Introduction: How Mental Health Matters

Anne E. Becker, Giuseppe Raviola & Arthur Kleinman

The underpinnings of today's mental health crisis include both social structural inequities and neurobiological vulnerabilities. The COVID-19 pandemic has compounded and escalated a long-standing problem, rendering the mental health crisis and its dangerous consequences visible and exigent. We now possess a clearer and more nuanced understanding of the broken mental health care system and its serious inadequacies, as well as its potential for effective caregiving. The professional forms of knowledge and practice are paralleled by an even more substantial system of care involving families, networks, communities, and, of course, those living with mental health conditions themselves. Even when delivered by community care workers, psychotherapy can be as effective as somatic treatments for some mental health conditions. Harm reduction and other public health approaches offer means of preventing or mitigating the disastrous human toll of the substance use disorder epidemic. Social technology offers new opportunities for enhancing mental health and well-being. With these informal systems alongside standardized health care systems, the future could realize a mental health care system with much greater potential to avert the worst harms and offer effective care to many more.

Everyone finally seems to get it now. The COVID-19 pandemic has made it so very clear and convincing: we are all vulnerable to mental distress. The types may be diverse – depression, anxiety, panic, trauma, eating disorders, psychosis – but the choke, the sting, the fear, the psychic pain and chaos are terribly real and very disabling, and the residual effect of the pandemic on mental health has been enormous. For the time being, even the outright discrimination and subtler forms of stigma attached to mental illness have subsided enough to empower more and more of us to disclose our inner struggles and trace their connection to our highly stressed worlds. In turn, we learn that there are effective therapies and competent practitioners, only not enough of them. And the systems of care are just as problem-plagued, costly, and egregiously inadequate as the rest of health care.[1]

In high-, middle-, and low-income countries alike, half of the world's population will develop a mental illness over the course of their lives. Worldwide, de-

https://doi.org/10.1162/daed_e_02029

pression is among the most disabling health conditions.[2] Alzheimer's disease and schizophrenia are among the costliest health problems to treat.[3] War, migration, and the intersection of violence and poverty, especially as they affect women and children, create a huge toll of trauma. As does loneliness for both physical and psychic pain, as well as social media for adolescent anxieties. The epidemic of substance abuse killed more than one hundred thousand Americans in 2021 through overdose deaths, representing a nearly 29 percent increase from the prior year.[4] The intersecting epidemic of suicide may again be worsening.[5] The syndemic of domestic, street, and community violence also is neither controlled nor lessening. Climate change has brought with it the growth of climate anxiety – along with the traumatic consequences of extreme weather events – as yet another mental health consequence of the increasing recognition of how dangerous and uncertain our times are. Yet mental illness, which contributes significantly to suicide, has been repeatedly shown by researchers not to be a significant cause of the mass murders that also beset America. Guns are.[6]

So broken and failing are our health care services in the United States for the chronically mentally ill that, in actuality, it is on the streets of American cities, in our jails and prisons, in emergency rooms and primary care clinics where most of those with chronic psychosis are to be found. Deinstitutionalization has taken us from too many hospital beds for the mentally ill in the 1950s to far too few today, and it never was followed up with robust community services as intended and promised.

Globally, low- and middle-income nations spend less than 2 percent of their total health budgets on mental health care, despite epidemiological studies showing that mental health problems are among the largest contributors to the global burden of disease in their countries and among the top causes of disability.[7] Between 75 percent and 90 percent of people living with serious mental health problems in these underresourced countries do not receive a formal diagnosis or treatment.[8] For the past two decades, the World Health Organization (WHO) has recommended a range of components of formal and informal community mental health services that can be built within and outside of clinical facilities.[9] For example, the WHO encourages providing a spectrum of mental health services, including general hospital services, specialty clinical care and support, and psychosocial rehabilitation and residential services, that extend care delivery to homes and public spaces in the communities where people live.[10]

But what are the most useful ways of responding to the mental health crisis? Is it through medicalized mental health care systems? Or is it via the preventive and harm-reduction approaches of public health? Or do we need to separate out those problems that are better handled in families and communities from those requiring medical treatment? Indeed, is the medical model of psychiatry more availing for ordinary depression and anxiety disorder? Or is it more helpful to reimagine

these conditions as responses to loss and other types of social adversity that require a different kind of societal response? Will technologies that strengthen telepsychiatry remake the mental health care system? And as we seek to increase access to treatment – especially for the poor – what quality of care will they receive? Have the prioritization of commercial interests in health delivery and a solely economic language of mental health policy undermined quality care?

The essays in this issue of *Dædalus* do not provide definitive answers to these crucial questions. Rather, the authors seek to characterize the many facets of the contemporary reality of mental health in society. They present views of where we are, what works, what has failed, and what is most promising. They also draw on history to explain how we have gotten to where we are and to help us reimagine where we might head to create a more useful future state for mental health. We are told, in a variety of ways, how the basic science and clinical disciplines seeking to understand and respond to mental illness and its attendant suffering have fallen short. These deficits are apparent across the spaces of psychiatry, psychopharmacology, neuroscience, psychology, social work, public health, and a range of services in each of these areas. These essays direct our attention to where and how our current approaches have not gone far enough or have outright failed, what we can learn from these shortcomings, and how we can reenvisage paths toward improving mental health. With a particular focus on the social determinants of poor mental health, several of the authors make the important point that the clinical targets of intervention in mental health make up too narrow a scope to be effective in reducing the enormous burden of suffering. Across the essays in this issue, regardless of whether the authors examine the targets of intervention, therapeutic approaches and their mode of delivery, or focus on scale and location of delivery, they converge on the conclusion that mental health needs are urgent and will demand a more robust, extensive, and innovative range of responses than what is presently offered.

This collection is a serious rebuttal and rebuke to a great deal that is ineffective, myopic, and inadequate about the aspirationally allied fields dedicated to understanding mind, body, society, and their interface with mental health and well-being. Importantly, it also points to remedies and innovations that can retool these approaches and have potentially transformative impacts on mental health. Several of the essays contest the adequacy of biomedicine – and the scientists, other academics, and health professionals who operate within its logics – to frame the right questions and to respond to mental distress and suffering that are outcomes of historical and contemporary structural violence. They justifiably critique a narrow view of who is authorized to generate knowledge to respond to mental health needs, and ask whose perspectives, voices, and ways of knowing have been excluded. Among those who have been disregarded and historically marginalized are communities of those with relevant lived experience, whose exclusion not

only replicates the dynamics of structural inequities, but also misses opportunities to integrate cultural knowledge germane to the repair of historical injustices and to the healing of collective harms that continue to perpetuate distress, suffering, and all the injuries of adversity.

We are experiencing a true crisis of care. Psychiatrist Thomas Insel and others have described this crisis convincingly as stemming from, among other deficiencies, a lack of capacity of the current mental health system, access to quality care, and social safety nets. With deinstitutionalization over the past half-century, there has been a 95 percent reduction in state mental health beds in the United States. This sequence of events and its fallout paved an unfortunate path to what has been, in effect, the criminalization of mental illness and the transformation of the criminal justice system as the de facto mental health system.[11] People living with serious mental illness are, moreover, among the most vulnerable in our society; on average, they experience a reduction in life expectancy of more than ten years.[12] And yet, there are a variety of proven and effective treatments available for treating mental disorders. These include not only medications, but psychological treatments, newer biological and neuromodulatory treatments, and rehabilitative interventions, such as assertive community treatment, supportive employment and academics, supportive housing, family psychoeducation, and clubhouse models of care. And despite a collection of effective interventions in the United States, with 21 percent of Americans experiencing a mental illness, over half of people living with a mental illness are not receiving care.[13] This is in a country with more than 40,000 psychiatrists, well over 100,000 psychologists and other therapists, and more than 700,000 social workers. The crisis of care is therefore also clearly a crisis of care *delivery* that requires strategic solutions to restructure the workforce and the way health care providers work.

A human rights approach is a key foundation for further needed change. The United Nations Convention on the Rights of Persons with Disabilities, adopted in 2006, is an international human rights treaty that serves as a cornerstone for the contemporary disability movement.[14] It has given voice to those who are among the most unheard and most stigmatized, and it has insisted on the protection and advancement of their rights. A more recent movement to integrate concepts of neurodiversity and neurodivergence for describing conditions of human cognition, such as autism, attention-deficit hyperactivity disorder, and dyslexia, represents an ongoing evolution toward greater demedicalization of supports for those living with these conditions.[15]

It is notable that the structural barriers that exist to access safe, effective, quality mental health care are so much greater for people of color and other less advantaged communities, and that these barriers have been both compounded and revealed by COVID-19. And they remain unchanged in the transition to a post-pandemic period. The essays in this volume speak to this reality and to the need

for new commitments to equity, cultural relevance, and structural competency in addressing it, and a future that will require placing a greater emphasis and priority on populations more at risk in the context of climate change and rapid social change. Mental health care needs to be reframed to better serve less advantaged communities. Mental health care delivery needs to be seen increasingly through the lens of diversity, social equity and justice, and decoloniality.

Taken together, these considerations are intended to inform our awareness, understanding, and attunement – our capacity to listen – to the emotional and social suffering of individuals living with a mental health condition. The COVID-19 pandemic has highlighted preexisting inequities in the availability of mental health services and raised awareness about the urgent need for functional and accessible systems of care delivery.[16] Global locations most affected by the pandemic also experienced the greatest increases in the prevalence of major depressive disorder and anxiety disorders, which disproportionally affect young people and women.[17] The United States saw increases in intimate partner violence, substance use, and the exacerbation and complications of preexisting medical and psychiatric problems – pandemics within the pandemic. COVID-19 ushered in a new era of "polycrisis," which has been described as a cross-cutting, cascading set of global challenges that spans the effects of the pandemic and climate change (for example, droughts, floods, mega-storms, wildfires, and extreme heat and cold) and that, by extension, drives human migration and growing refugee emergencies, conflict over resources, and political instability. It is now an era defined by growing complexity and uncertainty.[18] The manifestations of these inequities have been increasingly identified as requiring urgent attention at local and global levels.

The order of the contributions to this issue of *Dædalus* pivots around Kay Redfield Jamison's account of the *experience* of mental health problems by individuals suffering from depression and bipolar disorder.[19] Her essay brings the reader into lives lived with mental distress and illness, including her own. At the level of the individual human being, ordinary mental illness everywhere and at all times is anchored in inner pain and, in some cases, breakdown, and also places great pressure on the family, network, and entire community. The meanings and values associated with this core experience, including the experience of treatment, will, of course, represent cultural, class, caste, and community differences that affect the way symptoms (and healing) are expressed, and how their putative causes are understood.[20] Nonetheless, there is something abidingly noxious in the experience of mental illness that resists even greatly different historical eras and cultures from remaking these experiences any way their inhabitants might wish. This makes experiences of healing equally important in understanding how mental health is lived.

Anchored in such an appreciation of the emotional injury and breaking of the supports in the lives of real people, and how they experience healing, our contributors whose essays precede Jamison's offer population and societal examinations of mental health. These include the epidemiology of mental illness preceding, during, and following the earliest stages of the COVID-19 pandemic, and the mental health and social disparities associated with poverty, racism, coloniality, and indigeneity, as well as their contributions to society-wide, and even global, morbidity and mortality. Substance use, gun violence, suicide, and mental disorders from depression to psychosis are depicted as epidemics in America today. And the precarious condition of America's broken mental health care systems is illustrated, as are failures in their reform. That sad and saddening societal reality becomes the basis for rethinking and reimagining what mental health care systems might be if they emphasized public health prevention and continuity of care over conventional clinical models, well-being over pathology, and policies about controlling guns, funding affordable housing, and changing the criminal justice approach to substance use over what we have in place now.

More specifically, Laura Sampson, Laura D. Kubzansky, and Karestan C. Koenen document how COVID-19 catapulted mental health into a societal priority owing to the overwhelming evidence of its widespread and devastating effects.[21] They also demonstrate how a population-based public health approach responds to the mental health crisis in ways that can add to the public good. Jeffrey W. Swanson and Mark L. Rosenberg show in necessary detail that while mental illness is a significant contributor to suicide, serious mental illness is *not* a major cause of gun violence.[22] That the latter requires much better gun-control policies is not likely to alter the politics of gun ownership and rights in America. But it should make the truth about how gun violence and policies intersect more convincing and harder to deny.

Helena Hansen, Kevin J. Gutierrez, and Saudi Garcia contend that the medical model of American psychiatry has relatively little to offer the crisis of substance use and abuse.[23] They argue that an effective response to this worsening mental health epidemic requires an entirely different approach than what is offered by the dominant medical and prison industrial complexes and, moreover, that addressing upstream causes such as poverty, racism, coloniality, and other sources of health and social inequalities is greatly needed. Their blueprint for a more adequate approach centers on harm reduction as a social movement for health justice and augmenting and crosslinking mental health services with more community-based programs. Jonathan M. Metzl reinforces their perspective with the shocking story of how schizophrenia became medicalized into a disorder of Black men, and how the field of psychiatry turned its back on the racist underpinnings of this extraordinary perversion of clinical reality.[24] Not surprisingly, like Hansen, Gutierrez, and Garcia, Metzl calls for a more circumscribed place for psychiatry in

mental health care, as well as for much greater attention to the social structural (not just the cultural) forces that need to be addressed through societal change and greater public health engagement. Both essays show that a sociogenic model of mental health problems and solutions should play a much larger role in psychiatry and in the much broader mental health field.

Gary Belkin brings further support to this vision of repairing the inadequacies of prevailing practices for mental health care delivery with his dystopic account of the failure of a greatly ambitious mental health program in New York City despite its sponsorship by political leaders.[25] The problem here was not with the program's vision or its objective, which also aimed to address upstream causes, but rather with failed administration and governance, and the persistence of long-standing beliefs about the connection between violence and those experiencing serious mental illness. Sadly, this is not a one-off story in the mental health field.

Joseph P. Gone's essay is an account of why Indigenous historical trauma is a more effective and culturally congruent way of representing the devastating long-term effects of ethnocidal North American governmental policies toward Indigenous communities than is post-traumatic stress disorder (PTSD) – today's ubiquitous category for handling emotional and moral injury by the mental health professions.[26] Gone writes with outrage (that knowing readers may well share) about how PTSD, and the medicalized interventions it legitimates, pathologizes the individual victim and in doing so distracts from what Indigenous communities could do to produce fundamental change if provided with the necessary resources. He critiques this formulation for ignoring history and culture and for its lack of an interdisciplinary analysis. Turning away from pathologizing language to traditional idioms and methods for cultural revitalization and uplift hold, for him, a greater power for transformation.

All the essays that precede Jamison's regard mental health as a much wider and more multidisciplinary field than mental illness or psychiatry. For the authors, the problems of substance use, suicide, violence, and common mental disorders interdigitate with and result from the social world, history, and political economy, creating profound inequalities and destructive destinies. Theirs is also a population-based view. In contrast, the authors that follow Jamison pivot to address more highly focused questions about neurobiology, genetics, pharmacology, psychotherapy, social therapies, community-based health care delivery, and quality in mental health care.

Anne Harrington's history of the four decades of failure in biological research in psychiatry to come up with new and more effective medications (with fewer side effects) puts into question the very enterprise of psychopharmacological research.[27] With so much lack of success, why has academic psychiatry continued to prioritize biological research instead of research on psychotherapy, community care, social epidemiology, or caregiving more generally? Reading her trenchant account does

not lead to an antipsychiatry conclusion, but to a rationale for rebuilding psychiatry's social, psychological, and clinical research, training, and education as part of a reassessment of its place in the broader mental health care system. Steven E. Hyman examines the same history that Harrington reviews, but from the more optimistic perspective of a medical geneticist who seeks to improve and develop the potential of large-scale genetic studies to illuminate complex polygenic influences on psychological processes and vulnerability to social determinants of disease.[28] He argues that, hampered by a lack of mechanistic understandings of psychiatric illness, previous therapeutic advances have been largely serendipitous or incremental. In contrast, advancements in genomic technologies and computational tools have opened new avenues for understanding causal mechanisms underlying polygenic mental disorders such as schizophrenia. These innovations, in turn, are likely to lead to evidence that can direct treatments, as in the rest of medicine, to target specific biological processes involved in the pathophysiology of disease – a goal long sought in the biomedical quest for an understanding of mental illness and its treatment.

Allan V. Horwitz and Jerome C. Wakefield take yet another perspective on the social and biomedical aspects of mental health research and treatment. In their sociological reading of history, the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* abandoned the well-established distinction between normative experience and pathology in depression, which in the past had excluded bereavement for a close loved one and other significant losses in making the diagnosis of depressive disorders.[29] For the authors, episodes of depression owing to such serious social losses are acute, and naturally remit over time as precipitating circumstances resolve. In contrast, medically significant depressions may be more enduring and less responsive to changes in social circumstances. This then is a fundamental distinction between "normal" emotional variation, including depressed affect, in response to and even expected in the setting of social circumstances such as losses and other serious stressors, and pathological medical depressions, which require a very different kind of diagnostic formulation and approach to treatment. Intriguingly, social epidemiology in cardiology, oncology, and infectious disease seems to be moving in the reverse direction, implicating social context (and its structural sources) in health inequalities for biomedical disorders from tuberculosis and HIV/AIDS through diabetes, stroke, and heart failure.

Isaac R. Galatzer-Levy, Gabriel J. Aranovich, and Thomas R. Insel introduce the potentially very important role that digital technologies can play in mental health care.[30] They focus on three transformative applications: the use of sensors and artificial intelligence to provide more objective assessments of mental health problems, the development of telehealth services that increase access and convenience for patients and providers, and the creation of digital therapeutics from virtual reality to chatbots for delivering structured therapies. These technologies – these tech-savvy authors contend – can also improve quality and accountability,

perhaps paradoxically making care more human, while also leading to new concerns regarding trust, privacy, and equity. This suggests that a social technology framing – one that requires social science and engineering collaboration from planning, through design to implementation and evaluation – is essential to avoid the unintended consequences found so often in other areas of health technology.[31] Surely, going forward, this subject will be at the forefront of questions surrounding what mental health care can and cannot do, and should and should not do.

Vikram Patel and Atif Rahman draw upon their respective research in India and Pakistan to show that, globally, the majority of persons with mental health problems who now have no access to effective psychological treatments can feasibly receive effective treatments from lay counselors and community health workers.[32] This practice – known as "task-sharing" of psychological interventions for depression, anxiety, and stress-related conditions and their precursors – has been *the* seminal finding of the field of global mental health, informing much work in the field over the past fifteen years. They demonstrate a paradigm shift in mental health care systems by which even poor communities have the local resources to address mental health problems. The upshot, however, is a very different kind of system in which experts play a much more limited role, and local communities become the centerpiece of care. There is growing enthusiasm today for this model, not only in low- or middle-income societies, but in American mental health care as well, albeit not yet by the professional guilds and insurance companies that drive the political economy of mental health care delivery. Effective task-sharing depends on collaboration across provider cadres and systems; and highly competitive mental health markets within which community-based care has been starved of resources for decades may not yet be conducive to this approach.

In the final contribution, Arthur Kleinman and Caleb Gardner review the quality of mental health care.[33] They show that, as in the rest of health care, quality is not directly measured. Instead, measures of institutional efficiency are taken to represent quality of care. As a result, patient and provider assessments are devalued by health care institutions in favor of bureaucratic and commercial goals, reflecting prioritization of efficiency and financial profit. Will digital technologies, the engagement of community-care workers, or any of the other changes in mental health care envisaged across this volume create high quality mental health care? If not, and if an adequate quality of care cannot be sustained in mental health care delivery, what are the consequences for systems and societies? And is this situation any different from what is happening to health care in general in the United States and globally?

There is resonance across the essays in this volume of *Dædalus* in calling for the inclusion of a broader range of perspectives to guide action. There are still more voices that could contribute invaluable insights. First, our colleagues from the Global South have much to add to this conversation.[34] By this,

we mean to underscore that it is essential to include not just insights that emanate from having engineered workarounds to resource constraints – and there is much to learn from these successes, as Patel and Rahman's essay suggests – but also perspectives about navigating inequities that apply to resources and opportunities alike. Unmet mental health needs require even more exigent action in the Global South. Moreover, although the most vulnerable suffer the most precarity, the most well-resourced regions are not necessarily in the vanguard of innovative treatment. It is incumbent upon us all to learn from, and then enable and amplify, these essential contributions to the mental health discourse to achieve mental health equity that draws upon the expertise of all stakeholders. In particular, those of us who populate academic institutions in the Global North can disrupt and begin to repair the legacy of colonialism and privilege that diminishes opportunities for academic participation and leadership.

When the mental health workforce is considered, the focus is largely on how to expand their numbers, extend their reach and capacities, and enhance their performance. These are all important questions, as are various strategies to compensate for these health workforce shortfalls. A community-based workforce will need more supports than exist today as accepted standards of practice. Learning from expertise in community health, broadly, will also be critical. Delivering care from community-based platforms, using peer-based supports and counseling, and drawing upon cultural resources are all promising avenues for expanding the capacity to promote mental well-being and to better respond to mental health problems. The essays in this volume also make a compelling argument for both a broader remit for mental health promotion as well as deeper and more thoughtful engagement by mental health professionals. These arguments ring true, and yet how can we square this with another truth: that there are too few health professionals to meet mental health needs – even in enviably high-resourced settings – and that many of these health providers are also under intensifying institutional pressures that compress the time spent in providing face-to-face clinical care.

The professional agency of mental health clinicians is not without its own social structural constraints. The challenges faced by clinicians in offering high-quality mental health care in high-income countries such as the United States are, of course, dwarfed by the kinds of constraints that undermine mental health clinicians in low-income regions beset by workforce shortfalls, drug stockouts, and inadequate public health infrastructure. But these constraints are also not inconsequential. For example, administrative actions designed to optimize clinical revenue through cost savings and greater throughput of patients, in turn, generate pressures that diminish clinician time to care for patients, or limit the therapeutic options they can offer. In some cases, moreover, shortfalls in ancillary health providers and administrative health staff shift low-value tasks to specialized health professionals. In an ironic twist, this circumstance reverses the intended direction

of task-sharing and undermines care when more highly skilled physicians absorb low-value tasks as ancillary health provider and clerical positions are eliminated or unfilled. Factors such as these contribute to health professional burnout, which is prevalent in the United States, may be associated with adverse impacts on clinician mental health as well as the quality of care they provide to their patients, and must be addressed in part at a systems level.[35]

There is an imperative to resocialize mental health training – that is, to make it more attentive to historical, socioeconomic, and cultural aspects of illness and care – so that we do a better job of providing education for trainees to work with communities. Across this collection of essays, there is agreement that meeting the needs of mental health and well-being will require a broader field of understanding, intervention, and response. It will further require that we educate and equip trainees so they can be effective and caring, but also that we better prepare them to integrate a more capacious set of aims that both encompass and vigorously redress the social determinants of poor mental health, and redesign mental health care to better emphasize the priorities and preferences of communities being served. To do this well, the trainees themselves will need robust support as they undertake careers with an expanded vision of mental health care delivery.

We have taught courses for undergraduates and medical and public health students at Harvard University on the foundations of global health, psychiatry, mental health, and the delivery of mental health care, in which we have integrated a social medicine perspective to critique and expand the scope of approaches to mental health.[36] It is important for all mental health professionals-in-training, early on, to see a world of experience outside the clinic, in order to incorporate a more encompassing model of practice that engages people beyond the formal health care system, and uses the concepts of well-being and preclinical distress on one hand, and recovery from illness on the other. A social medicine perspective also alerts us to other potential pitfalls in the field of mental health, as they relate to the unintended consequences of our interventions and treatments, and the various manifestations of biopower – from the history of white supremacy in the United States and its expression in policy, knowledge, and practice, to the role of psychiatric institutions and prisons in asserting social control, to the immense influence of global pharmaceutical firms, insurance companies, and governing professional bodies for each of the mental health professions in dictating the protocols and political economy of clinical practices as they are implemented and managed today.

The field of global mental health has evolved and learned from the experience of global health care delivery for infectious diseases such as HIV/AIDS and tuberculosis. We have personally learned much through our collaborations and long-standing relationships with implementers and academics from the world of global health, including our extraordinary colleague and friend, the late Paul Farmer, and colleagues at the organization he cofounded, Partners In Health.[37] The ben-

efits and lessons of a philosophy and practice of "accompaniment" that he elaborated stand to offer us much in addressing mental health through presence and partnership with those who are forgotten by society. Accompaniment is an essential theory of practice of engagement in addressing clinical and social problems together, over the long-term, and in developing interventions that are person- and context-centered.[38] Several additional aspects of Farmer's legacy can inform our thinking and practice as we consider the essays in this volume. From a values perspective, this includes the moral prioritization of the most vulnerable people for the highest quality of care, and their active engagement, where they live, through the deployment of community health workers and other community members to create layers of contextually informed care. From a clinical perspective, it means to confront social and clinical complexity and comorbidity head on, to not shy away from providing care for the sickest people, as well as to build effective care delivery systems for those people living with unremitting and severe forms of illness and under conditions of the most vexing social adversities. It also means prioritizing the actual care of those people, as well as research that studies that care, as a foundation for the strengthening of the health care delivery system. Additionally, from a systems perspective, the financial commitments need to be made for creating the opportunity for the delivery of humane, high-quality, and "person-centered" care.[39] That is to say, mental health care systems need to reject what Farmer decried as "socialization for scarcity" – a mindset in which health delivery is adjusted to make do with inadequate resources – and instead marshal resources that are both adequate to meet the full scope of health needs and also commensurate with health care delivery in well-resourced contexts.[40] Perhaps most important, as it relates to the challenges to mental health care delivery, is to place effective listening at the center of a moral praxis that prioritizes people who are suffering from mental health conditions, not only as a clinical condition but also due to and greatly exacerbated by well-documented social and structural constraints.

Among these, we especially view accompaniment as a conceptual framing that can work well to resocialize the conventional construct of health care and broaden it beyond clinical outcomes so, for example, basic needs are fulfilled alongside clinical needs. In this way, an expanded scope of care would also address structural determinants of poor mental health that undercut therapeutic interventions in situations of privation, social complexity, and comorbidity: situations that are not uncommon, but are, rather, the norm. In this respect, accompaniment animates an ethos of responsibility to deliver the right kinds of care – including prevention and health promotion, as well as clinical care – and to provide it via public health, social welfare, and community-wide systems that have the broadest scope and capacity to reduce social suffering and advance social justice.

We are living through a truly dangerous time, when conditions in the world are coming together to worsen mental health. Many more people are waking up to the

realization that mental health really matters and must be protected. The time has come to make mental health a global priority. The essays that follow demonstrate that we have the wherewithal to act. They also describe the realities, possibilities, limits, and major questions that must be dealt with if our actions are to have significant effects. We hope readers will join us in this still incipient but rapidly expanding movement for mental health. If not now, when?

ABOUT THE AUTHORS

Anne E. Becker is the Maude and Lillian Presley Professor of Global Health and Social Medicine, Professor of Psychiatry, and Dean for Clinical and Academic Affairs at Harvard Medical School. She is the author of *Body, Self, and Society : The View from Fiji* (1995), coeditor of *Global Mental Health Training and Practice : An Introductory Framework* (with Bibhav Acharya, 2024), and serves on the editorial boards of *Anthropology & Medicine* and *Harvard Review of Psychiatry*.

Giuseppe Raviola is Assistant Professor of Psychiatry, Global Health and Social Medicine at Harvard Medical School. He is also the Associate Director of the Chester M. Pierce, MD Division of Global Psychiatry at Massachusetts General Hospital and the Director of Mental Health for the international health care delivery organization Partners In Health. He has published in journals such as *The Lancet, Global Mental Health*, and *Psychiatric Services*.

Arthur Kleinman, a Fellow of the American Academy since 1992, is the Esther and Sidney Rabb Professor of Anthropology at Harvard University, and Professor of Medical Anthropology in Global Health and Social Medicine and Professor of Psychiatry at Harvard Medical School. He is the author of twelve books, including *The Soul of Care : The Moral Education of a Husband and a Doctor* (2019), *A Passion for Society : How We Think about Human Suffering* (with Iain Wilkinson, 2016), and *Rethinking Psychiatry : From Cultural Category to Personal Experience* (1988).

ENDNOTES

[1] There is no single coherent and integrated mental health care system in the United States, so throughout this essay we refer to mental health care *systems*.

[2] Institute for Health Metrics and Evaluation at the University of Washington, "Global Burden of Disease Compare," https://vizhub.healthdata.org/gbd-compare (accessed October 6, 2023); and John J. McGrath, Ali Al-Hamzawi, Jordi Alonso, et al., "Age of Onset and Cumulative Risk of Mental Disorders : A Cross-National Analysis of Population Surveys from 29 Countries," *The Lancet Psychiatry* 10 (9) (2023): 668–681, https://doi.org/10.1016/s2215-0366(23)00193-1.

[3] Aditi Kadakia, Maryaline Catillon, Qi Fan, et al., "The Economic Burden of Schizophrenia in the United States," *Journal of Clinical Psychiatry* 83 (6) (2022): 22m14458, https://

doi.org/10.4088/jcp.22m14458; Arindam Nandi, Nathaniel Counts, Simiao Chen, et al., "Global and Regional Projections of the Economic Burden of Alzheimer's Disease and Related Dementias from 2019 to 2050: A Value of Statistical Life Approach," *eClinical Medicine* 51 (2022): 101580, https://doi.org/10.1016/j.eclinm.2022.101580; and Winston Wong, "Economic Burden of Alzheimer Disease and Managed Care Considerations," *American Journal of Managed Care* 26 (8) (2020): S177–S183, https://doi.org/10.37765/ajmc.2020.88482.

[4] National Center for Health Statistics, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," Centers for Disease Control and Prevention, November 17, 2021, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[5] National Center for Health Statistics, "Suicide Increases in 2021 after Two Years of Decline," Centers for Disease Control and Prevention, September 30, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220930.htm.

[6] See Jeffrey W. Swanson and Mark L. Rosenberg, "American Gun Violence and Mental Illness: Reducing Risk, Restoring Health, Respecting Rights & Reviving Communities," *Dædalus* 152 (4) (Fall 2023): 45–74, https://www.amacad.org/publication/american-gun-violence-mental-illness-reducing-risk-restoring-health-respecting-rights.

[7] World Health Organization, *Mental Health Atlas 2020* (Geneva: World Health Organization, 2021); and Institute for Health Metrics and Evaluation, "Global Burden of Disease Compare."

[8] World Health Organization, *Mental Health Atlas 2020*.

[9] World Health Organization, *Organization of Services for Mental Health: Mental Health Policy and Service Guidance Package* (Geneva: World Health Organization, 2003).

[10] World Health Organization, *World Mental Health Report: Transforming Mental Health for All* (Geneva: World Health Organization, 2022).

[11] Thomas Insel, *Healing: Our Path from Mental Illness to Health* (New York: Penguin Random House, 2022); and National Alliance on Mental Illness, "People, Place and Purpose: A Vision for the Failing Mental Health System," May 2, 2022, https://www.youtube.com/watch?v=iyaTeMW3Waw.

[12] Andrea Fiorillo and Norman Sartorius, "Mortality Gap and Physical Comorbidity of People with Severe Mental Disorders: The Public Health Scandal," *Annals of General Psychiatry* 20 (2021): 52, https://doi.org/10.1186/s12991-021-00374-y.

[13] Maddy Reinert, Danielle Fritze, and Theresa Nguyen, *The State of Mental Health in America 2023* (Alexandria, Va.: Mental Health America, 2022), https://mhanational.org/issues/state-mental-health-america#:~:text=over%20half%20(54.7%25)%20of,illness%20did%20not%20receive%20care.

[14] United Nations General Assembly, *Convention on the Rights of Persons with Disabilities* (A/RES/61/106), December 12, 2006, https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities.

[15] Nancy Doyle, "Neurodiversity at Work: A Biopsychosocial Model and the Impact on Working Adults," *British Medical Bulletin* 135 (1) (2020): 108–125, https://doi.org/10.1093/bmb/ldaa021.

[16] George Makari, "What COVID Revealed about American Psychiatry," *The New Yorker*, July 13, 2023, https://www.newyorker.com/culture/essay/what-covid-revealed-about-american-psychiatry.

[17] Ronald C. Kessler, Patricia Berglund, Olga Demler, et al., "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62 (6) (2005): 593–602, https://doi.org/10.1001/archpsyc.62.6.593; and Damian F. Santomauro, Ana M. Mantilla Herrera, Jamileh Shadid, et al., "Global Prevalence and Burden of Depressive and Anxiety Disorders in 204 Countries and Territories in 2020 Due to the COVID-19 Pandemic," *The Lancet* 398 (10312) (2021): 1700–1712, https://doi.org/10.1016/S0140-6736(21)02143-7.

[18] Michael Lawrence, Scott Janzwood, and Thomas Homer-Dixon, "What Is a Global Polycrisis? And How Is It Different from a Systemic Crisis?" Technical Paper 2022–4 (Victoria, British Columbia: Cascade Institute, 2022), https://cascadeinstitute.org/technical-paper/what-is-a-global-polycrisis.

[19] Kay Redfield Jamison, "Disorders of Mood: The Experience of Those Who Have Them," *Dædalus* 152 (4) (Fall 2023): 151–165, https://www.amacad.org/publication/disorders-mood-experience-those-who-have-them.

[20] For example, Roberto Lewis-Fernandez and Neal Aggarwal and their colleagues have developed the Cultural Formulation Interview for DSM-5. This interview schedule systematically assesses the influence of culture and other social factors on individuals' experiences of mental illness, and is used for research, training, and treatment. Recent research on its utility can be found in Neil Krishan Aggarwal, G. Eric Jarvis, Ana Gómez-Carillo, et al., "The Cultural Formulation Interview since DSM-5: Prospects for Training, Research and Clinical Practice," *Transcultural Psychiatry* 57 (4) (2020): 496–514, https://doi.org/10.1177/1363461520940481.

[21] Laura Sampson, Laura D. Kubzansky, and Karestan C. Koenen, "The Missing Piece: A Population Health Perspective to Address the U.S. Mental Health Crisis," *Dædalus* 152 (4) (Fall 2023): 24–44, https://www.amacad.org/publication/missing-piece-population-health-perspective-address-us-mental-health-crisis.

[22] Swanson and Rosenberg, "American Gun Violence and Mental Illness."

[23] Helena Hansen, Kevin J. Gutierrez, and Saudi Garcia, "Rethinking Psychiatry: Solutions for a Sociogenic Crisis," *Dædalus* 152 (4) (Fall 2023): 75–91, https://www.amacad.org/publication/rethinking-psychiatry-solutions-sociogenic-crisis.

[24] Jonathan M. Metzl, "The Protest Psychosis and the Future of Equity and Diversity Efforts in American Psychiatry," *Dædalus* 152 (4) (Fall 2023): 92–110, https://www.amacad.org/publication/protest-psychosis-future-equity-diversity-efforts-american-psychiatry.

[25] Gary Belkin, "Democracy Therapy: Lessons from ThriveNYC," *Dædalus* 152 (4) (Fall 2023): 111–129, https://www.amacad.org/publication/democracy-therapy-lessons-thrivenyc.

[26] Joseph P. Gone, "Indigenous Historical Trauma: Alter-Native Explanations for Mental Health Inequities," *Dædalus* 152 (4) (Fall 2023): 130–150, https://www.amacad.org/publication/indigenous-historical-trauma-alter-native-explanations-mental-health-inequities.

[27] Anne Harrington, "Mental Health's Stalled (Biological) Revolution: Its Origins, Aftermath and Future Opportunities," *Dædalus* 152 (4) (Fall 2023): 166–185, https://www.amacad.org/publication/mental-healths-stalled-biological-revolution-its-origins-aftermath-future-opportunities.

[28] Steven E. Hyman, "The Biology of Mental Disorders: Progress at Last," *Dædalus* 152 (4) (Fall 2023): 186–211, https://www.amacad.org/publication/biology-mental-disorders-progress-last.

[29] Allan V. Horwitz and Jerome C. Wakefield, "Two Sides of Depression: Medical and Social," *Dædalus* 152 (4) (Fall 2023): 212–227, https://www.amacad.org/publication/two-sides-depression-medical-social.

[30] Isaac R. Galatzer-Levy, Gabriel J. Aranovich, and Thomas R. Insel, "Can Mental Health Care Become More Human by Becoming More Digital?" *Dædalus* 152 (4) (Fall 2023): 228–244, https://www.amacad.org/publication/can-mental-health-care-become-more-human-becoming-more-digital.

[31] Arthur Kleinman, Hongtu Chen, Sue E. Levkoff, et al., "Social Technology: An Interdisciplinary Approach to Improving Care for Older Adults," *Frontiers in Public Health* 9 (2021): 729149, https://doi.org/10.3389/fpubh.2021.729149.

[32] Vikram Patel and Atif Rahman, "Empowering the (Extra)Ordinary," *Dædalus* 152 (4) (Fall 2023): 245–261, https://www.amacad.org/publication/empowering-extraordinary.

[33] Arthur Kleinman and Caleb Gardner, "Good Mental Health Care: What It Is, What It Is Not, and What It Could Be," *Dædalus* 152 (4) (Fall 2023): 262–279, https://www.amacad.org/publication/good-mental-health-care-what-it-what-it-not-and-what-it-could-be.

[34] Tom L. Osborn, Akash R. Wasil, John R. Weisz, et al., "Where Is the Global in Global Mental Health? A Call for Inclusive Multicultural Collaboration," *General Psychiatry* 33 (6) (2020): e100351, https://doi.org/10.1136%2Fgpsych-2020-100351.

[35] Alexander Hodkinson, Anli Zhou, Judith Johnson, et al., "Associations of Physician Burnout with Career Engagement and Quality of Patient Care: Systematic Review and Meta-Analysis," *British Medical Journal* 378 (2022): e070442, https://doi.org/10.1136/bmj-2022-070442; and Pascale Carayon, Christine K. Cassel, Elisabeth Belmont, et al., *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being* (Washington, D.C.: National Academies Press, 2019), https://doi.org/10.17226/25521.

[36] The Department of Global Health and Social Medicine at Harvard Medical School has contributed to the mental health field over the long term, including the first *World Mental Health* report–Robert Desjarlais, Leon Eisenberg, Byron Good, and Arthur Kleinman, eds., *World Mental Health: Problems and Priorities in Low-Income Countries* (Oxford: Oxford University Press, 1995); the first collaboration on mental health with the World Bank–World Bank Group and World Health Organization, *Out of the Shadows: Making Mental Health a Global Development Priority* (Washington, D.C., and Geneva: World Bank Group and World Health Organization, 2016); and the Global Mental Health program at Harvard, led by Vikram Patel, https://ghsm.hms.harvard.edu/programs/mental-health.

[37] Partners In Health, "Paul Farmer," https://www.pih.org/paul-farmer (accessed October 5, 2023).

[38] Paul Farmer and Gustavo Gutiérrez, *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutiérrez*, ed. Michael Griffin and Jennie Weiss Block (Ossining, N.Y.: Orbis Books, 2013), 166.

[39] Jed Boardman and Subodh Dave, "Person-Centred Care and Psychiatry: Some Key Perspectives," *The British Journal of Psychiatry International* 17 (3) (2020): 65–68, https://doi.org/10.1192/bji.2020.21.

[40] Arjun Suri, Jonathan Weigel, Luke Messac, et al., "Values and Global Health," in *Reimagining Global Health: An Introduction*, ed. Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matthew Basilico (Berkeley: University of California Press, 2013), 245–286.