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Children With Serious Emotional Disorders

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Each year since 1997, the Missouri Kids Count Databook has reported data on the number of children receiving services for Serious Emotional Disorders (SED). In 2003 these data indicated that the Missouri Department of Mental Health provides mental health services to 3 percent of the children and youth between 0 and 18 years of age in the state of Missouri who have been described as having serious emotional disturbance – see **Table 1**. This includes primarily children and youth with the following mental health disorders: bipolar disorder, schizophrenia, and attention deficit disorder. While these data suggest that a relatively tiny number of children and youth are categorized as SED, this number fails to address the number of children who experience mental health problems in non-clinical settings, such as depression and anxiety.

Many more children experience mental health problems that interfere with normal development and functioning. Durlak (1995) noted that between 10 and 20 percent of children experience moderately serious clinical problems, and between 1 and 3 percent have very serious problems. More recently, estimates are that 1 in 10 children and adolescents suffer from mental illness se-

vere enough to cause some level of impairment (Department of Health and Human Services, DHHS, 2000). More importantly, in any given year, only 1 in 5 of these children receives mental health services (DHHS, 2000).

Offord (2000) noted that for children between 1 and 19 years of age in the United States, the cluster of conditions that impacts quality of life most negatively are emotional and behavioral problems as well as their associated problems. Children and youth who experience these problems are at higher risk of leaving school early and of not acquiring the knowledge and skills they need to function as citizens. When one considers that the prevalence rate for these disorders ranges between 10 and 30 percent, it becomes apparent that all sectors of society are affected, especially the education, child welfare, and juvenile justice systems in this nation.

In a study of students 13 years of age from 12 special education classes for children with emotional disturbance, Forness (2000) found prevalence of depression (33.3%) and attention deficit/hyperactivity disorder (ADHD) (25%). In the cases of abuse, post-traumatic stress disorder (PTSD) was often a secondary disorder. Parents of children in the study recognized these problems when the child was 3.5 years of age, on average, and outside agencies,

such as schools, recognized the problems when the child was 5 years of age, on average. While the first documentation of **any** service was 6.5 years of age, eligibility for special education was about 7.8 years of age. In about 50 percent of the cases in this study, the children were classified as learning disabled and received service for emotional problems at 10 years of age.

Landsverk (2000) highlighted the fact that foster care children are at particular risk of childhood disorders. Half of the children between 0 and 17 years of age in foster care have adaptive functioning scores in the problematic range. These problems can be seen in the following ways: between 50 and 65 percent of children between 0 and 6 years of age have problems in terms of developmental status; between 50 and 60 percent of children between 2 and 17 years of age have behavior problems; and about 40 percent of children and youth between 6 and 17 years of age meet criteria for diagnosis of moderate impairment.

According to Offord (2000), the frequency of mental health problems is highest among the very poor. However, most children with mental health problems are in the middle class, especially as those problems are related to anxiety, ADHD, and mood disorders. With this in mind, children in the foster care system use mental health services 15 times more often than those in the Medicaid system, likely due to court ordered treatment. In other words, parents who have Medicaid do not have to seek mental health services for their children, whereas foster parents must seek help for foster children when it is ordered by the court as a function of foster placement. African American children and Hispanic children

are least likely to receive services, and they must display pathologies to be referred for services.

These findings are troublesome in light of the fact that childhood disorders continue into adulthood. For example, 74 percent of young adults 21 years of age with mental disorders have had prior problems (Offord, 2000). There is considerable evidence that this nation lacks an infrastructure to help children with emotional and behavioral problems. In the absence of this infrastructure, children whose problems go unidentified and untreated will ultimately be found in psychiatric facilities, jails, and prisons across the nation. In an old muffler commercial that appeared on television, the muffler man stated, "pay me now or pay me later." The muffler man speaks to prevention.

Gullatto (1994) suggested that if prevention were found effective for only 20 percent of those who would otherwise develop problems, the same number of children would be helped as are being helped with traditional treatment strategies. In other words, large-scale prevention programs could at least double the number of children who receive needed attention and have the potential to reduce the personal, social, and economic toll that accompanies maladjustment in childhood (Durlak, 1995). There is a clear argument for prevention in addressing the mental health problems of children and youth.

Clarizio (1979) estimated that approximately 30 percent of clinically dysfunctional children will also have serious adjustment problems as adults, and about 8 percent of well-adjusted children will have similar outcomes. In 1995, there were 47 million children in

elementary and secondary schools in the United States (Durlak, 1995). Of this population approximately 15 percent had clinical-level problems (7,050,000); 85 percent had only mild problems or were well-adjusted (39,950,000). Over time, 2,115,000 disturbed adults came from the 7,050,000 children (using the 30 percent continuance rate); 3,196,000 disturbed adults came from 39,950,000 children (8 percent continuance rate).

Using those estimates, the “normal” population of children contributed about 50 percent more cases than the clinically distressed population of children to the number of maladjusted adults. As the DHHS (2000) noted, the unmet need for children’s mental health services remains as high now as it was 20 years ago. The World Health Organization projected that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent. In this context, children’s mental health warrants attention in terms of understanding at the state, national, and international levels. Internationally, childhood mental health disorders are expected to be 1 of the 5 most common causes of morbidity, mortality, and disability among children.

References

Departments of Education, Health and Human Services, and Justice. (2000). *Report of the surgeon general’s conference on children’s mental health: A national action agenda*. Washington, DC: Government Printing Office.

Clarizio, H. F. (1979). *School psychologists and the mental health needs of children*. In G. D. Phye & D. J. Reschly (Eds.), *School psychology: Perspectives and Issues* (pp. 181-216). New York: Academic Press.

Durlak, J. (1995). *School-based prevention programs for children and adolescents*. Thousand Oaks, CA: SAGE Publications.

Forness, S. (2000). Schools and identification of mental health needs. *Report of the surgeon general’s conference on children’s mental health: A national action agenda*. Washington, DC: Department of Health and Human Services.

Gullatto, T. (1994). The what, who, why, where, when, and how of primary prevention. *Journal of Primary Prevention*, 15, 5-14.

Kazdin, A. (1990). Psychotherapy for children and adolescents. *Annual Review of Psychology*, 41, 21-54.

Landsverk, J. (2000). Child welfare and identification of mental health needs. *Report of the surgeon general’s conference on children’s mental health: A national action agenda*. Washington, DC: Department of Health and Human Services.

Offord, D. (2000). Identification of mental health needs. *Report of the surgeon general’s conference on children’s mental health: A national action agenda*. Washington, DC: Department of Health and Human Services.