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A Response to the President's Call to Support Public Mental Health

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INTRODUCTION

In his 2022 State of the Union address, President Biden outlined an ambitious plan for supporting public mental health in the U.S., which he said faces an unprecedented mental health crisis.[1] To support that claim, he cited statistics showing that during the peak of the pandemic, nearly 40% of Americans experienced symptoms of anxiety and depression, whereas access to mental health treatment remains poor, particularly for African American and Latino individuals. He also cited emerging evidence of the harms of social media use on the mental health of adolescents and young adults, echoing recent comments from the Surgeon General.[2] Yet, just a few days before Biden's address, the Centers for Disease Control and Prevention (CDC) released a report that stated that the overall rate of suicide in the U.S. declined in 2020, the second consecutive year of a decline in suicide deaths.[3]

Public health practitioners may find these 2 messages from our government leaders somewhat counterintuitive. However, when situated within historical trends and pandemic-induced changes, these messages point to a need for investment in public mental health. This commentary aims to contextualize these statistics and respond to the proposed White House Strategy.

UNDERSTANDING THE NUMBERS

Although the suicide rate declined in 2019 and 2020, in absolute terms, these represent modest decreases after nearly 20 years of continuous growth. As CDC noted, these declines occurred primarily among non-Hispanic White adults; the rate of suicide increased for adolescents and many racial and ethnic minority groups during this same period. Moreover, despite the modest decline, the current suicide rate is 30% higher than it was in 2000; in

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2019 alone, more than 48,000 Americans died by suicide.[3] Furthermore, these numbers substantially underestimate the true burden of suicide in the U. S. First, suicide deaths are often misclassified as unintentional deaths, particularly overdose, which reached more than 100,000 deaths for the first time in 2020.[4] In addition, focusing only on suicide mortality ignores attempted suicide: there were more than 1 million attempts in 2020, approximately 20 for every suicide death, and more than 12 million Americans seriously think about attempting suicide each year.[5] So although CDC news regarding recent declines in suicide deaths is welcome, they are less reassuring when placed in a broader context, which suggests significant preventable mortality because of poor mental health and a need for focused attention on adolescent and minoritized groups.[6]

Moreover, suicide and overdose deaths provide an inadequately narrow view of population mental health because mortality statistics cannot quantify the true impact of mental disorders. In 2017, the WHO named depression the leading cause of disability globally,[7] reflecting that this condition remains common (25 million Americans currently live with depression) and burdensome. Other mental disorders, such as anxiety disorders, bipolar disorder, and schizophrenia, also represent leading causes of disability worldwide. Although substantial, these numbers reflect only the direct impact of mental health on overall public health; they do not reflect the indirect effects and consequences of poor mental health for work and employment (e.g., absenteeism, productivity)[8] nor their influence on the development and management of cardiovascular disease, diabetes, and other chronic conditions.[9]

AVAILABILITY, ACCESSIBILITY, AND ACCEPTABILITY OF MENTAL HEALTH CARE

Despite the demonstrated efficacy of psychotherapy and medications to treat depression, only one third of adolescents and two thirds of adults with depression receive any care each year, a statistic that has remained largely unchanged over the past decade.[10] Among those who receive care, only a small fraction receive high-quality, guideline-concordant care.[11] The vast majority of mental health care takes place in general medical settings by primary care physicians and consists solely of pharmacological treatment, whereas a few (even those with private insurance) can access specialty mental health care in a timely manner.[12] Even before the pandemic, wait times for psychiatric care remained so long as to often become ineffective (e.g., substantial waits for a suicidal individual to obtain an appointment with a psychiatrist).[13]

A CALL FOR A SYSTEMS-LEVEL APPROACH TO SUPPORTING PUBLIC MENTAL HEALTH

Among the multiple factors that contribute to poor availability of mental health care, the White House plan did not address inadequate reimbursement by private health insurance and public payers, including Medicaid (the primary payer for behavioral health care in the U. S.) and Medicare. Today, most mental health specialty providers (psychiatrists and psychologists) in the U.S. do not take health insurance coverage for their services.[14] Therefore, even if the White House plan succeeds in increasing the size of the behavioral health workforce, those providers may remain inaccessible to most Americans, particularly those with lower SES who cannot afford to pay for care out of pocket.

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Moreover, as illustrated by the March 2022 passing of the Lorna Breen Health Care Provider Protection Act,[15] our existing healthcare workforce has experienced substantial burnout and unmet mental health needs. Although provider burnout occurred before coronavirus disease 2019 (COVID-19), the pandemic has heightened this issue, with spillover implications for patient care.[16] Importantly, although workplace wellness initiatives abound, most of these programs focus on self-care rather than on organizational or systemic changes to reducing provider burnout. Instead, these programs become another to-do item for burned-out providers. Indeed, few nations or healthcare organizations have instituted programs in the workplace to systematically support the mental health of all providers and address the root causes of burnout.[17] Furthermore, workplace wellness interventions must include structural changes to reimbursement and incentives that support the delivery of ongoing mental health care as a key goal of behavioral health programs and policies rather than solely offering crisis intervention.

To make mental health care accessible to all, our nation needs to invest both in new payment models and new care models. In addition to too few providers, the limited racial, ethnic, and gender diversity of the mental health workforce[18] means that current care offerings often do not meet the preferences or needs of those who may benefit from care.[19] One strategy to help address this that as included in the White House Strategy is an investment in alternative models of mental health care, including peer support, with corresponding mechanisms of revenue (i.e., new codes for billing/reimbursement) to support and sustain these new programs. Beyond paraprofessionals and peers, technology has incredible potential to support mental health promotion and management. Beginning before the pandemic and accelerated by it, the use of telehealth and mobile applications as a means of both symptom monitoring and accessing peer support has dramatically increased.[20] Changes to reimbursement for telehealth necessitated by the pandemic need to remain in place to ensure that individuals in rural communities and those without reliable transportation can continue to receive care where and when they need it.[21] Although there are elements of the White House Strategy that address issues of parity, integrated care, and rural health, without system-level changes that implement such elements in a financially sustainable manner, they are unlikely to achieve their stated goals long-term.

NO (PUBLIC) HEALTH WITHOUT MENTAL HEALTH

What would a nationwide public mental health promotion effort look like in the U.S.? What stakeholders would need to participate, and what should they focus on first? The White House Strategy emphasizes many stakeholders beyond healthcare providers who are key to this effort, particularly school administrators and educators and community-based and social-service organizations. The strategy includes several specific elements focused on children; however, promoting and supporting mental health across the life course remains essential. Individuals in mid and late life face the highest suicide risk,[22] and psychiatric conditions impact prognosis, course, and outcomes for the leading causes of preventable premature mortality, including diabetes, heart disease, and cancer.[9] Achieving the stated goal of "transforming our health and social services infrastructure to address mental health holistically and equitably"[2] requires that we consider citizens across all life stages. In addition, considering the mental health of middle-aged and older adults will help to ensure

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that any gains from investments in early life remain for years to come. Finally, the proposed strategy lacks an explicit role for people living with a mental health condition and their families. Mental health advocacy groups have both expertise and direct experience with our system's strengths—and weaknesses—and these groups deserve a central role in this effort.[23] Indeed, without their insights, this effort is unlikely to achieve its goals.

In 1999, the U.S. Surgeon General David Satcher issued the first report on mental health from this office, which called attention to many issues (e.g., poor access and affordability of treatment, a need for insurance reform, culturally responsive mental health care) that remain salient today.[24] President Biden's call for an ambitious plan to support mental health in the U.S. should be applauded, and the elements discussed in this paper should be a central part of that effort. Otherwise, discussions 20 years from now will likely be retreading these same issues rather than reflecting on the tremendous gains that this investment has the potential to provide.

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