

# Latest Findings **IN** Children's Mental Health

A COLLABORATION OF RUTGERS UNIVERSITY, US DEPT OF HEALTH & HUMAN SERVICES AND THE ANNIE E. CASEY FOUNDATION

## ABOUT THIS BRIEF

Welcome to *Update: Latest Findings in Children's Mental Health*, a series of short bulletins designed for policymakers and their staffs, mental health professionals, child advocates, and the community of all those who care about the well-being of children and adolescents.

*Update's* goal is to provide you with a timely, nonpartisan assessment of equity in children's mental health care.

We've planned more issues of *Update*, each of which will use new national estimates to focus on special populations, illnesses or treatment settings. The children and adolescents to be covered include pre-schoolers, minority group members, youth with multiple mental health problems and those in residential treatment centers. Other issues will focus on disparities in access, quality and outcomes.

*Update* is the result of a partnership among three organizations:

- **Rutgers University's** School of Social Work and Institute for Health, Health Care Policy, and Aging Research, which analyzed the data to create the national estimates and these briefs;
- **The US Department of Health and Human Services** Substance Abuse and Mental Health Services Administration Center for Mental Health Services, which collected the data;
- **The Annie E. Casey Foundation**, which provided financial support for the analysis and publication of these briefs.

We hope that *Update* will launch a dialogue about children's mental health and the equity of services offered. We invite your comments, questions and insights.

Kathleen J. Pottick  
Principal Investigator, Rutgers University  
pottick@rci.rutgers.edu



The Annie E. Casey Foundation

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services



A public-private partnership...translating research into action for children's mental health

## Children's Use of Mental Health Services Doubles, New Research – Policy Partnership Reports

More than 1.3 million children under the age of 18—or one out of 50—received mental health services in the US during 1997, according to a new, watershed study which provides the first reliable detailed statistics ever of children's mental health service use. The number is almost double the estimate of children who received treatment in 1986, although the extent of unmet need for youth in our country is unknown. Researchers attribute the increased use to public policy changes made during the last 15 years that have launched innovative state- and federally-funded System of Care Programs and community-based wraparound services. Those efforts are now severely threatened by state and federal budget deficits and soaring health care costs.

### THE IMPORTANCE OF MENTAL HEALTH CARE

Reductions in services could harm children because other research shows that, without treatment, psychological problems disrupt their social, academic and emotional development, sometimes permanently. Lack of treatment also causes turmoil for their families.

### THE DATA THAT WERE USED

The new report is part of a three-year, public-private collaboration funded by the Annie E. Casey Foundation. (See *About This Brief*, left). For the report, researchers at Rutgers University analyzed data from a 1997 survey conducted by the US

Department of Health and Human Services (HHS). The survey is the first with a sample large enough to allow researchers to calculate reliable, national estimates of subgroups of youth under 18 in mental health services. More recent data are not available; HHS plans to conduct a comparable survey in 2007.

### WHAT THE STUDY COVERS

The new research looks at access, quality, and outcomes for youth, with an eye to investigating service inequities among

children of different races, ages, genders, socioeconomic status and diagnosis. It will develop regional "report cards" for youngsters' mental health services across the country. (See *About This Research* on page 3.) The data are rich, allowing researchers to uncover special populations of youngsters who have never been described in depth and who practitioners could help if they were. The analysis, which is still underway, reveals sharp differences among children of different races; in different treatment facilities; and who use public or private insurance to cover the cost of treatment.

The results also suggest types of treatment that should be available in communities, guidance that may be particularly helpful during this time of diminishing public resources.

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**"Policymakers and child advocates need to make informed decisions about how best to allocate scarce resources in the service of youth. This analysis will provide important guidance to develop policies and programs that encourage appropriate placement, equal treatment, continuity of care and smooth transitions for disadvantaged and seriously emotionally disturbed children."**

David Mechanic – Director,  
Rutgers' Institute for Health, Health Care Policy, and Aging Research

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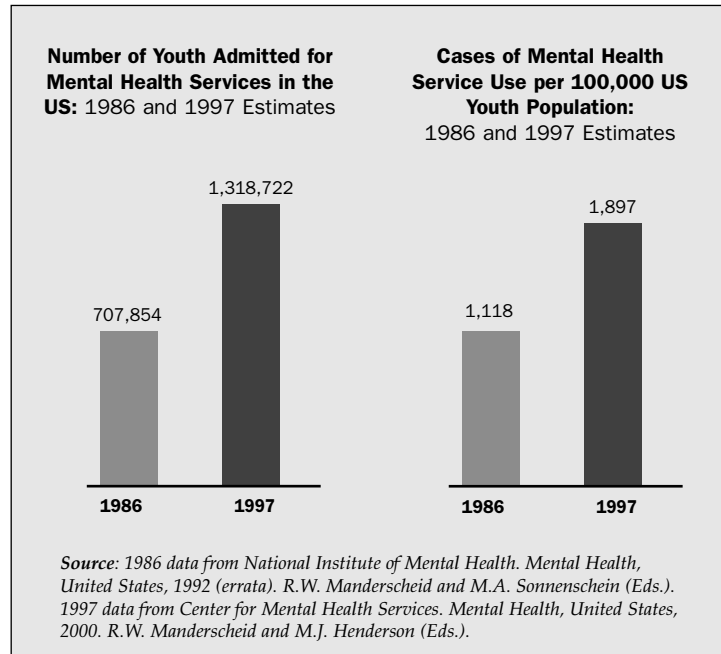
# Answers to Key Policy Questions

## Question 1: Have US programs and policies intended to improve children's access to mental health services done so?

Perhaps. The rate at which children received services jumped by 70% during an 11-year period, increasing from 1,118 per 100,000 children in 1986 to 1,897 per 100,000 children in 1997. US programs and policies designed to make mental health services more accessible to youngsters appear to have been working, although use of services may not have increased equally among poor or minority children or those in socially stressed or resource-deprived communities.

## Question 2: Where do youngsters receive services?

In 1997, the vast majority of youth—almost three-quarters (73%)—were treated in outpatient services. About 20% were hospitalized at inpatient facilities. Despite increasing rates of use of residential mental health services among youth from 1986 to 1997, residential mental health services play a very small role in treating children with mental health problems; only 5% of youth were admitted to these program settings in 1997. The dominance of outpatient treatment is generally a good thing: youngsters should receive treatment in the least restrictive



settings possible. But the large number of youth with complicated social, emotional and mental health needs means that there is a need for more intensive home- and community-based services plus a role for inpatient and residential care. (See *What We Mean: A Glossary of Terms.*)

## Question 3: Who are the children using mental health services in the US?

**Age**—The majority of youngsters (51%) receiving mental health services in 1997

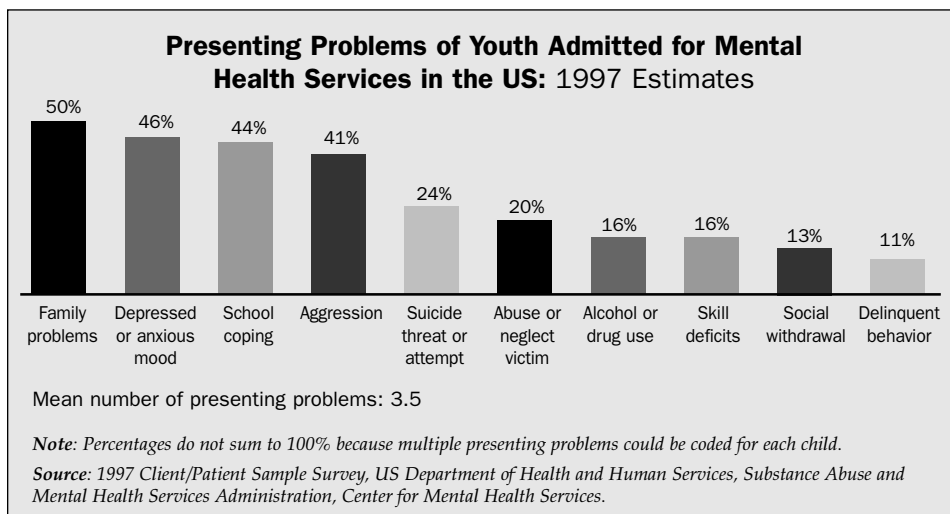
were adolescents aged 13-17 years old; 40% were between the ages of 5 and 12; and a surprising 9% were preschoolers—nearly 120,000 children under the age of 6.

**Gender and Race**—More boys (56%) than girls (44%) received mental health services, as did more Whites (65%) than Blacks (19%) or Hispanics (14%).

**Income**—More than half (57%) of the children were poor: their care was paid

for by Medicaid (42%), other public insurance (10%) or charity care (5%). Less than a third (31%) had private insurance, or paid with personal resources (9%). This suggests that modifications in existing Medicaid policy and other public mental health insurance programs could have a profound impact on the availability of mental health resources for our nation's youth.

**Living Situation**—Most children lived with one or both natural parents (68%) or with other relatives in kinship care (11%) or in step or adoptive families (3%). However, 13% lived in custodial arrangements (foster care, group homes, or jail and juvenile detention). Children in custodial arrangements may be particularly vulnerable since unstable and insecure living arrangements are likely to interfere with use of services, quality of treatment, and timely and smooth transitions between community services and home.



#### Question 4: What kinds of mental health problems do these children have?

Over two-thirds of youth had one of three diagnoses: disruptive behavior disorders (31%), mood disorders (21%) or adjustment disorders (16%). Almost 40% were “seriously emotionally disturbed,” using the most stringent definition provided by HHS. (See *What We Mean: A Glossary of Terms.*)

The survey revealed another fact that has significant service implications: half (50%) of the youngsters were diagnosed with two disorders; 42% were diagnosed with one, while 7% entered the mental health service system with no psychiatric diagnosis whatsoever. Dual disordered youth are difficult to treat: known effective interventions, including medication, generally target specific single disorders. Program planners, physicians, and mental health clinicians will need more information on these youngsters to treat them effectively.

#### Question 5: What other problems do youngsters entering services have?

Children came with many serious problems in their lives. Half of them had problems with family (50%); nearly half (46%) had problems such as eating disturbances, sleep problems, grief and loss reactions, or post-traumatic stress—warning signs of depression or anxiety. In addition, 44% had problems coping with school; and 41% had problems with aggression. Nearly one-quarter (24%) threatened or attempted suicide, while fully 20% were victims of abuse or neglect. These factors seriously complicate and compromise their recovery, and put them at greater risk for chronic mental illness.

#### ABOUT THIS RESEARCH

*Mental Health Care for Youth: A National Assessment* analyzes data from the 1997 Client/Patient Sample Survey conducted by the US Department of Health and Human Services Substance Abuse and Mental Health Service Administration (SAMHSA) Center for Mental Health Services (CMHS). The survey sampled more than 8,000 youth in approximately 1,600 mental health care facilities. It is the first such survey with a sample size large enough to allow researchers to calculate national estimates from it. It is also the most recent survey of its type; there are no comparable data available for the years since 1997.

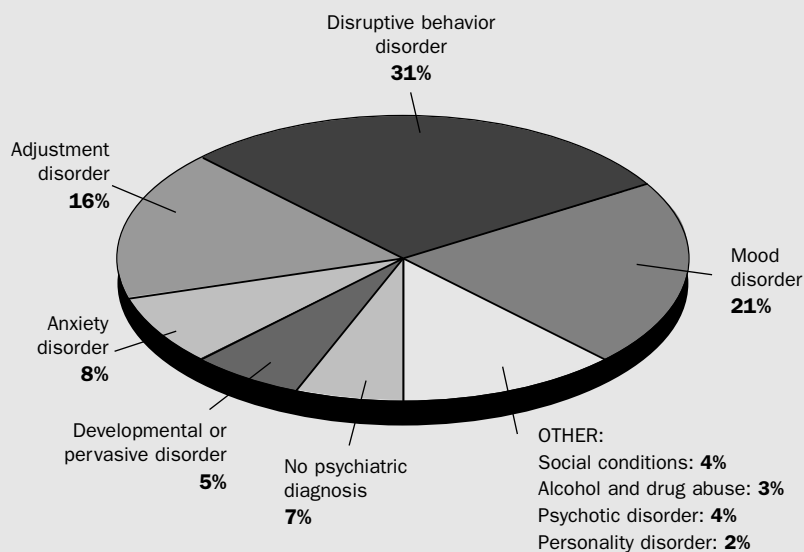
All of the children surveyed were seen at some type of community mental health facility, whether that was a clinic, hospital, community center or social service agency. This means that estimates of youth served are conservative. They do not include youth who consulted only with individual therapists and paid for that treatment with private insurance or personal funds.

The goal of this analysis is straightforward: to provide policymakers and child advocates with a timely, nonpartisan assessment of equity in children’s mental health services. It focuses on three issues: access, service equity and community resources available nationally for children’s mental health care. It is based on three assumptions.

- The best mental health care places children in the least restrictive settings possible.
- Nondiscriminatory care requires equity in the provision and the extent of care.
- Effective mental health care demands smooth and timely transitions among service settings and the community.

To assess how well the nation is satisfying these characteristics of care, the partnership is especially interested in determining if service patterns are inequitable based on race-ethnicity, insurance coverage or economic situations. Moreover, it wants to understand how mental health services work in socially-stressed and resource-deprived communities—those in most need of creative dialogue and informed public policies that respect the challenges endemic to multiple-problem communities.

#### Prevalence of Psychiatric Diagnoses of Youth Admitted for Mental Health Services in the US: 1997 Estimates



*Note:* Youth population includes all children and adolescents under age 18. This table represents 4,014 observations from the 1997 Client Patient Sample Survey. US territories of Puerto Rico, Guam and the US Virgin Islands were excluded (21 observations).

*Source:* 1997 Client/Patient Sample Survey, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

# What We Mean: A Glossary of Terms

## SERVICES

**Inpatient Care**—A licensed psychiatric hospital or a separate psychiatric service in a general hospital that provides assigned professional staff for 24-hour care.

**Outpatient Care**—A mental health clinic or other agency that provides individual counseling, group therapy and other mental health services on an ambulatory basis, i.e. patients live outside of the facility. A psychiatrist generally assumes medical responsibility for all patients and the direction of the mental health program.

**Residential Care**—A facility with round-the-clock staffing, such as a group home, in which patients live and receive a program of individually planned mental health services. Residential centers are not licensed as psychiatric hospitals, but are directed by mental health professionals who have at least a master's degree.

## MENTAL HEALTH

**Mental Health Problems**—The range of all diagnosable emotional, behavioral and mental disorders in children and adolescents. This includes depression, attention deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others.  
*Source: HHS Center for Mental Health Services*

**Serious Emotional Disturbances**—The above disorders when they cause children or adolescents to score 50 or lower on the Global Assessment of Functioning (GAF), a standardized diagnostic tool. The low score means that such children have a "moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area," symptoms include suicidal preoccupations, obsessive rituals, frequent anxiety attacks, refusal to attend school or frequent episodes of aggressive or other anti-social behavior.  
*Source: HHS Center for Mental Health Services*

## PSYCHIATRIC DIAGNOSES

**Adjustment Disorder**—The essential feature of adjustment disorder is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors. Symptoms of this diagnosis include depressed mood, anxiety, conduct disorders, or mixtures of these. Youth experience marked distress that is in excess of what would be expected from exposure to the stress or significant impairment in social or school functioning.  
*Source: American Psychiatric Association*

**Disruptive Behavior Disorder**—Youth with diagnoses of either conduct disorder or attention deficit/hyperactivity disorder (ADHD) have disruptive behavior disorder. Youth with conduct disorder have a persistent pattern of behavior in which they violate the rights of others, or violate norms or rules that are appropriate to their age. The behaviors are more than mischievous pranks, and youth frequently have serious difficulties in school, at home, and in the community. Youth with ADHD have significant problems paying attention and concentrating, and frequently behave hyperactively and impulsively. Despite good intentions, youth have severe trouble listening to parents, getting along with peers, and following rules.  
*Source: American Academy of Child and Adolescent Psychiatry*

**Mood Disorder**—Youth diagnoses of either major depression disorder, bipolar disorder (manic depression) or dysthymia have mood disorder. Youth with these types of diagnoses have symptoms that may include intense feelings of sadness, irritability, significant loss of interest or pleasure in activities formerly enjoyed, feelings of hopelessness, or marked changes in mood between extreme elation or happiness and severe depression.  
*Source: American Academy of Child and Adolescent Psychiatry*

## FOR MORE INFORMATION, CONTACT:



**Kathleen J. Pottick**  
Professor of Social Work  
Rutgers University  
Institute for Health, Health Care Policy,  
and Aging Research  
732-932-6582  
pottick@rci.rutgers.edu



The Annie E. Casey Foundation

**Mareasa Isaacs**  
Senior Associate  
Policy Reform and Initiative Management  
Annie E. Casey Foundation  
410-547-6600  
misaacs@aecf.org  
www.aecf.org



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services

**Ronald W. Manderscheid**  
Chief, Survey and Analysis Branch  
Center for Mental Health Services  
SAMHSA  
US Department of Health and Human Services  
301-443-3343  
rmanders@samhsa.gov