Trend Magazine

TREND ARTICLE

America's Mental Health Crisis

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Young people are contending with anxiety, jails have become de facto mental health centers, and deaths are rising from drug overdoes—but we know the way forward, if we have the will.

Our nation is facing a new public health threat. Accelerated but not solely caused by the COVID-19 pandemic, feelings of anxiety and depression have grown to levels where virtually no one can ignore what is happening. A CNN/Kaiser Family Foundation poll put a number to it: 90% of Americans feel we are in a mental health crisis.

They are right.

A report in JAMA Health Forum has noted that 38% more people are in mental health care since the onset of the pandemic than before. And an unprecedented White House report from earlier this year begins, "Our nation is facing a mental health crisis among people of all ages, and the COVID-19 pandemic has only made these problems worse."

In truth, we are facing three distinct crises, which partially overlap. There is the youth mental health crisis, highlighted in an advisory from the surgeon general. There is a crisis around serious mental illnesses, such as schizophrenia and bipolar disorder, contributing to social

problems including homelessness and incarceration. And there is the ongoing substance use disorder (SUD) or addiction crisis, fueled by prescription opiates such as oxycontin but complicated by new, lethal drugs such as fentanyl. These three crises have somewhat different drivers, but the remarkable and hopeful truth is that we have solutions to resolve each of them if we have the will to embrace them.

The Problem

Youth mental health

Over the past 60 years, U.S. surgeons general have released advisories for major public health threats: smoking (1964), AIDS (1986), and obesity (2001). Surgeon General Vivek Murthy's advisory on youth mental health (2021) states, "The pandemic era's unfathomable number of deaths, pervasive sense of fear, economic instability, and forced physical distancing from loved ones, friends, and communities have exacerbated the unprecedented stresses young people already faced. It would be a tragedy if we beat back one public health crisis only to allow another to grow in its place."

The Centers for Disease Control and Prevention (CDC) monitors mental health and substance abuse through the Youth Mental Health Survey, a poll of high school students collected as questionnaires every two years since 2011. The most recent data, from 2021, was stunning: 42% "experienced persistent feelings of sadness or hopelessness," up from 28% in 2011. And 22% "seriously considered attempting suicide," up from 16% in 2011. While the 2021 data might reflect some of the most difficult months of the pandemic, the trends were apparent before 2021.

Historically, youth have had low rates of suicide mortality, but that began changing about a decade ago. Today, youth and young adults (ages 10-24) account for 15% of all suicides, an increase of 52.2% since 2000. Suicide has become the second-leading cause of death for this age group, accounting for 7,126 deaths. The highest rates are found among non-Hispanic American Indian or Alaska Native youth, with a suicide rate three times greater than the general population. Youth who identified as sexual minorities (LGBTQ+) had a fivefold higher rate of attempting suicide.

Serious mental illness

While there is no clear boundary between serious mental illness (SMI) and mild or moderate mental illness, the term generally refers to disorders that are disabling. Psychotic disorders, such as schizophrenia and bipolar disorder, and severe mood and anxiety disorders (including depression and PTSD) are in the SMI category. In contrast to the increased prevalence of youth mental health problems, the SMI crisis is a crisis of care. While we have effective medications, psychological treatments, and, most important, rehabilitative care (such as supportive housing and supported employment), less than half of the people with SMI are getting care.

Many receive treatment only in jails or prisons, which have become the de facto institutions for people with SMI because we no longer have sufficient public hospital beds for them. Many have become homeless because of the shredded safety net for people with disabilities. And very few receive the range of rehabilitative services that are essential for recovery.

The statistics are grim. Life expectancy for people with SMI is about 20-25 years shorter than that of the general population. While 70% say they want to work, less than 20% are employed. People with SMI are 10 times more likely to be incarcerated than hospitalized and, relative to the general population, are 16 times more likely to be killed by police. Considered as a minority group, people with SMI would be the most disenfranchised and marginalized segment of our society, literally our untouchables.

Substance use disorder

Addiction is not a new problem in America, but it has become a crisis largely because of its new lethality. The advent of powerful opiates, especially fentanyl, has driven mortality rates to unprecedented levels. The CDC reported 105,452 drug overdose deaths for 2022, more than a fivefold increase from 2002 and double the number from 2015. The highest death rates are in males ages 35-44. For context, there were roughly 43,000 auto fatalities in 2022. Lung and bronchial cancers, which cause the most deaths of any form of cancer, accounted for 127,070 deaths in 2022, mostly people over age 50.

Recognizing that some overdoses and alcohol-related deaths may be intentional, public health officials now describe drug overdoses, alcohol-related deaths, and suicide mortality as “deaths of despair.” Combined, these deaths of despair were posited to be reducing life expectancy in the U.S. before the pandemic. Today, the number surpasses 264,000, a figure

that would no doubt be considered the public health crisis of the century had we not just lost over 1.1 million lives to COVID-19.

These three crises—youth mental health, serious mental illness, and substance use disorder—frequently overlap. Roughly three-quarters of people with SMI report onset before age 25. And approximately half of the over 20 million people in the U.S. with an SUD also experience a mental health disorder. Roughly one-third of the 50 million adults with a mental health disorder experience a co-occurring SUD. Perhaps more important, these three crises share some common solutions.

Solutions

Engagement

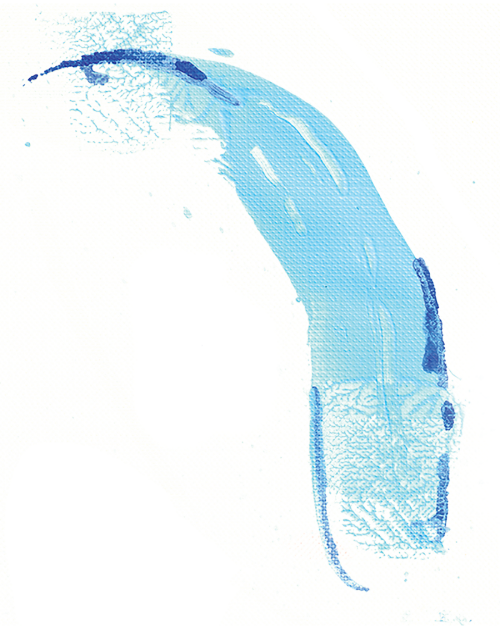
One of the great challenges for solving these mental health crises is engagement. As noted above, we have effective treatments, yet relatively few people receive them. Why? A common answer is the lack of capacity: too few therapists for youth, too few hospital beds and intensive outpatient programs for people with SMI, and too little access to medication-assisted treatment programs for people with opiate addiction. There is some truth to the deficit explanation—we need more capacity—but investing in more care centers may not solve the engagement problem, because the problem runs deeper than access.

In contrast to people with physical health disorders, especially those involving pain, people suffering with the emotional pain of mental disorders often avoid care, and those with the most severe illnesses are the least likely to engage. This is not an indictment of the people with these illnesses; it's a recognition that these illnesses often preclude their own treatment. Depression creates hopelessness, anxiety creates avoidance, and psychosis creates denial, including denial of illness.

Solving for engagement requires intervening early (before hopelessness, avoidance, and denial set in), meeting people where they are (not asking someone to wait six weeks for a clinic appointment), and building trust by offering something of value (not simply a diagnosis) at the first meeting. But that's not how our health care system works. Health care has been built for payers and providers who need a diagnosis for reimbursement. It has not been built for patients and families looking for efficient and effective care.

The revolution in digital mental health has helped by democratizing care, giving patients a choice of providers and often delivering care within hours instead of weeks. This has increased the number of people in care, but it has not yet solved the issue of engagement. That solution requires a proactive and preemptive approach: moving youth mental health care from clinics to schools, building community teams of coaches for people with SMI, and creating a harm reduction approach to addiction.

Quality



For those who seek mental health care, the experience is too often delayed, fragmented, and frustrating. Most antidepressant and anti-anxiety prescriptions are written by primary care physicians who are not able to provide psychotherapy. Most psychotherapists have not been trained in the skill-based treatments, such as cognitive behavior therapy or dialectical behavior therapy, that evidence shows have the greatest benefit. And very few providers of mental health care measure outcomes with standard metrics. This lack of fidelity to scientific evidence and neglect of measurement would be unimaginable in other areas of medicine, but it has been endemic to mental health care. While both public and private insurance might require standards of care, few mental health specialists accept insurance, often because insurance reimbursement does not match what they can receive as direct out-of-pocket payment.

The remedies for lack of quality are not complicated. Training of providers in skill-based psychotherapy, as is done across the U.K., is essential for improving quality and has been shown to improve population health. Measuring outcomes and ultimately tying payment to outcomes, a strategy known as value-based care, can improve quality. Mental health parity, which requires reimbursement for mental health care on par with physical health care, incentivizes better care through better reimbursement.

Recovery

While parity argues for the equality of mental health and physical health care, we need to consider that people with mental health disorders require more than medical care. Perhaps one of the greatest drivers of the current mental health crises has been this fundamental misunderstanding. Mental health requires much more than mental health care. More clinics, more medication, and even more psychotherapy may not reduce the morbidity, mortality,

and costs of mental illness. While it is true that the current costs are driven more by lack of care than by care itself, we will bend the curve only when we move from a focus on reducing symptoms (as we do in a clinic) to a focus on recovery.

What is recovery? It is more than a reduction in symptoms or even remission of illness. Recovery requires a focus on the 3 P's: people, place, and purpose. When we can build a care system that ensures social support, a safe and nurturing environment, and a reason or mission to recover, then we will see the current mental health crises resolve. Seem impossible? California's new Medicaid waiver allows providers to write a prescription for food or rent. A clubhouse, a community where people with SMI can get all 3 P's every day, is now covered as a Medicaid benefit in California. These are inexpensive interventions, especially in comparison with emergency room visits and incarcerations. But they require a shift in mindset from a medical model that focuses only on diagnosis and treatment to a recovery model that focuses on the 3 P's. Of course, the medical model is necessary. It is simply insufficient for resolving the crisis.

The Way Forward

It's tempting to compare the mental health crisis to the COVID-19 pandemic. Both have been massive killers, reducing life expectancy in the U.S. for the first time in a century. But the differences are instructive: Mental illness decimates young people (roughly 8,000 people under age 34 died of COVID-19; over 140,000 died of deaths of despair during the pandemic). Mental illness is usually chronic or relapsing, and, in contrast to where we were early in the pandemic with COVID-19, for virtually every mental illness we have an effective treatment. This is perhaps the greatest tragedy of the national mental health crisis. We know what to do, we have effective interventions, we have innovations to scale those interventions, and yet we have been unable to marshal the collective will to end this crisis.

But that lack of will is changing. In a nation torn apart by political polarization and culture wars, mental health remains a personal problem, not a political cause. The Bipartisan Safer Communities Act of 2022 was arguably the biggest federal commitment to mental health since President John F. Kennedy's Community Mental Health Act of 1963. It committed $8.5 billion to fund a network of clinics dedicated to recovery for people with SMI and SUD in all 50 states. In 2021, Congress mandated a new national approach to the mental health crisis, designating 988 as a single phone number across the nation ensuring someone to call, offering someone to come, and providing someplace to go for those in a mental health crisis. Several states have taken on the youth mental health crisis, with California launching a $4.7 billion program to support a new workforce in schools, virtual platforms for youth, care for new families, and a telehealth network linking pediatricians to child psychiatrists.

The crisis is indeed personal, not political. There are, in fact, only two kinds of families in America: families struggling with a mental illness and those not struggling with a mental illness yet. The prevalence is that high—50% of us will be affected at some point. And we now find ourselves facing this trifecta of youth mental health, SMI, and SUD challenges. But the solutions—engagement, quality, and recovery—are neither complicated nor expensive. Digital innovation will help. New policies and enforcement of old policies, like parity, will help. But most of all, we need a clear vision that the current public health crisis is not inevitable. With what we know today, we can, as a nation, resolve this crisis.

The Takeaway

> Anxiety and depression have become a new public health threat for Americans of all ages, but we have the tools to resolve this crisis through better engagement, quality care, and a focus on people and recovery.

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