

Health Priority: Mental Health and Mental Disorders

Objective 4: Access to Care (Template)

Long-term (2010) Subcommittee Outcome Objectives:

4a: By 2010, Wisconsin’s public mental health clients who have access to "Best Practice" mental health treatments will increase by 10 percent.

4b: By 2010, Wisconsin's public mental health clients who have access to "Evidence-based" mental health treatments will increase by 10 percent.

Long-term outcome objective updated as of: Sept 2004

- Priority Ranking and Relationship to *Healthy People 2010* - The Mental Health Subcommittee identified 86 initial objectives. Of the 11 semi-final objectives, the following related to access to services: (1) screen and serve children having difficulties in childcare and school for emotional problems; (2) establish mental health/substance abuse insurance parity; (3) address the shortage of mental health providers in children’s mental health, infant mental health, and geriatric psychiatry, especially in rural areas of Wisconsin; and (4) stimulate and fund innovative local mental health delivery services.
- Achieving this 10-year outcome objective will contribute to the shared vision of the public health system of *healthy people in healthy Wisconsin communities* as demonstrated in (a) a more healthy Wisconsin population; (b) a more productive population; (c) reduced suicides across the life span; and (d) improved family relationships.

Wisconsin Baseline	Wisconsin Sources and Year
The number of clients served through Community Support Programs in 2000 was 4,905. There are no current data to document Community Support Program's level of adherence to the evidence-based Program of Assertive Community Treatment model, but we will proceed under the assumption that Community Support Programs are evidence-based treatments for now. The objective is developmental because other evidence-based treatments and best practices are yet to be selected.	The number of Community Support Program clients is collected through the Community Support Program Monitoring Report. Future plans are to identify a limited number of “Best Practices” and “Evidence-based treatments” from the Center for Mental Health Services roster of treatments. The Community Support Programs which use the Program of Assertive Community Treatment model will be one of these. Then, use of these treatments will be tracked on a client-level basis such as through the Mental Health module of the Human Services Reporting System data system.

Federal/National Baseline	Federal/National Sources and Year
See Appendix A for baseline and target data on adults with mental disorders receiving treatment.	<i>Healthy People 2010</i> , November 2000, USDHHS, cites the following sources for this baseline data: Epidemiologic Catchment Area Program, National Institutes of Health, National Institute of Mental Health; National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, Office of Assistant Secretary; National Comorbidity Survey, Center for Mental Health Services

Federal/National Baseline	Federal/National Sources and Year
12% of families experience difficulties or delays in obtaining healthcare or did not receive needed care in 1996. This refers to all healthcare, not mental healthcare specifically.	<i>Healthy People 2010</i> , November 2000, United States Department of Health and Human Services, cites the following sources for this baseline data: Medical Expenditures Panel Survey, Agency for Healthcare Research and Quality (formerly Agency for Health Care Policy) and Research

Related USDHHS Healthy People 2010 Objectives			
Chapter	Goal	Objective Number	Objective Statement
18 - Mental Health and Mental Disorders	Improve mental health and ensure access to appropriate, quality mental health services.	18-7	(Developmental) Increase the proportion of children with mental health problems who receive treatment.
		18-9	Increase the proportion of adults with mental disorders who receive treatment.
1- Access to Quality Health Services	Improve access to comprehensive, high-quality healthcare services.	1-6	Reduce the proportion of families that experience difficulties or delays in obtaining healthcare or do not receive needed care for one or more family members.

Definitions	
Term	Definition
Evidence-based medicine	A decision-making framework that facilitates complex decisions across different and sometimes conflicting groups. It involves considering research and other forms of evidence on a routine basis when making healthcare decisions (Donald, 2002).
Mental health parity	Health insurance coverage for mental disorders that is no more restrictive than coverage for other health conditions.
Best practice guidelines	Guidelines, most generally developed by professional associations or expert panels, that identify what research and practice currently suggest is the most efficacious way to identify and respond to health conditions. Best practice guidelines generally identify evidence-based treatment as well as other practices that are believed to be useful in responding to a disorder, even though well-controlled scientific studies may not be available.
Recovery	As accepted by the Wisconsin Council on Mental Health (July 2001), recovery from a mental illness means the process of growth over time in the improvement of a person's attitudes, feelings, values, goals, skills, and roles. Recovery is measured by a decrease in symptoms of illness and an increase in the person's level of health, wellness, stability, self-determination, and self-sufficiency. Recovery means the development of hope, dignity, a new and valued sense of self, meaning and purpose, and quality of life.

Definitions	
Term	Definition
Professional training schools	Schools of advanced education for healthcare professionals. These might include, but are not limited to, schools of nursing, social work, medicine and psychology.
Mental health/AODA redesign initiative	Four county-based sites developing under contracts with the Wisconsin Department of Health and Family Services to demonstrate how the recommendations of the Governor’s Blue Ribbon Commission on Mental Health can be implemented.
Prevention	Prevention activities are those that occur before a mental illness is diagnosed. Prevention can be universal, selective, or indicated. Universal prevention programs are created for a whole population. Selective programs benefit members of an “at-risk” population. Indicated prevention is aimed at populations showing early signs and symptoms associated with mental disorders.
Early intervention	Action to hinder or alter a person’s mental disorder or abuse of alcohol or other drugs in order to reduce the duration of early symptoms or to reduce the duration of severity of mental illness or alcohol or other drug abuse that may result (Wisconsin State Statutes, Mental Health Act: s.51.01 Wis Stats).
Referral	The process of assisting an individual to obtain services from a health professional who can assess and treat, if necessary, a suspected health condition.
Assessment	The process used to evaluate an individual’s present problems with an accompanying description of the reported or observed conditions which led to the classification or diagnosis of the individual’s illness.
Partner systems	Service systems combining to work on increased screening in order to improve identification and referral of individuals who may be experiencing mental disorders. These include education, corrections, healthcare, social services, aging, child care, and early childhood.

Rationale:

As a first step in developing this 10-year long term outcome objective, the members of Mental Health and Mental Disorders Subcommittee spent time identifying current and emerging problems concerns access to care. These include:

Problems identified:

- People lack health insurance coverage.
- Most health insurance policies have more restrictive coverage for mental disorders.
- Insurers fail to utilize best practice “access to care” guidelines for persons presenting with mental disorders.
- Limited public funding for mental health services.
- Uneven availability of appropriately trained professionals to provide mental health services across the state.

Outside influences:

- Opposition to government-sponsored universal healthcare has prevented large-scale reform in this area. Incremental reforms have reduced the percentage of uninsured in Wisconsin, but may be inadequate for reducing uninsured to 0 percent.
- Economic health of the state and nation influences government's ability to expand "publicly funded" healthcare.
- Rising cost of health insurance is straining business' ability to expand health insurance coverage to employees.
- Polls have shown strong support for expanding access to healthcare, especially for children.
- Strong opposition to parity from small businesses and, to a lesser degree, from health insurers.
- State law cannot impact coverage for self-insured plans. This can only be done by federal legislation.
- Broad-based coalition of consumer, provider, citizen, faith-based, and labor groups support parity.
- Limited parity has been enacted on federal level. Additional action in the year 2001 will likely influence state efforts.
- Thirty-two other states have passed some form of parity legislation.
- Increasing research and development of consensus documents may facilitate efforts.
- Economic health of the state will impact ability to fund services if increased funds are required.
- Stigma continues to impact ability to fund mental healthcare.

Documentation:

- According to the *Global Burden of Disease* study commissioned by the World Health Organization and the World Bank, mental disorders represent 4 of the 10 leading causes of disability for persons age 5 and older. Among developed nations, including the United States, major depression is the leading cause of disability (Murray and Lopez, 1996).
- Twenty percent of the United States population has a mental disorder in one year; 3 percent has both a mental and addictive disorder; 6 percent has an addictive disorder (Regier et al., 1993).
- The indirect costs of mental disorders in 1990 were \$78.6 billion (Rice and Miller, 1996).
- Ninety percent of people who kill themselves have depression or another diagnosable mental or addictive disorder.
- There are significant disparities in how mental disorders present themselves and are treated:
 - Major depression is diagnosed in twice as many women as men.
 - It is reported that racial and minority groups are underserved as compared to the majority population.
 - Depression rates are much higher among older Americans who experience a physical health problem.
- Of the 28 percent of the adult population with a mental or addictive disorder in a given year, only about one-third receive mental health services and, of these, less than half receive services from a mental health specialist. The rest receive care from medical, human services, or voluntary support. These numbers are similar for children (Regier et al., 1996; Kessler et al., 1996).
- Among the actions urged by the Surgeon General in his report on mental health are the following:

- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state of the art treatment.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment (U.S. Department of Health and Human Services, 1999).

Outcomes:

Short-term Outcome Objectives (2002-2004)

- By 2003, there will be an increase, as measured by standard polling, in the percentage of the population that supports increased access to health insurance coverage.
- By 2003, citizens and policymakers will be aware of the hidden costs in failing to provide health insurance coverage to all persons.
- By 2003, changes that reduce insurance costs for small businesses will be identified.
- By December 2003, key stakeholders (e.g., providers, insurers, policymakers) will “buy-in” to best practice guidelines.
- By 2004, parity legislation will be passed in Wisconsin.
- By 2004, major state healthcare contracts (e.g., Medicaid/BadgerCare) will incorporate requirements for use of identified best practice guidelines.
- By June 2003, the public, legislators, and policymakers will have an increased awareness that serious mental illness is treatable and that recovery is possible.
- By December 2004, preliminary data from current projects will improve the knowledge base for making decisions about funding for mental health services.
- By 2004, three professional training schools for non-mental health specialists will agree to enhance their curricula to ensure that their professionals are better able to identify and respond to mental health disorders.
- By 2004, one new project involving technology to provide mental health treatment or consultation services to an underserved area will be implemented.

Medium-term Outcome Objectives (2005-2007)

- By 2005, policy changes will expand access to insurance through Wisconsin Medicaid and BadgerCare.
 - By April 2005, legislators will have a clearer understanding of what they are “buying” when funding public mental health services and will therefore be more willing to do so.
- By 2005, legislation will implement small business health insurance reform that will reduce health insurance costs for small businesses and increase access to insurance for employees.
- By 2005, all commercial group health insurance policies in Wisconsin will implement the parity provisions.
 - By 2005, citizens will be knowledgeable about their right to mental health services through their insurance companies.
 - By 2005, insured individuals will receive medically necessary mental healthcare.
 - By 2005, changes to program standards, policies, and statutes will be implemented that support use of best practice guidelines.
 - By 2005, policies and practices that are barriers to access will be eliminated.

- By 2005, insurers and providers will be using best practice guidelines for persons in need of mental health services.
- By 2005, procedures will be in place for evaluating whether guidelines are being implemented properly.
- By 2005-2007, biennium funding for public mental health services will be based on number of persons needing services and better knowledge of the actual cost to provide services. Outcome indicators will guide funding decisions. (The actual level of funding may or may not increase based on the increase in the number of people served by the private sector, the use of more efficient services under managed care, etc.).
- By 2005-2007, biennium statutory changes will implement changes to state/county funding that result in adequate and equitable public funding statewide for mental healthcare.
- By 2007, two additional professional training programs for non-mental health specialists will enhance their training curricula.
- By 2007, two additional projects will use technology to provide mental health treatment or consultation services to underserved areas.

Long-term Outcome Objectives (2008-2010)

- By 2010, reduce by 10 percent the proportions of the population that reports difficulties, delays, or the inability to receive "Best Practice" mental health treatment.
- By 2010, increase the number of people with a mental health need to have timely access to evidence-based treatment.

Inputs: (*What we invest – staff, volunteers, time money, technology, equipment, etc.*)

- Designated state staff to guide and develop the process
- Bureau of Community Mental Health/Division of Supportive Living
- Division of Public Health
- Wisconsin Medicaid – Division of Health Care Financing, Department of Health and Family Services
- Office of the Commissioner of Insurance
- Fiscal support to convene a mental health workgroup that will consist of identified leaders in the mental health field to oversee the implementation of the four Mental Health/Mental Disorders Subcommittee objectives.
- Fiscal support to develop and disseminate training materials on best-practice and evidence-based treatment.
- Distance learning technology to provide consultation on best-practice and evidence-based treatment.

Partner systems with the needed expertise to achieve the identified objectives:

- Business owners and their representatives
- Insurance carriers
- Legislators
- Mental health professionals
- Representatives from professional training schools
- Representatives from county human services
- Tribes
- Local health departments

- Investment of time from all identified individuals.

Outputs: (*What we do – workshops, meetings, product development, training. Who we reach-community residents, agencies, organizations, elected officials, policy leaders, etc.*)

Activities:

- Coalitions will be established/joined for enacting parity, enacting legislation to control health insurance costs for small businesses, and addressing other barriers to insurance.
- Uninsured populations will be identified.
- Reasons for lack of insurance will be identified.
- Solutions to lack of insurance will be identified.
- Strategies to implement solutions to lack of insurance will be put in place.
- Key parties (e.g., businesses, health insurers, legislators) will be contacted and educated.
- Public education will be provided through the media.
- Legislators and businesses will be educated about true costs and benefits of parity.
- Citizens and stakeholders will be informed about parity and mobilized to advocate with legislators.
- Stories will be presented in media to educate the general population about the need for and value of mental healthcare as part of treating the whole person.
- Model guidelines will be issued for access to treatment that identify timeliness standards, assessment and evaluation, treatment planning, and best practice or evidenced-based treatments.
- Proposed changes will be made to program standards, policies, and statutes.
- Informational hearings will be conducted to inform a wide audience of proposals and receive feedback.
- Model guidelines will be disseminated for access to treatment and best practice or evidence-based treatment.
- Ongoing monitoring of research will be conducted to identify potential revisions to guidelines over time.
- The Mental Health/Alcohol and Other Drug Abuse (AODA) Redesign Initiative will be implemented in four sites. Outcome and cost data will be determined.
- Proposals will be developed for best ways for state and county to share funding for public mental health services.
- Impact of recovery-oriented practices and prevention/early intervention practices will be documented and disseminated.
- Public awareness campaign will be implemented.
- Legislators will receive written information and face-to-face meetings educating them about efficacy of treatment and budget needs.
- Number and type of mental health professionals serving the state will be identified.
- Enhanced training and education of allied professionals to provide mental health services will be planned.

- Expanded use of technology to provide mental health services or consultation to underserved areas will be planned.

Participation/Reach:

The mental health workgroup formed to oversee implementation of Mental Health and Mental Disorders Subcommittee Objectives will include representatives from the following partner systems:

- Healthcare and HMOs
- Primary care
- Education
- Corrections - jails/prisons
- Social services
- Aging-including - area agencies on aging
- Child care and early childhood
- Local health departments
- Tribes
- Local mental health agencies and organizations
- Public and county organizations
- Wisconsin Department of Health and Family Services
- Legislature
- Statewide professional organizations, public health system disciplines and partners:
 - Wisconsin Health and Hospital Association
 - Wisconsin Primary Health Care Association
 - Wisconsin Nurses Association
 - Wisconsin Medical Society
 - Wisconsin Public Health Association

Evaluation and Measurement

The four mental health objectives combined will lead to the long-term outcomes identified above. The following table identifies objectives and measures that will allow us to evaluate our achievements.

Outcome	Measure	Source
A healthier Wisconsin population	Questions that have been added to Wisconsin’s Family Health Survey to measure prevalence of mental disorder among children and adults.	Family Health Survey-Department of Health and Family Services
	Questions on mental health status	Behavioral Risk Factor Surveillance System
A more productive Wisconsin population	Questions that have been added to Wisconsin’s Family Health Survey to identify degree to which mental or emotional problems interfere with functioning.	Family Health Survey-Department of Health and Family Services

Outcome	Measure	Source
Reduced suicides across the life span	Number and rate of suicides by age group	National Vital Statistics System, Centers for Disease Control and Prevention, National Center for Health Statistics
	Number of students in grades 9 through 12 who reported suicide attempts that required medical attention in the 12 months preceding the survey	Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Improved family relationships or social connectedness	Survey questions	Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
	Survey questions	National Health And Nutrition Examination Survey
Increase screening of mental health	Questions that have been added to Wisconsin's Family Health Survey.	Family Health Survey-Department of Health and Family Services
Increased access	Number of adults aged 18 years and older who report symptoms of depression and that they received help from a mental health professional divided by number of adults aged 18 years and older who report symptoms of depression	Healthy People 2010 measure-- National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Access to Primary and Preventive Health Services: Improved access to mental health services will increase the likelihood that persons will see not only mental health specialists but primary care physicians as well. This will occur because the mental health professionals may help individuals identify certain primary care needs and also because some individuals will go to their primary care physicians to receive medications to treat their mental disorders.

Alcohol and Other Substance Use and Addiction: Rates of co-occurrence of mental disorders with alcohol and other drug abuse disorders are significant. Identification and treatment of a mental disorder will therefore also increase identification of persons with alcohol and other drug abuse disorders.

High Risk Sexual Behavior: High risk sexual behavior can occur in response to an unsatisfactory life situation. Treatment for mental disorders may identify individuals who are in such situations and provide for earlier intervention. This may lead to a reduction in persons engaging in high risk sexual behavior.

Intentional and Unintentional Injuries and Violence: Almost 600 people die from suicide each year in Wisconsin. Many others attempt but do not complete suicide. Increased access to mental

health

services should help identify persons at risk for suicide and intervene before their mental disorder deteriorates.

Social and Economic Factors that Influence Health: Persons with mental disorders have a higher mortality rate than the general population and are less likely to receive basic medical care. By the identification and treatment of mental disorders, general health can be improved.

Tobacco Use and Exposure: Individuals with mental disorders have high rates of tobacco use. Screening, referral, and treatment may decrease tobacco use.

Integrated Electronic Data and Information Systems: Lack of good data about prevalence and outcomes of treatment for mental disorders makes it difficult to address mental health issues in many systems. Such data is critical to gaining support of non-traditional partners, such as legislators and the business community.

Community Health Improvement Processes and Plans: Because of the huge impact of mental illness on society (see rationale above) any community health improvement must address screening, referral, and treatment for mental disorders.

Sufficient, Competent Workforce: The supply of trained mental health professionals, especially those specializing in children and older adults and those competent to work with cultural/ethnic minority populations (e.g., Hispanic, Native American), undermines the ability to provide access to appropriate treatment.

Equitable, Adequate, and Stable Financing: Financing is a major issue. Public health systems are struggling to meet the needs of current clients and limits on private insurance coverage for mental disorders often leave individuals with no way to pay for identified treatment needs.

Significant Linkages to Wisconsin's 12 Essential Public Health Services

Identify, investigate, control, and prevent health problems and environmental health hazards in the community: Improved access to mental health services will allow better control of the negative impact of mental disorders, prevent on-going difficulties and mitigate other health problems (since persons with mental illness have poorer health outcomes in other areas).

Educate the public about current and emerging health issues: The success of this objective rests on educating the public, including the legislature, that mental illnesses are real, common, and treatable. This involves understanding the costs of failure to treat mental disorders, the actual costs and success rates of providing treatment, and the long-range benefits of doing so.

Promote community partnerships to identify and solve health problems: The actions identified for this objective will require developing important partnerships with the legislature, the business community, and the insurance industry. The process also entails partnerships among mental health professionals and a wide range of other systems, including education, primary and acute care, aging, etc.

Create policies and plans that support individual and community health efforts: Development and/or dissemination of guidelines for access and treatment will support individual and community health

efforts. These guidelines will ensure the most efficient use of scarce resources and increase the likelihood for positive outcomes.

Enforce laws and regulations that protect health and insure safety: Link people to needed health services. Limitations on health insurance generally, and on insurance for mental healthcare in particular, are major barriers to individuals receiving mental healthcare. This objective seeks to remove those barriers.

Evaluate effectiveness, accessibility, and quality of personal and population-based health services: Best-practice and evidence-based guidelines represent an effort to identify and ensure effective health services for mental disorders.

Assure access to primary healthcare for all: Improved access to mental healthcare should also increase access to primary care, as individuals with mental disorders often do not have adequate access to primary care.

Foster the understanding and promotion of social and economic conditions that support good health: Success in this objective will require that the general public better understands the relationship between current limitations in health insurance for mental illness and poor health outcomes for individuals with these disorders.

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010

Protect and promote health for all: As noted in the “Rationale,” the burden of disease associated with mental illness is significant. Health promotion must address these conditions.

Eliminate health disparities: As noted in the “Rationale,” there are significant disparities in both the prevalence of certain mental disorders across different populations and the access to care for these disorders.

Transform Wisconsin’s public health system: The public health system is ideally situated to identify and respond to persons with mental disorders in an environment that does not come with the stigma that is attached to mental health services. By becoming more informed and competent in identifying and referring, the public health system will realize its potential to reduce the devastating effect that mental disorders have on individuals and on the community.

Key Interventions and/or Strategies Planned:

- Increase access to health insurance for Wisconsin citizens.
- Pass legislation mandating parity in insurance coverage for mental health and substance abuse treatment services.
- Develop model guidelines for access to care and delivery of best practices and work to have these adopted by providers and payors.
- Build on the recommendations of the Governor’s Blue Ribbon Commission on Mental Health, ensure adequate and equitable funding for public mental health services.
- Increase availability of trained professionals to provide mental health services in underserved areas in the State.

References:

Donald, A. *Evidence-Based Medicine: Key Concepts*. Medscape. Psychiatry and Mental Health Journal. 7(2), 2002.

Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., & Wittchen, H.U. (1994). Lifetime and 12-month Prevalence of DSM-III-R Psychiatric Disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry*. 51(1). 8-19.

Kessler, R.C., et al. 1996. *The 12-month Prevalence and Correlates of Serious Mental Illness*. In Manderscheid, R.W., & Sonnenschein, M.A., Eds., Mental Health, United States. 1996 DHHS Publication No. (SMA) 96-3098, pp. 59-70. Washington, DC: U.S. Government Printing Office

Murray, C.J.L. and Lopez, A.D., Eds. 1996. *The Global Burden of Disease. A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard School of Public Health.

Regier, D.A., Narrow, W.E., Raie, D.S., Manderscheid, R.W., Locke, B.Z., & Goodwin, F.K. (1993). The de Facto US Mental and Addictive Disorders Service System. Epidemiologic Catchment Area Prospective 1-year Prevalence Rates of Disorder and Services. *Archives of General Psychiatry*. 50(2). 85-94.

Rice, D.P., & Miller, L.S., 1996. *The Economic Burden of Schizophrenia: Conceptual and Methodological Issues, and Cost Estimates*. In M. Moscarelli, A. Rupp, and N. Sartorius, Eds., Handbook of Mental Health Economics and Health Policy. Vol. 1: Schizophrenia (pp. 321-324). New York: John Wiley and Sons.

Shaffer, D., Fisher, P, Dulcan, M.K., et al. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 35(7). 865-877.

Shaffer, D. & Craft, L. 1999. Methods of Adolescent Suicide Prevention. *Journal of Clinical Psychiatry*. 60 (Suppl. 2) 70-74.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999, pp. 22-23.

Wisconsin State Statutes. S.51.01 Wis. Stats. Mental Health Act. Revisor of Statutes Bureau. Madison, WI.

APPENDIX A

Healthy People 2010, November 2000, United States Department of Health and Human Services cites the following baseline and target data:

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