

Mental Health

Background

A person's ability to carry on productive activities and live a rewarding life is affected not only by physical health but by mental health. In addition, mental well-being can affect physical well-being in many ways,¹ yet many people still find that treatment is difficult to access.

Mental health is a broad and complex issue with many facets to consider. A wide range of symptoms and conditions can lead to disruptions in mental well-being, and consequently to self-care and social abilities. Some of these conditions are severe enough to be considered "illnesses," consisting of clusters of symptoms. These are the conditions most often cited in reference to mental health. However, the most common mental health disruptions are milder and may fall short of a diagnosable condition, though they still impact daily functioning for many.²

Health Equity Highlight: Women

A person's gender can impact the presentation and prevalence of mental illness due to differences in environmental, social, hormonal and physiological factors.

- Women are more likely than men to report experiencing days when their mental health was not good (2.7 versus 4.1 mentally unhealthy days in the past 30 days.)³
- Women are at a greater risk for experiencing depression and anxiety than men regardless of age. More than 1 in 4 women have ever been diagnosed with depression and 1 in 5 have been diagnosed with an anxiety disorder.³
- Women are more than twice as likely as men to have an unmet need for mental health treatment or counseling.³

Reports issued by DHHS show that:

- 12.1% of persons 18 and older reported severe psychological distress in the past year in 2006, with 8.8% reporting at least one major episode of depression.⁴
- Among 18-25 year olds, about 1 in 5 people reported severe psychological distress in the past year.⁴
- 1 in 8 new mothers in Maine is diagnosed with depression.⁵
- 7.2% of children ages 0-17 have emotional, developmental, or behavioral problems for which they need treatment or counseling.⁶

The Public Health Response:

While state mental health services have often been focused on children and the severely and persistently mentally ill, there is a growing recognition that there is need for interventions for a wider range of mental health needs. Data on mental health among Maine citizens is regularly collected on several public health surveys, including the Maine Integrated Youth Health Survey, the Pregnancy Risk Assessment Monitoring System, and the Behavioral Risk Factor Surveillance System.

Comprehensive, population-based approaches to promoting mental health continue to be primarily focused on early identification and linkages to care for those with mental health needs, while the prevention of mental illness lacks evidence-based practices. The current efforts have been hampered by the lack of communication and cooperation between the public health and mental health communities, despite the well-known cross connections between mental health and chronic disease, as well as the strong causal links with substance abuse. Maine has worked to address these needs by forging links between traditional medical providers and mental health practitioners, through pilot programs in federally qualified health centers

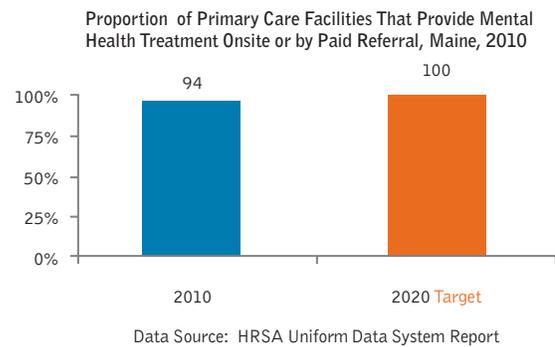
and through screening education programs for MCDC sub-grantees and other medical providers. These pilot projects, which have included the co-location of services and coordination of care, show promise.

Efforts to address mental health issues are also challenged by the underreporting and consequent under-treatment of these conditions, often due to the pervasive socio-cultural stigma attached to those who are diagnosed and treated for mental health issues. This stigma is part of the reason that persons with mental health issues often find themselves struggling to pay or find coverage for treatment, as health insurance plans often do not cover mental health-related issues as thoroughly as those traditionally seen as solely physical in nature.⁷ Policy approaches, including mental health parity laws for health insurance have made some progress.

HM2020 Objectives

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

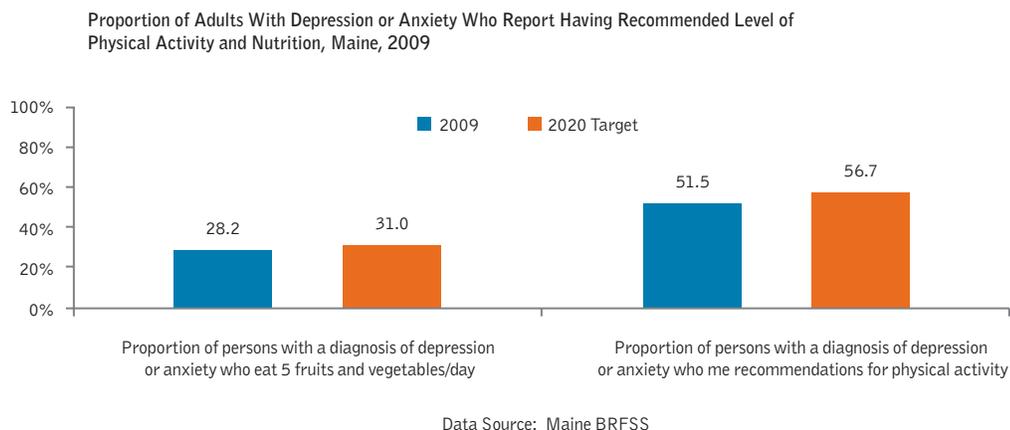
Evidence has shown that co-location of primary care and mental health services increases access and collaboration, resulting in better outcomes for both physical and mental health.⁸



This small sample of primary care providers indicates that co-location of services is being implemented in 94% of facilities; the Healthy Maine 2020 goal is 100%. With funding from the Health Resources and Services Administration, grantees may be better able to create infrastructure to make co-location happen, although pilot projects also occur outside of these settings. This baseline data does not give us information regarding the degree of integration and collaboration.

2. Increase healthy behaviors of people with mental health issues

People with mental health issues report fewer healthy behaviors such as physical activity, good nutrition, no tobacco use and moderate or no alcohol use. These healthy behaviors can impact the incidence of other chronic diseases, as well as help to manage depression and other mental illnesses.¹



Proportion of Adults With Depression or Anxiety Diagnosis Who Do Not Drink Heavily or Smoke, Maine, 2006, 2008-2010



Data Source: Maine BRFSS

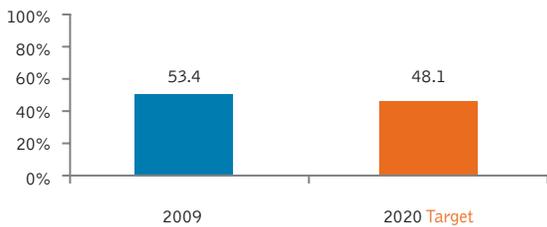
In 2009, only 29.2% of adults with depression or anxiety reported eating 5 or more fruits and vegetables a day; and 51.5% met recommendations for physical activity. The Healthy Maine 2020 goal is increase those numbers to 31% and 56.7%, respectively.

In 2010, 94.9% of adults diagnosed with depression or anxiety did not smoke and 72.7% were not heavy drinkers. The Health Maine 2020 goal is to increase those numbers to 99.6% and 80%, respectively.

3. Reduce co-morbidity for persons with mental illness

Those with mental illness are more likely to also have a range of other chronic diseases. Self-management of chronic disease can also be more challenging for those with a mental illness. Reducing co-morbidity can result in better quality of life as well as reduce early mortality for this population.⁹

Proportion of Persons With a Diagnosis of Anxiety or Depression Who Have at Least One Selected Chronic Disease (Diabetes, Asthma, Hypertension), Maine, 2009



Data Source: Maine BRFSS

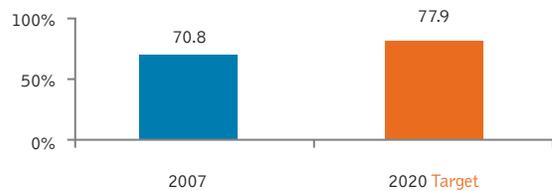
In 2009, approximately 53.4% of Mainers diagnosed with anxiety or depression had at least one chronic disease (diabetes, asthma, hypertension); the Healthy Maine goal is 48.1%.

4. Increase the proportion of children with mental health problems who receive treatment

Research has shown that half of all lifetime cases of mental illness develop before age 14.¹⁰ Untreated mental illness can lead to more severe symptoms that are difficult to treat and increases the risk for co-occurring mental illnesses.¹¹

Although 70% of children and adolescents who need mental health treatment are currently receiving treatment, almost 1 in 3 in need of treatment are not receiving it. 2007 was the first year this indicator was available.

Proportion of 2-17 Year-old Children Who Needed Mental Health care Who Received Such Care, Maine, 2007



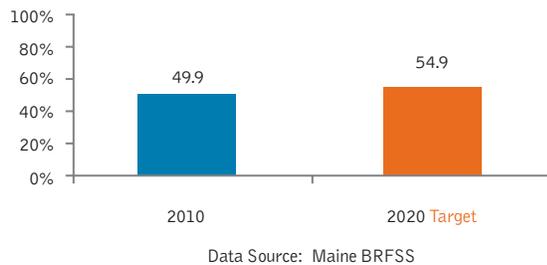
Data Source: National Survey of Children's Health

5. Increase the proportion of adults with mental health disorders who receive treatment

There are evidence-based treatments that can positively affect the quality of life for those with depression. Treatment for depression can also positively affect co-occurring health issues and reduce suicide.¹²

In 2009, approximately half of adults who reported depression were receiving mental health treatment; the Healthy Maine goal is 54.9%. The survey question used for this indicator was first asked in a 2009 survey, therefore trend data is not yet available.

Proportion of Adults With Moderate to Severe Depression, Who Report That They Are Receiving Counseling or Medication for Their Mental Health, Maine, 2010



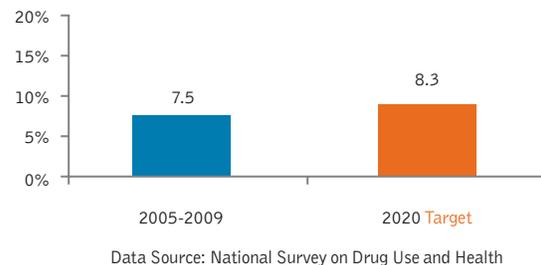
6. Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders

Studies have shown that serious mental illness is correlated with illicit drug use and that adults who were heavy alcohol users in the past month were more likely to have a serious mental illness than those who were not.¹³ Some 60% of people with severe and persistent mental illnesses abuse

substances. Substance abuse is also relatively common among persons with less severe forms of mental illness.¹⁴ Among all types of mental illness and age groups, substance abuse compounds the existing problem and makes effective treatment more difficult. Over the past ten years, Maine has been among the leaders nationally in attempting to address the problem of dual diagnosis,¹⁴ however much work remains to be done in the coming decade.

In the period of 2005-2009, 7.5% of adults with co-occurring serious psychological distress and alcohol or illicit drug dependence or abuse received treatment or counseling at a treatment facility in the last year. The Healthy Maine 2020 goal is 8.3%.

Adults 18+ With Co-occurring Serious Psychological Distress and Alcohol or Illicit Drug Dependence or Abuse Who Received Mental Health Treatment/Counseling and Illicit Drug or Alcohol Treatment at a Specialty Facility in the Past Year, Maine, 2005-09



Methodology

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

Measure: Percent of primary care facilities that provide mental health treatment onsite or by paid referral.

Numerator: Number of primary care facilities receiving HRSA grant funds that provide mental health treatment on site or paid by referral.

Denominator: Number of primary care sites receiving HRSA grant funds.

Target setting method: Complete achievement, less than a 10% improvement.

Other notes: This is data reported by HRSA grantees as part of the Uniform Data System Report. It does not include any primary care sites that do not receive HRSA funding. It does not detail the extent of services available. There is a need for more information from a broader array of primary care providers, but there are no better data sources available at this time. This is a Healthy People 2020 objective. Although this data source is imperfect, no other Maine-based data sources were considered practical for this objective.

2. Increase healthy behaviors of people with mental health issues

SUB-OBJECTIVES:

2a. Increase the proportion of persons with a diagnosis of depression or anxiety who eat five fruits and vegetables per day.

Measure: Percent of persons with a diagnosis of depression or anxiety who eat five fruits and vegetables per day.

Numerator: Number of respondents who report that they have ever been diagnosed with depression or anxiety who report that they have eaten at least 5 fruits or vegetables per day during the past week.

Denominator: Number of respondents who report they have ever been diagnosed with depression or anxiety and responded to fruit and vegetable question.

2b. Increase the proportion of persons with a diagnosis of depression or anxiety who meet the recommendations for physical activity.

Measure: Percent of persons with a diagnosis of depression or anxiety who meet recommendations for physical activity.

Numerator: Number of respondents who report that they have ever been diagnosed with depression or anxiety who report that they have participated in at least 20 minutes of vigorous activity at least 3 days/week or 30 or more minutes of moderate exercise 5 or more days per week

Denominator: Number of respondents who report they have ever been diagnosed with depression or anxiety and responded to physical activity question.

2c. Increase the proportion of persons with a diagnosis of depression or anxiety who do not smoke.

Measure: Percent of persons with of persons with a diagnosis of depression or anxiety who do not smoke.

Numerator: Number of respondents who report that they have ever been diagnosed with depression or anxiety who report that they are not current smokers (RFSMOK2).

Denominator: Number of respondents who report they have ever been diagnosed with depression or anxiety and responded to smoking question.

2d. Increase the proportion of persons with a diagnosis of depression or anxiety who are not heavy drinkers.

Measure: Percent of persons with a diagnosis of depression or anxiety who are not heavy drinkers who report that they have ever been diagnosed

with depression who report that they are not heavy drinkers (>2 drinks per day for men, >1 drink per day for women).

Denominator: Number of respondents who report they have ever been diagnosed with depression or anxiety and responded to binge drinking question.

Target setting method: 10% Improvement, except for 2d., which is a 5% improvement.

Other notes: Data are statistically weighted to be more representative of the general adult population of Maine and to adjust for non-response.

3. Reduce co-morbidity for persons with mental illness

Measure: Percent of persons with a diagnosis of anxiety or depression who have at least one selected chronic disease (diabetes, asthma, hypertension).

Numerator: Number of respondents who report ever having been diagnosed with anxiety or depression and who report being diagnosed with asthma, diabetes, or hypertension.

Denominator: Number of respondents with a diagnosis of depression or anxiety and responded to asthma, diabetes or hypertension questions.

Target setting method: 10% Improvement.

Other notes: Data are statistically weighted to be more representative of the general adult population of Maine and to adjust for non-response.

4. Increase the proportion of children with mental health problems who receive treatment

Measure: Percent of 2-17 year old children who needed mental health care who received such care

Numerator: Number of 2-17 year olds for whom parent/guardian answers yes to both “Does [CHILD] have any kind of emotional, developmental, or behavioral problem for which

[he/she] needs treatment or counseling”? and “Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers. During the past 12 months, has [CHILD’S NAME] received any treatment or counseling from a mental health professional?”

Denominator: Number of 2-17 year olds for whom parent/guardian answers yes to “Does [CHILD] have any kind of emotional, developmental, or behavioral problem for which [he/she] needs treatment or counseling?”

Target setting methods: 10% improvement (same method as HP2020).

Other notes: This is a Healthy People 2020 measure, but uses a different data source, the National Survey of Children’s Health. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [01/05/12] from childhealthdata.org. Significant changes were made to the denominator, question, and introduction of this indicator in the 2007 NSCH survey. In 2007 the age range was restricted to children age 2-17 years. Also in 2007, examples of mental health professionals and services were added to wording of the question introduction and text. It is for these reasons that only 2007 data are presented. The NSCH is only conducted every 4 years.

5. Increase the proportion of adults with mental health disorders who receive treatment

Measure: Percent of adults who met the criteria for current moderate or severe depression on the PHQ-8, who report that they are receiving counseling or medication for their mental health.

Numerator: Number of adults who meet the criteria for current moderate or severe depression on the PHQ-8 (PHQ-8 score ≥ 10) and respond “yes” to receiving counseling for their mental health.

Denominator: Number of adults who meet the criteria for current moderate or severe depression on the PHQ-8 (PHQ-8 score ≥ 10) and respond “yes” or “no” to receiving counseling for their mental health.

Target setting method: 10% improvement.

Other Notes: Data are statistically weighted to be more representative of the general adult population of Maine and to adjust for non-response. Maine includes a depression screening module on the BRFSS, which is not available in all states. This is more inclusive than the HP 2020 measure from National Survey of Drug Use in Households (NSDUH), which is limited to those experiencing a major depressive episode. The Maine data for this indicator has small numbers and therefore is not able to be tracked. Additional data from NSDUH on treatment for those with any mental illness may be added in the future.

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

Measure: Five year aggregate percentage of persons aged 18 or older with co-occurring serious psychological distress (SPD) and alcohol or illicit drug dependence or abuse who received mental health treatment/counseling and illicit drug or alcohol treatment at a specialty facility.

Numerator: Number of people who reported serious psychological distress (SPD) and alcohol or illicit drug dependence or abuse, and reported receiving treatment for both. Mental Health Treatment/Counseling is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves,

or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Estimates were based only on responses to items in the Adult Mental Health Service Utilization module. Received Illicit Drug or Alcohol Treatment at a Specialty Facility refers to treatment received at a hospital (inpatient), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Denominator: Number of people who reported serious psychological distress (SPD) and alcohol or illicit drug dependence or abuse. Serious Psychological Distress (SPD) is defined for this table as having a score of 13 or higher on the K6 scale in the past year.

Target setting method: 10% improvement.

Other Notes: Estimates for 2005, 2006, and 2007 are based on an adjusted SPD variable and may differ from estimates published in prior NSDUH reports. See Section B.4.5 in Appendix B of the Results from the 2008 National Survey on Drug Use and Health: National Findings.

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