

# THE BIPOLAR VOID: WE WANT TO BE SEEN AND WE WANT TO LIVE

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## EXECUTIVE SUMMARY: THE ARCHITECTURE OF SURVIVAL

Nine years ago, I wrote my first call to action. I was a survivor of Bipolar I fighting for a seat at the table. Today, I am no longer asking for a seat—we are building a new table.

This isn't just about awareness. This is about the lethal reality of Bipolar I, a disease that claims 11% to 15% of our community to suicide—the highest rate in all of psychiatry. We are currently living under a National Standard of Neglect, where 51% of our people receive no medical care.

**THE MANDATE:** We must transition to a National Standard of Care that treats the brain as the physical organ it is. We aren't asking for charity; we are demanding the Right to be Well.

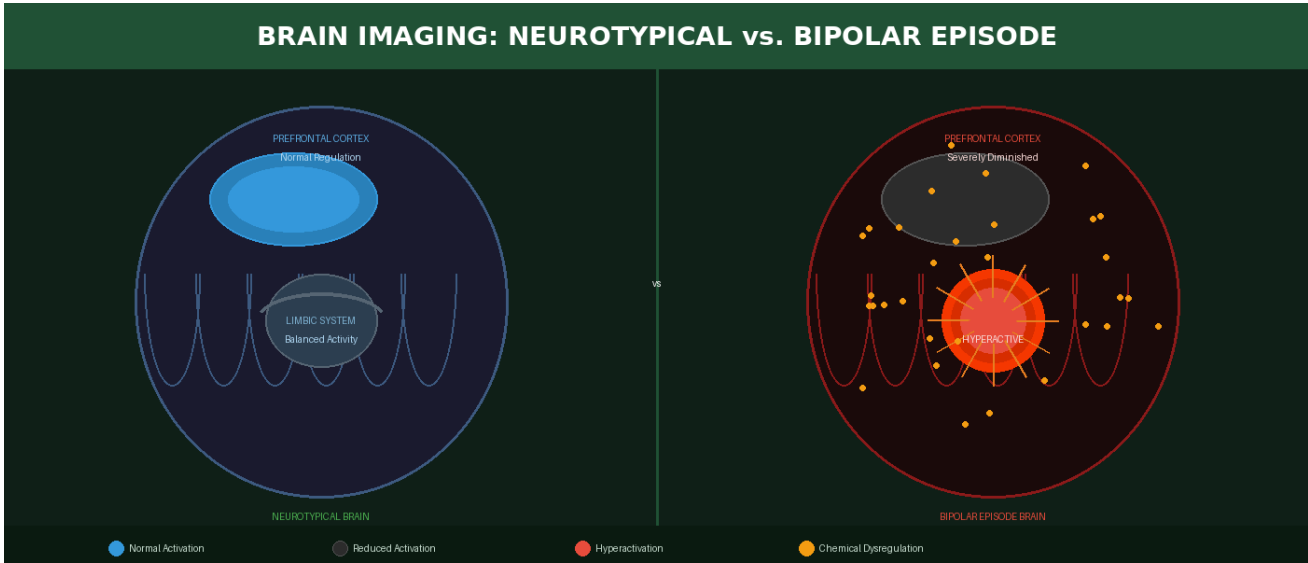
## I. THE LETHAL REALITY: BIPOLAR I AS A KILLER DISEASE

We must confront a devastating truth: Bipolar disorder is a killer disease that claims roughly 11% to 15% of our community over our lifetime [1]. That is approximately 30,000 American lives every single year—nearly one every 15 minutes. Yet, there remains a glaring mismatch between the enormous impact of this condition and society's limited commitment to addressing it.

In 2017, I called for spending equality. Today, the demand has evolved. Alongside the National Shattering Silence Coalition (NSSC), I am moving beyond Awareness to usher in the Era of Accountability. We aren't asking for ribbons; we are demanding medical equity. Lives are at stake.

## II. SCIENCE DOES NOT LIE: MENTAL ILLNESS IS A PHYSICAL ILLNESS

Bipolar disorder is a brain disease—a chemical and structural imbalance that can be mapped and measured. We must stop treating brain disorders as behavioral choices and start treating the brain as the physical organ it is.



MRI Scan Comparison: Neurotypical Brain vs. Brain During a Bipolar Manic/Depressive Episode.

Look at the comparison above. You aren't looking at a mood or a character flaw; you are looking at a biological brain crisis. In Bipolar I, the Manic Surge is a state of hyper-activation where the brain's frontal lobes—the brakes—fail, while the amygdala—the engine—runs at full throttle [2].

When we tell families to “just use voluntary programs” for someone in the throes of this pathology, we are asking a physically compromised organ to fix itself. Furthermore, we must address anosognosia—the neurological impairment occurring in the right hemisphere of the brain that prevents an individual from recognizing their own illness. It affects approximately 50% of those with Bipolar I [3]. True liberty is not found in abandonment; it is found in the Right to be Well. You cannot have liberty if your prefrontal cortex is offline. By treating the brain, we aren't taking away agency—we are restoring it.

### III. THE NUMBERS: A NATIONAL STANDARD OF NEGLECT

Bipolar disorder is among the ten most disabling medical conditions worldwide. While it affects approximately 2.8% of the U.S. adult population (7 million people), it carries the highest burden of severity in all of psychiatry: a staggering 82.9% of cases are classified as severe [4].

#### THE CLINICAL VOID

**1 IN 3:** Individuals with Bipolar disorder who will attempt suicide at some point in their lives [5].

**51%:** Those currently receiving zero medical treatment [6].

**3X:** Individuals with SMI are 3x more likely to end up in a jail cell than a hospital bed [7].

**10 YEARS:** The average delay between the onset of symptoms and first treatment [8].

### IV. THE PEDIATRIC PIPELINE: PREVENTING CLINICAL STAGE-SHIFTING

The most damning evidence of our Standard of Neglect is found in the pediatric pipeline. Half of all lifetime cases of SMI begin by age 14, and 75% by age 24 [8]. Yet, the average delay between the onset of symptoms and first treatment is 8 to 10 years.

When we ignore early-onset Bipolar I, we aren't just "watching and waiting"—we are allowing neuroprogression, where the brain becomes physically more resistant to treatment over time [9]. This is often called Clinical Stage-shifting. By denying early intervention, the state forces children to progress from Stage 1 (manageable) to Stage 4 (treatment-resistant disability). This neglect fuels the School-to-Prison Pipeline, as symptomatic children are met with disciplinary suspension rather than clinical stabilization. By the time these children reach adulthood, they are often already veterans of a criminal system that replaced their pediatrician.

## V. THE "NEGLECT TAX": THE COST OF A FAILING SYSTEM

While the \$343.2 Billion figure represents the annual economic burden of schizophrenia alone [10], Bipolar Disorder is a primary—and even more expensive—driver of this systemic financial drain.

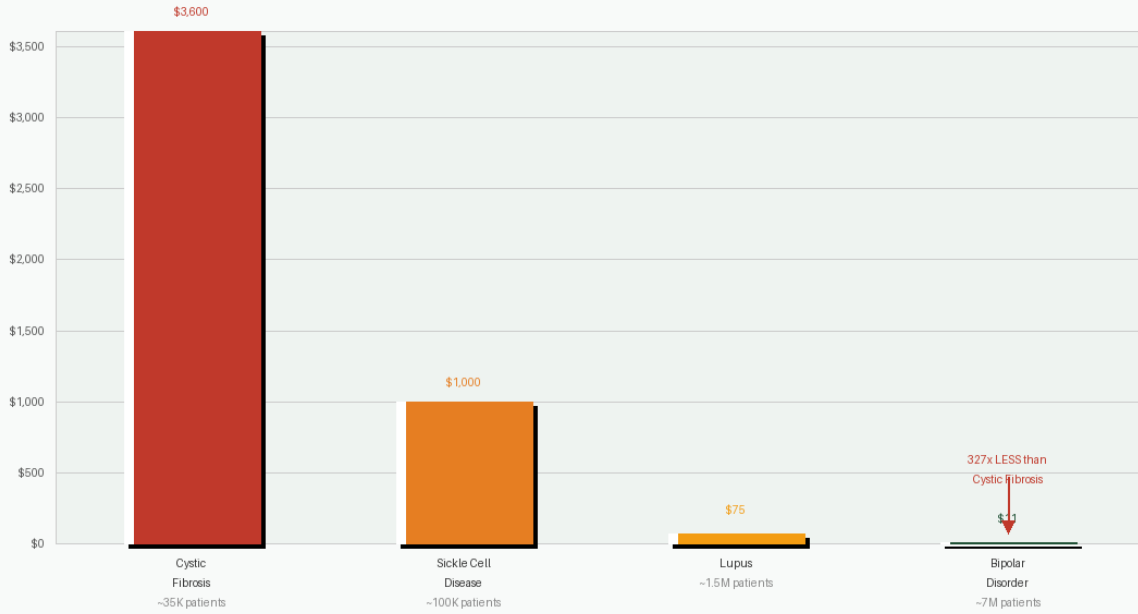
- The Manic Surge Surcharge: Bipolar costs taxpayers twice as much as major depression per individual [11].
- The Incarceration Drain: Every day, we spend \$11 million to incarcerate those with SMI rather than treat them [12].
- The Macro-Economic Reality: When we aggregate Bipolar I, Schizophrenia, and the massive displacement of caregiver productivity (Caregiver Erasure), the true Neglect Tax on the American economy is estimated to exceed \$1.1 Trillion annually [13]. We are already paying for Bipolar Disorder—we are simply paying for the most expensive, least effective treatment possible.

## VI. SHEDDING LIGHT ON FUNDING DISPARITY

The inequality is most glaring when you look at diseases that receive significantly higher federal research funding despite impacting far fewer people. This is the price of stigma.

Condition	Est. U.S. Population Impacted	NIH Funding Per Patient
Cystic Fibrosis	~35,000	\$3,600+
Sickle Cell Disease	~100,000	\$1,000+
Lupus	~1.5 Million	\$75
Bipolar Disorder	7 Million	<b>\$11</b>

## NIH RESEARCH FUNDING DISPARITY: DOLLARS PER PATIENT



Source: NIH Research Portfolio (Approximate figures). This disparity reflects the cost of stigma, not the science.

Source: NIH Research Portfolio (Estimates 2023–2024).

The disparity between Bipolar Disorder (\$11/patient) and conditions like Cystic Fibrosis (\$3,600/patient) reflects the cost of stigma, not science. We aren't asking for new money; we are asking for a reallocation of the Neglect Tax into clinical infrastructure.

## VII. A CALL TO ACTION: JOIN THE SMI PEER ALLIANCE

We are done waiting for the system to change itself. At NSSC, we are turning our lived experience into systemic power. We are inviting those living with Bipolar I, Schizophrenia, and other no-fault brain diseases to join the SMI Peer Alliance at [nsscoalition.org](http://nsscoalition.org) and use the ground-truth of your lived experience to help champion a National Standard of Care.

- WE CAN** mandate medical accountability.
- WE CAN** build clinical oversight into our communities.
- WE CAN** restore the Right to be Well.

I say this not just as a policy expert, but as a woman who lives with Bipolar I. I have stood on the edge of that clinical void, and I am only here today because I was lucky enough to receive treatment. We must stop relying on luck and start relying on a National Standard of Care.

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- [13] The Scale of the Neglect Tax: The \$343B figure represents Schizophrenia alone (Kadakia et al., 2022). When expanded to include Bipolar I and “Caregiver Erasure,” the total burden rises to \$467B (NASMHPD, 2023). Newer macro-economic models accounting for lifetime lost earnings place the ultimate “Neglect Tax” at over \$1.1 Trillion annually (National Bureau of Economic Research [NBER], 2024).

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