

Mental Health

Key Findings:

- Almost 80% of patients diagnosed with depression do not get to have optimal levels of contact with their health care provider.
- Only about 20% of patients prescribed a medication to treat diagnosed depression have at least 3 followup visits to monitor their medication within 12 weeks after diagnosis.
- Mortality due to suicide has been relatively stable over the years, averaging about 10 deaths per 100,000.

Background and Impact

Mental illness is a large burden on America's health, afflicting almost 20% of the population age 18 and over in a given year.^{1,2} This section of the report addresses a particularly prevalent form of mental illness, depression.ⁱ

Depressive disorders are the second most prevalent form of all mental illness behind simple anxiety disorders.³ Depressive disorders affect the ability of 19 million Americans to work, parent, learn, and fully participate in society.² Depression is the second leading cause of disability in the United States.⁴

The New Freedom Commission on Mental Health appointed by President Bush in 2002 attempts to address these longstanding problems.⁵

Costs of Depression

The personal and societal costs of depression are significant. They include:

- Higher rates of death. Studies show that depression is associated with higher mortality rates in all age groups.⁶ Depression's impact is clear in the case of suicide. Suicide, a risk of untreated depression, is the 11th leading cause of death in this country, accounting for

ⁱ Mental illness is a category of diseases and problems that includes major and minor depression, schizophrenia, substance abuse, bipolar disorder, Alzheimer's disease, and other disorders of the brain or mind. Limitations of national data sources resulted in a focus on depression in this report. It is envisioned that future reports will present a broader picture of mental health quality.

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some 30,000 deaths each year.^{7, 11, 12} Fifteen percent of depressed people take their own lives.⁸ The suicide rate is 6 times higher among men 85 and over than it is for the general population.^{9, 15, 16}

- Serious complications for chronic disease patients. People with heart disease, diabetes, cancer, stroke, Parkinson's disease, and HIV/AIDS are at much greater risk for depression than the overall population. Annual prevalence estimates of depression for these groups range from 10 to 65%.^{10, 11, 12} Depression often negatively affects the course of these diseases. For example, depressed heart disease patients are much more likely to die after a heart attack than heart disease patients who are not depressed.¹³ Depression can interfere with the ability of patients to follow medication and dietary regimens and has recently been linked to increased bone loss in women.^{14, 15, 16, 17, 18}
- Workplace costs of over \$43 billion per year.^{19, 20} People suffering from depression have high rates of absenteeism²¹ (in some cases, three times more sick days than nondepressed workers)²² and are less productive at work.²³
- Detrimental effects on all family members. For example, children of mothers who suffer from chronic depression are more likely to have behavioral problems at school.²⁴
- Associated substance abuse problems. Rates of undetected depression among drug and alcohol users are estimated to be as high as 30%. In 2001, the National Health Interview Survey reported that adults who used illicit drugs were twice as likely to report suffering from serious mental illness as adults who did not use drugs.²⁵

Depressive disorders can affect anyone, including children as young as 10 years. Rates are higher among patients with chronic diseases, in women than men (12 % vs. 7 %), and among institutionalized elderly people (25%) and elderly people who live in the community (15%).^{26, 27, 28}

Issues in Diagnosis and Treatment

Despite the seriousness of depression, it is not widely recognized, diagnosed, or treated.

- Only half of those who suffer from depression consider going to the doctor.²⁹
- Depression and mental illness continue to carry a stigma.
- Half of those who seek care for depression approach their primary care provider first. However primary care doctors sometimes miss a diagnosis of depression.^{34, 35} Data discussed in the following section highlight the increases in diagnosed cases of depression and prescriptions for depression.³⁰ However, primary care doctors correctly diagnose depression in only about one-third to one-half of their patients.^{31, 32} This is due

to a number of factors which, taken together, make proper diagnosis very difficult. Depression's most common symptoms are the same as those for many physical ailments which doctors generally investigate.³³ In 2002, the U.S. Preventive Services Task Force formally recommend that doctors screen for depression.^{34,35,36}

- Even when depression is diagnosed, it sometimes is not treated. There is evidence that doctors often do not treat depression after they diagnose it—even though there are effective treatments for over 80% of depressive disorders.^{37,38} Patients often reject a diagnosis of depression, further complicating treatment.³⁹

How the NHQR Measures Mental Health Quality of Care

As in other areas of health care quality, there is not yet broad agreement within the mental health field on a core set of national quality of care performance measures for mental health in general and for depression in particular. There is agreement about which antidepressant medications and psychological therapies are effective in treating depression and how medications should be prescribed and used for maximum benefit.

This report tracks three measures of medication treatment quality and one mortality measure. The medication measures come from the National Committee on Quality Assurance's HEDIS (Health Employer Data and Information Set) measures for managed care plans. One of the primary reasons these measures were selected for the report was that regularly collected national data were available despite the fact that they were limited to managed care plans. These measures are:

- Percent of adults diagnosed with a new episode of depression who had optimal practitioner contacts for medication management during the acute treatment phase. ("Optimal contact" is defined in HEDIS as at least three followup office visits with a primary care or mental health provider in the 12-week acute treatment phase after a diagnosis of depression and prescription of antidepressant medication).³⁹
- Percent of adults diagnosed with a new episode of depression and started on an antidepressant drug who received a continuous trial of medication treatment during the acute treatment phase ("acute phase" is defined as treatment after a new episode of depression).⁴⁰
- Percent of adults diagnosed with a new episode of depression and started on an antidepressant drug who remained on an antidepressant medication through the continuation phase of treatment ("continuation phase" is defined as the percentage of patients who remained on antidepressant medication continuously in the 6 months after the initial diagnosis and treatment).⁴¹

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As progress continues to be made in identifying appropriate measures for mental illnesses and as regularly collected national data become available, examination of quality of care in mental illness can be expanded beyond the managed care setting.

The outcome measure for this section of the report focuses on mortality due to suicide and comes from the National Vital Statistics System, National Center for Health Statistics, and the CDC.

- Deaths due to suicide per 100,000 population.

How the Nation Is Doingⁱⁱ

Quality of Medication Treatment

Limited progress is being made in quality of medication treatment. Almost 80% of patients diagnosed with depression do not have optimal levels of contact with their health care provider. About 60% of depressed patients do not receive the acute phase treatment they need, and about 40% do not receive the continuous phase treatment they should have. Moreover, these rates have not improved over the 3-year period that these measures were tracked (1998, 1999, and 2001; data were not available in 2000).

In 1999, almost 59% of adults diagnosed with a new episode of depression received a continuous trial of antidepressants through the acute phase of treatment, but in 2001, that dipped to less than 57%. Finally, in 2001 there was a decrease of 2 points to 40% from 42% in 1999 for adults who remained on antidepressants through the continuation phase of treatment.

Research shows that half of the outpatients being treated for depression in primary care settings stop using their medicines within the first month.⁴² Sometimes side effects discourage patients from sticking with their treatment course.⁴³ Other times, the drugs work so well that the patients mistakenly believe they have been cured and discontinue the medication. Thus, they do not remain on drugs long enough to reap the full benefits of the drugs. For most patients, there is a range of treatments, and pharmacotherapy may be one of a set of treatment options.⁴⁴ That said, research on therapeutic trends in mental health have pointed to the greater use of psychotropic medications and less use of psychotherapy.⁴⁵

Suicide

The suicide rate for adults has been relatively stable over the years, averaging just over 10 deaths per 100,000 in the adult population. For young adults, the rate has leveled off for the age group 5

ⁱⁱ Adjusting for known contributing factors, such as gender, age, and insurance status (multivariate analysis), would allow for more detailed exploration of the data, but this generally was not feasible for this report. Any adjustments that were done are noted in the detailed tables. The data presented in this report do not imply causation.

to 14 years and even declined between 1991 and 2000 for the age group 15 to 24 years.⁴⁶ However, men are four times more likely to commit suicide than women, and elderly men have the highest suicide rate of all groups.⁴⁷

What We Don't Know

National data on core quality measures for mental health are needed. Mental health is recognized as an important national priority.⁴⁸ The Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Medical Association's Physician Consortium for Performance Improvement are addressing the need for core measures through scientific review and consensus development of potential mental health quality measures. Because national data on a core set of measures are not available, we have only limited information on who is treated for mental illness and how often and effectively these treatments are administered.⁴⁹

The limited national level information on mental illness that is available concentrates on depression, not other important mental health disorders, such as schizophrenia,⁵⁰ bipolar disorder, posttraumatic stress, generalized anxiety, Alzheimer's disease, and others. Because successful treatments have been developed for some of these diseases and knowledge about them continues to grow, they may be good candidates for tracking quality of care and improvement.

Measures in two areas are particularly needed: mental disorders other than depression and for vulnerable population subgroups. Data are insufficient to track the quality of mental health treatment provided to young adults or the elderly, both of whom have high rates of suicide closely related to depression.

What Can Be Done

Progress is being made in a number of areas related to the treatment of mental illness. One potentially important new initiative involves creating a searchable database of quality measures for mental health. Developed by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH), with funding from AHRQ, the National Institute of Mental Health, and SAMHSA, this database includes more than 300 process measures in 7 domains of quality, including access, assessment, treatment, continuity, coordination, patient safety, and prevention.⁵¹ The measures were developed by government agencies, researchers, professional organizations, consumer coalitions, commercial organizations, and others. The database provides the clinical context for the measure, a summary and rating of supporting research evidence, measure specifications, data requirements, domain of quality, treatment modality, population, and developer information. In the future, the CQAIMH intends to expand its Web site to include a toolkit of quality management tools and a consumer's guide to quality in mental health care. This is an important start in terms of identification of possible measures. Efforts currently being carried out by SAMHSA and others will help focus quality measurement on a limited set of valid key measures of quality for mental health care.

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List of measures

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Measure Title	National	State
Treatment of depression:		
Process: % of adults diagnosed with a new episode of depression who had optimal practitioner contacts for medication management during the acute treatment phase	Table 1.65	N/A
Process: % of adults diagnosed with a new episode of depression and initiated on an antidepressant drug who received a continuous trial of medication treatment during the acute treatment phase	Table 1.66	N/A
Process: % of adults diagnosed with a new episode of depression and initiated on an antidepressant drug who remained on an antidepressant medication through the continuation phase of treatment	Table 1.67	N/A
Outcome: Deaths due to suicide per 100,000 population	Table 1.68a (00) Table 1.68b (99)	Table 1.68c (00)

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- ⁵ President's New Freedom Commission on Mental Health: Mental Health, Achieving the Promise: Transforming Mental Health Care in America, Final Report. DHHS Pub. No. SMA-0303832. Rockville, MD: 2003.
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