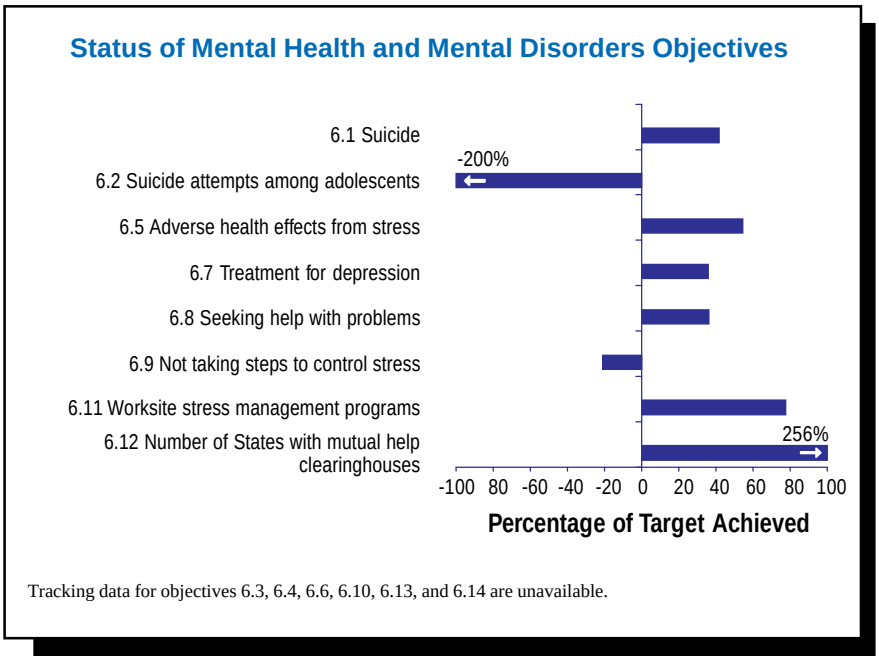
6 Mental Health and Mental Disorders



Tracking data for objectives 6.3, 6.4, 6.6, 6.10, 6.13, and 6.14 are unavailable.

Lead Agencies: ***Substance Abuse and Mental Health Services Administration***
National Institutes of Health

MENTAL HEALTH AND MENTAL DISORDERS

Prevention of mental disorders and promotion of mental health has a long history. The framework of primary, secondary, and tertiary prevention dates back to the 1957 Commission on Chronic Illness. The National Mental Health Association report in 1986, *The Prevention of Mental-Emotional Disabilities*,[1] defined prevention as "intervening in a deliberate and positive way to counteract harmful circumstances before they cause disorder or disability." A National Prevention Coalition was established in 1987 to promote the acceptance and use of prevention services as a part of the continuum of mental health services. In 1993, the Institute of Medicine (IOM) of the National Academy of Sciences report, *Reducing Risks for Mental Disorders*,[2] identified three prevention strategies: universal low-cost preventive interventions directed at the total population; selective preventive interventions targeted to at-risk populations; and preventive interventions for individuals who manifest a risk factor, symptom, or abnormality that identifies them at high risk for the development of mental disorders.

An estimated 41.4 million adults[3] have had a mental disorder at some time in their lives, and 7.5 million children[4] suffer from mental and emotional disturbances such as depression, autism, and attention deficit disorder. About one-fifth of people with AIDS[5] will develop AIDS-related cognitive dysfunction and two-thirds will develop neuropsychiatric problems.[6] Only one in six adults[7] with serious mental health problems gets needed care and only about one-third of children[8] receive services.

The societal costs of mental illness are considerable—$74.9 billion in 1990.[9] Major depression accounts for more bed days than any impairment except cardiovascular disorders.[10] People with job-related stress, anxiety, and depression miss an average of 16 work days annually.[11] People with untreated mental illnesses consume almost twice as much medical care as the average individual.[12]

The Center for Mental Health Services (CMHS) of the Substance Abuse Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH)/National Institute of Mental Health (NIMH) have conducted special activities that facilitate progress on HEALTHY PEOPLE 2000 mental health objectives. SAMHSA/CMHS sponsored a conference on prevention services in 1993 that identified the need for improved coordination between the mental health, health, and welfare sectors. NIH/NIMH has sponsored annual national prevention research conferences since 1990; in these conferences the state of development of intervention models in selected areas was reviewed and related recommendations made for strengthening the research, training prevention scientists, and improving the organization of the scientific effort. The congressionally mandated IOM report identified 39 preventive intervention programs based on rigorous research methodologies that can now be tested under different population and systemic conditions. About three-quarters of these models address behavioral, emotional, and learning problems of children and adolescents through risk reduction and developmental enhancement, most of which

*In May 1995 NIMH was recognized as the co-lead for the Mental Health and Mental Disorders priority area.

relied on health, preschool or school interveners. The model program interventions with children and adolescents include: high quality prenatal and perinatal care; childhood immunizations; home nurse visitation for improved parenting; intensive and prolonged center-based early childhood education combined with home visitation; center-based early childhood education starting to improve parenting and enhance behavioral or cognitive development from infancy onward; multiple strategies to enhance self-regulation and interpersonal as well as cognitive skills of elementary school children; the use of specific instructional methods in classrooms and individual tutoring to reduce learning problems; enhancement of various family stress coping skills during the elementary school years; normative changes strategies in school and peer settings to reduce early substance abuse by adolescents or community norms toward aggression; and risk factor reduction through alterations in the nature and structure of schooling and school experiences or empowerment of school communities in initiating such alterations.

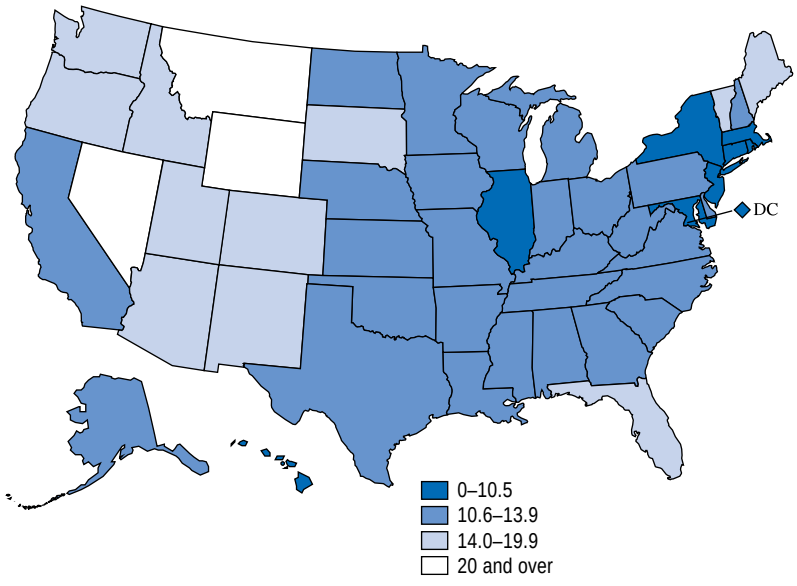
CMHS initiated this year a focus on prevention services for 0–7-year-olds in multiagency child and adolescent programs for planning and system development and services implementation. In 1994 SAMHSA/CMHS spent approximately $10 million in support of prevention demonstrations and training activities. NIMH estimates 1993 expenditures totaling $43.9 million on research on the reduction of disorders addressed in the HEALTHY PEOPLE 2000 Mental Health priority area.[13] Other prevention research focuses on physical or behavioral outcomes to which mental disorders contribute or antecedents to known causes of mental disorders that are addressed in $17.9 million of expenditures in other HEALTHY PEOPLE 2000 priority areas.[14]

The NIH Depression Awareness, Recognition, and Treatment (D/ART) program educates the public, primary care providers, and mental care providers about depression. D/ART's primary goals are to help people recognize the symptoms of depression and to encourage individuals to seek help.

Review of Progress

More than 30,000 suicides occur each year. The ninth leading cause of death in 1992, suicide is

Objective 6.1: *Reduce suicides to no more than 10.5 per 100,000 people*



Source: CDC/NCHS, Vital Health Statistics, 1991

the third leading cause of death among adolescents and young adults aged 15–24. Adults over the age of 65 have high suicide death rates; in 1992, 16.5 per 100,000 population. The rates increase substantially to 22.8 per 100,000 among people over 85 years of age.

Since 1987, the rate of suicides has declined; the percentage of people seeking help for mental problems has risen; and the percentage of people in treatment for depression has increased. Suicide attempts by adolescents have, however, increased. The increase may be linked to improved reporting and recognition of injurious suicide attempts as well as possible increases in substance abuse. There are no new data to estimate the overall prevalence of mental disorders among children or adults.

The workplace has become an important site to address mental health issues. In 1992, 37 percent of employers with 50 or more employees offered information, resource materials, group classes, or lectures to reduce employees' stress. Individual counseling was offered by 27 percent of employers. The use of community support programs and the number of States with suicide prevention in the jails have no data updates.

The 1992 Primary Care Providers' Survey provides baseline data on the extent to which providers are routinely reviewing patients' mental functioning. For adults, the survey shows that counseling is not widespread. The results for children are more promising. Among pediatricians 62 percent routinely inquired about cognitive function; 55 percent reported routinely inquiring about parent-child relationships; and 47 percent inquired about emotional/behavioral functioning. As for treatment referrals, the pediatricians reported routinely referring 51 percent of patients for cognitive problems, 45 percent for emotional/behavioral problems, and 34 percent for treatment of parent-child relationships. For adults, 40 percent of nurse practitioners reported inquiring about emotional/behavioral function and 35 percent inquired about cognitive functioning; among internists the level of counseling was 25 and 18 percent respectively. Obstetricians/gynecologists and family physicians reported even lower levels of inquiry.

1995 Revisions

A new objective on depression has been added with a special population target for women. Research shows that depression is often comorbid with other psychiatric and physical illnesses. Depression is one of the strongest risk factors for attempted and completed suicides. Primary care physicians often fail to recognize the symptoms of depression in their patients, and the symptoms of depression often mimic those of physical illnesses. Depression is a significant public health problem with potentially fatal consequences to its victims. Approximately 80 percent of patients[15] can be treated successfully, yet less than 40 percent of individuals with depression have seen a health care provider about their illness.[16]

A new baseline and target include expanded diagnostic criteria for children and adolescents for objective 6.3. The revised rates are population based and more accurately reflect the estimated prevalence of mental disorders in this age group.

Objective 6.12 has been revised to recognize that networked communications make the linkage of Federal and State self-help information, resources, and activities more effective than State self-help clearinghouses alone.

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