SAMHSA's Latest Report on the Nation's Mental Health

Every two years since 1980 the Substance Abuse and Mental Health Services Administration (SAMHSA) has published a new volume in the *Mental Health, United States* series. The latest report, *Mental Health, United States, 2010,* compiles statistics from 35 data sources on the mental health of Americans, on service providers and settings, and on payers and payment mechanisms. As the nation implements health reform and parity, the need to monitor the service delivery system by collecting accurate data and conducting more targeted research is particularly pressing, the report notes.

In this regard, Section 6 of the 350-page report describes key gaps in available data sources and identifies areas in which further study is indicated. The authors note that despite the strengths of the data sources used to compile the report, the nation lacks a robust public health surveillance system that can track over time the population's overall mental health status; capacity of, access to, and receipt of treatment; and the degree to which the need for treatment is met. Existing surveillance systems that track other diseases, such as HIV-AIDS, could serve as examples for mental health.

Recovery from mental illness is an area singled out for more research. Data are needed to monitor and track mental illness from the onset of a person's symptoms through the period of recovery. Surveillance data are also needed for people in vulnerable subpopulations, the report notes. No reliable national or subnational-level data are available to monitor the mental health of children, people who are homeless, military families, and people in jails and prisons. As health care reforms broaden access in the next few years, researchers will also need to assess gaps in treatment capacity. This entails collecting data on treatment need and treatment receipt and then combining them. In this regard, the authors lament the lack of a single data source of data on the mental health workforce. Data are also lacking with which to reliably and regularly estimate Medicaid mental health spending. Also unreliable are current estimates of the amount of mental health care being provided by nonspecialty physicians, such as primary care physicians, and better data are needed.

Several new features of the 2010 volume enhance its usefulness. Perhaps the most significant addition is the state-level estimates section, which helps address the need for state-level data to inform day-to-day decisions on budgeting, planning, and care provision. Other new features provide expanded information on some special populations, such as children and members of the military; on mental health service provision in nontraditional settings, such as clubhouses; and on the impact of the recent recession on service provision.

The following are highlights of the data presented in *Mental Health, United States, 2010*:

♦ Approximately 11 million adults (4.8%) had a serious mental illness in 2009, more than a quarter of these adults had a co-occurring substance use disorder, and 40% reported not receiving any treatment.

♦ During the 2001–2004 period, one out of eight U.S. children aged 8 to 15 (or 13.1%) had a past-year mental disorder, and more than half of these children received treatment in a hospital, clinic, or office.

♦ In 2007, more than 34,000 deaths in the United States were due to suicide.

♦ In 2009, more than one in eight adults received some type of mental health treatment in the past year.

♦ Although mental health expenditures have increased (from $32 billion in 1986 to $132 billion in 2005), they have fallen as a share of all health expenditures (from 7.2% in 1986 to 6.1% in 2005).

♦ During the 2005–2009 period, utilization rates of outpatient specialty mental health treatment by state ranged from 3.0% to 9.5% for adults and from 8.0% to 16.9% for youths age 12 to 17.

The scope of the next volume in the series, *Behavioral Health, United States, 2012,* will be broadened to include information on substance use disorders. The authors note that this larger perspective on behavioral health will help strengthen the series' utility as a key resource for decision making in a changing and challenging health care landscape. The new report is available for download on the SAMHSA Web site at www.samhsa.gov/data/2k12/MHUS2010/index.aspx.

NASMHPD Outlines Steps Toward Integration of Care

In 2006, a groundbreaking report documented alarming facts about early mortality among people with serious mental illness, who die 25 years earlier than their fellow citizens. Six years later, the same organization that delivered this news has published a white paper that outlines steps toward a solution—the integration of behavioral health care and primary care. The new report by the National Association of State Mental Health Program Directors (NASMHPD) examines the role that state behavioral health agencies (SBHAs) can play in accelerating integration of care in the public system and provides several examples of innovative state programs to integrate care. Finally, the report also looks at Medicaid options that are available to states to design and finance delivery system changes to advance integration and collaborative care.

The report begins by pointing to the good news: a growing body of research and results from state initiatives demonstrate the value of integrating mental health, addiction, and primary care services—both in improving health of people with serious mental illness and controlling costs. An area of great promise is the reduction of risk factors for disease—lack of exercise, poor diet, and smoking—which are

prevalent in this population. The bad news is that a complex mix of socioeconomic, health system, and clinical factors contribute to early mortality, and the chronicity of these problems suggests that narrowing the mortality gap will take time. However, some investigators have estimated how much it will cost to do nothing to reduce excess health care costs among patients with comorbid psychiatric and general medical disorders: $300 billion annually in the United States.

The report describes several evolving models of integrated care and the ways in which SBHAs in various states have implemented them. Key lessons learned from state efforts are summarized, along with the following action steps. SBHAs should work closely with Medicaid offices to ensure that behavioral health is included in health homes for all chronic conditions and to carefully evaluate the potential for health homes for individuals with serious mental illness. SBHAs should work with Medicaid officials and health care providers to establish the means and incentives necessary to integrate general medical and behavioral health services. SBHAs should consider collaborating with behavioral health providers or other entities in designing and testing new service delivery models. SBHAs should strongly support the continued investment in colocation of primary care services in behavioral health settings and the robust evaluation of these programs and their ability to improve health status, especially of those with serious mental illness.

The 42-page white paper, *Reclaiming Lost Decades: The Role of State Behavioral Health Agencies in Accelerating the Integration of Behavioral Healthcare and Primary Care to Improve the Health of People With Serious Mental Illness,* is the first in a planned series of 12 reports in NASMHPD's "Cornerstones for Behavioral Healthcare Resource Series," which is designed to help SBHAs navigate the changing landscape of health care, provide background on key issues, and spotlight SBHA initiatives. It is available at www.nasmhpd.org/general_files/Publications/Integration%20Report_Final.pdf.

NEWS BRIEFS

AHRQ disparities report highlights health care challenges: The *National Healthcare Disparities Report, 2011* by the Agency for Healthcare Research and Quality (AHRQ) shows that access to health care was not improving for most racial and ethnic groups in 2002 through 2008. The congressionally mandated report, which AHRQ has produced annually since 2003, shows the persistent challenges: 50% of the measures that tracked disparities in access showed no improvement between 2002 and 2008, and 40% of those measures indicated worsening access. Specifically, Latinos as well as American Indians and Alaska Natives experienced worse access to care than whites on more than 60% of the access measures, African Americans on slightly more than 30%, and Asian Americans on 17%. In tandem with the report on disparities, AHRQ released the *National Healthcare Quality Report, 2011,* which tracks the health care system through quality measures. The quality report found that overall health care quality improved slowly for the general population between the years 2002 and 2008. Both reports will serve to track progress on the Affordable Care Act in the future.The reports are available on the AHRQ Web site at www.ahrq.gov.

Poll shows many seniors not getting mental health interventions: Large majorities of older Americans experience significant gaps in their health care, according to a new national survey, "How Does It Feel? The Older Adult Health Care Experience," released by the John A. Hartford Foundation. The poll focused exclusively on Americans age 65 and older and assessed whether in the past 12 months patients had received key medical services to support healthy aging, including an annual medication review, a falls risk assessment and history, depression screening, referral to community-based health resources, and discussion of their ability to perform routine daily tasks and activities without help—all critical elements of a standard geriatric assessment. This type of low-cost geriatric care can manage and lower risk of many preventable health problems. Yet only 7% of older adults surveyed received all recommended services, 52% reported receiving none or only one, and 76% received fewer than half. For example, when asked whether a health care provider had asked about "your mood, such as whether you are sad, anxious, or depressed," 62% said no. In addition, more than two-thirds had not heard of Medicare's annual wellness visit, which is available free to seniors and pays doctors nearly three times as much as an average office visit. This poll result may be overstated because Medicare's records suggest that uptake is only 6.5%. The poll, which was conducted for the first time earlier this year, surveyed 1,028 Americans age 65 and older and has a margin of error of ±3.1 percentage points. More information on the results is available at www.jhartfound.org/learning-center/hartford-poll-2012.

Evidence lacking on effectiveness of antipsychotics for children: Little research exists that directly compares the effectiveness or safety of first- and second-generation antipsychotics for psychiatric and behavioral conditions among children, adolescents, and young adults, a recent AHRQ review finds. Mental health problems affect one in five young people at any given time, and use of antipsychotics for children and adolescents has increased during the past 20 years. First- and second-generation antipsychotics have generally been found to be superior to placebo on symptom improvement and other efficacy outcomes. Future high-quality, head-to-head comparisons are needed to determine the relative effectiveness and safety of various antipsychotics for younger people, the report notes. The nearly 400-page research review includes a paper for researchers and research funders to help improve the comparative effectiveness evidence. The review is available at www.effectivehealthcare.ahrq.gov/ehc/products/147/835/CER39_Antipsychotics-Children-Young-Adults_20120221.pdf.