Midcourse Review

HEALTHY PEOPLE 2010

Mental Health and Mental Disorders

18

Co-Lead Agencies:

National Institutes of Health
Substance Abuse and Mental Health Services Administration

Contents

Goal: Improve mental health and ensure access to appropriate, quality mental health services.

Introduction*

Mental disorders have an enormous impact on the overall health of the Nation.[1] Four of the 10 leading causes of disability for persons aged 5 years and older involve mental disorders.[1] Within developed nations, including the United States, major depression is the leading cause of disability. More than one in four adults in the United States have suffered from some form of mental illness in the past 12 months, and among these 22 percent have experienced serious mental illness (SMI).[2, 3, 4] Nearly half of all Americans will meet the criteria for a mental disorder some time in their life, with first onset usually in childhood or adolescence.[4] Suicide is one tragic consequence of undiagnosed, untreated, or undertreated mental illness.

The United States continues to recognize the challenges resulting from mental illness[5] and, in 2002, established the President's New Freedom Commission on Mental Health. In 2003, the direct and indirect yearly economic costs of mental illness were estimated to total $150 billion, not including the costs of research.[6] The Government's findings confirm that unmet needs and identified barriers to care for persons with mental illnesses continue to exist.

Progress has been made in the Healthy People 2010 mental health objectives. The objective for primary care screening and assessment exceeded its target. Objectives for juvenile justice facility screening and State plans addressing elderly persons both moved toward their targets.

Within the U.S. Department of Health and Human Services (HHS), agencies including the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA) are working in partnership with the nine Cabinet-level Departments to transform mental health care for all Americans by focusing on a wide range of research and programs to improve mental health care delivery systems.

Significant gains have been made in integrating mental health care services into federally funded primary care centers and juvenile residential facilities, as well as in improving the monitoring of strategic planning for mental health at the State level. Trend data on the efforts to eliminate health disparities remain limited, although available data suggest that disparities exist in the treatment of mental disorders.

Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

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* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at http://wonder.cdc.gov/data2010. See the section on DATA2010 in the Technical Appendix for more information.

The objective for SMI among homeless adults (18-3) was reworded to more accurately reflect the data source used, and its baseline and target were also reestablished. For the objective regarding employment of persons with SMI (18-4) and the subobjectives relating to treatment of adults with SMI (18-9a, b, and d), the data sources were changed, the baselines were set using baseline data from this decade, and the targets were set using available racial and ethnic population data and the better-than-the-best target setting method. The objective for State plans addressing elderly persons (18-14) was reworded to reduce complexity and more accurately reflect the data source.

Four developmental objectives were reworded to fit new data sources and became measurable:

- Disordered eating behaviors (18-5).[7]
- Primary care facilities providing treatment (18-6).
- Juvenile justice facility screening (18-8).
- Adult jail diversion programs (18-11).

Also becoming measurable with the identification of data sources, but not altered in language, were treatment for children with mental health problems (18-7) and treatment for co-occurring disorders (18-10).

Progress Toward Healthy People 2010 Targets

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 18-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

Progress was noted for primary care facilities providing mental health treatment (18-6), juvenile justice residential facilities that provide mental health screening (18-8), and State plans addressing mental health for elderly persons (18-14). Three objectives moved away from their targets: suicide (18-1), adolescent suicide attempts (18-2), and homeless persons with mental health problems who received services (18-3). Disordered eating behaviors among adolescents in grades 9 through 12 (18-5) and State tracking of consumer satisfaction (18-12) demonstrated no change toward or away from their targets.

Data became available to measure the employment of persons with SMI (18-4), treatment for children with mental health problems (18-7), treatment for co-occurring disorders (18-10), and the proportion of counties served by adult jail diversion programs or mental health courts (18-11). However, progress for these objectives could not be assessed at the midcourse due to lack of a second data point.

Objectives that met or exceeded their targets. One objective, primary care facilities providing treatment for mental disorders (18-6), exceeded its target, moving from a 2000 baseline of 62 percent of primary care facilities offering mental health services onsite or by referral to 74 percent having provided this service in 2003. The objective achieved 200 percent of the targeted change.

Mental disorders frequently co-exist with, and have a negative impact on, physical health.[8] For example, depression impairs self-care and adherence to treatments for chronic illnesses.[8] Depression may also be a factor in the onset of certain chronic diseases such as high blood pressure, heart disease, and stroke.[9, 10, 11, 12, 13]

For these reasons, primary health care settings have long been identified as the initial point of contact for many adults with mental disorders.[14] For some adults, these providers are their only source of mental health care services. Increased screening and assessment in primary care can promote early detection and intervention for mental health problems.[14] However, large numbers of mental illnesses go undiagnosed in primary care settings.[6] The Mental Health/Substance Abuse Service Expansion Grant, offered through HRSA's Bureau of Primary Health Care, Division of Health Center Development, is increasing the capacity of community health centers to establish new or expand existing mental health/substance abuse services.[15]

Objectives that moved toward their targets. Juvenile justice residential facility screenings (18-8) moved from a baseline of 50 percent in 2000 to 53 percent in 2002 of such facilities offering admission mental health screening exams. Objective 18-8 achieved 60 percent of the targeted change. The Juvenile Residential Facility Census, which measures objective 18-8, is one component of a multitiered effort to monitor youth placed in residential facilities, as well as the environments within those facilities, to maximize mental health.

In 2004, the National Center for Mental Health and Juvenile Justice published a resource guide for practitioners on screening and assessing mental health disorders among youth in the juvenile justice system.[16] The guide provides clinicians and other professionals working with youth[17] in the juvenile justice system with a range of best practice information. It reviews and synthesizes information about the most effective instruments for screening and assessing youth for mental health at various points in the juvenile justice system. A closer linkage between mental health agencies and juvenile justice agencies is needed to ensure further progress for this objective.

The number of States, Territories, and the District of Columbia with plans addressing mental health care needs of elderly persons (18-14) increased from 18 to 22 jurisdictions between 2000–01 and 2001–02, achieving 12 percent of the targeted change.[8] The target is 50 States and the District of Columbia. This objective anticipates that the baby boom population will present society with unprecedented challenges in organizing, financing, and delivering effective prevention and treatment services for mental disorders in elderly persons in the near future. An operational plan at the State level represents a first step in developing a comprehensive strategy for addressing the special mental health issues society faces as the population ages.[18]

Objective 18-14 also addresses the significant advances in research that have successfully challenged the underlying belief that mental health problems are an inevitable part of aging.[18] The medical community increasingly recognizes that depression and certain cognitive losses are not inevitable with aging and are treatable disorders.[18] Increased awareness will improve diagnostic precision for people in later life and enhance the provision of age-appropriate treatment.[18] SAMHSA's Center for Mental Health Services has administered Mental Health Block Grants that require each State to include a plan for its mental health expenditures, a portion of which is often devoted to older persons.[19]

Objectives that demonstrated no change. The number of States tracking consumer satisfaction with the mental health care services they receive (18-12) remained unchanged at 40 in 2002 and 2003. The target is 50 States and the District of Columbia.[8] Adolescents engaging in disordered eating behaviors (18-5) remained constant at 19 percent in 2001 and 2003. The target is 16 percent.

Objectives that moved away from their targets. Reduction in the suicide rate (18-1) moved away from the target of 4.8 deaths per 100,000 population. Between 1999 and 2002, the age-adjusted suicide rate increased from 10.5 deaths per 100,000 population to 10.9 deaths per 100,000 population. Suicide attempts among students in grades 9 through 12 (18-2) increased from 2.6 percent of students in 1999 to 2.9 percent in 2003, moving away from the target of 1 percent.

Multiple suicide prevention initiatives exist. The National Strategy for Suicide Prevention lays out a framework for action to prevent suicide and guides the development of an array of services and programs.[20] The Suicide Prevention Resource Center provides technical assistance to States and communities in their efforts to develop effective suicide prevention efforts.[21] Progress in reducing the rates for attempted and completed suicide depends on additional research into risk assessment methods, tailored prevention programs for vulnerable populations, and strategies for program dissemination and implementation.

Objective 18-3 focuses on homeless persons aged 18 years and older who receive mental health care services. Twenty-seven percent of homeless adults with mental health problems received mental health care services in 2000, and 26 percent received services in 2003, which represented a movement away from the target of 30 percent. The Projects for Assistance in Transition from Homelessness (PATH) supports community-based outreach and case management services for homeless persons with mental health problems.[22]

Objectives that could not be assessed. Progress toward several objectives and subobjectives could not be assessed because data beyond the baseline were not available for the midcourse review: employment of persons with SMI (18-4), treatment for adults with mental disorders (18-9a, b, and d), and treatment for co-occurring disorders (18-10). For these objectives, the National Comorbidity Survey—Replication was used for baseline data; followup data points are anticipated by the end of the decade. The subobjective measuring increases in the proportion of adults aged 18 years and older with schizophrenia who have received treatment (18-9c) requires further development of a data source. Treatment for children with mental health problems (18-7) is anticipated to have several data points from the annual National Health Interview Survey. Annual data are also anticipated for adult jail diversion programs and/or mental health courts (18-11).

State plans for addressing cultural competence (18-13) was the only objective without baseline data at the midcourse review. Data are anticipated for the objective by the end of the decade through the National Technical Assistance Center for State Mental Health Systems.

Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 18-2), which displays information about disparities among select populations for which data were available for assessment.

The white non-Hispanic population had the best rate for five of the six objectives with significant racial and ethnic disparities. The disparities in treatment of mental illness (18-9a, b, and c) between the white non-Hispanic (best group) and the Hispanic and black non-Hispanic populations were between 50 percent and 99 percent. The disparity between the black and white non-Hispanic (best) populations in the treatment of mental illness (18-7) in persons aged 4 to 17 years was also in the 50 percent to 99 percent range.

The Asian or Pacific Islander population and the black non-Hispanic population had the lowest (best) rate for suicide (18-1). The rate for the white non-Hispanic population was twice the rates of these populations, and the disparity increased between 1999 and 2002. In the Asian or Pacific Islander population and the black non-Hispanic population (best groups), the suicide rate decreased; in contrast, the suicide rate for the white non-Hispanic population increased. However, the white non-Hispanic population consistently had the best rate for accessing and receiving treatment for a variety of mental disorders (18-9). The white non-Hispanic population also was best for persons with SMI obtaining employment (18-4), although the differences among racial and ethnic populations were not statistically significant.

Females had better rates than males for four of the six objectives and subobjectives with significant gender differences. The disparities between the two populations were generally less than 50 percent, with the notable exception of suicide (18-1). Between 1999 and 2002, male suicide rates were consistently more than double those of females.

Persons with at least some college had the best rates for three of the five objectives with significant differences among education levels, while high school graduates had the best rates for two objectives. Persons with less than a high school education did not have the best rate for any mental health objective. For this population, the treatment rate for schizophrenia (18-9c) and employment for persons with SMI (18-4) demonstrated disparities of more than 50 percent from the best group rates. During the period 1999 and 2002, the disparity in the suicide rate between the population with less than a high school education and the best group (those with at least some college) declined. The suicide rate for persons with a high school education was twice the rate observed in the best group. Limited data exist to examine disparities among populations by income level.

Data demonstrate that the rates for mental disorders are similar across all populations in the United States. Yet, select populations face significant barriers in accessing quality and culturally competent behavioral health care.[5] The Surgeon General's report on mental health, culture, race, and ethnicity offers several recommendations for addressing these disparities.[23] The recommendations include the expansion of scientific research into mental health in select populations, more widespread geographic distribution and availability of mental health care services, integration of mental health with primary care, improved linguistic access for mental health care services, and coordinated care to vulnerable, high-need populations.

Opportunities and Challenges

Many barriers to mental health services exist for Americans, including cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness.[23] Additional challenges—mistrust and fear of treatment, racism and discrimination in the health care environment, and differences in language and communication styles—deter some populations.[23] The ability of consumers and providers to communicate with one another is essential for all aspects of health care.[23] This ability carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior.[23] The diagnosis and treatment of mental disorders depend on verbal communication and trust between patient and clinician.[23] The cumulative weight and interplay of all barriers to care, rather than any single barrier, is likely to be responsible for continued mental health disparities.

The research literature on promising practices related to clinical and community settings continues to grow. Promising practices, defined as smaller controlled studies that demonstrate efficacy, have been developed that directly relate to several objectives. Evidence-based practices that could be more widely implemented include, but are not limited to, assertive community treatment, new medication and medication management, psychiatric rehabilitation, and integrated treatment for individuals with co-occurring mental illness and substance abuse. Policy experts recognize that the expansion of these services must take place within the broader efforts to transform the mental health care system through improving access and addressing the fragmentary nature of mental health care.[6]

Emerging Issues

A multifaceted and sustained approach is required to address the broader systemic challenges of a fragmented mental health care system, the social stigma attached to mental illness, and mental health's continued lack of parity with physical health regarding insurance coverage.[6] Expanded research into the workings of the brain and the development of new psychopharmaceuticals and other treatment methods must be combined with evidence-based improvements and expansions in mental health care services.[24, 25]

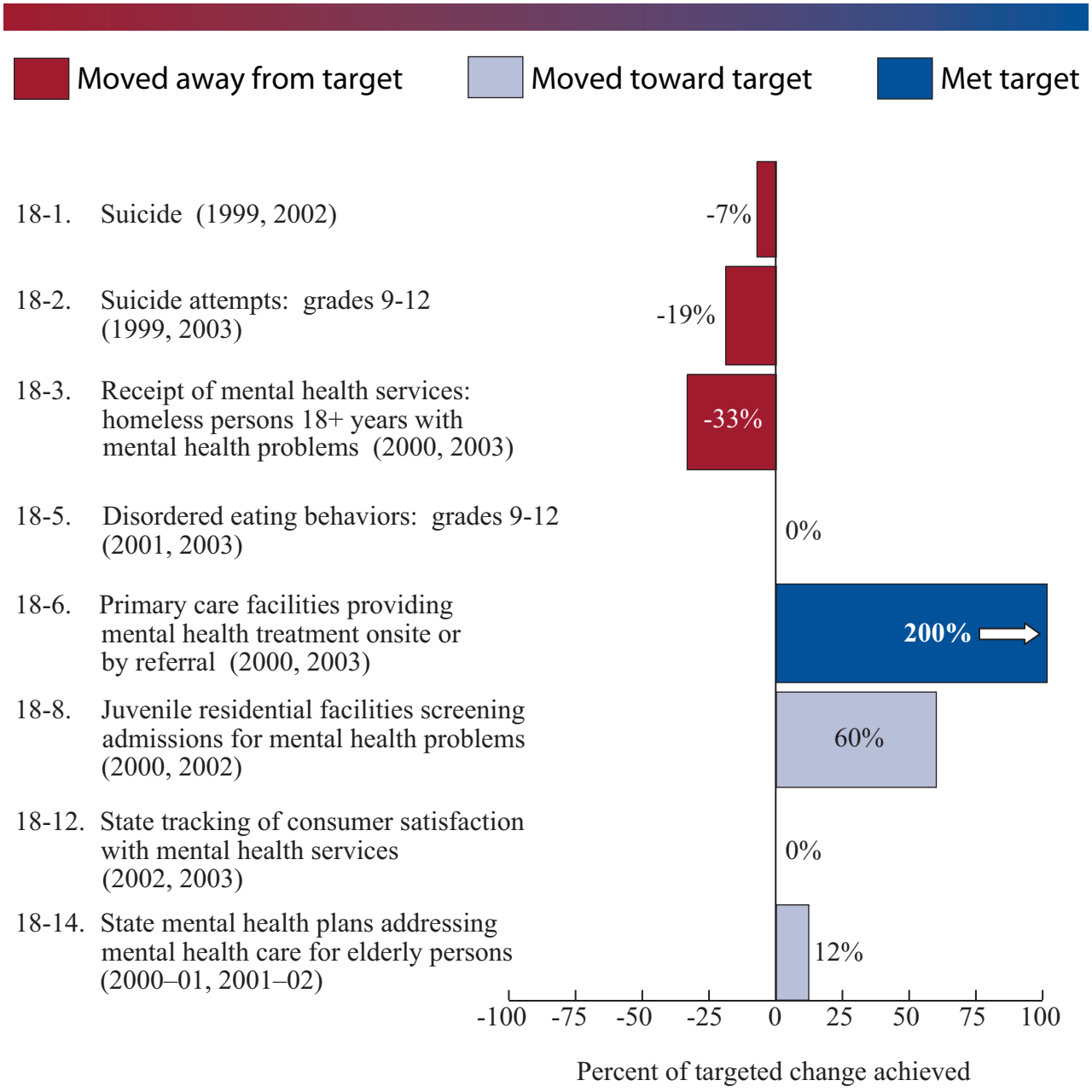
Several issues of concern are emerging, including co-occurring mental health and substance abuse disorders and the outcomes resulting from this combination. Approximately half of the adults who have a diagnosable mental disorder will also have a substance abuse disorder at some point during their lifetime.[6] Co-occurring disorders tend to be more chronic and disabling than either disorder alone. Individuals with co-occurring disorders are more likely to experience a chronic course or to require more services than persons with either type of disorder alone.[26]

Early intervention and treatment can lessen the severity of co-occurring disorders.[26] Too often, however, individuals are treated for only one of the two disorders, if they are treated at all.[26] Furthermore, the fragmented nature of the mental health care system presents additional challenges to the development of integrated treatment and overall care for individuals who have co-occurring disorders.[6] Another emerging issue is the need for further research and collaboration between the mental health field and the substance abuse treatment field to better identify this population and develop effective treatments.

As the baby boom population grows older, several issues related to mental health among older adults are emerging. Increasing numbers of new cases of depression and the accompanying risk of suicide among older adults will be important. The co-occurrence of depression and chronic diseases associated with aging, such as cardiovascular disease, rheumatologic disorders, diabetes, and high blood pressure, are adding additional burdens to the health care system.[16] In addition, increasing numbers of new cases of dementia and the associated costs of treatment continue to be subjects of concern.

Finally, in the changing environmental landscape in which people live, issues like terrorism- and war-related posttraumatic stress disorder and difficulties in providing culturally competent care in a diverse society may present increasing challenges and are important to consider when addressing health disparities.

Figure 18-1. Progress Quotient Chart for Focus Area 18: Mental Health and Mental Disorders



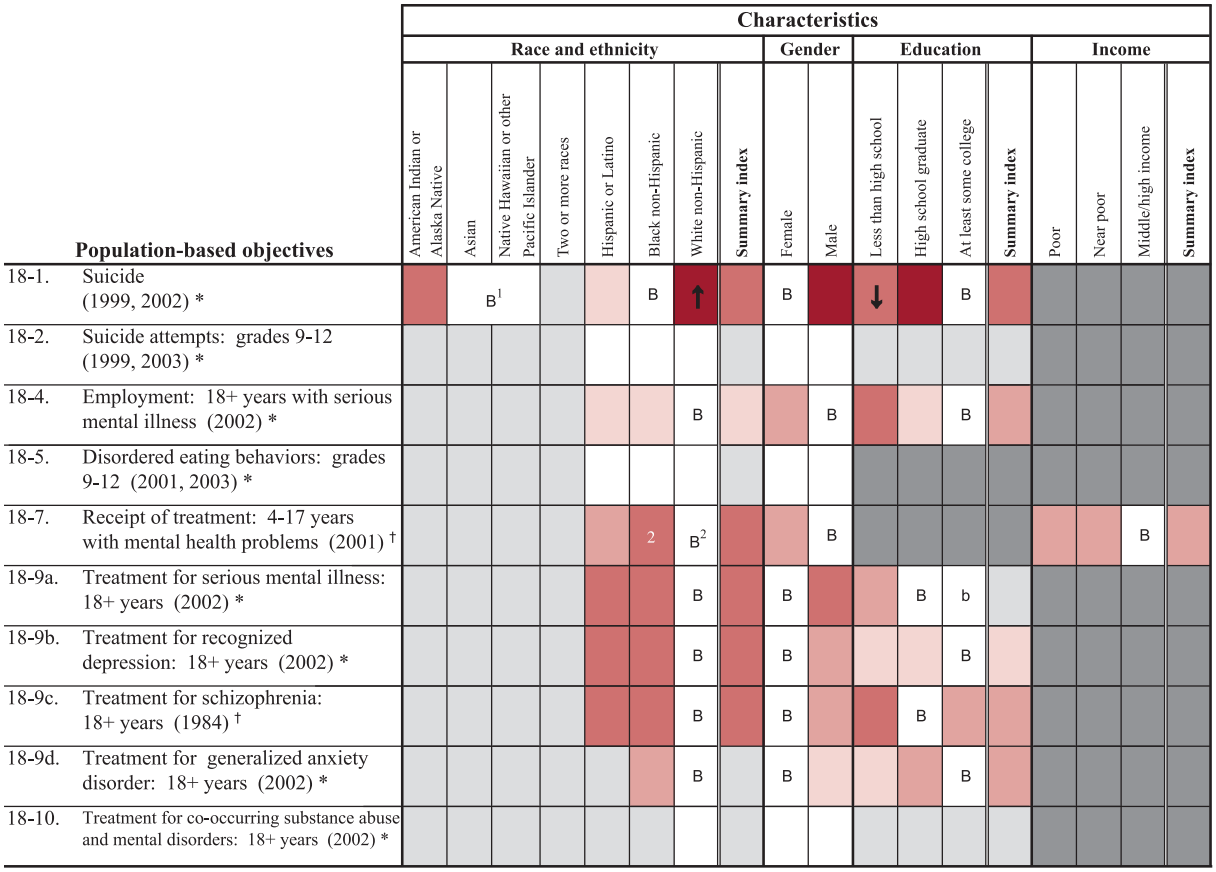
Notes: Tracking data for objectives 18-4, 18-7, 18-9a through d, 18-10, 18-11, and 18-13 are unavailable.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left(\frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}}\right) \times 100$$

Figure 18-2. Disparities Table for Focus Area 18: Mental Health and Mental Disorders

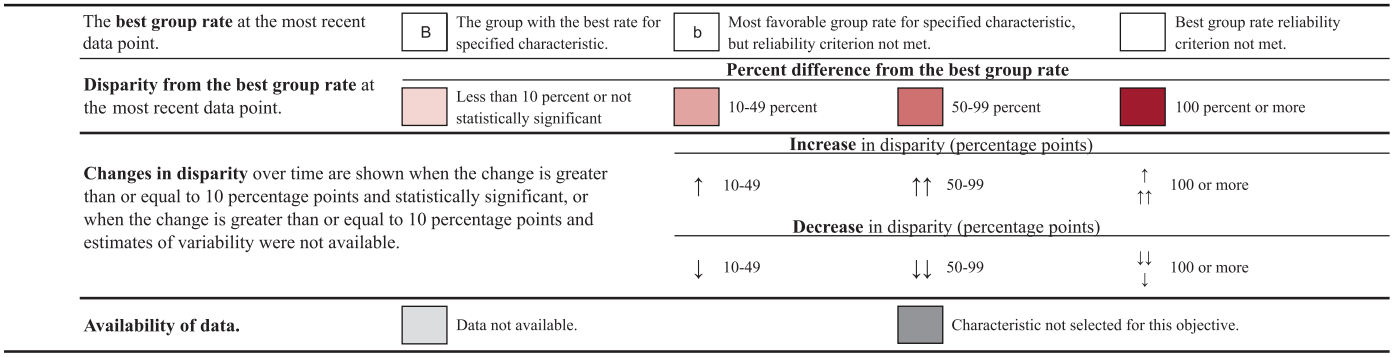
Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.



Notes: Data for objectives 18-3, 18-6, 18-8, and 18-11 through 18-14 are unavailable or not applicable.

Years in parentheses represent the baseline data year and the most recent data year (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (for example, race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.



* The variability of best group rates was assessed, and disparities of ≥ 10% are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

† Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

[1] Data are for Asians or Pacific Islanders.

[2] Data include persons of Hispanic origin.

Objectives and Subobjectives for Focus Area 18: Mental Health and Mental Disorders

Goal: Improve mental health and ensure access to appropriate, quality mental health services.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010.*

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.[1]

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

[1] See Technical Appendix for more information on baseline and target revisions.

Mental Health Status Improvement

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

18-1. Reduce the suicide rate.

Target: 4.8[1] suicides per 100,000 population.

Baseline: 10.5[2] suicides per 100,000 population occurred in 1999[2] (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

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

[1] Target revised from 5.0 because of baseline revision after November 2000 publication.
[2] Baseline and baseline year revised from 11.3 and 1998 after November 2000 publication.

NO CHANGE IN OBJECTIVE

18-2. Reduce the rate of suicide attempts by adolescents.

Target: 12-month average of 1.0 percent.

Baseline: 12-month average of 2.6 percent of adolescents in grades 9 through 12 attempted suicide in 1999.

Target setting method: Better than the best.

Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

ORIGINAL OBJECTIVE

18-3. Reduce the proportion of homeless adults who have serious mental illness (SMI).

Target: 19 percent.

Baseline: 25 percent of homeless adults aged 18 years and older had SMI in 1996.

Target setting method: 24 percent improvement. (Better than the best will be used when data are available.)

Data source: Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS.

OBJECTIVE WITH REVISIONS

18-3. **~~Reduce~~Increase the proportion of homeless adults ~~who have~~ with mental health ~~illness (SMI).~~problems who receive mental health services.**

Target: ~~19~~ 30 percent.

Baseline: ~~25~~ 27 percent of homeless adults aged 18 years and older with mental health problems received mental health services~~had SMI~~ in ~~1996~~2000.

Target setting method: ~~24~~ 10 percent improvement. (Better than the best will be used when data are available.)

Data source: Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS.

REVISED OBJECTIVE

18-3. **Increase the proportion of homeless adults with mental health problems who receive mental health services.**

Target: 30 percent.

Baseline: 27 percent of homeless adults aged 18 years and older with mental health problems received mental health services in 2000.

Target setting method: 10 percent improvement. (Better than the best will be used when data are available.)

Data source: Projects for Assistance in Transition from Homelessness (PATH) Annual Application, SAMHSA, CMHS.

ORIGINAL OBJECTIVE

18-4. **Increase the proportion of persons with serious mental illness (SMI) who are employed.**

Target: 51 percent.

Baseline: 43 percent of persons aged 18 years and older with SMI were employed in 1994.

Target setting method: 19 percent improvement. (Better than the best will be used when data are available.)

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

OBJECTIVE WITH REVISIONS

18-4. Increase the proportion of persons with serious mental illness (SMI) who are employed.

Target: 54 ~~51~~ percent.

Baseline: 52 ~~43~~ percent of persons aged 18 years and older with SMI were employed in ~~1994~~2002.

Target setting method: ~~19 percent improvement. (~~Better than the best ~~will be used when data are available.)~~

Data source: National Comorbidity Survey—Replication (NCS—R), NIH, NIMH~~Health Interview Survey (NHIS), CDC, NCHS~~.

REVISED OBJECTIVE

18-4. Increase the proportion of persons with serious mental illness (SMI) who are employed.

Target: 54 percent.

Baseline: 52 percent of persons aged 18 years and older with SMI were employed in 2002.

Target setting method: Better than the best.

Data source: National Comorbidity Survey—Replication (NCS—R), NIH, NIMH.

ORIGINAL OBJECTIVE

18-5. (Developmental) Reduce the relapse rates for persons with eating disorders including anorexia nervosa and bulimia nervosa.

Potential data source: Prospective studies of patients with anorexia or bulimia nervosa, NIH, NIMH.

OBJECTIVE WITH REVISIONS

18-5. ~~(Developmental)~~ Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight~~relapse rates for persons with eating disorders including anorexia nervosa and bulimia nervosa~~.

Target: 16 percent.

Baseline: 19 percent of adolescents in grades 9 through 12 engaged in disordered eating behaviors in an attempt to control their weight in 2001.

OBJECTIVE WITH REVISIONS *(continued)*

Target setting method: Better than the best.

~~Potential d~~Data source: ~~Prospective studies of patients with anorexia or bulimia nervosa, NIH, NIMH~~Youth Risk Behavior Surveillance Survey (YRBSS), CDC, NCHS.

REVISED OBJECTIVE

18-5. Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.

Target: 16 percent.

Baseline: 19 percent of adolescents in grades 9 through 12 engaged in disordered eating behaviors in an attempt to control their weight in 2001.

Target setting method: Better than the best.

Data source: Youth Risk Behavior Surveillance Survey (YRBSS), CDC, NCHS.

Treatment Expansion

ORIGINAL OBJECTIVE

18-6. (Developmental) Increase the number of persons seen in primary health care who receive mental health screening and assessment.

Potential data source: Primary Care Data System/Federally Qualified Health Centers, HRSA.

OBJECTIVE WITH REVISIONS

18-6. ~~(Developmental)~~ Increase the ~~number~~ proportion of primary care facilities that provide mental health treatment onsite or paid by referral. ~~of persons seen in primary health care who receive mental health screening and assessment.~~

Target: 68 percent of HRSA-funded primary care facilities.

Baseline: 62 percent of HRSA-funded primary care facilities provided mental health treatment onsite or paid by referral in 2000.

Target setting method: 10 percent improvement.

~~Potential d~~Data source: ~~Primary Care Data System/Federally Qualified Health Centers~~Uniform Data System (UDS), HRSA.

REVISED OBJECTIVE

18-6. Increase the proportion of primary care facilities that provide mental health treatment onsite or paid by referral.

Target: 68 percent of HRSA-funded primary care facilities.

Baseline: 62 percent of HRSA-funded primary care facilities provided mental health treatment onsite or paid by referral in 2000.

Target setting method: 10 percent improvement.

Data source: Uniform Data System (UDS), HRSA.

ORIGINAL OBJECTIVE

18-7. (Developmental) Increase the proportion of children with mental health problems who receive treatment.

Potential data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS.

OBJECTIVE WITH REVISIONS

18-7. ~~(Developmental)~~ Increase the proportion of children with mental health problems who receive treatment.

Target: 66 percent.

Baseline: 59 percent of children with mental health problems received treatment in 2001.

Target setting method: Better than the best.

Potential data source: National Health Interview Survey (NHIS), CDC, NCHS. ~~Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS~~.

REVISED OBJECTIVE

18-7. Increase the proportion of children with mental health problems who receive treatment.

Target: 66 percent.

Baseline: 59 percent of children with mental health problems received treatment in 2001.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

ORIGINAL OBJECTIVE

18-8. (Developmental) Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.

Potential data source: Inventory of Mental Health Services in Juvenile Justice Facilities, SAMHSA.

OBJECTIVE WITH REVISIONS

18-8. ~~(Developmental)~~ Increase the proportion of juvenile justice residential facilities that screen new admissions for mental health problems.

Target: 55 percent.

Baseline: 50 percent of juvenile residential facilities screened admissions for mental health problems in 2000.

Target setting method: 10 percent improvement.

~~Potential d~~Data source: ~~Inventory of Mental Health Services in Juvenile Justice Facilities, SAMHSA.~~Juveniles in Residential Facilities Census (JRFC), National Center for Juvenile Justice.

REVISED OBJECTIVE

18-8. Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.

Target: 55 percent.

Baseline: 50 percent of juvenile residential facilities screened admissions for mental health problems in 2000.

Target setting method: 10 percent improvement.

Data source: Juveniles in Residential Facilities Census (JRFC), National Center for Juvenile Justice.

ORIGINAL OBJECTIVE

18-9. Increase the proportion of adults with mental disorders who receive treatment.

Target and baseline:

Objective	Increase in Adults With Mental Disorders Receiving Treatment	1997 Baseline (unless noted)	2010 Target

ORIGINAL OBJECTIVE *(continued)*

		Percent	
18-9a.	Adults aged 18 to 54 years with serious mental illness	47 (1991)	55
18-9b.	Adults aged 18 years and older with recognized depression	23	50
18-9c.	Adults aged 18 years and older with schizophrenia	60 (1984)	75
18-9d.	Adults aged 18 years and older with generalized anxiety disorder	38	50

Target setting method: 17 percent improvement for 18-9a. (Better than the best will be used when data are available.) Better than the best for 18-9b, 18-9c, and 18-9d.

Data sources: Epidemiologic Catchment Area (ECA) Program, NIH, NIMH; National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS; National Comorbidity Survey, SAMHSA, CMHS; NIH, NIMH.

OBJECTIVE WITH REVISIONS

18-9. Increase the proportion of adults with mental disorders who receive treatment.

Target and baseline:

Objective	Increase in Adults With Mental Disorders Receiving Treatment	~~1997~~2002 Baseline (unless noted)	2010 Target
		Percent	
18-9a.	Adults aged 18 ~~to 54~~ years and older with serious mental illness	~~47 (1991)~~62	~~55~~68
18-9b.	Adults aged 18 years and older with recognized depression	~~23~~58	~~50~~64
18-9c.	Adults aged 18 years and older with schizophrenia	60 (1984)	75
18-9d.	Adults aged 18 years and older with generalized anxiety disorder	~~38~~60	~~50~~79

Target setting method: Better than the best.~~17 percent improvement for 18-9a. (Better than the best will be used when data are available.~~

Data sources: Epidemiologic Catchment Area (ECA) Program, NIH, NIMH; ~~Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS;~~ National Comorbidity Survey—,Replication (NCS—R), NIH, NIMH.

REVISED OBJECTIVE

18-9. Increase the proportion of adults with mental disorders who receive treatment.

Target and baseline:

Objective	Increase in Adults With Mental Disorders Receiving Treatment	2002 Baseline (unless noted)	2010 Target
		Percent	
18-9a.	Adults aged 18 years and older with serious mental illness	62	68
18-9b.	Adults aged 18 years and older with recognized depression	58	64
18-9c.	Adults aged 18 years and older with schizophrenia	60 (1984)	75
18-9d.	Adults aged 18 years and older with generalized anxiety disorder	60	79

Target setting method: Better than the best.

Data sources: Epidemiologic Catchment Area (ECA) Program, NIH, NIMH; National Comorbidity Survey—Replication (NCS—R), NIH, NIMH.

ORIGINAL OBJECTIVE

18-10. (Developmental) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Potential data sources: National Health Interview Survey (NHIS), CDC, NCHS; National Household Survey on Drug Abuse (NHSDA), SAMHSA, OAS; Replication of National Comorbidity Survey, NIH, NIMH.

OBJECTIVE WITH REVISIONS

18-10. ~~(Developmental)~~ Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Target: 57 percent.

Baseline: 51 percent of persons with co-occurring substance abuse and mental disorders received treatment for both disorders in 2002.

Target setting method: 10 percent improvement. (Better than the best will be used when population data are available.)

OBJECTIVE WITH REVISIONS *(continued)*

~~**Potential d**~~**Data sources:** ~~National Health Interview Survey (NHIS), CDC, NCHS; National Household Survey on Drug Abuse (NHSDA) Replication of~~ National Comorbidity Survey—Replication (NCS—R), NIH, NIMH.

REVISED OBJECTIVE

18-10. Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Target: 57 percent.

Baseline: 51 percent of persons with co-occurring substance abuse and mental disorders received treatment for both disorders in 2002.

Target setting method: 10 percent improvement. (Better than the best will be used when population data are available.)

Data source: National Comorbidity Survey—Replication (NCS—R), NIH, NIMH.

ORIGINAL OBJECTIVE

18-11. (Developmental) Increase the proportion of local governments with community-based jail diversion programs for adults with serious mental illness (SMI).

Potential data source: National Survey of Jail Mental Health Diversion Programs, SAMHSA.

OBJECTIVE WITH REVISIONS

18-11. ~~(Developmental)~~ Increase the proportion of ~~local governments with~~ counties served by community-based jail diversion programs and/or mental health courts for adults with ~~serious~~ mental ~~illness (SMI)~~ health problems.

Target: 7.6 percent.

Baseline: 6.9 percent of counties were served by community-based jail diversion programs and/or mental health courts for adults with mental health problems in 2004.

Target setting method: 10 percent improvement.

~~**Potential d**~~**Data source:** ~~National Survey of~~ Jail ~~Mental Health~~ Diversion Programs Database, SAMHSA.

REVISED OBJECTIVE

18-11. Increase the proportion of counties served by community-based jail diversion programs and/or mental health courts for adults with mental health problems.

REVISED OBJECTIVE *(continued)*

Target: 7.6 percent.

Baseline: 6.9 percent of counties were served by community-based jail diversion programs and/or mental health courts for adults with mental health problems in 2004.

Target setting method: 10 percent improvement.

Data source: Jail Diversion Program Database, SAMHSA.

State Activities

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

18-12. Increase the number of States and the District of Columbia that track consumers' satisfaction with the mental health services they receive.

Target: All States and the District of Columbia.

Baseline: 40[1] States tracked consumers' satisfaction with the mental health services they received in 2002.[1]

Target setting method: Total coverage.

Data source: Uniform Reporting System (URS), SAMHSA.

[1] Baseline and baseline year revised from 36 and 1999 after November 2000 publication.

NO CHANGE IN OBJECTIVE

18-13. (Developmental) Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.

Potential data source: State Mental Health Agency Profiling System, National Association of State Mental Health Program Directors, National Research Institute.

ORIGINAL OBJECTIVE

18-14. Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.

Target: 50 States and the District of Columbia.

ORIGINAL OBJECTIVE *(continued)*

Baseline: 24 States had an operational mental health plan that addressed mental health crisis interventions, ongoing screening, and treatment services for elderly persons in 1997.

Target setting method: Total coverage.

Data source: National Technical Assistance Center for State Mental Health Systems, National Association of State Mental Health Program Directors, National Research Institute; SAMHSA, CMHS.

OBJECTIVE WITH REVISIONS

18-14. Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses specialized mental health ~~crisis interventions~~services ~~ongoing screening, and treatment services~~ for elderly persons.

Target: All States and the District of Columbia.

Baseline: ~~24~~18 States had an operational mental health plan that addressed specialized mental health crisis interventions, ongoing screening, and treatment services for elderly persons in ~~1997~~2000–01.

Target setting method: Total coverage.

Data source: State Mental Health Agency Profiling System, National Association of State Mental Health Program Directors, National Research Institute. ~~National Technical Assistance Center for State Mental Health Systems, National Association of State Mental Health Program Directors, National Research Institute; SAMHSA, CMHS.~~

REVISED OBJECTIVE

18-14. Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses specialized mental health services for elderly persons.

Target: All States and the District of Columbia.

Baseline: 18 States had an operational mental health plan that addressed specialized mental health services for elderly persons in 2000–01.

Target setting method: Total coverage.

Data source: State Mental Health Agency Profiling System, National Association of State Mental Health Program Directors, National Research Institute.

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[1] Murray, C.J.L., and Lopez, A.D., eds. *The Global Burden of Disease and Injury Series, Vol. 1: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020.* Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

[2] Mental illness as used in the National Comorbidity Survey—Replication (NCS–R) includes anxiety, mood, impulse-control, and substance abuse disorders as defined by the *Diagnostic and Statistical Manual for Psychiatric Disorders-IV* (DSM-IV), 4th ed., American Psychiatric Association, 2000. This data source does not capture schizophrenia and some other disorders with low rates of new cases.

[3] According to the NCS–R, serious mental illness is defined as having a mental disorder that resulted in functional impairment within the past 12 months.

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[17] The boundaries of the juvenile justice system vary from State to State (lower age of jurisdiction, upper age of jurisdiction, and extended age of jurisdiction). In most States, youth as young as age 10 years (or 7) through age 18 years fall under the original jurisdiction of juvenile court; the court's jurisdiction for the purposes of disposition typically extends up to the 21st birthday. Personal communication with the National Center for Juvenile Justice, August 9, 2006.

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Related Objectives From Other Focus Areas

1. Access to Quality Health Services

1-1. Persons with health insurance
1-3. Counseling about health behaviors
1-4. Source of ongoing care
1-5. Usual primary care provider
1-6. Difficulties or delays in obtaining needed health care
1-7. Core competencies in health profession training
1-8. Racial and ethnic representation in health professions
1-10. Delay or difficulty in getting emergency care
1-11. Rapid prehospital emergency care
1-12. Single toll-free number for poison control centers
1-13. Trauma systems
1-14. Special needs of children
1-15. Long-term care services

2. Arthritis, Osteoporosis, and Chronic Back Conditions

2-4. Arthritis counseling

3. Cancer

3-10. Provider counseling about cancer prevention

6. Disability and Secondary Conditions

6-1. Standard definition of people with disabilities in data sets
6-2. Feelings and depression among children with disabilities
6-3. Feelings and depression interfering with activities among adults with disabilities
6-4. Social participation among adults with disabilities
6-5. Sufficient emotional support among adults with disabilities
6-6. Satisfaction with life among adults with disabilities
6-7. Congregate care of children and adults with disabilities
6-8. Employment parity
6-9. Inclusion of children and youth with disabilities in regular education programs
6-10. Accessibility of health and wellness programs
6-11. Assistive devices and technology
6-12. Environmental barriers affecting participation in activities
6-13. Surveillance and health promotion programs

7. Educational and Community-Based Programs

7-1. High school completion
7-2. School health education
7-3. Health-risk behavior information for college and university students
7-4. School nurse-to-student ratio
7-5. Worksite health promotion programs

7-6. Participation in employer-sponsored health promotion activities
7-10. Community health promotion programs
7-11. Culturally appropriate and linguistically competent community health promotion programs
7-12. Older adult participation in community health promotion activities

9. Family Planning

9-1. Intended pregnancy
9-2. Birth spacing
9-3. Contraceptive use
9-4. Contraceptive failure
9-5. Emergency contraception
9-6. Male involvement in pregnancy prevention
9-7. Adolescent pregnancy
9-8. Abstinence before age 15 years
9-9. Abstinence among adolescents aged 15 to 17 years
9-10. Pregnancy prevention and sexually transmitted disease (STD) protection
9-11. Reproductive health education

11. Health Communication

11-1. Households with Internet access
11-2. Health literacy
11-3. Research and evaluation of communication programs
11-4. Quality of Internet health information sources
11-5. Centers for excellence
11-6. Satisfaction with health care providers' communication skills

13. HIV

13-1. New AIDS cases
13-5. New HIV/AIDS cases
13-13. Treatment according to guidelines
13-17. Perinatally acquired HIV/AIDS and AIDS
13-18. Heterosexually transmitted HIV/AIDS in women

15. Injury and Violence Prevention

15-10. Emergency department surveillance systems
15-11. Hospital discharge surveillance systems
15-12. Emergency department visits
15-33. Maltreatment and maltreatment fatalities of children
15-34. Physical assault by intimate partners
15-35. Rape or attempted rape
15-36. Sexual assault other than rape
15-37. Physical assaults
15-38. Physical fighting among adolescents
15-39. Weapon carrying by adolescents on school property

16. Maternal, Infant, and Child Health

16-2. Child deaths
16-3. Adolescent and young adult deaths
16-4. Maternal deaths
16-5. Maternal illness and complications due to pregnancy
16-6. Prenatal care
16-14. Developmental disabilities
16-17. Prenatal substance exposure
16-18. Fetal alcohol syndrome
16-19. Breastfeeding
16-22. Medical homes for children with special health care needs
16-23. Service systems for children with special health care needs

20. Occupational Safety and Health

20-5. Work-related homicides
20-6. Work-related assaults
20-7. Elevated blood lead levels
20-9. Worksite stress reduction programs

23. Public Health Infrastructure

23-2. Public access to information and surveillance data
23-3. Use of geocoding in health data systems
23-4. Data for all population groups
23-6. National tracking of Healthy People 2010 objectives
23-7. Timely release of data on objectives
23-8. Competencies for public health workers
23-9. Training in essential public health services
23-10. Continuing education for public health personnel
23-11. Performance standards for essential public health services
23-12. Health improvement plans
23-13. Access to public health laboratory services
23-14. Access to epidemiology services
23-17. Population-based prevention research

25. Sexually Transmitted Diseases

25-3. Primary and secondary syphilis
25-9. Congenital syphilis
25-11. Responsible adolescent sexual behavior

26. Substance Abuse

26-7. Alcohol- and drug-related violence
26-8. Lost productivity
26-9. Substance-free youth
26-10. Adolescent and adult use of illicit substances
26-11. Binge drinking

26-12. Average annual alcohol consumption
26-13. Low-risk drinking among adults
26-14. Steroid use among adolescents
26-15. Inhalant use among adolescents
26-16. Peer disapproval of substance abuse
26-17. Perception of risk associated with substance abuse
26-18. Treatment for alcohol or illicit drugs
26-22. Hospital emergency department referrals
26-23. Community partnerships and coalitions