



# Statistical Notes

From the CENTERS FOR DISEASE CONTROL AND PREVENTION/National Center for Health Statistics

## Operational Definitions for Year 2000 Objectives: Priority Area 6, Mental Health and Mental Disorders

Fred Seitz, Ph.D. and Bruce Jonas, Ph.D.

### Introduction

*Healthy People 2000*, with its Midcourse Revisions, includes 319 objectives to improve the health of Americans by the year 2000 (1,2). Because these objectives are national, not solely Federal, the achievement of these objectives is dependent in part on the ability of health agencies at all levels of government to assess objective progress. To permit comparison of local, State, and Tribal health data with national data and that of other States and localities, *Healthy People 2000* objective 22.3 targets the development, dissemination, and use of collection methods that improve comparability among data collected by all levels of government. The objective states:

Develop and disseminate among Federal, State, and local agencies procedures for collecting comparable data for each of the year 2000 national health objectives and incorporate these into Public Health Service data collection systems.

Achieving this objective entails determining and defining the information needed to measure progress toward each national health objective. The purpose of this Statistical Note is to provide definitions and data collection specifications for objectives in Priority Area 6: Mental Health, one of 22 priority areas in *Healthy People 2000*. In

this publication, the text ([appendix A](#)) and operational definitions of the objectives are presented, important data issues are discussed, and references are cited for expanded discussions of the data systems ([appendix B](#)) that provide data for the national objectives.

[Table 1](#) is a data comparability worktable with objective definitions, data sources, and issues. This table presents the short text of each objective, the measure, the operational definition (numerator and denominator where applicable), national data source, and a brief description of data issues. The data issues for each objective are discussed in greater detail below. When appropriate, the text of questionnaire items used to measure the objectives is provided in [table 2](#).

### Objective 6.1: Suicide

Suicides for the total population and for American Indian and Alaska Native males (6.1d) are measured by the age-adjusted death rate (using the 1940 U.S. standard population) expressed as deaths per 100,000 resident U.S. population. Three special population subobjectives (6.1a-c) target high-risk groups (youth 15–19, males 20–34, and white males 65 years of age and over) and are measured as age-specific rates per 100,000 resident population within the designated age groups.

Suicide deaths are coded as ICD–9 codes E950–E959; data are collected from death certificates by States and



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention  
National Center for Health Statistics



tabulated in the National Vital Statistics System (NVSS) within the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). An important data issue is the determination of the intent of the deceased by the coroner or the medical examiner. Classification of the death as accidental or suicide may depend on evidence such as suicide notes, prior suicide attempts or other information. Without this evidence, suicides might not be reported accurately. Therefore the total count is probably an undercount of the actual number of suicides. NCHS provides written guidelines for these determinations (3). Another issue is possible misreporting of race of American Indian and Alaska Native suicides on the death certificates; American Indians and Alaska Natives may be incorrectly reported as white or another racial group (4).

The denominators for the rates are the U.S. Bureau of Census resident population estimates. The methodology for age adjustment is described in the NCHS publication entitled "Direct standardization (age-adjusted death rates)" (5).

This objective is duplicated as objective 7.2 in *Healthy People 2000* priority area 7, Violence and Abusive Behavior.

### **Objective 6.2: Injurious suicide attempts by adolescents 14–17 years**

Adolescent suicide attempts are measured as a percent. The numerator is the number of adolescents in grades 9 through 12 in public and private schools who reported suicide attempts which required medical attention during the twelve months prior to the administration of the Youth Risk Behavior Survey (YRBS); the denominator is the number of adolescents in grades 9 through 12 in public and private schools. The YRBS is a biennial survey conducted and analyzed by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) within CDC. A detailed discussion of the methodology (including sampling design) is described in an MMWR (6). The survey also includes information about suicidal ideation, plans, and attempts, but only the attempts which required medical attention are included in tracking the objective. The survey questions are shown in [table 2](#). Although there is no external validation of the suicide attempts, a methodological study has shown that this survey is highly reliable (7). However, the exclusion of adolescents not in school may yield underreporting of these attempts (8).

This objective is duplicated as objective 7.8 in *Healthy People 2000* priority area 7, Violence and Abusive Behavior. Females 14–17 years of age are included as a special population target (6.2a).

### **Objective 6.3: Mental disorders among children and adolescents 18 years and under**

The baseline for this objective is the percent of mental disorders derived from a meta-analysis of two studies, one conducted in Puerto Rico (9), the other in a Pittsburgh Health Maintenance Organization (HMO) (10). Both studies used the Child Behavior Checklist (CBCL) and the Diagnostic Interview Schedule for Children (DISC). Both

interviews included the Children's Global Assessment Scale (CGAS) (11).

The sampling designs were somewhat different for the two studies. The Puerto Rican study involved interviews in the households and schools; the Pittsburgh study collected data from people visiting the HMO with their children. Inclusion criteria, based on scores on the CGAS, were different in the two studies; scores over 61 were used in the Puerto Rican study whereas the 90th percentile was used in the Pittsburgh study. The prevalence estimates from the two studies were 15 percent for the Puerto Rican study and 22 percent for the Pittsburgh study. The National Institute for Mental Health (NIMH) used the two estimates to generate the objective baseline of 20 percent.

National supplemental data from the 1988 National Health Interview Survey (NHIS) Child Health Supplement are also available for this objective. The NHIS supplement used different criteria (parental report of emotional/behavioral problems of greater than 3 months duration, growth or developmental delay, or learning disability) and generated a prevalence estimate of 22 percent.

Additional data for this objective will not be available until the end of the decade and will be obtained from a modified version of the CBCL to be included in the redesigned NHIS core survey which will be used starting in 1998. These data will not be directly comparable to the baseline for this objective because they will be based on a different population.

### **Objective 6.4: Mental disorders among people 18 years and over**

The baseline for this objective is from 1-month prevalence estimates and reflects the percent of people who reported any type of mental disorder (excluding alcohol or substance abuse disorders) during the month prior to their interview. Data are from the Epidemiologic Catchment Area (ECA) study conducted by NIMH in five primarily urban areas (New Haven, Connecticut; Baltimore, Maryland; St. Louis, Missouri; Durham, North Carolina; and Los Angeles, California) using the Diagnostic Interview Schedule (DIS) (12). To facilitate tracking the objective, NIMH reanalyzed the ECA data to generate a 1-year prevalence estimate and weighted the data to be nationally representative.

The updates are 1-year prevalence estimates from the National Comorbidity Survey (NCS), a national survey using the Composite International Diagnostic Interview (CIDI). The CIDI included the expanded diagnostic categories in the revised Diagnostic Statistical Manual (DSM-III-R) (13) which were not included in the DIS. NIMH reanalyzed the NCS data to generate comparable diagnostic categories to those included in the ECA's DIS.

The data for both the ECA and the NCS were limited to the noninstitutionalized, non-rural, white, black, and Hispanic population 18–54 years of age.

### **Objective 6.5: Adverse health effects from stress**

This objective is measured by the percent of people in the civilian, noninstitutionalized population who reported

experiencing “a lot or some adverse health effects from stress” during the year prior to being interviewed for the NHIS (14). There is one subobjective that targets people with disabilities; these people are defined as those who reported any limitation of activity due to a chronic condition. The questions to measure this objective were included on the 1984, 1990, 1993, and 1995 NHIS and have remained unchanged since 1984. See [table 2](#) for the survey questions.

### **Objective 6.6: Use of community support by people with mental disorders**

This objective is measured as a percent. The numerator is the number of civilian, noninstitutionalized people who reported mental disorders (excluding alcohol and substance abuse) that interfered with their work or efforts to find work who sought help from community mental health services in the year prior to reporting. The denominator is the number of noninstitutionalized people who reported having a mental disorder (excluding substance or alcohol abuse) that interfered with their work or efforts to find work. The baseline for the objective was calculated by SAMHSA’s Office of Community Mental Health Services (CMHS) in their Community Support Program Client Followup Study using data on visits to community mental health facilities and estimates of the prevalence of mentally ill persons (15). The 1994 update is from the NHIS Disability Supplement on the proportion of people reporting mental disorders (defined above) who sought help for their illness in the year prior to the interview. See [table 2](#) for the survey questions. The NHIS questions were designed with input from CMHS staff who conducted the baseline study: the update is comparable with the baseline data.

### **Objective 6.7: Treatment for depression**

Objective 6.7 is measured as a percent where the numerator is the number of people in the noninstitutionalized population who reported major affective disorders and sought treatment for these disorders. The denominator is the number of people in the noninstitutionalized population who reported major affective disorders. The baseline data are from the Epidemiologic Catchment Area (ECA) study conducted by NIMH and covered a 6-month period prior to the interview. The tracking data used a 1-year time frame and included data from the ECA and the National Comorbidity Survey (NCS). The data for both the ECA and the NCS were limited to the noninstitutionalized, non-rural, white, black, and Hispanic population 18–54 years of age. See the discussion of the issues and analyses related to these surveys in the text for objective 6.4, above.

### **Objective 6.8: Seeking help with personal and emotional problems**

This objective is measured as a percent. The numerator is the number of people in the civilian, noninstitutionalized population who reported seeking help for personal or

emotional problems from family, friends, therapist, counselor, or self-help group during the year prior to the National Health Interview Survey (NHIS) interview. The denominator is the number of people in the civilian, noninstitutionalized population who reported a personal or emotional problem during the year prior to the interview. Like objective 6.5, the questions used to measure this objective have been included and have remained unchanged in the 1984, 1990, 1993, and 1995 NHIS surveys. See [table 2](#) for the survey questions. A subobjective for people with disabilities is targeted for this objective; these are people who reported any limitation in activity due to chronic conditions.

### **Objective 6.9: Not reducing or controlling stress**

This objective is measured as the percent of people not taking steps to reduce stress. The numerator is calculated as the number of people who reported experiencing a great deal of stress several days a week or almost every day, but did not take steps to control or reduce the stress. The number who reported stress several days a week or almost every day is the denominator. The data source is the Prevention Index, developed and administered by Rodale Press, Incorporated (16). This is a telephone survey with a sample of approximately 1300 households weighted to be nationally representative using census data on households with telephones. The survey is administered annually and the questions have not been changed during the monitoring period. Contact Rodale Press, Incorporated, for information on the questions used for this objective (16).

### **Objective 6.10: Number of states with suicide prevention protocols in jails**

The measure used for the baseline and setting the target for this objective is the number of States with protocols meeting the National Center for Institutions and Alternatives’ (NCIA) standards for suicide prevention in jails. NCIA recommends that States develop standards that combine those outlined in the American Correctional Association (ACA) standards for jails with those developed by the National Commission on Correctional Health Care (NCCHC). This combination yields six requirements covering the areas of staff training, intake screening and assessment, housing, close supervision of inmates at risk, intervention following suicide attempts, and administrative review after suicide attempts. Both the ACA and the NCCHC guidelines include these emphases in their standards, but NCIA’s recommendations stress greater specificity and incorporation of these standards at the State level (17). The State-level focus of the NCIA standards complicates monitoring of the objective, because most jails are administered by counties or municipalities. Additionally, data on States which meet NCIA standards are not available on a regular basis for tracking this objective.

Supplemental data show the percent of jails with ACA accreditation. The numerator is a count from a list of jails with ACA accreditation obtained from the American Correctional Association; the denominator is from the Bureau of Justice Statistics (BJS) data on the number of jails in the U.S. These unpublished data are available for multiple years and will probably be available for several updates during the monitoring period for this objective. An important issue affecting these data is that not all jails seek ACA accreditation. Many jails may meet the standards, but would not be reported in this statistic.

Supplemental data for 1993 are from the BJS National Census of Jails and represent the proportion of jails in the U.S. which reported having suicide prevention policies and staff training in suicide prevention. While the census is taken biennially, questions relating to the existence of suicide prevention policies and staff training for suicide prevention in the jails were first included in the 1993 version; these questions may be included in subsequent jail census surveys (18). Because of the irregular reporting intervals, all three measures are included when assessing progress for this objective.

This objective is duplicated as objective 7.18 in *Healthy People 2000* priority area 7, Violence and Abusive Behavior.

### **Objective 6.11: Worksite stress management programs**

The measure for this objective is the percent of non-government worksites with 50 or more employees that offered information or activities related to stress management during the 12 months before the survey. This telephone survey of more than 1500 non-government worksites was sponsored by the Office of Disease Prevention and Health Promotion in the Office of Public Health and Science (formerly the Office of the Assistant Secretary for Health). See [table 2](#) for the survey questions. An important issue is that a given business or industry could have multiple worksites (locations); these worksites may have different health promotion activities. Hence, worksites were selected as the unit of analysis. The businesses and industries sampled covered six major categories: manufacturing, wholesale/retail, service, transportation/communication, finance/real estate, and agriculture/mining/construction (19). Another issue is that both active (for example, classes) and passive (for example, brochures) methods were counted as worksite stress management programs.

### **Objective 6.12: Mutual self-help clearinghouses**

This objective was revised during the *Healthy People 2000* midcourse review (2,20) and calls for establishment of a network of mutual self-help clearinghouses for people and families experiencing emotional distress. Prior to the midcourse review, the objective targeted establishment of clearinghouses in 25 States. Since the review, the objective has been measured by the number of State and federal mental health clearinghouses identified by SAMHSA. There are eight States with State-funded clearinghouses and two clearinghouses funded by CMHS that provide services to all 50 States (21).

### **Objective 6.13: Clinical review of patients' mental functioning**

This objective is monitored by a set of measures indicating inquiries, treatment, or referrals provided by selected primary care providers (including family physicians, obstetricians/gynecologists, nurse practitioners, and internists) for various problems. The measures are the proportion of the various providers (grouped by provider types) who reported that they routinely inquire about cognitive or emotional functioning and the proportions of provider types who provided treatment or referral for emotional or cognitive functions for patients who needed these interventions. The data were collected in the Primary Care Provider Surveys (PCPS) conducted by the Office of Disease Prevention and Health Promotion in the Office of Public Health and Science (22). See [table 2](#) for the survey questions.

Interpretation of these measures is complicated by the fact that the data refer to the proportions of clinicians who reported providing these services to 81–100 percent of their patients and that the basis for treatment or referral may be independent of the inquiry conducted by the clinician. All data are self-report. A recent study has indicated that provider estimates of the level of preventive services delivered may be substantially higher than the level documented in the patient records (23). The providers sampled were members of selected professional associations; hence, the data are not nationally-representative. Response rates across the provider groups were highly varied, ranging from 50 to 80 percent. A modified version of the PCPS was re-administered to a similar group of professional organizations in late summer 1997; results should be available in early 1998.

### **Objective 6.14: Clinician review of children's mental functioning**

Like objective 6.13, this objective is measured using data from the PCPS, but focuses on children's cognitive and emotional functioning and also parent-child interaction. For objective 6.14, the provider groups surveyed included pediatricians, nurse practitioners, and family physicians. The data issues described for objective 6.13 are applicable to this objective. The survey questions are presented in [table 2](#).

### **Objective 6.15: Prevalence of depression**

This objective is measured as the proportion of people who reported major affective disorders on the DIS or the CIDI. The subobjective (6.15a) focuses on women 18 years and over. The data for both the ECA and the NCS were limited to the noninstitutionalized, non-rural, white, black, and Hispanic population 18–54 years of age. The data for this objective are from the ECA and the NCS and are affected by the same data issues described in the sections for objectives 6.4 and 6.7.

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.1 <b>Suicide deaths</b>	6.1 and 6.1d: Number of deaths per 100,000 population (age-adjusted)	Number of deaths coded to ICD-9 E950-E959	Mid-year U.S. resident population	NVSS, CDC, NCHS	Suicides may be undercounted due to difficulty in determination of suicidal intent by coroner or medical examiner.  American Indians and Alaska Natives are undercounted on death certificates.  Age-adjusted rates use 1940 U.S. standard population.
Special population targets:					
6.1a Youth 15-19 years of age					
6.1b Males 20-34 years of age					
6.1c White males 65 years and over	6.1a-c: Number of deaths per 100,000 population				
6.1d American Indian/Alaska Native males					
6.2 <b>Injurious suicide attempts among adolescents 14-17 years</b>	Percent	Adolescents enrolled in grades 9-12 in public and private schools who reported suicide attempts that required medical attention in the 12 months prior to the survey	Adolescents enrolled in grades 9-12 in public and private schools	YRBS, CDC, NCCDPHP	YRBS is a school-based survey; exclusion of adolescents not in school could affect estimates.
Special population target:					
6.2a Females 14-17 years of age		(See table 2 for survey questions)			

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.3 Mental Disorders among children and adolescents	Percent	Baseline: Number of children 18 years and under who were scored more than 61 on the CGAS using the data collected with the CBCL (Costello) and the DISC (Bird)	Number of children 18 years and under in families selected in Puerto Rican ECA study and scored by parents and teachers	Bird HR. Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico. Archives of Gen Psychiatry 45: 1102–26, 1988.	Baseline is based on meta-analysis of two small sample studies; it is not nationally representative. The two studies used the same instruments (CBCL and DISC), but different cutoffs for inclusion. Additionally, the sampling designs were very different (Puerto Rican ECA subsample vs Pittsburgh HMO visits).  Updates for this objective will come from future NHIS core items which will use a different methodology than either baseline source.
		Baseline : Number of children 18 years and under who scored above the 90th percentile on the CGAS and other scales using data collected with the CBCL and DISC (Costello)	Number of children 18 years and under with parents who agreed to be interviewed in a Pittsburgh HMO during a 1-year period (Oct. 1984–Nov. 1985)	Costello EJ, et al. Psychiatric disorders in pediatric primary care: Prevalence risk factors. Archives of Gen Psychiatry 45: 1107–16, 1988.	
		Supplemental: Number of children 6–17 years of age reporting emotional or behavioral problems that lasted 3 months or more or required psychological help, or ever had a delay in growth or development, or ever had a learning disability	Number of children 6–17 years of age	NHIS , CDC, NCHS	

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.4 Mental disorders among adults	Percent	Number of people 18–54 years of age reporting symptoms during the past 12 months in any diagnostic category listed on DIS (baseline) or CIDI (update), excluding substance and alcohol abuse diagnoses	Number of people 18–54 years of age	Baseline: ECA, NIH, NIMH  Update: NCS, NIH, NIMH	<p>Study populations were limited to non-institutionalized, non-rural, white, black or Hispanic people.</p> <p>Baseline data were from five “catchment areas” in predominantly urban settings; updates are from a national survey.</p> <p>Baseline and target were set using 1-month prevalence data; tracking data are 1-year prevalence data.</p> <p>Baseline data were collected prior to revisions in DSM categories; revised DSM categories were used in the update source. However, comparable diagnostic categories and prevalence periods were constructed from both sources to facilitate tracking the objective.</p>
6.5 Adverse health effects from stress	Percent	Number of people 18 years and over who reported experiencing “a lot or some” adverse health effects during the past year	Number of people 18 years and over	NHIS, CDC, NCHS	Civilian, non-institutionalized population only.
Special population target: 6.5a People with disabilities		(See table 2 for survey questions)			People with disabilities are those who report any limitation of activity due to chronic conditions.
6.6 Use of community support by people with mental disorders	Percent	Number of people 18 years and over who reported mental disorders (excluding alcohol and substance disorders) in the past year that interfered with their ability to work or find work who sought help from community mental health services.	Number of people 18 years and over who reported mental disorders during the past year that interfered with their ability to work or find work	Baseline: NIMH Community Support Program Client Followup Study, SAMHSA Update: NHIS, CDC, NCHS	<p>Civilian, non-institutionalized population only.</p> <p>The questions used in the 1994 NHIS Disability Supplement were developed by the CMHS staff who developed the baseline survey and provide comparable data.</p>
		(See table 2 for survey questions)			

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.7 Treatment for depression	Percent	Number of people 18–54 years of age reporting major affective disorders listed on DIS (baseline) or CIDI (update) who sought treatment for these disorders	Number of people 18–54 years of age who reported major affective disorders on the DIS (baseline) or CIDI (update)	Baseline: ECA, NIH, NIMH  Update: NCS, NIH, NIMH	<p>Study populations were limited to non-institutionalized, non-rural, white, black, and Hispanic people</p> <p>Baseline data were from five "catchment areas" in predominantly urban settings; updates are from a national survey.</p> <p>Baseline and target were set using 6-month service data; tracking data are 1-year service data.</p> <p>Baseline data were collected prior to revisions in DSM categories; revised categories were used in the update source. However, comparable diagnostic categories and prevalence periods were constructed from both sources to facilitate tracking objective.</p>
6.8 Seeking help with personal and emotional problems	Percent	Number of people 18 years and over who reported seeking help with personal and emotional problems	Number of people 18 years and over	NHIS, CDC, NCHS	<p>Civilian, non-institutionalized population only.</p> <p>People with disabilities are those who report any limitation in activity due to chronic conditions.</p>
Special population target: 6.8a People with disabilities		(See table 2 for survey questions)			
6.9 Not reducing or controlling stress	Percent	People 18 years and over who reported experiencing a great deal of stress several days a week or almost every day who do not take steps to reduce or control their stress	People 18 years and over reporting stress several days a week or almost every day	Prevention Index, Rodale Press, Inc.	<p>Limited to households with telephones.</p> <p>There have been minor revisions to the order of questions during the monitoring period for this objective.</p>

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.10 Number of States with suicide prevention protocols in jails	Number	States that meet NCIA standards	Not applicable	National Study of Jails, NCIA	No regular updates; most jails are under municipal or county jurisdiction and do not have standards set at the State level.
	Percent	Jails that meet ACA standards	Number of jails in U.S.	Supplemental: ACA accreditation	Not all jails seek ACA accreditation.
	Percent	Jails that reported having suicide prevention policies	Number of jails in U.S.	Supplemental: National Census of Jails, DOJ, BJS	Only one year of data is currently available.
6.11 Worksite stress management programs	Percent	Number of worksites with 50 or more persons that offered activities or information related to stress management during the past 12 months  (See table 2 for survey questions)	Number of worksites with 50 or more persons	NSWHPA, OPHS, ODPHP	Government worksites were not included in the survey.  Telephone survey.  One business can have multiple worksites.  Both active and passive methods were counted as stress management programs.
6.12 Network of mutual self-help clearinghouses	Number of State clearinghouses	State mental health clearinghouses	Not Applicable	SAMHSA	Revised objective does not have a target, but all 50 States are served by federal clearinghouses.
	Number of federal clearinghouses	SAMHSA clearinghouses			

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.13 Clinician review of patients' mental functioning	Percent	<p>Number of clinicians within a specific discipline who reported providing the following assessment to 81–100% of their adult patients at regular intervals:</p> <p>Inquiry about cognitive functioning</p> <p>Inquiry about emotional/behavioral functioning</p> <p>Number of clinicians within a specific discipline who reported providing the following treatment or referral to 81–100% of their adult patients who needed the intervention:</p> <p>For cognitive problems</p> <p>For emotional/behavioral problems</p> <p>(See table 2 for survey questions)</p>	Number of clinicians within a specific discipline who responded to the survey	PCPS, OPHS, ODPHP	<p>Sample included nurse practitioners, obstetricians/gynecologists, internists, and family physicians who are members of professional associations; it is not nationally representative.</p> <p>Response rates varied from 50-80 percent across provider groups.</p> <p>No validation for level of preventive services reported by clinician in patient records or other sources.</p>

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues	
		Numerator	Denominator			
6.14 Clinician review of childrens' mental functioning	Percent	Number of clinicians within a specific discipline who reported providing the following assessment to 81–100% of their child patients at regular intervals:	Number of clinicians within a specific discipline who responded to the survey	PCPS, OPHS, ODPHP	Sample included nurse practitioners, obstetricians/ gynecologists, internists, and family physicians who are members of professional associations; it is not nationally representative.	
		Inquiry about cognitive functioning				
		Inquiry about emotional/ behavioral functioning				Response rates varied from 50-80 percent across provider groups.
		Inquiry about parent-child relationship				No validation for level of preventive services reported by clinician in patient records or other sources.
		Number of clinicians within a specific discipline who reported providing the following treatment or referral to 81–100% of their child patients who needed the intervention:				
		For cognitive functioning				
		For emotional/ behavioral functioning				
For parent-child relationship						
		(See table 2 for survey questions)				

Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.

Objective	Measure	Operational definition		Healthy People 2000 data source	Data issues
		Numerator	Denominator		
6.15 Prevalence of depression	Percent	Number of people 18–54 years of age with major affective disorders included on DIS (baseline) or CIDI (update)	Number of people 18–54 years of age	Baseline: ECA, NIH, NIMH Update: NCS, NIH, NIMH	Study populations were limited to non-institutionalized, non-rural, white, black, and Hispanic people.  Baseline data were from five "catchment areas" in predominantly urban settings; updates are from a national survey.  Baseline and target were set using 1-month prevalence data; tracking data are 1-year prevalence data.  Baseline data were collected prior to revisions in DSM categories; revised categories were used in update. However, comparable diagnostic categories and prevalence periods were constructed from both sources to facilitate tracking the objective.
Special population target: a. Women					

**Table 1. Objective definitions, data sources, and issues for *Healthy People 2000* priority area 6—Con.**

**Data system and assessment tool abbreviations:**

CBCL	Child Behavior Checklist
CGAS	Children's Global Assessment Scale
CIDI	Composite International Diagnostic Interview
DIS	Diagnostic Interview Schedule
DISC	Diagnostic Interview Schedule for Children
DSM	Diagnostic Statistical Manual
ECA	Epidemiologic Catchment Area Study
ICD	International Classification of Diseases
NCS	National Comorbidity Survey
NSWHPA	National Survey of Worksite Health Promotion Activity
NHIS	National Health Interview Survey
NVSS	National Vital Statistics System
PCPS	Primary Care Providers Survey
YRBS	Youth Risk Behavior Survey

**Agency Abbreviations:**

ACA	American Correctional Association
BJS	Bureau of Justice Statistics
CDC	Centers for Disease Control and Prevention
CMHS	Community Mental Health Services
DOJ	Department of Justice
HMO	Health Maintenance Organization
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCHS	National Center for Health Statistics
NCIA	National Center on Institutions and Alternatives
NIMH	National Institute of Mental Health
NIH	National Institutes of Health
OSPMS	Office of Public Health and Science
ODPHP	Office of Disease Prevention and Health Promotion
SAMHSA	Substance Abuse Mental Health Services Administration

Table 2. Survey questions used to monitor Mental Health and Mental Disorders objectives

Objective	Survey Questions	Data Source
6.2 Injurious suicide attempts	<input type="checkbox"/> During the past 12 months, did you ever seriously consider attempting suicide?  <input type="checkbox"/> If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?	1995 Youth Risk Behavior Survey, NCCDPHP, CDC
6.5 Adverse health effects from stress	<input type="checkbox"/> During the past year, would you say that you experienced a lot of stress, a moderate amount of stress, relatively little stress, or almost no stress at all?  <input type="checkbox"/> In the past year, how much effect has stress had on your health - a lot, some, hardly any or none?	National Health Interview Survey, Health Promotion Disease Prevention Supplement (1985, 1990, 1993, 1995), NCHS, CDC
6.6 Use of community support by persons with mental disorders	<input type="checkbox"/> During the past 12 months, did (names of persons 18 years of age and older) have - <ol style="list-style-type: none"> <li>1) Schizophrenia?</li> <li>2) Paranoid or delusional disorder, other than schizophrenia?</li> <li>3) Manic episodes or manic depression, also called bipolar disorder?</li> <li>4) Major depression? Major depression is a depressed mood and loss of interest in almost all activities for at least 2 weeks?</li> <li>5) Anti-social personality, obsessive-compulsive personality or any other severe personality disorder?</li> <li>6) Alzheimer's disease or another type of senile disorder?</li> <li>7) Alcohol abuse disorder?</li> <li>8) Drug abuse disorder?</li> </ol> <input type="checkbox"/> Because of [this/any of these] mental or emotional problem(s) is (name of person) unable to work or limited in the kind of work or activity (he/she) can do?  <input type="checkbox"/> Because of [this/any of these] mental or emotional problem(s) does (name of person) have trouble finding or keeping a job or doing tasks?  <input type="checkbox"/> Because of this/these mental or emotional problems has (name of person) received any services from a mental health community support program?	National Health Interview Survey, 1994 Disability Supplement, NCHS, CDC
6.8 Seeking help with personal and emotional problems	<input type="checkbox"/> During the past year, would you say that you experienced a lot of stress, a moderate amount of stress, relatively little stress, or almost no stress at all?  <input type="checkbox"/> In the past year, did you think about seeking help for any personal or emotional problem from family or friends?  <input type="checkbox"/> From a helping professional or self-help group?  If yes,  <input type="checkbox"/> Did you actually seek any help?	National Health Interview Survey, Health Promotion and Disease Prevention Supplement (1985, 1990, 1993, 1995), NCHS, CDC

**Table 2. Survey questions used to monitor Mental Health and Mental Disorders objectives — Con.**

Objective	Survey Questions	Data Source
<b>6.11 Worksite stress management programs</b>	<input type="checkbox"/> During the past 12 months, did your worksite offer any information or activities concerning stress management?  <input type="checkbox"/> Which of the following were offered relating to stress management:?  - Individual classes - Group classes - Resource materials, such as posters, brochures, pamphlets or videos - Job redesign, personnel reassignments	National Survey of Worksite Health Promotion Activities (1985, 1992), ODPHP, OPHS
<b>6.13 Clinicians review of patients' mental functioning</b>	Please place an "X" inside the box that best estimates the percentage of your current patients (for whom you are the primary care provider) who routinely receive each service.  <input type="checkbox"/> Inquiry about cognitive functioning <input type="checkbox"/> Inquiry about emotional and behavioral functioning  0-20% 21-40% 41-80% 81-100% N/A  Please answer the following questions about patients' receipt of counseling/treatment services in terms of the percentage of your patients who need the intervention, not the percentage of your total patient population.  <input type="checkbox"/> Treatment and/or referral to specialist for cognitive problems <input type="checkbox"/> Treatment and/or referral to specialist for emotional or behavioral problems  0-20% 21-40% 41-80% 81-100% N/A	1992 Primary Care Provider Surveys, ODPHP, OPHS

**Table 2. Survey questions used to monitor Mental Health and Mental Disorders objectives — Con.**

Objective	Survey Questions	Data Source
<b>6.14 Clinician review of childrens' mental functioning</b>	<p>Please place an "X" inside the box that best estimates the percentage of your current patients (for whom you are the primary care provider) who routinely receive each service.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Inquiry about cognitive functioning</li> <li><input type="checkbox"/> Inquiry about emotional and behavioral functioning</li> <li><input type="checkbox"/> Inquiry about and/or observation of parent-child relationship</li> </ul> <p>0-20% 21-40% 41-80% 81-100% N/A</p> <p>Please answer the following questions about patients' receipt of counseling/treatment services in terms of the percentage of your patients who need the intervention, not the percentage of your total patient population.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Treatment and/or referral to specialist for cognitive problems</li> <li><input type="checkbox"/> Treatment and/or referral to specialist for emotional or behavioral problems</li> <li><input type="checkbox"/> Counseling and/or referral for treatment of parent-child interaction problems</li> </ul> <p>0-20% 21-40% 41-80% 81-100% N/A</p>	1992 Primary Care Provider Surveys, ODPHP, OPHS

## References

1. U.S. Department of Health and Human Services. *Healthy people 2000: National health promotion and disease prevention objectives*. Washington: Public Health Service. 1990.
2. U.S. Department of Health and Human Services. *Healthy people 2000 midcourse review and 1995 revisions*. Washington: Public Health Service. 1995.
3. U.S. Department of Health and Human Services. *Medical examiners' and coroners' handbook on death registration and fetal death reporting*. Hyattsville: National Center for Health Statistics. 1987.
4. Information or issues related to reporting American Indian and Alaska Native mortality and health status may be obtained from the Indian Health Service, Office of Planning, Evaluation, and Legislation, Division of Program Statistics in Rockville, Maryland.
5. Curtin L and Klein R. Direct standardization (Age-adjusted death rates). *Healthy People 2000 Statistical Notes*, number 6. Hyattsville, Maryland: National Center for Health Statistics. 1995.
6. Centers for Disease Control and Prevention. Youth risk behavior surveillance: United States, 1995. *MMWR* 45(SS-4). 1996.
7. Brener N, et al. Reliability of the youth risk behavior survey questionnaire. Presented at the American Public Health Association annual meeting: Washington. 1994.
8. Centers for Disease Control and Prevention. Health risk behaviors among adolescents who do and do not attend school: United States, 1992. *MMWR* 43:129–32. 1994.
9. Bird H, et al. Estimates of the prevalence of childhood maladjustment in a community survey in Puerto Rico. *Archives of General Psychiatry* 45:1120–6. 1988.
10. Costello E, et al. Psychiatric disorders in pediatric primary care. *Archives of General Psychiatry* 45: 1107–16. 1988.
11. Shaffer D, et al. A children's global assessment scale (CGAS). *Archives of General Psychiatry* 40:1228–31. 1988.
12. Regier D, et al. The de facto U.S. mental and addictive disorders service system. *Archives of General Psychiatry* 50:85–94. 1993.
13. Kessler R, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the U.S. *Archives of General Psychiatry* 51:8–19. 1994.
14. Benson V and Marano MA. Current estimates from the National Health Interview Survey, 1993. *National Center for Health Statistics. Vital Health Stat* 10(1 90). 1994.
15. Details on the methodology for the Community Support Program Client Followup Study are available from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, in Rockville, Maryland.
16. Details on the methodology for the Prevention Index are available from Rodale Press or Princeton Survey Research Associates in Princeton, New Jersey.
17. National Center for Institutions and Alternatives. Jail standards and suicide prevention: another look. *Jail Suicide/Mental Health Update*. Vol 6(4):1–5. 1996.
18. U.S. Department of Justice. *National Census of Jails, 1993*. Washington: Bureau of Justice Statistics. 1994.
19. U.S. Department of Health and Human Services. 1992 National survey of worksite health promotion activities: final report. Washington. 1992.
20. Turczyn K and Ryan C. *Healthy people 2000 midcourse revisions: A compendium*. Statistical Notes no 13. Hyattsville, Maryland: National Center for Health Statistics. 1997.
21. Information on mental health clearinghouses is available from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, in Rockville, Maryland.
22. Information on the Primary Care Provider Surveys is available from the Office of Disease Prevention and Health Promotion, Office of Public Health and Science, Office of the Assistant Secretary for Health, in Washington, DC.
23. Stange K. One size doesn't fit all. Unpublished study presented at the National Coordinating Committee on Clinical Preventive Services meeting on March 14, 1997, in Rockville, Maryland.

### Published issues of *Healthy People 2000 Statistical Notes*

Number	Title	Date of Issue
1	Health Status Indicators for the Year 2000	Fall 1991
2	Infant Mortality	Winter 1991
3	Health Status Indicators: Definitions and National Data	Spring 1992
4	Issues Related to Monitoring the Year 2000 Objectives	Summer 1993
5	Revisions to <i>Healthy People 2000</i> Baselines	July 1993
6	Direct Standardization (Age-Adjusted Death Rates)	March 1995
7	Years of Healthy Life	April 1995
8	Evaluating Public Health Data Systems: A Practical Approach	June 1995
9	Monitoring Air Quality in <i>Healthy People 2000</i>	September 1995
10	Health Status Indicators: Differentials by Race and Hispanic Origin	September 1995
11	Operational Definitions for Year 2000 Objectives: Priority Area 20, Immunization and Infectious Diseases	February 1997
12	Operational Definitions for Year 2000 Objectives: Priority Area 13, Oral Health	May 1997
13	<i>Healthy People 2000</i> Midcourse Revisions: A Compendium	August 1997
14	Operational Definitions for Year 2000 Objectives: Priority Area 14, Maternal and Child Health	December 1997
15	Priority Data Needs: Sources of National, State, and Local-Level Data and Data Collection Systems	December 1997
16	Operational Definitions for Year 2000 Objectives: Priority Area 6, Mental Health and Mental Disorders	February 1998

## APPENDIX A: Mental Health and Mental Disorders Objectives

---

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

**Duplicate objective: 7.2**

**6.1a\*:** Reduce suicides among youth aged 15–19 to no more than 8.2 per 100,000.

**Duplicate objective: 7.2a**

**6.1b\*:** Reduce suicides among men aged 20–34 to no more than 21.4 per 100,000.

**Duplicate objective: 7.2b**

**6.1c\*:** Reduce suicides among white men aged 65 and older to no more than 39.2 per 100,000.

**Duplicate objective: 7.2c**

**6.1d\*:** Reduce suicides among American Indian and Alaska Native men to no more than 17.0 per 100,000.

**Duplicate objective: 7.2d**

**6.2\*:** Reduce to 1.8 percent the incidence of injurious suicide attempts among adolescents aged 14–17.

**Duplicate objective: 7.8**

NOTE: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

**6.2a\*:** Reduce to 2.0 percent the incidence of injurious suicide attempts among female adolescents aged 14–17.

**Duplicate objective: 7.8a**

**6.3:** Reduce to less than 17 percent the prevalence of mental disorders among children and adolescents.

**6.4:** Reduce the prevalence of mental disorders (exclusive of substance abuse) among adults living in the community to less than 10.7 percent.

**6.5:** Reduce to less than 35 percent the proportion of people aged 18 and older who report adverse health effects from stress within the past year.

NOTE: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.

**6.5a:** Reduce to less than 40 percent the proportion of people with disabilities who report adverse health effects from stress within the past year.

**6.6:** Increase to at least 30 percent the proportion of people aged 18 and older with severe, persistent mental disorders who use community support programs.

**6.7:** Increase to at least 54 percent the proportion of people with major depressive disorders who obtain treatment.

**6.8:** Increase to at least 20 percent the proportion of people aged 18 and older who seek help in coping with personal and emotional problems.

**6.8a:** Increase to at least 30 percent the proportion of people with disabilities who seek help in coping with personal and emotional problems.

**6.9:** Decrease to no more than 5 percent the proportion of people aged 18 and older who report experiencing significant levels of stress who do not take steps to reduce or control their stress.

**6.10\*:** Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent suicide by jail inmates.

**Duplicate objective: 7.18**

**6.11:** Increase to at least 40 percent the proportion of worksites employing 50 or more people that provide programs to reduce employee stress.

**6.12:** Establish a network to facilitate access to mutual self-help activities, resources, and information by people and their family members who are experiencing emotional distress resulting from mental or physical illness.

**6.13:** Increase to at least 60 percent the proportion of primary care providers who routinely review with patients their patients' cognitive, emotional, and behavioral functioning and the resources available to deal with any problems that are identified.

**6.14:** Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning with appropriate counseling, referral, and follow-up, in their clinical practices.

**6.15:** Reduce the prevalence of depressive (affective) disorders among adults living in the community to less than 4.3 percent.

**6.15a:** Reduce the prevalence of depressive (affective) disorders among women living in the community to less than 5.5 percent.

**\*Duplicate objective.**

## **APPENDIX B:**

### **Bibliography for major *Healthy People 2000* data systems**

---

#### **General:**

- Kovar MG. Data Systems of the National Center for Health Statistics. *Vital Health Stat* 1(23). 1989.
- National Center for Health Statistics. *Health, United States, 1995*. Hyattsville, Maryland: Public Health Service. 1996. Appendix I.

#### **National Health and Nutrition Examination Survey (including HHANES):**

- McDowell A, et al. Plan and operation of the second National Health and Nutrition Examination Survey, 1976–80. National Center for Health Statistics. *Vital Health Stat* 1(15). 1981
- Maurer KR. Plan and operation of the Hispanic Health and Nutrition Examination Survey, 1982–84. *Vital Health Stat* 1(19). 1985.
- Plan and operation of the third National Health and Nutrition Examination Survey, 1988–94. National Center for Health Statistics. *Vital Health Stat* 1(32). 1994.
- Ezzati TM, et al. Sample design: Third National Health and Nutrition Examination Survey. National Center for Health Statistics. *Vital Health Stat* 2(113). 1992.

#### **National Survey of Family Growth:**

- Waksberg J, Sperry S, Judkins D, Smith V. National Survey of Family Growth, Cycle IV, evaluation of linked design. National Center for Health Statistics. *Vital Health Stat* 2(117). 1993.
- Judkins DR, Mosher WD, Botman S. National Survey of Family Growth: Design, estimation, and inference. National Center for Health Statistics. *Vital Health Stat* 2(109). 1991.
- Waksberg J and Northrup DR. Integration of sample design for the National Survey of Family Growth, Cycle IV, with the National Health Interview Survey. *Vital Health Stat* 2(96). 1985.

#### **National Health Interview Survey:**

- Massey JT, Moore TF, Parsons VL, Tadros W. Design and estimation for the National Health Interview Survey, 1985–94. National Center for Health Statistics. *Vital Health Stat* 2(110). 1989.
- Questionnaires from the National Health Interview Survey, 1985–89. National Center for Health Statistics. *Vital Health Stat* 1(31). 1993.
- National Center for Health Statistics. Current estimates from the National Health Interview Survey. National Center for Health Statistics. *Vital Health Stat* 10. Published annually.

#### **National Hospital Discharge Survey:**

- Simmons WR and Schnack GA. Development of the design of the NCHS Hospital Discharge Survey. *Vital Health Stat* 2(39). 1970.
- Haupt BJ and Kozak LJ. Estimates from two survey designs: National Hospital Discharge Survey. National Center for Health Statistics. *Vital Health Stat* 13(111). 1992.
- National Center for Health Statistics. Detailed diagnoses and procedures, National Hospital Discharge Survey. National Center for Health Statistics. *Vital Health Stat* 13. Published annually.

#### **National Vital Statistics System:**

- National Center for Health Statistics. *Vital Statistics of the United States*. Volume I. *Natality*; and Volume II. *Mortality*. Hyattsville, Maryland: National Center for Health Statistics. Published annually.
- National Center for Health Statistics. Advanced report of final natality statistics; and Advanced report of final mortality statistics. *MVSR*, suppl. Hyattsville, Maryland: National Center for Health Statistics. Published annually.

#### **National Notifiable Disease Surveillance System:**

- Centers for Disease Control and Prevention. Summary of notifiable diseases, United States. *Morbidity and Mortality Weekly Report*. Published annually.

#### **Youth Risk Behavior Survey:**

- Kann L, Kolbe LJ, Collins JL (eds.). *Measuring the health behavior of adolescents: The Youth Risk Behavior Surveillance System and recent reports on high-risk adolescents*. *Public Health Reports* 108 (Suppl 1):1–67. 1993

#### **School Health Policies and Programs Study:**

- Errecart MT, Ross JG, Robb W, et al. The School Health Policies and Programs Study (SHPPS): Methodology. *J of School Health* 8(65):295–301. 1995.

#### **Mental health and mental disorders surveys:**

- Regier D, et al. The de facto U.S. mental and addictive disorders service system. *Archives of General Psychiatry* 50:85–94. 1993.
- Kessler R, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the U.S. *Archives of General Psychiatry* 51:8–19. 1994.

**DEPARTMENT OF  
HEALTH & HUMAN SERVICES**

Centers for Disease Control and Prevention  
National Center for Health Statistics  
6525 Belcrest Road  
Hyattsville, Maryland 20782-2003

---

**OFFICIAL BUSINESS  
PENALTY FOR PRIVATE USE, \$300**

---

To receive this publication regularly, contact  
the National Center for Health Statistics by  
calling 301-436-8500  
E-mail: [nchsquery@cdc.gov](mailto:nchsquery@cdc.gov)  
Internet: [www.cdc.gov/nchswww](http://www.cdc.gov/nchswww)

---

**FIRST CLASS MAIL  
POSTAGE & FEES PAID  
PHS/NCHS  
PERMIT NO. G-281**