One in Five U.S. Adults Had a Diagnosable Mental Disorder in the Past Year, Survey Finds

Twenty percent of American adults age 18 or older—nearly 46 million persons—experienced mental illness in the past year, according to 2010 data from the National Survey on Drug Use and Health (NSDUH). Among young adults, the rate of mental illness was more than twice as high as the rate among older adults—29.9% in the 18-to-25 group, compared with 14.3% in the 50-and-older group. Women were more likely than men to have had a mental illness in the past year (23.0% versus 16.8%). In addition, 11.4 million adults—or 5% of the adult population—had a serious mental illness in the past year.

Rates of past-year mental illness varied by racial-ethnic group. The rate was highest among persons reporting two or more races—25.4%—followed by 20.6% among whites, 19.7% among African Americans, 18.7% among American Indians or Alaska Natives, 18.3% among Hispanics, and 15.8% among Asians. An estimated 8.7 million adults (3.8%) had serious thoughts of suicide in the past year, according to the NSDUH report. The percentage was highest among persons age 18 to 25 (6.6%), followed by those age 26 to 49 (4.1%) and those age 50 and older (2.5%). A total of 2.5 million adults (1.1%) made suicide plans in the past year, and 1.1 million adults (.5%) attempted suicide.

These 2010 prevalence estimates are similar to estimates from previous years and give no indication of dramatic increases or decreases. NSDUH is an annual survey of approximately 67,500 persons in the civilian, noninstitutionalized population age 12 and older conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey covers residents of households and persons in noninstitutional group quarters (such as shelters, rooming and boarding houses, college dormitories, and halfway houses). Excluded are persons with no fixed household address, active-duty military personnel, and residents of institutional group quarters (such as correctional facilities, nursing homes, and long-term hospitals). Because of its statistical power, it is the nation's premier source of statistical information on the scope and nature of many behavioral health issues. The NSDUH defines mental illness among adults as having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) in the past year on the basis of *DSM-IV* criteria. A serious mental illness is defined as one that results in functional impairment that substantially interferes with or limits one or more major life activities.

Substance use disorders were far more prevalent among adults with past-year mental illness, the NSDUH data show. Adults with any mental illness were more than three times as likely as those with no mental illness to meet criteria for substance dependence or abuse—20.0% compared with 6.1%. Among adults with serious mental illness, the rate of co-occurring substance use disorders was even higher (25.2%). In 2010 young adults (age 18 to 25) had the highest rate of co-occurring disorders (9.6%), followed by adults age 26 to 49 (4.7%) and adults age 50 and older (1.3%).

Rates of co-occurring disorders rose with increasing poverty: 3.2% among adults with a family income at or above 200% of the federal poverty level, 4.7% among those with income between 100% and 199% of the poverty level, and 6.7% among those with an income below 100% of the poverty level. Among adults enrolled in Medicaid in 2010 or whose children were in the Children's Health Insurance Program, 6.7% had co-occurring disorders, similar to the rate among adults without health insurance (6.6%) and higher than the rate among adults with private health insurance (3.0%). The prevalence of co-occurring disorders also rose with unemployment: 3.3% among adults employed full-time, 5.4% among those employed part-time, and 8.2% among unemployed adults. By race-ethnicity, co-occurring disorders were most prevalent among American Indians or Alaska Natives (7.7%). Rates for other groups in 2010 were 1.8% among Asians, 2.3% among Native Hawaiians or other Pacific Islanders, 4.0% among whites, 4.2% among blacks, 4.3% among Hispanics, and 5.8% among persons reporting two or more races.

Among American adults who experienced a mental illness in 2010, about four in ten people (39.2%) received mental health services during that period. The rate of treatment among those with a serious mental illness was notably higher (60.8%).

The complete report, *Results From the 2010 National Survey on Drug Use and Health: Mental Health Findings*, is available on the SAMHSA Web site at www.samhsa.gov/data/nsduh/2k10mh_findings.

NEWS BRIEFS

Kaiser Commission update on state Medicaid budgets: Midway through the 2012 fiscal year (FY), the Kaiser Commission on Medicaid and the Uninsured held structured discussions with leading Medicaid directors and sent e-mail surveys to the remaining states. For most states, the growth in Medicaid spending and enrollment is equal to or below original projections for FY 2012, the commission found, and most states do not anticipate significant midyear cuts. However ten states—California, Colorado, Louisiana, Maine, Maryland, North Carolina, Pennsylvania, Tennessee, Washington and West Virginia—are trying to close 2012 budget gaps by making midyear revisions, including restricting additional benefits and provider payment rates. Looking ahead to FY 2013, many states are planning to take advantage of new opportunities available under the Affordable Care Act (ACA) to integrate care for persons dually eligible for Medicare and Medicaid. Many states are also preparing to implement the ACA Medicaid coverage

expansion in 2014, and several states are moving forward with creating insurance exchanges. States will continue to face the dual challenges of implementing health care reform and coping with another year of budget shortfalls heading into FY 2013. The eight-page report is available on the Kaiser Commission Web site at www.kff.org/medicaid/upload/8277.pdf.

Key issues in Medicaid managed care for people with disabilities: As many states expand use of managed care in Medicaid, more beneficiaries with disabilities are being enrolled in risk-based managed care arrangements for at least some of their care. Further growth in managed care is expected in 2014, when the ACA expands Medicaid eligibility to many uninsured low-income adults. A 17-page brief released by the Kaiser Commission examines issues related to the development and implementation of managed care programs with the capacity to serve Medicaid beneficiaries with disabilities. Drawing on existing research, the brief highlights policy considerations related to setting plan payment rates, developing adequate provider networks and delivery systems, and ensuring sufficient beneficiary protections and plan oversight. The brief considers the wide range of intensive and specialized medical and long-term care needs facing Medicaid beneficiaries with disabilities that may include traumatic brain injuries, autism, Alzheimer's disease, and severe mental illness and the challenges that states face in designing effective managed care programs that successfully meet those needs. The issue brief is available on the Kaiser Commission site at www.kff.org/medicaid/upload/8278.pdf.

AHRQ resources on the patient-centered medical home: Two new resources—a "decision-maker brief" and a white paper—from the Agency for Healthcare Research and Quality (AHRQ) discuss how to improve the quality of the evidence and evaluations for the patient-centered medical home (PCMH) to ensure optimal policy decisions. The brief describes why effective evaluations of medical home demonstrations are needed and how best to commission them. It provides insights into the choice of appropriate outcomes to assess and the need to include control practices and account for clustering in evaluations. The white paper provides information about how to determine the effect sizes a given study can expect to detect, identifies the number of patients and practices required to detect achievable effects, and demonstrates how evaluators can select the outcomes and types of patients included in analyses to improve a study's ability to detect true effects. The 53-page white paper and the four-page issue brief are available from the AHRQ's PCMH Resource Center at pcmh.ahrq.gov.

MHA Web site on shared decision making: Mental Health America (MHA) has launched a new Web site, "You're on the Team," designed to promote shared decision making in mental health treatment. The site is designed to separately educate consumers and providers on how the process works, how it can help them, and how to handle difficult issues. At the heart of the site are videos introducing shared decision making in mental health treatment and demonstrating how it works. MHA president and CEO David Shern, Ph.D., and Allen Dyer, M.D., a psychiatrist, explain the concept. During an office visit, Randy lays out his concerns to Dr. Dyer about new side effects that undermine his performance at work. Randy shares a checklist that he completed at the suggestion of Cicely, a peer specialist. He and Dr. Dyer discuss possible solutions and find one that Randy is willing to try. The site (www.mentalhealthamerica.net/go/youreontheteam) also features an extensive list of links to helpful external resources on shared decision making.

Federal blueprint to provide integrated care to Asian Americans: As part of its ongoing commitment to eliminate disparities in behavioral health for racial and ethnic minority populations, the Office of Minority Health of the U.S. Department of Health and Human Services partnered with the National Asian American Pacific Islander Mental Health Association to convene a summit meeting in August 2011 of more than 40 key stakeholders committed to improving the quality of life for Asian American, Native Hawaiian, and Pacific Islander communities. The stakeholders' goal was to develop a national agenda to address the health and behavioral health needs of these populations through integrated care. Recommendations to promote integrated care in four areas are presented, including strategies to eliminate disparities, workforce development and training, community-based participatory research and evaluation, and health information technology. The 43-page document, *Integrated Care for Asian Americans, Native Hawaiians, and Pacific Islanders Communities: A Blueprint for Action,* is available at www.integration.samhsa.gov.

CDC report documents high cost of child abuse. A new report from the Centers for Disease Control and Prevention found that the negative effects of child maltreatment over a survivor's lifetime generate many costs that have impacts on the U.S. health care, education, criminal justice, and welfare systems. The total lifetime estimated financial costs associated with just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse, and neglect) is approximately $124 billion, according to the report. The study looked at confirmed child maltreatment cases in the United States for a 12-month period (1,740 fatal and 579,000 nonfatal cases); the costs estimated were for childhood and adult medical care, child welfare, criminal justice, special education, and productivity losses. The lifetime cost for each victim who lived was comparable to other costly health conditions, such as stroke or type 2 diabetes. The article, "The Economic Burden of Child Maltreatment in the United States and Implications for Prevention," appears in the journal *Child Abuse and Neglect* and is available at www.sciencedirect.com/science/journal/aip/01452134.