Mental Health and Mental Disorders

U.S. Department of Health & Human Services • Public Health Service

December 17, 2003

PROGRESS REVIEW

In the 16th in a series of assessments of *Healthy People 2010,* Acting Assistant Secretary for Health Cristina Beato chaired a focus area Progress Review on Mental Health and Mental Disorders. Dr. Beato noted that President George W. Bush has made mental health a priority of his administration, as evidenced by the establishment of the New Freedom Commission on Mental Health. The recommendations of the Commission's Final Report, as well as the National Strategy for Suicide Prevention and other programs of the U.S. Department of Health and Human Services (HHS), will contribute to the transformation of the mental healthcare system and to the advancement of mental health as a vital component of the overall health and well-being of the nation. In conducting the review, Dr. Beato was assisted by staff of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health, the co-lead agencies for this *Healthy People 2010* focus area. Also participating were representatives of other HHS offices and agencies.

Charles Curie, Administrator of SAMHSA, expanded on Dr. Beato's remarks about the New Freedom Commission by outlining SAMHSA's plans to take transformative steps to improve the nation's mental healthcare system in line with the 6 goals and 19 recommendations contained in the Commission's Report. The President and HHS Secretary Tommy G. Thompson had charged SAMHSA with assessing the Commission's recommendations and delineating the role of the Federal Government. Many of the report's goals and recommendations correspond closely with objectives of *Healthy People 2010* (e.g., to prevent suicide and to increase employment of people who have mental illness). SAMHSA is already working with other Federal agencies in a synergistic approach to providing state partners with the flexibility and incentives needed to exert the full force of resources available for improving the lives of people with mental disorders.

The complete text for the Mental Health and Mental Disorders focus area of *Healthy People 2010* is available at **www.healthypeople.gov/document/html/volume2/18mental.htm**. The meeting agenda, data presentation (tables and charts), and other materials for the Progress Review can be found at **www.cdc.gov/nchs/about/otheract/hpdata2010/focusareas/fa18-mentalhealth.htm**.

Data Trends

Edward Sondik, Director of the National Center for Health Statistics, presented an overview of data that define the status of selected objectives in this focus area. Indicating the magnitude of mental health-related issues, Dr. Sondik noted that mental illness ranks first among illnesses that cause disability in the United States, Canada, and Western Europe. Of $1 trillion spent on health care in the United States in 1997, $71 billion went toward the direct costs of treating mental illness. Dr. Sondik devoted particular attention to five *Healthy People 2010* objectives: two that are indicators of mental health status, one that concerns the expansion of resources for treatment, and two that relate to state activities.

HEALTHY PEOPLE 2010

In 2001, the age-adjusted rate of suicide for the total population was 10.7 per 100,000, a slight increase from the 1999 rate of 10.5. In terms of gender, males died by suicide at roughly 4½ times the rate of females in 2001 (18.1 compared with 4.0 per 100,000). Among males, firearms were the leading suicide modality in 2001 for all age cohorts for whom data were available, except those from 10 to 14 years of age. In that age group, among whom suicide is the third leading cause of death, suffocation was the predominant modality for both males and females. Firearms accounted for less than 40 percent of suicides in all age cohorts of females, whereas poisoning accounted for a much larger proportion of female suicides at all life stages above 10 years of age than it did for comparable age cohorts of males. Of five racial and ethnic groups, non-Hispanic whites had the highest rate of suicide in 2001 (12.5 per 100,000, age-adjusted), followed by American Indians/Alaska Natives at 10.6 per 100,000. Asians/Pacific Islanders, Hispanics, and blacks had rates less than 6 per 100,000 in 2001. Among people 15 to 17 years of age, American Indians/Alaska Natives died by suicide in 2001 at a rate of more than 14 per 100,000, which is more than twice the rate for the total population in that age group. The highest rates of suicide in 2001 (13.0 to 19.8 per 100,000) generally occurred in the western mountain states, Alaska, and Florida. The 2010 target rate for suicide is 5.0 per 100,000 (Obj. 18-1).

Suicide attempts are more common than suicide deaths. According to a 2001 survey of students in grades 9 through 12, 2.6 percent reported a suicide attempt in the preceding year that required medical attention. The rate for female students (3.1 percent) was about 50 percent higher than that for male students (2.1 percent). By gender, race, and ethnicity, the highest rate of suicide attempts was recorded for Hispanic females, the second highest for black males. The target is 1.0 percent (Obj. 18-2). Major depression is associated with suicide attempts. Data collected during the period 1988–1994 show that women in the age group 17 to 39 years reported having experienced at least one major episode of depression at a rate of 11.2 percent, almost twice the rate (6 percent) of men in the same cohort.

In 1998, 64 percent of juvenile justice facilities screened new admissions for mental health problems. A target has yet to be set for the objective (18-8) to increase the proportion of such facilities that do so. In preliminary data for 2003, 39 states and the District of Columbia reported tracking consumers' satisfaction with the mental health services they receive, up from 36 entities in 1999. The target is 51 (Obj. 18-12). In 2002–2003, 21 states and the District of Columbia reported having an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for older people, a decrease from the 24 entities that had such a plan in 1997. The target is 51 (Obj. 18-14).

Key Challenges and Current Strategies

In the presentations that followed the discussion of data, the principal discussants were Thomas Insel, Director of NIH's National Institute of Mental Health (NIMH), and Kathryn Power, Director of SAMHSA's Center for Mental Health Services. Participants in the review identified a number of obstacles to achieving the objectives and discussed activities under way to meet these challenges, including the following:

- Until now, the major points of contact with people who have mental illness have too often consisted of homeless shelters, the criminal justice system, and the welfare system, thus depriving many individuals with mental disorders of the opportunity for diagnosis and treatment.
- About 30,000 deaths from suicide are said to occur each year in the United States, and this figure may seriously underestimate the actual total.

- Suicide deaths are undercounted for many reasons, including the stigma attached to suicide and the variable standards of training and performance for coroners and medical examiners who complete death certificates.
- In the United States and other industrialized nations, about 90 percent of suicides are associated with mental illness, including alcohol and substance abuse disorders.
- The risk for suicide goes up as immigrant groups become more acculturated in the United States, possibly reflecting the erosion of familial protective factors accompanied by an increasing intensity of cultural clashes.
- CDC efforts to expand the National Violent Death Reporting System beyond the current 13 states may appear to increase rates of suicide because of more accurate classification of deaths that would have been misclassified previously.
- SAMHSA is creating a public/private alliance to oversee and govern the National Strategy for Suicide Prevention and is funding a national suicide prevention resource center.
- In fiscal year (FY) 2003, NIMH support for suicide research totaled about $26 million, an amount that will increase in FY 2004 with the funding of several developing centers on interventions for suicide prevention. Most suicide prevention research has focused on treating people at high risk for suicide (i.e., those with a mental disorder who have made a recent suicide attempt). Approximately 40 percent of people who die by suicide have made a prior suicide attempt.
- SAMHSA is working with the National Association of State Mental Health Program Directors to develop a Uniform Reporting System (URS) so that all states will be able to use common measures and definitions in providing consistent mental health data that can be aggregated into a national database. The URS will include data for children in age groups from 0 to 3, 4 to 12, and 13 to 17 years. Heretofore, national surveys have not covered children younger than 12 years.
- Bipolar disorder, schizophrenia, depression, and autism, among other mental disorders, are characterized in part by distinctive organic changes in the brain. Research in this area may open new pathways to treatment and prevention.
- In the past two decades, new medications have been developed, such as SSRIs (selective serotonin re-uptake inhibitors) for depression and atypical antipsychotics for schizophrenia. These medications control many of the more troubling symptoms of mental illnesses.

Approaches for Consideration

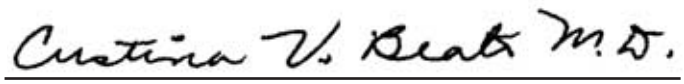
During the review, the following suggestions were made for steps to bring about further progress toward achievement of the objectives:

- Increase research on both the risk-enhancing and the protective effects of culture in regard to suicide rates among racial and ethnic groups, including the testing of interventions to reduce both depression and proneness to suicide.
- Focus more intently on suicide prevention interventions among population groups at highest risk (e.g., older white males, 70 percent of whom had seen a physician within 1 month of committing suicide).
- Provide incentives for physicians to make mental health assessment a routine part of their physical examinations of patients.
- Explore new approaches in the provision of mental health services, applying lessons learned and successful models from other fields of health care.
- Ensure that cultural competency on the part of providers is incorporated into mental health service programs at all levels.

- Give greater attention to the role of spirituality as a component of mental health.
- Seek greater understanding of the long-term effects of medications prescribed to young children.
- To reduce the perceived stigma associated with mental disorders, encourage wider use of group practice settings that include the provision of both physical and mental health services.
- Strive to improve coordination across primary health care and mental health care systems for the greater benefit of the patients served.

Contacts for information about *Healthy People 2010* focus area 18—Mental Health and Mental Disorders:

- Substance Abuse and Mental Health Services Administration—Nancy Brady, nbrady@samhsa.gov
- National Institutes of Health—Lisa Colpe, lisa.colpe@nih.hhs.gov
- Office of Disease Prevention and Health Promotion (coordinator of the Progress Reviews)—Sue Martone (liaison to the focus area 18 workgroup), smartone@osophs.dhhs.gov



Cristina V. Beato, M.D.
Acting Assistant Secretary for Health