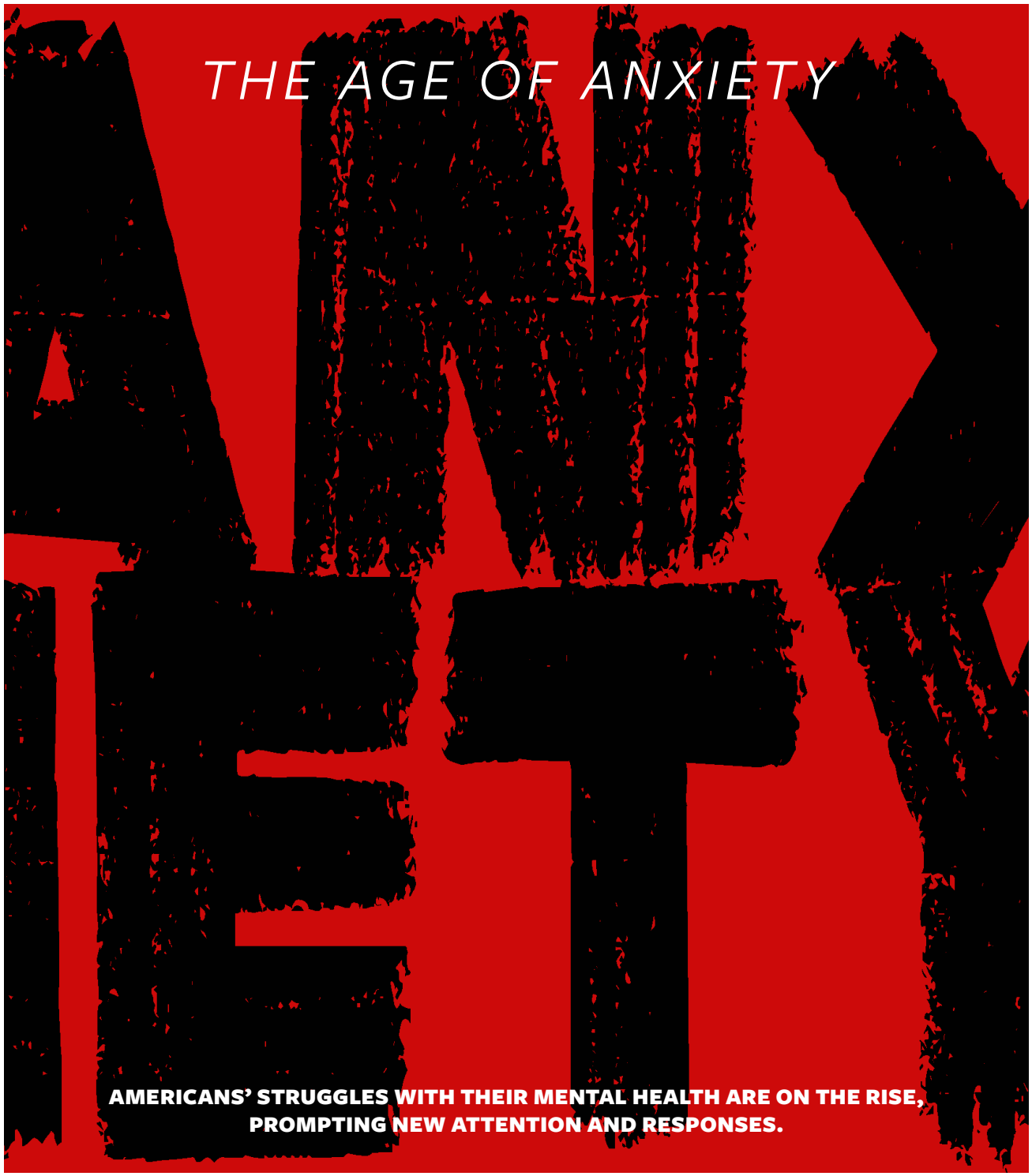
TREND

Analysis of the Facts, Numbers, and Trends Shaping the World
THE PEW CHARITABLE TRUSTS



mental health

[men(t)l helTH]

noun

1. the condition of being sound mentally and emotionally that is characterized by the absence of mental illness and by adequate adjustment especially as reflected in feeling comfortable about oneself, positive feelings about others, and the ability to meet the demands of daily life
2. a person's condition with regard to their psychological and emotional well-being
3. a growing national concern with more than 1 in 5 American adults living with mental illness

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FALL 2023 / 08

Read *Trend* online at pewtrusts.org/trend

Addressing Anxious Times

When Simone Biles became the world all-around champion in October for the sixth time—becoming the most decorated gymnast in the history of the sport—she did more than prove she is an extraordinary athlete. She showed the importance of putting her mental health first.

Remember the headlines she garnered for stepping away from the Tokyo Olympics two years ago. While she faced a backlash from some quarters for her decision to face the "twisties"—that dangerous condition when a gymnast's brain and body aren't in synch—she showed admirable courage in going public. And since then, she has proved to have amazing resilience in regaining her footing.

Her story and that of other athletes like Michael Phelps and actors like Mayim Bialik (who shares her personal journey in this issue of *Trend*) have helped push our national conversation on mental health into the open after too many years in the shadows. It is happening none too soon. The number of Americans contending with anxiety, depression, and other mental illnesses had been on the rise before COVID-19 became a continuing part of our daily lives. And only a year into the pandemic, an alarming acceleration was clear when a Pew Research Center survey reported that a third of U.S. adults were experiencing regular sleeplessness and anxiety.

TREND

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The concerns have only grown. Earlier this year, the Center reported that mental health was the top fear parents had for their children, with 4 in 10 saying they were extremely or very worried that their children might struggle with anxiety or depression—higher than worries about bullying, drug use, or violence. At the same time, the nation has seen dramatic increases in suicide and a rise in substance use disorders, with statistics showing that half of those battling these disorders also grapple with mental illness.

The Pew Charitable Trusts hopes to bolster the civic infrastructure we need to contend with these concerns and help make systemic changes that improve lives and help us all thrive. We're working to improve the continuum of care for those people who find themselves in the criminal justice system because of mental health episodes; to raise public awareness of the 988 Suicide and Crisis Lifeline, which increases access to counseling; to see suicide screening become part of the routine questions patients answer in their interactions with their doctors; and to ensure that those suffering from substance use disorder have needed medications through telemedicine so that they have time to live and work rather than spending hours each day in clinics.

Beyond those critical efforts, we also are publishing this issue of *Trend*. We hope it helps illuminate the scope of the mental health problem facing the nation, removes the stubborn stigma too often assigned to those facing mental health issues, and contributes to the conversations that lead to lasting change. Much is needed to make that change, including a cultural shift in the workplace—where mental health is integrally related to efforts to improve diversity, equity, and inclusion—and finding ways to build resilience in children.

The challenges are great and deserving of attention and remedy. As Dr. Thomas Insel—the former director of the National Institute of Mental Health, who's been called the "nation's psychiatrist"—writes in this issue, there are two kinds of American families: those struggling with mental illness and those not struggling—yet.

I always ask Pew's remarkable staff and our partners to take good care of each other. By calling attention to the systemic improvements necessary to care for those in need, I hope as a society we are all led to take good care of each other, too.

Susan K. Urahn, *President and CEO*

CRUNCH

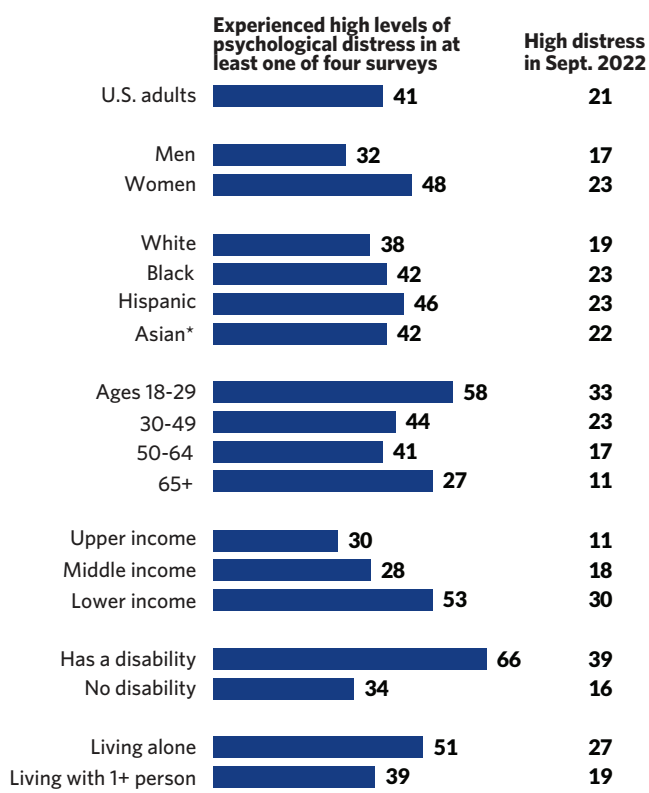
America's Age of Anxiety

Even before the COVID-19 pandemic, U.S. teenagers were worried about their mental health. A 2019 Pew Research Center survey found that 70% of teenagers said anxiety and depression were major problems for people their age—topping a list of concerns that also included bullying, drugs, alcohol, poverty, and teen pregnancy. The pandemic has only intensified the discussion around Americans and mental health.

AT LEAST FOUR IN 10 U.S. ADULTS (41%) HAVE EXPERIENCED HIGH LEVELS OF PSYCHOLOGICAL DISTRESS AT SOME POINT DURING THE PANDEMIC, ACCORDING TO FOUR PEW RESEARCH CENTER SURVEYS CONDUCTED BETWEEN MARCH 2020 AND SEPTEMBER 2022.

Young adults are especially likely to have experienced high psychological distress since March 2020

% of U.S. adults who have reported high levels of psychological distress in at least one of four surveys conducted between March 2020 and September 2022



*Estimates for Asian adults are representative of English speakers only.

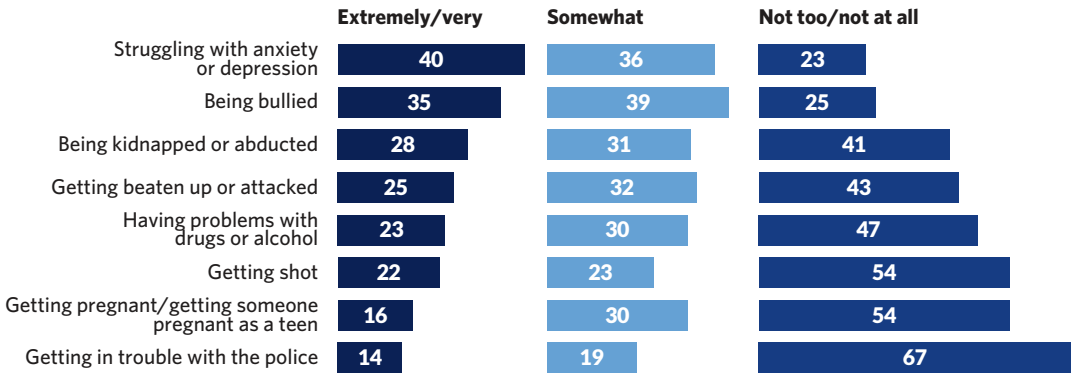
28%

ROUGHLY THREE IN 10 (28%) PARENTS OF TEENS TOLD PEW RESEARCH CENTER IN 2022 THAT THEY ARE EXTREMELY OR VERY WORRIED THAT THEIR TEEN'S USE OF SOCIAL MEDIA COULD LEAD TO PROBLEMS WITH ANXIETY OR DEPRESSION AND A SIMILAR PERCENTAGE (27%) SAID IT COULD LEAD TO LOWER SELF-ESTEEM.

FOUR IN 10 U.S. PARENTS TOLD PEW RESEARCH CENTER IN 2022 THAT THEY'RE EXTREMELY OR VERY WORRIED ABOUT THEIR CHILDREN STRUGGLING WITH ANXIETY OR DEPRESSION.

Mental health tops the list of parental concerns

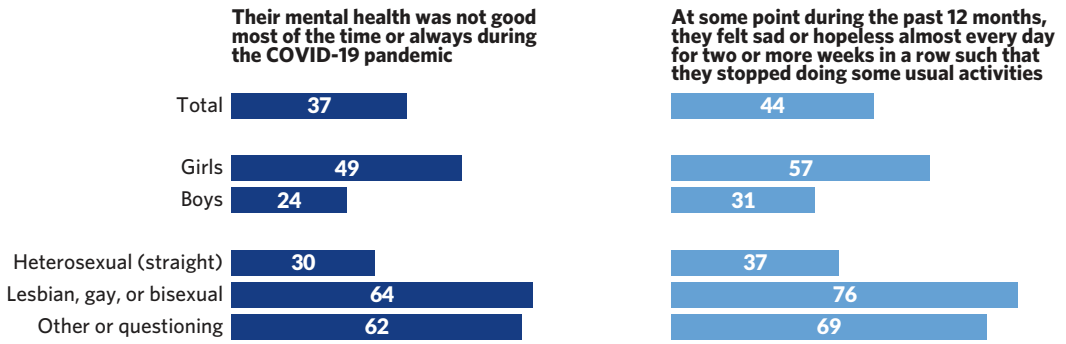
% of parents saying they are ___ worried about each of the following happening to any of their children at some point



MORE THAN A THIRD OF HIGH SCHOOL STUDENTS—37%—REPORTED MENTAL HEALTH CHALLENGES DURING THE PANDEMIC, ACCORDING TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

Among U.S. high schoolers in 2021, girls and LGB students were most likely to report feeling sad or hopeless in the past year

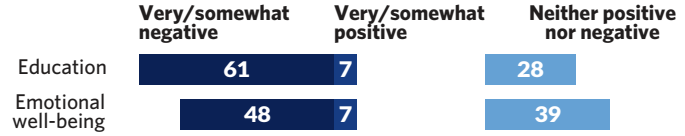
% of high school students who said



PARENTS TOLD PEW RESEARCH CENTER THAT THE FIRST YEAR OF THE PANDEMIC AFFECTED THEIR CHILDREN'S EMOTIONAL HEALTH.

On balance, K-12 parents say the first year of COVID had a negative impact on their kids' education, emotional well-being

% of parents of K-12 students saying the first year of the COVID-19 pandemic had a ___ effect on their children's ...



FOREWORD

WHY I'M TALKING ABOUT MY MENTAL HEALTH

BY MAYIM BIALIK

They meant well.

I was a teenager and I didn't feel good, so I talked to my internist. She put me on birth control pills, even though I was not yet sexually active. She meant well. She sent me to a psychiatrist—whom I could afford only because I had recently come into money as an actress on a TV show. I told the psychiatrist that sometimes I felt like I was going to die, like my heart was going to beat out of my chest, and I was going crazy. She put me on Xanax. That psychiatrist meant well.

No one thought to ask me what my home life was like as a child or what was going on in my home that very year: an unraveling of everything I had pretended was stable.

My parents meant well in their own way. The same way their parents, in the years after the Holocaust and the Great Depression, meant well. Yet when I was a teenager, everything started to collapse around me—but no one thought to ask me about that.

No one thought to ask if I was one of the millions raised in the shadow of intergenerational trauma because of war, poverty, and abuse. No one thought to ask if the grown-ups who were supposed to protect me instead frightened me. No one asked about fists thrown and promises broken and holiday dinners destroyed. And certainly, no one talked about those of us raised in homes where addiction reigned; where alcohol, drugs, and pornography were sources of confusion and endless battles; and where more "acceptable" addictions such as shopping, bingeing, and even restricting food in the name of beauty prevailed.

Because 30 years ago, we didn't ask about those things. Doctors, meaning well, often tried to make everything OK with a little numbing. A little "taking the edge off"—that's what my psychiatrist called it. She gave me a pat on the back as I walked out of her office clutching that piece of paper that was supposed to help even things out. Those were the days of knowing what to write to bill insurance companies and knowing which drugs could make us presumably hurt less.

Mental wellness was not something we knew to talk about or fight for. Finally, that has changed.

When the COVID-19 pandemic began, many people experienced mental health challenges for the first time. Those of us raised with persistent challenges to our mental wellness, either because of trauma or stress in the environment or a genetic predisposition—or a combination of the two—were no strangers to anxiety, depression, insomnia, catastrophic thinking, compulsive behaviors, and incessant rumination. My partner, Jonathan Cohen, and I started a podcast ("Mayim Bialik's Breakdown") with the specific purpose of democratizing mental wellness. We had been in the trenches of mental health challenges as teenagers and were told in one way or another not to talk about it. Tuck it away, keep your chin up, take it like a man—they told us all of these things to keep it under wraps.

As adults, we consciously chose to seize the opportunity to be vulnerable in the service of those who were new to the world of mental health struggles. I have chosen to be vulnerable, raw, and brutally honest about what plagues me, what scares me, what ails me, what has worked for me, and also what hasn't. We started our mental health podcast and built a community around the simple premise that access to mental health is an inalienable human right. Access to substantive, scientifically informed, compassionate mental health support is a right of every human being on the planet—no matter what kind of home you come from, how much money you have, what insurance you do or don't have, and no matter what ails you.

What Jonathan and I have found is that sharing our own personal struggles is not a sign of weakness; it is a sign of strength. We all want to feel better, live better, and experience more joy and less suffering. We cannot do this if we live shrouded in shame, secrecy, and a lack of understanding of the nervous system and how it operates and creates the spectrum of mental wellness.

I remember the fantasy I had as a teenager that one day I would meet "the man of my dreams" and start a new life and never have any problems. I would live happily ever after. While there have been tremendous joy and accomplishments in my life and I have much to be grateful for, I see myself as a relic from another time in the world of mental health. I come from an era of shoving it down, hoping it would go away, and stewing in anxiety, hopelessness, and fear. I am honored to be alive to witness a new consciousness that is taking hold in a world increasingly challenged by misconceptions about mental health and wellness.

My little slice of the mental health world as it evolves in the 21st century has given me so many reasons to be hopeful. The ability to understand ourselves has increased as more resources become available to more people everywhere. Mindfulness is being taught to young children in public schools. Inexpensive and readily available tools, from free meditation apps to vast online communities providing support and education, are at the disposal of more and more people. And we no longer have to live in shame about needing help.

And mostly, the notion that we all need and deserve more is no longer a fantasy—it's the reality we are all living in and helping to create.

Mayim Bialik is an actor, writer, and neuroscientist who hosts "Jeopardy!" and the podcast "Mayim Bialik's Breakdown."

ILLUSTRATIONS BY GABY BONILLA/
THE PEW CHARITABLE TRUSTS

America's Mental Health Crisis

The nation is facing historic numbers of young people contending with anxiety, a lack of care for people with serious mental illness, and rising deaths from drug overdoses. We know the way forward—if we have the will to follow the path.

BY THOMAS INSEL, M.D.

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.

Thomas Insel, M.D., is a psychiatrist and neuroscientist, the former director of the National Institute of Mental Health, and author of Healing: Our Path From Mental Illness to Mental Health.

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.

For Too Many With Mental Illness, America's Prisons and Jails Are the Default Placement

More than a million people who are incarcerated have behavioral health conditions, and many of them probably never needed to be jailed in the first place.

BY DEBRA A. PINALS, M.D.

ILLUSTRATIONS BY CARA BAHNIUK/
THE PEW CHARITABLE TRUSTS

A man I'll call Ty is 52 years old. During his 20s, he was dishonorably discharged from the Army with a diagnosis of chronic paranoid schizophrenia. The symptoms of his illness had become evident over time. At one point he told his superiors that voices in his head were harassing him and his commanding officer was communicating with him through microchips. More recently, he has lost touch with family and slept in a cardboard box in an overcrowded tent encampment of unhoused people. For months he has been sitting in jail awaiting adjudication after allegedly assaulting a police officer. The correctional staff offer medications to quell the voices, but he usually refuses them. They offer coloring books to let him pass the time, but he has no interest. He yells so much from his cell about the microchips that he frequently is put in the "hole," an isolated cell.

A woman I'll call Teresa sits alone in a county jail cell, longing for her children. She has been in and out of jail for 10 of her 32 years on Earth, for charges related to drug dealing and drug use. Removed from her biological parents as a young girl after experiencing terrible abuses, she spent her early years in foster care and juvenile hall. There were abusive boyfriends. Though there were a few kind social workers, none remained in her life and she trusts no one. Her two children are in the custody of her mother. She is diagnosed with post-traumatic stress disorder and major depressive disorder, along with opioid and methamphetamine use disorders.

Ty and Teresa are composite characters, built on traits and experiences that I've seen in countless detention facilities in the United States over the past three decades.

This nation incarcerates more people than any other country on the globe, with somewhere between 6 million and 6.5 million under correctional supervision, including prisons, jails, parole, and probation. Exact estimates vary slightly, but we in the field agree that about 16% of this population has some form of significant mental illness.

That means there are about 1 million Tys and Teresas. And it means that their jails have become their de facto mental health institutions, which the facilities were never intended to be.

And even those overwhelming numbers don't fully portray a growing national concern. Suicide rates among incarcerated people are increasing. The co-occurrences of serious substance use disorders among the correctional populations are on the rise. And intersecting facets of who this population is—Black, Hispanic, Native American, often poor—mean these numbers will grow for these populations because they have a higher likelihood of arrest—often for minor infractions—and have longer stays in detention settings.

Or a higher chance of not landing behind bars at all because statistics show they have much greater chances of dying early either from medical conditions or from being shot by police during encounters that get out of hand. *The Washington Post* noted in 2018 that 1 in 4 people fatally shot by police the prior year suffered from mental distress, according to a report by the Treatment Advocacy Center.

THE STIGMA ASSOCIATED WITH THOSE WITH MENTAL HEALTH ISSUES AND WITH THOSE IN THE CRIMINAL JUSTICE SYSTEM MUST BE OVERCOME.

That there is over-representation of people with these "behavioral health" conditions (things like mental illness, substance use disorders and even mixed with intellectual and developmental disabilities) in the criminal legal system is not news. But the COVID-19 pandemic brought new attention to the challenges of mental illness in a society with over 30% of the population reporting anxiety or depression, and ongoing alarming rates of suicide, overdose, and homelessness. And the laser-focused attention on the disparities for people of color with these challenges has renewed efforts for a more equitable service system that provides the right care and support at the right time and in the right place. In the criminal justice system, that means new practices—jail diversion programs, mental

health and drug courts, and other interventions—are being developed that try to stem the tides. But with the growing numbers of people affected, these innovations must get up and running faster and become more effective.

Society as a whole would benefit from these innovations by reducing prison costs and allowing law enforcement to expend its resources on fighting crime instead of providing mental health crisis responses for which it is not trained or equipped.

Fortunately, there is a roadmap to a successful future if we have the will to follow it.

People in the criminal justice system pass through many decision gates before incarceration; each one is an opportunity to identify their mental health and substance use needs, allowing people to be intercepted and referred to the care that they need.

It begins with the first encounter with someone in crisis, often because of a call to 911. The country's new 988 lifeline, formally established in July 2022, is meant for those facing a mental health or substance use crisis issue, and the number is already seeing a rise in calls. Often, those in need can be helped just by talking to the trained responder on the line, and a response from police is unnecessary.

If a physical response is necessary, who shows up is also changing. A growing number of communities are creating mobile crisis response teams that include trained mental health staff, or specially trained medical personnel (and yes, sometimes police officers with specialized training). These teams can de-escalate difficult situations that otherwise might lead to arrest or an armed police response. They can get people diverted to the mental health care that is required and often follow up on cases to ensure that longer-term treatment is arranged—and arrests are avoided.

When those efforts are successful, they allow people to avoid the criminal justice system. For those who are arrested, there is the next series of intercept points. Many localities now have specialized problem-solving courts such as drug courts, veteran treatment courts, and mental health courts. These courts can divert individuals into alternative treatment programs and replace incarceration with care. And for those who are incarcerated, some communities are able to provide care through specific treatment programs within jails and prisons.

The final intercept point is for those people who go through the criminal justice system, are incarcerated, have served their sentence and now face re-entry to society.

The initial months out in society after incarceration are often especially perilous for those with mental health and substance use issues. The risk of death from overdose, for example, is almost 13 times higher for people being released from prison within the first two weeks after their release compared with the general population. There are many reasons for this, and more support is needed to address gaps when services provided within the prison abruptly end. That's when community services need to step in—but instead people usually face fragmented and disconnected care as they transition out of prison and into the community.

OUR CRIMINAL JUSTICE SYSTEM IS FILLED WITH PEOPLE WHO BOUNCE THROUGH COURTS, JAILS, PRISONS, PAROLE, AND PROBATION—PEOPLE WHO NEED MENTAL HEALTH AND SUBSTANCE USE CARE TO PREVENT THEM FROM RE-ENTERING THE SYSTEM AT A COST TO THEM AND TO SOCIETY.

Fortunately, there is a growing recognition of the challenges faced by people with mental health and substance use disorders, prompting new efforts at the federal, state, and local levels to build out a robust and more interconnected system to provide a continuum of care. This includes services to keep both youth and adults in home- and community-based programs, providing care that helps them avoid reaching the crisis points that could prompt a law enforcement response that funnels them into the criminal justice system.

Other efforts are underway to help those already in the system as well.

A new initiative through Medicaid is helping by covering some services up to 90 days before a person is released from a correctional setting. California was the first state to receive approval for this, and there have been and will be others. Such funding of services pre-release can ensure smoother transitions to care for these persons by community providers once they are out of prison. A key component is the use of peer counselors: Research has increasingly recognized the value of lived experience, from those who have gone through the system, in mentoring people and helping them achieve better outcomes and recovery.

The federal government is also expanding the Certified Community Behavioral Health Clinic (CCBHC) model of services. These clinics provide rapid access for anyone who wants treatment, providing screening for anyone who enters the door regardless of ability to pay or type of insurance. The CCBHC model also sets up mobile crisis intervention services and partnerships with local sheriffs and law enforcement to focus some outcomes on diversion from arrest and jail, provide substance use treatment services, and develop relationships with other community systems such as schools.

What makes this CCBHC model especially useful is its funding structure: Clinics aren't simply paid on the traditional fee-for-service arrangement but instead on the number of people served. Paying for non-billable yet still essential needs, such as clinic infrastructure, means communities can be nimble in providing quick and effective treatment to those who need it.

These innovative programs and funding designs provide a roadmap that can lead to a better future. And we certainly can see the problem that needs to be addressed. So the one last ingredient of success comes down to vision.

Collectively as a nation, we must consider what public safety really looks like today—and how it can be made better for us all. Our criminal justice system is filled with people who bounce through courts, jails, prisons, parole, and probation—people who need mental health and substance use care to prevent them from re-entering the system at a cost to them and to society. Indeed, it's the very care that could have prevented them from entering the criminal justice system from the start if only they had received attention they needed and deserve.

Great need often sparks a great response, and that is where we are today as a nation. With local, county, state, and federal governments and all the many potential partners working on improving access to mental health and substance use disorder services, there are opportunities to turn the statistics around and to demonstrate success.

But it will require a cultural change, too. The stigma associated with those with mental health issues and with those in the criminal justice system must be overcome. Someone with a broken bone must get a cast and help recovering. Someone with diabetes must receive needed treatment and help recovering. And someone with post-traumatic stress disorder or schizophrenia or substance use disorder must receive the medication, counseling, and therapy needed to provide help recovering. And they must receive this help before the criminal justice system becomes the place of last resort.

From the 988 system to new funding opportunities for services geared for those re-entering society from jails and prisons, we have the tools to make a difference. To be sure, part of the journey for the Tys and Teresas will be the work they must do to help themselves move to a better place in life, to make healthier choices for their personal wellness, and to make positive decisions. But experience shows us that we must offer support, hope, and opportunities to enhance their well-being and safety and the safety of others. We must realize that society will be enhanced if we do more than simply lock them up.

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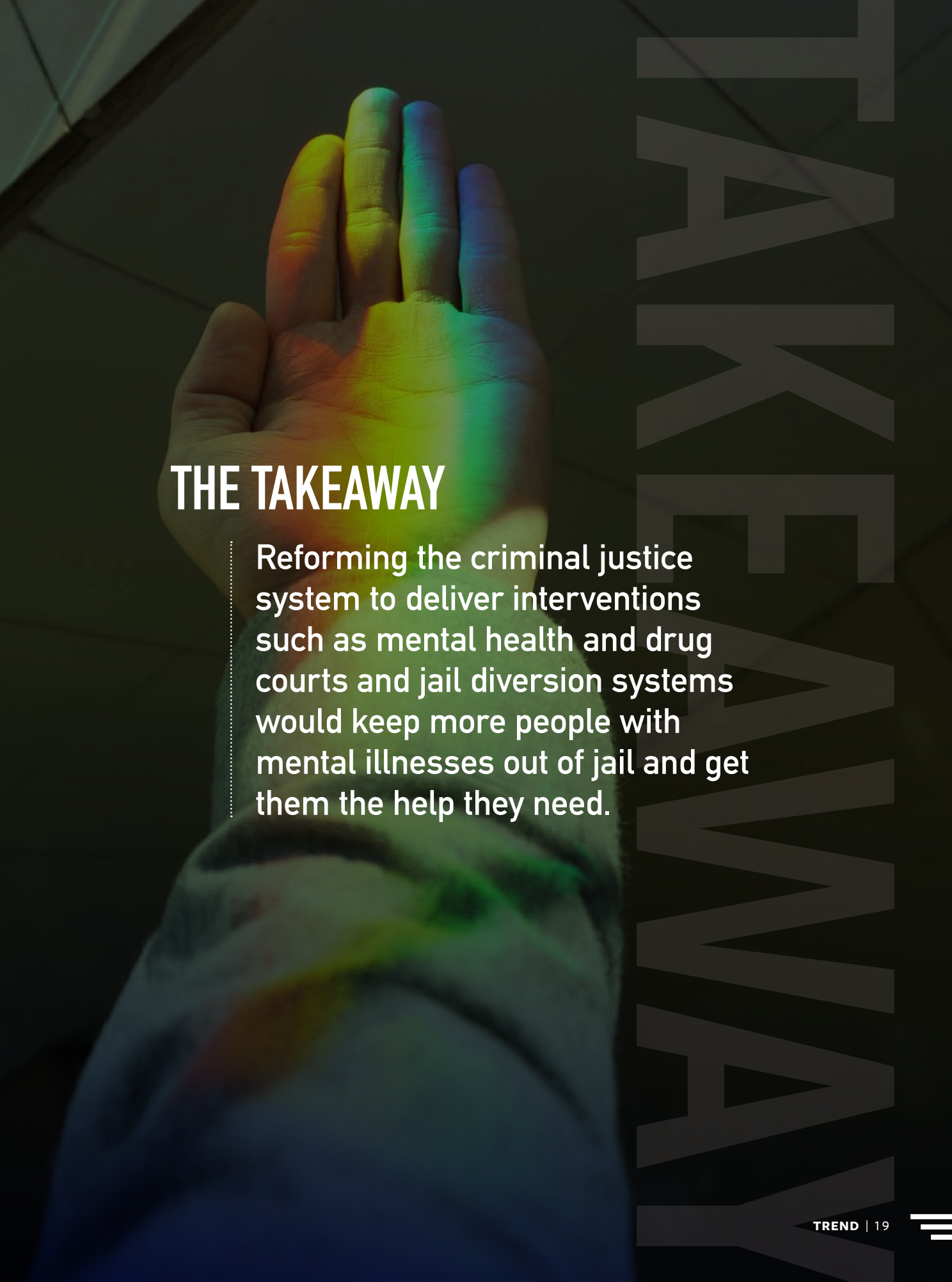


THE TAKEAWAY

Reforming the criminal justice system to deliver interventions such as mental health and drug courts and jail diversion systems would keep more people with mental illnesses out of jail and get them the help they need.

It's Time to Create Mentally Healthy Workplaces

Whether working for business, in nonprofits, or for government, employees are becoming more mindful about the connections between work and well-being—and their bosses are starting to respond.

BY KELLY GREENWOOD

ILLUSTRATIONS BY GABY BONILLA/
THE PEW CHARITABLE TRUSTS

More than a decade ago, I experienced severe anxiety while working for an organization that didn't have the healthiest of cultures. The situation ultimately spiraled into a debilitating depression, which forced me to take a leave of absence from my job, which shattered my sense of self. Ambitious high achievers couldn't have depression, right?

That, of course, is a myth. Earlier this year, U.S. Senator John Fetterman from Pennsylvania went public with his clinical depression. The way he managed—and messaged—it should serve as a model for public figures. The same goes for Diane Patrick, the former first lady of Massachusetts and high-powered attorney who in 2007 was hospitalized for depression. Her husband, Governor Deval Patrick, cut back on his work to be with his wife.

Given the persistent stigma around mental health, these were brave acts by high-profile employers. But momentum is building for leaders not to sweep anything under the rug. C-suite executives at Pinterest, the Minnesota Vikings, Google, Siemens Energy, and more have come forward to share their own mental health struggles. Companies, nonprofits, and government entities are making mental health part of their internal programming to grapple with increasingly complex workplaces.

As we know, workplace mental health came into sharper focus during the pandemic and the racial justice reckoning. A landmark study that my nonprofit organization conducted in 2021 surveyed 1,500 U.S. adults in full-time jobs, with statistically significant representation across race, ethnicity, gender, LGBTQ+ status, generation, levels of seniority, and more. We found that mental health challenges are pervasive among employees no matter how you slice the data. More than 75% of respondents reported at least one symptom of a mental health condition.

In the same report, an overwhelming 84% said that at least one workplace factor negatively affected their mental health—not too surprising since work is where we spend much of our time and is often a main source of our stress. Younger workers in the Gen Z and Millennial cohorts, as well as Black, Hispanic, and LGBTQ+ employees, were affected even more severely. These workers pointed to emotionally draining work—meaning stressful, overwhelming, or boring. Notably, Black and Hispanic respondents were more likely to leave roles for mental health reasons. Women, as we know, also face additional barriers at work because of gender stereotypes and the lingering male-dominant architecture of the workplace—realities that serve only to exacerbate anxiety.

And for some, workaholism—a way to cover up issues we may be trying to avoid—is par for the course of having a high-octane job. As Harvard professor Arthur C. Brooks wrote in *The Atlantic*, "[W]hen it comes to work, people reward you for addictive behavior. No one says, 'Wow, an entire bottle of gin in one night? You are an outstanding drinker.' But work 16 hours a day and you'll probably get a promotion."

WORKPLACE MENTAL HEALTH CAME INTO SHARPER FOCUS DURING THE PANDEMIC AND THE RACIAL JUSTICE RECKONING.

In recent years, however, many employees at all levels are becoming more mindful of the interplay between work and well-being. Mental health isn't just an individual's responsibility anymore. It's also becoming the collective responsibility of employers to normalize mental health challenges and promote a mentally healthy culture, including mitigating the workplace factors that can contribute to poor mental health for everyone. In addition, health is not an "us" versus "them" issue—we're all in this together. We all experience some sort of mental health challenge during our lives—be it stress, grief, burnout, anxiety, depression, or another diagnosable condition.

"A healthy workforce is the foundation for thriving organizations and healthier communities," said U.S. Surgeon General Dr. Vivek Murthy, with whom we worked on the federal government's workplace mental health priorities. "As we recover from the worst of the pandemic, we have an

opportunity and the power to make workplaces engines for mental health and well-being. ... It will require organizations to rethink how they protect workers from harm, foster a sense of connection among workers, show workers that they matter, make space for their lives outside work, and support their growth. It will be worth it, because the benefits will accrue for workers and organizations alike."

The broad issue of mental health is one of the rare issues that virtually all Americans can agree is important. In a 2022 Kaiser Family Foundation/CNN survey, 9 out of 10 people said they believed that there's a "mental health crisis" in the U.S. About half said they knew of someone in their family with a severe mental health crisis. In terms of who is responsible for addressing the situation, a sizable chunk (44%) of people named employers, after family and doctors.

How do we fix this?

At Mind Share Partners, we are changing the culture of workplace mental health so that both employees and organizations can thrive. As a national nonprofit, we provide custom workplace training, strategic advising, and implementation services, which serves as a research and development vehicle for our advocacy work. Our ultimate goal is twofold: to normalize mental health challenges at work and to create mentally healthy workplace cultures. Based on years of client work with industry leaders such as BlackRock, Morrison Foerster, and Pinterest, along with three in-depth public opinion research studies in partnership with Qualtrics, we've learned the essentials for employers and leaders looking to tackle mental health at work. In a nutshell, the answer is culture change.

Americans are the most stressed-out workers on the planet. Reasons include the workload, lack of autonomy, toxicity, systemic racism, and the ongoing remote/in-office debate. Tackling some or all of these features requires both a top-down and bottom-up approach. Senior leadership, not just H.R., must treat mental health as an organizational priority, with accountability mechanisms such as regular employee surveys, clear ownership over a mental health strategy, and employee protection policies.

MANY EMPLOYEES AT ALL LEVELS ARE BECOMING MORE MINDFUL OF THE INTERPLAY BETWEEN WORK AND WELL-BEING.

Culture change can be a big, amorphous term that's easily thrown around. To us, it means a commitment with specific action steps, including:

- **Getting to the root of the problem.** Although mental health apps and benefits can certainly be effective, they are not sufficient by themselves. Even companies with the best benefits won't see an uptick in usage unless a stigma-free culture exists. And benefits are simply a Band-Aid unless a sustainable, mentally healthy work culture is in place.

- **Upskilling** everyone by incorporating workplace mental health training into onboarding and ongoing professional development as well as implementing mental health employee resource groups (ERGs), peer listening, and mental health champion programs. (We have almost 500 organizations represented in our free community for leaders of mental health ERGs.)

- **Collaborating** with employees around working needs, styles, and preferences. It's not a one-size-fits-all.

- **Demonstrating** your organization's dedication to mental health through the employee life cycle, including creating a well-being statement that clearly defines what this means.

- **Measuring** the mental health of your employees and relevant workplace factors.

Among the biggest barriers to mental health support is stigma. The way to reduce shame—to make something less foreign or scary to people—is to normalize it and talk about it.

When nonprofit, government, and business leaders share their personal mental health stories, it normalizes experiences like anxiety and depression, burnout, bipolar disorder, and more. This vulnerability cracks open what can sometimes

be closed and antiquated workplace culture. It also, crucially, makes their workers more comfortable doing the same—talking openly about their own struggles—should they choose to do so. Earlier this year, 10 C-suite executives participated in our now-ongoing "Leaders Go First" storytelling campaign. It was heartening to see a growing number of senior leaders stepping up to break the traditional—and damaging—silence around mental health challenges as well as modeling mentally healthy behaviors.

Burnout has received an increasing amount of attention in the past few years. It continues to afflict women more than men. Pinterest's chief diversity, equity, and inclusion officer, Nichole Barnes Marshall, has relayed the story that she was once so burned out, she sat in her car and cried before work. Versions of this story aren't uncommon. Women also experience increased rates of depression, generalized anxiety disorder, and PTSD, in part because of systemic causes centered in gender inequities: the pay gap, underrepresentation at work, caregiving responsibilities, and gender-based violence. When it comes to men, mental health is one of the rare instances in which they face added challenges in our culture. Social norms often prevent men from talking about mental health and from seeking treatment.

What can employers do to mitigate these factors? They can take a proactive, preventive approach with a management and equity lens to workplace mental health. There's no need to dive into signs and symptoms—employers aren't therapists, nor should they be. But mental health training should provide baseline knowledge and dispel myths, as well as offer tools and strategies to navigate workplace mental health and foster mentally healthy cultures.

Looking to the future

This fall, we released Mind Share Partners' 2023 Mental Health at Work Report in partnership with Qualtrics, which includes pre- and post-pandemic trends. It also provides employers a roadmap for moving forward in this new era of work. Three trends stood out to us.

Invest in culture change, not just shiny tech objects. To reiterate, employers have historically rallied around a productized, individualized approach to mental health care—therapy, apps, time off. These Band-Aids serve only to equip workers with the resources to self-manage their mental health on their own time. In our new study, 78% of workers said a healthy and sustainable culture would be moderately, very, or extremely helpful in improving their mental health.

Stay the course on DEI. According to our study respondents, employers' efforts at diversity, equity, and inclusion are paying off. It would be a poor business decision—and a mentally unhealthy one—to scale back or mute DEI programs, despite the current political climate that is attacking such programs. Mental health is a newer category within DEI as well as intersectional with our multifaceted identities and demographic groups.

Back to the basics. Although every organization is different, there are core foundations that every workplace must meaningfully address in order to cultivate a mentally healthy workforce. These include psychological safety, financial stability, autonomy/flexibility, and belonging. The ability to show up authentically, make meaningful connections, and feel a holistic sense of community with others is what we want all employees to experience.

As organizations prepare for the future of work—including recruitment, retention, DEI, and artificial intelligence—they should actively begin a culture shift. As with other innovations, AI will not be a substitute for culture change. A new technology is a tool, not a panacea. Unlike older generations, Millennials and Gen Z workers expect true investment and sustainability in workplace mental health. They are wise beyond their years on this one.

Kelly Greenwood, who has worked in the corporate and foundation sectors, is the founder and CEO of Mind Share Partners, a national nonprofit organization working with employers to improve workplace mental health.

THE TAKEAWAY

Workplace mental health came into sharper focus during the pandemic and the racial justice reckoning, and more employers are beginning to normalize mental health challenges and promote a mentally healthy culture—including mitigating workplace factors that can contribute to poor mental health.

Kids and Teens Need Resilience

They can learn it—and we can help

BY MARY K. ALVORD, PH.D.

ILLUSTRATIONS BY CARA BAHNIUK/
THE PEW CHARITABLE TRUSTS

A few decades ago, I met a 6-year-old girl from Russia. For her privacy, I'll call her K. I saw many Russian-born children in my practice as a clinical psychologist because Russian was my first language, and I have ties to the international adoption community. In her home country, K's early life was filled with trauma. She was neglected as a child, separated from her younger sister, and after her mother died by suicide, taken to an orphanage. Then, American parents adopted her, and she moved to the United States. Certainly, her challenges were severe.

But K is intelligent, hardworking, and has an easygoing disposition. She had a supportive family, and several of her school environments were a good fit, helping her form friendships and build self-confidence. Today, K is in her early 30s and reports being happy and successful, with children of her own to nurture.

What enabled K to overcome such difficult obstacles? How did she successfully adapt despite the challenges of fending for herself, early abandonment, and changing cultures, languages, and families? How did she cope? She is persistent, proactive, resourceful, and empathic. When faced with problems, she takes action rather than being passive or feeling like a victim, and she was always able to come up with a plan after her setbacks. For example, when one school was not meeting her needs, she advocated for changing to another. She continues to be open to help from others and seeks out opportunities to further develop her personal and professional skills. Facing learning challenges, in college she changed her major to education to best match her abilities. She is now an elementary school teacher, a profession that allows her to apply her strengths: patience, creativity, empathy, and an understanding of child development.

Some would call K stress resistant or invulnerable. Some say she has sheer grit. These days, however, we'd be more likely to call her resilient.

Put simply, resilience is the ability to deal with stress and adapt to big and small challenges throughout life. It involves using various characteristics and skills to positively adapt to traumatic situations, natural disasters, social struggles, learning disabilities, and mental and emotional disorders. This does not mean that resilient people don't experience grief, sadness, or other strong, difficult emotions, nor that they can control all aspects of their lives. It means that they are proactive about what they can control. People can bounce back from severe adversity if they are resilient or *learn* to apply resilience. That's right. While we may be resilient in some areas of our life, we can also build it in other areas. And we can help our children learn it and build it in themselves.

Children in particular need resilience skills to meet the hardships they encounter daily in order to become well-adjusted, successful adults. According to the Centers for Disease Control and Prevention, in the decade leading up to the pandemic, feelings of persistent sadness and hopelessness—as well as suicidal thoughts and behaviors—increased by about 40% among young people in grades 9-12.

Then, during the COVID-19 pandemic, more than 200,000 kids lost a parent or primary caregiver, 29% of U.S. high school students had a parent or caregiver who lost their job, 55% were emotionally abused by a parent or caregiver, and 11% were physically abused.

In a 2023 survey of more than 130,000 kids and teens ages 9-18 conducted by the Boys & Girls Clubs of America, 7 out of 10 youths said that when something important goes wrong in their lives, they can't stop worrying about it; 67% said they try to keep anyone from finding out; and 70% rated their ability to cope with challenges as medium to very low.

But teaching children resilience skills can help them overcome these major obstacles as well as daily anxiety. According to the journal *Child Development*, an analysis of 97,000 students showed that those who participated in a resilience program were 11% more likely to graduate from college and were less likely to suffer from mental health problems or be arrested.

It's often the at-risk kids who need resilience skills the most. For example, a randomized control study in economically marginalized schools, conducted by Resilience Across Borders, Catholic University, and Alvord, Baker & Associates and published this year, found significant increases in resilience and a sense of self-mastery after children engaged in resilience training in a small-group setting. In Resilience

Across Borders, the nonprofit I helped found to increase young people's access to mental health interventions, we help teachers provide lessons on resilience—through topics that include mental flexibility, coping with anxiety, assertiveness and self-advocacy, teamwork, and leadership—to their entire classroom, an approach designed to help all students increase mental wellness.

In short, resilience is a set of skills that we can learn, we can build, and we can support.

During my 40-plus years of clinical practice, I've learned that parents, teachers, physicians, mentors, psychologists, therapists, coaches, volunteer leaders, and other caring adults can play a huge role in helping kids adapt to risks, hardships, and challenges, bolstering children's resilience for the rest of their lives. Kids of all ages can learn how to incorporate the following skills into their lives.

Be proactive. Kids who can take initiative and believe in their own effectiveness have the primary characteristics of resilience. Too often, however, anxiety, self-doubt, and plain old fear encourages kids to avoid a hard situation or do nothing. We've all seen the child (or maybe we *were* that child) who avoided the class trip for fear of being left out or sitting alone—missing out on the fun and on a learning opportunity. Being proactive means that we generate many possible steps we can take to address challenges; there is almost always more than one way to tackle a difficulty, and we can typically *do something*. Helping children recognize avoidance and decide to take a brave step in spite of negative thoughts can build their confidence and affect the way they think about their own potential. For example, I have worked with teens who find long-term projects daunting and, as a result, frequently procrastinate. A few have set up a buddy system with a friend, and together they develop a plan. They break down the project into smaller steps, devise a timeline, and then check in with each other for encouragement and accountability. They even set up a reward system for themselves for accomplishing tasks, be it getting together with friends, going to a movie, or putting aside time to draw or practice other creative projects they enjoy.

Self-efficacy. Those who believe they can have an impact on an outcome will be more resilient. Encourage kids to realize that they have the ability to affect what happens to them, such as asking for help before an exam, joining a club at school to meet new people, or taking up a new hobby during a lockdown. During the pandemic, when schools were shut down, I asked children and teens in my groups about what they could control. They immediately began to understand that they could make decisions related to using their free time—learning a new skill like playing the guitar—or how they behaved at home when they weren't learning online. Many rode their bikes. Older teens took walks to see friends (while social distancing, of course).

Problem-solving. Kids can learn to think of various solutions to a problem, consider pros and cons, and choose the most effective plan of action. Adults can model problem-solving by discussing a current issue (e.g., conflicts with peers or siblings; managing anger; trying out for a team; facing a fear, such as the first day of school), identifying steps to take, and asking children to generate their own solutions. For example, I have worked with many kids and teens who are socially anxious and avoid peer groups or joining activities. We brainstorm possible small steps they can take to achieve their goal. Because several students enjoyed musical instruments, we worked on taking lessons with one instructor and then possibly moving to lessons with several students at the same time. Then we worked on talking with the band teacher to explain their hesitation with group situations. Ultimately, we focused on signing up for band at school or playing with a group of friends outside of school. Problem-solving by generating possibilities, as in this example, also helps kids develop cognitive flexibility, the skill to mentally switch gears and consider alternative perspectives.

Increasing self-esteem. Children have their own areas of competence. Kids need to give themselves credit for their own strengths and continue to develop them while maintaining a healthy perspective on what areas could be improved. Adults can provide children with a range of opportunities to succeed, inside and outside of school, exposing them to everything from traditional sports teams, the school newspaper, photography, and volunteering to help at food banks or with younger children to

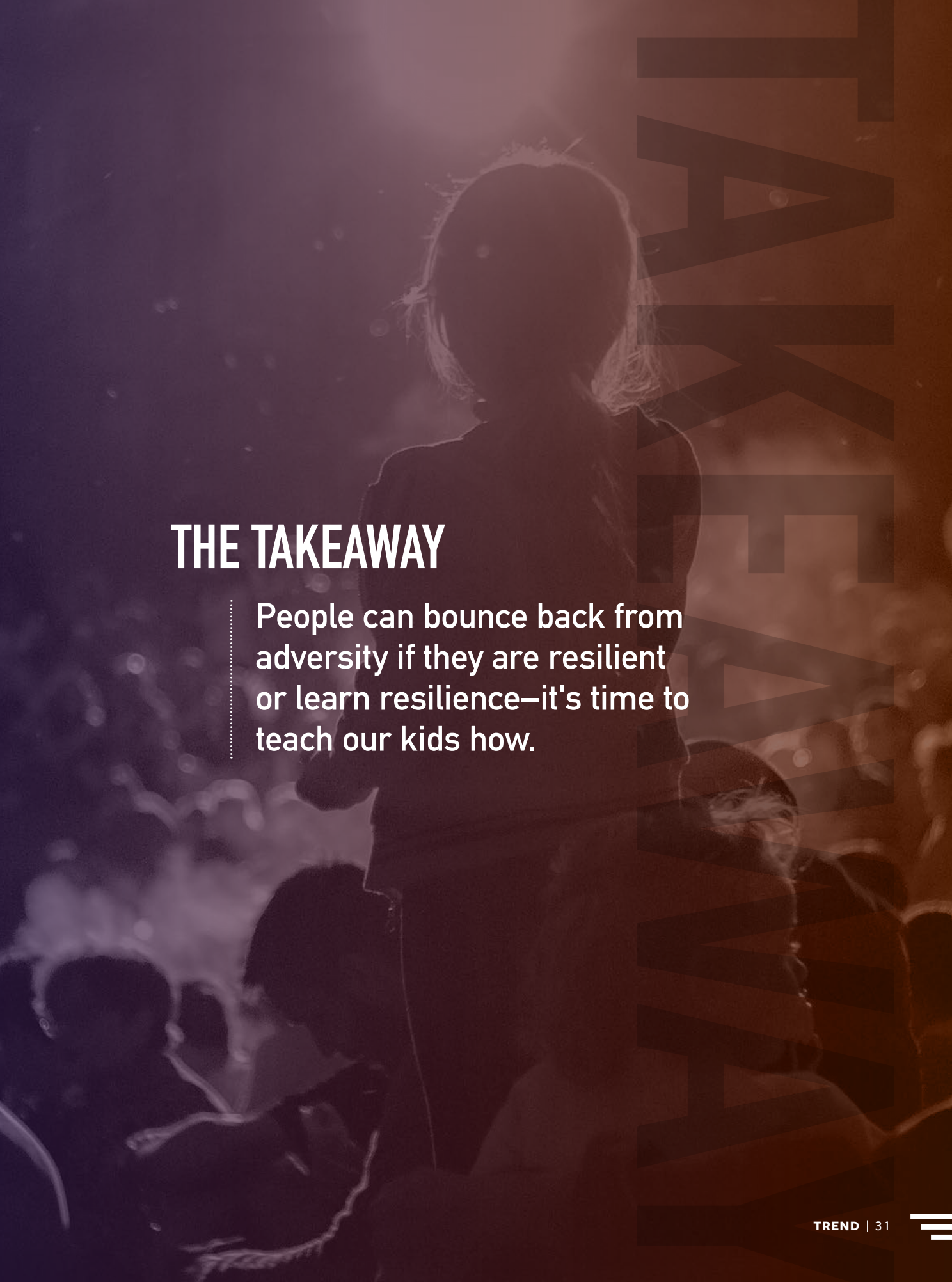
theater, music, and more. Authentic self-esteem comes from specific external feedback (You did well on this science project. You really shined onstage in the school musical.) as well as internal acknowledgement of efforts and achievements.

Self-control and active coping strategies. We all have self-talk, an inner dialogue that can be helpful and encouraging (I have done this before, I can do it again) or unhelpful (I am so stupid. This is so terrible). People of all ages can learn thinking patterns by challenging thoughts that get in the way. They might ask themselves, What is the worse thing that can happen? How likely is it to happen? What might I tell my friend who is thinking the same thought or in the same situation? There are also active ways to relax the body, which in turn calms the mind: muscle relaxation, calm diaphragmatic (from the abdomen rather than the chest) breathing visualization, and physical movement like plain old exercise. Combining these strategies to take action increases effective coping. Teens are often anxious about tryouts, for example, but breaking down the steps necessary to reach the athletic field or the stage can lessen the stress. I have them visualize being in the car going to the tryout, stepping out of the car, getting close to the field, seeing the coach or director, seeing the other kids there, etc. Then, we break down the steps and visualize taking action in each one, and we incorporate breathing exercises and calming techniques at each stage, when needed. Finally, we do each step in the actual environment: We drive to the tryout parking lot, walk to the field, watch a game, and then practice and expose them via small steps to the process leading to the tryout.

Relationship building. "You are not alone" is a phrase I often reiterate because kids can always find people who care and who can support them. Learning to reciprocate, empathize, and read nonverbal cues nurtures connections with people—family, friends, teachers, adult mentors, and others in the community. In what I call the Resilience Builder Program, we practice conversations that go back and forth and are reciprocal using the analogy of playing ball with someone rather than just throwing the ball at them, as in a one-way conversation. We apply the skill by starting a conversation to ensure it is reciprocal (a conversation builder) rather than interrupting, going off topic, or talking without listening (conversation busters). Finding ways for children to build connections with their peers through in-person events, phone and video chats, or text helps build social support. We also teach kids to recognize how their actions and words are received, a concept called intent versus impact. Intention is the message you want to communicate. Impact is how it is received. How one delivers the message affects its impact, and with this awareness comes better communication.

These skills can be taught at home and in club settings, a faith community, school, and small-group settings. But like playing an instrument or being good at a sport, resilience requires practice, and professionals, parents, teachers, community leaders, and mentors can help create situations to encourage it. We *can* help the country's children develop resilience, making them happier, better adjusted, and more productive members of society. We can help them face their obstacles, big and small, every day.

Mary Karapetian Alvord, Ph.D., is a licensed psychologist, founder of Resilience Across Borders—a nonprofit that helps educators provide resilience training—and an adjunct associate professor of psychiatry and behavioral sciences at the George Washington University School of Medicine and Health Sciences. She co-authored The Action Mindset Workbook for Teens: Simple CBT Skills to Help You Conquer Fear and Self-Doubt and Take Steps Toward What Really Matters.



THE TAKEAWAY

People can bounce back from adversity if they are resilient or learn resilience—it's time to teach our kids how.

ILLUSTRATIONS BY BRIANA OKEBALAMA/
THE PEW CHARITABLE TRUSTS

Nature: A Key Ingredient for Mental Health

A growing body of research shows how being in nature helps people contending with mental illness.

BY ROBERT ZARR, M.D., AND WINNIE CHAN, PH.D.

When was the last time you went to a park? Do you take breaks during your day to go outside? Is your home or office filled with green plants? It turns out that all of these things are good for our mental health.

A 2015 study by researchers at Stanford University, published in *Proceedings of the National Academy of Sciences*, found that compared with participants who walked in a high-traffic urban setting, people who walked for 90 minutes in a nature area showed decreased activity in a region of the brain associated with depression.

Nature-rich experiences can also reduce stress and restore attention, including our brain's ability to focus. While workers in the U.S. are largely praised for their ability to efficiently multitask, doing so can result in brains that are overworked in discerning what to focus on and what to ignore, which can lead to fatigue and poor mental health. But recent science shows us that nature can help rest and restore the neural pathways that underlie our focus and attention. For example, using an experimental design, researchers from the University of Michigan found that people who completed a difficult cognitive task and then took a walk through an arboretum reported a happier mood and better working memory than those who did the same task and then walked around an urban setting.

Interactions with nature can also promote overall well-being. Researchers in Israel surveyed 776 adults in 2021, during the COVID-19 pandemic, to understand the association between nature exposure and positive feelings. They found that viewing nature from windows, living near nature, and being outdoors were associated with high levels of self-reported positive emotions. Moreover, the participants able to view nature from their windows reported feeling happier. In the U.S., researchers from the University of Iowa who conducted an online survey during the pandemic found a similar benefit: Among the 558 adults who completed the survey, those who had greater access to nature reported higher levels of well-being.

A growing body of evidence shows that spending time in nature bolsters our mental health, promotes positive emotions, and helps reduce negative thoughts—all of which has led an increasing number of health professionals to prescribe nature as a cure or treatment for a variety of ailments.

But what does it mean to prescribe nature? Nature prescriptions (Nature Rx) fall under the larger umbrella of social prescriptions—like healthy sleep habits, eating fruits and vegetables, or even reading to your child at night. And they are synonymous with park prescriptions (spending time in an established park) but are broader and more encompassing—especially for people with limited access to safe and quality outdoor spaces. There is a diversity of park prescription programs in the U.S., and several organizations and agencies—including the Centers for Disease Control and Prevention, the National Park Service's Healthy Parks Healthy People program, the National Environmental Education Foundation, and the Institute at the Golden Gate—have all contributed generally to the nature and health movement and specifically to nature/park prescriptions.

And early studies are showing the benefit: A randomized trial of park prescriptions, conducted by researchers from the University of California, San Francisco; the University of California, Berkeley; and Cornell University found that weekly park visits reduced stress and loneliness in low-income parents after three months of participation. Stress was measured by saliva cortisol, and loneliness was measured by the modified UCLA Loneliness Scale. Seventy-eight parents were enrolled in the study, and all participants received counseling from their physicians about the value of nature, along with maps of local parks. Fifty of them received additional support, such as additional text and phone call reminders, free transportation, food, and structured programming at the parks. Participants who received additional support did not report lower stress levels than those who did not receive additional support.

Park Rx America (PRA), a nonprofit founded in 2017, has gone a step further to establish a community of health care professionals who share the common goal of issuing nature prescriptions to their clients as part of patients' treatment plans. Among PRA's 1,700 registered health professionals, nearly 15% work in the mental health field as psychiatrists, psychologists, licensed social workers, or counselors.

PRA's nature prescribing platform is accessible to all, regardless of geographical location or type of practice. After providers watch a short instructional video to train themselves, they can begin immediately prescribing nature within the confines of a comfortable "architecture"—with each prescription including a place, activity, frequency, and duration. Since providers are already adept and comfortable with the structure of medication prescriptions, nature prescriptions are similar enough. However, there are some fundamental differences.

Medication prescriptions don't require much conversation with the patient, except to clarify allergies, potential drug interactions, and side effects. And as a general rule, patients don't have much say in terms of which medications and dosages they're going to take. In contrast, when writing nature prescriptions, providers ask patients pertinent questions to better understand their readiness to make a behavioral change, as well as potential social and structural barriers.

PRA's nature prescription comes with standard prompts that put the patient in the driver's seat while capitalizing on the provider's medical expertise to safely maximize therapeutic potential. For example, let's look at the case of Mr. Jimenez, a 75-year-old Mexican-American with a history of long-standing diabetes, hypertension, and congestive heart failure, who was recently diagnosed with depression after the recent loss of his life partner. Here are a few clarifying questions the provider might ask:

Will you walk alone or with someone, possibly even a pet?

Might there be a body of water nearby, like a river, lake, or pond?

Do you intend to listen to music or a podcast while walking?

These help the provider take into account the patient's health status (especially his congestive heart failure and depression) as well as the potential benefits of social contact, the positive effects of a nearby body of water, and the calming and attention-restoring effect of engaging his

sense of hearing—especially the rustling of leaves and the chirping of birds. After a few minutes of consultation, the provider can write a nature prescription that considers how Mr. Jimenez can safely and comfortably spend more time in nature:

Walk along a trail near a pond, with a neighbor or friend, without earbuds, for a half-hour, every day.

An electronic prescription reminder allows patients to log their time and keeps the provider and patient connected from one visit to the next. And at his next visit, after Mr. Jimenez is asked the same series of questions about place, activity, frequency, and duration for his follow-up, his blood pressure is rechecked, and he undergoes a quick depression symptom inventory, his prescription could easily change to:

Visit a Japanese garden, sit near a pond, and notice the sounds and smells around you for 20 minutes, twice a week.

Rather than focusing solely on a patient's "problem list"—literally a list of medical problems that health professionals use to frame the encounter—nature prescriptions focus on what is positive, fostering hope and possibility and finding creative ways to improve health and help individuals feel better. In this way, nature prescriptions can be viewed as a tool to empower patients to improve their health in their own way, imparting a feeling of control—patients can rely on their assets rather than focusing on their deficits. And as every person is unique, individual circumstances will help providers formulate a unique plan for their patients' interactions with nature.

Just as clinicians consider an individual's readiness to initiate behavioral change, it is useful to look at the larger context within which patients live, work, study, entertain, recreate, and sleep—the social and physical determinants of health. Imagine recommending that your patients eat more fresh fruits and vegetables when they are unemployed, disabled, or live in a neighborhood that is a food desert. Furthermore, layers of structural racism and inequities create additional barriers that prevent individuals from marginalized communities from accessing the resources necessary to follow evidence-based advice. Keeping in mind an individual's readiness and capacities, as well as social and structural environments, will only help the patient realize improved health.

NATURE-RICH EXPERIENCES CAN REDUCE STRESS AND RESTORE ATTENTION, INCLUDING OUR BRAIN'S ABILITY TO FOCUS.

Some might be wondering why prescriptions for nature are even necessary in the first place. After all, isn't it just common sense to spend more time outside, given all the obvious health benefits, especially the mental health benefits of reduced stress; increased focus; improvements in depression, anxiety, and ADHD; opportunities for awe; increased creativity; and a sense of connectedness to the larger world? Yet, most of us spend upward of 90% of our awake and asleep time indoors. Many of us would in fact benefit from receiving not just a recommendation but also an actual prescription to spend more time in nature.

After several decades of research showing the obvious connections between positive health outcomes and time spent in nature, why haven't we changed our routines to include more time in nature? Those who live within the structural confines of racism, poverty, ageism, ableism, and heterosexism can justifiably explain the lack of nature inclusion. Many people still don't have access to safe and quality nature-rich spaces. Some may not have the resources, such as transportation and time, to participate in nature-based activities. People in some communities, such as those that include immigrants and refugees, may not know how and where to access nature-based activities. Nature prescriptions that do not address these structural barriers are less effective. Asking individuals to incorporate nature into their lives and daily routine without structural support is not the best path forward.

How might policy changes in our workplaces and schools affect the likelihood of our spending more time in nature? How might new policies

dictate the degree of designs that connect us to nature in our built environment? What does a healthier and happier workforce mean for productivity from an economic standpoint? These are questions that science may not yet have answers for but that could be prioritized in research agendas. Rather than expecting individuals to make these changes in their lives, perhaps it's time to take more seriously system-level changes that make the "right decision" become the "easy decision."

And what about health care providers? Of the 18 million health care providers in the U.S., why the embarrassingly low level of adoption of nature interventions into their practice? So many providers continue to work in rooms with no sunlight and no indoor plants and have no inclination to issue nature prescriptions or similar nature intervention in their practices. This is because nature and health curriculum in health professional training is largely absent. Continuing education courses for providers rarely, if ever, include the preponderance of data linking improved health outcomes to time spent in nature. For many mental health professionals, nature as therapy simply isn't on their radar.

Nevertheless, there are examples of innovations—like walk and talk therapy, where therapists literally take their clients on walks to reap the therapeutic advantages of both movement and nature. Jennifer Udler, licensed clinical social worker—certified, the author of *Walk and Talk Therapy: A Clinician's Guide to Incorporating Movement in Nature Into Your Practice*, writes, "the physical act of moving forward seems to trigger a mental movement toward open mindedness." In her guide, she shares many client anecdotes that illustrate how people's observation of the natural world can serve as a metaphor for what they experience internally. Although this type of practice is encouraging, it remains rare among mental health professionals.

Research in this area remains in its infancy. Not only do we need to better understand the change in health outcomes as a result of issuing nature prescriptions, but we also need to better understand through implementation science (the study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers) where, exactly, the tipping point lies within the health professions to fully embrace nature interventions in practice settings.

If the topic of mental health and nature resonates with you, consider self-reflection as a first step. Given the low side effects of nature prescriptions and their relative ease of use, doing this yourself—for yourself—can provide meaningful insight into many of the benefits nature can bring for mental well-being.

Meaningful change, whether it be individual or systemwide, is more likely to be realized when we have a deeper understanding not only of the barriers to change but also an appreciation of our assets. Whether you are a health professional or the client of one, this kind of experiential knowledge can take you closer to improving your own mental health and that of the world all around.

Robert Zarr, M.D., holds a master's degree in public health and is a physician researcher and public health pediatrician as well as the founder of Park Rx America. He is also a certified nature and forest therapy guide.

Wing Yi (Winnie) Chan, Ph.D., is a community psychologist and serves as the senior program director for the education program at Child Trends, a nonpartisan research center promoting the well-being of children, youth, and families.

THE TAKEAWAY

A wealth of new science shows that being around nature benefits our mental health by reducing stress and negative emotions, restoring attention, promoting positive well-being, and helping us feel happier—and some doctors are now even prescribing time outdoors.

5 Myths About Mental Health

Even as attention increases on the state of the nation's mental health, misconceptions persist, often contributing to stigma. Myths about mental health can cause real harm, affecting those who suffer, preventing progress on policy improvements, and even misleading those who wish to help those in need.

Daniel Bates, Ph.D., a licensed professional clinical counselor in Kentucky and Ohio, takes on five myths about mental health and debunks them. He is an assistant professor of counseling at Truman State University and has contributed to Psychology Today, *and his recent books include* Even a Superhero Needs Counseling: What Superheroes and Super-Villains Teach Us About Ourselves.

MYTH 1: DEEPLY DISTURBED PEOPLE HAVE MENTAL ILLNESSES, NOT NORMAL PEOPLE.

In TV shows and movies, mental illness is often depicted as someone who's visibly disturbed, stuck in a straitjacket, and rocking back and forth in a padded room. But in reality, many mental health conditions aren't extreme like that, or maybe even noticeable. Many aspects of mental illness are hidden from the public view, and it's not always obvious when someone is dealing with a mental health issue just by looking at them.

In fact, a lot of people with mental health challenges have become experts at hiding their symptoms, to avoid drawing attention and blend in. Some of them are high functioning, which means they can go about their daily lives, hold down jobs, and maintain relationships, all while silently dealing with their mental health issues. Experts in the mental health field call this masking, which refers to the practice of disguising or suppressing one's actual thoughts and feelings in order to conform to social expectations or norms.

Although people with mental illness might not show outward signs of distress, that doesn't mean they don't need support and treatment. In fact, even high functioning individuals, those who outwardly have it all together, need support and help. So, the way mental illness is often portrayed in the media doesn't capture the full picture of what it's really like for most people.

MYTH 2: THERE'S NO COMING BACK FROM A MENTAL ILLNESS.

There's this idea or worry floating around that once someone goes through a mental health challenge, they are forever broken or changed in a way that can never be fixed. This myth assumes that once a person struggles with mental illness, they are contaminated. In a manner of speaking, mental illness is "icky." Many clients have reported to their therapists that after they'd been open and honest about their struggles with family and friends, people started treating them differently. People began keeping their distance and treating them with kid gloves, as if they were fragile.

It's true that mental illness can alter a person; it's hard not to be changed by such an experience. But these changes aren't necessarily negative. In fact, they often turn out to be changes for the better.

Going through mental illness is, first of all, normal. Full stop; read that again. Mental illness is a feature, not a bug, of the human experience because, as some experts argue, mental illness can be adaptive. For instance, people, every day, find creative and profound ways of tapping into deep reservoirs of strength and courage in the face of their struggles. It's like a trial by fire that pushes people to dig deep and discover their own resilience. More often than not, struggling through mental illness increases compassion and empathy for the suffering of other humans. People working through mental illness become more aware of the struggles that others go through and are motivated to offer support. They also learn resilience, which becomes a well of strength they can draw from throughout their lives.

MYTH 3: MENTAL ILLNESS IS AN EXCUSE TO BE NARCISSISTIC.

There's a harmful idea out there that suggests people dealing with mental health issues are just looking for sympathy or attention. But most suffering with mental illness would never broadcast their struggles for the sake of garnering attention. In fact, many hide their struggles and bitterly battle feelings of shame, isolation, and a sense that they are broken. They envy those who wake up in the morning without a debilitating sense of lethargy, lack of motivation, or anxiety. If you think mental illness is a choice, those who struggle with mental illness would strongly disagree. If anything, given the opportunity, they would wish *not* to have a mental illness. But no genie in the bottle exists, and many people who battle mental illness suffer in silence, as opposed to seeking the spotlight.

To put things in perspective, mental illness can feel like a relentless uphill battle that makes day-to-day functioning near impossible, depending on the nature and severity of the disorder.

And really, this myth is built on a misunderstanding of narcissism. A classic narcissist would be the last to admit they have a problem or struggle. According to the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), a true narcissist would go to great lengths to avoid the appearance of vulnerability and outwardly would present only a glossy façade of confidence, superiority, and perfection.

So, it's not about wanting attention; it's about trying to survive. People with mental health conditions often hide their struggles, worried about being judged, discriminated against, or stigmatized. This fear of judgment can lead to isolation, making it even harder for them to reach out and ask for the help they desperately need. When a person does admit to struggling with mental illness, it's critical that we understand that making that confession is an act of bravery and demonstrates a willingness to care for themselves, knowing that there may be a social cost.

MYTH 4: TREATING MENTAL ILLNESS IS SOLELY FOCUSED ON REDUCING SYMPTOMS.

The relationship between our physical health and emotional well-being is closely interconnected through what experts call the *mind-body connection*. This connection underscores that mental and emotional states are deeply connected to and impactful on physical health. The reverse is also true: Physical health, or the lack thereof, also has a deep impact on mental health. For example, if you've ever felt like a 25-pound dumbbell was sitting on your chest when you were stressed about a work deadline, you have experienced the mind-body connection. Or, if you overindulged on junk food and for the next few hours, or even for an entire day, you felt lethargic and unmotivated, you have experienced the mind-body connection. The connection between thoughts and feelings and our physical health affects every aspect of our overall health; recent research has only scratched the surface of all

the profound connections.

However, the mental health field has not always adopted a holistic point of view and historically has been guilty of limiting treatment to the reduction of symptoms. Boiling down a person's experience to a set of symptoms that fall within a diagnostic category, with the goal of reducing the severity of the problem, is less than ideal. At best it offers temporary relief without addressing the underlying causes, can lead to overreliance on medication, inadvertently increases stigma surrounding mental illness, and primarily assumes a reactive stance rather than one that is preventive and proactive. In essence, it neglects the holistic nature of a person's health and well-being.

Thankfully, therapists have recognized that caring and supporting a person's overall health must take into consideration everything that makes up a person's identity and being, including their social functioning, emotional well-being, physical health, and even their views, perceptions, and feelings. It's not enough to focus on only one piece of the puzzle, such as symptoms. For a competent counselor, symptoms are only one chapter of the story, one movement in a symphony, that provide a limited but important snapshot into how the client is functioning. Really, the big idea is that mental health care has to be *holistic health care* that goes beyond symptom reduction to acknowledge the intricate interplay between a person's mental, emotional, and physical well-being. What this looks like, in a practical sense, is the promotion of preventive strategies such as purposefully spending time in nature, adjusting eating habits, getting regular exercise and engaging in physical activity, spending time with friends and loved ones, and contributing in meaningful ways to a group or community as well as practicing activities that promote mental health such as going to a counselor, journaling, and, in some cases, taking prescribed psychotropic medications.

MYTH 5: THERAPY IS MONOCULTURAL AND TEACHES PEOPLE OF COLOR TO BE WHITE.

People of color may feel that therapy isn't for them because the majority of those providing and receiving mental health care are White. According to the American Psychological Association and the American Counseling Association (and the Bureau of Labor Statistics), most therapists, psychologists, and social workers practicing in the United States are White. For people of color, it can be a real challenge to locate a therapist who understands their racial or ethnic background. Without representation among mental health providers, the unique cultural experiences and values of people of color often aren't adequately understood and integrated into the process of therapy. These concerns are shared not only by clients but also by counselors and counselor educators who are actively working to make the mental health field more diverse and culturally competent.

Many therapists in various health care settings are striving to create a safe and welcoming environment for clients. In these spaces, clients can freely explore their own identities and experiences without feeling the need to edit or self-censor their unique cultural perspectives. Moreover, therapists not only recognize but value cultural differences, seeing them as sources of empowerment and resilience. This shift toward inclusivity and cultural competence is helping to bridge the gap and address the concerns potential clients may have when seeking mental health support.

What Happens When You Call 988?

A call center expert talks about running a mental health, suicide, and substance use disorder hotline.

In July 2022, the National Suicide Prevention Lifeline changed its phone number from 10 digits to three, and its name to the 988 Suicide and Crisis Lifeline. The goal was to be more inclusive of a range of mental health needs and make the Lifeline simpler to use. Since then, call centers have fielded more than 4 million calls, chats, and texts—nearly doubling the annual average rate of calls received between 2017 and 2021. Additionally, average wait times dropped from almost three minutes to less than a minute nationally. Lifeline also launched a pilot program to support LGBTQ youth, a population four times more likely to attempt suicide than their peers.

As the country continues to see increases in deaths by suicide and suicidal thoughts and behaviors, 988 serves as an important, easily accessible tool for people experiencing suicide risk. It enables them to speak to a trained counselor for immediate support and, if needed, to be connected to appropriate ongoing treatment and care services. The use of 988 suggests that more people are reaching out for help, and it appears to be working: 988 has reported that nearly 98% of people who reach out to the lifeline get the crisis support they need without requiring additional emergency services in that moment.

In Columbia, Maryland—about halfway between Baltimore and Washington, D.C.—the nonprofit Grassroots Crisis Intervention Center offers 24/7 suicide prevention, behavioral health, shelter, and housing support services. In addition to responding to 988 calls, Grassroots houses a walk-in counseling program and operates a mobile crisis team to respond to behavioral health emergencies.

Mariana Izraelson, Psy.D., Grassroots' executive director, is a licensed clinical alcohol and drug counselor with several decades of experience in nonprofit management in health care settings. She spoke with *Trend* about how her call center has managed the introduction of 988.

HOW HAS YOUR CALL VOLUME CHANGED SINCE 988 LAUNCHED?

It's increased gradually, to 30% higher now than it was pre-988. The biggest volume increase has been in the text and chat functions; we're finding that the younger generation uses those functions more. Young people seem to perceive a level of confidentiality in text or chat that they don't feel from picking up the phone.

On our end, it has been a matter of making sure we have the appropriate staffing in order to answer the calls.

WHAT TYPES OF CALLS ARE YOU GETTING?

The majority of our calls are from people thinking about suicide. We've

also had a lot of third-party callers, such as concerned family members who want to know how 988 works and how to connect a loved one with us. And we have more health care providers calling 988 than before, looking for assistance for their clients or patients.

There's also a significant number of people who call 988 regularly for support—and were doing so even before we transitioned to 988. And since last year, we've had a partnership with Howard County's police department so that any calls the department gets about nonemergency mental health issues can be dispatched directly to our call center.

At its core, 988 is a support line. The idea is that the counselor will work with you to help resolve your crisis or anxiety, so then you can go on with your day.

CAN YOU WALK US THROUGH A TYPICAL CALL?

First, we would say, "Hi. Thank you for calling 988," and then we'd ask, "How are you doing today?" Then we get into a normal rhythm of a conversation, with the counselor focusing on the caller and their needs. We also try to gather demographics in an empathetic way, to give us a little more insight on how to be helpful and thoughtful in discussing the caller's crisis.

When it comes to suicidality—a term that encompasses suicidal thoughts, plans, deliberate self-harm, and suicide attempts—we focus on the crisis at hand. We ask the caller what thoughts they're having and if something happened during the day that impacted their feelings. Crisis counselors try to give them time and space to explain and help navigate their feelings. The hope is that by providing that release, the caller won't engage in any dangerous behavior. The counselors aim to help bring the caller's anxiety down and stabilize the person so they feel heard and understood.

Some of the calls we get are from people struggling with grief, loneliness, or heartbreak. There's this misunderstanding sometimes that only those who have a mental health condition call the hotline, but suicidality can be a separate issue. For example, you can be heartbroken and experience feelings of sadness that may lead to suicidal thoughts.

HOW ARE STAFF TRAINED TO RESPOND TO SOMEONE EXPERIENCING THOUGHTS OF SUICIDE?

Our center is accredited by the American Association of Suicidology, whose specific trainings we follow. We require that new hires undergo 60 hours of training—both in person and online. After they pass practice exercises, they're qualified to begin shadowing a counselor for three weeks.

During the shadowing process, a new hire will pick up calls, and the supervisor will listen in and evaluate their progress.

We also require all employees to complete a crisis counselor certification within a year of employment. In addition, we can never have one person alone staffing 988; there must be two people plus a supervisor available at all times.

WHAT DO YOUR CRISIS COUNSELORS DO TO MAKE CALLERS FEEL CARED FOR?

The key is to make people feel listened to. Our crisis counselors listen to callers and validate their emotions, and help them work through what they're feeling. We let them express their feelings without judgment or criticism.

Counselors also make sure a caller is safe before they disconnect the line. They do that by checking what other connections or resources—whether family, friends, or a therapist—are available to the caller to help them feel better. Counselors will also ask if they can do a follow-up phone check with the caller the next day. And if a caller expressed thoughts of suicide, we follow up within 24 hours to check on whether they've connected with a mental health provider or gotten in touch with a loved one.

DO YOU COORDINATE WITH 911 WHEN NEEDED?

We have very specific, detailed protocols. We use a short questionnaire called the Columbia Suicide Severity Rating Scale—which is endorsed by the Substance Abuse and Mental Health Services Administration—to assess suicide risk. If a counselor determines that the caller can't be stabilized over the phone and appears to have access to a weapon or other lethal means, that call gets escalated to 911.

WHAT HAPPENS THEN?

The counselor remains on the line throughout the entire 988 call. If a person is attempting to die by suicide and has access to a weapon or lethal means, we call the police. If the person is not actively planning suicide and is willing to participate in safety planning, we send out a mobile crisis team—made up of mental health professionals—to talk to the caller face-to-face and de-escalate the situation.

But an "active rescue" component, where we call law enforcement or send out the mobile crisis team, happens rarely—only about 7% of our calls. Most of the time, we're able to resolve situations over the phone.

HOW DO YOU COUNT A CALL AS "RESOLVED"?

A successful call is where we can de-escalate the situation to the point that the level of anxiety has decreased drastically; the person is no longer having active suicidal thoughts and is safe.

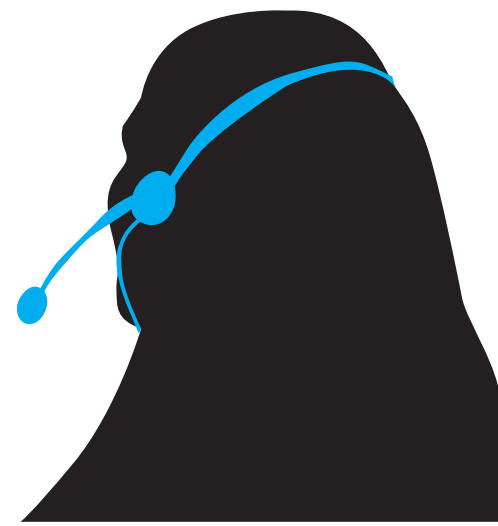
Normally, when the crisis is reduced, the caller doesn't want to talk anymore. They would rather go on with their day and hang up. For us, there's a sense that the person felt heard and that they're comfortable with the resources at hand to help them.

HAVE YOU EXPERIENCED ANY CHALLENGES SINCE THE 988 LAUNCH?

Our most pressing challenge is staffing. I have adequate funding but I don't have adequate staff, even though we've increased counselors' salaries by at least 40% in the past two years. We can't compete with some other industries. And to be a counselor at Grassroots, we require a bachelor's degree.

Plus, it takes a certain type of person to want to do this job. Counselors are mostly talking to individuals who are unhappy, and while there's a satisfaction in the resolution of the call, most calls are difficult. We recognize that we need to take care of our counselors. We offer a licensed clinical counselor or social worker for them to consult during particularly difficult calls, which is one of the ways we create a supportive environment.

If you or someone you know needs help, please call or text the Suicide and Crisis Lifeline at 988 or visit 988lifeline.org and click on the chat button.



OBSTACLES TO CARE

From stigma to a fragmented and unresponsive health care system to personal self-doubts, many obstacles prevent individuals with mental health concerns from receiving care. In 2019, national survey data showed that 57% of people with mental illness and 80% of those with substance use disorder did not get needed care. Sometimes, only people's perseverance and resilience are what gets them help.

THE POWER OF SHAME

By Barb Gay

My first suicide attempt was in high school.

I didn't know how to manage my mental health; we had a lot of violence at home, and I wanted a way out. But after my attempt, I felt ashamed. My family did too. There was such a stigma attached to suicide for everyone involved. Like most people when they hear about such things, my family did the best they could at the time, but they didn't know what to say and were ashamed to seek help. I had an in-patient hospital stay and received a referral for additional treatment after I went home, but my parents and I never talked about my attempt again, so I never had follow-up care.

I needed support, and I had more attempts. But I didn't have anyone to talk to about why I wanted to stop living.

In college, I went into the behavioral health care field carrying the stigma of having attempted suicide. After graduation, I worked in an addiction treatment program and in crisis services but never talked about my own experience. I knew the way I would have wanted to be treated when I was in care. I knew that different treatment would have mattered to me, and I used my experience to help others but never revealed that I had been there too. I thought

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WHEN THE SYSTEM IS THE BARRIER

By Amanda Williams

When my daughter went into fourth grade in 2019, our family needed a reset. In third grade, my daughter had had a tough time with classroom bullying and a difficult teacher. But the next year, she was getting back on track right before the holiday break. She was meeting regularly with the school counselor and looking forward to moving up to a new school building for fifth grade. We had high hopes for 2020.

Then in March, everything shut down because of COVID. We live in a multigenerational household and my mother was at home with us, but I'm in health care and an essential worker, and my husband and I continued to go into the office. My other daughter, 10 years older and in college, was home but had her own challenges with the pandemic and couldn't really help her sister.

My younger daughter felt really alone. During the pandemic, she became a shell of her former self, creating rules for herself about what she wanted to do and what she didn't. She has a Gifted Individualized Education Plan—kids with them tend to be more socially awkward—and the whole pandemic experience further isolated her and exacerbated her social anxiety. We also had lots going on at home. Relationships, finances, communication—things that were barely being

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WHEN YOU DON'T KNOW YOU NEED HELP

By Ana Pelico

I am a migrant who moved to the United States from Guatemala in 2017, hoping to earn the money to pay debts at home and to support my children as well as my mother's medical needs. Without feeling and noticing it, I also came here as a victim of psychological and emotional trauma from abuse by my former husband, as well as other events I experienced during my childhood and youth.

I was not paying attention to how this trauma was manifesting itself in my body and mind. I only knew that my stay in the United States initially made me feel like a zombie. Life was routine and mechanical. I felt deep humiliation from many years of mistreatment from my husband. He had looked at me as a child-making machine that had no other value when I was no longer able to bear children. He not only left us, he left us in heavy debt. This is when I adopted the name Olga and asked my closest friends and family to start using my new name. I considered Ana to be dead.

The change of name was a facade to also hide other situations in my life. At a young age I was sexually abused on two occasions, without my parents realizing it. I was the victim of other types of harassment in school and in society. When I came to the United States, harassment became a

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I would be seen as weak and unwell. I thought that having made an attempt would stigmatize me. It's something that's always with you.

I had never shared my experience, not even with my husband and kids. But when my son was 11, he was learning about mental health in health class. I realized then that if I shared my experience, I could show others that it's possible to get better and come out on the other side. I could have an impact, but I'd have to tell my family first.

My son's reaction to my story was everything to me. "Wow! Look at you! You have a great life," he said. "It's awesome that you can be OK after that."

He helped me see the whole picture: That I'm doing really well. That's the story.

At the time, I was working as the executive director of a nonprofit that provided crisis services, such as the 988 line, emergency youth shelters, and mobile crisis counselors. I decided to tell one person at work, and she was very supportive, so I decided to openly share my story. The staff never knew what happened after counseling people who were thinking of taking their own lives. And here I was—a living, breathing example of someone who was OK. And it allowed others around me to say, "Yes, I've had a similar experience."

I know there's fear around talking to people who are thinking of ending their lives. But I also know that if someone had talked to me at my low points, it would have helped. I needed someone to know how much pain I was in and to be understood.

It's OK to ask really direct questions when you suspect someone is at risk. People who are thinking of killing themselves are also afraid that they'll have to go to the hospital, have restrictions put on them, and that they'll lose everything. But not wanting to live anymore or thinking about suicide doesn't always mean action. It just may mean that life hurts and living is hard.

The stigma is really about misunderstanding.

The conversation in this country really is changing. People want to know more. Some very public suicides, such as that of Robin Williams, have opened up the opportunity to talk more, and that reduces the stigma. But we're not fully there yet.

We need to do more to change the conversation. We can all have a role in reducing the fear and stigma that surround suicide. Using

> I didn't have anyone to talk to about why I wanted to stop living.
>
> Barb Gay

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held together pre-COVID—totally fell apart with the stress of being essential workers. We weren't equipped to manage any of it, especially how it affected my daughter's rising anxiety and her negative perception of herself. We needed to help her.

> **The system itself is a huge barrier to mental health care, the reason why so many don't seek it out.**
>
> Amanda Williams

When classes resumed in person in late 2020, she didn't know any of the kids in her class. Like a lot of parents, we realized she would have anxiety about re-entry to school. We tried to connect with the school counselors, but they were so busy with so many kids who needed them. It was very difficult to meet with them.

The counselors provided recommendations for therapists outside the school. But there were waiting lists for all of them. It took six months or longer just to schedule an evaluation—not even treatment. I went to a specialty clinic in Center City Philadelphia that assesses and treats children and adolescents with anxiety disorders but had to go through another intake evaluation. That whole process took a year.

In addition to our trouble finding treatment, my daughter didn't want to go to therapy. Because I work in health care, I know the benefits of therapy. But convincing an 11-year-old is tough. The early part of her therapy was unproductive because she wasn't into it. At that time, her social anxiety was affecting her daily life. We'd go places, and she wouldn't get out of the car. She wouldn't give her order at a coffee shop; instead, she'd whisper it to me. She and her friends would stand around in a circle texting each other but not talking.

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latent experience in my housing complex.

After working for two years selling produce in a shop outside of Philadelphia, I began to feel deep back pain that limited my mobility and ability to work. I went to a city health center but could only book an appointment for months later, so I went to a private American doctor who gave me pain medication but also sexually harassed me. When I finally got in at the city health center, I was examined and referred to a specialist who diagnosed my pain as psychological, coming from extreme stress and a deep depression. There was no need for pain medication; my pain needed other forms of treatment.

I started psychological treatment with a therapist. I found it incredibly hard to talk about myself and to recognize the events that had been causing me so much distress. My victimizers were people I once knew and trusted, and I cried as I told my therapist what had happened to me. It was so painful that I often refused to take the time needed for my therapy. Then, when my therapist told me that we were going to see each other less frequently, my commitment to treatment changed because I feared losing it. I started allowing myself to unravel my story and truly started understanding the importance of psychological treatment.

Two years into treatment, in 2022, I began to recognize my potential as a person. I apologized to my therapist for not using my real name and said that my real name was Ana. This moment was crucial for my existence. Allowing Ana to live again made the constant thoughts of death stop—something that had been the norm for me since I was a child. As I started to recognize myself, I started realizing that my life had been full of joyless actions. As I began to live more authentically, I realized that I had always been a joyful person, but that part of me had been overshadowed by so much pain. Today, providing support to others, both in my personal and professional life, comes from my true self. I now see the help I give others as acts of love and no longer as being used by other people for their own purposes.

As I began my own work to promote mental health, I would tell people, "When we go to primary care doctors, we allow them to undress us, examine us, and tell us what is wrong and how

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different language is one place to start. Rather than using the phrase "committed suicide," which associates suicide with "committing" illegal acts, we can say "died by suicide." It can be hard to remember to be kind to yourself, and, if you use the old phrase, to go back and make the correction. But when I do that with people, it opens the door for me to share why I am doing it, which opens the door to say more about suicide and care for those who have suicidal experiences.

Another step we can all take is to refer to suicide care, and behavioral health care overall, as "health care." There is no shame in seeking professional care when your heart is ailing or when you have a limp. The same is true for our brains. When we talk about physical health care, we don't say someone "committed heart failure."

Talking openly about suicide is suicide prevention. Take some time to understand the issues concerning suicide, find out about risk and protective factors related to suicide, and find resources that provide suicide care. This will help reduce the fear that many of us have when we or those we care about think about suicide, and it prepares us to offer support. Be someone who will start the conversation, share resources for treatment—such as 988—and offer to be a partner on the journey to recovery.

Barb Gay, associate director of the Zero Suicide Institute at the Education Development Center, is a certified prevention specialist and expert in suicide prevention and behavioral health.

The therapy did help her deal with anxiety, but when we asked about evaluating for ADHD (attention-deficit/hyperactivity disorder) or depression, they couldn't because those conditions weren't their expertise—so we had to look for another provider again. It's hard to find someone who has a good reputation to do the evaluations and challenging, if not impossible, to get holistic treatment.

Not only was I looking for a practice that specialized in children and adolescents, but as a Black family, we needed one with people of color. It took eight long months to find the right fit, and in the end, I chose to pay out-of-pocket for her therapy. For families that are beholden to a particular network and can only choose from certain providers, mental health care may not work if they can't find a therapist that is a good fit.

I'm a health care executive, and I found the whole experience to be infuriating. How is it that I have good health insurance, with providers in my network, and I'm on a waiting list for six months to a year? Meanwhile, I watched my child struggle.

Now, we're trying to find another program. Her school counselor made a referral, but we can't connect with them. It's been over a month, and we still can't connect. We'll play phone tag for a few days, then a week goes by without contact. They also can only do an intake session from 9 to 5. My daughter doesn't get home from school until 4. Tell me how that works for teens!

The system itself is a huge barrier to mental health care, the reason why so many don't seek it out. We make it so difficult.

Amanda Williams is a mother of two and an experienced health care leader who resides in the Greater Philadelphia area, where she is an advocate for health equity and addressing health disparities in the communities she serves.

to fix it. When it comes to mental health, we have to be willing to do the same. We have to be willing to open up our minds, to examine what is hurting us, and to come up with how to fix it." My own experiences have led me to recognize the true importance of mental health services. Our minds need to be healthy to live full and harmonious lives.

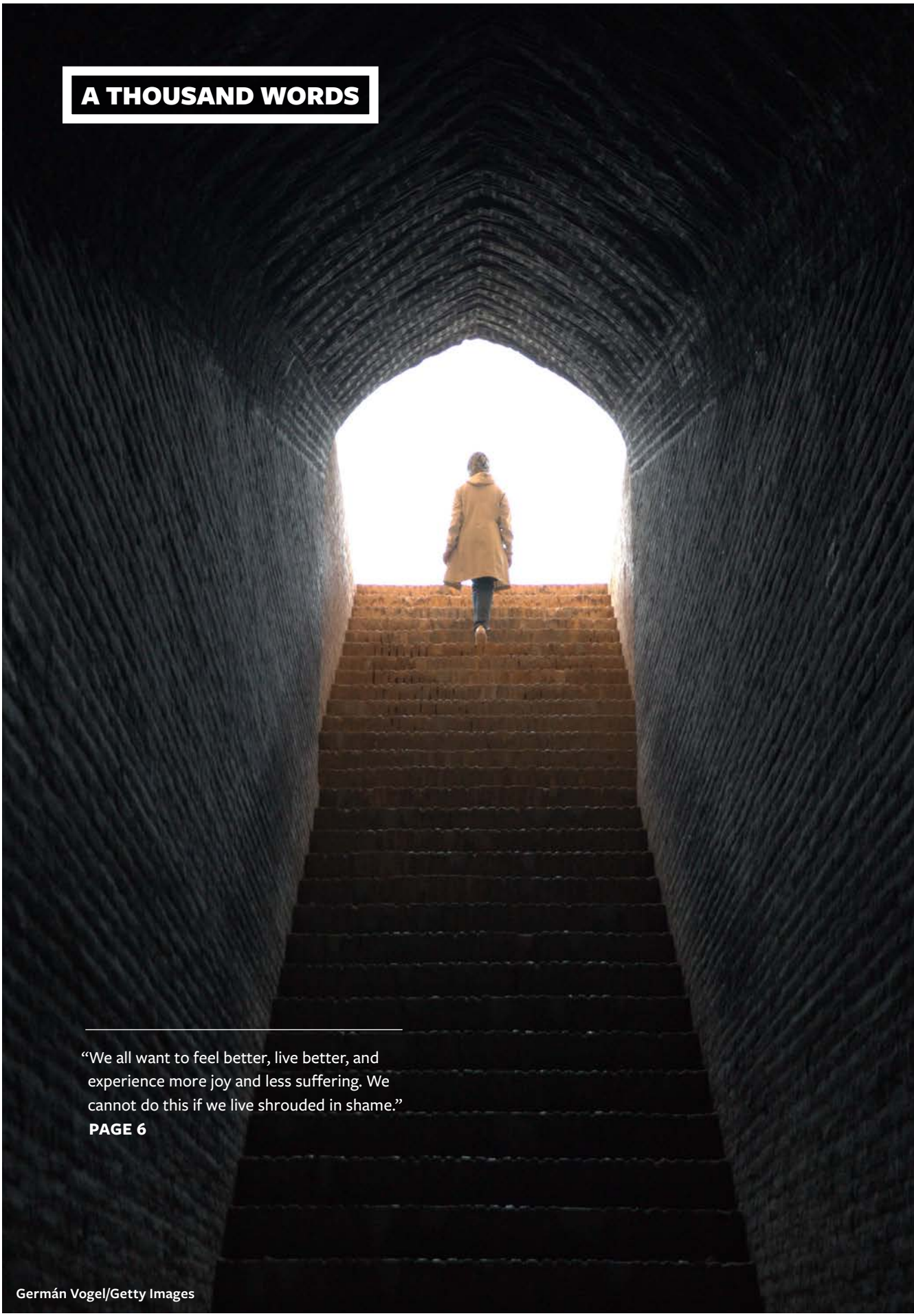
> **I was not paying attention to how this trauma was manifesting itself in my body and mind. I only knew that my stay in the United States initially made me feel like a zombie.**
>
> Ana Pelico

My two years of therapy transformed my way of thinking about and seeing life. It also allowed me to become a more authentic and empathic supporter of my family, my friends, and my community. I no longer feel like a flower bud that refuses to open; instead, I am blooming every day.

To hear my name again, to feel like the true Ana that I am, makes me able to look in the mirror and say that I admire and love myself, that I can be vulnerable and not defeated. I love life and I water it constantly with my resilience.

Ana Pelico works for Nuevo Movimiento Santuario, a faith-based organization for immigrants, and also is a community health worker for Puentes de Salud, a health and wellness center for Hispanic immigrants in Philadelphia.

A THOUSAND WORDS



"We all want to feel better, live better, and experience more joy and less suffering. We cannot do this if we live shrouded in shame."
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Germán Vogel/Getty Images

The pandemic increased concerns about Americans' mental health and exposed a lack of access to treatment and a growing demand for services—all issues that existed before the COVID-19 outbreak. A series from Pew's podcast, "After the Fact," explores how communities are responding to these needs and how stigma can still be an obstacle to care. Listen at pewtrusts.org/afterthefact.

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