

Health Officers Association of California Fall 2016 Semiannual meeting

Measuring Mental Health Status and Mental Health Care of the Community: Why It Matters

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Measuring Mental Health: Why It Matters

It depends on the purpose:

- Analyze the health/mental health status of the community
- Evaluate the health resources, services, and systems of care within the community
- Assess attitudes toward community health services and issues
- Identify and measure disparities in mental health
- Monitor trends and changes in disparities
- Identify priorities, establish goals, and determine courses of action to improve the health/mental health status of the community
- Establish an epidemiologic baseline for measuring improvement over time

“I am not interested in measurement per se. I am obsessed by improvement and the role measurement has in **that process.**”

Dan Berwick, IHI

Importance of Mental Disorders for Public Health

- **+14% of the global burden of disease** is from neuropsychiatric disorders, arising from **disability**.
- Mental disorders **increase risk for communicable and non-communicable diseases**, and contribute to unintentional and intentional injury.
- Many health conditions increase the risk for mental disorders and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis.
- **Growing movement of global mental health** and recognition of its importance, and need to include in mental health status measurement

Why Mental Health Matters

Mental disorders:

1. Are among **the most prevalent** classes of chronic diseases in the general population.
2. **Co-occur** within themselves, with substance use disorders, and with many physical conditions.
3. Typically have **much earlier ages of onset than other chronic diseases.**

“Let’s recognize that there is no health without mental health.”

Mental Health

No health without mental health

It was also emphasized that day that mental health is essential for “personal wellbeing, family relations, and the ability of persons to contribute to society.”

Li-moon
10, 2008

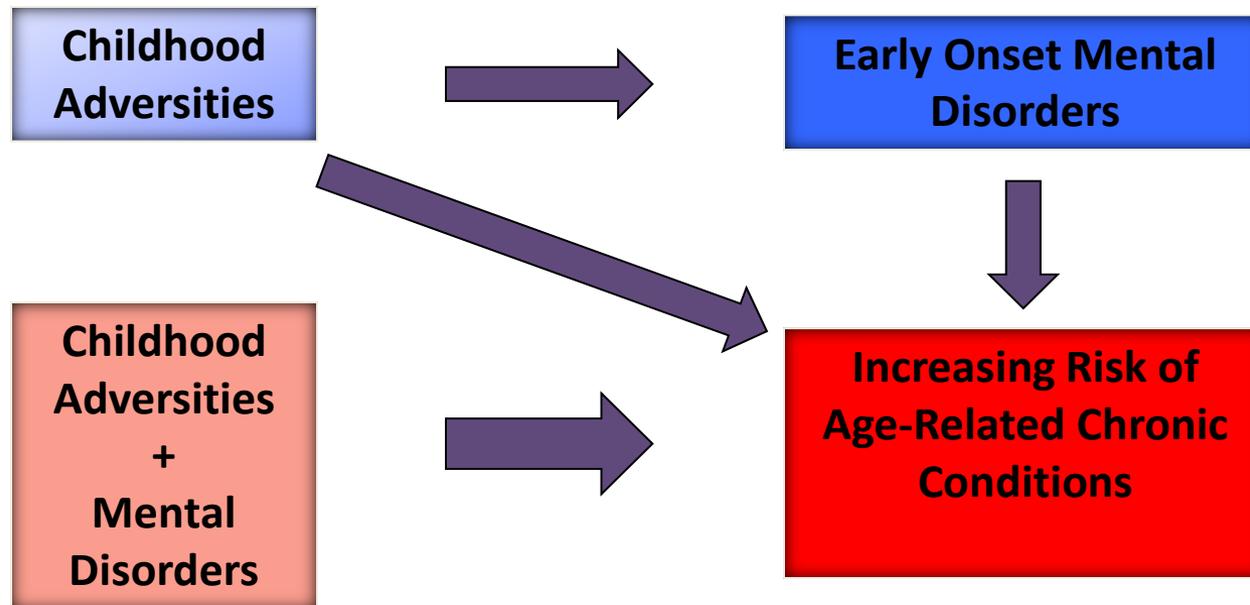


The Case for Integration

- 1. Comorbidities are the rule rather than the exception**
- 2. Mental health in primary care:**
 - Primary care is the main point of service delivery entry and where the patients are.
 - Primary care is the ‘de facto’ health care system for common mental disorders.
- 3. Medical care in mental health care settings:**
 - Patients with severe mental disorders (SMI) receive poor medical care and die on average 25 years earlier than those without SMI.

Precursors, Manifestations and Consequences

- **Childhood adversities** may increase risks of early onset mental disorders, while **both childhood adversities and early onset mental disorder** may increase risks of a range of physical diseases in later life.



Magnitude and Impact of Mental Disorders

Mental disorders:

4. Are among **the most disabling** of all chronic health conditions.
5. Are associated with **significant adverse societal, individual and family costs**.
6. Only **a minority** with mental health needs **receive treatment** in the preceding year.

Classificatory Systems Relevant for MH

1. *International Classification of Diseases, ICD-10, Chap. V mental and behavioral disorders (F00-F99) (WHO 2010)*
2. *Diagnostic and Statistical Manual of Mental Disorders (DSM – IV / DSM V)*
3. *International Classification of Functioning, Disability and Health (ICF), (WHO, 2001)*

Measuring MH at the Population Level

- **Administrative records (CSI, Medi-Cal, etc.):**
 - requires good records
 - does not capture population not accessing services
- **Population surveys (NCS-R, CHIS, etc.)**
 - High level of stigma about MH disorders generates under-reporting
 - Complex construct to measure

Broad Issues to Consider

- Categories of mental health disorders
- Clinical scales vs survey tools
- Measuring impairment vs activity limitations

Categories of Mental Disorders

1. CMD vs SMD

Common Mental Disorders (CMD)

- Less severe
- Common (higher rates of endorsement)
- Typically include depression and anxiety

Severe Mental disorders/Illness (SMD/SMI)

- More severe
- Less common than CMD
- Typically include schizophrenia, schizoaffective disorder, bipolar disorder and major depressive disorder

2. Cognitive vs Psychological problem vs psychiatric disorders

Clinical Scales Used as Survey Instruments

- **Diagnosis of mental disorder(s):**
 - Self report scales asking about symptoms
 - Observation by clinician and rating behaviors and symptoms

- **Common scales used in surveys primarily by trained survey interviewers:**
 - WHO's Composite International Diagnostic Interview (CIDI) in World Mental Health Survey – very long and detailed; wide range of disorders
 - Structured Clinical Interview for DSM (SCID)
 - Center for Epidemiological Study Depression Scale (CES-D)
 - K6 and K10 Kessler scales; psychological distress
 - PHQ9, PHQ8 and PHQ 2: Presence and severity of depression; screener; PHQ9 includes suicidal ideation.

Kessler-6

- A mental health ‘screener’ that asks how often in the past 30 days a respondent feels:
 - Sad
 - Nervous
 - Worthless
 - Hopeless
 - Restless
 - If everything is an effort
- A composite score of 13 or greater indicates serious psychological distress (good estimate of SMI)

Sheehan Disability Scale

- A 4-item scale that captures the extent of interference in four life domains due to emotions
 - Work (if less than 70 years old)
 - Chores
 - Social life
 - Personal Relationships
- Domains are scored as 0 (no impairment), 1 (moderate), and 2 (severe impairment)
- Any score of 1 or greater indicates at least a moderate level of interference in at least one domain

Impairment vs. Activity Limitations

- **Symptoms** of mental disorders are **impairments of mental functioning**
- **Activity limitations** are the **consequences** of these symptoms
- Complex **domains of functioning** primarily **affected by mental health symptoms** (e.g., taking care of others, domestic activities, interpersonal interactions, etc.)
- Complex domains are **more difficult to measure in a clear manner in surveys** (i.e., inherent feature of individual or external **feature of environment**)

Mental Health in Surveys

Different ways to address MH in surveys

JMIR MENTAL HEALTH

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“Accurate reporting of patient symptoms is critical for diagnosis and therapeutic monitoring in psychiatry. Smartphones offer an accessible, low-cost means to collect patient symptoms in real time and aid in

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- **Surveys with questions on mental health/disorders to evaluate differences in some areas (e.g., employment, economic conditions, etc.)**

CHIS MH content and measures

- **Content for Adults (age 18+) includes:**
 - Kessler 6: Serious psychological distress (SPD) 30-day, 12-months (07, 09)
 - Sheehan disability scale: Extent mental health interfered with daily activities/relationships (07, 09)
 - Perceived need of mental/emotional health services
 - Use of mental/emotional health services, # of visits
 - Current use/Reasons for ending treatment (07, 09)
 - Reasons for not seeking treatment (07, 09)
 - Role of primary care physician/general practitioner in screening for mental/emotional health, communicating, and providing treatment (2007—Calif. Office of the Patient Advocate)
 - Suicide ideation and attempts (*new in 2009*)
 - Veteran status (*new in 2009*)

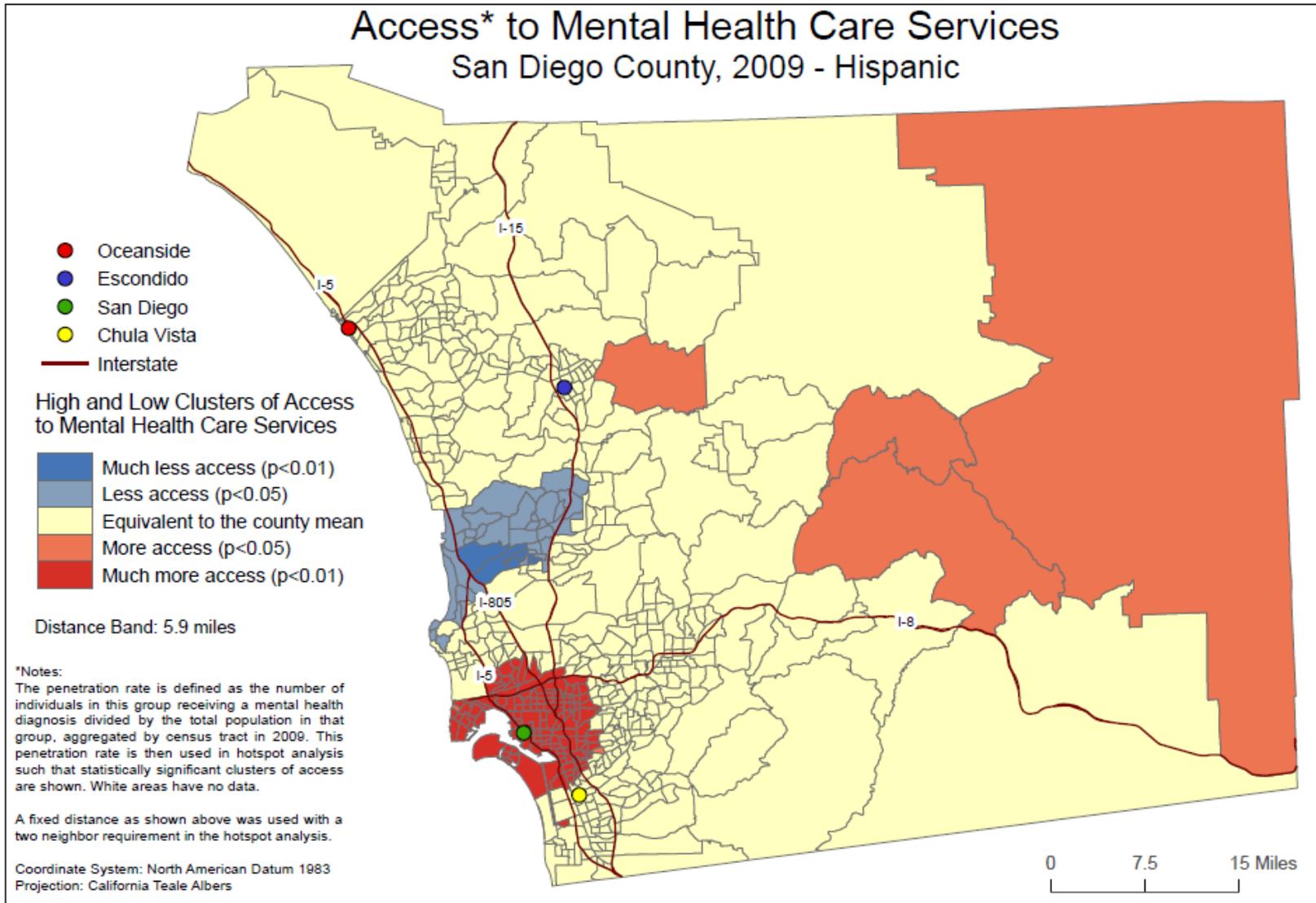
CHIS mental health content

- **Adolescent content (age 12 to 17)**
 - Mental health assessment
 - 2003 & 2005: CES-D
 - 2007 & 2009: Kessler 6
 - Perceived need of mental health services
 - Use of mental health services, alcohol/drug counseling
 - Doctor discuss mental/emotional health
- **Child content (age 0 to 11)**
 - Emotional functioning (SDQ)
 - Mental/emotional health condition
 - Parental concerns w/ social-emotional development (PEDS)
 - Knowledge of developmental screening/referral (2007, 2009)
 - Perceived need for psych/emotional counseling
 - Utilization of psych/emotional counseling

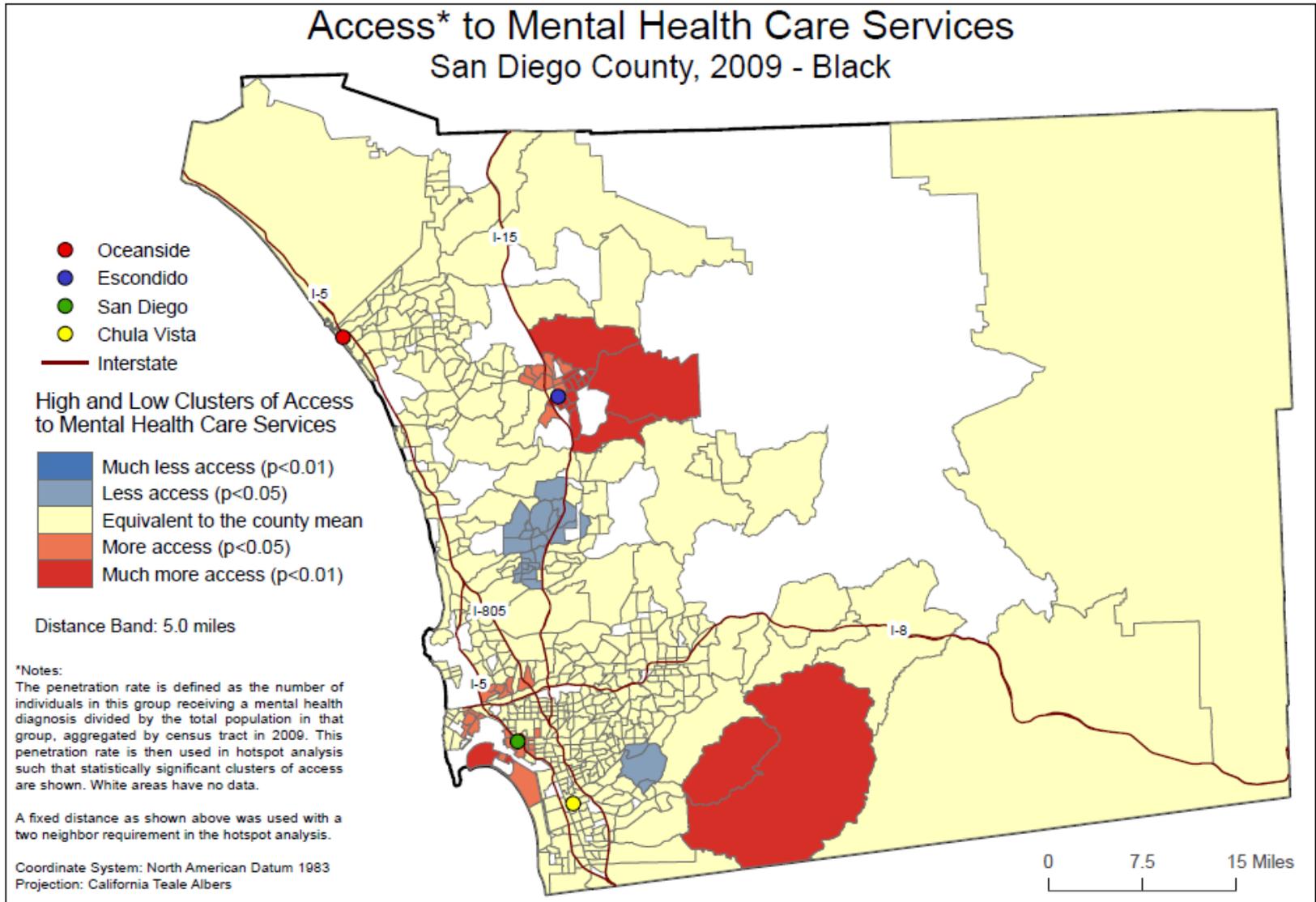
Hot Spot Analysis

- It's a method for testing the statistically significant clusters of a variable (such as the penetration rate)
 - The analysis value (penetration rate) in a census tract is compared to a designated set of neighboring census tracts defined by distance and/or the number of neighbors (creating a local mean)
 - The local mean is compared to the overall mean for the dataset (in this case, California)(later, San Diego)
 - Areas of intense clustering of **high values** are **hot spots** and areas of intense clustering of **low values** are **cold spots**

Access – Hispanic



Access – African American



Interpretation

nd	nd	there are no data for the specified population
yellow	yellow	access and utilization are equivalent to the state mean
yellow	red	access is equivalent to the state mean, but utilization is high
yellow	blue	access is equivalent to the state mean, but utilization is low
red	yellow	access is high, but utilization is equivalent to the state mean
blue	yellow	access is low, but utilization is equivalent to the state mean
red	red	access and utilization are high (potential overuse of services)
red	blue	access is high and utilization is low
blue	red	access is low and utilization is high (potentially sicker individuals)
blue	blue	access and utilization are low (more services may be needed)

* Numbers inside boxes indicate the percentage of census tracts of that color

The statewide perspective - SMI

SMI	All Patients (age 18-64)		Male		Female		White		Black		Hispanic		Asian/Pacific Islander		Native Am/ Alaskan Native	
	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U
County Name																
Sacramento	6	2	45	28	8	1	97	2	97	1	5	7	68		22	71
San Benito	11															
San Bernardino	72	12	25		72	11	41		9	6	29	3	3	1	4	2
San Diego	93	57	96	53	84	57	90	52	51	44	70	63	63	24	12	27
San Francisco	100	100	100	3	100	100	100	37	100	7	100	1	74	91		3
San Joaquin	87	10	77	68	66	73	96		29		3	3				

SMI	Age 18-24		Age 25-44		Age 45-54		Age 55-64	
	A	U	A	U	A	U	A	U
County Name								
Sacramento	47	69	9		26	8		24
San Benito							11	
San Bernardino	37	3	49		21	8	70	4
San Diego	82	56	90	54	98	59	88	52
San Francisco	6	98	100	30	100	84	100	100
San Joaquin	88	77	63	76		3	3	71

Trend: adults have high levels of access AND utilization of MH services in San Diego

The statewide perspective - SED

SED County Name	All Patients (age 12-17)		Male		Female		White		Black		Hispanic		Asian/Pacific Islander		Native Am/ Alaskan Native	
	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U
Sacramento	3		5		45		40		2	1	2				1	32
San Benito							86			33					nd	nd
San Bernardino	53	8	51	13	51	**	39	5	14	4	57		24	11	12	
San Diego	79	4	83	***	54	6	29	9	9	3	87	3	12			19
San Francisco		100		88	34	100	100		100	61	46	59	100	100	70	
San Joaquin	79	89	83	69	78	83	82	31	6	21	85	73	60	2		

Trend: youth have high levels of access (except Native Americans), utilization low for some

Do clients have less serious mental health problems (so fewer visits per patient), are they more stable or is there a problem with follow-up care?

Mental Health Treatment Gap

- About 20% of the world population suffer from mental illness each year
- > 2/3 of people with mental illness receive **no** treatment
- In U.S, 67% and in Europe 74% receive **no** treatment
- In some population groups in the U.S., < 10% are treated

Treatment Gap in the U.S.

- Levels of **unmet need** (not receiving specialist or generalist care in past 12 months, with identified diagnosis in the same period)
 - Hispanics – 70%
 - African Americans – 72%
 - Asian Americans – 78%
 - Non-Hispanic Whites – 61%

Mexican American Prevalence and Service Survey (MAPSS)

Who utilized services in the last 12-months of those suffering from mental disorders?

- 38% of U.S. born received care
- 15% of immigrants received care
- 9% of migrant agricultural workers received care

Untreated Mental Illness

- Intensify over time...can reduce life expectancy
- Causes intense and prolonged suffering to individuals and their families
- Limits individuals' ability to reach social and educational normative goals
- Leads to significant costs to individuals, families, and communities



Measuring in the Context of Communities

- Need to situate mental health measurement into the **context of particular communities**
 - **Direct engagement with communities** beyond need assessments
 - Allowing the **measurement agenda to be responsive to community needs**
- **Feedback to state and national level to inform policy, practice and research**

Relevant Questions

- How can we **identify patients' non-medical health needs as part of their overall care?**
- How can we connect patients to local services/resources that help people avoid getting sick in the first place or better manage illness, including mental health needs?
- How can we **be a strong leader and champion to collaborate with other sectors** to improve health where patients live, learn, work, and play?
- How can we **connect community residents to jobs in the health care sector** – one of the largest employers?
- How can we **use community health workers to provide services or link patients to needed supports?**