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Premature death among state mental health agency consumers: assessing progress in addressing a quiet tragedy

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The Problem. Consumers served by the State mental health agencies die 25 years younger than the general population. As a result of this quiet tragedy, male consumers are likely to die at about age 53; female consumers, at 59. This 25 year disparity is due to two factors, chronic physical disabilities (which account for 15–20 years of the difference) and mental factors, such as suicide (which account for 5–10 years). These troubling numbers were uncovered by Craig Colton and me[1] and reported in Preventing Chronic Disease in April ((http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm). Compared with findings from a much earlier related study[2], mental health consumers' disparity in length of life appears to be worse in 2006 than in 1986!

The causes are equally disturbing. The chronic physical disabilities contributing to this disparity are the lifestyle problems suffered by many Americans: obesity, high blood pressure, diabetes, stroke, chronic heart disease, and heart attack. Collectively, these chronic health problems are known as the "metabolic syndrome". However, unlike most other Americans, public mental health consumers are much less likely to receive care for these problems. As a result, they die prematurely.

Mental disabilities experienced by consumers can lead to suicide. Although effective treatments exist for many of these mental disabilities, the public mental health system has only recently begun to embrace the concept of recovery, and its related notions of hope and independence[3]. Frequently, consumers tell us that they have lost hope and don't envision a future for themselves, in which they can live valued and productive lives in the community.

Some Proposed Solutions. *Addressing this silent tragedy must be a very high priority for the entire mental health field. Solutions are likely to be found through coordinating good care for chronic physical disabilities* ***and*** *good mental health care that lead to independence and hope. The concept of recovery encompasses both of these. Consumers can and should provide leadership for this endeavor. They have great insight about how current care systems can be improved. The "wellness model"[4], published almost 30 years ago, can also provide guidance in this work. Of note, the recent Institute of Medicine report on Improving the Quality of Healthcare for Mental and Substance Use Conditions[5] is a blueprint for coordinating mental health and primary care.*

A major first national step has been to define a very clear goal, with an ironclad commitment to achieve it. The Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) has articulated this goal: to reduce 10 years of the disparity within a 10 year period. We must demand no less!

To address the problem of premature death, the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) has convened Workgroups under the leadership of Dr. Joseph Parks of Missouri These Workgroups have developed a series of policy papers now available on the NASMHPD website (www.nasmhpd.org). The intent of these documents is to serve as the basis for developing a coordinated state strategy.

Community mental health centers have been at the forefront of efforts to coordinate mental health and primary care for the

past decade. Exciting new initiatives are underway to bring primary care services into these centers. The National Council of Community Behavioral Healthcare is taking strong leadership in these initiatives (see www.thenationalcouncil.org).

In 2008, Paolo Delvecchio and I served as Guest Editors for the summer issue of the International Journal of Mental Health[6]. This special issue explores the policy, training, and data implications of introducing a wellness model to the mental health field, in which consumers can play a key role.

Key Data to Monitor Progress. *In setting the national goal, it is very important that we also assure that a national data system is available to monitor progress. The Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) can play a central and key role in this continuing assessment.*

The BRFSS is conducted annually by State public health agencies through funding from the CDC, using a stratified sample of telephone respondents and comparable core data modules. Thus, the BRFSS is capable of producing both national and State estimates. It is one of the few health surveys containing person and state level data on both mental health and physical health issues.

Prior to 2006, the BRFSS mental health question was quite general: "Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?" Persons who self-report mental ill health for 14 or more days were categorized as having Frequent Mental Distress (FMD).

In 2006, through funding from CMHS, SAMHSA, a more specific optional mental health module was added to the BRFSS, the Patient Health Questionnaire-8 (PHQ-8), a validated screening instrument for current symptoms of depression. Additionally, respondents were asked if they had ever been told by a health professional that they had depression or anxiety disorder. Responses to these mental health questions can be related to the core BRFSS data on health risk, chronic health conditions, and preventive health care. A total of 38 States responded. In 2007, the K-6, a measure of whether a person has serious mental illness (SMI) was substituted for the PHQ-8, with the intent that these two modules would alternate from year to year. A total of 36 States responded. In 2008, the optional PHQ-8 scale was again used. A Total of 6 States responded. The decrease in number of States responding was directly attributable to funding reductions. CMHS, SAMHSA did not have sufficient funds available to continue this important work at the level required.

The BRFSS is exceptionally valuable in helping us to understand the specific linkages between mental illness and chronic physical diseases in State populations. This is so because it is the only survey that covers both of these disability areas. Covering both is required to address the 25 year disparity in lifespan experienced by public mental health clients. Hence, I conclude that the BRFSS modules on mental health are essential for monitoring progress in addressing this 25 year disparity. To assure that these essential modules are available in the future, provision of sufficient financial resources must be addressed by the new Administration as part of its initiative on National Health Reform.

References

1. Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost and causes of death among public mental health clients in eight states. Prev Chronic Dis 3 [serial online] 2006 Apr. Available from: URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm

2. McCarrick AK, Manderscheid RW, Bertollucci DE; Goldman H, Tessler R. Chronic medical problems in the chronic mentally ill. Hosp Community Psychiatry 1986;37:289–91.

3. New Freedom Commission on Mental Health. Achieving the promise. Transforming mental health care in America. Final report. Rockville, MD: US Department of Health and Human Services, 2003.

4. Ng LKY, Davis DL, Manderscheid RW. Toward a conceptual formulation of health and wellbeing. In: Ng KLY and Davis DL eds. Strategies for Public Health: promoting health and preventing disease. New York: Van Nostrand Reinhold Co, 1981:44–58.

5. Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board on Health Care Services, Institute of Medicine. Improving the quality of health care for mental and substance-use conditions. Washington, DC: National Academies Press, 2006.

6. Manderscheid RW, Delvecchio P Guest Eds. Mortality and wellness. Int J Mental Health 2008;37:3–7

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