

## **BIBLIOGRAPHY OF RESOURCE DOCUMENTS FOR PREVALENCE RATES AND OTHER DATA FOR MHSA PLANNING UPDATED 10/25/05<sup>1</sup>**

There are several major surveys that have been, and some continue to be, conducted on a regular basis that contain questions about the respondents health and mental health status, demographics, health history, and service use. In addition, there are smaller surveys that are conducted to address specific health and mental health information needs. Following is a list of the major surveys with a brief description of each when known. After the descriptions, is an annotated bibliography of some of the articles that have been published using these data sources. Any of the rates should be used cautiously in applying them to smaller populations.

Epidemiological Catchment Area (ECA) study. This includes studies that were done in 5 sites throughout the country between 1980 and 1985 using the Diagnostic Interview Schedule (DIS). The studies were sponsored by the National Institute for Mental Health (NIMH) and have been used extensively in reporting on the prevalence of mental disorders among adults. At least one book and over 400 articles have been published using the ECA data. The publication series Mental Health, United States includes a number of articles based on ECA data. In addition, the NIMH website can be searched for prevalence studies.

National Co-Morbidity Study (NCS). The NCS is “the first nationally representative mental health survey in the U.S. to use a fully structured research diagnostic interview to assess the prevalence and correlates of DSM-III-R disorders.” The baseline NCS was conducted in 1991-92 and the respondents were re-interviewed in 2001-02. In addition, a new sample of adults was also interviewed at that time in the NCS-Replication (R) and a sample of adolescents was included to provide data on the prevalence and correlates of mental illness in youth. The survey is based on face-to-face interviews with English-speaking respondents only. Data from the first survey have been widely published and data from the 2002-02 surveys are just now becoming available. The surveys from this later period used instruments based on DSM-IV criteria. The June 2005 issue of the Journal of the American Medical Association has 5 articles based on these studies, and many other articles have recently been published based on the new results. The following website includes some of the findings from these studies  
<http://www.hcp.med.harvard.edu/ncs/>.

The National Latino and Asian American Study (NLAAS) and the National Survey of American Life are nationally representative community household surveys that estimate the prevalence of mental disorders and rates of mental health service utilization by Latinos and Asian Americans (NLAAS) and African-Americans (NLAS). The studies use similar methodologies to the NCS-R with unique survey questions and interview procedures that match the target populations. Researchers are just beginning to analyze the data from these surveys, and there is no published literature to date reporting results.

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National Health Interview Survey (NHIS). This survey is sponsored by the National Center for Health Statistics (NCHS) and is conducted annually. The survey is actually conducted within each state using a standard instrument and protocol specified by NCHS although the state can add questions to meet specific state needs. In California, the California Health Interview Survey (CHIS) is conducted by the University of California at Los Angeles, and information is accessible at [www.chis.ucla.edu](http://www.chis.ucla.edu). This is a telephone-based survey of persons living in households and includes about 50,000 people in California. Because the sample size is so large, the results can be reviewed by county for counties over 100,000 population.

Behavioral Risk Factor Surveillance Survey (BRFSS). The survey is sponsored by the Centers for Disease Control and Prevention (CDC) to collect information to monitor the prevalence of major behavioral risks among adults associated with premature morbidity and mortality. The survey was first tested in the early 1980's in a sample of states and by 1994 all states collected the data on an on-going basis. Like the NHIS, there is a core set of questions asked in each state each year, and the state has the option to ask additional questions to meet specific state needs. In California, the survey includes about 5,000 persons living in households. The website for further information is <http://www.cdc.gov/brfss/>.

#### MENTAL HEALTH, UNITED STATES publications

These have excellent summary articles on prevalence, services, staffing and funding of mental health services. These were published by the National Institute of Mental Health in the past, and the Center for Mental Health Services starting with the 1992 edition. Most of the reports show national data only. Although the source data are old in many cases, these are still used as authoritative sources. Data specific to California can be obtained for more recent years based on the California Health Interview Survey (CHIS). This is the California version of the NHIS.

#### **1985**

Chapter 1. Prevalence of Selected Mental Disorders, Ben Z. Locke, M.S.P.H. and Darrel A. Regier, M.D., M.P.H.

This article gives prevalence rates for Serious Mental Illnesses (SMI) by diagnosis by 3 sites from the ECA. It shows 6-month prevalence rates of 18.7% for any Diagnostic Interview Schedule (DIS) disorder, 14.4% for any DIS disorder except phobia, and 14.0% for any DIS disorder except substance abuse.

#### **1990**

Chapter 6. Prevalence of Selected Mental Disorders in Nursing and Related Care Homes, Genevieve W. Strahan

This is based on the 1985 National Nursing Home Survey (NNHS) and shows that 65% of residents have a mental disorder, although 46.7% were organic brain syndromes, including Alzheimer's, 5.6% was for retardation, and 3.9% for alcohol and drug abuse. Other rates are 11.2% for depressive disorders, 13.1% for schizophrenia and other psychoses, 11.0% for anxiety, and 1.2% for other mental illnesses.

## **1992**

Chapter 7. Serious Mental Illness and Disability in the Adult Household Population: United States, 1989, Peggy R. Barker, M.P.H.; Ronald W. Manderscheid, Ph.D.; Gerry E. Hendershot, Ph.D.; Susan S. Jack, M.S.; Charlotte A. Schoenborn, M.P.H.; Ingrid Goldstrom, M.Sc.

This article is based on the 1989 special supplement to the National Health Interview Survey (NHIS). It provides a more flexible operational definition of SMI for the household population and looks at service use and disability program participation. The definition of SMI was any psychiatric disorder during the past year that seriously interfered with one or more aspects of a person's daily life.

The survey based on civilian noninstitutionalized population shows a rate of 18.2 adults per 1,000 persons. 47.2% of persons with SMI were reported unable to work (28.9%) or limited in work (18.4%) because of the mental disorder.

Summary... "Placed in the context of the entire adult population, these findings suggest that the SMI population can be conservatively estimated to include 4-5 million adult Americans, or 2.1% to 2.6% of the adult population."

## **1994**

Chapter 3. National Prevalence and Treatment of Mental and Addictive Disorders, Karen H. Bourdon, M.A.; Donald S. Rae, M.A.; William E. Narrow, M.D., M.P.H.; Ronald W. Manderscheid, Ph.D.; Darrel A. Regier, M.D., M.P.H.

This is one of the primary references for prevalence data based on the ECA. It is based on all 5 ECA sites, provides 1 month and 1 year prevalence rates, services use, by diagnosis and shows overlap with substance use. The study includes a community household sample of 18,344 persons and the institutional sample of 1,947 persons residing in mental hospitals, nursing homes and penal institutions, for a total of 20,291 persons.

The study found an annual prevalence rate of 28.1% for the adult population for any DIS disorder including substance use disorders. There was an annual rate of 22.1% for any DIS disorder except alcohol or drug abuse only. Rates for specific disorders include 1.1% for Schizophrenia/schizophreniform disorders which is similar to rates found in international studies, 9.5% for affective disorders, and rates for other specific disorders.

Be cautious in using the rate for phobia which resulted from a high rate in Baltimore that the researchers later found questionable.

This also provides rates of the percent of people who received services, what sector (general medical or specialty mental health), and whether or not they had a diagnosis. The graph on page 27 is excellent.

Chapter 4. Mental Health Service Needs, Use, and Costs for Children and Adolescents with Mental Disorders and their Families: Preliminary Evidence, Kimberly Hoagwood, Ph.D., and Agnes Rupp, Ph.D.

This chapter explains “why the generation of reliable data on need for and “use of services for youth has been slow to emerge.” There is still no single consistent or comprehensive data but the article cites studies done in the mental health, education, and juvenile justice areas and their findings.

## **1996**

Chapter 5. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI), Ronald C. Kessler, Ph.D.; Patricia A. Berglund, M.B.A.; Shanyang Zhao, Ph.D.; Philip J. Leaf, Ph.D.; Anthony C. Kouzis, Ph.D.; Martha L. Bruce, Ph.D., M.P.H.; Robert M. Friedman, Ph.D.; Rene C. Grosser, Ph.D.; Cille Kennedy, Ph.D.; William E. Narrow, M.D., M.P.H.; Timothy G. Kuehnel, Ph.D.; Eugene M. Laska, Ph.D.; Ronald W. Manderscheid, Ph.D.; Robert A. Rosenheck, M.D.; Timothy W. Santoni, M.A.; Max Schneier, J.D.

This is based on the 1990-91 National Comorbidity Survey (NCS) that assessed the prevalence of DSM-III-R disorders among persons aged 15-54 and is supplemented by data from the Baltimore ECA study for older persons. This provided rates of 2.6% for Serious and Persistent Mental Illness (SPMI), 5.4% for SMI, and 23.9% for any 12-month DSM-III-R mental disorder.

Serious mental illness is defined based on diagnosis, disability, and duration. Certain diagnoses are specified along with other factors to indicate severity, such as hospitalization or use of major psychotropic medications. In addition, either a planned or attempted suicide during the last 12 months, substantial impairment with vocational capabilities, and serious interpersonal impairment. Of those with SMI, 46.6% received any service.

Chapter 6. Prevalence of Serious Emotional Disturbance in Children and Adolescence, Robert M. Friedman, Ph.D.; Judith W. Katz-Leavy, M.Ed.; Ronald W. Manderscheid, Ph.D.; Diane L. Sondheimer, M.S., M.P.H.

This is based on the synthesis of 7 different studies (some of which include several studies) which generally used a DSM diagnosis and level of impairment based on the CGAS for youth as the criteria for Serious Emotional Disturbance (SED). The studies

include youth aged 9 through 17 only. There were widely varying rates but these were summarized to rates of 5-9% for SED with extreme functional impairment, 9-13% for SED with substantial functional impairment, and 20% for youth with any diagnosable disorder.

## **1998**

Chapter 9. A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness, Ronald C. Kessler, Ph.D.; Patricia A. Berglund, M.B.A.; Ellen E. Walters, M.S.; Philip J. Leaf, Ph.D.; Anthony C. Kouzis, Ph.D.; Martha L. Bruce, Ph.D., M.P.H.; Robert M. Friedman, Ph.D.; Rene C. Grosser, Ph.D.; Cille Kennedy, Ph. D.; Timothy G. Kuehnel, Ph.D.; Eugene M. Laska, Ph.D.; Ronald W. Manderscheid, Ph.D.; William E. Narrow, M.D., M.P.H.; Robert A. Resenheck, M.D.; and Max Schneier, J.D

“This chapter describes the methodology and estimates produced by the technical expert committee charged with operationalizing the definition of adult SMI and presents national survey data on patterns of service use among persons with SMI.”

Chapter 10. Prevalence of Serious Emotional Disturbance: An Update, Robert M. Friedman, Ph.D.; Judith W. Katz-Leavy, M.Ed.; Ronald W. Manderscheid, Ph.D.; and Diane L. Sondheimer, M.S., M.P.H.

Applies the prevalence rates described in the 1996 edition to updated population estimates by state.

Chapter 11. Mental Illness and Disability in the U.S. Adult Household Population, Angela Gonzalez Willis, Ph.D.; Gordon B. Willis, Ph.D.; Alisa Male, M.A.; Marilyn Henderson, M.P.A.; and Ronald W. Manderscheid.

“This chapter builds on previous surveys and presents data on 12-month prevalence rates of mental/emotional problems in the civilian noninstitutionalized U.S. household population, and profiles functional limitations and service utilization patterns in this population.” The data are based on the National Household Interview Survey – D (NHIS-D), which consists of the core questions used each year in the NHIS and supplemental questions about disabilities and conditions that may result in disability. Based on the questions used in this survey, the prevalence rates for mental/emotional problems ranged from 4.9 percent to 9.9 percent for the adult household population. The differences in the estimates are based on the level of functional limitations related to the mental/emotional problems. The prevalence estimate of 4.9 percent indicates that the symptoms seriously interfered with the ability to work or attend school or to manage day-to-day activities while the 9.9 percent estimate does not require serious interference with activities.

## **2000**

Chapter 5. Psychiatric Epidemiology: Recent Advances and Future Directions, Ronald C. Kessler, Ph.D; Elizabeth J. Costello, PhD.; Kathleen Ries Marikangas, Ph.D.; and T. Bedirhan Ustun, M.D.

This includes a discussion of past and current survey methods in US and other countries, possible problems in measurement tools and methodology where rates are close to 50% for lifetime prevalence, problems with underreporting, challenges of developing rates for youth, and other issues.

Chapter 10. Co-occurring Addictive and Mental Disorders, Fred C. Osher, M.D.  
This article provides some general prevalence rates from several studies on co-occurring disorders. However, the main focus is on a treatment model and integrated services. It also shows the diagram that ADP uses showing 4 quadrants with combinations of mental health and substance use disorders and the combination and severity of each.

Chapter 13. Refugee Mental Health: Issues for the New Millennium, James Jaranson, M.D., M.A., M.P.H.; Susan Forbes martin, Ph.D.; and Solvig Ekblad, D.M.Sc.

This provides a discussion of past, current, and emerging issues related to refugees. There are numerous references that would provide detailed prevalence rates for specific groups. There is a brief general summary of prevalence rates. The estimated prevalence rate of Post Traumatic Stress Disorder (PTSD) is 4-20% with one study as high as 50%. Also, among several groups, there are higher anxiety and higher depression rates.

Chapter 19. Estimates of Mental and Emotional Problems, Functional Impairments, and Associated Disability Outcomes for the U.S. Child Population in Households, Lisa J. Colpe, Ph.D., M.P.H.

This is based on the National Household Interview Survey – Disabled (NHIS-D) during 1994-1996. It included 41,100 youth aged 5-17 and excluded Down's Syndrome.

Screener questions were

Does your child have a problem or delay in mental/cognitive development?

Does your child have a problem/delay in emotional/behavioral development?

If there was a yes response to either of these, the child was placed in the Disability Group.

Functional limitation was defined by 4 variables.

Significant problems at school paying attention in class.

Significant problems at school in controlling behavior.

Significant problems at school communicating with others.

Because of a physical, mental or emotional problem, difficulty in playing or getting along with others his/her own age.

If there was a yes response to any of these, the child was placed in the Disability Group.

Disability was defined by limitation in school activities, number of school days missed in past 2 weeks, global health status, and service utilization in the past 12 months.

There was an overall prevalence rate of 9.2% for the Disability Group – 5% with Functional Limitations only, 1.2% with Mental/Emotional Problems only, and 3% with both. An interesting finding is that there was a higher percentage of youth aged 7-8 in the Disability Group than the reference group. Most rates for youth start at 9-17 so this may provide helpful information for younger age groups.

## **2002**

### Chapter 8. Prevalence of Mental Disorders and Contacts with Mental Health Professionals Among Adults in the United States: National Health Interview Survey, 1999, Wayne C. Dickey, Ph.D.; Stephen J. Blumberg, Ph.D.

This is based on the parts of the Composite International Diagnostic Interview - Short Form (CIDI-SF) to test for major depression, generalized anxiety disorder, and panic attacks. Approximately 8.8% of adults had one or more of these disorders, 6.2% had one disorder only, and 2.5% had at least two. Individually, the rates were 6.3% for major depression, 2.8 % for generalized anxiety disorder and 2.7% for panic attack. 38.7% of the people with major depression or generalized anxiety disorder experience a lot of interference with life or activities and an additional 36.9% experienced some interference. Specific rates are shown by age, gender, race/ethnicity, income, education, marital status, MSA size and birthplace.

Although there were some differences in age ranges 15-54 vs 18+ between this and the NCS, there are differences in the rates of major depression - 6.3 here and 10.3 for the NCS. They used difference versions of the CIDI and one has more stem questions. Differences in rates by demographic characteristics were similar to other prevalence studies.

### Chapter 9. Estimates of Attention, Cognitive, and Emotional Problems, and Health Service Use by U.S., School-Age Children, Gloria A. Simpson, M.A.; Gulner Scott, M.P.A.; Marilyn J. Henderson, M.P.A.; Ronald W. Manderscheid, Ph.D.

This article is based on parent response to the 1998 and 1999 National Health Interview Survey (NHIS). This includes children aged 5 through 17. The total for both years was 26,555.

Following are the questions related to mental health:

Has a doctor ever told you that your child had ADD/ADHD, mental retardation, other developmental delay, or learning disability? (Each was asked separately.)

There were also behavioral questions from the Child Behavior Check List (CBCL) that were combined into a Mental Health Index score) and a question on being unhappy, sad, depressed.

Service use questions included:

Use special education services, seeing a mental health professional, seeing a medical doctor, or specialist, inability to afford mental health care, taking prescription medication.

Perceived unmet need was defined by questions related to delayed or didn't receive care due to cost.

The study found that 6.6% had an attention deficit disorder, 3.6% had a developmental delay, 8.2% had a learning disability, 3.7% were unhappy, sad or depressed, and 13.6% had a mental health problem as indicated by the MH Index calculated from the CBCL.

The report also gives specific rates of service use by type of service for those with/without a problem. Also, the children with the highest level of unmet need were in families below 100% of the federal poverty level or were uninsured or in single parent households.

Chapter 10. The Prevalence of Parenthood in Adults with Mental Illness: Implications for State and Federal Policymakers, Programs, and Providers. Joanne Nicholson, Ph.D.; Kathleen Biebel, Ph.D.; Judith Katz-Leavy, M.Ed; Valerie F. Williams, M.A., M.S.

Data from New York shows that 45% of women under 35 receiving intensive case management services were parents and, of these, 20% were the custodial parent. Data from Massachusetts shows 33-50% of the female adult clients were mothers. 20% of males were fathers.

The data presented is based on the 1990 and 1992 NCS which includes a sample from the noninstitutionalized population only. They primarily used the CIDI to make the diagnosis, included only birth parents and used lifetime prevalence rates rather than 12-month since parenthood is long term.

Percentages of women and men with and without children are substantially the same for no mental or substance use disorder, mental disorder only, substance use only, and both. For no mental disorder 62.4% of women have children and 52.0% of men have children. For persons with psychiatric disorders only, 68% of the women have children and 54.5% of the men have children. However, the NCS may overestimate the prevalence. When the criteria for selection is 12-month prevalence of SPMI, however, the rates are still high – 67.2% of the women with SPMI are mothers and 75.5% of the men with SPMI are fathers.

The article further presents data by disorder, age of illness onset, age at birth of first child, marital status, education, poverty and number of children.

Chapter 12. Estimating the Prevalence and Correlates of Serious Mental Illness in Community Epidemiological Surveys. Ronald C. Kessler, Ph.D.; Patricia A. Berglund, M.B.A.; Meyer D. Glantz, Ph.D.; Doreen S. Koretz, Ph.D.; Kathleen R. Merikangas, Ph.D.; Ellen E. Walters, M.S.; Alan M. Zaslavsky, Ph.D.

This chapter discusses the requirement for the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop an operational definition of SMI to assist states in planning services. The initial efforts of the task force based on using the

Epidemiologic Catchment Area (ECA) studies and National Co-Morbidity Survey (NCS) resulted in an estimate of 5.4% of the noninstitutionalized civilian adult population meeting criteria for SMI at some time during the year. The second step was to develop such estimates at the state and county levels. However, the prediction equations using these survey results were too weak to detect true differences across counties and states.

The task force considered three SMI screening scales that could be used in already existing population-based surveys to obtain sufficient samples to make estimates of prevalence at the county level. Of the three considered and tested, the task force recommended the K6 as being the most powerful predictor of SMI. The K6 questions resulted in 1-month rates of SMI from 2.7% to 3.3%, and a 12-month rate of 7.2%. The article shows rates by various demographic characteristics which are generally similar to other methods although not identical. The task force suggested that counties could initiate volunteer efforts to conduct sample surveys in their areas using the K6 and associated questions.

Chapter 13. Prevalence of, and Payments for, Mental Health and Substance Abuse Disorders in Public and Private Section Health Plans, Eric Finkelstein, Ph.D.; Jeremy Bray, Ph.D.; Mary Jo Larson, Ph.D.; Kay Miller, B.A.; Chris Tompkins, Ph.D.; Allen Keme, M.P.H.; Ronald W. Manderscheid, Ph.D..

This chapter presents data on the prevalence of and payments for mental health (MH) and substance abuse (SA) services based on utilization data rather than population based surveys. It also shows the costs of treatment services for these conditions as well as asthma and diabetes for comparison. Despite limitations in the data bases, the results show that “between 7 and 16% of all enrollees and between 10 and 19% of claimants had evidence of an MH/SA condition during the analysis period” of 12 months.

Psychiatric Disorders in America, Edited by Lee N. Robbins, Ph.D. and Darrel A. Regier, M.D., M.P.H., The Free Press, 1991

This is a book and is a good single source for information about the ECA as a study and the findings. Chapter 13, An “Overview of Psychiatric Disorders in America” is a good summary chapter for overall prevalence rates by disorder and demographic characteristics.

### **RECENT PUBLICATIONS BASED ON THE NATIONAL CO-MORBIDITY SURVEY (NCS)**

New England Journal of Medicine, June 16, 2005

“Prevalence and Treatment of Mental Disorders, 1990-2003,” Ronald C. Kessler, Ph.D.; Olga Demier, M.A., M.S.; Richard G. Frank, Ph.D.; Mark Olfson, M.D.; Harold Alan Pincus, M.D.; Ellen E. Walters, M.S.; Philip Wang, M.D., Dr. P.H.; Kenneth B. Wells, M.D.; Alan M. Zaslavsky, Ph.D.

This article uses the data from the NCS conducted between 1990-1992 and the NCS Replication conducted between 2001-2003. The 12-month prevalence of mental disorders was about 30% in both time periods, but the rate of treatment increased from 20% to almost 33%, with the largest increases in services provided by the general medical sector, psychiatric services, and other mental health services. The article discusses some of the possible reasons for the increase in treatment rates as well as differences based on sociodemographic characteristics.

Archives of General Psychiatry, June 2005, Vol. 62, No. 6

1. "Psychiatric Epidemiology, It's Not Just About Counting Anymore," Commentary by Thomas R. Insel, M.D.; Wayne S. Fenton, M.D.

An excellent overview of past efforts and good introduction and summary of the four articles that are published in this same issue. Those four articles are summarized below.

2. "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication," Ronald C. Kessler, Ph.D.; Patricia Berglund, M.B.A.; Olga Demier, M.A., M.S.; Robert Jin, M.A.; Kathleen R. Merikangas, Ph.D.; Ellen E. Walters, M.S.

The NCS Replication is based on surveys from 9,282 English-speaking respondents. The lifetime prevalence rate found in this study was 46.4%. Rates for specific disorders include 28.8% for anxiety disorders, 20.8% for mood disorders, 24.8% for impulse control disorders and 14.6% for substance use disorders. "Half of all lifetime cases start by age 14 and three-fourths by age 24." "Interventions aimed at prevention or early treatment need to focus on youth."

3. "Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication," Philip S. Wang, M.D., Ph.D.; Patricia Berglund, M.B.A.; Mark Olfson, M.D., M.P.H.; Harold A. Pincus, M.D.; Kenneth B. Wells, M.D., M.P.H.; Ronald C. Kessler, Ph.D.

"Cumulative lifetime probability curves show that the vast majority of people with lifetime disorders eventually make treatment contact, although more so for mood disorders than for anxiety, impulse control and substance disorders. Delay among those who eventually make treatment contact ranges from 6-8 years for mood disorders and 9-23 years for anxiety disorders."

4. "Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication," Ronald C. Kessler, Ph.D.; Wai Tat Chiu, A.M.; Olga Demier, M.A., M.S.; Ellen E. Walters, M.S.

The twelve-month prevalence rate for any disorder was 26.2%. Rates for specific disorders were 18.1% for anxiety, 9.5% for mood disorders, 8.9% for impulse control disorders, and 3.8% for substance use disorders. "Of 12-month cases, 22.3% were classified as serious, 37.3% as moderate, and 40.4% as mild." (This would result in a 1-

month prevalence rate of 5.8% of the total adult population as having a serious disorder, 9.8% as having a moderate disorder, and 10.6% as having a mild disorder.)

5. "Twelve-Month Use of Mental Health Services in the United States," Philip S. Wang, M.D., Dr.P.H.; Michael Lane, M.S.; Mark Olfson, M.D., M.P.H.; Harold A. Pincus, M.D.; Kenneth B. Wells, M.D., M.P.H.; Ronald C. Kessler, Ph.D.

"Of 12-month cases, 41.1% received some treatment in the past 12 months, including 12.3% treated by a psychiatrist, 16.0% treated by a nonpsychiatrist mental health specialist, 22.8% treated by a general medical provider, 8.1% treated by a human services provider, and 6.8% treated by a complementary and alternative medical provider. Overall, cases treated in the mental health specialty sector received more visits (median, 7.4) than those treated in the general medical sector (median, 1.7)." "Unmet need for treatment is greatest in traditionally underserved groups, including elderly persons, racial/ethnic minorities, those with low incomes, those without insurance, and residents of rural areas."

## **OTHER PUBLICATIONS AND REFERENCES**

### **PREVALENCE RATES FOR SPECIFIC POPULATION (Note: not an exhaustive list)**

#### **LATINO POPULATIONS**

"12-Month Prevalence of DSM-III-R Psychiatric Disorders among Mexican Americans: Nativity, Social Assimilation, and Age Determinants," William A. Vega, William A. Sribney, Sergio Aguilar-Gaxiola and Bohdan Kolody. *The Journal of Nervous and Mental Disease*, Vol. 192, No. 8 (2004) pp. 532-541.

The burden of disease attributable to mental illnesses has major costs and human services implications in the United States. Mexican Americans compose two thirds of the nation's largest and fastest-growing minority group, Latinos. We report 12-month DSM-III- R psychiatric disorder rates among Mexican Americans derived from a population survey of immigrants and US-born adults of Mexican origin conducted in rural and urban areas of central California. Rates of 12-month total mood, anxiety, and substance disorders were 14.2% for immigrant women, 12.6% for immigrant men, 27.8% for US-born women, and 27.2% for US-born men. For immigrants, younger age of entry and longer residence in the United States were associated with increased rates of psychiatric disorders. Three dominant explanations are reviewed to explain these differences: selection, social assimilation and stress, and measurement artifact. Our results and other research studies collectively support a social assimilation explanation based on aversive impact on health behaviors and protective resources such as families. Greater social assimilation increases psychiatric morbidity, with rates for subjects who are US-born of Mexican origin approximately the same as rates for the US general population. (PsycINFO Database Record (c) 2005 APA, all rights reserved) (journal abstract)

## AMERICAN INDIANS ON RESERVATIONS

“Prevalence of DSM-IV Disorders and Attendant Help-Seeking in 2 American Indian Reservation Populations,” Janette Beals, Ph.D.; Spero M. Manson, Ph.D.; Nancy R. Whitesell, Ph.D.; Paul Spicer, Ph.D.; Douglas K. Novins, M.D.; Christina M. Mitchell, Ph.D., *Archives of General Psychiatry*, January 2005, Vol. 62, No. 1.

The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP) estimated the lifetime and 12-month prevalence rates of mental disorders, their demographic correlates, and service utilization in 1,446 persons living on or close to their home reservation in the Southwest and 1,638 persons living on or close to their home reservation in the Northern Plains. “Overall lifetime prevalence ... ranged from 35.7% for Southwest women to nearly 50% for both groups of men. Alcohol abuse and dependence were the most common disorders for men, with posttraumatic stress disorder most prevalent for women.” “A majority of participants with lifetime disorders had sought help from mental health professionals, other medical personnel, or culturally traditional sources.”

## HOMELESS

1. Reference in a draft report by Kessler, Fischer and Breakey (1991) A number of small surveys have assessed the prevalence of psychiatric disorders among homeless people. As reviewed by Fischer and Breakey, these estimates averaged approximately 50%. Fischer, P. J., Breakey, W.R., (1991). “The Epidemiology of alcohol, drug, and mental disorders among homeless persons,” *American Psychologist*: 46. 1115-1125.
2. “The Prevalence of Specific Psychiatric Disorders Among Homeless Individuals in the Inner City of Los Angeles,” P. Koegel, M. A. Burnam, R. K. Farr, Referenced as report LRP-198812-02 by Rand of California. (I no longer have a copy of this, but I think it was done in the mid-1980’s.) Published in the *Archives of General Psychiatry*, v. 145, no. 12, Dec 1988, p. 1085-1092.  
“It was estimated that 28% of subjects in this inner-city homeless sample were chronically mentally ill, a percentage that was consistent with well-designed studies employing nondiagnostic standardized measures of mental illness, but lower than results of studies relying on clinical judgment to assess the prevalence of specific disorders.”
3. “Are Rates of Psychiatric Disorders in the Homeless Population Changing?,” Carol S. North, M.D., M.P.E.; Karin M. Eylich, M.S.W., M.P.E.; David E. Pollio, Ph.D.; and Edward L. Spitznagel, Ph.D., *American Journal of Public Health*, January 2004, Vol. 94, No.1.

This article is based on the results of 3 studies conducted in 1980, 1990 and 2000 on the homeless population in St. Louis, Mo. using the same research methodology and instruments. As stated in the summary...”The prevalence of psychiatric illness, including substance abuse and dependence, is not static in the homeless population. Service

systems need to be aware of potential prevalence changes and the impact of these changes on service needs.”

The rate of any psychiatric disorder, including both mental disorders and substance use disorders, increased over the 3 time periods, and in 2000, 88% of men and 69% of women had any psychiatric disorder. The rates of alcohol and substance abuse were higher than mental disorders. The rates of alcohol and substance abuse were higher in males, while the rates for most mental disorders were higher for females. The rate for any Axis I disorder, other than substance abuse, was about 47% for women and about 38% for men. Depression was the most common Axis I disorder at about 35% for women and about 22% for men. The rates for schizophrenia, bipolar and panic disorder increased for both men and women, while the rate of antisocial personality disorder stayed about the same or decreased.

## INCARCERATED

Youth. “Psychiatric Disorders in Youth in Juvenile Detention,” Linda A. Teplin, Ph.D.; Karen M. Abram, Ph.D.; Gary M. McClelland, Ph.D.; Mina K. Dulcan, M.D.; Amy A. Mericle, Ph.D.; Archives of General Psychiatry, December 2002, Vol. 59, No. 12,, 1133-1143.

This study is based on the DIS for children, version 2.3. The researchers interviewed 1,829 youth 10-18 years old arrested and detained in Cook County, Il (Chicago and suburbs) and developed 6-month prevalence rates including rates for affective disorders, anxiety, psychosis, AD/HD, disruptive behavior disorders and substance use disorders.

The data showed that two-thirds of the males and three-quarters of the females met diagnostic criteria for one or more disorders. About half were addicted to drugs. (I only have the abstract which gives some rates but doesn't isolate rates without substance use only for example. It would be best to review the entire article.)

Inmates. Los Angeles Daily New article about training for the LA Police on how to deal with people who have mental illnesses.

The Police chief stated that nationally about 16% of persons incarcerated “suffer from some sort of mental illness.” It is not clear if this includes prisons or jails or both.

## REFUGEES

“Moving to New Homeland Doesn't Ease Trauma”, Ken Hausman, from an article by Marshall, et.al., in the August 3, 2005 issue of the Journal of the American Medical Association.

This study was conducted by researchers at RAND Corporation and CSU Long Beach on a stratified random sample of 490 Cambodian refugees, aged 35-75, living in Long Beach, CA, now who had lived in Cambodia during the Khmer Rouge regime. The mean number of reported traumas was 15 per individual. The Composite International

Diagnostic Interview (CIDI) version 2.1 was used to evaluate for PTSD and depression. The interviews were conducted in Khmer, and the results showed that 62% of the respondents had PTSD, 51% had major depression, and 42% had both. Only 4% had symptoms of any alcohol-use disorder and this was significantly associated only with exposure to trauma in this country.

## SCHIZOPHRENIA

“How Prevalent is Schizophrenia?” Saha, S.; Chant, D.; Welham, J.; McGrath, J. A systematic review of the prevalence of schizophrenia. DOI: 10.1371/journal.pmed.0020141, [www.plosmedicine.org](http://www.plosmedicine.org)

These authors analyzed “a total of 1,721 estimates from 188 studies, covering 46 countries, and found that the estimate of 1% for the lifetime prevalence rate of schizophrenia that is often used is perhaps too high. Their analysis indicated it was closer to 0.7-0.8%.

## CHILDREN AND YOUTH

“U. S. Children with Emotional and Behavioral Difficulties: Data from the 2001, 2002, and 2003 National Health Interview Surveys,” Gloria A. Simpson, M.A.; Barbara Bloom, M.P.A.; Robin A. Cohen, Ph.D.; Stephen Blumberg, Ph.D.; and Karen H. Bourdon, M.A. [www.cdc.gov/nchs/data/ad/ad360.pdf](http://www.cdc.gov/nchs/data/ad/ad360.pdf)

Most prevalence rates for youth start with age 9 since there are very few instruments that have been found for reliable use with younger children. However, this recently published data shows rates for youth as young as 4 years old. The survey was completed by the person in the household most knowledgeable about the health of the child. The child was selected randomly by the interviewer if there was most than one child in the household.

The results showed that “approximately 5% of U.S. children age 4-17 years had emotional or behavioral difficulties, and, for approximately 80% of these children, there was an impact on their functioning.” These findings were based on the Strengths and Difficulties Questionnaire (SDQ) which has approximately 30 questions that “ascertain psychological symptoms or difficulties, duration of the symptoms, and the impact of these difficulties.” The report focuses primarily on the question whether children have “difficulty in any of the following areas: emotions, concentration, behavior, or being able to get along with others.” The results show higher rates for males, older children, white non-Hispanic and black non-Hispanic children, children in poverty, children in single parent households, and children with Medicaid or other public health insurance. The report also shows that about 39% of the youth visited a general practitioner for an emotional or behavioral problem, 44% had a contact with a mental health professional, 23% received special education for an emotional or behavioral problem, and 9% needed but could not afford mental health services.

## CALIFORNIA HEALTH INTERVIEW SURVEY (CHIS)

This survey is California's version of the National Health Interview Survey (NHIS). It contains certain core questions that are asked in all states and may contain additional questions based on state priorities and needs. The data from the CHIS are available at the following web site <http://www.chis.ucla.edu/>

The sample size is sufficiently large, about 55,000 per year, that data can be obtained by county or for clusters of smaller counties. The web site allows one to request the specific geographic area and questions of concern.

## **OTHER DATA, SURVEYS AND PUBLICATION RESOURCES**

1. Uninsured. "Characteristics of the Uninsured: A View From the States", prepared by the State Health Access Data Assistance Center (SGADAC) at the University of Minnesota for the Robert Wood Johnson Foundation, May 2004. [www.shadac.org](http://www.shadac.org)

The report is based on data collected in the Behavioral Risk Factor Surveillance System Survey (BRFSS). This report shows the rate of adults who are uninsured by state with some demographic data and some data on service needs although mental health is not separately identified.

2. California HealthCare Foundation has an excellent web site at [www.chcf.org](http://www.chcf.org) and has numerous health related topics. One that may be helpful with the MHSA planning is the topic related to the uninsured population. One section labeled Snapshot: California's Uninsured 2004 has several tables with details on the employment status, income level, age, and race/ethnicity of the population that is uninsured.

3. "Therapy In America 2004", survey and report prepared by Harris Interactive, on behalf of Psychology Today and PacifiCare Behavioral Health. [www.harrisinteractive.com](http://www.harrisinteractive.com)

The report is based on 2 surveys:

"A 15-minute telephone survey with a nationally representative cross-section of 500 adults."

"A 15-minute self-administered online survey of 1,730 members of the Harris Poll Online Panel who have needed or received treatment for a MH problem within the last 2 years." This Online Panel is composed of over several million persons who are registered in Harris' online database. The 1,730 individuals have also been screened as having needed or having received mental health services. The values were weighted to represent the total population. People can self select and apply to be part of the database. It is unclear what biases this may introduce into the results although the authors report that it was the most accurate of the polling surveys.

The telephone instrument was shorter. The online instrument was similar, although not identical, for the first part and then included more questions than the telephone instrument.

Results show that 30% of the adults needed MH services within the past 2 years, and of these, almost 2/3 received services. It is not clear if this is from mental health professionals only or if it also includes health professionals. Women, younger respondents and single respondents were more likely to indicate a need for services. (This is consistent with other studies.)

Questions also included experience with MH services, satisfaction with treatment, insurance coverage, stigma, sources of MH treatment, alternatives, and sources in the popular media. The questions on stigma may be helpful in considering programs to eliminate stigma and how to approach outreach programs.

4. National Survey on Drug Use and Health (NSDUH), formerly known as the National Household Survey on Drug Abuse (NHSDA), is a project of the Substance Abuse and Mental Health Services Administration (SAMHSA). This annual survey of the civilian, non-institutionalized population aged 12 years and older has been conducted by the Federal Government since 1971 and is the primary source of statistical information on the use of illegal drugs. Several reports will be noted below on the co-occurrence of mental disorders and substance use disorders. The survey includes questions on demographic characteristics, the K6 questions on severity and frequency of emotional distress, and use of illicit drugs by type of drug, questions to discriminate between use, abuse and dependence, and treatment services received. Publications are available at the following website <http://www.oas.samhsa.gov/systems.htm#NHSDA>

a. "Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders, 2002," Joan Epstein, Peggy Barker, Michael Vorburger, Christine Murtha, SAMHSA, Office of Applied Studies.

The estimated prevalence of SMI for adults was 8.3%, with higher percentages for the younger age groups. The rate for persons aged 18-25 was 13.2%, followed by adults aged 26-49 at 9.5%, and adults aged 50 and over at 4.9%. Rates were higher for females at 10.5% than for males at 6.0%. Among race/ethnicity groups, the highest prevalence rates were for those reporting more than one race at 13.6%, and for American Indians and Alaska Natives at 12.5%. Among all adults with SMI, 28.9% had used an illicit drug in the past year.

(A note of caution, it is important to remember the point of view when discussing co-occurrence of mental health and substance use disorders, that is, is it persons with SMI who have co-occurring substance use disorders, or persons with substance use disorders who have SMI.)

Among the total adults surveyed, approximately 6.4% had SMI only, 7.4% had a substance use disorder only, and 1.9% had both SMI and a substance use disorder. Substance use disorders include both alcohol and drug use. Almost half (48.7% and 48.0%, respectively) of persons with SMI only or with both SMI and a substance use disorder received treatment in the mental health or substance abuse sectors within the

prior 12 months. The report provides further data on the sociodemographic characteristics as well as type of disorder(s).

b. “Overview of Findings from the 2003 National Survey on Drug Use and Health”

The 2003 survey shows a higher SMI prevalence rate than the prior year at 9.2%. The overview and full report are available on the SAMHSA website.

c. “2004 National Survey on Drug Use and Health: Overview”

The report notes that while it has referred to prevalence rates for SMI, these rates should more appropriately be considered as measures of Serious Psychological Distress (PSD). The report also notes that the measure is highly correlated with SMI. The 2004 survey shows a higher SMI prevalence rate than the prior year at 9.9%. The overview and full report are available on the SAMHSA website.