Mental Health and Mental Disorders

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PROGRESS REVIEW

In the 15th session in the second series of assessments of *Healthy People 2010*, Anand Parekh, Acting Deputy Assistant Secretary for Health (Science and Medicine), chaired a focus area Progress Review on Mental Health and Mental Disorders. He was assisted by staff of the co-lead agencies for this *Healthy People 2010* focus area, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). Also participating in the review were representatives from other U.S. Department of Health and Human Services (HHS) offices and agencies. Dr. Parekh noted that, not so long ago, the subject of mental health was treated as secondary within the larger conceptual framework of health in general. Despite the lingering stigma that, to a degree, is still associated with mental illness, the connection between physical and mental health is now widely recognized as taking many forms, such as depression and heart disease, for example. Also now accepted is the clear linkage between poor levels of mental health and such co-morbidities as substance abuse. Even now, in the first decade of the 21st century, disparities in mental health status persist among certain racial, ethnic, gender, and age groups, and these must be addressed with greater force and determination if they are to be resolved.

The complete November 2000 text for the focus area of *Healthy People 2010* is available online at **www.healthypeople.gov/document/html/volume2/18mental.htm**. Revisions to the focus area chapter that were made after the January 2005 Midcourse Review are available at **www.healthypeople.gov/data/midcourse/html/focusareas/fa18toc.htm**. Additional data used in the Progress Review for this focus area's objectives and their detailed definitions can be accessed at **wonder.cdc.gov/data2010**. For comparison with the current state of the focus area, the report on the first-round Progress Review (held on December 17, 2003) is archived at **www.healthypeople.gov/data/2010prog/focus18/2003fa18.htm**. The meeting agenda, tabulated data for all focus area objectives, charts, and other materials used in the Progress Review can be found at a companion site maintained by the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS): **www.cdc.gov/nchs/about/otheract/hpdata2010/focusareas/fa18-mentalhealth2.htm**.

Data Trends

In his overview of data for the focus area, Richard Klein of NCHS began by noting the remarkably high prevalence of mental disorders in the United States. According to 2002 data, more than 25 percent of adults aged 18 years and older had at least one mental disorder and approximately 5 percent had three or more. In descending order of prevalence, the four most widespread disorders were anxiety disorders (affecting approximately 18 percent of the population), mood disorders, impulse disorders (among the age group 18 to 44 years), and

substance disorders. With regard to the prevalence of major mental disorders among adults, approximately 5 percent had a serious mental illness (SMI) involving role impairment in 2002, about 6 percent had a major depressive disorder, and about 3 percent had a generalized anxiety disorder. Mental disorders are a leading cause of disability, absenteeism, and lost productivity in the workplace. The cost of treatment for such disorders reached $100 billion in 2003. Moreover, the impact of mental disorders is not limited to the mental sphere. Depression, for example, is associated with the development of hypertension, heart disease, diabetes, and stroke. Mr. Klein then examined in greater detail the objectives highlighted during the Progress Review.

(Obj. 18-1): The age-adjusted rate of suicide increased from 10.5 per 100,000 population in 1999 to 10.9 per 100,000 in 2004. The 2010 target is 4.8 per 100,000 for all population groups. Among five racial and ethnic groups for which data were available, the age-adjusted suicide rate per 100,000 in 2004 was 5.5 among non-Hispanic blacks, 5.8 among Asians/Pacific Islanders, 5.9 among Hispanics, 12.2 among American Indians/Alaska Natives, and 12.9 among non-Hispanic whites. In 2004, the suicide rate for females was 4.5 per 100,000, compared with 18.0 per 100,000 for males. In general terms, higher rates of suicide occur most frequently in the mountainous western States and in Alaska.

(Obj. 18-2): In 1999, 2.6 percent of adolescents in grades 9 through 12 made a suicide attempt that required medical attention, compared with 2.3 percent in 2005. The target is 1.0 percent. The proportion of adolescent males who made such attempts in 2005 was 1.8 percent, compared with 2.9 percent of adolescent females.

(Obj. 18-5): The proportion of adolescents in grades 9 through 12 that engaged in disordered eating behaviors (DEBs) decreased from 19 percent in 2001 to 17 percent in 2005. The target is 16 percent for all groups. Among adolescent males, the proportion that engaged in disordered eating in 2005 was 11 percent, compared with 23 percent of adolescent females.

(Obj. 18-7): The proportion of children aged 4 to 17 years who received services for their serious mental health problems increased from 60 percent in 2001 to 62 percent in 2006. The target is 67 percent for all groups. The proportion of male children who received such services was 64 percent, compared with 58 percent of female children. Among three racial and ethnic groups for which data were available, the proportions of children receiving such services in 2006 were as follows: non-Hispanic white, 66 percent; Hispanic, 54 percent; and non-Hispanic black, 51 percent.

(Obj. 18-4): In 2002, 52 percent of adults aged 18 years and older with SMI were employed (46 percent of females and 60 percent of males). Data on employment of adults with SMI in 2002 by racial and ethnic group were as follows: 54 percent of non-Hispanic whites were employed, as were 50 percent of Hispanics, and 48 percent of non-Hispanic blacks. By achieved level of education, the proportions employed were as follows: 60 percent of adults with SMI who had some college education, 55 percent of adult high school graduates with SMI, and 34 percent of adults with SMI who had not finished high school. The target is 54 percent for all groups.

(Obj. 18-9a): In 2002, 62 percent of adults aged 18 years and older with SMI received treatment for their disorders. The target is 68 percent for all groups. By racial and ethnic group, gender, and education level, the proportions of adults with SMI receiving treatment in 2002 were as follows: non-Hispanic whites, 68 percent; non-Hispanic blacks, 51 percent; Hispanics, 45 percent; females, 70 percent; males, 52 percent; those with at least some college education, 65 percent; high school graduates, 64 percent; and those who had not finished high school, 55 percent.

(Obj. 18-9b): In 2002, 58 percent of adults aged 18 years and older with depression received treatment for their disorder. The target is 64 percent for all groups. By racial and ethnic group, gender, and education level, the proportions of adults with depression receiving treatment in 2002 were as follows: non-Hispanic whites, 63 percent; non-Hispanic blacks, 43 percent; Hispanics, 42 percent; females, 62 percent; males, 52 percent; those with at least some college education, 59 percent; high school graduates, 57 percent; and those who had not finished high school, 56 percent.

(Obj. 18-9d): In 2002, 60 percent of adults aged 18 years and older with generalized anxiety disorder received treatment for their disorder. The target is 79 percent for all groups. By racial and ethnic group, gender, and education level, the proportions of adults with generalized anxiety disorder receiving treatment in 2002 were as follows: non-Hispanic whites, 63 percent; non-Hispanic blacks, 46 percent; females, 63 percent; males, 55 percent; those with at least some college education, 65 percent; those who had not finished high school, 64 percent; and high school graduates, 51 percent.

(Obj. 18-3): The proportion of homeless adults aged 18 years and older with mental health problems who received mental health services increased from 27 percent in 2000 to 41 percent in 2005, then declined to 37 percent in 2006. The target, which was first surpassed in 2002, is 30 percent. The survey population was composed of clients receiving social services through SAMHSA's Projects for Assistance in Transition from Homelessness program.

(Obj. 18-6): The proportion of primary care facilities funded by the HHS Health Resources and Services Administration that provide mental health treatment increased from 62 percent in 2000 to 79 percent in 2006, surpassing the target of 68 percent.

(Obj. 18-11): The proportion of counties served by community-based jail diversion programs and/or mental health courts for adults with mental health problems increased from 6.9 percent in 2004 to 10.6 percent in 2006, surpassing the target of 7.6 percent.

Of the 17 objectives and subobjectives comprised by the focus area, 3 have met or exceeded their targets, 2 are improving, 1 is receding from its target, 5 show little or no change from the baseline, and 6 have only baseline data.

Key Challenges and Current Strategies

In presentations that followed the data overview, the principal themes were introduced by Kana Enomoto, Principal Senior Advisor to the Administrator/SAMHSA; Richard Nakamura, Deputy Director, National Institute of Mental Health (NIMH)/NIH; and Kathryn Power, Director, Center for Mental Health Services (CMHS)/SAMHSA. Their statements and Progress Review briefing materials identified a number of barriers to achieving the objectives, as well as activities under way to meet these challenges, including the following:

Barriers

- The HHS Agency for Healthcare Research and Quality reported recently that almost one in four stays in U.S. community hospitals (or over 7 million stays) by patients aged 18 years and older involved depression, bipolar disorder, schizophrenia, or other mental or substance abuse disorders.
- Emerging factors that contribute to the prevalence of mental disorders in the United States include an aging population and the large proportion of

veterans returning from Iraq and Afghanistan with post-traumatic stress disorder, depression, and anxiety.

- According to an NIMH-funded study, half of all lifetime occurrences of mental disorders begin by age 14 and three-quarters by age 24. Despite the existence of effective treatments for many disorders, long delays—sometimes for decades—typically occur between the first onset of symptoms and the point at which individuals seek and receive treatment. Mental disorders often have their roots in childhood trauma which, if left untreated, can result in family and school problems, violence, and suicide.
- In 2004, suicide was the 11th overall cause of death in the United States and the 8th leading cause of death for males. Research suggests there may be between 8 and 25 suicide attempts for every suicide death. As with suicide deaths, risk factors for attempted suicide in adults include depression and substance abuse.
- Adolescents who have died by suicide commonly have a history of depression, a previous suicide attempt, a family history of psychiatric disorders (especially depression and suicidal behavior), family disruption, and certain chronic or debilitating physical disorders or other psychiatric illnesses. Substance abuse and disruptive behavior disorders are common among adolescent male suicide decedents. Suicide accounts for 12 percent of deaths in the age group 10 to 24 years.
- All DEBs fall on a spectrum that encompasses varying combinations of negative body image, binge-eating, and unhealthy forms of weight management, such as restrictive dieting, self-induced vomiting after eating, and abuse of laxatives, diuretics, diet pills, and exercise. DEBs such as anorexia nervosa and binge-eating disorder are on the severe end of the spectrum. Bulimia affects 1 to 2 percent of middle and high school girls, and anorexia nervosa 0.2 to 5.0 percent of that group. Rates are considerably lower for boys, but data suggest that the prevalence for adolescent boys has been increasing.
- Research strongly suggests that most youth held in custody in juvenile justice facilities meet the criteria for at least one mental disorder and that at least one out of every five has what is considered to be a serious emotional disorder, often in conjunction with a co-occurring substance abuse disorder.
- As many as 700,000 people in the United States may be homeless, of whom an estimated 20 to 25 percent have SMI and about one-half have an alcohol or drug abuse problem.
- Disparities in access and quality of mental health care reflect a complex set of factors, including differential patterns of insurance coverage, or lack of coverage for members of minority groups; the stigmatizing perception that minority males are dangerous; and the inadequate availability of community-based mental health services, particularly in urban areas.

Activities and Outcomes

- Under the leadership of the U.S. Surgeon General, the HHS National Strategy for Suicide Prevention (NSSP) has brought together a variety of disciplines and perspectives to create a system of interventions targeted at multiple levels of society, such as the family, the individual, schools, the community, and the healthcare system. The NSSP is guided by a comprehensive set of goals and objectives that integrate Federal, State, and local government efforts with those of nonprofit and community-based organizations to address suicide prevention at all levels.
- Through the Mental Health Transformation State Infrastructure Grants, CMHS funded seven States in 2005 to strengthen their mental health services infrastructure.

- To help address the issue of male veterans' twofold greater risk of dying by suicide as compared with the risk for non-veteran males, SAMHSA recently concluded an interdepartmental agreement with the Department of Veterans Affairs (VA) to make its national suicide hotline available to all veterans. SAMHSA is also exploring options with the Department of Defense for assisting active duty military personnel and their families in accessing telephone crisis counseling and referrals.
- Using data collected by NCHS, the Federal Interagency Forum on Child and Family Statistics has adopted a National Child Mental Health Measure, an indicator intended to provide a national prevalence measure for serious emotional disturbance and behavioral problems on an annual basis.
- By providing job coaching, transportation, assistive technology, specialty training, and individually tailored supervision, a component of rehabilitation services referred to as supported employment has shown considerable success in helping people with SMI move into jobs and retain those jobs for extended periods. A SAMHSA/CMHS toolkit developed to help disseminate this intervention to the field is available at **mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment**.
- The landmark Institute of Medicine report, *Improving the Quality of Health Care for Mental and Substance Use Conditions* (2006), has had a significant impact in promoting collaborative care between the mental health and substance abuse fields. Efforts are under way to implement the report throughout each of these fields.
- A recent initiative undertaken by NIMH addresses the problem of trauma-related mental disorders in high-risk occupations, such as first responders, military personnel, and disaster relief volunteers.
- Advances in neuroscience and neurobiology are creating new opportunities for developing fast-acting antidepressant drugs. One recently tested medication led to dramatic improvement in clinical depression within 24 hours. Cognitive-behavioral psychotherapy also improves depression and reduces the risk of illness relapse.
- Recent studies indicate that individuals at high risk for psychotic illness can be reliably identified before symptoms appear. Ongoing research raises the hope that early intervention during the precursor stages of schizophrenia may slow the cognitive decline and disability so often associated with this illness.
- Between 2002 and 2005, the number of States that monitor consumer satisfaction with mental health services increased from 34 to 46 (inclusive of the District of Columbia).

Approaches for Consideration

Participants in the Progress Review made the following suggestions for public health professionals and policymakers to consider as steps to enable further progress toward achievement of the objectives for Mental Health and Mental Disorders:

- Ensure that early intervention efforts to protect and promote mental health, including screening and the promotion of mental health awareness, become an essential component of primary care visits and school health assessments.
- Because mental health difficulties often present initially as physical problems, encourage pediatricians, family practitioners, and family care physicians to conduct screening for symptoms of mental illness. Screening is particularly needed for depression and anxiety disorders, which are among

the most prevalent and often debilitating mental illnesses, but which have been relatively neglected in the past.

- Using community health centers as a possible starting point, pursue development of a national data source to capture information on mental health screening activities by primary care physicians.
- Given that the majority of persons with chronic diseases such as diabetes and heart disease also suffer from depression, which can exacerbate the course of these disorders if untreated, promote appropriate screening for depression in populations that suffer from chronic diseases.
- Increase the emphasis on identifying persons with elevated levels of mental disorder symptoms that do not yet meet diagnostic criteria, because mental health symptoms occupy a continuum, but mental disorder diagnostic criteria are either "met" or "not met."
- Increase research to find ways to mitigate the drawbacks and side effects of drugs used for treating mental disorders.
- Strive to a greater degree to make consumers of mental health services active participants in their own care.
- Seek to develop measures to better identify components of successful treatment of mental disorders and to chart progress along the pathway of recovery from the many forms that mental illness can take.
- Direct additional research toward identifying the biochemical and behavioral markers indicative of schizophrenia in its precursor stage.
- Endeavor to identify and mitigate the factors that act as impediments to the reception of mental health services, including any limitations on employer-based health insurance coverage.
- In planning and implementing programs and activities relating to the provision of mental healthcare services, ensure that appropriate emphasis is accorded to the importance and influence of life-changing events in shaping an individual's mental health status.
- Devote greater attention and resources to the challenge of meeting the mental health needs of returning war veterans.
- Broaden and intensify the collaboration of HHS components in programs and activities to meet the mental health needs of the American people.

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[Signed February 21, 2008]

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