

23. MENTAL HEALTH AND MENTAL DISORDERS

Number	Objective
1	Suicide
2	Injurious suicide attempts
3	Unipolar major depression
4	Mental disorders among children and adolescents
5	Serious mental illness among homeless people
6	Employment of persons with serious mental illness
7	Disabilities associated with mental disorders
8	Mental health services for people with mental and emotional problems
9	Culturally competent mental health services
10	Provider training in screening for mental health problems in children
11	Provider training in addressing mental health problems in young children
12	Provider review of patients' cognitive, emotional, and behavioral functioning
13	Primary care provider assessment of mental health of children
14	Mental health benefits
15	Access to mental health services
16	Children's access to mental health services
17	Comparability of mental health and physical health care coverage
18	Children with mental health insurance
19	Jail diversion for serious mentally ill adults
20	Mental health screening by juvenile justice facilities
21	Crisis and ongoing mental health services for the elderly
22	State plans to address co-occurring disorders
23	Consumer satisfaction with services
24	Offices of Consumer Affairs for Mental Health Services

Mental Health and Mental Disorders

Goal

Improve the mental health of all Americans by ensuring appropriate, high-quality services informed by scientific research.

Terminology

(A listing of all acronyms used in this publication appears on page 27 of the Introduction.)

Comorbidity: The presence of two or more coexisting disorders. In this document, the term refers to the co-occurrence of mental illness and substance abuse disorders or physical illness.

Cultural competence: A set of knowledge, skills, and attitudes that allows individuals, organizations, and systems to work effectively with diverse racial, ethnic, religious, and social groups.

Disability-Adjusted Life Years (DALYs): The sum of the number of years lost due to premature death and the years of life lived with a disability.

Homeless: An individual (whether a member of a family or not) who lacks housing, including an individual in transitional housing or whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations.

Juvenile justice facility: Such facilities include the following entities, as defined by the Office of Juvenile Justice and Delinquency Prevention: detention centers, shelters, reception or diagnostic centers, training schools, ranches, forestry camps or farms, halfway houses and group homes, and residential treatment centers.

Mental health services: Diagnostic, treatment, and preventive interventions designed to help improve the behavioral, physical, emotional, and social functioning of individuals with or at risk of diagnosable mental illnesses.

Mental illness: Any one of an array of clinically significant behavioral or psychological syndromes, each of which ranges along a continuum of severity and manifests through specific, distinguishing, psychologic or behavioral distress (and, frequently, concomitant impairment in functioning). They may arise without regard to age, gender, or ethnicity, as a product of genetic, biological, environmental, social, physical, or behavioral factors, acting alone or in combination.

Screening for mental health problems: A brief formal or informal process designed to identify individuals with or at risk for diagnosable mental health problems to determine whether further evaluation is needed and, if indicated, to link the individual to the most appropriate and available mental health services.

Serious emotional disturbances (SED): Persons from 0 to 18 years with a diagnosable mental disorder of such severity and duration as to result in functional impairment that substantially interferes with or limits functioning in family, school, community, or other major life activities.

1 **Serious mental illness (SMI):** Persons aged 18 or over with a diagnosable mental disorder of such
2 severity and duration as to result in functional impairment that substantially interferes with or limits major
3 life activities.
4

5 **Overview**

6 *Prevalence of Mental Illnesses*

7
8
9 To a greater or lesser degree, mental illnesses affect children, adolescents, adults, and older Americans of
10 all ethnicities and racial groups, both sexes, and all educational and socioeconomic strata. No one is
11 immune from the risk of mental illness. Approximately 40 million Americans, aged 15 to 54, experienced
12 some type of mental disorder within the past year.¹ An estimated 8 million people in the same age bracket
13 had both a mental disorder and a substance use disorder (SUD) within the past year. The chance of
14 developing a diagnosable mental illness over the course of the lifespan, however, is higher: approximately
15 35 percent in the population aged 15 to 54.² Thus, the prevalence of mental disorders is roughly
16 comparable to the prevalence of many physical illnesses³ and may be a coexisting condition that has an
17 effect on the course of the physical illness.
18

19 Schizophrenia affects more than 2 million Americans over the course of their lifetimes. Approximately 40
20 percent of all hospitalized psychiatric patients in the United States experience this disorder. Ten to 15
21 percent of all individuals with schizophrenia end their lives by suicide.⁴ Among the mood disorders,
22 clinical depression affects 1 in 7 women and 1 in 13 men over a lifetime. In a study of six disorders—
23 hypertension, diabetes, lung disease, arthritis, heart disease, and depression—only severe heart disease was
24 found to be more disabling and result in more hospital days and lost days of productivity than depression.⁵
25 Bipolar disorder (manic depressive illness) affects about 1 percent of Americans between the ages of 15
26 and 40. As many as 20 percent of people with this illness will end their lives by suicide.⁶ Anxiety
27 disorders—posttraumatic stress disorder, panic disorder, obsessive compulsive disorder, and phobias,
28 among others—are the most common of the mental disorders and affect 16 million Americans. Many
29 suffer from comorbid conditions, such as substance abuse, that exacerbate their mental health problem,
30 increase disorder-related disability, and complicate treatment.⁷
31

32 *Racial/Ethnic Differences*

33
34 Discussion of racial and ethnic differences in the prevalence of mental illnesses must be approached
35 cautiously. Studies focusing on the prevalence rates among ethnic subgroups are limited and often
36 inconclusive. Socioeconomic status, education, and employment status have been found to be related to
37 the prevalence of mental disorders and explain some of the variance in the prevalence of mental illnesses
38 across racial, ethnic, and economically diverse groups.⁸ It is difficult to determine the specific influence of
39 social conditions such as discrimination and stereotyping on disorders with paranoid, depressive, and
40 antisocial symptomatology. However, low socioeconomic status and education, regardless of ethnicity,
41 have been found to be contributing factors in the onset of certain disorders.⁹ Equally important, a
42 discussion of prevalence rates must consider the cultural meaning of mental illness. Mental health
43 behaviors need to be defined in the context of each individual's culture to determine normative behaviors.
44 Nonetheless, it remains instructive to examine existing large-scale studies, with the caution that sampling
45 may have affected the outcome data and that findings should be viewed as tentative pending further study.
46

1 ***Gender Differences***
2

3 Important gender differences arise in the prevalence of particular mental disorders. For example, major
4 depression and dysthymia affect approximately twice as many women as they do men.¹³ Women of color,
5 women on welfare, and women who are poor, less educated, or unemployed are more likely to experience
6 depression than women in the general population.¹⁴ Anxiety, panic, and phobic disorders affect 2 to 3
7 times as many women as men. Eating disorders are nearly unique to women. Risk for engaging in suicidal
8 behaviors also differs greatly by gender. Females *attempt* suicide at greater rates than males;¹⁵ males
9 *complete* suicides at higher rates across the lifespan.^{16,17} A history of physical and sexual abuse, more
10 prevalent among women, appears to be a serious risk factor for suicide attempts.¹⁸
11

12 Specific mental disorders affect women at particular stages of life. Eating disorders, affecting up to 2
13 percent of the population, arise nearly exclusively in young women (accounting for 90 percent of all cases),
14 with among the highest mortality rates of any mental disorders.¹⁹ Older women are at some what greater
15 risk of Alzheimer's disease than men, a disease thought to be responsible for 60 to 70 percent of all cases
16 of dementia and one of the leading causes of nursing home placements.²⁰
17

18 ***Children and Adolescents***
19

20 At least one in five children and adolescents may have a diagnosable mental, emotional, or behavioral
21 problem that can lead to school failure, alcohol or other drug use, violence, or suicide.²¹ Early-onset
22 mental disorders have been found to be strongly associated with reduced educational attainment.²²
23 Further, adolescent emotional problems may increase the likelihood of risk-taking behaviors, including
24 early sexual activity.^{23,24} Critically among children and adolescents, development of a substance use
25 disorder (SUD) often postdates that of mental illness by as many as 5 to 10 years, creating a window of
26 opportunity during which intervention may slow or eliminate the development of SUD as a comorbid
27 condition.²⁵ The link between childhood or adolescent sexual abuse and emotional problems in later life
28 also is well established.²⁶ Several studies have found an association between Attention-Deficit
29 Hyperactivity Disorder (ADHD) and Conduct Disorder (CD) with violent and aggressive behavior.^{27,28}
30

31 Nine to 13 percent (3.5 to 4 million) of youth aged 9 to 17 years experience a serious emotional
32 disturbance (SED) that imposes substantial functional impairment in the conduct of daily living, school,
33 family, and community activities.²⁹ Of the children and adolescents with SED, 2.1 to 2.8 million
34 experience extreme functional impairment. Children and adolescents at both levels of impairment,
35 however, are considered to have an SED.³⁰ Twenty percent of students with SED are arrested at least once
36 before they leave school, compared to 6 percent of all students. Nearly 50 percent of youth with SED are
37 arrested within 5 years of leaving school.³¹ (These Department of Education data rely on definitions
38 established by that Department and are not necessarily comparable with those based on DSM-III-R or
39 DSM-IV diagnostic criteria.)
40

41 ***Older Americans***
42

43 The Nation as a whole is aging; so, too, is the population of individuals experiencing mental illnesses.
44 Some individuals will have experienced mental health problems throughout their lifetimes; others will
45 experience them for the first time in later life. Mental disorders are as common in late life as they are at
46 other ages, although prevalence rates for mental disorders vary by age and gender.³² The 1-year
47 prevalence of major depression in individuals age 65 and up is approximately 1 percent, compared to 2.3
48 percent among those aged 45 to 64.³³ Interestingly, the same study reported no gender differences in

1 prevalence of major depression among older individuals, in contrast to younger populations, where the
2 prevalence of depression is greater in women than in men. However, when other affective disorders (e.g.,
3 adjustment, dysthymic, and bipolar disorders) are added to the definition, rates of all depressions combined
4 were found to increase with age.³⁴ Moreover, the gender disparity reemerges, with women experiencing
5 higher rates of all the different types of depression than men, across all ages. Among older Americans who
6 are experiencing a chronic or acute physical problem—an increasing problem as age rises—rates of
7 depression are much higher. For example, depression prevalence rates of older persons in nursing homes
8 range between 15 and 25 percent;³⁵ among those hospitalized for physical illnesses, the prevalence of
9 major depression is 12 percent.³⁶

10
11 Prevalence rates of significant cognitive deficits as a result of the dementias—primarily Alzheimer’s
12 disease—are as high as 12 percent among persons age 65 and up.³⁷ By age 85, the prevalence of dementia
13 rises to one in four.³⁸ In contrast, the prevalence of primary psychotic disorders diminishes with age,³⁹
14 with schizophrenia and primary persistent paranoid disorders affecting fewer than 0.5 percent of older
15 adults.⁴⁰

16
17 Perhaps not entirely surprisingly, mental illnesses in the elderly—predominantly depression—place these
18 individuals at considerably greater risk of disability, comorbid physical impairments, and death, including
19 the risk of suicide.⁴¹⁻⁴³ While older populations have a much lower rate of suicide attempts than younger
20 age groups,⁴⁴ the rate of completed suicide is highest among elderly men, who account for about 80
21 percent of suicides age 65 and older.⁴⁵ Moreover, elderly white males have a suicide rate 6 times the
22 national average rate.⁴⁶

Comorbidity

23
24
25
26 Comorbidity of mental and addictive disorders is not uncommon. Among those with an alcohol disorder,
27 37 percent also experience a mental disorder;⁴⁷ among those with other drug disorders, 53 percent
28 experience a mental disorder.⁴⁸ Antisocial personality disorder is 21 times more likely; schizophrenia, 4
29 times more likely; and anxiety and depressive disorders, twice as likely in people with alcohol disorders.⁴⁹
30 The NCS⁵⁰ found that the vast majority (79 percent) of lifetime mental disorders appear to be comorbid
31 illnesses; an even greater proportion of 12-month disorders occur in individuals with a lifetime history of
32 comorbidity. The data suggest that the major economic and social burdens of psychiatric disorders in our
33 society are likely concentrated in those who experience significant comorbidity.⁵¹

34
35 Fifty to 60 percent of homeless individuals who have major affective or psychotic disorders also
36 experience a co-occurring substance use disorder. They have been homeless longer and more often than
37 other homeless subpopulations, and 78 percent have had at least one prior psychiatric inpatient episode.⁵²

38
39 Co-occurring mental and addictive disorders also are found among children and adolescents.⁵³
40 Externalizing disorders among children and adolescents—more prevalent in males—such as oppositional
41 defiant disorder, conduct problems, and ADHD, appear to be strongly related to similarly externalizing
42 adolescent behaviors, such as alcohol use, violence, and delinquency.⁵⁴ Critically, among a more youthful
43 population as noted previously, development of an SUD often postdates that of mental illness by as many
44 as 5 to 10 years, creating a window of opportunity for mental health services which potentially may slow or
45 eliminate the development of SUD as a comorbid condition.⁵⁵

1 Among the elderly, mental disorders most often co-occur with physical illnesses rather than with drug
2 abuse. Indeed, in some cases, psychiatric symptoms may be a product of a physical illness per se or the
3 result of a drug-drug interaction, whether prescribed medication or over-the-counter preparations.

4 *Costs of Mental Illness*

5
6
7 Without regard to the etiology of the disease, a growing body of evidence suggests that mental disorders
8 have important social consequences as well as financial costs.⁵⁶⁻⁵⁸ Mental illnesses cost the Nation nearly
9 \$150 billion in 1990. Direct health care costs to treat these disorders—\$67 billion—represent less than half
10 of the total cost. Lost productivity due to illness or premature death accounted for another \$74.9 billion.
11 Crime, criminal justice costs, and property loss contributed the final \$6 billion in costs associated with
12 mental illnesses.⁵⁹ The annual financial burden of clinical depression alone is estimated to be more than
13 \$16 billion in medical costs and lost productivity.⁶⁰

14
15 Federal, State, and local expenditures for *overall* health care represent around 14 percent of total
16 expenditures; however, the same sources represent 28 percent of all funding for mental health care alone.⁶¹
17 For those with *severe* mental disorders who actually seek treatment, Federal (Medicare and other
18 programs), State, and local government programs, combined, support 57 percent of the expenditures for
19 care and treatment. Public expenditures for mental health services totaled approximately \$12.2 billion in
20 1990. States contributed 80 percent; the Federal Government contributed 15 percent; local governments
21 contributed 2 percent.⁶²

22 *Dynamics of the Problem*

23
24
25 Today, the vast majority of individuals needing mental health services do not receive them at all. Four in
26 10 individuals with a lifetime history of at least one mental disorder ever obtain professional help for their
27 illnesses; of those, only one in four receives treatment in the mental health sector.^{63,64} For comparative
28 purposes, it is useful to note that 60 to 80 percent of those with cardiovascular disease seek care.^{64a} An
29 estimated two-thirds of all young people with mental health problems do not receive treatment.⁶⁵ Ethnic
30 minority populations are less likely to seek and use formal mental health services; instead, those receiving
31 formal mental health services—particularly youthful minority populations—often gain entry through
32 alternative systems such as judicial placement or school referral. Also, ethnic subgroups are less likely to
33 have private health insurance, leading to a higher number of placements in public mental health facilities
34 rather than community-based care for those with SMI or SED.

35
36 Homelessness among individuals with SMI usually occurs as a product of one of three factors: (1) their
37 psychiatric condition precipitates a housing crisis; (2) ineffective institutional discharge does not make
38 adequate linkages with community-based resources, or (3) their community-based support network is
39 exhausted. When family and friends can no longer provide the day-to-day case management and support
40 needed, often the result is eviction, poverty, and loss of contact with the community-based care system.⁶⁶

41
42 What are the critical differences that explain the inability or unwillingness of individuals with diagnosable
43 mental illnesses to seek or achieve care? The answer lies in three terms—accessibility, availability, and
44 affordability—the absence of any of which can impede access to care.

45 *Accessibility*

- 46
47
48 • Stigma: The persistence of fear and misunderstanding of mental illnesses continues to stand as a social
49 and psychological barrier between a person in need and mental health services.

- 1
2 • Culturally Competent Care: Access to care cannot be sought if the words to ask for care are not
3 understood, whether the barrier is one of language, education, or age. Similarly, treatment and other
4 supportive services cannot be as effective as possible if the ethos that underlies the treatment is not
5 shared by professional and patient and if the services are not responsive to cultural, ethnic, religious, or
6 racial differences or needs.
7
8 • Primary Providers of Health Care: The vast majority of people seeking care do so in the primary care
9 sector (74 percent), not in the specialized mental health sector.⁶⁷ The capacity to provide effective
10 screening and diagnosis (and referral, where appropriate) is critical, but not necessarily consistently
11 available to individuals in need of care.
12
13 • Belief Systems: Some individuals, because of their age or cultural context, do not experience
14 symptoms of mental illness as a problem. Thus, access to care is inhibited or delayed. Others may not
15 readily confide in a person outside the family and similarly do not seek needed care.
16

17 *Availability*

- 18
19 • Outreach: Are available mental health services known by those in potential need or by their families?
20 In what ways, if any, are homeless individuals or those living in isolated areas alone reached? Are
21 outreach services culturally competent for the potential user of services; that is, are they compatible
22 with cultural beliefs?
23
24 • Physical Proximity: Are services readily accessible (nearby or reachable by public transportation) in
25 both rural and urban areas?
26
27 • Scope of Services: Is the range of service needs present at one site or even available at all anywhere in
28 the area? Do they include tangible support services such as child care and bus tokens?
29

30 *Affordability*

- 31
32 • Costs of Care: Are the long- and short-term mental health service needs being met through the private
33 insurance sector? Are they being met through the public sector? What are the nonmedical costs of
34 care? What about services of the uninsured?
35

36 **Progress Toward the Year 2000 Objectives**

37
38 Healthy People 2000 Priority Area 6, Mental Health and Mental Disorders, had as its co-lead agencies the
39 Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health
40 Services (CMHS) and National Institutes of Health (NIH)/National Institute of Mental Health (NIMH).
41 This partnership continues for Healthy People 2010 development. The following list summarizes progress
42 on Healthy People 2000 Mental Health and Mental Disorder objectives.
43

- 44 • Objectives 6.6 (the use of community support programs) and 6.12 (the establishment of a national
45 network of access to self-help activities and resources) met their targets.
46
47 • Objectives 6.1 (suicide), 6.4 (prevalence of mental disorders among adults), 6.5 (adverse health effects
48 from stress), 6.8 (proportion of people who seek help with personal or emotional problems), and 6.11

(proportion of worksites that provide programs to reduce employee stress) showed progress toward the year 2000 targets.

- Objectives 6.2 (suicide attempts), 6.7 (proportion of individuals who obtain treatment for depressive disorders), 6.9 (not taking steps to control stress), 6.10 (number of States that have protocols to prevent suicide in jails), and 6.15 (prevalence of depression) moved away from the targets.
- Objectives 6.3 (prevalence of mental disorders among children and adolescents) and 6.13 and 6.14 (proportion of primary care providers that screen for cognitive, emotional and behavioral functioning) had no data beyond the baseline.

Draft 2010 Objectives

- 1. (Former 6.1) Reduce suicides to no more than 9.6 per 100,000 people.** (Baseline: age-adjusted baseline: 11.2 per 100,000 in 1995)

Select Populations	1995
African American males	12.4
American Indian/Alaska Native males	20.1
Asian/Pacific Islander males	9.7
Hispanic males	12.3
White males aged 65+	38.7
Youth aged 15-19	10.5
Men aged 20-34	26.3

Target Setting Method: Better than the best.

Data Source: National Vital Statistics System (NVSS), CDC, NCHS.

- 2. (Former 6.2) Reduce to 1.8 percent the prevalence of injurious suicide attempts among youth in grades 9 through 12.** (Baseline: 2.8 percent in past 12 months in 1995)

Target Setting Method: National average.

Data Source: Youth Risk Behavior Survey (YRBS), CDC, NCCDPHP.

Suicide is the ninth leading cause of death in the United States.⁶⁸⁻⁷⁰ The risk factors for suicide frequently occur in combination. Scientific research has shown that almost all people who take their own lives have a diagnosable mental or substance abuse disorder; and the majority have more than one disorder. Suicide is a complex behavior that requires intensive preventive interventions. Scientific research has shown that recognition and appropriate treatment of mental and substance abuse disorders is the most promising way to prevent suicide and suicidal behavior in all age groups. Because most elderly have visited their primary care physician in the month prior to their suicides, recognition and treatment of depression in the medical setting is a promising way to prevent elderly suicide. School and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse and aggressive behaviors are most likely to be successful in the long run.⁷¹

1 **3. (Developmental) Reduce the absolute number and relative rank of unipolar major depression**
2 **as causing lost years of healthy life without a commensurate increase in the absolute numbers**
3 **for other health conditions.**

4
5 Disability-Adjusted Life Years (DALYs) are the sum of the number of years lost due to premature death
6 and the years of life lived with a disability. The DALYs of unipolar major depression are unique among
7 the leading health conditions in that they are composed virtually entirely of disability and not premature
8 death.

9
10 DALYs were designed to provide estimates of the impact of major health conditions that take into account
11 both premature death and the disabling sequelae of conditions that do not cause death.^{71a} A second aspect
12 of DALYs is that they are designed to offer an objective, comparative picture of the relative impact of
13 health conditions for use by health care decisionmakers.

14
15 The high ranking of neuropsychiatric conditions as a leading cause of DALYs throughout the world
16 surprised the professional community and the public alike. Within the Established Market Economies
17 (EMEs), of which the United States is one, the position of unipolar major depression as the second leading
18 cause of DALYs for people of all ages in the year 1990, and projected for the years 2000 and 2010, has
19 brought additional focus to that mental disorder in particular. Of note is that with ongoing prevention,
20 treatment, and rehabilitation activities over the next decade, the number of DALYs for all conditions is
21 expected to decline. However, the absolute number of DALYs attributed to unipolar major depression, the
22 overall percentage, and the rank order of unipolar major depression are not expected to decrease over the
23 next decades without additional attention.

24
25 In the year 2000, unipolar major depression is projected to account for a total of 6.7 million DALYs, or 6.7
26 percent of the 100.5 million DALYs in the EMEs for people of all ages.⁷² By 2010, unipolar major
27 depression is projected to account for 6.6 million, or 6.7 percent, of the 98.6 million total DALYs in the
28 EME. Unipolar major depression is second to the ischemic heart diseases and comes before
29 cerebrovascular disease.

30
31 **4. (Developmental/Former 6.3) Reduce to __ percent the prevalence of mental disorders among**
32 **children and adolescents.**

- 33
34 **a. Eating disorders**
35 **b. Children in foster care**
36 **c. Prevention (early-life risk and protective factors)**
37

38 **Potential Data Source:** National Institute of Mental Health Survey, NIH.

39
40 Objectives in the area of eating disorders, foster care, and prevention related to early-life risk and
41 protective factors that are relevant to a variety of negative mental health outcomes in childhood and
42 adolescence are under development.

43
44 From 1990 through 2020, neuropsychiatric conditions are estimated to be the fourth leading cause of years
45 of healthy life lost for children and adolescents under 15 years of age in the Established Market Economies
46 (EMEs). Among the neuropsychiatric conditions for this age group, data are specific only for epilepsy. For
47 conditions such as dementia and other degenerative, hereditary, central nervous system conditions, drug
48 use, and posttraumatic stress disorder, data are insufficient, to date, to develop estimates of years of healthy

1 life lost for children. To develop these estimates, incidence, prevalence, functional status, mortality,
2 treatment efficacy, and service utilization figures are required.

3
4 **5. (Developmental) Decrease to __ percent the number of homeless people age 18 and older who**
5 **have serious mental illness.** (Baseline: 33 percent in 1989)

6
7 **Potential Data Source:** Projects for Assistance in Transition from Homelessness (PATH) Annual
8 Application, SAMHSA.

9
10 A variety of point prevalence estimates of homeless individuals (shelter users on a given night, people
11 using soup kitchens, tallies taken by outreach workers on a sample day, etc.) show that approximately 33
12 percent of homeless individuals at any point in time are people assessed to have an SMI.⁷³

13
14 Research shows that virtually every homeless person with SMI has had prior experience with the mental
15 health service delivery system.^{73a} The growth of this population points to significant issues in the service
16 system concerning the relevance and effectiveness of the services offered to these individuals during their
17 contact episodes. More than a decade of research and demonstration provides new approaches to working
18 with these individuals and suggests opportunities to reduce the representation of persons with SMI among
19 the homeless.

20
21 Nontraditional approaches to reaching homeless people with SMI illnesses are primary. Persistent and
22 patient outreach and engagement strategies by service providers help homeless individuals reengage with
23 the mainstream treatment system. It is essential to provide additional services that augment psychiatric
24 treatment. Services need to address problems in several life domains, including general physical health
25 status. Finally, once housing is located, the value of providing appropriate supports so that individuals
26 with mental illness maintain their housing is essential. Much of this support occurs in the form of case
27 management, which must be responsive both to emerging clinical issues and to the skills the consumer
28 needs to thrive and function in a community setting.

29
30 **6. (Developmental) Of those persons with serious mental illness, increase to __ percent the**
31 **proportion of working-age individuals who are employed.**

32
33 **Potential Data Source:** National Household Survey on Drug Abuse (NHSDA), SAMHSA.

34
35 Rehabilitation is an essential component of care for adults with severe mental illness. In order to enhance
36 independent living as fully as possible, rehabilitation programs often assess individuals for employment
37 and provide continuing support and reasonable accommodations at the worksite. Research indicates that
38 individuals with SMI experience many positive personal and economic effects of working. In addition to
39 providing remuneration and social contacts, employment promotes improvement in self-esteem,
40 independence, community integration, and self-management of illness.^{74,75} A majority of people with
41 mental illness want to be employed and ranked employment as a primary personal goal.⁷⁶ Helping people
42 with mental illness secure employment can reduce the utilization of costly mental health services and
43 reduce the number of people who receive disability payments from the Federal and State government.^{77,78}
44 One study in California noted that State taxpayers saved \$200 per month per individual with mental illness
45 who was employed and not receiving disability payments and saved on average \$187 per month in public
46 mental health services costs.⁷⁹

1 **7. (Developmental) Reduce disabilities associated with mental disorders for women.**
2

3 **Potential Data Sources:** National Health Interview Survey (NHIS), CDC, NCHS;
4 Planned NIMH epidemiologic survey, NIH, NIMH.
5

6 Three mental disorders rank among the top 10 leading causes of years of healthy life lost for women of all
7 ages in the EMEs. In 1990, the leading cause of years of healthy life lost for women of all ages in EMEs
8 was unipolar major depression, which has been projected to remain as the leading cause of years of healthy
9 life lost in the years 2000 and 2010. Both schizophrenia and bi-polar depression also appear in the top 10
10 leading causes for women of all ages in the EMEs for those same decades.^{79a}
11

12 While these projections are based on the measure of DALYs that combines years of life lost due to
13 premature death with the number of years lived with a disability, mental disorders are unusual among
14 conditions in that years lived with a disability is virtually the only factor accounting for mental health
15 DALYs. Mental disorders are less likely than other major health conditions to be fatal.
16

17 The impact of disabilities on women with mental disorders is supported by several national surveys and
18 administrative data sets. For example, mental disorders rank first as the reason that women receive
19 disability benefits from both Social Security Disability Insurance (SSDI) and Supplemental Security
20 Income (SSI) programs. In specific domains of disability, women with mental disorders rank eighth, fifth,
21 and seventh, respectively, for limitation on activity, work, and personal care.
22

23 Women disabled by mental disorders are relatively younger than those disabled in the general population.
24 They are predominantly in their childbearing and child-rearing years, the same years in which they are
25 likely to be working and caring for older parents.
26

27 **8. (Developmental) Of the adults who report limitations due to mental or emotional problems,**
28 **increase to __ percent the proportion who received services for their problems in the previous 12**
29 **months from a mental health professional.**
30

31 **Potential Data Source:** National Health Interview Survey (NHIS), CDC, NCHS.

32 Untreated mental illness increases costs to society and suffering of individuals. Suicide is the eighth
33 leading cause of death in the United States and the third leading killer of young people between the
34 ages of 15 and 24.⁸⁰ Without regard to the etiology of the disease, whether related to genetic,
35 neurochemical, environmental, social, physical, or behavioral factors, acting alone or in combination, a
36 growing body of evidence suggests that mental disorders have important social consequences as well
37 as financial costs.⁸¹⁻⁸³ Lost productivity due to illness or premature death accounts for significant
38 financial costs. Crime, criminal justice costs, and property loss contributed \$6 billion in costs
39 associated with mental illness.⁸⁴ Finding effective ways of helping individuals with mental illness to
40 seek and use scientifically based treatments is essential.
41

42 **9. (Developmental) Increase to __ the number of States that have a plan to develop cultural**
43 **competence within their mental health delivery system.**
44

45 **Potential Data Source:** National Technical Assistance Center for State Mental Health Systems,
46 SAMHSA.
47

48 Timely, cost-effective and successful utilization of mental health services by people from racially and
49 ethnically diverse backgrounds requires understanding cultural ideas about mental health services and their
50 effect on access to and outcomes of service. Research shows that various ethnic groups underuse mental

1 health services, either by dropping out of services or entering services at a much later stage in the illness,
2 thereby creating a need for costlier services.⁸⁵⁻⁸⁷ This pattern of use has been attributed to the lack of
3 culturally relevant, responsive, and accessible mental health service systems.⁸⁸⁻⁹² Other data on admission
4 to inpatient facilities reveals disproportionately high rates of admission for people of color to public and
5 private general hospitals with psychiatric facilities and psychiatric facilities.⁹³⁻⁹⁶ Between 1980 and 1992
6 the rate of admission for all persons to State hospitals in the United States was approximately 163.6 per
7 100,000 people. The rate of inpatient admission for white Americans was 136, for Hispanic Americans it
8 was 146, and for American Indian/Alaska Natives it was 142. The admissions rate to State hospitals for
9 African Americans during the same period was 364.2 per 100,000.⁹⁷

10
11 **10. (Developmental) Increase to __ the proportion of primary care providers who are trained to**
12 **screen for mental health problems for infants, toddlers, preschool children, school-aged**
13 **children, and adolescents.**

14
15 **11. (Developmental) Increase to __ percent the proportion of primary care providers who are**
16 **trained to offer information and make referrals for parent training that focuses on the mental**
17 **health needs of infants, toddlers, and preschoolers.**

18
19 Numerous mental health problems that manifest in adolescence and young adulthood have their roots in
20 early childhood.^{98, 98a} Although the research about infant mental health is more broad based than specific,
21 studies have shown that the primary caregiving relationship is the primary moderator of malleable
22 biological risk factors as well as the conduit by which psychosocial risk factors are transmitted.⁹⁹

23
24 An important risk factor for infants and children of all ages is the occurrence of psychopathology of the
25 primary caregivers.¹⁰⁰ Screening for mental disorders and, if appropriate, referring for treatment by a
26 primary care provider is a strategy to increase the number of caregivers who receive treatment.

27
28 Studies about conduct disorder, one of the most formidable psychiatric disorders of childhood and
29 adolescents, reveal a growing body of knowledge that its early beginnings are in preschool and early
30 elementary school.¹⁰¹⁻¹⁰³ Early identification of risk factors becomes a critical factor. Interventions related
31 to identifying parental psychopathology and punitive parenting styles indicate a potential for delaying or
32 preventing the predicted developmental trajectory toward conduct disorder for the child. In addition to
33 appropriate treatment for depression or other mental disorders, parent training has shown to be effective in
34 altering the coercive style of parenting.

35
36 Primary care providers are encouraged to screen for such issues and make appropriate referrals. Early
37 detection of behavioral problems is key to preventing or delaying onset.¹⁰⁴ Depression in childhood and
38 adolescence provides another opportunity for the primary care provider to identify a treatable disorder.
39 General prevalence rates for diagnosed disorders is less than 3 percent in children and about 5 to 8 percent
40 in adolescents; however, the prevalence rates of depressive symptoms is higher at about 15 percent in
41 children and 25 percent in adolescents.¹⁰⁵ The length of an episode could last from 7 to 9 months and
42 could affect a student's performance in school. About 20 percent of children do not recover from
43 depression for a year and approximately 10 percent do not recover until the second year.^{106,107} Early
44 detection of suicidal ideation or serious attempts, if identified by primary care providers, can be addressed
45 by a referral to a mental health provider when appropriate.

1 **12. (Former 6.13) Increase to at least 60 percent the proportion of primary care providers who**
2 **routinely review with patients their cognitive, emotional, and behavioral functioning and the**
3 **resources available to deal with any problems that are identified.** (Baseline: 35 percent of nurse
4 practitioners in 1992)

5
6 **Target Setting Method:** Retain year 2000 target.

7
8 **Data Source:** Primary Care Providers Survey, ODPHP.

9
10 Between one-half and two-thirds of people who commit suicide visit a physician less than 1 month before
11 the incident.^{108,109} Primary care providers are urged to be alert to signs of mental and emotional disorders
12 in their patients, giving particular attention to those going through major life transitions such as a recent
13 divorce, separation, bereavement, unemployment, or serious medical illness. In addition, primary care
14 providers treating patients with chronic diseases such as heart disease or diabetes have an opportunity to
15 screen for mental problems such as depression.

16
17 **13. (Former 6.14) Increase to at least 75 percent the proportion of providers of primary care for**
18 **children who include assessment of cognitive, emotional and parent-child functioning with**
19 **appropriate counseling, referral, and followup in their clinical practice.** (Baseline: pediatricians
20 55 percent and nurse practitioners 55 percent in 1992)

21
22 **Target Setting Method:** Retain year 2000 target.

23
24 **Data Source:** Primary Care Providers Survey, ODPHP.

25
26 Developmental and behavioral assessment is recommended by the American Academy of Pediatrics as a
27 component of well-child care. Primary care providers are encouraged to screen for such issues and make
28 appropriate referrals. Early detection of behavioral problems and subsequent treatment are key in helping
29 children resume a healthy developmental course.

30
31 **14. (Developmental) Increase to __ percent the proportion of full-time employees who have mental**
32 **health benefits for both inpatient and outpatient services.** (Baseline: 80 percent inpatient and 79.4
33 percent outpatient in 1993)

34
35 **Potential Data Source:** Employee Benefits in Medium and Large Private Establishments Survey of
36 1993, Department of Labor, Bureau of Labor Statistics.

37
38 **15. (Developmental) Decrease to __ percent the proportion of adults who felt they needed mental**
39 **health care or counseling but did not get it because they could not afford it.**

40
41 **Potential Data Source:** National Health Interview Survey (NHIS), CDC, NCHS.

42
43 With respect to the two previous objectives, access to mental health services can be influenced by the cost
44 of services and the ability of the potential user to pay for service. An aspect of affordability is measured by
45 indicating the percentage of employees who have mental health benefits for both inpatient and outpatient
46 services. Often mental health benefits for inpatient and outpatient services are significantly less than the
47 benefits for physical health problems. Financial barriers that inhibit the provision of quality mental health
48 services are important to measure so that initiatives can be developed to surmount the problem.

1 **16. (Developmental) Decrease to __ percent the proportion of adults who felt one of their children**
2 **needed mental health care or counseling but did not receive it because they could not afford it.**

3
4 **Potential Data Source:** National Health Interview Survey (NHIS), CDC, NCHS.

5
6 A longitudinal study of children and adolescents estimated that one in five children has an emotional or
7 behavioral disorder.^{109a} Approximately 4 percent were seen by a mental health provider (psychiatrist,
8 psychologist, or psychiatric social worker).

9
10 Delay or absence of treatment has consequences for the development of mental health in children. ADHD,
11 the most common mental disorder of childhood, carries great public health significance in terms of
12 prevalence, severity, and impact. For one-third of affected children, ADHD is a chronic condition that will
13 last a lifetime; for another one-third the problems persist through adolescence and for the remaining third
14 they decrease or abate before adolescence. Eventual outcomes associated with continuing ADHD include
15 depression, anxiety, alcoholism, job instability, and a broad range of adult impairments (including
16 criminality in a small subset of ADHD adults). Effective treatments are available for individuals with
17 ADHD at all ages, as well as for children and adolescents who have other diagnosable disorders.

18
19 **17. Increase to 25 percent and 10 percent, respectively, the proportion of full-time employees who**
20 **have mental health care benefits comparable to their physical health coverage for both inpatient**
21 **and outpatient services.** (Baseline: inpatient=13.8 percent, outpatient=3.3 percent in 1993)

22
23 **Target Setting Method:** 100 and 200 percent improvement respectively.

24
25 **Data Source:** Employee Benefits in Medium and Large Private Establishments Survey, Department
26 of Labor, Bureau of Labor Statistics.

27
28 Access to mental health services can be influenced by the cost of services and the ability of the potential
29 user to pay for the service. An aspect of affordability is measured by indicating the percentage of
30 employees who have mental health benefits for both inpatient and outpatient services. Often mental health
31 benefits for inpatient and outpatient services are significantly less than the benefits for physical health
32 problems. Financial barriers that inhibit the provision of quality mental health services are important to
33 measure so that initiatives can be developed to surmount the problem.

34
35 **18. (Developmental) Increase to __ percent the proportion of children with mental health**
36 **insurance.**

37
38 **Note:** There is *no data source* that reports the percentage of children who have *mental health*
39 *insurance*. A measure of the percentage of children with health insurance could be used as a proxy
40 measure. It is believed that most insurance policies include *some* mental health coverage although the
41 coverage may be inadequate.

42
43 **Potential Data Source:** Current Population Survey, U.S. Census Bureau.

44
45 The issue of insurance clearly relates to issues of access. Unfortunately, today the vast majority of
46 individuals needing mental health services do not receive them. Only 4 of every 10 with a lifetime history
47 of at least one mental disorder ever obtained professional help for their illnesses; of those only one in four
48 received treatment in the mental health sector. An estimated two-thirds of all young people with mental
49 health problems do not receive treatment. Children and adolescents with mental health problems are less
50 likely than those with adult-onset illness to receive treatment and services when they become adults.¹¹⁰

1
2 **19. (Developmental) Increase to __ percent the proportion of counties and municipalities that have**
3 **programs to divert serious mentally ill adults from jails to appropriate community-based**
4 **services.**
5

6 In June 1992, over 3,300 U.S. jails held over 444,000 detainees.¹¹¹ Research indicates that individuals
7 with SMI were overly represented in jails compared to the general population. Some individuals with SMI
8 need to receive mental health services while serving time in jail and others who have been arrested for
9 nonviolent crimes could be better served if diverted from the jail system to a community-based mental
10 health treatment program.¹¹² Within the last several years, jail diversion programs have been developed to
11 address this issue. A jail diversion program has four key elements: (1) a specific program for diversion
12 with resources and assigned staff; (2) a specific, identified target population; (3) a defined program goal to
13 avoid or decrease the time of incarceration; and (4) a means of linking individuals with community-based
14 mental health services.
15

16 **20. (Developmental) Increase to __ percent the proportion of juvenile justice facilities that screen**
17 **every juvenile for mental health problems.**
18

19 **Potential Data Source:** Inventory of mental health services in juvenile justice facilities, SAMHSA.
20

21 Studies indicate that more than 100,000 youths are placed in a juvenile justice facility each year.¹¹³
22 Although the exact prevalence rates of mental disorders for those entering the system are not available, it is
23 clear that the prevalence rate is substantially higher than in the general population. Studies also have
24 suggested that problems of suicide, self-injurious behavior, and affective disorders are significant among
25 youth in the juvenile justice system.^{114,115} By measuring the percentage of juvenile justice facilities that
26 screen for mental health problems, this objective encourages the establishment of protocols that routinely
27 screen for such problems. Such implementation could contribute to the systematic identification of mental
28 health services needed by youths and facilitate the understanding of the prevalence of mental disorders
29 among this population. Screening protocols need to include qualified mental health personnel who are
30 trained to conduct a mental health screening with structured instruments and interview parents or
31 caregivers about the juvenile's history.¹¹⁶ Systematic screening permits the initiation of a systematic
32 referral protocol for treatment of those youths positively identified as having a potential diagnosable and
33 treatable mental disorder.
34

35 **21. (Developmental) Increase to ___ percent the proportion of States with State plans that address**
36 **crisis and ongoing mental health services for elderly.**
37

38 **Potential Data Source:** Count the number of States with State plans for the elderly, SAMHSA.
39

40 The American population is growing older and this will become increasingly evident as the number and
41 proportion of the population will grow very rapidly after the year 2010. Some projections indicate that the
42 elderly population will grow by 2.6 percent annually. Mental disorders are as common in late life as they
43 are at other ages. Mood disorders affect between 2 and 4 percent of community-living elders;¹¹⁷ older
44 Americans who experience clinically significant depressive symptoms range from 10 to 15 percent of the
45 population.¹¹⁸ As the Nation ages, mental health services for the elderly need to be addressed.
46

1 **22. (Developmental) Increase to ___ the number of States with State plans to address services for**
2 **individuals with co-occurring mental health and substance abuse disorders.**

3
4 **Potential Data Source:** Count the number of States with plans addressing co-occurring disorders,
5 SAMHSA.

6
7 Co-occurring mental and addictive disorders are not uncommon. Among those with an alcohol disorder,
8 37 percent also experience a mental disorder;¹¹⁹ among those with other drug disorders, 53 percent
9 experience a mental disorder.¹²⁰ How public service systems can address the clinical and systemic issues
10 of treating persons with co-occurring substance-related and mental health disorders remains a challenge.
11 No consensus has been reached in answering the questions about best clinical practices or how to address
12 delivery of services. Most likely, State treatment protocols for co-occurring disorders will be enhanced as
13 the field progresses toward clarifying definitions, discovering promising practices, and identifying effective
14 mechanisms for the delivery of services, as well as effective training methods. Formal mechanisms
15 instituted by States to review research data and other sources of knowledge may be the most expedient
16 ways to incorporate new findings into practice.

17
18 **23. (Developmental) Increase to __ percent the proportion of consumers of mental health services**
19 **who indicate they are satisfied with the services they receive.**

20
21 **Potential Data Source:** Mental Health Statistics Improvement Program, CMHS, SAMHSA.

22
23 **24. (Developmental) Increase to __ the number of States that have an office of consumer affairs for**
24 **mental health services or a statewide consumer organization that addresses issues identified by**
25 **users of services and their families.**

26
27 Users of services can play a critical role in the development and evaluation of mental health services. As
28 early as 1978 the World Health Organization's report on primary health care discussed the right and duty
29 of those receiving health care to participate in the implementation of health care services.¹²¹ In the last 20
30 years there has been an increased awareness of the benefits of involving mental health consumers in the
31 design, delivery, and evaluation of mental health services. Decreased costs of service delivery as well as
32 improved efficacy of treatment through development of services that are responsive to users of service
33 have been noted in the literature.^{122,123} By involving consumers in the evaluation process, decisionmakers
34 are more accountable for the consumer's view of the efficacy of treatment. Additional benefits include
35 increased access to services by using invaluable experiential data from consumers to engage individuals
36 who have refused traditional treatment.¹²⁴

37 Recent studies indicate that the health care industry is actively involving consumers in the development of
38 services. Nearly 90 percent of health care executives reported that they have expanded both the number
39 and type of services due to consumer preferences. Patient satisfaction studies are standard practice for
40 many health care organizations and executives in health care recently surveyed indicated that consumers
41 have a major impact in the development of a health care product, with consumer impact measuring 4.69 on
42 a scale of 1 to 5.¹²⁵

43
44 Through executive order, Federal agencies are required to include consumers in all phases of planning and
45 implementation, to develop and track consumer service standards, including consumer satisfaction.¹²⁶

1 **Related Objectives From Other Focus Areas**

2
3 **Goal 1**

- 4 6 People with good, very good, or excellent health
5 7 Healthy days
6 8 Able to do usual activities
7 9 Years of healthy life
8 10 Years of healthy life, older adults
9

10 **Physical Activity and Fitness**

- 11 1 Leisure time physical activity
12 6 Vigorous physical activity, grades 9-12
13 7 Moderate physical activity, grades 9-12
14 9 Physical education requirement in schools
15 13 Worksite physical activity and fitness
16

17 **Nutrition**

- 18 1 Healthy weight
19 3 Overweight and obesity in children/adolescents
20

21 **Tobacco Use**

- 22 2 Cigarette smoking during pregnancy
23 3 Adolescent tobacco use
24 8 Smoking cessation by new mothers
25 9 Smoking cessation attempts among adolescents
26 10 Advice to quit smoking
27 11 Treatment of nicotine addiction
28 12 Providers advising smoking cessation
29

30 **Educational and Community-Based Programs**

- 31 1 High school completion
32 2 School health education
33 3 Undergraduate health risk behavior information
34 4 School nurse-to-student ratio
35 5 Worksite health promotion programs
36 6 Participation in employer-sponsored health promotion activities
37 7 Patient satisfaction with health care provider communication
38 8 Patient and family education
39 9 Community disease prevention and health promotion activities
40 10 Community health promotion initiatives
41 11 Culturally appropriate community health promotion programs
42 12 Elderly participation in community health promotion
43

44 **Environmental Health**

- 45 11 Blood lead levels
46 17 Testing for lead-based paint
47

48 **Injury/Violence Prevention**

- 49 6 Child death review systems
50 23 Hip fractures

- 1 34 Maltreatment of children
- 2 35 Physical abuse by intimate partners
- 3 36 Forced sexual intercourse
- 4 37 Involuntary first sexual intercourse
- 5 38 Emergency housing for battered women
- 6 39 Sexual assault other than rape
- 7 40 Physical assaults
- 8 41 Physical fighting among adolescents

9

Occupational Safety and Health

- 11 3 Workplace injury and illness surveillance
- 12 14 Worksite stress reduction programs

13

Access to Quality Health Services

- 15 A.1 Uninsured children and adults
- 16 A.2 Insurance coverage
- 17 A.3 Routine screening about lifestyle risk factors
- 18 A.4 Reporting on service delivery
- 19 A.5 Training to address health disparities
- 20 B.1 Source of ongoing primary care
- 21 B.2 Failure to obtain all needed health care
- 22 B.3 Lack of primary care visits
- 23 B.4 Access to primary care providers in underserved areas
- 24 B.5 Racial/ethnic minority representation in the health professions
- 25 B.6 Preventable hospitalization rates for chronic illness
- 26 C.5 Special needs of children
- 27 C.6 Followup mental health services
- 28 D.1 Functional assessments
- 29 D.2 Primary care evaluation

30

Family Planning

- 32 2 Repeat unintended births
- 33 7 Adolescent pregnancy

34

Maternal, Infant, and Child Health

- 36 8 Maternal morbidity
- 37 14 Postpartum visits
- 38 15 Very low birthweight babies born at Level III hospitals
- 39 17 Low birthweight
- 40 18 Preterm birth
- 41 21 Alcohol use during pregnancy
- 42 23 Drug use during pregnancy
- 43 24 Fetal alcohol syndrome
- 44 25 Prenatal exposure to teratogenic prescription medications
- 45 37 Primary care services for babies 18 months and younger
- 46 38 Screening for vision, hearing, speech, and language impairments
- 47 39 Service systems for children with chronic and disabling conditions

48

Medical Product Safety

- 50 1 Monitoring of adverse drug reactions

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- 1 3 Response from managed care organizations regarding adverse drug reactions
- 2 4 Linked automated information systems
- 3 5 Drug alert systems
- 4 6 Provider review of medications taken by patients
- 5 7 Complementary and alternative health care
- 6 8 Safety-related labeling changes
- 7 9 Updates to drug alert systems
- 8 10 Patient information about prescriptions

9

10 **Public Health Infrastructure**

- 11 6 Access to public health information and surveillance data
- 12 7 Tracking Healthy People 2010 objectives for select populations
- 13 8 Data collection for Healthy People 2010 objectives
- 14 9 Use of geocoding in health data systems
- 15 10 Performance standards for essential public health services
- 16 11 Health improvement plans
- 17 12 Access to laboratory services
- 18 13 Access to comprehensive epidemiology services
- 19 14 Model statutes related to essential public health services
- 20 15 Data on public health expenditures
- 21 16 Collaboration and cooperation in prevention research efforts
- 22 17 Summary measures of health and the public health infrastructure

23

24 **Health Communication**

- 25 1 Public access to health information
- 26 2 Centers for excellence
- 27 3 Evaluation of communication programs
- 28 4 Satisfaction with health information
- 29 5 Health literacy programs
- 30 6 Quality of health information
- 31 7 Health communication/media technology curricula

32

33 **Arthritis, Osteoporosis, and Chronic Back Conditions**

- 34 4 Help in coping

35

36 **Disability and Secondary Conditions**

- 37 2 Depression
- 38 3 Days of anxiety
- 39 5 Personal and emotional support
- 40 6 Satisfaction with life
- 41 9 Inclusion of children with disabilities in regular education programs

42

43 **Substance Abuse**

- 44 6 Adolescent use of illicit substances
- 45 12 Alcohol and drug-related violence
- 46 18 Services for school-aged children
- 47 19 Screening and treatment of patients 60 and older
- 48 21 Community partnerships and coalitions

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