

Mental Health and Substance Abuse

Measures

- Process: Treatment for depression
- Outcome: Suicide deaths
- Process: Treatment for illicit drug use or alcohol problem
- Process: Completion of substance abuse treatment
- Outcome: Emergency department visits with a principal diagnosis related to mental health, alcohol or substance abuse, by age and income

Treatment for Depression

- Treatment for depression can reduce symptoms and associated illnesses and return individuals to a productive lifestyle.
- Sequenced Treatment Alternatives to Relieve Depression (STAR*D) studied treatment:
 - Funded by the National Institute of Mental Health.
 - Involved both primary care and specialty care settings.
 - Included people with complex health conditions, such as multiple concurrent medical and psychiatric conditions.
 - Was the largest clinical trial ever of depression treatment.
 - Found that 28% to 33% of participants were symptom free after the first round of medication, and nearly 70% achieved remission after 12 months (Insel & Wang, 2009).
- Cost-benefit analyses show that compared with usual care, strategies for treating depression in primary care settings, such as the collaborative care model, have produced positive net social benefits (Glier, et al., 2010).

Outcomes of Treatment for Depression

- About 50% to 60% of patients have symptoms even after adequate first-line treatment for depression.
- Patients' thinking and behavior play a huge role in determining outcomes, making them candidates for psychosocial treatment.
- Evidence-based psychological therapies can help patients overcome interpersonal difficulties, health beliefs, stigmas, medication nonadherence, anhedonia (inability to feel pleasure), and rumination.
- Psychological therapies can help modify health beliefs, treat comorbid anxiety and other disorders, and incorporate environmental and contextual factors, thus enabling patients to facilitate their recovery (Casey, et al., 2013).

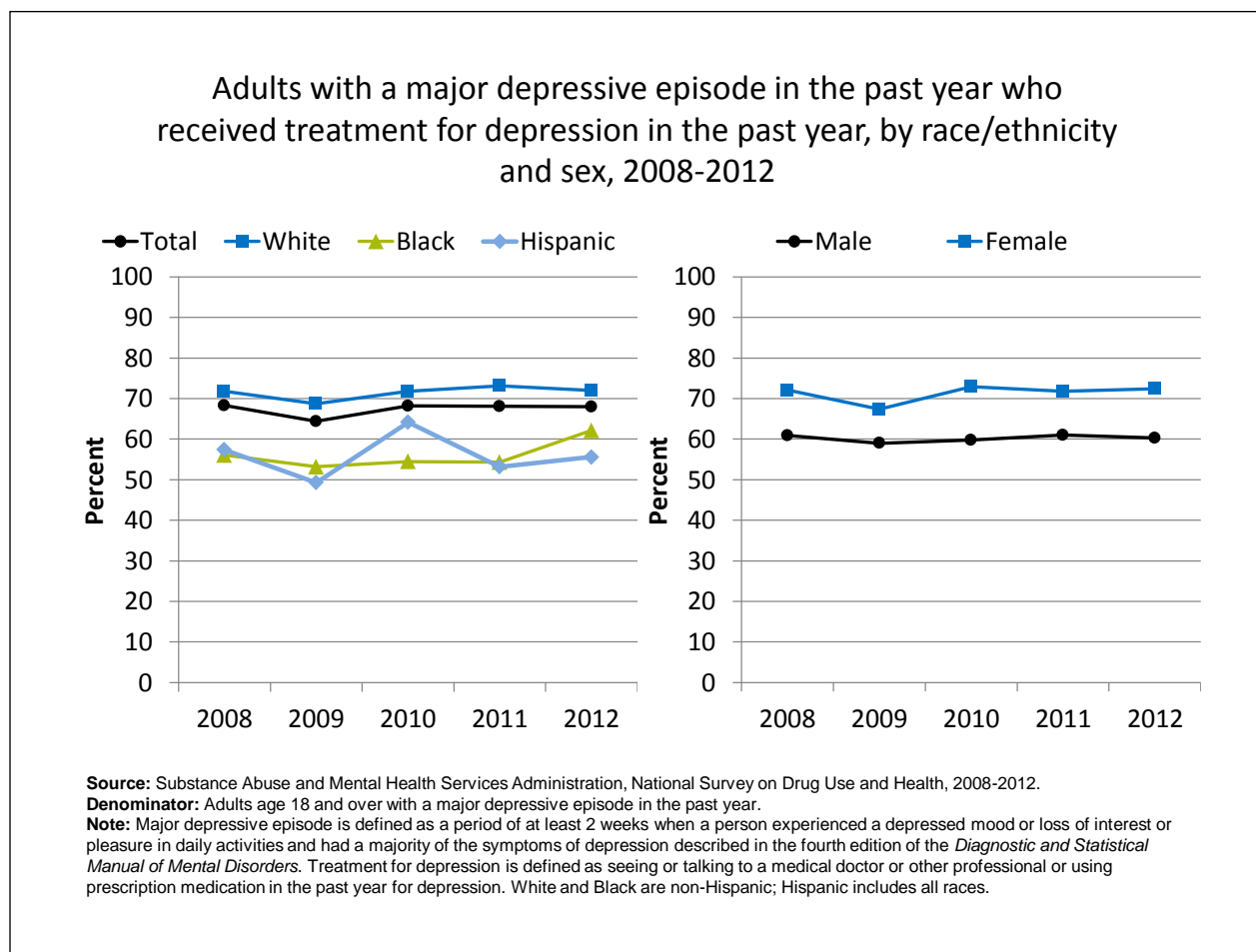
Barriers to High-Quality Mental Health Care

- Barriers to high-quality mental health care include:
 - Cost of care,
 - Lack of sufficient insurance for mental health services,
 - Discrimination and negative attitudes toward mental health problems,

- Fragmented organization of services, and
- Mistrust of providers.
- In rural and remote areas, limited availability of skilled care providers is also a major problem.
- For racial and ethnic populations, lack of culturally and linguistically competent providers is a major barrier.

Receipt of Treatment for Depression

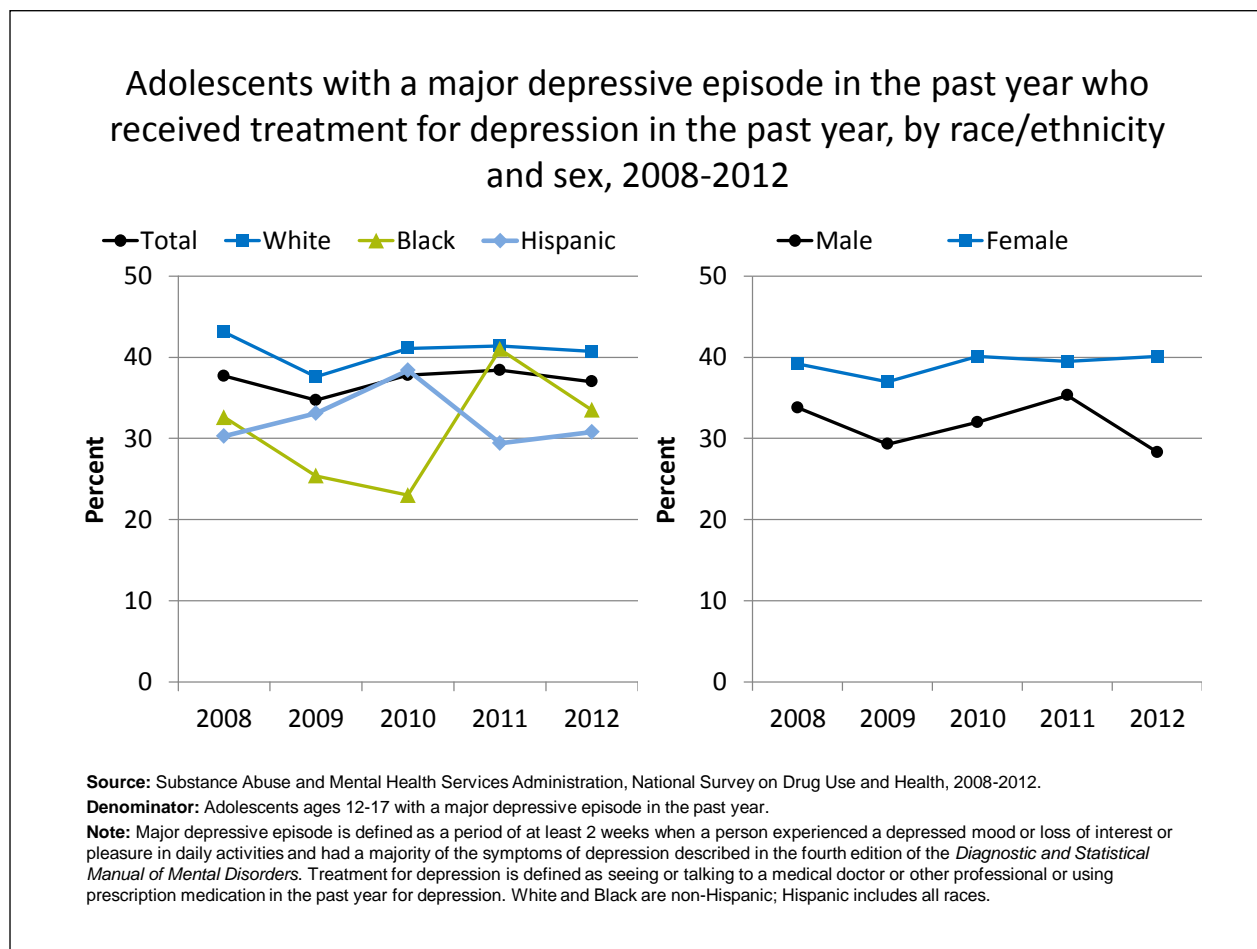
Adults



- **Importance:** The United States Preventive Services Task Force (USPSTF) recommends screening adults for depression when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and followup (USPSTF, 2015a).
- **Overall Rate:** In 2012, 68% of adults with a major depressive episode received treatment for depression.
- **Groups With Disparities:**
 - In all years, Black adults with depression were less likely than White adults to receive treatment.

- In every year except 2010, Hispanic adults with depression were less likely than White adults to receive treatment.
- From 2008 to 2012, females with a major depressive episode were more likely than males to receive treatment.

Adolescents



- **Importance:**
 - Outpatient mental health treatment and psychotropic medication use in children and adolescents increased in the United States between 1996-1998 and 2010-2012. Although youths with less severe or no impairment accounted for most of the absolute increase in service use, youths with more severe impairment had the greatest relative increase in use, yet less than half accessed services in 2010-2012 (Olfson, et al., 2015).
 - The United States Preventive Services Task Force (USPSTF) recommends screening of adolescents ages 12-18 years for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and followup (USPSTF, 2015b).
- **Overall Rate:** In 2012, 37% of adolescents with a major depressive episode received treatment for depression.

- **Groups With Disparities:**

- In 3 of 5 years (2008, 2009, and 2010), Black adolescents with depression were less likely than White adolescents to receive treatment.
- In 3 of 5 years (2009, 2010, and 2012), females with depression were more likely than males to receive treatment.

Suicide Deaths

- Suicide may be prevented when its warning signs are detected and treated.
 - The growing use of standardized screening instruments and electronic medical records will likely increase clinicians' ability to identify suicidal ideas and plans among individuals being treated for depression.
 - A recent study found that about half of people who died by suicide made a health care visit within 4 weeks of death. Only 24% had a mental health diagnosis (Ahmedani, et al., 2014).

Probability of Suicide

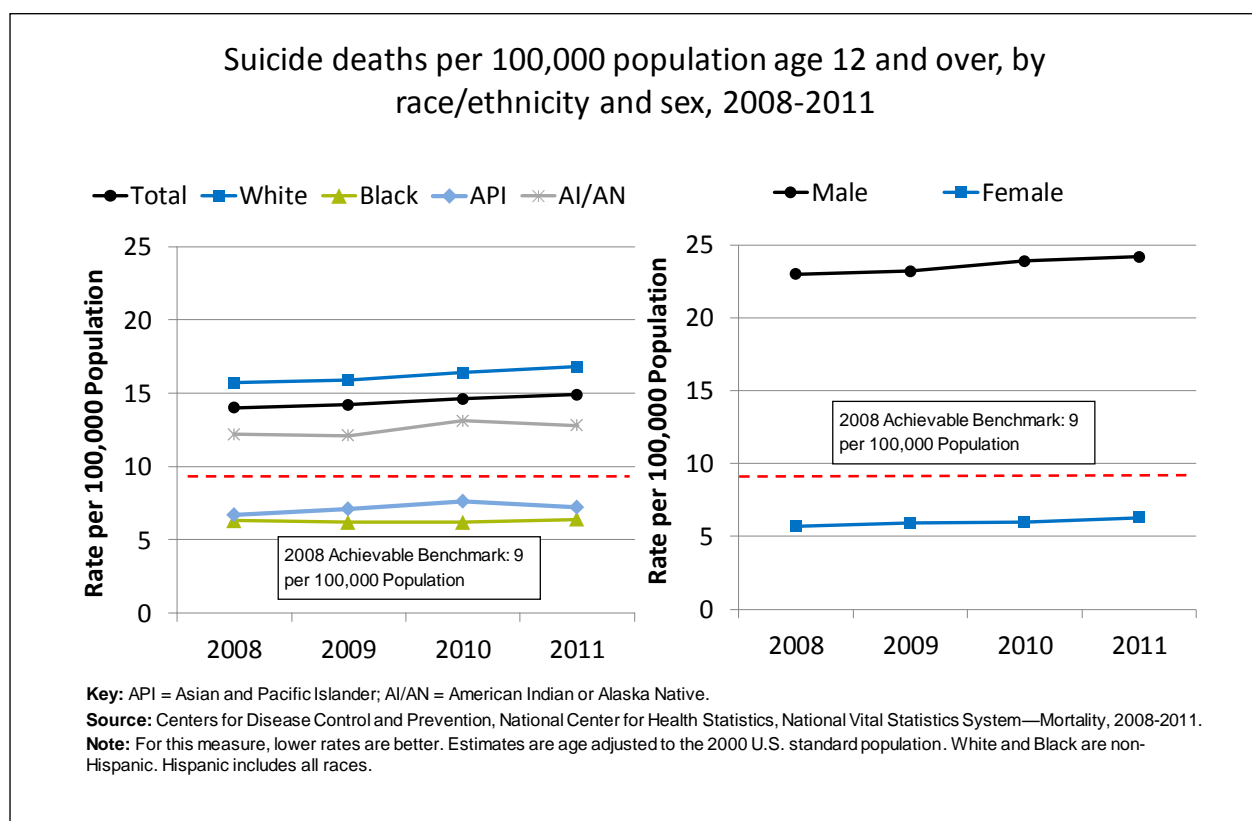
- Risk factors for suicide include:
 - Psychotic experiences:
 - ◆ Individuals with psychotic experiences are about 5 times more likely to report suicidal ideation and nearly 10 times more likely to report a suicide attempt (DeVylder, et al., 2015). Assessing psychotic experiences among individuals with suicidal ideation could reduce suicide attempts.
 - Suicidal ideation:
 - ◆ Progression from ideation to suicide attempt varies by suicide plan and major depression status.
 - ◆ Research needs to explore factors that affect suicide attempts and death by suicide among high-risk individuals with suicidal ideation (Han, et al., 2015).
 - ◆ About 13% of suicidal ideators in a given year attempt suicide during that year. Suicidal ideation is the strongest known clinical predictor for death by suicide (Han, et al., 2015).
 - Positive responses to the item "Thoughts that you would be better off dead, or of hurting yourself in some way" on the Patient Health Questionnaire for depression (Simon, et al., 2013).

Suicide Prevention

- Suicide prevention is multifaceted, including:
 - Educating physicians and keeping lethal weapons away from suicidal people (Mann, et al., 2005).
 - Using cognitive-behavioral therapy (Tarrier, et al., 2008).

- Implementing various strategies depending on risk:
 - ◆ Universal strategies that target entire populations (e.g., public education and awareness programs),
 - ◆ Selective strategies that address at-risk populations (e.g., peer “natural helpers” and accessible crisis services), and
 - ◆ Indicated strategies that address specific high-risk individuals (e.g., case management and parent support programs) (Nordentoft, 2011).
- Ongoing research shows promising results for Internet-based cognitive-behavioral therapy and psychoeducation in treating individuals with conditions such as mood, eating, and sleep disorders (Thorndike, et al., 2013).
- As “mobile health” interventions become more sophisticated, they can be adapted to be culturally specific and sensitive (Burns, et al., 2013).

Suicide Death Rate



- **Overall Rate:** In 2011, the overall suicide death rate was 14.9 per 100,000 population age 12 and over.
- **Trends:** From 2008 to 2011, the suicide death rates worsened for the total population, Whites, and both sexes.

- **Groups With Disparities:**

- From 2008 to 2011, Blacks, Asians and Pacific Islanders, and American Indians and Alaska Natives had lower suicide death rates than Whites.
- In all years, males had higher suicide death rates compared with females.
- In all years, people living in medium metropolitan, small metropolitan, micropolitan, and noncore areas had higher suicide death rates compared with people living in large fringe metropolitan areas (data not shown). For more information on suicide death rates by geographic location, refer to the Rural Health Reform Policy Research Center 2014 *Update of the Rural-Urban Chartbook*, available at <https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf>.

- **Achievable Benchmark:**

- The 2008 top 5 State achievable benchmark was 9 suicide deaths per 100,000 population. The top 5 States that contributed to the achievable benchmark are Connecticut, District of Columbia, Massachusetts, New Jersey, and New York.
- APIs, Blacks, and females have achieved the benchmark.
- The total population, AI/ANs, Whites, and males are moving away from the benchmark.

Treatment for Substance Abuse Disorders

- Substance abuse disorders can lead to:
 - Addiction.
 - Increased risk of certain cancers.
 - Damage to the liver, brain, and other organs.
 - Birth defects, such as fetal alcohol spectrum disorders.
 - Increased risk of death from car crashes and other injuries.

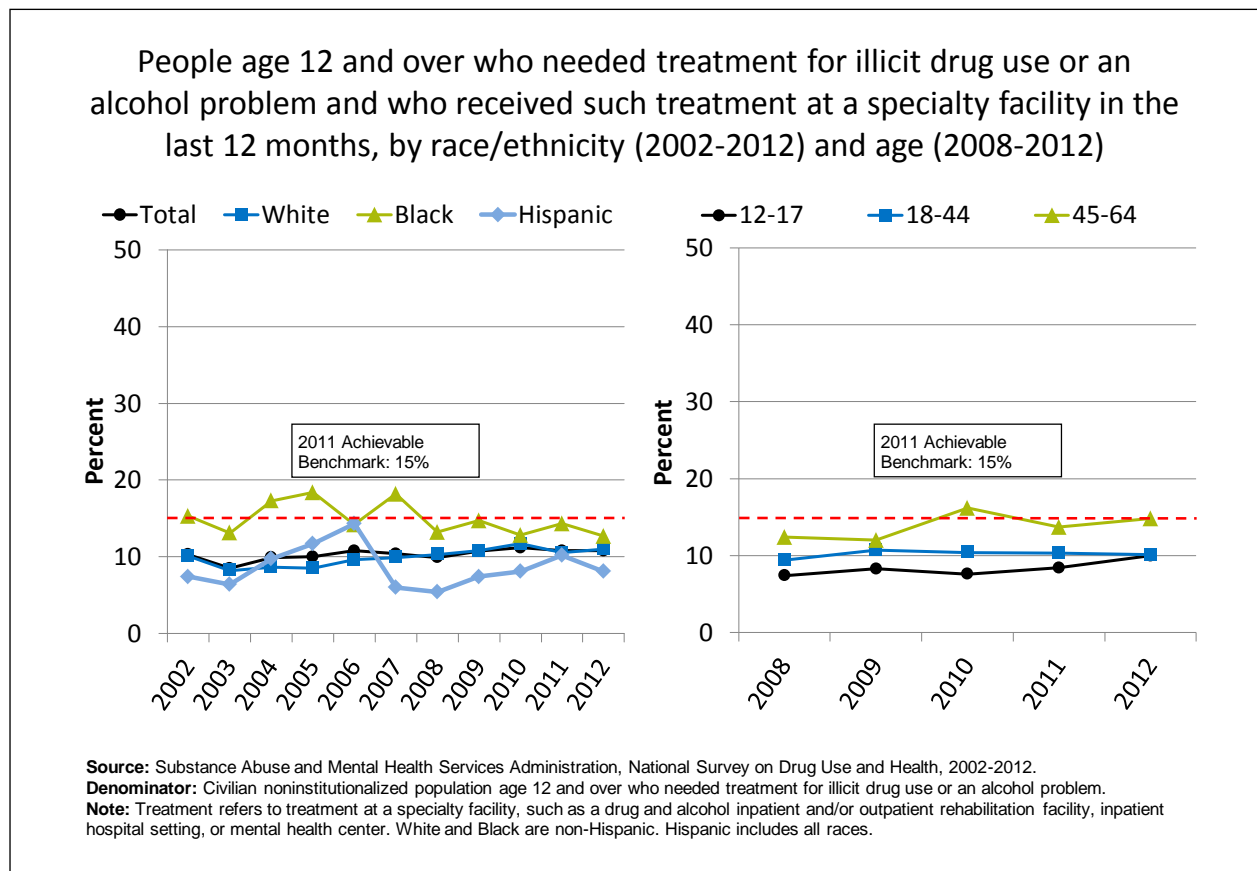
Importance of Treatment

- In 2011, about 2.5 million emergency department (ED) visits resulted from medical emergencies involving drug misuse or abuse:
 - 1.25 million involved illicit drugs,
 - 1.24 million involved nonmedical use of pharmaceuticals, and
 - 0.61 million involved drugs combined with alcohol (SAMHSA, 2014).
- Substance abuse disorders can be effectively treated at specialty facilities.

Treatment Needs

- In 2013, nearly 23 million Americans age 12 years and over needed treatment for substance abuse.
- An estimated 2.5 million people received treatment at a specialty facility (hospital [inpatient], drug or alcohol rehabilitation [inpatient or outpatient], or mental health center), but more than 20 million people who needed this type of treatment did not receive it (SAMHSA, 2014).

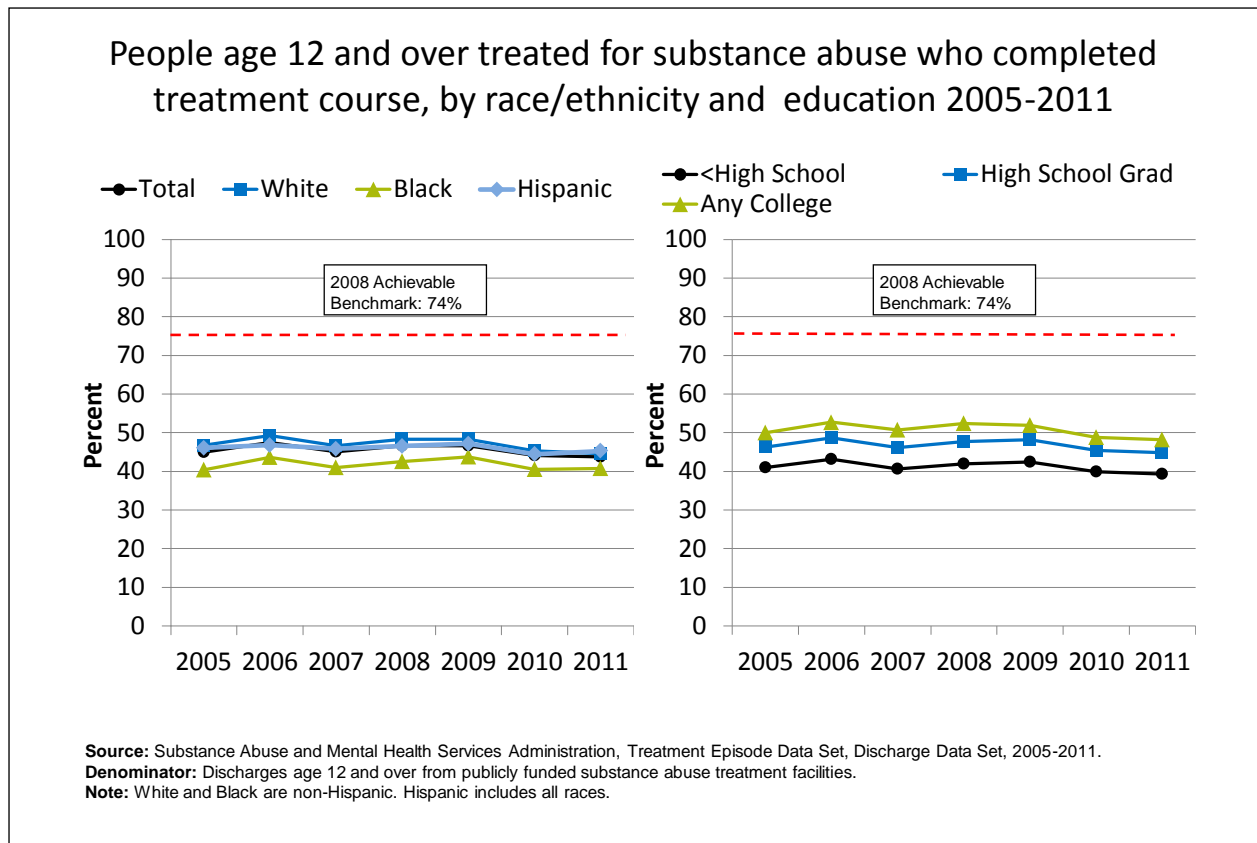
Receipt of Substance Abuse Treatment



- **Overall Rate:** In 2012, only 10.8% of people age 12 and over who needed treatment for illicit drug use or an alcohol problem received such treatment at a specialty facility in the last 12 months.
- **Groups With Disparities:** From 2002 to 2012, there were no statistically significant differences by race/ethnicity; and from 2008 to 2012, there were no statistically significant differences by age.
- **Achievable Benchmark:**
 - The 2011 top 5 State achievable benchmark was 15%. The top 5 States that contributed to the achievable benchmark are Alabama, Alaska, Delaware, Maryland, Oregon, and Utah.
 - At the current rate, the total population would need 30 years to achieve this benchmark. People ages 12-17 would take 9 years, while people ages 18-44 would take 49 years. It would take people ages 45-64 less than 1 year to achieve the benchmark. Whites could achieve the benchmark in 15 years while Blacks and Hispanics are moving away from the benchmark.

Process: Completion of Substance Abuse Treatment

- For patients receiving treatment for substance abuse, studies have shown that increased length of treatment correlates with improved outcomes (McLellan, et al., 1996), such as long-term abstinence.
- Dropout from treatment often leads to relapse and return to substance use.



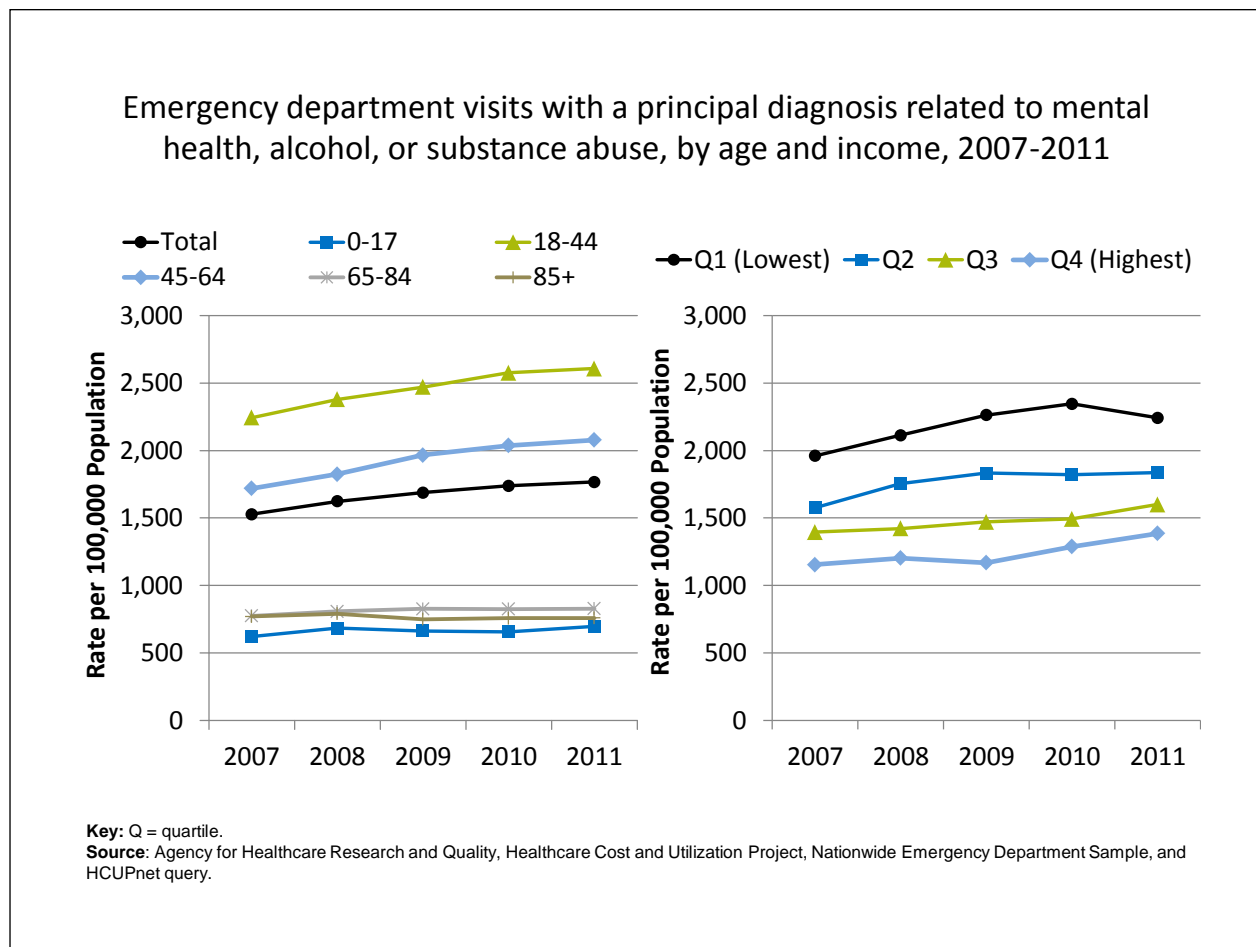
- **Overall Rate:** In 2011, 43.7% of people age 12 and over treated for substance abuse completed their treatment course.
- **Groups With Disparities:**
 - In 4 of 7 years, Blacks who were treated for substance abuse were significantly less likely than Whites to complete treatment.
 - In all years, people with less than a high school education who were treated for substance abuse were less likely than people with any college education to complete treatment.
- **Achievable Benchmark:**
 - The 2008 top 5 State achievable benchmark was 74%. The top 5 States that contributed to the achievable benchmark are Colorado, Connecticut, District of Columbia, Mississippi, and Texas.
 - No group showed progress toward the benchmark.

Potentially Avoidable Emergency Department Visits

- About one in three individuals has had a mental health or substance abuse (MHSA) condition within the last 12 months.
- In 2007, 12 million ED visits involved a diagnosis related to MHSA, accounting for 12.5% of all ED visits in the United States.

- Health care providers are concerned about the rise in ED visits for MHSA, as ED overcrowding can reduce quality of care and increase the likelihood of medical error (Owens, et al., 2010).

Outcome: Emergency Department Visits Related to Mental Health and Substance Abuse



- Overall Rate:** From 2007 to 2011, the overall rate of ED visits with a principal diagnosis related to mental health, alcohol, or substance abuse significantly increased from 1,527.8 to 1,766.8 per 100,000 population.
- Groups With Disparities:**
 - In all years, individuals ages 0-17 and 65 and over were significantly less likely to have an ED visit with a principal diagnosis related to mental health, alcohol, or substance abuse than individuals ages 18-44.
 - In 2011, individuals in the highest income quartile were less likely to have an ED visit with a principal diagnosis related to mental health, alcohol, or substance abuse than individuals in all other income groups.
 - For more ED measures for mental health and substance use disorders, refer to the 2014 Care Coordination chartbook at <http://www.ahrq.gov/research/findings/nhqrd/2014chartbooks/carecoordination/index.html>.

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