Q&A: Top Issues in Mental Health

Rising suicide rates, youth mental health, access barriers among major concerns

Dr .Jessica Gold

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Dr. Gold obtained her medical degree from the Yale University School of Medicine in 2014. She completed her residency in psychiatry at Stanford University, where she served as chief resident and received numerous awards including membership into Alpha Omega Alpha, the American Psychiatric Association leadership fellowship and others. She also holds a master's degree in anthropology from the University of Pennsylvania.

Through residency and her time at Washington University, she has been a prolific lecturer and author for professional journals. She also has contributed articles to popular media including *InStyle* and *Self Magazine*, as well as physician media such as *Psychiatry Times*, *Medscape* and others. Most recently she authored a commentary in *TIME*, "The Dangers of Linking Gun Violence and Mental Illness."

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How have treatments for mental illness improved in the last 5-10 years?

The best example to illustrate this is the pharmacological treatment of depression. We used to only have tricyclics and monoamine oxidase enzymes (MAOIs) to treat major depression, and they had a lot of associated side effects. Then, in the late 1980s, Prozac was developed and treatments changed at a much faster pace after that as other SSRIs were developed and then SNRIs in the 1990s. After Prozac, many of the "new" medications were "me too" medications and did not change outcomes very much. Yet, while we know that antidepressants work and are more effective than a placebo, we also know that one third of patients do not respond to them.

For that group of patients who have treatment-resistant depression, there are novel treatments on the horizon. Beyond electroconvulsive therapy (ECT)—which remains one of the best tools in a psychiatrist's shed—we also now have transcranial magnetic stimulation (TMS) and an entirely new class of antidepressant drugs, like nasal ketamine, being approved by the FDA. The Washington University Department of Psychiatry, through the Taylor Family Institute for Innovative Psychiatric Research, has done a lot of work in this area. They are looking at, among other things, novel neurosteroids and laughing gas (nitrous oxide) as treatments through research. In the future, we might also be able to better understand who needs which intervention or treatment and why. Hopefully we will also learn why someone responds to some medications and not others and be able to personalize care more accurately than we do now.

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Data from the CDC shows that the suicide rate increased 33% from 1999 to 2017. What are your thoughts on the reasons for the increase?

There are a lot of drivers of the suicide rate increase in this country, and no single answer will explain the increases. Many have proposed really simple hypotheses. One group of studies has led to the thinking that some overdose deaths are not accidental. The current opioid epidemic is correlated and some real links exist between opioid use and suicidal behavior in drug users, their children and families.

Another important key is to notice suicide rates are rising more among youth ages 10-14 than any other group. This is very important as it highlights the need to be more aware of young people's mood, symptoms and warning signs, and to help those at risk get into treatment early. Some increases among youth are hypothesized to be related to social media use, which in turn can be associated with bullying, less meaningful interactions with others and loneliness. Beyond that, I think teens, particularly as they transition to college, are affected by their sociopolitical environments. With terrorism, school shootings, climate change and whatever else this current culture is dealing with, it is perhaps not surprising that they are having anxiety and depression at higher rates. Whatever the reason, this showcases the need to focus more resources and attention on these rising rates

and on mental health treatment access and prevention in this country.

Do many people (all ages) with mental health conditions continue to go untreated? Does there continue to be a stigma associated with receiving mental health treatment? How can we encourage people to seek treatment?

Absolutely. It is definitely true that things may be better than they were in 1972 when Missouri Sen. Thomas Eagleton was removed as the Democratic vice presidential nominee, after it was revealed he had been hospitalized for depression and received electroshock therapy. To be a successful U.S. senator with a Harvard and Amherst education, Eagleton actually was a great major depression success story. Yet today, even though we may be more comfortable than we were in the 1970s with mental health, stigma continues to be a huge problem in all age groups.

Stigma may originate from one's own beliefs, yet it can also come from the public's perception (portrayals on television, in the news), or from family, or from culture, even if the individual patient did not initially have those beliefs themselves. This prevents them from getting help and from valuing the need for help early on. This results in people waiting to get help until they are very sick and need a more intensive intervention.

I think we can encourage people to seek treatment by talking more about the prevalence of mental illness and about prevention and warning signs. When people like Kevin Love, an NBA basketball player, share their stories of mental health issues, this causes people to listen and opinions to change. There are far too many others who suffer in silence and we only learn about it after a tragedy.

To what extent is access to mental health care an issue? What can or should be done to ensure that more people who need mental health care can obtain it?

Part of the problem tends to be the number of trained specialists. The other is the how and where health care is delivered. As mental health and substance use disorders have increased, we are fortunate that treatments have improved, but unfortunately, in parallel, access has not. We need more resources to be able to help all of the patients in need. We need to have affordable, local community services to help patients with mental illness recover and also reduce the numbers of those on the street, in jail and in the hospital. We need to invest in opioid and other substance use disorder programs and increase public health efforts to curb gun violence, as both contribute to increasing mental illness, suicide and rates of harm in our community.

You have done a lot of work in physician wellness. Physician suicide is on the rise. What particular pressures do physicians face that make it hard to get help? What does the medical community need to do to address this issue?

Physicians have burnout and very high rates of suicide, but the data is old. It suggests male doctors have suicide rates up to 40% more than the general population and female doctors up to 130% higher. One issue may be substance use disorders. Many physicians who have sought treatment for their substance abuse have reported that they were relieved to be discovered and sent to treatment. Often, it was either suicide or treatment. A huge issue for this, again, is stigma. Physicians fear getting psychiatric treatment because it might be reportable to the medical board (luckily it no longer is in Missouri) and many even self-medicate to avoid seeing another doctor. Access is also an issue as with physician hours—we often do not have time to get treatment or easily accessible resources for it. The issues are inherent to the profession and the workplace, and not only are fixes mandated by the AAMC and ACGME, but they are truly needed.

You have worked with medical students, among whom suicide rates are high. What is the cause of mental health problems with medical students? What needs to be done?

If you look at the data, medical students come in with the same rates of depression and suicide as age-matched, education-matched peers, but over the four years this changes. This means there is something inherent in how we train doctors—and what we prioritize for doctors—that affects students. Some of this is the hours, demands, electronic medical records, work stress and lack of modeled empathy. Some of this is hierarchy and feeling like there is no place to turn for help that feels safe and responsive. Some of this is access to both health information, but also lethal medications. Additionally, as someone who has focused on sexual harassment and inequity in the workplace, it also is clear that the rates of burnout and depression are higher for women physicians. This is likely related to the dynamics in the workplace as well.

What are some other pertinent issues in mental health that we haven't covered?

Mental illness and substance use disorders are so common that they are the major causes of death and disability in the U.S. Life expectancy in our country has started to decline for these reasons. There are safe and effective treatments that exist, but we need to learn to identify the warning signs and those who need help right now, so we can help them to actually seek out treatment before it is too late.

It is important that we advocate for patients with mental illness and mental health reform in any way we can—from talking more about it, to legislative advocacy, to using our voices on social media or in journals or popular press pieces. This population and the lack of access they face, and the stigma they harbor, affects every single specialty in medicine. No one should be silent, and we should all be talking about it until change occurs.