



Vol. 18, No. 1
Feb. 2008

Children's Mental Health

Contributors

Jason Parkin, M.A.
Karen Weston, Ph.D.
Center for Advancement of Mental Health
Practices in Schools
University of Missouri

"The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them. It is time that we as a Nation took seriously the task of preventing mental health problems and treating mental illnesses in youth."

--Report of the Surgeon General's
Conference on Children's Mental Health, 1999

The poor state of children's mental health has become an increasing national concern with the publication of reports by the Surgeon General (1999) and the President's New Freedom Commission on Mental Health (2003). Approximately 20% of children and adolescents are diagnosed with mental health problems that result in mild functional impairments, and an estimated 10% have moderate to severe impairments (Duchnowski, Kutash, & Friedman, 2002; Power, Eiraldi, Clarke, Mazzuca & Krain, 2005). To make matters worse, less than 50% of children receive adequate (or any) services, especially minority children (Kataoka, Zhang, & Wells, 2002). Mental health problems can have a profound influence on children's development and affect their functioning at home, at school and in the community.

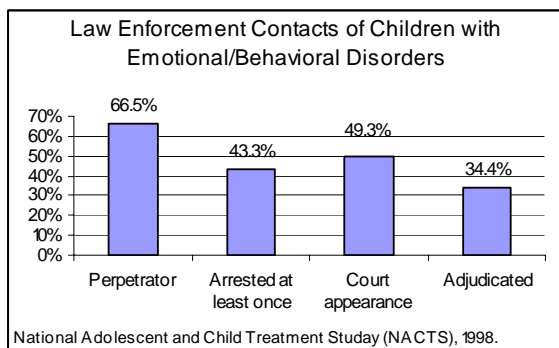
Longitudinal studies have linked mental health problems with numerous

types of aversive outcomes. For example, researchers have demonstrated that adolescents diagnosed with depressive disorders are more likely to develop later depression and anxiety problems in adulthood, display suicidal behavior, suffer from nicotine dependence, become young parents, and demonstrate academic and employment difficulties (Fergusson & Woodward, 2002). Also, persistent aggressive behavior in elementary school is strongly associated with later delinquency in adolescence (Broidy et al., 2003). Further, individuals diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) demonstrate lower levels of educational attainment and occupational success (Barkley, Fischer, Smallish & Fletcher, 2006).

Students with mental health problems are often categorized in the education system as emotionally disturbed (E/BD). According to the National Longitudinal Transition Study-2 (Wagner & Cameto, 2004), almost 75% of students with E/BD in high school report having been expelled or suspended from school at least once. During any single school year, the parents of 44% of these students report that their child has been suspended, twice the rate of students with other disabilities. In addition, during any single school year, 42% of parents report that their child with E/BD was involved in a fight, whereas a similar percentage of parents report that their child with E/BD was bullied. Academically, these students earn lower grades across *all* subject areas in comparison to their typically developing peers (Reid, Gonzalez, Nordness, Trout, & Epstein, 2004), have a

higher course failure rate, and are more likely to drop out of school than any other disability group (U.S. Department of Education, 1994). Approximately 50% of students with E/BD drop out of school, and consequently, have poor employment outcomes (U. S. Department of Education, 2001). Moreover, the pervasiveness of academic deficits does not appear to improve over time (Mattison, Hooper, & Glassberg, 2002), and may even deteriorate (Greenbaum et al., 1998) as students progress through school. Evidence suggests that a relationship between academic failure and social failure emerges early in life (Kauffman, 2001), indicating that early intervention is key.

The results from the National Adolescent and Child Treatment Study (NACTS; Greenbaum et al., 1998) are likewise discouraging (see graph below).



For example, of the 753 children with E/BD followed in the study, who had complete data on contact with law enforcement, 66.5% were reported to be involved in crimes in which they were the perpetrator. Furthermore, 43.3% of children in the study were arrested at least once, 49.3% made a court appearance before a judge, and 34.4% were adjudicated for a crime. Other studies demonstrate that, in general, youth with E/BD have more difficulty adjusting to the social demands of adult life than their typically developing or mildly-disabled peers, are more likely to be unemployed, and more likely to develop substance abuse problems (Frank, Sitlington, & Carson, 1995; Kauffman, 2001).

Use of Mental Health Services

Kataoka and colleagues (2002; Power et al., 2005) reviewed three major

surveys investigating families' use of mental health services for children between the ages of 3 and 17. They noted striking similarities in the results of these studies. They indicated that between 6% and 8% of households surveyed receive mental health services for children, with school-aged children being three times more likely to be in treatment than preschool-aged children. Boys were more likely to receive services than girls, and white children were more likely to receive services than African American and Latino children. Kataoka and colleagues concluded that only 21% of children who need mental health services actually receive it. Their synthesis strongly indicates that there is a large unmet need for children's mental health services, especially for children in minority groups.

Some research suggests that when children do receive mental health services, those services are provided by schools (Burns et al., 1995). Schools have been rapidly increasing the number and diversity of services they provide. The last 20 years have seen an enormous increase in the number of school-based health centers providing services to children (Hunter, 2004). Weist and colleagues (1999) reported that the severity of concerns treated by school-based clinics does not differ from traditional community clinics. Many of the children they serve do not appear to have a past history of mental health treatment. Their findings suggest that school-based mental health clinics may reach students who may not otherwise receive services (Weist et al., 1999).

Missouri Trends

The state of mental health among children and adolescents in Missouri is similar to U.S. averages. However, several indicators suggest a sharp increase in mental illness among Missouri youth and are cause for concern:

- The number of Missouri children that have received mental health services for serious emotional disorders has doubled from 23,310 in 2000 to 45,449 in 2005 (OSEDA, Kids Count 2006).
- According to the National Survey of Children's Health, conducted by the

Child and adolescent Health Measurement Initiative (2003), 8.7% of children ages 3-17 in Missouri have moderate or severe difficulties with emotions, concentration, behavior, and getting along with others; compared to 9.2% nationally.

- In 2003, the Missouri Department of Mental Health and/or the Department of Social Services provided mental health services to approximately 3% of children and youth between 0 and 18 years of age for serious emotional disturbances (SED) (Markward & Klein, 2005). (See updated data in [Table 1](#)). While these data suggest that a relatively small number of children are categorized as SED, the data do not account for the number of children who experience mental health problems and receive treatment in other settings (e.g., the pediatrician's office), or do not receive treatment, is unaccounted for by these.
- Results from the 2005 Youth Risk Behavior Survey (YRBS) indicate that over 25% of high school students in Missouri felt so sad or hopeless that they stopped doing some usual activities during the previous 12 months. Over 15% reported seriously considering suicide, and 7.1% reported actually attempting suicide. Alcohol use was high; 41% of Missouri students reported they drank alcohol in the previous month, and 25% reported episodic heavy drinking in the previous month. Almost one-fourth of students reported that they had their first drink before the age of 13. In the area of drug use, 18% reported having used marijuana in the last month, 12% reported use of inhalants at least once in their lives, 7% reported having used cocaine at least once, and over 6% reported having ever used methamphetamines.
- The 2007 Kids Count data reveal that among youth ages 10-17, there were 59 per 1,000 referrals for a juvenile law violation in 2005 – a

child may have multiple referrals. Research conducted at the University of Missouri indicates that approximately 70% of youth involved in the juvenile justice system have a mental health concern (Missouri Juvenile Justice Association, 2002).

- To illustrate the magnitude of the impact on Missouri public schools, in 2006 there were over 900,000 students enrolled, which means that approximately 81,000 children with moderate or severe difficulties were in attendance. An additional 90,000 students with less severe problems—but significant enough to impact school functioning—were in attendance.

Low-Income Children in Missouri:

Children living near poverty, defined as income below 200% of the federal poverty level, are particularly vulnerable to mental health problems.

- 43% (188,314) of children in Missouri under age 6 live in low-income families.
- 37% (348,284) of children age 6 or older live in low-income families.
- 5% (25,174) of low-income children live in families with no parent present.
- 2% (17,967)* of all low-income children live in families with no parent present.

Missouri's income eligibility for health insurance is among the highest in the country at 300 percent of the federal poverty level, while income eligibility for child care subsidies is the lowest in the nation at 110 percent of poverty.

Reference: *State Early Childhood Policies, Improving the Odds*, May 2007, National Center for Children in Poverty, state profiles,

www.nccp.org/projects/improvingtheodds.html

What to Do If You Suspect a Child Has a Mental Health Problem

According to the Missouri Department of Mental Health (<http://dmh.mo.gov>), parents and educators are the most likely to detect a mental illness or emotional disorder because of their

constant contact with children. Warning signs include:

- a noticeable drop in school performance
- unwarranted and persistent worry or anxiety
- an inability to cope with day-to-day problems
- frequent outbursts of anger
- changes in sleeping or eating habits
- frequent or severe aggression toward others
- an excessive fear of getting fat, of not being liked, etc., beyond the normal adolescent anxieties
- a pattern of deliberate disobedience
- Fidgeting or constant movements beyond regular playtime activities
- Pronounced difficulties with attention, concentration, and organization
- A pattern of truancy, theft, or vandalism
- Alcohol or drug abuse
- Early sexual activity or sexual promiscuity
- Persistent nightmares or physical complaints
- Marked change in sleeping habits
- Strange thoughts or feelings tied to unusual behaviors
- Self injury or talk of suicide
- Pronounced sadness lasting longer than several weeks

Facing a mental health problem in a child can be difficult and scary for parents. Professionals in schools and community agencies need to support parents and welcome them as equal partners in developing and carrying out plans for their child's mental health care. Parents, teachers, and others who work on a daily basis with children should be given information so that they can recognize problems before they become severe. If a problem is suspected, information and help can be sought from the following resources:

- The school counselor, school nurse, school social worker, or school psychologist
- The child's family doctor or pediatrician

- The local department of health
- The Missouri Department of Mental Health Network of Care (http://missouri.networkofcare.org/home_state.cfm?stateid=30) to locate mental health services in a specific location

References

- Barkley, R.A., Fischer, M., Smallish, L., & Fletcher, K. (2006). Young adult outcome of hyperactive children: Adaptive functioning in major life activities. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 192-202.
- Broidy, L.M., Nagin, D.S., Tremblay, R.E., Bates, J.E., Brame, B., Dodge, K.A., Fergusson, D., Horwood, J.L., Loeber, R., Laird, R., Lynam, D.R., Moffitt, T.E., Pettit, G.S., & Vitaro, F. (2003). Developmental trajectories of childhood disruptive behaviors and adolescent delinquency: A six-site, cross-national study. *Developmental Psychology, 39*, 222-245.
- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. Z., Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 148-159.
- Costello, E.J, Angold, A., Burns, B.J, Stangl, D.K., Tweed, D.L., Erkanli, A., Worthman, C.M., (1996a). The Great Smoky Mountains Study of Youth: Goals, design, methods, and the prevalence of DSM-III-R disorders. *Archives of General Psychiatry, 53*, 1129-1136.
- Child and Adolescent Health Measurement Initiative (2003). *National Survey of Children's Health, 2003: Missouri State Profile*. <http://nschdata.org/Content/StatePrevalence.aspx?geo=Missouri> Accessed October 1, 2006
- Cosetllo, E.J., Angold, A., Burns, B.J., Erkanli, A., Stangl, D.K., & Tweed, D.L. (1996). The Great Smoky Mountains Study of Youth: Functional impairment and serious

- emotional disturbance. *Archives of General Psychiatry*, 53, 1137-1143.
- Duchnowski, A. J., Kutash, J., & Friedman, R. M. (2002). Community-based interventions in a system of care and outcomes framework. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 16-37). New York: Oxford University Press.
- Fergusson, D.M. & Woodward, L.J. (2002). Mental health, educational and social role outcomes of adolescents with depression. *Archives of General Psychiatry*, 59, 225-231.
- Frank, A. R., Sitlington, P. L., & Carson, R. R. (1995). Young adults with behavioral disorders: A comparison with peers with mild disabilities. *Journal of Emotional and Behavioral Disorders*, 3, 156-164.
- Greenbaum, P. E., Dedrick, R. F., Friedman, R. M., Kutash, K., Brown, E. C., Lardieri, S. P., & Pugh, A. M. (1998). National Adolescent and Child Treatment Study (NACTS): Outcomes for children with serious emotional and behavioral disturbance. In M. H. Epstein, K. Kutash, and A. Duchnowski, *Outcomes for Youth with Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices*, (pp. 21-54). Austin, TX: Pro-Ed.
- Hunter, L. (2004). The value of school-based mental health services. In K. E. Robinson (Eds.), *Advances in School-Based Mental Health Interventions: Best Practices and Program Models* (pp. 1-10). Kingston, NJ: Civic Research Institute.
- Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159, 1548-1555.
- Kauffman, J. M. (2001). *Characteristics of emotional and behavioral disorders of children and youth* (8th ed.). Upper Saddle River, NJ: Merrill/Prentice Hall.
- Leaf, P. J., Alegria, M., Cohen, P., Goodman, S. H., Horwitz, S. M., Hoven, C. W., Narrow, W. E., Vanden-Kiernan, M., & Regier, D. A. (1996). Mental health service use in the community and schools: Results from the four-community MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 889-897.
- Mannuzza, S., Klein, R.G., Bessler, A., Malloy, P., & Lapidula, M. (1993). Adult outcome of hyperactive boys: Educational achievement, occupational rank, and psychiatric status. *Archives of General Psychiatry*, 50, 565-576.
- Markward, M., & Klein, T.L. (2005). *Children with serious emotional disorders*. <http://www.oseda.missouri.edu/step/vol15/no2/step0405.html>. Accessed September, 11, 2006
- Mattison, R. E., Hooper, S. R., & Glassberg, L. A. (2002). Three year course of learning disorders in special education students classified as behavioral disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 1454-1461.
- Office of Social and Economic Data Analysis: Missouri State Profile (2004). *Missouri Kids Count Data Book Online*. <http://oseda.missouri.edu/kidscount/index.html#profiles>. Accessed October 2, 2006
- Power, T.J., Eiraldi, R.B., Clarke, A.T., Mazzuca, L.B., & Krain, A.L. (2005). Improving Mental Health Service Utilization for Children and Adolescents. *School Psychology Quarterly*, 20, 187-205.
- President's New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report for the President's New Freedom Commission on Mental Health* (SMA Publication No. 03-3832). Rockville, MD: Author.

Reid, R., Gonzalez, J. E., Nordness, P. D., Trout, A., & Epstein, M. H. (2004). A meta-analysis of the academic status of students with emotional/behavioral disturbance. *The Journal of Special Education, 38* (3), 130-143.

Satcher, D. (2001). *Report of the Surgeon General's conference on children's mental health: A National Action Agenda*. Retrieved May 1, 2005, from <http://www.hhs.gov/surgeongeneral/topics/cmh/childreport.htm>.

U. S. Department of Education. (2001). *Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act*. Washington, D.C.: Author.

Wagner, M., & Cameto, R. (2004). *The characteristics, experiences, and outcomes of youth with emotional disturbances: A report of the National Longitudinal Transition Study-2. Volume 3, Issue 2*. National Center on Secondary Education and Transition, University of Minnesota: Minneapolis, MN.

Weist, M.D., Myers, C.P., Hastings, E., Ghuman, H., & Han, Y.L. (1999). Psychosocial functioning of youth receiving mental health services in the schools versus community mental health centers. *Community Mental Health Journal,*