



the mental health
advocate

Summer/Fall 2005

MEN AND DEPRESSION

**DEPRESSION IN MEN
IS NOT UNCOMMON;
HOWEVER, MEN ARE
MORE UNLIKELY TO
ADMIT TO
DEPRESSIVE SYMPTOMS**

**EVERY YEAR, DEPRESSIVE
ILLNESSES AFFECT AN
ESTIMATED 6.2 MILLION
MEN IN THE U.S.**



DEPRESSION IN MEN IS AN UNDER-RECOGNIZED ILLNESS

Men More Unlikely to Admit to Depressive Symptoms

Depression is a serious but treatable medical condition that can strike anyone regardless of age, ethnic background, socioeconomic status, or gender. However, depression may go unrecognized by those who have it, their families and friends, and even their physicians. Men, in particular, may be unlikely to admit to depressive symptoms and seek help. But depression in men is not uncommon: in the United States every year, depressive illnesses affect an estimated seven percent of men (more than six million men).

Depression comes in different forms, just as is the case with other illnesses such as heart disease. The three main depressive disorders are: major depressive disorder, dysthymic disorder, and bipolar disorder (manic-depressive illness). Not everyone with a depressive disorder experiences every symptom. The number and severity of symptoms may vary among individuals and also over time.

SYMPTOMS OF DEPRESSION IN MEN

Research and clinical findings reveal that while both men and women can develop the standard symptoms of depression, they often experience depression differently and may have different ways of coping. Men may be more willing to report fatigue, irritability, loss of interest in work or hobbies, and sleep disturbances rather than feelings of sadness, worthlessness, and excessive guilt.

- * Persistent sad, anxious, or "empty" mood
- * Feelings of hopelessness, pessimism
- * Feelings of guilt, worthlessness, helplessness
- * Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- * Decreased energy, fatigue, being "slowed down"
- * Difficulty concentrating, remembering, making decisions
- * Trouble sleeping, early-morning awakening, or oversleeping
- * Appetite and/or weight changes
- * Thoughts of death or suicide, or suicide attempts
- * Restlessness, irritability
- * Persistent physical symptoms, such as headaches, digestive disorders, and chronic pain, which do not respond to routine treatment

Some researchers question whether the standard definition of depression and the diagnostic tests based on it adequately capture the condition as it occurs in men.

Men are more likely than women to report alcohol and drug abuse or dependence in their lifetime; however, there is debate among researchers as to whether substance use is a "symptom" of underlying depression in men, or a co-occurring condition that more commonly develops in men. Nevertheless, substance abuse can mask depression, making it harder to recognize depression as

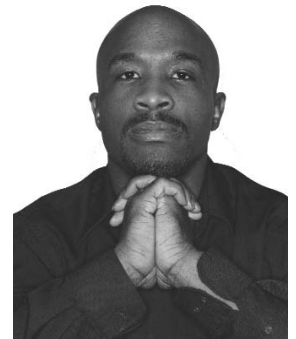
a separate illness that needs treatment.

Instead of acknowledging their feelings, asking for help, or seeking appropriate treatment, men may turn to alcohol or street drugs when they are depressed, or become frustrated, discouraged, angry, irritable and, sometimes, violently abusive. Some men may deal with depression by throwing themselves compulsively into their work, attempting to hide their depression from themselves, family, and friends; other men may respond to depression by engaging in reckless behavior, taking risks, and putting themselves in harm's way. Four times as many men as women die by suicide in the United States, even though women make more suicide attempts during their lives. In light of research indicating that suicide is often associated with depression, the alarming suicide rate among men may reflect the fact that men are less likely to seek treatment for depression. Many men with depression do not obtain adequate diagnosis and treatment, which may be life saving.

More research is needed to understand all aspects of depression in men, including how men respond to stress and feelings associated with depression, how to make them more comfortable acknowledging these feelings and getting the help they need, and how to train physicians to better recognize and treat depression in men. Family members, friends, and employee assistance professionals in the workplace also can play important roles in recognizing depressive symptoms in men and helping them get treatment.

SEEK HELP FOR DEPRESSION

If you are having symptoms of depression or know someone who is, seek help. There are several places in most communities where people with depressive disorders can be diagnosed and treated. Help is available from family doctors, mental health specialists in mental health clinics or private clinics, and from other health professionals.



A variety of treatments, including medications and short-term psychotherapies (i.e., "talking" therapies), have proven effective for depressive disorders: more than 80 percent of people with a depressive illness improve with appropriate treatment. Not only can treatment lessen the severity of depression, but it may also reduce the duration of the episode and may help prevent additional bouts of depression.

*The Mental Health Association in Texas is part of the **Outreach Partnership Program**, a nationwide outreach initiative of the National Institute of Mental Health (NIMH) with support from the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS). This program enlists state and national organizations in a partnership to help close the gap between mental health research and clinical practice, inform the public about mental illnesses, and reduce the stigma and discrimination associated with mental illness.*

2005 RING OF HONOR EVENT

Honorees: Lone Star Girl Scouts Council, The University of Texas, School of Social Work, Mobilus Media

Join the Mental Health Association in Texas for the 2005 Ring of Honor event to recognize the contributions in mental health of Etta Moore and Julia Cuba with the Lone Star Girl Scouts Council and Dr. Darlene Grant with The University of Texas, School of Social Work for the project **Enterprising Girl Scouts Beyond Bars** and Ellen Spiro and Karen Bernstein with Mobilus Media for the film **Troop 1500-Girl Scouts Beyond Bars**.

This year's event is scheduled for Friday, October 21st, from 6:30 pm - 9:00 pm at the George Washington Carver Museum and Cultural Center (1165 Angelina Street) in Austin, Texas.

It will begin with a pre-event reception in recognition of our honorees and continue with an exclusive mental health premiere of the film **Troop 1500 - Girl Scouts Beyond Bars**.

ABOUT THE FILM TROOP 1500

Their mothers may be convicted thieves, murderers and drug dealers, but the girls of Troop 1500 want to be doctors, social workers and marine biologists.

With meetings once a month at Hilltop Prison in Gatesville, Texas, Enterprising Girl Scouts Beyond Bars, an innovative Girl Scout program brings daughters together with their inmate mothers, offering them a chance to rebuild their broken relationships. Intimately involved with the troop for several years, the directors Ellen Spiro and Karen Bernstein (Mobilus Media) took their cameras far beyond meetings to explore the painful context of broken families. Powerful insight comes from interviews shot by the girls themselves, which reveal their conflicted feelings of anger and joy, abandonment and intimacy-as well as the deep influence their mothers still have on the girls.

An estimated 1.5 million children have incarcerated parents and 90 percent of female inmates are single parents. Their daughters are six times more likely to land in the juvenile justice system. TROOP 1500 poignantly reveals how an inspired yet controversial effort by the more than 90-year old Girl Scouts organization is working to help these at-risk young girls build self-esteem, deal with their unique circumstances and break the cycle of crime within families.

WE ARE VERY APPRECIATIVE AND GRATEFUL OF EVERY GIFT IN ANY AMOUNT.

Your sponsorship and contributions to the Ring of Honor are vital. Proceeds from the Ring of Honor will help the Mental Health Association in Texas continue its mission and address key issues surrounding mental health and mental illnesses through research, programming, legislative campaigns and public awareness initiatives.

THANK YOU FOR YOUR SUPPORT!

We sincerely hope that you will join the Mental Health Association in Texas as a sponsor at the 2005 Ring of Honor. Attached you will find a variety of sponsorship opportunities and a registration form. As with all of our giving opportunities, we welcome donations made in honor of or in memory of an individual, family or friend.

Please direct questions regarding the 2005 Ring of Honor to Traci Patterson, Communications Director or Daisy Wei, Communications Assistant at (512) 454-3706.

To attend, complete the 2005 Ring of Honor donation form and return it along with your contribution to:

Mental Health Association in Texas
2005 Ring of Honor
1210 San Antonio Street, Suite 200
Austin, Texas 78701

For more assistance, please call Traci Patterson, Communications Director or Daisy Wei, Communications Assistant at 512-454-3706 or visit our website www.mhatexas.org/.

I WILL NOT ATTEND THE 2005 RING OF HONOR, but I would like to donate to the Mental Health Association in Texas with my tax-deductible gift in the amount of \$_____.

I WILL ATTEND THE 2005 RING OF HONOR, and I would like to support the Mental Health Association in Texas with my tax-deductible gift in the amount of (check one below):

- \$5,000 TROOP LEADER
- \$2,500 SENIOR SCOUT
- \$1,000 CADETTE SCOUT
- \$500 JUNIOR SCOUT
- \$100 BROWNIE SCOUT
- \$25 DAISY SCOUT

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INSIDE THIS ISSUE

DEPRESSION IN MEN IS AN UNDER-RECOGNIZED ILLNESS.....	2
2005 RING OF HONOR AWARD RECIPIENTS.....	3
79TH LEGISLATIVE SESSION SUMMARY PART II: OTHER PRIORITY LEGISLATIVE ISSUE AREAS.....	4
MENTAL ILLNESS EXACTS HEAVY TOLL, BEGINNING IN YOUTH.....	6
COGNITIVE THERAPY REDUCES REPEAT SUICIDE ATTEMPTS BY 50 PERCENT.....	7

79TH LEGISLATIVE SESSION SUMMARY PART II: OTHER PRIORITY LEGISLATIVE ISSUE AREAS

In the last issue of the Advocate (Spring/Summer 2005) we described the Mental Health Association in Texas' efforts in priority legislative areas such as advocacy for the Department of State Health Services (DSHS) budget, parity in private insurance for mental health benefits, the insanity defense, child protective services reform, and potential reorganization of the local community mental health system. In this issue, we will outline developments in other priority legislative issue areas.

Funding Equity Between MHMR Regions

HB 1862 (Uresti) would have required the Executive Commissioner of Health and Human Services to develop and implement a plan that achieves equity in the distribution and funding of mental health services among communities in Texas by 2011. State funds have historically been distributed inequitably across the state, causing some centers to have markedly more funding per capita than other centers.

Although HB 1862 did not pass, a "Special Provision" was added to the Health and Human Services budgets that requires the Department of State Health Services (DSHS) to implement an equity plan from 2006 - 2013. The goal of the plan is to achieve as much equity as possible by 2013, but it prohibits any funding reductions to a local authority from exceeding 5% in any given year. New state or federal funds are to be distributed in accordance with the plan. The law allows the plan to consider factors other than just population (e.g. poverty level) in developing the equity plan.

Rights & Safety

A number of bills were introduced that will help protect the rights and safety of individuals with mental illnesses. The Mental Health Association in Texas and other advocacy groups supported many of these bills.

Bills that Passed

SB 325 (Zaffirini/Naishtat) prohibits certain types of restraint and seclusion practices from being used on individuals residing in mental health facilities, residential treatment centers, nursing homes, and other facilities regulated by the health and human service system. Juvenile and adult correctional facilities are not included. Requires the Health and Human Services Commission to adopt rules regarding restraint and seclusion, and establishes a task force that will make recommendations to the Commission on best practices, data collection, minimum standards, and other issues.

SB 465 (West/Naishtat) requires a court hearing before administering psychoactive medications without their consent to individuals committed to psychiatric facilities under "Not Guilty by Reason of Insanity" or "Incompetent to Stand Trial" standards. Previous law only required hearings for individuals civilly committed to psychiatric hospitals.

SB 1473 (Lindsey/Coleman) is known as the "Bob Meadours Act" after an individual with mental illness who was killed by a police officer who did not know how to respond appropriately. The Bob Meadours Act will require police chiefs and peace officers to receive training on de-escalation and crisis intervention techniques in interactions with persons with mental impairments.

HB 291 (Goolsby/Carona) requires a victim of someone acquitted under a "Not Guilty by Reason of Insanity" (NGRI) verdict to be notified when the person is released from a mental health facility. Advocates had concerns about this bill because it could cause an individual with mental illness who was no longer any danger to others to have difficulty finding housing in a community due to

the negative publicity that would be generated upon their release.

HB 2518 (Coleman/Duncan) establishes and outlines the rights available to a person participating in a "mental health court" in lieu of a criminal court. Includes the right to counsel, the right to withdraw at any time and to proceed through the regular criminal justice system, and other protections. Also expands the purview of the courts to include individuals charged with felonies. (Prior law only allowed mental health courts to be used for misdemeanors.)

Bills that did not pass

HB 3089 (Dutton) and SB 1760 (Gallegos) would have allowed DSHS to contract with a private provider to operate a state hospital if it is determined that the private entity would operate the hospital at least 5% less than the state agency. **The bill also required DSHS to use the contractor to build a new state hospital.** MHAT vigorously opposed this bill and worked to kill it up until the midnight deadline the last day the House can debate bills. (The bill was just minutes from being considered on the floor of the House when the deadline struck.) Mental health advocates uniformly want dollars put in the community mental health safety net -- rather than into a brand new state hospital -- so individuals do not get into crisis situations to begin with.

HB 3303 (Davis) would have allowed a physician to *order* a peace officer to apprehend, take into custody, and transport a person to an inpatient facility if the physician believes he or she may be a harm to themselves or others. This process would have circumvented the appropriate process where a doctor, peace officer and local community center crisis worker jointly decide who needs to be transported to a state hospital for possible involuntary commitment. MHAT opposed this bill.

SB 1305 (Brimer) would have extended the amount of time an individual can be held on an "emergency detention" from 24 hours to 72 hours. Advocates, including MHAT, opposed this bill based on a lack of compelling evidence that more time is needed for hospitals to initially assess an individual to determine if they need to remain in the state hospital involuntarily due to their potential for harm to self or others.

SB 1582 (Zaffirini) would have permitted detaining a person for mental health purposes in a jail or non-medical facility only as a matter of last resort, and only if an emergency room or other appropriate facility is over 75 miles away. The bill would also have limited detention in such facilities to a period of not more than twelve hours. It also would have prohibited the use of certain restraints during apprehension, detention, or transportation of a person suspected of having mental illness to minimize the risk of accidental injury or death.

School Discipline

A large number of bills were filed that would have addressed school discipline, an issue which especially impacts the 35,000 children with emotional disorders in public schools - many of whom are sent to disciplinary placements under schools' "Zero Tolerance" policies when they act out due to their disability. Representative Dora Olivo and Senator Royce West were the most prolific, and introduced various bills relating to:

- ♦ Requiring school security and peace officers to receive training in behavior management and de-escalation techniques.

con't from page 4-Summary Part II

- ♦ Requiring school districts to assign the Texas Assessment of Knowledge and Skills (TAKS) test score results for students in disciplinary alternative schools (known as Disciplinary Alternative Education Placements, or DAEPs) back to the campus the student originally attended. This would help offset the incentive to send low-performing students off campus in order to improve campus test scores.
- ♦ Requiring school districts to provide transportation to students in DAEPs and requiring the schools to provide a full 7-hour school day.
- ♦ Requiring DAEPs to report information to the Texas Education Agency regarding how many of their students receive special education services; and others.

None of these proposals passed.

One bill that did pass, however, recognizes the relationship between a student's emotional disorder and their possible involvement in behavior subject to disciplinary treatment or removal. HB 603 (Eissler/Lindsay) includes a requirement that campus and district student codes of conduct must specify if consideration is given to whether the student's disability substantially impairs the student's capacity to appreciate the wrongfulness of the student's conduct in decisions to order suspension, removal to a DAEP or expulsion. Thanks to Kay Lambert of Advocacy, Inc. for assistance in legislative analysis of education bills.

Passed - but in a different form!

HB 122 (Naishtat) would have required the Health and Human Services Commission (HHSC) to allow Medicaid recipients to receive Medicaid-reimbursed counseling from a licensed psychologist, licensed marriage and family therapist, licensed professional counselor, or licensed master of social work. HB 122 did not pass, but its provisions were included in an omnibus Medicaid reform package, SB 1188, by Senator Jane Nelson. Without this legislation, only psychiatrists could be reimbursed by Medicaid for providing counseling services - severely limiting the availability of counseling for the average consumer!

Unfortunately, SB 1188 also added language that says the services only have to be provided "subject to appropriations," and it is not clear if there will be adequate appropriations to cover all the individuals who will now be able to access a Medicaid-covered counselor.

HB 173 (Hochberg) would allow certain prescription drugs to be imported from Canada if the Canadian pharmacy meets specific Texas Board of Pharmacy criteria. Although HB 173 did not pass, the importation provisions were included in the State Board of Pharmacy "sunset" reauthorization bill. MHAT supported this provision as a way for some consumers to obtain otherwise unaffordable medications.

HB 339 (Naishtat) outlined standards for the administration of psychoactive medications to children in foster care and did not pass. However, Representative Naishtat was able to get provisions addressing this concern into the omnibus adult and child protective services legislation (SB 6) highlighted in the Spring/Summer Advocate.

Other miscellaneous bills of interest:

HB 270 (Farrar/Zaffirini) passed, which amends the Texas Family Code to state that a sibling of a child may file a suit requesting access to the child if the siblings are separated because of divorce of the child's parents or due to action taken by DFPS. The bill states that the court shall order reasonable access to a child by the child's sibling if the court finds that access is in the best interest of the child. MHAT supported this bill.

HB 2606 (Guillen), which did not pass, would have (1) required automatic authorization in Medicaid and CHIP of a psychotropic medication to treat a mental illness; (2) restored CHIP benefits to the original benefits package; (3) eliminated the waiting period from the CHIP program; (4) defined criteria for the mental health priority population as being based on the urgency of a person's need for services, and not based solely on their diagnosis; and (5) restored counseling services in Medicaid. MHAT obviously supported this bill as it included many of MHAT's top legislative priorities. A special thank you to Representative Ryan Guillen of Rio Grande City.

SB 1340 (Madla/Delisi) passed and will require the Health and Human Services Commission to explore implementing a pilot program to provide Medicaid mental health services through "telemedicine" and "telehealth" programs.

Riders

In the Spring 2005 issue of the Advocate the legislative appropriation for DSHS was highlighted. However, a number of important budget riders and "special provisions" were attached to the budget (or that of other agencies important to mental health) that will also impact services and the availability of funding for some programs.

Specifically:

Rider 8 to the Health and Human Services Commission (HHSC) budget requires the agency to develop a plan to prevent custody relinquishment of youth with serious emotional disorders and to request any necessary waivers from the federal government.

A HHSC budget rider sets aside \$75,000 each year of the biennium to be granted to a non-profit organization for the purpose of developing a pilot project for serving individuals dually diagnosed with mental retardation and mental illness.

A special provision authorizes local mental health authorities to expend up to 15% of their New Generation Medication (NGM) funding on related services and direct services to clients. Another rider allows up to 17.5% of funds designated for state hospitals to be transferred to community services.

Riders on the Department of State Health Services (DSHS) budget and the Texas Commission on Jail Standards (TCJS) budget require jails to -- working with their local mental health authority's CARE system database -- check each offender upon intake to determine if the offender is currently, or has been previously, in the mental health system. Local mental health authorities are to respond to such referrals within 72 hours.

Rider 83 on the Texas Department of Criminal Justice (TDCJ) appropriation allocates \$160,000 per year for a mental health deputy pilot program for Midland and Ector counties.

Once again the Mental Health Association in Texas is grateful to a long list of legislators (mentioned in this and the previous Advocate article as bill sponsors and authors of bills MHAT supported), their staff, agency officials, and colleagues in the advocacy field for all their assistance before, during, and after the legislative session. A special thanks to all the attorneys and program specialists at Advocacy, Inc, who share information and expertise so readily in all the above areas.

**THANK
YOU!**

The Mental Health Association in Texas would like to express sincere gratitude to **George Christian** for his legislative expertise and mental health advocacy.

MENTAL ILLNESS EXACTS HEAVY TOLL, BEGINNING IN YOUTH

Researchers supported by the National Institute of Mental Health (NIMH) have found that half of all lifetime cases of mental illness begin by age 14, and that despite effective treatments, there are long delays - sometimes decades - between first onset of symptoms and when people seek and receive treatment. The study also reveals that an untreated mental disorder can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses.

The landmark study is described in four papers that document the prevalence and severity of specific mental disorders. The papers provide significant new data on the impairment - such as days lost from work - caused by specific disorders, including mood, anxiety, and substance abuse disorders. These measures will allow researchers to determine the degree of disability and the economic burden caused by mental illness, as well as trends over time.

The papers are reported in the June 6 issue of the Archives of General Psychiatry by Ronald Kessler, Ph.D., and colleagues. The study was a collaborative project between Harvard University, the University of Michigan, and the NIMH Intramural Research Program.

This study, called the National Comorbidity Survey Replication (NCS-R), is a household survey of 9,282 English-speaking respondents, age 18 and older. It is an expanded replication of the 1990 National Comorbidity Survey, which was the first to estimate the prevalence of mental disorders (using modern psychiatric standards) in a nationally representative sample. The expansion includes detailed measures that will significantly improve estimates of the severity and persistence of mental disorders, and the degree to which they impair individuals and families, and burden employers and the U.S. economy.

"These studies confirm a growing understanding about the nature of mental illness across the lifespan," says Thomas Insel, M.D., Director of the National Institute of Mental Health. "There are many important messages from this study, but perhaps none as important as the recognition that mental disorders are the chronic disorders of young people in the U.S."

Prevalence and Age-of-Onset of Mental Disorders

Unlike most disabling physical diseases, mental illness begins very early in life. Half of all lifetime cases begin by age 14; three quarters have begun by age 24. Thus, mental disorders are really the chronic diseases of the young. For example, anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20's. Unlike heart disease or most cancers, young people with mental disorders suffer disability when they are in the prime of life, when they would normally be the most productive.

The risk of mental disorders is substantially lower among people who have matured out of the high-risk age range. Prevalence increases from the youngest group (age 18-29) to the next-oldest age group (age 30-44) and then declines, sometimes substantially, in the oldest group (age 60+). Females have higher rates of mood and anxiety disorders. Males have higher rates of substance use disorders and impulse disorders.

The survey found that in the U.S., mental disorders are quite common; 26 percent of the general population reported that they had symptoms sufficient for diagnosing a mental disorder during the past 12 months. However, many of these cases are mild or will

resolve without formal interventions.

It is likely, however, that the prevalence rates in this paper are underestimated, because the sample was drawn from listings of households and did not include homeless and institutionalized (nursing homes, group homes) populations. In addition, the study did not assess some rare and clinically complex psychiatric disorders, such as schizophrenia and autism, because a household survey is not the most efficient study design to identify and evaluate those disorders.

Failure and Delay in Initial Treatment Contact

The study documents the long delays between the onset of a mental disorder and the first treatment contact, as well as the accumulated burden and hazards of untreated mental disorders.

These pervasive delays in getting treatment tend to occur for nearly all mental disorders, though they vary according to specific diagnostic categories. The median delay across disorders is nearly a decade; the longest delays are 20-23 years, for social phobia and separation anxiety disorders. This is possibly due to the relatively early age of onset and fears of therapy that involve social interactions.

Shorter delays between onset of disorder and treatment seeking - still a protracted 6-8 years - are seen for mood disorders, and are likely attributable to public awareness campaigns, the marketing of newer therapies directly to consumers, and expanded insurance coverage.

While approximately 80 percent of all people in the U.S. with a mental disorder eventually seek treatment, there are public health implications from such long delays in treatment. Untreated psychiatric disorders can lead to more frequent and more severe episodes, and are more likely to become resistant to treatment. In addition, early-onset mental disorders that are left untreated are associated with school failure, teenage childbearing, unstable employment, early marriage, and marital instability and violence.

"The pattern appears to be that the earlier in life the disorder begins, the slower an individual is to seek therapy, and the more persistent the illness," said Dr. Kessler, a professor of health care policy at Harvard Medical School. "It's unfortunate that those who most need treatment are the least likely to get it."

Treating cases early could prevent enormous disability, before the illness becomes more severe, and before co-occurring mental illnesses develop, which only become more difficult to treat as they accumulate, according to the researchers.

Severity and Comorbidity of Mental Disorders

The second paper reports that even though mental disorders are widespread throughout the population, the main burden of illness is concentrated in those with a severe disorder - about 6 percent. A "serious" disorder involves a substantial limitation in daily activities or work disability, or a suicide attempt with serious lethal intent, or psychosis. The serious group reported a mean of 88.3 days - nearly 3 months of the year - when they were unable to carry out their normal daily activities.

Unfortunately, say the researchers, individuals with one mental disorder are at a high risk for also having a second one (comorbidity). Nearly half (45 percent) of those with one mental disorder met criteria for two or more disorders, with severity strongly related to comorbidity.

CON'T ON PAGE 7

COGNITIVE THERAPY REDUCES REPEAT SUICIDE ATTEMPTS BY 50 PERCENT

Recent suicide attempters treated with cognitive therapy were 50 percent less likely to try to kill themselves again within 18 months than those who did not receive the therapy, report researchers supported by the National Institutes of Health's (NIH) National Institute of Mental Health (NIMH) and the Center for Disease Control and Prevention (CDC). A targeted form of cognitive therapy designed to prevent suicide proved better at lifting depression and feelings of hopelessness than the usual care available in the community, according to Gregory Brown, Ph.D., Aaron Beck, M.D., University of Pennsylvania, and colleagues, who published their findings in the August 3, 2005 Journal of the American Medical Association (JAMA).

"Since even one previous attempt multiplies suicide risk by 38-40 times and suicide is the fourth leading cause of death for adults under 65, a proven way to prevent repeat attempts has important public health implications," said NIMH Director Thomas Insel, M.D.

To achieve a large enough sample to reliably detect differences in the effectiveness of interventions, the researchers first screened hundreds of potential suicide attempters admitted to the emergency room of the Hospital of the University of Pennsylvania in Philadelphia, ultimately recruiting 120 patients into the study.

Averaging in their mid-thirties, 61 percent of the participants were female, 60 percent black, 35 percent white, and 5 percent Hispanic and other ethnicities. Most had attempted to kill themselves by drug overdosing (58 percent), with 17 percent by stabbing, 7 percent by jumping and 4 percent by hanging, shooting or drowning. Seventy-seven percent had major depression and 68 percent a substance use disorder.

After a clinical evaluation, each participant was randomly assigned to one of two conditions: cognitive therapy or usual care — services available in the community. Cognitive therapy was developed by Beck in the 1970s and has been applied successfully in a wide variety of psychiatric disorders. Those in the cognitive group were scheduled to receive 10 outpatient weekly or biweekly cognitive therapy sessions specifically developed for preventing suicide attempts. The sessions helped patients find a more effective way of looking at their problems by learning new ways to handle negative thoughts and feelings of hopelessness. In a relapse-prevention task near the end of their therapy, they were asked to focus directly on the events, thoughts, feelings and

behaviors that led to their previous suicide attempts and explain how they would respond in a more adaptive way. If they passed this task successfully, their cognitive therapy ended; if they were unsuccessful, additional sessions were provided.

Both groups were encouraged to receive usual care from clinicians in the community and were tracked by study case managers by mail and phone throughout the 18 month follow-up period. The case managers offered referrals to — but not payment for — local mental health and drug abuse treatment and social services.

About half of the participants in both groups took psychotropic medications and about 13 to 16 percent received drug abuse treatment. About 27 percent of those in the usual care group received psychotherapy outside of the study, compared to 21 percent of those also receiving cognitive therapy.

Over the year-and-a-half follow-up period, only 24 percent (13) of those in the cognitive therapy group made repeat suicide attempts, compared to 42 percent (23) of the usual care group. Although the groups did not differ significantly in suicidal thoughts, those who received cognitive therapy scored better on measures of depression severity and hopelessness, which the researchers suggest "may be more highly associated with a reduced risk of repeat suicide attempts."

"We were surprised by the amount of energy and resources it takes to reach out to individuals who attempt suicide," noted Brown. "This population lacks a positive attitude toward the mental health system and often fails to show up for scheduled appointments. However, the combination of cognitive therapy plus case management services was effective in preventing suicide attempts." He suggests that cognitive therapy's short-term nature makes it a good fit for treatment of suicide attempters at community mental health centers.

"Suicide and suicide attempts are serious public health problems that devastate individuals, families and communities," added Dr. Ileana Aria, Director, CDC's National Center for Injury Prevention and Control. "This research provides valuable insight for those treating people at risk, so that they can learn adaptive ways to handle stress and resolve their problems and thereby reduce the likelihood they will resort to suicidal behavior as a solution."

FROM PAGE 6 MENTAL ILLNESS EXACTS HEAVY TOLL, BEGINNING IN YOUTH

This finding supports the suggestion by a growing portion of researchers that the boundaries between some diagnostic categories may be less discrete than previously believed.

Use of Mental Health Services

The study indicates that the U.S. mental health care system is not keeping up with the needs of consumers and that improvements are needed to speed initiation of treatment as well as enhance the quality and duration of treatment. For instance, over a 12-month period, 60 percent of those with a mental disorder got no treatment at all.

The good news is that the proportion of people who reported 12-month mental health service use is higher now - at 17 percent - than a decade ago in the baseline NCS survey, at 13 percent. The expansion was mainly in the general medical sector, with more

primary care physicians providing psychiatric services. People with mental or substance abuse disorders were more likely to get treatment from a primary care physician/nurse or other general medical doctor (22.8 percent), or from a non-psychiatrist mental health specialist (16 percent), such as a psychologist, social worker, or counselor, than from a psychiatrist (12 percent), though the survey did show that the adequacy of treatment - measured by number of visits - is best when provided by mental health practitioners. About 9.7 percent sought help from a counselor or spiritual advisor outside of a mental health setting; and 6.9 percent used a complementary-alternative source, such as a chiropractor or self-help group. This held true even for those with severe mood disorders.

Traditionally underserved groups, such as the elderly, racial/ethnic minorities and those with low income or without insurance, had the greatest unmet need for treatment.



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4-10 **National Suicide Prevention Week**

OCTOBER 2005

3-9 **Mental Illness Awareness Week**
8 **World Mental Health Day**
9 **National Depression Screening Day**
17-23 **National Healthcare Quality Week**

ADVOCATE Newsletter Subscription Information

- I would like to receive a quarterly subscription to the Mental Health Advocate newsletter.
- Update the Mental Health Advocate mailing list with my new address information.
- I would like to discontinue my subscription to the Mental Health Advocate.

Mr. / Mrs. / Miss / Ms. / Dr. *(circle one)*

Name _____

Title _____

Mailing Address _____

This is my home or business address

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