

**COMPdata Monthly Monitor - Montana**  
**April/May 2005**  
**Adult Behavioral Health**

**INTRODUCTION**

This report focuses on adult behavioral health, which includes mental health and substance abuse. A similar COMPdata Monthly Monitor Report focusing on pediatric patients was published in January 2005.

In the first Surgeon General's report ever issued on mental health in 1999, two key messages were delivered:<sup>1</sup>

- "The qualities of mental health are essential to a healthy life."
- "Mental disorders are real health conditions that have an immense impact on individuals and families throughout the US and the world."

The Surgeon General's report also noted that despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment. The many barriers to behavioral health care are discussed below.

The magnitude of the impact associated with behavioral health problems was demonstrated in the 1996 World Health Organization led Global Burden of Disease Study. The project established a single measure to allow comparison across different disease categories.<sup>2</sup> The Disability Adjusted Life Years (DALYs) measures the lost years of health life regardless of whether the years were lost to premature death or disability. Using the DALYs measure:

- Among specific sources of disease, major depression ranked second only to ischemic heart disease in magnitude of disease burden in established market economies.
- Among illness categories, all mental illness ranks second (behind all cardiovascular conditions) and accounts for 15.4 percent of disease burden, greater than all cancers combined.
- Alcohol and drug use together rank fourth among all categories, accounting for 6.2 percent of disease burden.

More recently, in 2003 The President's New Freedom Commission on Mental Health reported that mental illness and substance abuse affect nearly every American family, with an estimated 5% to 7% of adults suffering a severe mental illness in any given year.<sup>3</sup> The Commission's findings confirmed that there are unmet needs and that many barriers impeded care for people with mental illnesses. See the Appendix for the Commission's six major goals for transforming the mental health system.

**Mental Health Statistics**

An estimated 1 in 5 adults suffer from a diagnosable mental disorder in a given year.<sup>4</sup> Many people suffer from more than one mental disorder at a time.

**Depressive Disorders**<sup>4</sup>

Depressive disorders encompass major depressive disorder, dysthymic disorder, and bipolar disorder. Approximately 9.5% of the adult (18 and older) U.S. population has a depressive disorder. Nearly twice as many women, 12.0%, as men, 6.6%, are affected by a depressive

disorder each year. Depressive disorders often co-occur with anxiety disorders and substance abuse.

- Major depressive disorder affects about 5.0% of the U.S. adult population in a given year. While major depressive disorder can develop at any age, the average age at onset is the mid-twenties.

- Dysthymic disorder (chronic, mild depression) symptoms must persist for at least two years in adults to meet criteria for the diagnosis. Approximately 5.4% of the adult population is affected by this disease during their lifetime. About 40% of adults with dysthymic disorder also meet criteria for major depressive disorder or bipolar disorder in a given year.

- Bipolar disorder affects 1.2 percent of the U.S. adult population in a given year. Men and women are equally likely to develop bipolar disorder. The average age for a first manic episode is the early twenties.

### **Schizophrenia** <sup>4</sup>

Schizophrenia, a serious disorder that affects how a person thinks, feels, and acts occurs in about 1.1% of the adult population in a given year, affecting men and women with equal frequency. Schizophrenia often appears earlier in men, usually in the late teens or early twenties, compared to the twenties or early thirties for women.

### **Anxiety Disorders** <sup>4</sup>

Anxiety disorders include panic disorder, obsessive-compulsive disorder, post traumatic stress disorder, generalized anxiety disorder, and phobias. Approximately 13.3 percent of adults aged 18 to 54 have an anxiety disorder. (All of the remaining statistics for Anxiety Disorders in this section are for adults aged 18-54.)

- Panic Disorder typically develops in late adolescence or early adulthood and affects about 1.7% of adults in a given year. About one in three people with panic disorder develop agoraphobia.

- Obsessive-Compulsive Disorder is found in 2.3 percent of adults, though the first symptoms generally begin during childhood or adolescence.

- Post-Traumatic Stress Disorder affects as many as 3.6% of adults. PTSD can develop at any age, including childhood. This disorder can result from any number of personal or social tragedies or disasters. It is estimated that some 30% of Vietnam veterans experienced PTSD at some point after the war.

- Generalized Anxiety Disorder occurs in about 2.8 percent of adults. GAD can begin at any age though the risk is highest between childhood and middle age.

- Phobias affect a great number of American adults. Social phobia typically develops in childhood or adolescence and affects some 3.7% of adults. Agoraphobia affects another 2.2% of adults and other specific phobias occur in 4.4% of the adult population.

### **Eating Disorders** <sup>4</sup>

The three main types of eating disorders – anorexia nervosa, bulimia nervosa, and binge-eating disorder – primarily affect women. Between 85% to 95% of people with anorexia or bulimia and an estimated 65% of those with binge-eating disorder are female. During their lifetime, as many as 3.7% of females suffer from anorexia and 4.2% from bulimia. The mortality rate among people with anorexia is estimated to be 5.6% per decade.

### **Alzheimer's Disease** <sup>4</sup>

The most common form of dementia among people 65 and older, Alzheimer's disease affects an estimated 4 million Americans. The duration of illness from onset to death is typically 8 to 10

years.

### **Serious Mental Illness – U.S. and Montana Statistics** <sup>5</sup>

Serious mental illness is defined as having a diagnosable mental, behavioral or emotional disorder that resulted in function impairment that substantially interfered with or limited one or more major life activities. In the U.S. the average percent for 2002 and 2003 of adults 18 or older having a serious mental illness was 8.8. In Montana, the average for the same period was 9.8%. Looking at the age group of 18 to 25 years, the U.S. average was 13.6% and for Montana it was 15.2%. For persons aged 26 or older the U.S. average was 7.9% and in Montana it was 8.9%.

### **Substance Abuse Statistics**

The following statistics on national and Montana substance abuse are drawn from the Substance Abuse and Mental Health Services Administration Office of Applied Studies 2002-2003 National Surveys on Drug Use and Health. <sup>5</sup> In 2003 an estimated 21.6 million Americans (aged 12 or older) were classified with dependence on or abuse of either alcohol or illicit drugs.

### **Alcohol Dependence or Abuse in Past Year**

The following statistics report the estimated average percent for 2002 and 2003 of persons dependent on or abusing alcohol in the past year:

- U.S., 12 years or older 7.6%
- U.S., 12-17 years: 5.9%
- U.S., 18-25 years: 17.4%
- U.S., 26 years or older: 6.1%
  
- MT, 12 years or older 10.7%
- MT, 12-17 years: 11.2%
- MT, 18-25 years: 23.4%
- MT, 26 years or older: 8.4%

### **Illicit Drug Dependence or Abuse in Past Year**

The following statistics report the estimated average percent for 2002 and 2003 of persons dependent on or abusing illicit drugs in the past year:

- U.S., 12 years or older 2.9%
- U.S., 12-17 years: 5.4%
- U.S., 18-25 years: 8.0%
- U.S., 26 years or older: 1.7%
  
- MT, 12 years or older 3.2%
- MT, 12-17 years: 7.2%
- MT, 18-25 years: 8.5%
- MT, 26 years or older: 1.7%

### **Dual Diagnosis** <sup>6</sup>

A person who has both an alcohol or drug problem and an emotional/psychiatric problem is said to have a dual diagnosis. As many as 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Of those diagnosed as mentally ill, an estimated 29%

abuse either alcohol or drugs.

### **Suicide**

In 2003, suicide was the 11th leading cause of death in the U.S. accounting for 30,642 deaths.<sup>7</sup> The age-adjusted rate of 10.5 per 100,000 persons was down slightly from 2002 when the rate was 10.9. When categorized by age and race, the highest suicide rate was among white men over the age of 85 at 54 deaths per 100,000 persons, more than five times the national average.<sup>8</sup> More than four times as many men as women die by suicide, although women report attempting suicide during their lifetime about three times as often as men. Suicide is the third leading cause of death among people 15 to 24 years of age. Some research has show that 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders.<sup>9</sup>

### **ADULT BEHAVIORAL HEALTH INPATIENTS IN MONTANA**

All of the following inpatient statistics exclude newborns – Major Diagnostic Category. Adult inpatients are categorized by age in this report as 18 years of age and older. The following Montana hospital statistics illustrate the depth of inpatient adult behavioral health patients.

#### **Mental Illness** (ICD-9 Diagnosis codes: 290-290.9, 293-302.9, 306-319)

In 2004 there were 18,023 adult inpatients discharged with a principal or secondary diagnosis of mental illness or 20.4% of all adult patients. The number of total inpatients with a principal or secondary diagnosis of mental illness increased from 15,897 in 2001 to 18,023 in 2004, a 13.4% change.

Of the 18,023 inpatients who had a mental illness diagnosis, it was the principal diagnosis for 3,259 or 18.1%. This was a 3.2% decrease from 2001 when there were 3,367 patients with a principal diagnosis of mental illness. The 3,259 patients with a principal diagnosis of mental illness in 2004 represented 3.7% of all adult inpatients.

Mental illness was a secondary diagnosis for 16,769 cases in 2004 or 19.0% of all adult inpatients. This was a 14.5% increase since 2001 when there were 14,640 cases with a secondary mental illness diagnosis.

#### **Adult Inpatients with Principal Mental Illness Diagnosis**

The following statistics explore in more detail the characteristics of the 3,259 adult inpatients who had a principal mental illness diagnosis in the year 2004.

- More than two-thirds, 67.5%, of adult mental health inpatients were diagnosed with psychoses, DRG 430. Another 10.6% were diagnosed with depressive neuroses, DRG 426.
- With respect to the dual diagnosis of substance abuse and mental illness, there were 1,615 cases with a principal mental illness diagnosis and a secondary substance abuse diagnosis or 1.8% of all adult inpatients with a principal mental illness diagnoses.

#### **Admission and Discharge Patterns**

- Most adult mental health inpatients were admitted through the emergency room, 71.2%, while 18.3% were admitted with a physician's referral.
- Just over one-half, 54.7%, were urgent admissions, 32.0% were emergencies, and 12.9% were classified as elective for admission type.
- The majority, 81.0%, of adult mental health inpatients were discharged to home, 6.8%

were discharged or transferred to a skilled nursing or intermediate care facility, and 4.3% were discharged or transferred to another type of facility, most likely a free-standing psychiatric hospital or a hospital with a psychiatric unit.

- The majority, 61.2%, were discharged from hospitals in other urban areas while 38.8% were discharged from hospitals in rural areas.

### **Patient Characteristics**

- More females, 54.2%, than males, 45.8%, were mental health inpatients in 2004.

- The most frequent payer for mental health patients was Medicare, 24.3%, followed by commercial payers, 21.5%, self pay, 18.0%, and Medicaid, 8.7%.

- The average age of an adult mental health patient was 43.5 years.

- The average total charge for adult mental health inpatients was \$6,458 and the average length of stay was 4.9 days.

### **Substance Abuse** (ICD-9 Diagnosis codes: 303-305.93)

In 2004 there were 14,115 adult inpatients discharged with a principal or secondary diagnosis of substance abuse. The number of total inpatients with a principal or secondary diagnosis of substance abuse increased from 12,242 in 2001 to 14,115 in 2004, a 15.3% change.

Of the 14,115 who had a substance abuse diagnosis in 2004, it was the principal diagnosis for 703 or 5.0%. This was a 19.1% decrease from 2001 when there were 869 patients with a principal diagnosis of mental illness. The 703 patients with a principal diagnosis of mental illness in 2004 represented 0.8% of all adult inpatients.

Substance abuse was a secondary diagnosis for 13,700 cases in 2004 or 15.5% of all adult inpatients. This was a 16.3% increase since 2001 when there were 11,782 cases with a secondary substance abuse diagnosis.

### **Adult Inpatients with Principal Substance Abuse Diagnosis**

The following statistics explore in more detail the characteristics of the 703 adult inpatients who had a principal substance abuse diagnosis in the year 2004.

- Nearly one-half of substance abuse patients, 43.7%, had a DRG of "Alcohol/drug abuse or dependency without rehabilitation therapy without complications/comorbidities." Another 30.0% had a DRG of "Alcohol/drug abuse or dependence with complications/comorbidities," 14.1% had a DRG of "Alcohol/drug abuse or dependence with rehabilitation therapy without complications/comorbidities," and 11.8% had a DRG of "Alcohol/drug abuse or dependence, left against medical advice."

- The most frequent specific diagnosis among substance abuse patients was "Acute alcoholic intoxication-continuous," 19.4%, followed by "Continuous other and unspecified alcohol dependence," 16.6%, "Acute alcoholic intoxication-unspecified," 14.1%, and "Other and unspecified alcohol dependence-unspecified," 10.7%.

- There were 455 adult inpatients who had a dual diagnosis where substance abuse was the principal diagnosis and mental illness was a secondary diagnosis.

### **Admission and Discharge Patterns**

- More than one-half, 57.8%, of adult substance abuse patients were admitted through the emergency room, while 37.7% were admitted with a physician's referral.

- The most frequent admission type was urgent, 40.1%, followed by emergency, 33.0%, and elective, 28.5%.

- Most adult substance abuse inpatients, 82.8%, were discharged home. More than ten percent, 11.8%, left against medical advice.
- More than two-thirds, 70.6%, of adult substance abuse patients were discharged from hospitals in rural areas, while 29.4% were discharged from hospitals in other urban areas.

### **Patient Characteristics**

- The majority, 62.7%, of substance abuse patients were males.
- Two out of five, 20.9%, of substance abuse patients were covered by a commercial insurer, 19.2 % were covered by Medicare, 18.8% were self pay, and 11.8% were Medicaid.
- The average age of these patients was 42.1 years.
- The average total charge for adult substance abuse patients was \$5,741 and the average length of stay was 6.1 days.

### **Suicide (E-codes: E950-E959)**

In 2004 there were 209 inpatients discharged with an external cause of injury code (e-code) of suicide. These codes indicate a suicide attempt, not necessarily a suicide death. The number of total inpatients with an e-code of suicide decreased from 463 in 2001 to 209 in 2004, a -54.9% change.

### **Adult Inpatients with an E-Code of Suicide**

The following statistics explore in more detail the characteristics of the 296 adult inpatients who had an e-code of suicide in the year 2004.

- More than four out of five, 87.1%, inpatients with an e-code of suicide were classified in one of four DRGs: DRG 449 – Poison & toxic effects of drugs age > 17 with complications/comorbidities, 36.8%; DRG 430 – Psychoses, 24.9%, DRG 450 – Poison & toxic effects of drugs age > 17 without complications/comorbidities, 14.8%, and DRG 426 – Depressive neuroses, 10.5%.
- The most frequent principal diagnoses for these patients were: “Poisoning by antidepressants,” 10.5% of all suicide inpatients, “Depressive disorder not elsewhere classified,” 10.0%, and “Poisoning by benzodiazepine-based tranquilizers,” 9.1%.

### **Admission and Discharge Patterns**

- The great majority, 75.1%, of adult attempted suicide patients were admitted through the emergency room. Another 11.5% were admitted with a physician’s referral and 11.5% were transferred from another hospital.
- A majority of attempted suicide cases, 54.1%, had an admission type of emergency while 44.0% were urgent, and 1.4% were classified as elective for admission type.
- The great majority, 81.3%, of adult attempted suicide inpatients were discharged home, followed by 6.2% who were discharged/transferred to another type of facility, most likely a free-standing psychiatric hospital or a hospital with a psychiatric unit. An additional 3.8% were discharged/transferred to another short-term general inpatient hospital.

### **Patient Characteristics**

- More females, 58.4%, than males were admitted with an e-code of suicide.
- The most frequent payer category was self pay, 31.1%, followed by a commercial insurer, 27.3%, Medicaid, 13.9%, and Medicare, 12.9%.
- The average age of the 209 inpatients with a suicide e-code was 36.8 years.
- The average total charge for these patients was \$8,727 and the average length of stay was 4.2 days.

## **MONTANA STATISTICS FROM COMPdata**

All of the Montana patient statistics were derived from MHA's COMPdata. We encourage you to use COMPdata to examine your hospital community area(s) regarding adult behavioral health patients so that you might better understand the impact of these patients on your care and treatment of your patient population and the resources needed to diagnose, treat, and manage the adult behavioral health population.

The COMPdata graphing feature can be utilized to examine in a pictorial fashion trends in your state and hospital community area(s) regarding adult mental health. Click here to obtain a map that illustrates the number of principal adult mental health inpatient cases by county in Montana in 2004: <http://www.ihatoday.org/compdata/mtadbhmap.pdf>.

## **ADDITIONAL INFORMATION**

If you would like to develop the COMPdata reports that will provide similar statistics for your hospital or community, a training tool is available to guide you through the process. Click here to obtain the tool: <http://www.ihatoday.org/compdata/mtabhtool.pdf>.

## **APPENDIX**

### **Barriers to Care**

In spite of the existence of effective interventions for the care of patients with mental disorders, a great proportion of those with these disorders do not have access to care due to a series of barriers. These barriers to treatment are several, but reflect two dominant themes:

Lack of resources (financial, practitioners, facilities)

Stigma

### **Lack of Resources**

The system for delivering mental health services to patients and their families is complex, sometimes to the point of inscrutability—a patchwork of providers, interventions, and payers. Much of the complexity stems from the multiple pathways into treatment and the multiple funding streams for services.<sup>1</sup>

Many areas of the United States have a lack of or no doctors (psychiatrists and psychologists and other mental health providers) for people with behavioral health problems to access.

This lack of practitioners is compounded by the lack of facilities and lack of transportation to the facilities that do service behavioral health patients. Families are faced with difficulties because services are provided by so many different public sectors. In addition to problems with coordination, patients and caregivers encounter conflicting requirements, different atmospheres and expectations, and contradictory messages from system to system, office to office, and provider to provider. There is often a gap between what families need and what agencies provide.<sup>1</sup>

### **Stigma**

Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness. Stigma is widespread in the United States and other Western nations. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders—especially severe

disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health conditions internalize public attitudes and become embarrassed or ashamed such that they often conceal symptoms and fail to seek treatment.<sup>3</sup>

### **Myths About Mental Illness**

There continue to be a number of common misconceptions that are integral to the stigma associated with mental illness. The National Mental Health Association cites the following myths and corresponding facts:<sup>9</sup>

Myth: People who need psychiatric care should be locked away in institutions.

Fact: Today, most people can lead productive lives within their communities thanks to a variety of supports, programs, and/or medications.

Myth: A person who has had a mental illness can never be normal.

Fact: People with mental illnesses can recover and resume normal activities.

Myth: Mentally ill persons are dangerous.

Fact: The vast majority of people with mental illnesses are not violent. In the cases when violence does occur, the incidence typically results from the same reasons as with the general public such as feeling threatened or excessive use of alcohol and/or drugs.

Myth: People with mental illnesses can work low-level jobs but aren't suited for really important or responsible positions.

Fact: People with mental illnesses, like everyone else, have the potential to work at any level depending on their own abilities, experience and motivation.

### **THE FUTURE OF BEHAVIORAL HEALTH CARE IN AMERICA**

The principal recommendation of Mental Health: A Report of the Surgeon General (1999)<sup>1</sup> to the American people is to seek help if you have a mental health problem or think you have symptoms of a mental disorder. The report also recognizes the many hurdles that confront individuals as they make their way through today's behavioral health care system. The final chapter of the report identifies eight courses of action that are needed for all individuals to find the help they seek:

- Continue to build the science base.
- Overcome stigma.
- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.
- Tailor treatment to age, gender, race, and culture.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment.

A more recent effort to address the complexities of the American mental health system was The President's New Freedom Commission on Mental Health.<sup>3</sup> Their 2003 final report was entitled "Achieving the Promise: Transforming Mental Health Care in America" and included six goals and several recommendations for reaching a transformed mental health system. The six goals are:

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer and family driven.

- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.
- Excellent mental health care is delivered and research is accelerated.
- Technology is used to access mental health care and information.

## **RESOURCES FOR ADDITIONAL INFORMATION**

### **For Hospitals**

The “professionals” section of the Substance Abuse and Mental Health Services Administration (SAMHSA) web site (<http://www.mentalhealth.org/professionals/>) is a good starting point for hospitals to find information on events, funding, SAMHSA initiatives, news, resources, and Center for Mental Health Services programs. The Mental Health Services Locator, found throughout the SAMHSA site may be of value to hospitals who are searching for behavioral health providers in their own or more distant communities.

The National Association of Psychiatric Health Systems, a leading advocate for behavioral health care providers, is a natural source of information on behavioral health news, training, standards, guidelines, regulatory issues, and much more. The web site is <http://www.naphs.org>.

The President’s New Freedom Commission on Mental Health final report includes 12 model programs that illustrate efforts to achieve each of the six goals set forth in the report. Information on the Commission and to view or download the report, go to: <http://www.mentalhealthcommission.gov/reports/reports.htm>.

State-specific information is available from SAMHSA’s Office of Applied Studies (<http://www.dasis.samhsa.gov/webt/NewMapv1.htm>) for two projects: the Treatment Episode Data Set (TEDS) and the National Survey of Substance Abuse Treatment Services (N-SSATS). TEDS provides information on the demographic and substance abuse characteristics of admissions to treatment for abuse of alcohol and drugs in facilities that report to individual state administrative data systems. Facilities reporting data generally include those that receive state alcohol and/or drug agency funds. The N-SSATS is an annual survey that collects information from all facilities, both public and private, that provide substance abuse treatment.

### **For Patients and the Community**

The SAMHSA web site Resources section (<http://www.mentalhealth.org/resources/>) has several features of interest to patients, caregivers, and others. Among these are “Cornerstone: Mental Health Resources” which provides dozens of links to valuable information, hotline numbers, a mental health dictionary, a special kids section and link to all Spanish publications and other bilingual information from SAMHSA. The Mental Health Services Locator is another valuable resource for those looking for services in their own community or perhaps a family member’s.

There are three key areas of interest on the home page of the web site of the National Alliance for the Mentally Ill (<http://www.nami.org>). They are “Inform Yourself” with educational material on disorders, medications, treatments, and more; “Find Support” where individuals can locate a variety of support resources; and “Take Action,” an area for those people who want to join in advocacy efforts on behalf of the mentally ill.

The National Mental Health Association (<http://www.nmha.org>) provides a host of information for consumers and others including dozens of links to material under “Mental Health Information” (a link can be found at the top of the home page).

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