfectly reasonable response to the tremendous loss that our region has experienced: loss of life, loss of financial security, loss of social ties, loss of normalcy, and loss of time.

WE MUST ASK:

How can our mental health system work better—and more equitably—to meet the emerging, complex needs engendered by a global pandemic?

Look around—mental health is no longer a niche issue. At the peak of the pandemic, nearly half of adults in Northern Virginia were either experiencing clinical levels of anxiety and depression and/or actively demanding mental health services. Today, that rate has narrowed only slightly to 39 percent of our adult population: 760,000 people. Among the region's 228,000 young kids (5-11) and 208,000 youth (ages 12-17) who are not counted in these totals, rates are likely higher—historically, the latter population had rates of depression that were at least double that of the adult population.

Northern Virginians are not getting the help that they need; an estimated 39 percent of adults in the region who currently want therapy cannot get it. As we recover from the health, economic, and emotional effects of COVID-19, we must come together to deliver a better mental health system for Northern Virginia, with a focus on known barriers to receiving care.

1 ASKING FOR HELP

Natural wayfinders—doctors, clergy, confidential resource centers, and confidants—are a critical first step for many seeking mental health care, but may need additional support in identifying and directing people to appropriate resources. The region's primary care physicians (PCPs), who serve as both wayfinders and *defacto* mental health providers, may be particularly in need of additional training and resources to handle a surge in patients who have complex mental and physical health needs.

As a community, we must recognize, nurture, and expand the pool of mental health wayfinders.

- Develop resources that equip every Northern Virginian to help a child, parent, neighbor, friend, co-worker, student, etc. get help;
- Quantify the prevalence of partnerships between PCPs/pediatricians and mental health providers (such as Collaborative Care and medical homes for pediatric patients) in Northern Virginia and identify ways to expand their implementation, including understanding what barriers exist to creating and sustaining such a partnership; and
- Track the state's new regional call centers to understand how they will identify, triage, and direct callers to resources and information on available, accessible mental health services.

2 FINDING A PROVIDER

The mental health workforce is under its own type of stress, as the current level of demand outstrips the number of patients that individual therapists can see in a given week by 3 to 1. This short-term supply issue will likely mean longer wait times for those in need, and potentially worsening symptoms; it may be particularly hard for those whose population is underrepresented in the current workforce or who lack the financial and other means to "compete" with other patients.

As a community, we must explore innovative solutions to matching our supply of mental health professionals to current demand.

- Explore incentives for providers to reserve therapy slots for those with pressing mental health needs that have not risen to the level of crisis;
- Expand the number of therapists with training in serving a diverse population that mirrors Northern Virginia; and
- Identify options like group therapy and mental health consultations that allow mental health providers to serve a greater number of patients.

3 MANAGING THE COST AND LOGISTICS

Psychotherapy that is covered by insurance is expensive (around $900 for three months of weekly sessions) and will consume a substantial share many families' budgets. Without insurance—which about half of therapists do not accept—rates skyrocket to $2,800 for three months of therapy. The region has a dearth of low-cost treatment services for those with financial need who are not seriously mentally ill or in crisis; this population may also face additional logistical barriers associated with the time commitment of therapy.

As a community, we must lower the cost of therapy.

- Demand expanded coverage under employer- and government-provided insurance, the source of many residents' insurance;
- Learn more about why many therapists do not accept insurance, and how different sectors can facilitate and incentivize providers to accept insurance; and
- Examine telehealth and virtual therapy as an option for reducing the time commitment associated with commuting to therapy, with an eye toward effectiveness, time saving, and new constraints (such as privacy and broadband access).

4 SEEING RESULTS

Therapy and/or medication work, but their effectiveness depends heavily on treatment compatibility, patient adherence, and provider adequacy. As a result, many will struggle to see their symptoms improve. We must also recognize that we are living through a global pandemic, a community-level crisis that has resulted in needs that extend across populations and that may defy traditional treatment modalities. While therapy and medication will be crucial for some, others will see symptoms improve once the source of stress is removed.

As a community, we must deliver better, more responsive services, not just more/cheaper.

- Engage in honest dialogue about what types of treatment work, for whom, and under what circumstances, including the recognition that some individuals will respond better to non-traditional treatments (such as yoga, social clubs, art, and other forms of self-expression);
- As one of the nation's tech hubs, become a leader for using data, technology, and standardized screenings to better match people to the right treatment (technology-enabled prescribing);
- Continue to fight for a Northern Virginia that is affordable and accessible to all, recognizing that financial assistance and living-wage employment not only provide a means to more affordable treatment, but may also be the source of the individual's underlying need.

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ENDNOTES

1. Insight Region™ analysis of data from U.S. Census Bureau Household Pulse Survey, weeks 37-39 (September 1-October 11, 2021). For this analysis, Northern Virginia is defined as the Virginia portion of the DC metro area.
2. The GAD-2 and PHQ-2 are validated, reliable two-question mental health screeners used by clinicians to detect anxiety and depression; individuals who experience symptoms more than half of the days in the previous two weeks would screen positive for these mental health disorders and prompt additional assessment, including the long form of these screeners (GAD-7 and PHQ-9). In 2020, the U.S. Census Bureau, in collaboration with the Centers for Disease Control and Prevention, began including these mental health screening questions in its household pulse survey, allowing researchers to estimate the percent of adults evidencing clinical levels of depression (a score of '3' on the PHQ-2)and/or anxiety (a score of '3' on the GAD-2).
3. For more information on pre- and post-COVID rates of mental health, see Vahratian et al, 2020.
4. While individual records are confidential and anonymized, individuals who distrust government data collection efforts may be incentivized to distort their answers or not respond to certain questions. See McGeeney et al (2019) for prevalence estimates.
5. Mental Health America, 2021. For more on the mental health needs of children and youth in Virginia, see Dragas Center for Economic Analysis and Policy, 2020.
6. During the same time, overall medical claims were down by 50 percent and 20 percent, respectively. FAIR Health, 2021
7. Panchal et al, 2021
8. Racine & McArthur, 2021
9. Note that, historically, treatment rates for individuals with a serious mental illness are very high: about 70 percent received treatment in Virginia in 2018, the ninth highest treatment rate in the country. Treatment rates for mild and moderate mental illness are in line with the national average. See Kaiser Family Foundation, n.d.
10. NAMI, 2021
11. SAMHSA, 2020
12. For more information on mental health professional shortage areas, see USA Facts, 2021
13. Kupersanin, 2001
14. Parcesepe & Cabassa, 2013
15. Jones et al, 2018
16. Military.com, n.d.
17. Wang, Berglund, & Kessler, 2003
18. VanderWaal, Hernandez, & Sandman, 2012
19. For example, 37 percent of surveyed Christian clergy felt that mental illness could be caused by demonic possession, compared to 5 percent who felt that mental illness could have a biological or physical basis. Ibid
20. *Ibid*
21. Openshaw & Harr, 2009
22. Farrell & Goebert, 2008; VanderWaal, Hernandez, & Sandman, 2012
23. VanderWaal, Hernandez, & Sandman, 2012
24. Farrell & Goebert, 2008
25. Wang, Berglund, & Kessler, 2003
26. Hooley, Wang, & Hodge, 2020
27. Virginia Senate, 2021
28. Mental Health Association, 2000
29. Kravitz et al., 2006
30. Cunningham (2009) found that two-thirds of PCPs were unable to refer patients to quality mental health services.
31. One study found that a third of patients may refuse such a referral. See Donaldson et al, 1996.
32. In one study, half of PCPs surveyed deliberately miscoded at least one depressed patient in the previous 2 weeks due to diagnostic uncertainty, problems with reimbursement, jeopardizing insurability, and stigma. See Donaldson et al, 1996.
33. U.S. Department of Health and Human Services, 2016.
34. Among those who were screened, 47 percent resulted in a diagnosis, suggesting that the tool was administered to confirm suspected depression. See Akincigil & Matthews, 2017.
35. The screener will vary depending on the child's age; the GAD-7 and PHQ-9 have been validated with teenagers, but younger children may receive the Pediatric Symptoms Checklist.
36. Glascoe, 2015
37. Estimates derived from Virginia Department of Health Professions for psychologists (2021), licensed clinical social workers (2020), and professional counselors (2021). "Other" therapists represents the difference between the 5,130 MHPs in Northern Virginia (2020 County Health Rankings) and the total number of psychologists, clinical social workers, professional counselors, psychiatrists, and psychiatric NPs.
38. Psychiatrists (2020) estimate based on finding that Northern Virginia has 40.8 percent of the state's clinical psychologists and 29.7 percent of its physicians, multiplied by the total number of psychiatrists in the state (640) to estimate 220 psychiatrists. Psychiatric NP estimate based on Virginia Health Care Foundation, 2021. Note that an additional 1,100 therapists operate in the region as a secondary location.

39. Mojtabai & Olfson, 2008
40. Frank, Huskamp, & Pincus, 2003 c.f. Barktil-Oteo, 2013.
41. Mark, Levit,& Buck, 2009 c.f. Barkil-Oteo, 2013
42. Radovic et al (2014) found that just 25 percent of pediatricians would prescribe antidepressants to a teenager with moderate depression, compared to 60 percent who would refer to a psychiatrist.
43. There are just 1.7 child psychiatrists for every 100,000 children in Prince William County and 3.3 for every 100,000 children in Loudoun County. In contrast, Fairfax-Falls Church had a rate of 7.9 psychiatrists per 100,000 children, and Arlington-Alexandria had 8.2 per 100,000. See Centers for Disease Control & Prevention, 2015.
44. Best Places.Net, n.d.
45. Khazan, 2016. For additional research on the role of race and income in seeking therapy, see NCSL, 2018.
46. SAMHSA, 2020
47. Cohen Veterans Network, 2018
48. Mental Health America, 2021
49. The website FairHealth Consumer allows individuals to estimate the total cost they will pay for therapy (code 90834) by zip code: the rates for randomly selected zip codes in Arlington and Alexandria were $200, Prince William was $210, Loudoun was $175, and Fairfax was $232, for a weighted average of $215 based on MHP location (see County Health Rankings, 2020). For instructions on how to use this resource, see https://marshalucasphd.com/fair-accurate-insurance-reimbursement-therapy/.
50. Thervo, n.d.
51. Some research suggests therapy takes much longer than the 13 session mark. Shedler, & Gnaulati, 2020
52. Slobin, 2021
53. Carey & Gebeloff, 2018
54. Insight RegionTM random sample of 200 of the 2,700 therapists operating in Northern Virginia registered on the website Psychology Today.
55. U.S. Census Bureau. Small Area Health Insurance Estimates (SAHIE). Uninsured Persons, 2013 [datafile].
56. Mojtabai & Olfson, 2008
57. SAMHSA, 2020
58. Opinion polls find that that 72 percent of the general public believe that most people get better after treatment, versus 28 percent who believed that most people get better on their own. See Mojtabai, 2007.
59. SAMHSA, 2020. In another national study, 37 percent of individuals cited lack of confidence in treatment, 34 percent did not know treatment they needed, 25 percent cited cost, and 25 percent cited stigma. See Newson et al 2021; Kupersanin, 2001.
60. SAMHSA, 2020
61. Unless otherwise noted, all data from Cuijpers et al, 2014.
62. For a recent meta-analysis on the effectiveness of CBT with different racial and ethnic groups, see Fordham, 2021.
63. Viswanathan et al, 2020
64. Swift & Greenberg, 2012
65. Peterson, Takiya, & Finely, 2003
66. Kupersanin, 2001
67. Roseborough, McLeod, & Wright, 2016
68. Hansen, Lambert, & Forman, 2002
69. Jensen-Doss et al, 2018; Owings-Fonner, 2019
70. Jensen-Doss et al, 2018; Lewis et al, 2019
71. Craven & Bland (2013) note that in one study, only 25 percent to 50 percent of patients with depressive disorders were accurately diagnosed by primary care physicians. In addition, among those who were accurately diagnosed, 50 percent received doses lower than those recommended by expert guidelines, and less than 10 percent of patients received a minimally adequate number of psychotherapy visits.
72. See Chekroud et al (2016) for the application of machine-learning to psychotropic prescribing.

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