

OREGON PUBLIC HEALTH DIVISION • DEPARTMENT OF HUMAN SERVICES

PREVAILING ATTITUDES TOWARDS MENTAL ILLNESS IN OREGON

The measure of a society is found in how they treat their weakest and most helpless citizens.

President Jimmy Carter

State-by-state rankings of public attitudes towards mental illness were recently published by the Centers for Disease Control and Prevention.¹ It turns out that Oregonians have somewhat of a split collective personality when it comes to mental illness: we are among the most likely to believe in effectiveness of treatment (Oregon ranked 4th among states) but the least likely to believe that people are caring and sympathetic towards people with mental illness (Oregon ranked 51st among 52 states and territories) (Table 1). This *CD Summary* presents information on Oregon's rankings on various measures of the burden of mental illness, population attitudes, and mental health services.

WE'RE ALL AFFECTED

Oregon's burden of mental illness is substantial. Oregon has the 11th highest suicide rate, 16th high-

est percentage of adults with serious psychological distress in the past year, and 16th highest number of poor mental health days reported among adults. Measures of service provision aren't great either. Oregon is 36th in per capita mental health expenditures and 9th in percentage of adults reporting unmet mental health needs in the past year. What to make of all this? Perhaps our collective and substantial experience with mental illness contributes to familiarity with the benefits of treatment, and, sadly, frank recognition that stigma continues to attach to mental illness.

In any one year, 1 in 5 Americans experiences a diagnosable DSM (Diagnostic and Statistical Manual) IV disorder.² These include anxiety disorders (such as panic, generalized anxiety, agoraphobia, specific phobia, social phobia, posttraumatic stress, obsessive-compulsive or separation anxiety disorder), diagnosable mood disorders (such as major depression, bipolar disorder or dysthymia) and addictions. Because of its prevalence, typical onset in the most productive stages of life, and severity, mental ill-

ness ranks second among all diseases as a cause of productive life lost (Table 2).³

Table 2. Disease burden by category³

Disease/Condition	Percent of Total Life Years Lost to Disease*
All cardiovascular conditions	18.6
All mental illness (includes suicide)	15.4
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic diseases	2.8
All drug use	1.5

*Measured in disability adjusted life years lost to illness, a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration.

PRIMARY CARE AND MENTAL HEALTH

Forty-two percent of people with diagnosed major depression and 47 percent with generalized anxiety disorder were first diagnosed by a primary care physician.⁴ Though patients present to primary care practitioners with all sorts of scary-sounding somatic complaints—like chest pain, fatigue, dizziness, headache, edema, back pain, dyspnea, insomnia, abdominal pain, and numbness, 80 percent of all visits to primary care physicians are behavioral or psychological in nature, leaving only 20 percent of visits attributable to discoverable organic causes.⁵

INTEGRATIVE APPROACHES WORK

Treatment works. For example, many different social and clinical outcomes improve definitively among people with psychoses or major depressive disorders when they are treated with medicines, cognitive or psychosocial therapy, or both. Armed with this knowledge about treatment effectiveness and the overwhelming prevalence of behavioral issues among primary care patients, the state of Hawaii once went so far as to en-

Table 1. Oregon Rankings on Burden and Attitudes Towards Mental Illness

Attribute	Rank	Value	U.S. Mean
Percentage of population that believes that treatment can help people with mental illness ^a	4	93	89
Percentage of population that believes that people are caring and sympathetic to persons with mental illness ^a	51	48	57
Suicides (per 100,000 population) ^b	11	15.5	11.1
Percentage of adults with serious psychological distress, past year ^c	16	12.3	11.6
Number of poor mental health days in past month ^d	16	2.9	1.51
State mental health authority expenditures (\$) per capita ^e	36	60.79	95.70
Percentage of population reporting unmet mental health needs in past year ^f	42	6.0	5.4

^a From the Behavioral Risk Factor Surveillance System, 2007 (includes Washington, D.C. and Puerto Rico).¹

^b From the National Vitals Statistics System, 2004 (includes Washington, D.C.).⁷

^c From the National Survey on Drug Use and Health, 2004–5 (includes Washington, D.C.).⁷

^d From the Behavioral Risk Factor Surveillance System, 2006 (includes Washington, D.C.).⁷

^e From National Association of State Mental Health Directors, 2004 (includes Washington, D.C.).²

^f From the National Survey on Drug Use and Health, 2004–5 (includes Washington, D.C.).⁷



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roll Oahu's entire Medicaid population in a trial in which patients were randomly referred to receive psychotherapy regardless of whether or not they requested it or a specific mental illness had been diagnosed. Overall costs of care fell 38% for patients who were not chronically ill, 18% for patients who were chronically ill, and 15% for who had substance abuse diagnoses.⁶

Most people with a physical complaint won't accept or keep a referral to a mental health professional but will immediately talk with one as part of their health care visit. Consequently, behavioral adjuvants to medical care seem to work best when they are offered at the same time and in the same location as the medical visit. Reasonable people continue to disagree about the size of the so called "mental health cost-offset." Nevertheless, enough of us believe in the idea of integrated mental health and medical care that the new health care reform bill, the Patient Protection and Affordable Care Act, includes notable provisions to increase funding for "medical home" programs that focus on integrated physical and mental health services. Evidence is also building for the effectiveness of integrated and collaborative models of primary care and behavioral health that would not typically not be considered mental health treatment. These have come to be called *behavioral health coaching*.⁵ (Box)

RESOURCES — CLINICIANS

- The Substance Abuse and Mental Health Services Administration (SAMHSA) spotlights current research publications, resources, and statistics at www.samhsa.gov.

Behavioral Health Coaching. Effective Strategies for Integrating Behavioral Health and Primary Care⁵

- Disease self-management programs.
- Relaxation response method educations
- Health behavior modification programs (e.g. for smoking cessation, diet)
- Targeted social support
- Screening all patients for diagnosable mental illnesses
- Primary care to mental health specialist consultation for people with somatization who will not accept mental health referral

- Medscape from WebMD offers integrated medical information and educational tools, including online CME's at: <http://cme.medscape.com/resource/psychiatric-nursing/cme>.
- This Emotional Life is a three-part series weaving personal stories and scientific research related to mental health and emotional wellness at: www.pbs.org/thisemotionallife/series

RESOURCES — PATIENTS

- NAMI Oregon, a statewide organization offering education classes, family and peer support groups, and community resources for people with mental illness at www.nami.org or call toll-free 1-800-343-6264.
- Oregon and Southwest Washington's comprehensive support hub for community information and referral at www.211info.org.
- Mental Health America (MHA) at www.MentalHealthAmerica.net offers information on mental health conditions, treatments, insurance, and other topics of interest to patients.

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