



After the Fact | Mental Health in America: Battling Stigma

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TRANSCRIPT

Abby Coulter: My mental health was in such a bad place and I didn't have the supports that I needed, especially with family. Mental health was something you didn't talk about.

Dan LeDuc: There are a lot of Americans like Abby Coulter. Mental health, as she says, was "something you didn't talk about." Stressed by financial hardship, lacking support from family and friends, she turned to drugs for relief. Fortunately, she found help, as we'll hear later in this episode. But for many, stigma still surrounds mental health concerns.

We're tackling two subjects in this episode that often have a societal stigma associated with them that can prevent people who need help from getting the care that they need: substance use disorders and suicide risk. And our data point for this episode illustrates the concern: According to the American Psychiatric Association, more than half of the people with mental illness don't receive help for their disorders, often because of stigma. The negative effects from stigma can reduce people's sense of hope, their self-esteem, and their likelihood of continuing any treatment—while increasing their symptoms and the difficulties they may experience at work and in their social relationships.

We begin with substance use disorders, which are on the rise. Research shows there's a big overlap between those disorders and mental health. The National Institute of Mental Health reports that fully half of the people with substance use disorders also have a mental illness.

Sheri Doyle heads Pew's substance use prevention and treatment initiative and says a better understanding of the physiological effects of substance use disorders can reduce stigma and lead to people getting the treatment that they need.

Sheri Doyle: When I first got into this field, and actually, still today, there is a lot of stigma surrounding opioid use disorder. There was a lot of language around opioid use disorder being a moral failing. Nobody chooses to have opioid use disorder. It is a brain-related disorder; it changes the brain; it changes the reward system of the brain. This country has begun to address it in terms of public health and really understanding that there is a whole person here that needs to be treated.



Dan LeDuc: The data shows an overlap between mental illness and substance use disorders. What does that mean?

Sheri Doyle: Substance use disorders affect a person's brain and behavior. They are characterized by an inability to control one's use of drugs or alcohol despite negative consequences. About half of people who have a substance use disorder will have a mental health disorder and vice versa. The reason for that is certain risk factors for mental health disorders and substance use disorders are the same. That might include a family history of mental health or substance use disorder. So, there's a possible genetic component and then stress can be a trigger, as well as trauma, things like neglect, assault, going through a divorce, all of that can be considered trauma that may impact a person's risk of a substance use disorder or mental health disorder.

Dan LeDuc: And things have gotten worse as we struggled with the isolation and worry that came with COVID-19. Sheri told us that more than 70,000 people died in the U.S. from an opioid overdose during the first 12 months of the pandemic. Thousands more continue to struggle. But there are promising treatments to significantly reduce the risk of overdose.

Sheri Doyle: We know that medications for opioid use disorder work by helping people manage their withdrawal symptoms, reduce cravings, reduce illicit opioid use, and reduce risk of overdose. They are literally life-saving medications. Methadone and buprenorphine, in particular, have been proven highly effective and safe, yet they are the most regulated medications in this country. So that is incredibly limiting in terms of people getting treatment.

Dan LeDuc: Abby Coulter, who we heard from earlier, is one of those people. She takes methadone and now works as a methadone liaison with the National Urban Survivors Union. But she had challenges getting the help she needed.

Abby Coulter: I got pregnant and was a drug user. My partner and I had been together since we were younger. We're still together to this day. I remember standing in the middle of a Walmart. I had just taken a pregnancy test in the bathroom. We were unhoused at the time. We had just lost our car as well, which is what we were living in. And we basically looked at each other and said, "We are barely existing. We can't bring a baby into this. There's no way. We have to do something. Something has to change."

And at that point, we had been going strong for about five years, I would say more than the majority of that in chaos. Stigma played a huge part in why I was six months pregnant before I walked into an OB-GYN. The doctor that I saw insisted that I get on methadone.



She wanted to make sure I was safe and that I wasn't in withdrawal and that the baby wasn't in withdrawal. Prior to that, we'd had some experiences. My partner had actually been kicked out of one of the treatment facilities he was in for asking about methadone. They actually discharged him with the response that, "If that's what you're looking for, you're in the wrong place." And so, he was actually helped to pack his bags and was sent out the door. So, our experience around understanding what methadone was, was already tainted. We thought that it was this horrible thing when, in fact, that's why I'm sitting here today. That's why I was able to be a mom, a partner, a photographer, an advocate.

We started the methadone when I was pregnant, like I said. We lived in Morgantown, West Virginia, and we would drive every day, roundtrip, two hours—rain, snow, sleet, me pregnant—to get our dose for the day. And we did that for a long time until we were able to earn take-homes through the process. It was a personable experience. They were really inclusive, really working with us for my dose and being pregnant and what that meant.

I really quickly realized that a stable dose for me meant so much more than just not using street opiates, staying out of chaos. For me, it meant finding balance in my mental health that I was not able to find. And with a stable dose, I've actually been able to maintain my own mental health without additional medication. I consider myself one of the lucky ones.

Dan LeDuc: Abby's son will turn 20 this December. And she has continued her methadone medication, leading a more stable and rewarding life.

While her situation has improved, for many, stigma remains. That is something that Dr. Rahul Gupta is working to change. He is the director of the Office of National Drug Control Policy—the first physician in that role—and we spoke with him in our Washington studio.

Rahul Gupta: We know that less than 1 in 10 people with substance use disorders is able to get treatment when they need it. We're in the United States of America. Think about that. One of the things we talk about is, "Remove the stigma." It starts everything from language, the way we speak, the words we use, the agencies' names, for example, we have, to all the way to curricula.

Over the last several decades, we've created a network and systems where it's easier to write prescriptions for some medications of opioid nature. Some of those people will result in having addiction when, especially, it's used for long term. But the same individuals, when they need help with addiction, there are these barriers that are artificial in nature that prevents access to treatment for that addiction. And that is the problem we have inherently in the system, which is something we need to address in order to make sure that we're creating more accessible systems of care.



Dan LeDuc: So, Dr. Gupta says it's time to address stigma head on.

Rahul Gupta: As someone who's been practicing medicine for 25 years, I've seen this in practice myself. The medical community is not immune to stigma. In fact, if you go back 100 years, we used to have a very similar type of stigma with cancer. We have done a lot of work, especially in research and development and understanding stigma around cancer. I think we have hope when it comes to mental health and addiction and substance use disorders. But we have to be clear about this. This is something that not only affects individuals, but it also affects communities, affects societies.

Dan LeDuc: We now turn to another subject associated with mental health that also carries a stigma for many—suicide. It also is on the rise in this country as Allison Corr, who helps lead Pew's suicide risk reduction project, explains.

Allison Corr: The current suicide rate is 30% higher today than it was in 2000. And according to the CDC, in 2020, 46,000 people died by suicide, making it the 12th leading cause of death in our country. But that data only tells a part of the story, because 1.2 million adults and over 600,000 adolescents attempted suicide that year.

There are a couple of things to consider here. There's no one cause of suicide. There are a multitude of risk factors that contribute to suicide risk. Mental health conditions are one, like depression and anxiety, but there are also environmental conditions, like job loss, financial stress, lifestyle stresses, like losing a loved one or a primary caregiver. And the pandemic exacerbated these challenges for many people across the country. One in 5 adults reported poor mental health in 2020, and adolescents and adults have reported increased depression, anxiety, and substance use disorders across the pandemic.

We also know that in early 2021, emergency department visits were 50% higher for what we suspect were attempted suicides for female adolescents than in 2019.

Dan LeDuc: Allison says it's essential to speak frankly about suicide to reduce the stigma surrounding it. And that it's time to increase screening for everyone to help prevent suicide.

Allison Corr: The purpose of suicide risk screening is to gather information about whether a person is experiencing suicidal thoughts or suicidal behavior. The symptoms and signs of suicide risk may not be overt, and they might be easily missed. So, the practice of universal screening—of screening all patients at every medical encounter—can catch these people who we know move through our health care system undetected and might miss the opportunity to receive care with potentially life-saving treatment.



A study of emergency room departments showed that universal screening identified twice as many patients, and when the universal screening protocols were followed up with evidence-based treatment, they reduced suicide attempts by 30% for that year. We need to continue the conversation, and we need to dispel the lingering stigma around mental health and suicide.

Dan LeDuc: Dr. Kimberly Roaten is a psychologist at Parkland Health in Dallas. It's the first hospital system in the nation to implement universal suicide screening. They currently screen about 45,000 patients a month, and through that process are able to identify non-psychiatric patients who are at risk for suicide—people who would not have been screened otherwise.

Kimberly Roaten: The primary thing that we were responding to is the finding that so many patients, so many individuals who die by suicide, have contact with the health care system in the months and years before death. The most recent estimates are 30% had contact in the month before they die, and 90% in the year before. And so we really felt like there was a missed opportunity there, that we weren't catching these people where they were actually having contact with our system.

One of the things that we wanted to make sure of is that if somebody has suicide risk, we know it at the beginning, rather than later on in the care encounter. Typically, patients will have their vital signs checked, all of the usual things that happen when you go to see your doctor. As you're making your way through some of the social, more sensitive questions, that's when the suicide screening questions are asked.

The questions are very directly about suicide and thoughts of dying, not ambiguous other depression-related questions. And then the fifth item is very specifically, "are you having thoughts of killing yourself right now," which is really an important thing in a hospital system where you're trying to appropriately allocate resources. The patient who says yes to that question needs different care than the patient who says no to that question. Those patients in our system then immediately have someone assigned to observe them at all times to keep them safe in our environment.

Kimberly Roaten: I personally believe that because we ask these questions every single time we see our patients, the message that we care about all health is repeatedly reinforced. So yes, we care about your sprained ankle, but we also want to make sure that you're not struggling in other areas. So, I think, particularly for patients who get all of their care in our system, we are repeatedly saying to them and implying to them, we value both your physical and your emotional health.

Dan LeDuc: I'm just curious whether it's anecdotal or if you have any solid data on patients that you do identify some risk and start talking to them. You mentioned that they're often receptive



to those conversations. And that's interesting because I think some people might have the perception, oh, there's going to be some pushback. Is it generally more acceptance, and these are people who are grateful someone is offering help?

Kimberly Roaten: The vast majority of the time, individuals who feel comfortable saying yes to these suicide screening questions are looking for help. They would like something. And one thing that's been interesting with our program is that we now understand that sometimes it's actually not suicide risk that they're trying to inform us about. We've had patients who say yes to the suicide risk screening questions, but it turns out that there is some other different kind of stressor or crisis happening. And then we get the opportunity to help with that.

Dan LeDuc: What are some of those other stressors that might be troubling people? And does it actually maybe then lead to being able to help someone with some other behavioral issue or concern?

Kimberly Roaten: Absolutely. I think probably the most common other thing is some form of social stressor, so whether it's a financial stressor or access to housing, something like that. So, if somebody is telling us, "I'm in distress," but what we need to do to help that is not necessarily a psychiatric admission or an antidepressant. It is, how can we get you access to good, safe housing?

Probably the most dramatic example I have of detecting something other than suicide risk is from very early in the program. We identified a woman who came in with her partner, endorsed multiple suicide risk items. And per our protocol, we always ask family members to leave the room when we follow up to do our risk assessment. So we did that and her partner left the room, and she disclosed to us that he was holding her against her will in a vehicle in the parking lot and was using her dog as collateral. So that's obviously a very extreme example, but we were able to help her, even though suicide risk was not the primary issue in that encounter.

Dan LeDuc: What you're describing seems innovative and reflective of a new attitude among practitioners and policymakers about mental health treatment.

Kimberly Roaten: I think that we are making slow but steady progress towards recognizing the importance of mental health in the context of holistic care. But we have a long way to go. And the more conversations like these that we can have, the better off we are. Probably over the past 20 years, in particular, we've made some significant gains. We just have a lot of work ahead of us.

Dan LeDuc: The suicide screening that you do, do you think that can help relieve or alleviate some of the stigma?



Kimberly Roaten: I do. I think that will go a long way towards helping health care clinicians and systems understand that the risk is real, and that we really need to be paying attention to it, and very proactive about treating it.

Dan LeDuc: For a final word, we turn again to Dr. Gupta.

Rahul Gupta: One of the things we've done, unfortunately, successful as a nation is figured out a way to separate the head from the body. I think it's really important, and no time more important than now, to understand that it is all linked. When we are not doing well from a mental health standpoint, I think our performance, and physical activities, and everything is impacted as well.

One of the things we have to do is incorporate that back in. Understand that mental wellness dictates not just who we are, how we perceive the world, but also how people perceive us and our ability to make whatever we're doing in our social life, personal or professional life, to be able to function well.

Dan LeDuc: In our next episode we hope you'll join us for a conversation with Alec Tyson from the Pew Research Center.

Alec Tyson: What's become more important or less important in your own life since the pandemic? One of the things we found is that protecting personal health has become more important. There's just more appreciation for taking care of your own health.

Dan LeDuc: And given that new importance we'll also hear from a therapist and wellness advocate about treatment and care during these turbulent times. Thanks for listening. For The Pew Charitable Trusts, I'm Dan LeDuc and this is "After the Fact."

If you or someone you know needs help, please dial 988, call the National Suicide Prevention Lifeline at 800-273-8255, or text HOME to 741741 to reach a crisis text line counselor.