

MENTAL HEALTH

Note to readers and users of the *Healthiest Wisconsin 2020* Profiles: This *Healthiest Wisconsin 2020* Profile is designed to provide background information leading to collective action and results. This profile is a product of the discussions of the Focus Area Strategic Team that was convened by the Wisconsin Department of Health Services during October 2009 through February 2010. The objectives from this Focus Area have been recognized as objectives of *Healthiest Wisconsin 2020*. (Refer to Section 5 of the *Healthiest Wisconsin 2020* plan.) A complete list of *Healthiest Wisconsin 2020* Focus Area Strategic Team Members can be found in Appendix A of the plan.

Definition

“Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (World Health Organization, 2001). “Mental health is the foundation for well-being and effective functioning for an individual and community. It is more than the absence of mental illness; it is a resource vital to individuals, families and societies” (British Columbia, Ministry of Health, 2007).

Importance of the Focus Area

When comparing all diseases, mental illnesses rank first in terms of causing disability in the United States, Canada, and Western Europe (World Health Organization Report 2001). One out of five people, or 20 percent of the population, will experience a mental health problem of some type during a one-year period (Robins and Regier, 1991). Serious mental illness costs Americans at least \$193 billion a year in lost earnings alone (Kessler et al., 2008). Lost earnings are just one aspect of the total economic burden, which also includes direct treatment costs such as medications and physicians’ care (Kessler, 2008). Mental health disorders are an enormous social and economic burden to society by themselves, but are also associated with increases in the risk of physical illness (World Health Organization, 2009).

Indeed, mental and physical health are closely connected, and the statement “there is no health without mental health” accurately summarizes the relationship between the two (Prince et al., 2007). More specifically, mental health disorders are associated with increased rates of chronic health problems and risk factors such as smoking, physical inactivity, obesity, and substance abuse and dependence. In the U.S., persons with mental illnesses represent an estimated 44.3 percent of the tobacco market and are nicotine dependent at rates that are 2-3 times higher than the general population (Grant et al., 2004; Lasser, 2000). Data show that mental health clients treated in publicly funded systems of care have high rates of smoking-related medical illnesses (Grant, 2004) and premature death, resulting in as much as 25 years of potential life lost compared to the general population (Colton and Manderscheid, 2006).

Moreover, evidence suggests that the profoundly negative effects of poor mental health on physical health are not unique to those with the fewest resources, but are also evident among adults with mental health problems in the wider population. Among Wisconsin adults, the

burden of chronic physical disease falls heavily on those with mental health problems, as evidenced by comparatively higher rates of cardiovascular disease and diabetes. In addition, treatment for mental health problems is lacking for a large portion of those who need it (Wisconsin Department of Health Services, 2009).

The Behavioral Risk Factor Survey (Wisconsin Division of Public Health /U.S. Centers for Disease Control and Prevention) measures serious psychological distress using the K-6, a non-specific distress scale (Kessler, et.al.1998). The K-6 originally was developed to measure serious mental illness, but was subsequently found to better indicate serious psychological distress. Serious mental illness is defined as the presence of a DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, Version IV*) diagnosis and serious functional impairment in one or more major life areas.

Serious psychological distress defined

Serious psychological distress is a non-specific category of distress characterized by a DSM-IV mood or anxiety disorder and a lesser degree of functional impairment than serious mental illness. Serious psychological distress is considered to be an indicator of possible serious mental illness, with similar but less strict inclusion criteria.

Wisconsin data from the 2007 Behavioral Risk Factor Survey indicate that adults with past-month serious psychological distress have poor quality of life and poor physical health compared to other adults. The differences include significantly lower levels of social support and life satisfaction and higher rates of chronic diseases

Estimates of mental health disorders among adults ages 60 and older are of increasing importance, but require scrutiny, as they may be misleading for multiple reasons. First, many such estimates are based on survey data, which exclude adults who are cognitively impaired or are otherwise unable to live in non-institutional settings. In addition, what appear to be lower rates of mental health disorders among older adults (Kessler et al., 2005) may be, at least in part, a function of the high rate of premature death associated with such disorders. When dementia is added to the mix of psychiatric disorders, some estimates indicate that the occurrence rate of psychiatric symptoms among older adults will be approximately 20 percent by the year 2030 (Jeste, et al., 1999; Charney, et al., 2003).

Wisconsin Data Highlights

- Thirty-six percent (36 percent) of Wisconsin adults with serious psychological distress were current smokers, compared with 18 percent of adults without serious psychological distress (Wisconsin Department of Health Services, Behavioral Risk Factor Survey [BRFS], 2007 data).
- Forty-four percent (44 percent) of adults with serious psychological distress were obese, versus 25 percent of those without sensory processing disorder (BRFS, 2007 data).
- Among adults with serious psychological distress, less than half (49 percent) received mental health treatment or medication (BRFS, 2007 data).

Note: This text refers to "past year" and "past month" serious psychological distress because of the different reference periods used in the National Survey on Drug Use and Health (NSDUH) and the Behavioral Risk Factor Surveillance System. Both surveys use the K-6 scale (Kessler et al., 2003), a six-item screener to measure serious psychological distress, but because of the different reference periods, the measures are not strictly equivalent. They must be identified as "past month" or "past year" for the sake of clarity.

- Frequent mental distress was more prevalent among Wisconsin Hispanics (17 percent), American Indians (14 percent) and African Americans (15 percent) compared to Whites (8 percent) (BRFS, 2006-2008 data).
- Suicide rates in Wisconsin were highest among American Indians compared to other race/ethnicity groups – 16.6 per 100,000 population versus 7.1, Blacks/African American, 6.1, Asian/Pacific, 5.6, Hispanics/Latinos, and 12.1, White (Wisconsin Resident Death Certificates, unpublished data for 2001-2006).
- Women in Wisconsin were more likely to have past-month serious psychological distress than men, and adults with low educational attainment (less than high school) and low-incomes (less than \$25,000 in household income) had a higher prevalence of serious psychological distress than those with more education and higher-incomes (BRFS, 2007 data).
- Wisconsin high school girls were nearly twice as likely as boys (30 percent versus 16 percent) to have experienced symptoms of depression for two weeks or more in a row in the past 12 months (Youth Risk Behavior Survey, 2007).
- Forty-one percent of gay, lesbian, and bisexual youth considered suicide in the past 12 months, compared with 17 percent of youth with only opposite sex contact (Youth Risk Behavior Survey, 2007).

Objective 1

By 2020, reduce smoking and obesity (which lead to chronic disease and premature death) among people with mental health disorders.

Objective 1 Indicator

Smoking and obesity rates among people with depression or serious psychological distress (Behavioral Risk Factor Survey).

Objective 1 Rationale

A direct means to improving the health of people with mental health disorders is to reduce the prevalence of risk factors such as smoking and obesity that lead to chronic disease and premature death.

Objective 2

By 2020, reduce disparities in suicide and mental health disorders for disproportionately affected populations, including those of differing races, ethnicities, sexual identities and orientations, gender identities, educational or economic status.

Objective 2 Indicators

- Prevalence of mental health disorders in these population groups (Behavioral Risk Factor Survey, Youth Risk Behavior Survey).
- Suicide rates in these populations (Wisconsin Vital Statistics).
- Mental health provider capacity indicating access to mental health services. (Indicator to be developed.)

Objective 2 Rationale

Reducing the relatively high rates of suicide and mental health disorders in population groups identified by characteristics such as race/ethnicity, sexual orientation, and age will increase health equity and quality of life.

Objective 3

By 2020, reduce the rate of depression, anxiety and emotional problems among children with special health care needs.

Objective 3 Indicators

- Percent of children who have depression, anxiety or emotional problems (State and Local Area Integrated Telephone Survey – Children with Special Health Care Needs [SLAITS-CSHCN]).
- Percent of children who needed but did not receive mental health services in the previous year (SLAITS-CSHCN).
- Percent of CSHCN/non-CSHCN who received mental health treatment / counseling in the past year (SLAITS – National Survey of Children’s Health).

Objective 3 Rationale

Among youth ages 12-17, approximately 9 percent have a recent (past-year) major depressive episode in both Wisconsin and the U.S. (*National Survey on Drug Use and Health, 2005-2006*). The 2000 U.S. Surgeon General’s Report on Mental Health concluded that a high proportion of young people with a diagnosable mental disorder do not receive any mental health services at all (Burns et al., 1995; Leaf et al., 1996). Although two of five children receive some form of mental health intervention, but only one in five children with a serious emotional disturbance used some form of mental health specialty services, (Burns et al., 1995). Lack of access to mental health services is due to multiple factors including geography, costs and availability. However, lack of psychiatrists and other mental health professionals also contribute significantly to the lack of services.

Potential evidence- or science-based actions to move the focus area objectives forward over the decade

Tobacco

Mental health policies and programs will use a public health approach. Some identified strategies include:

- Require screening for tobacco use in all mental health and substance abuse treatment programs.
- Educate mental health and substance abuse professionals in evidence-based motivational interventions for smoking cessation that will be integrated into existing treatment/recovery plans. Other smoking cessation interventions may include self-help materials, and the nicotine patch.
- Incorporate smoking cessation models, which are tailored for persons with mental illnesses. Encourage mental health and substance abuse professionals to combine nicotine replacement therapy (NRT) with Cognitive Behavioral Therapy (CBT), a type of psychotherapy focusing on changing dysfunctional thoughts, emotions, and behavior.
- Fund projects such as, the Wisconsin Nicotine Treatment Integration Project: Mental Health, Alcohol and Other Drugs and Tobacco Dependence (WiNTiP) to promote the integration of evidence-based nicotine dependence treatment practices into Wisconsin's alcohol and other drug abuse, and mental health services statewide.
- Encourage mental health and substance abuse service providers to offer or refer their patients/clients/consumers for medication assisted smoking cessation as appropriate. Use of cessation interventions such as nicotine replacement therapy (NRT) or Bupropion in combination with individual or group counseling employing motivational interviewing or cognitive behavioral strategies are effective for persons with mental illnesses.

Smoking Cessation Resources

- Getting Ready, Implementing, and Sustaining the Effort: A toolkit for providers National Association of State Mental Health Program Directors, 2007.
- A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment Centers for Disease Control and Prevention, Office on Smoking and Health, 2006.
- The U.S. Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence, 2007.
- Morris, C., Waxmonsky, J., Giese, A., Graves, M., Turnbull, J., *The Tobacco Cessation Toolkit for Mental Health Providers*. University of Colorado at Denver and Health Sciences Center, Department of Psychiatry.

Reducing obesity

Mental health policies and programs will use a public health approach to implement comprehensive programs. Mental health programs and policies will need to address multiple drivers for health improvement which have been identified (Booske, 2009). A selection of these strategies are identified and listed below:

- Implement comprehensive programs that promote physical activity and nutrition through multi-component interventions aimed at diet, physical activity, and cognitive change.
- Promote increased use and access to fitness or community centers or athletic facilities across all ages of the population.
- Encourage employers to offer benefit packages to their employees which add incentives to increase physical activity including reduced health insurance premiums for members of fitness clubs/YMCA.
- Make water available; promote its consumption.
- Increase availability of fruits and vegetables, and other nutritious options.
- Ensure onsite cafeterias follow healthy cooking practices.
- Use point-of-decision prompts to highlight fruits and vegetables, and promote water consumption.
- Provide nutrition information in clinic waiting room.
- Provide clients/patients/consumers with tools for self-assessment and recording.
- Support comprehensive, center-based early childhood development programs.

Delivery of care

- Implement systemic changes to all health care delivery systems to provide comprehensive care coordination that requires an integrated care delivery model to support patient/family-centered medical homes.
- Encourage health systems to co-locate mental health practitioners in or near primary care including pediatric and family practice offices or encourage systems to implement and utilize a mental health consultative model with primary care physicians.
- Promote statewide use of “tele-health” to expand mental health services, which could include use of primary care as the service delivery site and billing entity. This would provide seamless coordination to expand access to mental health services for children and families and will provide primary care physicians’ access to mental health consultation when needed.
- Provide intensive training, support, and consultation for primary care providers’ in the treatment of children’s mental health problems.
- Promote the use of screening tools for depression, anxiety, and suicide risk across all medical settings, community, and schools. Examples of tools include the Columbia TeenScreen and the Signs of Suicide (SOS).
- Implement comprehensive mental health and school-based interventions with the wraparound process to involve all partners in all communities.
- Expand use of medical homes, which may enhance the capacity of primary care providers to provide and manage care for children with special health care needs and provide case coordinators to help children and families gain access to in-home services and supports.
- Incorporate family to family involvement and peer to peer support as core principles of service delivery, as families and peer consumers are playing a larger role in the provision of children’s mental health services.

Suicide prevention

A public health approach is essential to addressing suicide prevention. The following are featured prevention strategies found in the Burden of Suicide In Wisconsin Report (Kopp, et al., 2008):

- Develop statewide broad community-based coalitions.
- Develop and implement crisis intervention and “postvention” (what to do after a suicide occurs) plans or policies in all communities and regions statewide.
- Implement prevention strategies:
 - Complementary programs-Classroom curriculum that focuses on increasing youth assets has been shown to be a protective factor in suicide prevention. Specifically, problem-solving, coping skills and conflict resolution skills are important elements of resiliency that can reduce the likelihood of suicide.
 - Provide educational settings where environments are both physically and psychologically safe. Include programs that address bullying and violence prevention.
 - Promote use of screening tools for depression, suicidal ideation and suicidal acts. Examples include: Columbia TeenScreen and Signs of Suicide (SOS); Geriatric Suicide Ideation Scale (GSIS) is a validated screening tool for the elder population.
 - Educate mental health and substance abuse providers to recognize signs and symptoms of depression and to assess suicide risk.
- Implement community wide “gatekeeper trainings” to train persons (gatekeepers) who have regular contact with potentially vulnerable populations to more readily identify populations at-risk for suicide and refer them to appropriate services. An example of a gatekeeper training program is Question-Persuade-Refer (QPR).
- Utilize media guidelines to encourage members of the media to follow guidelines for reporting suicide so as not to encourage at-risk persons to attempt suicide.
- Promote and implement means restriction. Means restriction activities are designed to reduce access or availability to the means and methods of deliberate self-harm in an attempt to reduce the odds that an attempter will use a highly lethal means. Coordinate efforts with law enforcement, crisis responders, social services, mental health, and substance abuse professionals, and service organizations.
- Culturally tailor messages and implement comprehensive multi-component interventions in partnership with statewide and community-based coalitions to reduce suicides across all ages, racial/ethnic, deaf and hard of hearing, veteran, and sexual orientation populations.
- Adopt the Wisconsin Suicide Prevention Strategy (2002).
- Encourage the development of a statewide, comprehensive, and sustainable suicide prevention system with a central coordinator to facilitate and foster suicide prevention efforts.

Suicide Prevention Resources

- American Indian Life Skills Development/Zuni Life Skills Development. Suicide Prevention Resource Center (SPRC). Substance Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence-Based Programs and Practices (NREPP). September 2007
(http://www.sprc.org/featured_resources/ebpp/pdf/zuni_life_skills.pdf)
- CAST (Coping And Support Training) Effective Youth Suicide Prevention Screening Tool and Curriculum. Suicide Prevention Resource Center (SPRC). Substance

- Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence-Based Programs and Practices (NREPP). January 2008.
(<http://www.nrepp.samhsa.gov/programsfulldetails.asp>)
- Columbia University TeenScreen Program. Effective Youth Suicide Prevention Screening Tool. Suicide Prevention Resource Center (SPRC). Substance Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence-Based Programs and Practices (NREPP). November 2007.
(http://www.sprc.org/featured_resources/ebpp/pdf/columbia-teenscreen.pdf)
 - Effective Youth Suicide Prevention Screening Tool and Curriculum-(C-Care). Suicide Prevention Resource Center (SPRC). Substance Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence-Based Programs and Practices (NREPP). February 2008. (<http://www.sprc.org/feature-resources/ebpp/pdf/ccarecast.pdf>)
 - Evidence-Based Practices for Preventing Substance Abuse and Mental Health Problems in Older Adults: Excerpt: Prevention of Mental Health Problems: Suicide Prevention. SAMHSA Older Adults Technical Assistance Center II: 2005 National Reports. (<http://www.samhsa.gov/OlderAdultsTAC>)
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(http://www.sprc.org/featured_resources/ebpp/pdf/lifelines.pdf)
 - SOS: Signs of Suicide Screening Tool and Curriculum-(SOS: Signs of Suicide). Substance Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence-Based Programs and Practices (NREPP). May 2007.
(http://www.sprc.org/featured_resources/ebpp/pdf/sos.pdf)
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