DATA BRIEF
MAY 2020

Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries

Roosa Tikkanen, Katharine Fields, Reginald D. Williams II, and Melinda K. Abrams

HIGHLIGHTS

- About one-quarter of U.S. adults report having a mental health diagnosis such as anxiety or depression or experiencing emotional distress. This is one of the highest rates among 11 high-income countries.
- While U.S. adults are among the most willing to seek professional help for emotional distress, they are among the most likely to report access or affordability issues.
- Emotional distress is associated with social and economic needs in all countries. Nearly half of U.S. adults who experience emotional distress report such worries, a higher share than seen in other countries.
- The United States has some of the worst mental health–related outcomes, including the highest suicide rate and second-highest drug-related death rate.
- The U.S. has a relatively low supply of mental health workers, particularly psychologists and psychiatrists. Just one-third of U.S. primary care practices have mental health professionals on their team, compared to more than 90 percent in the Netherlands and Sweden.

Mental health is an important indicator of a society's overall well-being. Mental health interacts closely with physical health: people with chronic physical conditions often also have mental health issues.[1]

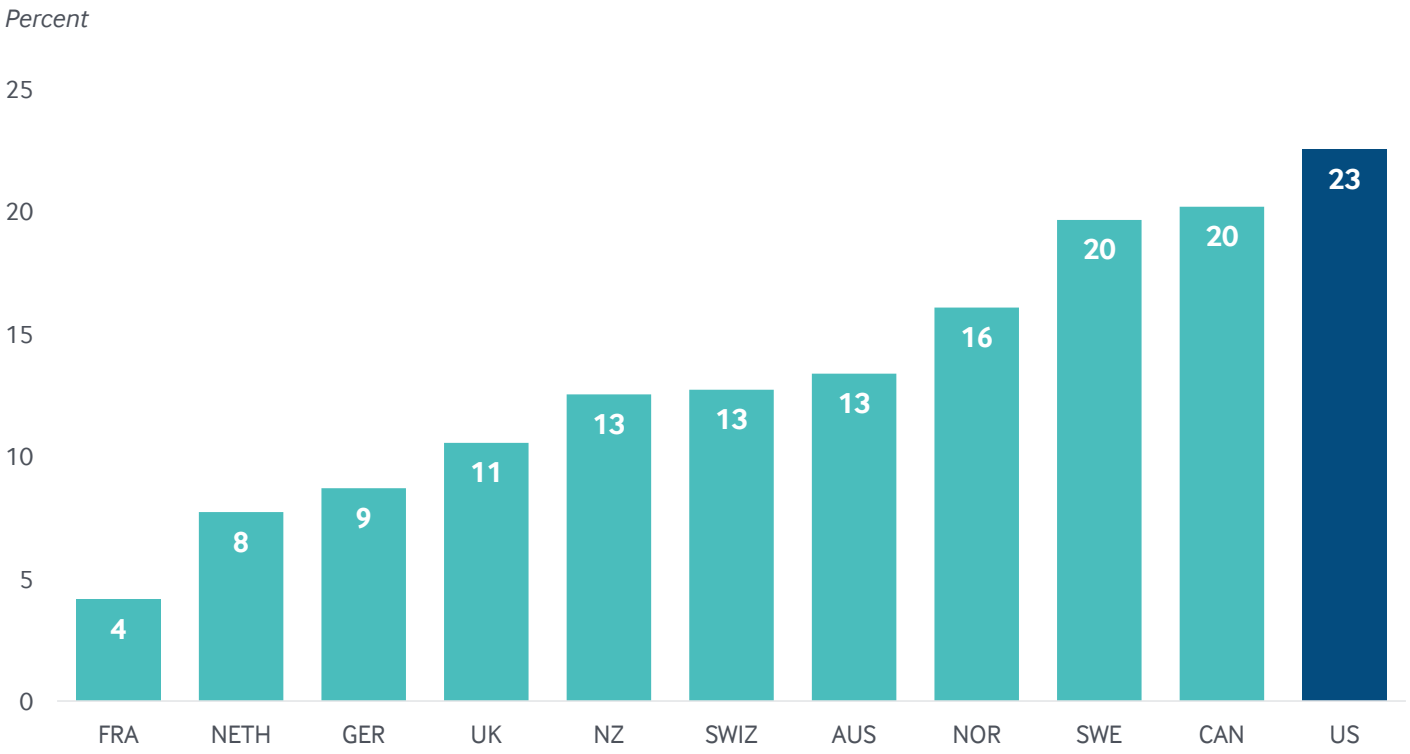
This data brief examines the mental health burden in the United States compared with 10 other high-income countries that participate in the Commonwealth Fund's annual international health policy survey. We also look at the relationship between mental health burden and social determinants of health, differences in seeking care, access and affordability of care, mental health and substance use disorder outcomes, and health system capacity. Such cross-country comparisons can provide valuable insights into how the provision of mental health and substance use care can be strengthened in the U.S. This analysis also can serve as a baseline measurement of underlying mental health needs across countries before the COVID-19 pandemic, which is likely to exacerbate mental health conditions in several countries experiencing social distancing measures.[2]

The Commonwealth Fund

MENTAL HEALTH BURDEN

More U.S. adults have received mental health diagnoses than adults in other high-income countries.

Depression, Anxiety, or Other Mental Health Diagnoses Among Adults, 2016



Question: Have you ever been told by a doctor that you have, or have had, depression, anxiety, or other mental health problems?

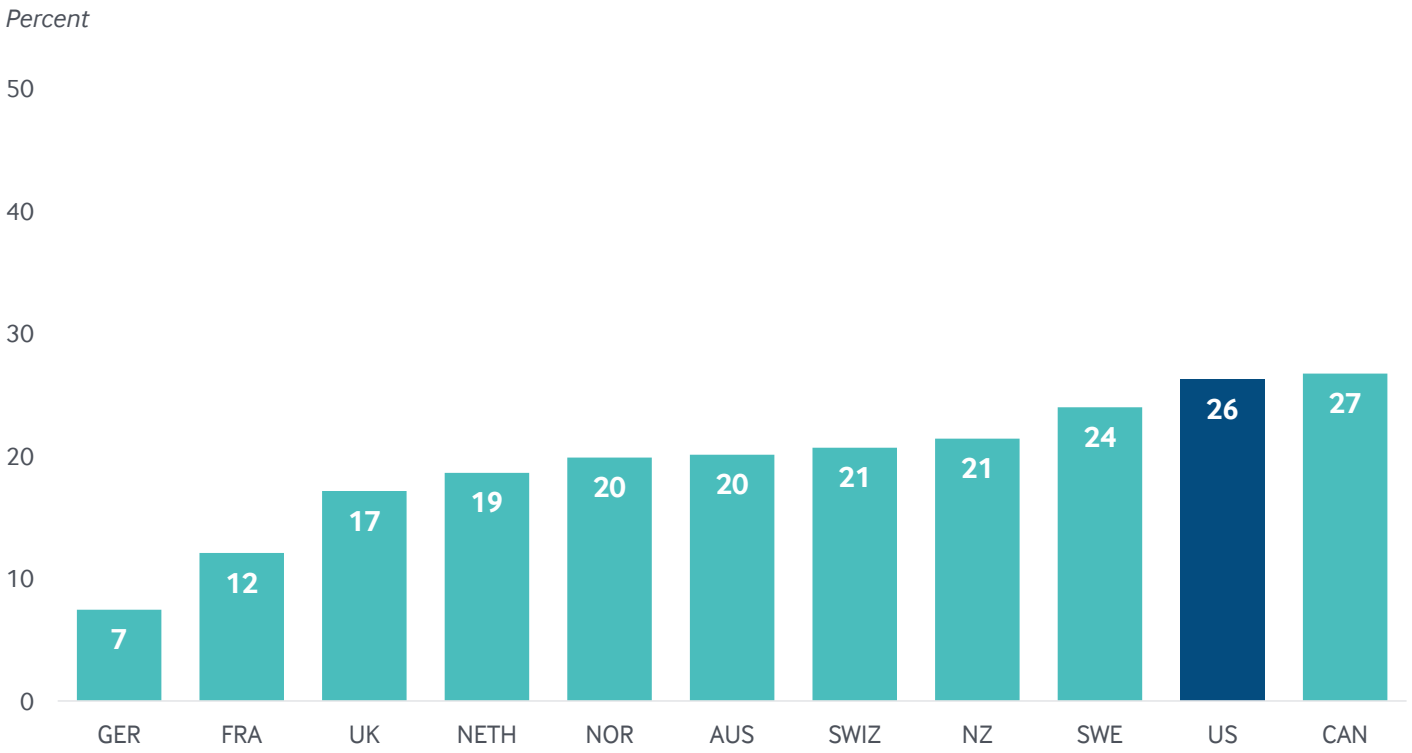
Data: 2016 Commonwealth Fund International Health Policy Survey.

Among adults in high-income countries, those in the U.S. were most likely to have been diagnosed with depression, anxiety, or other mental health conditions by a doctor. In 2016, nearly one-quarter (23%) of U.S. adults reported a mental health diagnosis, compared to fewer than 10 percent of adults in France, the Netherlands, and Germany.

MENTAL HEALTH BURDEN

Self-reported emotional distress rates are highest in Canada and the U.S.

Subjective Experience of Emotional Distress, 2016



Question: In the past two years, have you experienced emotional distress, such as anxiety or great sadness, which you found difficult to cope with by yourself?

Data: 2016 Commonwealth Fund International Health Policy Survey.

The incidence of mental health conditions may reflect differences in physician diagnostic patterns, in part because of different clinical guidelines or cultural factors in the 11 countries. Also, not everyone who experiences mental health symptoms goes to see a doctor. As a result, many psychiatric conditions may go undiagnosed and untreated. Self-reports of emotional distress may, therefore, provide a better understanding of actual mental health burden among the general population.

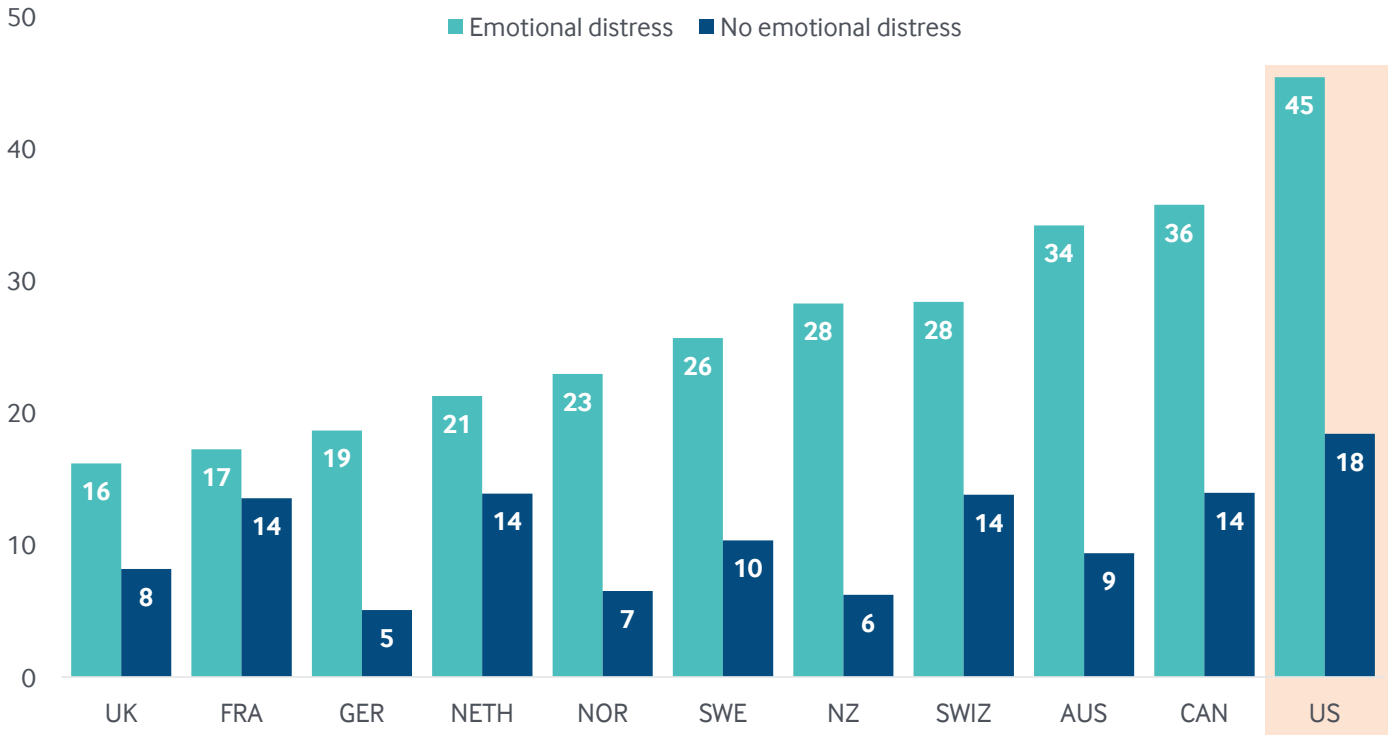
In 2016, slightly more than one-quarter (26%) of U.S. adults reported that in the past two years they had experienced emotional distress, such as anxiety or great sadness, that was difficult to cope with alone. The U.S. rate is similar to Canada's (27%) and Sweden's (24%), while only 7 percent and 12 percent of German and French adults reported emotional distress.

MENTAL HEALTH AND SOCIAL DETERMINANTS OF HEALTH

Emotional distress rates are higher among people worried about neighborhood safety issues or having enough money for food or housing. U.S. adults with emotional distress are the most likely among the countries to have these social and economic concerns.

Socioeconomic Needs Among Adults Who Had and Had Not Experienced Emotional Distress, 2016

*Percent who said "always" or "usually"**



Question: In the past 12 months, have you "always" or "usually" been worried or stressed about one or more of the following: having enough money to buy nutritious meals, crime or drugs in your neighborhood, and/or having enough money to pay your rent or mortgage?

* Other response categories: "sometimes," "rarely," "never."

Data: 2016 Commonwealth Fund International Health Policy Survey.

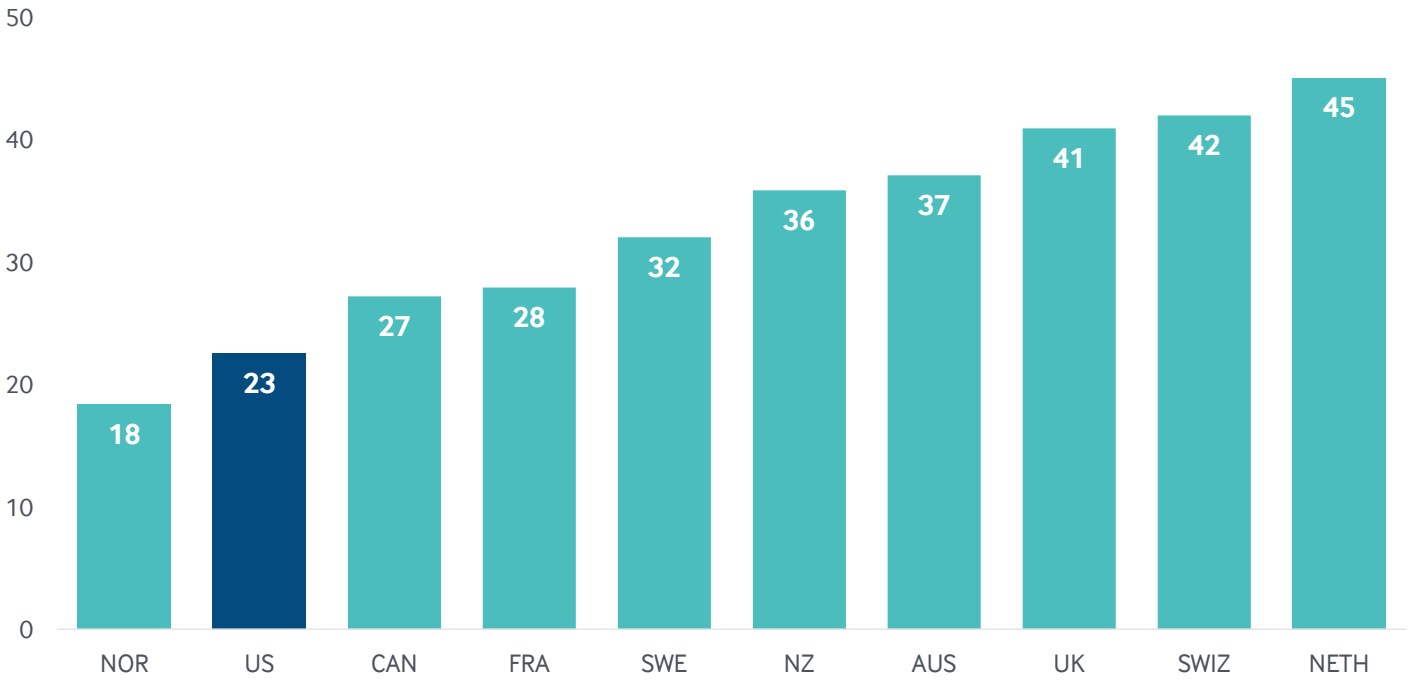
Nearly half (45%) of U.S. adults who reported experiencing emotional distress also reported being concerned about neighborhood safety or having enough money for housing or food. In contrast, only 16 percent to 19 percent of adults reporting emotional distress in the United Kingdom, France, and Germany reported unmet social and economic needs. This suggests that unmet social needs in the U.S. may be more prevalent than in other high-income countries, potentially contributing to the experience of emotional distress.

SEEKING CARE

U.S. adults are among the most likely to want to see a professional when experiencing emotional distress.

Did Not Want to See a Professional for Emotional Distress, 2016

Percent who had experienced emotional distress



Question: When you felt this way, were you able to get help from a professional when you needed it? *Response:* No, did not want to see a professional.

Notes: "Emotional distress" refers to adults who report they have experienced anxiety or great sadness which they found difficult to cope with by themselves in the past two years. No data shown for GER because of small sample size (n<100).

Data: 2016 Commonwealth Fund International Health Policy Survey.

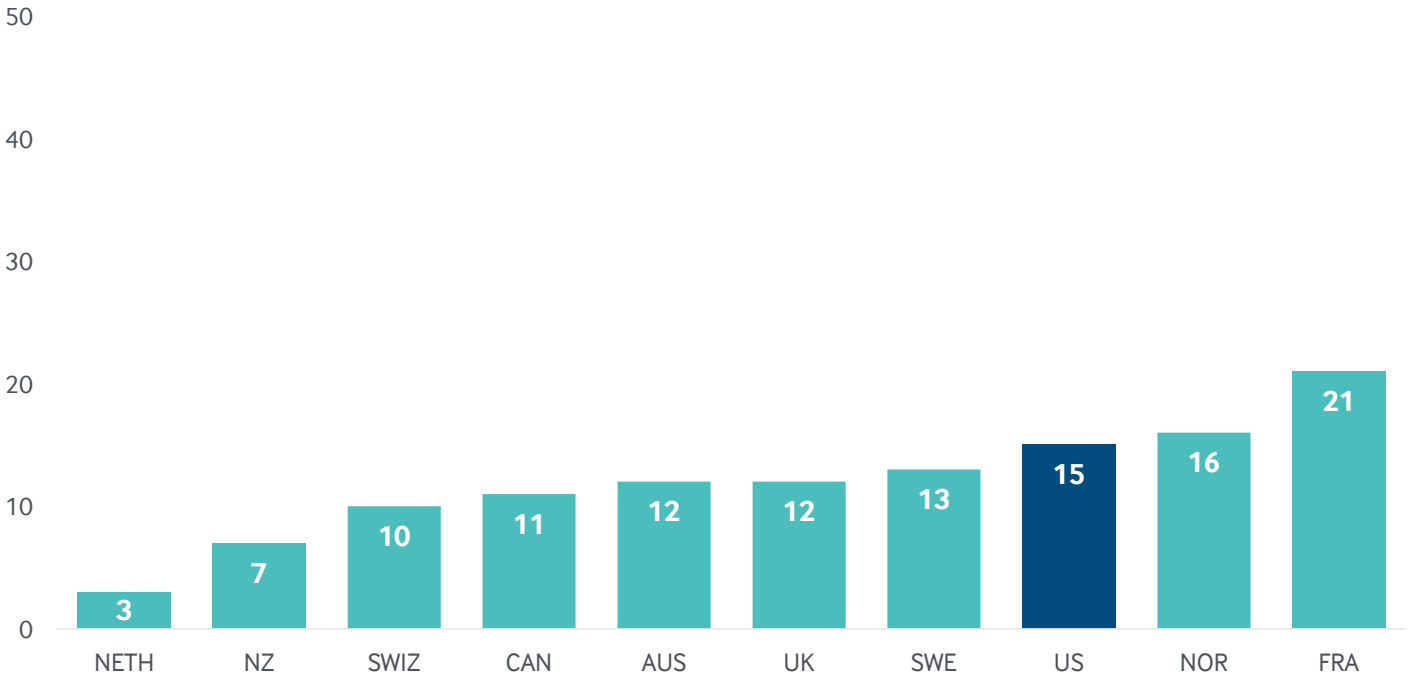
Cultural norms and stigma associated with psychological illness may contribute to differences in the likelihood of people seeking mental health care during a time of need.[3] While a considerable share of British, Swiss, and Dutch adults (41%–45%) reported not wanting to see a professional when experiencing emotional distress, only 23 percent of U.S. adults reported the same. This suggests that there may be less stigma associated with seeking mental health treatment in the U.S. than in some other high-income countries.

ACCESS AND AFFORDABILITY

One in six U.S. adults is unable to get or afford professional help when experiencing emotional distress.

Unable to Get or Afford Needed Mental Health Care, 2016

Percent who had experienced emotional distress



Question: When you felt this way, were you able to get help from a professional when you needed it? *Response:* No, could not get help or could not afford to see a professional.

Notes: "Emotional distress" refers to adults who report they have experienced anxiety or great sadness which they found difficult to cope with by themselves in the past two years. No data shown for GER because of small sample size (n<100).

Data: 2016 Commonwealth Fund International Health Policy Survey.

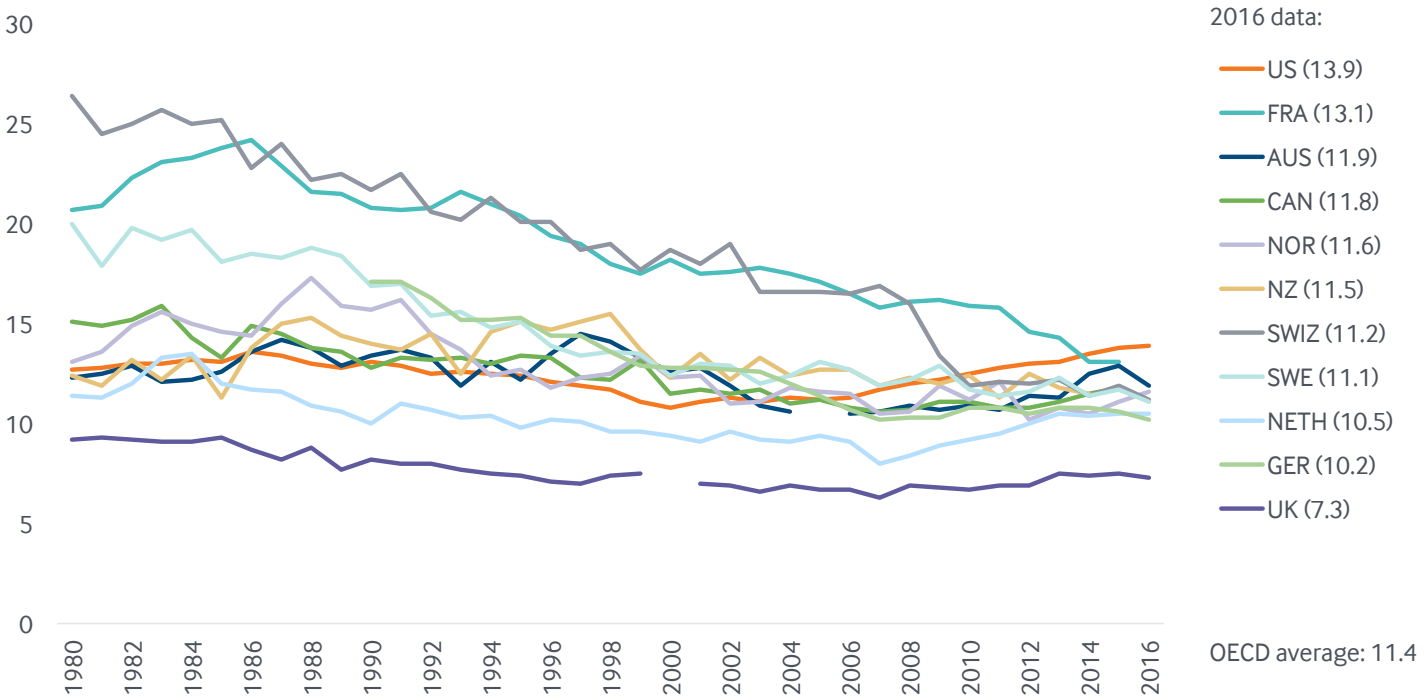
Access to professional mental health care can be lifesaving in a time of crisis. Among U.S. adults who had experienced emotional distress in the past two years, approximately one in six (15%) said that they could not get or afford professional help. However, rates were higher in France (21%) and similar in Norway (16%). In contrast, only 3 percent of Dutch and 7 percent of New Zealand adults experiencing emotional distress could not get or afford the help they needed.

OUTCOMES

The U.S. has the highest suicide rate among 11 high-income countries, and the rate has increased every year since 2000.

Trends in Suicides, 1980–2016

Deaths per 100,000 (standardized rates)



Note: Rates reflect age- and sex-standardized rates for 2016 or latest available year (2015 for CAN, FRA; 2014 for NZ).

Data: OECD Health Data 2019.

Barriers to accessing care may help explain why the U.S. has one of the highest suicide rates in the industrialized world.[4] At 13.9 suicides per 100,000 people, the 2016 rate is the highest among the 11 countries studied. While France also has a high rate, at 13.1 suicides per 100,000, the U.S. rate is nearly twice that of the country with the lowest number of suicides, the U.K. (7.3 per 100,000).

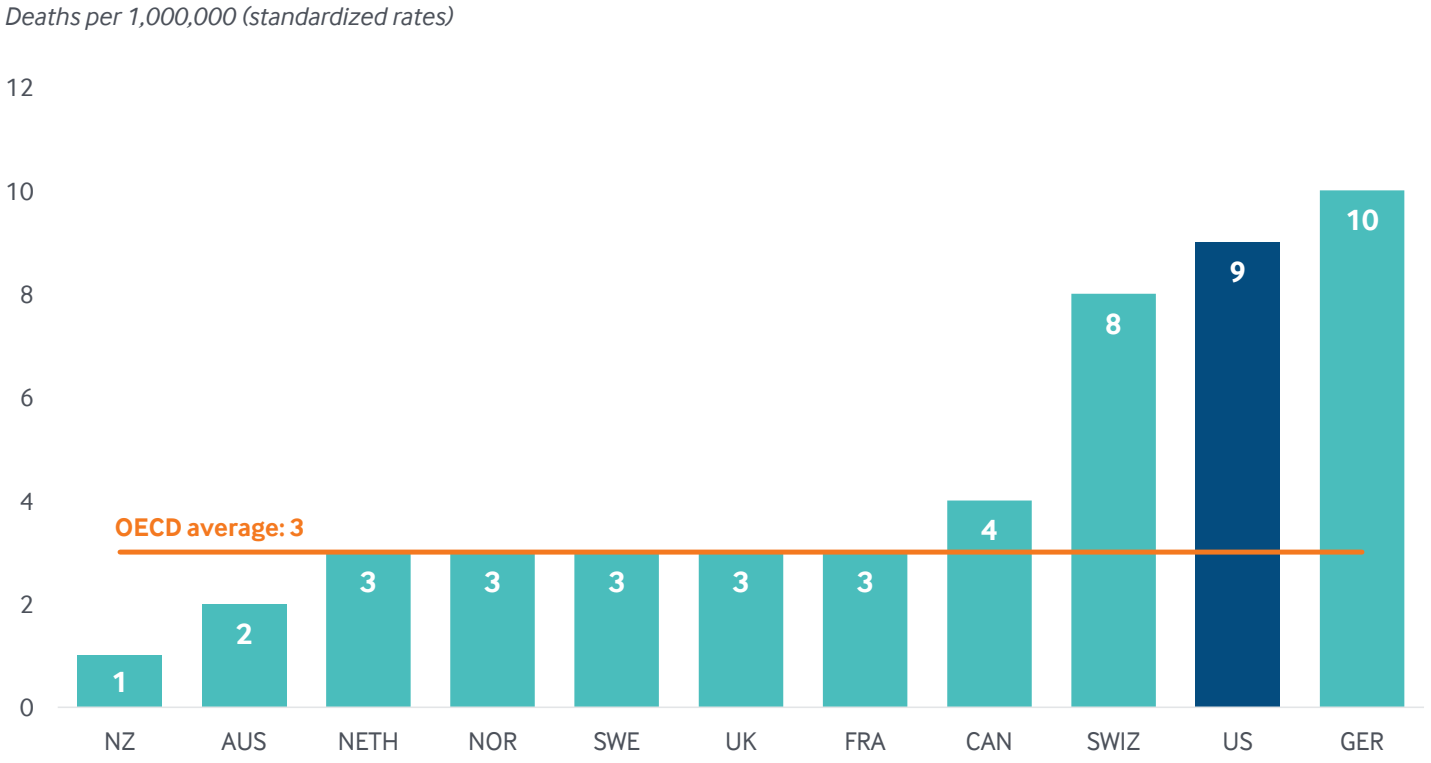
Looking at suicide trends over time reveals that the U.S. has historically had one the lowest rates among the 11 countries. However, since the early 2000s, the U.S. suicide rate has been steadily increasing. Deaths of despair, reflecting deaths from suicides, drug overdoses, and alcohol, also have increased in recent years.[5]

In most other countries, suicide rates have either remained stable or improved. A handful of other countries, including Australia, Canada, and the U.K., have also experienced increases in suicide rates in recent years, but these have been relatively small.

OUTCOMES

The U.S. has one of highest death rates from substance use disorders.

Deaths Related to Drug Use, 2016



Notes: Reflects deaths from psychoactive substance use, including from opioids, cannabis, sedatives, hypnotics, anxiolytics, cocaine, other stimulants, hallucinogens, nicotine, inhalants, and other psychoactive substances, but excluding alcohol. Rates reflect age- and sex-standardized rates for 2016 or latest available year (2015 for CAN, FRA; 2014 for NZ).

Data: OECD Health Data 2019.

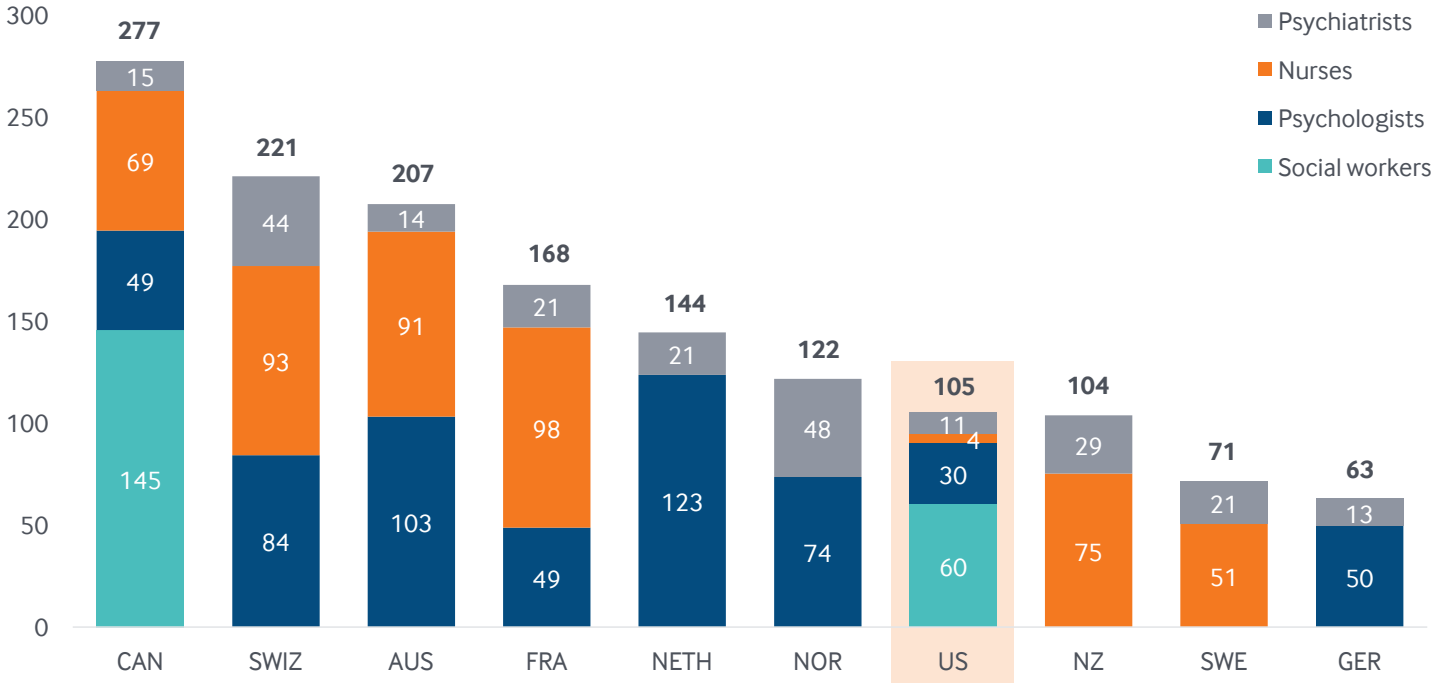
In 2016, nine of every million deaths in the U.S. was caused by a substance use disorder. In comparison, the majority of the countries studied had three or fewer deaths per million tied to substance use disorders. Along with the U.S., Switzerland and Germany had comparably high rates.

CAPACITY

The U.S. has a relatively low workforce capacity to meet mental health needs.

Mental Health Workforce Supply, 2017

Number of professionals working in the mental health sector, per 100,000 population



Notes: Data for 2017 or latest available year (2016 for NZ, NOR, SWE, US; 2015 for AUS, GER, NETH, SWIZ). No data available for UK. Because of rounding, the total number of professionals may not equal the sum of the four subcategories of workers.

Data: World Health Organization Global Health Observatory data repository.

The relatively high unmet mental health needs among U.S. adults may reflect a limited health system capacity to meet those needs. Compared to most other high-income countries, the U.S. has a smaller total supply of mental health workers, with 105 professionals per 100,000 people. Canada, Switzerland, and Australia have approximately twice that number of mental health workers.

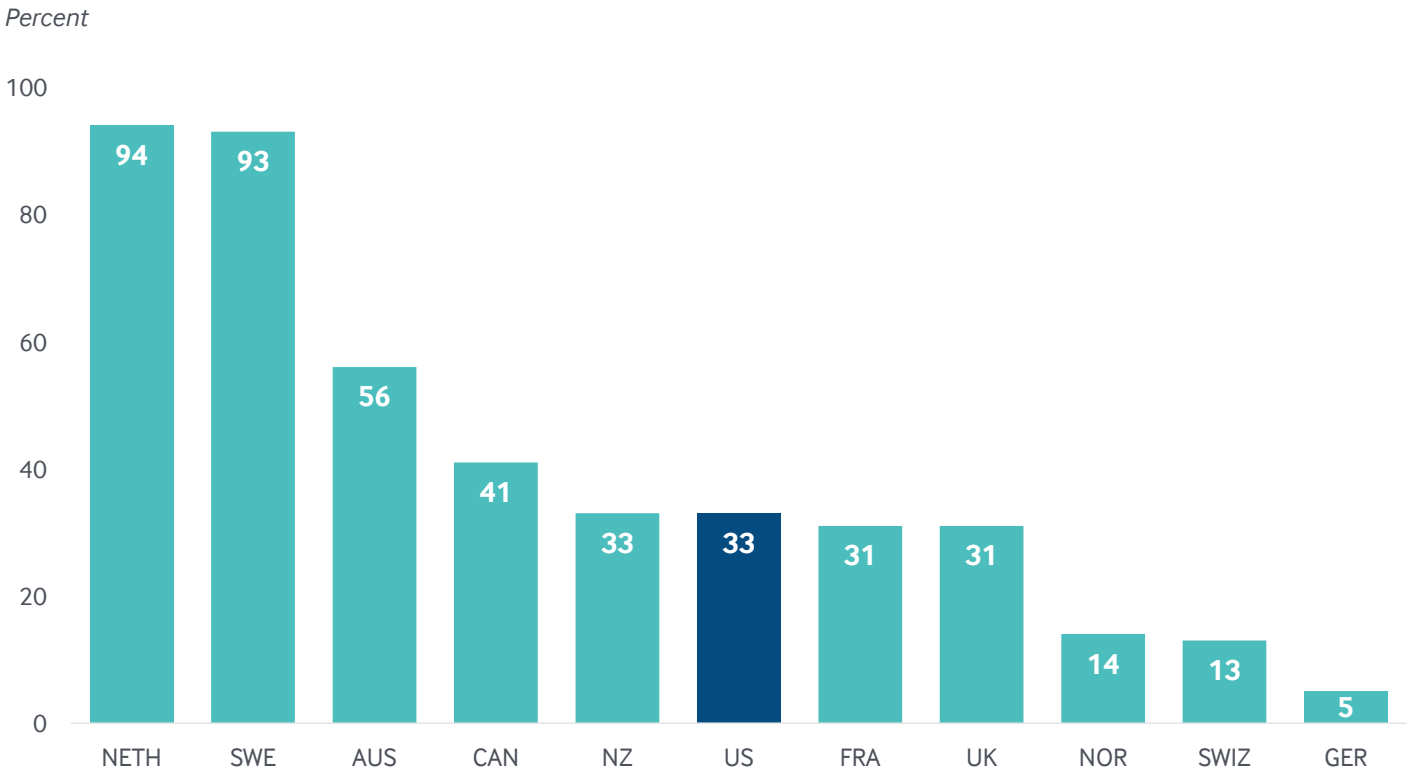
The United States is not the only country with capacity issues. New Zealand, Sweden, and Germany have an even lower supply of mental health workers than the United States.

In the U.S., social workers and nurses make up the majority of the mental health workforce, while the supply of psychologists and psychiatrists is far lower than in most other countries.

PRIMARY CARE INTEGRATION

Including mental health providers on primary care teams is less common in the U.S. than in some other countries.

Primary Care Practices with Psychologists or Mental Health Providers on Team, 2019



Note: Data reflect the share of primary care physicians who indicated that a psychologist or mental health provider work on their team to provide patient care.

Data: 2019 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

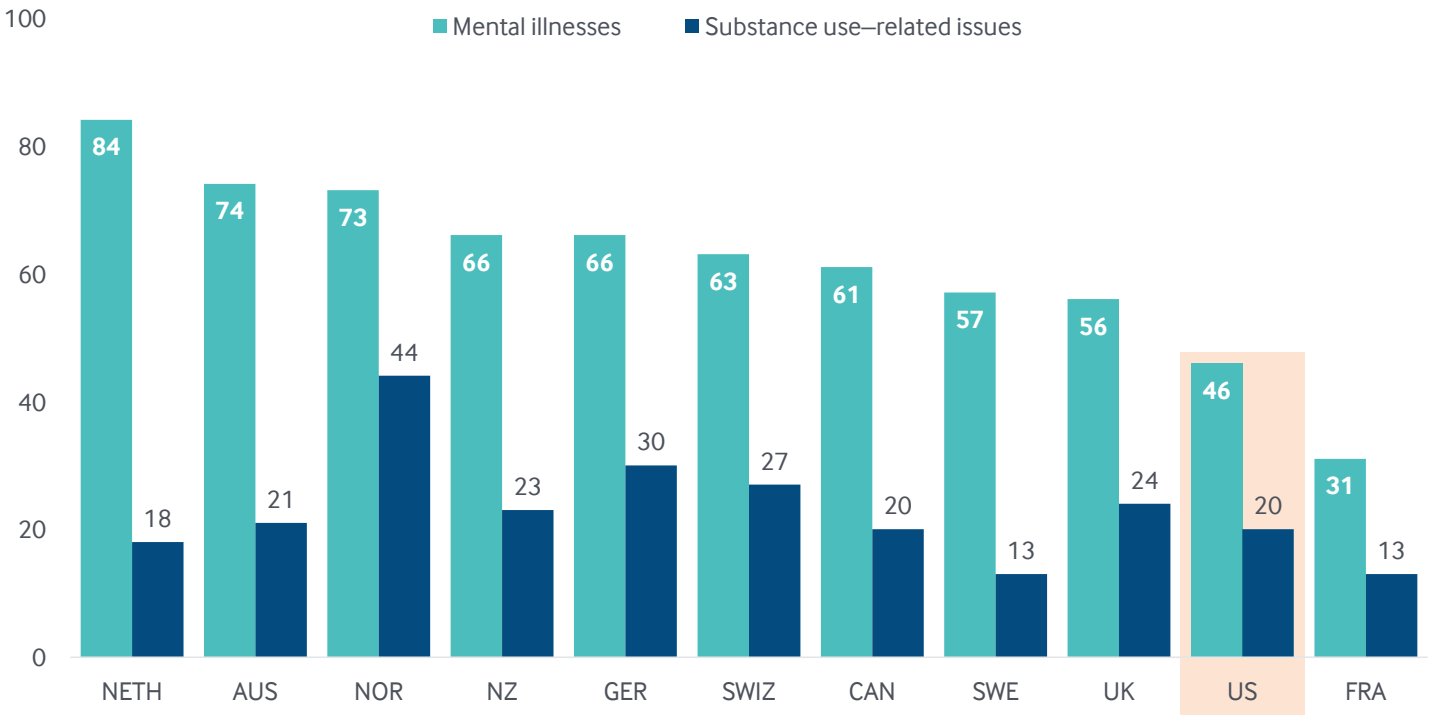
One-third of U.S. primary care practices have a mental health provider, such as a psychologist, on their patient care teams. This is comparable to the share of primary care practices in the U.K., France, and New Zealand. But some countries are more likely to integrate mental health into primary care. More than 90 percent of primary care practices in the Netherlands and Sweden reported having mental health providers.

PRIMARY CARE INTEGRATION

U.S. primary care practices are among the least prepared to manage patients with mental illnesses.

Primary Care Practice Preparedness to Manage Patients with Mental Illnesses or Substance Use–Related Issues, 2019

*Percent who said they were "well prepared"**



Note: Reflects primary care physicians who reported that their practices are "well prepared," with respect to having sufficient skills and experience, to manage care for patients with mental illnesses (e.g., anxiety, mild or moderate depression) or substance use–related issues (e.g., drug, opioid, alcohol use).

* Other response categories: "somewhat prepared," "not prepared." Data exclude those who said "do not see these patients" (0–2% for mental illness; <1%–10% for substance use–related issues).

Data: 2019 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

U.S. primary care physicians are among the least likely to report that their practices have sufficient skills and experience to treat patients with mental health conditions. Specifically, less than half of U.S. practitioners report being well prepared to manage these patients. In comparison, the vast majority of primary care practices in the Netherlands, Australia, Norway, New Zealand, and Germany are well prepared to care for patients with mental illnesses.

In general, primary care physicians across all countries were less prepared to manage patients with substance use–related issues than mental health conditions, with fewer than one-quarter reporting being well prepared in the U.S. and most other countries.

DISCUSSION

The United States has one of the highest mental health burdens among high-income countries studied. Structural capacity to meet mental health needs, in terms of workforce numbers and preparedness, is also relatively lower in the U.S. than in other high-income countries. Although the Affordable Care Act strengthened insurance coverage for, and access to, mental health care and substance use disorder treatment, considerable gaps remain.[6] We can draw four key strategies from abroad:

1. **In many high-income countries, primary care serves as the first-level setting for mental health care, offering ongoing treatment for mild-to-moderate conditions, such as depression or anxiety.** In France, ambulatory centers provide primary mental health care, including home visits. In Norway, local governments fund multidisciplinary mental health teams that do community outreach. In the U.S., team-based treatment models — such as assertive community treatment and coordinated specialty care — are available in some regions.[7] Coverage and affordability barriers remain, however.

2. **Other countries have taken steps to remove cost-related access barriers to some mental health care and substance use treatment services.** There is no cost-sharing toward primary care visits in Canada, Germany, Netherlands, or the United Kingdom, which helps eliminate financial barriers to first-level care. Some countries also have removed copayments for prescription drugs for individuals with mental health conditions. For example, France waives all copayments for care related to long-term chronic mental illnesses, such as bipolar disorder, schizophrenia, or severe forms of anxiety or depression. Many countries also have removed cost barriers to care for children and youth, recognizing that roughly half of mental illnesses start during teenage years.[8] For example, in Norway, children and youth under age 18 do not have to pay for mental health care or treatments.

3. **Faced with a dearth of psychiatrists and psychologists, the U.S. could expand on alternative workforce models that might enable greater access to care.** More than a decade ago, NHS England expanded access to talk therapies in primary care settings through the Increasing Access to Psychological Therapies program. Today, more than 1.4 million patients in the program are served by specialized, nonclinical mental health practitioners. The program has been described as "the world's most ambitious effort to treat depression,"[9] and favorable outcomes have been reported.[10]

4. **Because mental health problems and substance use disorder are often tied to social determinants of health — reflecting the conditions in which people live and work — collaboration is needed across social policy areas.** This is already happening in some regions of the U.S. For example, Los Angeles recently introduced a community-based mental health model known as the TRIESTE project. Imported from Trieste, Italy, the model addresses the social needs of individuals with mental health problems, including individuals experiencing homelessness.[11]

Some high-income countries have made mental health a national priority. For example, in 2018, the U.K. appointed its first-ever Minister of Suicide and, soon thereafter, a Minister of Loneliness was named. Similarly, the New Zealand government recently released its first Wellbeing Budget, which prioritizes mental health on par with physical health. U.S. leaders could learn from their counterparts abroad in terms of prioritizing mental health on the policy agenda, drawing attention to ways to reduce cost-related access barriers, and improving the availability of community-based care.

HOW WE CONDUCTED THIS STUDY

This analysis used data from the 2019 release of health statistics compiled by the Organisation for Economic Co-operation and Development (OECD), which tracks and reports on a wide range of health system measures across 36 high-income countries. Data were extracted between July and August 2019. While data collected by the OECD reflect the gold standard in international comparisons, one limitation is that data may mask differences in how countries collect their health data. Full details on how indicators were defined, as well as country-level differences in definitions, are available from the OECD.

We also used data from the 2016 Commonwealth Fund International Health Policy Survey and the 2019 Commonwealth Fund International Health Policy Survey of Primary Care Physicians. Further details on how these surveys were conducted are available on the Commonwealth Fund website including for the 2016 and 2019 surveys. Workforce data were derived from the World Health Organization's Global Health Observatory data repository. The 10 comparator countries included in this comparison represent those high-income countries[12] that take part in the Commonwealth Fund's annual International Health Policy Survey: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.

NOTES

1. Cynthia Boyd et al., *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Center for Health Care Strategies, Dec. 2010).

2. Betty Pfefferbaum and Carol S. North, "Mental Health and the COVID-19 Pandemic" (Perspective), *New England Journal of Medicine,* published online Apr. 13, 2020.

3. Taraneh Mojaverian, Takeshi Hashimoto, and Heejung S. Kim, "Cultural Differences in Professional Help Seeking: A Comparison of Japan and the U.S.," *Frontiers in Psychology* 3, no. 615, published online Jan. 11, 2013.

4. Stephanie Brooks Holliday, *The Relationship Between Mental Health Care Access and Suicide* (RAND Corporation, Mar. 2, 2018).

5. Steven H. Woolf and Heidi Schoomaker, "Life Expectancy and Mortality Rates in the United States, 1959–2017," *JAMA* 322, no. 20 (Nov. 26, 2019): 1996–2016.

6. Jesse C. Baumgartner, Gabriella N. Aboulafia, and Audrey McIntosh, "The ACA at 10: How Has It Impacted Mental Health Care?," *To the Point* (blog), Commonwealth Fund, Apr. 3, 2020; and Amanda J. Abraham et al., "The Affordable Care Act Transformation of Substance Use Disorder Treatment," *American Journal of Public Health* 107, no. 1 (Jan. 2017): 31–32.

7. Heather O'Donnell, Kristin Davis, and Samantha Mestan, "Building the Community-Based Mental Health Workforce to Expand Access to Treatment," *Health Affairs Blog,* Oct. 24, 2019.

8. Ronald C. Kessler et al., "Age of Onset of Mental Disorders: A Review of Recent Literature," *Current Opinion in Psychiatry* 20, no. 4 (July 2007): 359–64.

9. Benedict Carey, "England's Mental Health Experiment: No-Cost Talk Therapy," *New York Times,* July 24, 2017.

10. NHS England, "NHS Welcomes Record High Recovery Rate for Common Mental Illness," press release, Feb. 27, 2018.

11. Rob Waters, "A New Approach to Mental Health Care, Imported from Abroad," *Health Affairs* 39, no. 3 (Mar. 2020): 362–66.

12. "High income" is defined as per the World Bank Country and Lending Groups, https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

ABOUT THE AUTHORS

Roosa Tikkanen, M.P.H., M.Res., is a senior research associate in the Commonwealth Fund's International Health Policy and Practice Innovations program, where she tracks health care policy developments in industrialized countries; provides research support to and coauthors the Fund's annual international health policy surveys; provides support for the international issue briefs and an annual OECD data update; coedits and coordinates the *International Health News Brief;* and prepares presentations for the vice president. Before joining the Fund, she was a policy analyst at the Center for Health Law and Economics at Commonwealth Medicine based at UMass Medical School in Boston. Ms. Tikkanen holds a B.Sc. in neuroscience and an M.Res. in integrative biology from the University of Manchester in England, and an M.P.H. from the Harvard T.H. Chan School of Public Health.

Katharine Fields is a program assistant in the Commonwealth Fund's International Health Policy and Practice Innovations program. In this role, Ms. Fields provides daily administrative support to the vice president of the program, in addition to managing the program's grants, budgets, and assisting with the program's annual meetings. Prior to joining the Fund, she worked in fundraising for a New York area art museum as well as for a nonprofit theater organization. Ms. Fields is currently pursuing her M.P.A. at Baruch College and earned her B.A. cum laude in historic preservation from the University of Mary Washington.

Reginald D. Williams II is vice president of the International Health Policy and Practice Innovations program at the Commonwealth Fund. In this role, he is responsible for fostering international dialogue, exchange, and education that enables U.S. policymakers and health care leaders to learn from cross-national experiences. Mr. Williams is responsible for the organization's international benchmarking activities, its international research and policy analysis, and the educational exchanges it conducts with key international partners. Critical to all activities is the cultivation of a robust international network of senior policymakers and health care leaders, including the Commonwealth Fund's Harkness Fellowships in Health Care Policy and Practice. Prior to joining the Fund, Mr. Williams was at Avalere Health, a consulting firm dedicated to improving health care, where he served as managing director focusing on health care delivery innovation and digital health. Prior to joining Avalere, he was a member of the health policy team at the National Academy of Social Insurance. He serves on the board of directors of Mental Health America, a nonprofit dedicated to helping people live mentally healthier lives. Mr. Williams earned an A.B. in Biomedical Ethics from Brown University.

Melinda K. Abrams, M.S., senior vice president, oversees the Commonwealth Fund's Delivery System Reform and International Health Policy and Practice Innovations programs. Since coming to the Fund in 1997, Ms. Abrams has worked on the Fund's Task Force on Academic Health Centers, the Child Development and Preventive Care program, and most recently, she led the Patient-Centered Primary Care Program. Ms. Abrams has served on many national committees and boards for private organizations and federal agencies, and is a peer-reviewer for several journals. Ms. Abrams holds a B.A. in history from Cornell University and an M.S. in health policy and management from the Harvard T.H. Chan School of Public Health.

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For more information about this brief, please contact:
Roosa Tikkanen
Senior Research Associate
International Health Policy and Practice Innovations
The Commonwealth Fund
rt@cmwf.org

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