BRIEF

Children's Mental Health

What Every Policymaker Should Know

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National Center for Children in Poverty
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The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

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Mental health is a key component in a child's healthy development; children need to be healthy in order to learn, grow, and lead productive lives. The mental health service delivery system in its current state does not sufficiently meet the needs of children and youth, and most who are in need of mental health services are not able to access them. With the addition of effective treatments, services, and supports, the mental health system can become better equipped to help children and youth with mental health problems, or those who are at risk, to thrive and live successfully.

Children's Mental Health Problems are Widespread

Mental health and substance abuse problems occur commonly among today's youth[1] and begin at a young age.[2]

- One in five children birth to 18 has a diagnosable mental disorder.[3]
- One in 10 youth has serious mental health problems that are severe enough to impair how they function at home, in school, or in the community.[4]
- The onset of major mental illness may occur as early as 7 to 11 years old.[5]
- Roughly half of all lifetime mental health disorders start by the mid-teens.[6] [7]
- Individual and enviromental risk factors that increase the likelihood of mental health problems include receiving public assistance, having unemployed or teenage parents, or being in the foster care system. These and other factors can be identified and addressed in the early years.[8]
- Among youths aged 12 to 17, 4.4 percent had serious emotional disorders in 2008.[9]
- In 2008, 9.3 percent of youths were illicit drug users, and rates of alcohol use were 3.4 percent among persons aged 12 or 13; 13.1 percent of persons aged 14 or 15; and 26.2 percent of 16- or 17-year-olds.[10]
- The rate of substance dependence or abuse among youths aged 12 to 17 was 7.6 percent, slightly higher than that of adults aged 26 or older (7.0 percent).[11]

Children and youth at increased risk for mental health problems include those in low-income households, those in the child welfare and juvenile justice systems, and those in military families.

- Twenty-one percent of low-income children and youth aged 6 to 17 have mental health problems.[12]
- Fifty-seven percent of low-income children and youth come from households living at or below the federal poverty level.[13]

A greater proportion of children and youth in the child welfare and juvenile justice systems have mental health problems than those in the general population.

- Fifty percent of children and youth in the child welfare system have mental health problems.[14]
- Youth in residential treatment centers, 69 percent of whom come from the juvenile justice and child welfare systems, have extremely high rates of mental and behavioral health disorders compared to the general population.[15]
- Sixty-seven to seventy percent of youth in the juvenile justice system have a diagnosable mental health disorder.[16]

Children and youth in military families tend to have higher rates of mental health problems than those in the general population, and those mental health problems are especially pronounced during a parent's deployment.

- Thirty-two percent of children of military families scored as "high risk" for child psychosocial morbidity, 2.5 times the national average.[17]
- There is a higher prevalence of emotional and behavioral difficulties in youth aged 11 to 17 in military families compared to the general population.[18]
- During a parent's deployment, children exhibit behavior changes including changes in school performance, lashing out in anger, disrespecting authority figures, and symptoms of depression.[19]
- Children age 3 to 5 with a deployed parent exhibit more behavioral symptoms than their peers without a deployed parent.[20]
- The rate of child maltreatment in families of enlisted Army soldiers is 42 percent higher during combat deployment than during non-deployment.[21]

Most Children and Youth with Mental Health Problems Struggle to Succeed

Children and youth with mental health problems have lower educational achievement, greater involvement with the criminal justice system, and fewer stable and longer-term placements in the child welfare system than their peers. When treated, children and youth with mental health problems fare better at home, in schools, and in their communities.

Children and youth in preschool and elementary school with mental health problems are more likely to experience problems at school, be absent, or be suspended or expelled than are children with other disabilities.

- Preschool children face expulsion rates three times higher than children in kindergarten through 12th grade, due in part to lack of attention to social-emotional needs.[22]
- African-American preschoolers are three to five times more likely to be expelled than their white, Latino, or Asian-American peers.[23]
- In the course of the school year, children with mental health problems may miss as many as 18 to 22 days.[24]
- Their rates of suspension and expulsion are three times higher than those of their peers.[25]
- Among all students, African-Americans are more likely to be suspended or expelled than their white peers (40 vs. 15 percent).[26]

When treated, children and youth with mental health problems fare better at home, in schools, and in their communities.

Youth in high school with mental health problems are more likely to fail or drop out of school.

- Up to 14 percent of youth with mental health problems receive mostly Ds and Fs (compared to seven percent for all children with disabilities).[27]
- Up to 44 percent of them drop out of high school.[28]
- Over 10 percent of high school dropouts were attributable to mental health disorders.[29]

Youth in the child welfare and juvenile justice systems with mental health issues do less well than others. In the child welfare system, children with mental health issues experience additional problems compared to those without a mental health disorder.

- They are less likely to be placed in permanent homes.[30]
- They are more likely to experience a placement change than children without a mental health disorder.[31]
- They are more likely to be placed out of home in order to access services.[32]
- They are more likely to rely on restrictive or costly services such as juvenile detention, residential treatment, and emergency rooms.[33]

Many Children and Youth are Unable to Access Needed Services

In 2007, 3.1 million youth (12.7 percent) received treatment or counseling in a specialty mental health setting for emotional or behavior problems. An additional 11.8 percent of youth received mental health services in an education setting, along with 2.9 percent who received services in a general medical setting.[34] Though this indicates that some are able to access services, it is clear that most children and youth with mental health problems do not receive needed services.

- Seventy-five to 80 percent of children and youth in need of mental health services do not receive them.[35]
- Thirty-seven to 52 percent of adolescents and young adults who were hospitalized for a suicide attempt received mental health services in the month prior.[36]
- Only 29 percent of youth expressing suicide ideation in the prior year received mental health services.[37]

Delivery of and access to mental health services and supports vary depending on the state in which a child or youth with mental health needs lives.

- There is a 30 percent difference between the states with the highest and lowest unmet need for mental health services (51 to 81 percent).[38]

Children and youth from diverse racial and ethnic groups and from families who face language barriers are often less likely to receive services for their mental health problems than white children and youth.

- Thirty-one percent of white children and youth receive mental health services.[39]
- Thirteen percent of children from diverse racial and ethnic backgrounds receive mental health services.[40]
- Non-Hispanic/Latino white children and youth have the highest rates of mental health services usage, while Asian American/Pacific Islander children have the lowest rates.[41]
- Hispanic/Latino and African-American children in urban areas receive less mental health care than their white peers.[42]
- Among children in the child welfare system, African-Americans have less access to counseling than white children.[43]

Some children and youth with the most intense needs and some who are insured do not receive mental health services.

- In juvenile detention facilities, 85 percent of youth with psychiatric disorders report at least one perceived barrier to service usage, including the belief that problems would go away without help, uncertainty about where to go, or cost of services.[44]
- Eighty-five percent of children and youth in need of mental health services in the child welfare system do not receive them.[45]

It is clear that most children and youth with mental health problems do not receive needed services.

- Privately-insured families with children in need of mental health care face significantly greater financial barriers than families with children without mental health needs.[46]
- Families with children who have mental health problems bear a disproportionate amount of coinsurance, putting an added strain on caregivers.[47]
- Seventy-nine percent of children with private health insurance and 73 percent with public health insurance have unmet mental health needs.[48]
- In the child welfare system, both privately insured and uninsured children are less likely to receive needed mental health counseling than those with public insurance.[49]

A gap also exists between need and treatment for youth with substance use disorders that sometimes occur with mental health problems.

- Only 9.3 percent of the 1.2 million youths 12 through 17 years of age in need of treatment for an illicit drug use problem in 2008 received specialty facility-based treatment.[50]
- Of the 1.2 million youths who needed treatment for an alcohol use problem, only 6.2 percent received treatment at a specialty facility.[51]

The Public Mental Health Service Delivery System Remains Largely Ineffective for Children and Youth

Even among those children and youth who are able to access mental health services, quality of care is often deficient. There is an insufficient number of providers, and many of them do not use effective, evidence-based, or empirically supported practices.

The service delivery system lacks key elements of supportive infrastructure which results in poor provider capacity and competency. Components of a strong infrastructure include provider training and retention, adequate reimbursement, strong information technology systems, and robust family involvement in policy.

- Information technology, such as electronic health records and management and accountability systems, is a key component in infrastructure that supports efficiency and quality improvements.[52]
- Despite this, there is not currently widespread use of these tools.[53]
- Family advocacy, support and education organizations (FASEOs) are frequently asked to make up for the absence or inadequacy of local mental health services, while facing fiscal fragility and uncertain sources of revenue. This results in a family advocacy network that is largely unstable.[54]

Legislative Changes on the Horizon

Recent federal legislation holds promise for increasing access to and the quality of children's mental health services. Children's Health Insurance Program Reauthorization 2009 requires that mental health and substance abuse benefits are equal to other medical benefits in health insurance. Similar provisions are included in the Patient Protection and Affordability Care 2010. Consistent with the Wellstone-Domenici Act (2008), it requires mental health and substance abuse benefits in the individual and group market to be on par with medical benefits. It makes providers of mental health and substance abuse services a high priority in the law for increasing the work-force competency and availability of community based services. The law also provides for prevention and early intervention and includes mental health as part of the quality initiatives to manage chronic conditions, along with a range of initiatives to address disparities.

Financing for children's mental health remains inadequate. While there are no current estimates of overall national spending, it is projected that federal agencies contributed nearly $6 billion to preventive services in 2007.[55] Despite this financial support, and due in large part to a deficit of flexible fiscal support for the system and for service users, quality of care suffers and many children and youth do not receive the services they need.

- Finance policies drive the capacity and quality of the services provided for children and youth with mental health conditions.[56]
- Restrictive funding streams impede the ability of system leaders to provide services based on the individual needs of the child and family within the context of their community.[57]
- Flexible funding strategies improve service innovation and increase the system's ability to provide needed services.[58]
- Service capacity overflow leads to high use of costly forms of care, such as emergency rooms.[59]

A major strategy among policymakers for attaining optimal service quality is the implementation of evidence-based practices (EBPs), which are those practices for which there is valid scientific evidence of effectiveness. States encounter many barriers in adopting EBPs in large systems, including lack of fidelity to models, mismatch between provider preparation and expectations of practice, and large variation in the ability to transport from one setting to another.[60]

- Perspectives on evidence-based practices are mixed, with some providers expressing doubts and concerns about the effectiveness of EBPs.[61]
- Service users and family members are not well-informed about EBPs, and many consider receiving care with fidelity to EBP models a tertiary concern when they experience great difficulty in obtaining any quality care at all.[62]
- State infrastructure support to implement effective practices is variable, limited in scope, pays insufficient attention to cultural needs, and lacks consistent fiscal support.[63]

Effective Policy Strategies to Enhance Mental Health for Children, Youth, and Families

- **Increase access to effective, empirically-supported practices like mental health consultation with a specific focus on young children.** Preschool children with access to mental health consultation exhibit less disruptive behavior and have lower expulsion rates.[64]
- **Develop systems to identify at-risk children.** Identifying those children and youth most at risk for poor mental health outcomes is instrumental in designing effective strategies for prevention and intervention.[65]
- **Coordinate services and hold child- and youth-serving systems accountable.** Robust service coordination in the child welfare system reduces gaps in access to services between African-American and white children and youth.[66] Outcome-based systems are better able to track youth outcomes, improve provider capacity, and tailor services.[67]
- **Finance and provide mental health services and supports that meet the developmental needs of children.** Treatment and supports using a developmental framework are more likely to respond to the changing needs of children and youth.[68]
- **Increase adoption of electronic health records, and implement information systems for quality assurance, accountability, and data sharing across providers, agencies and counties.** A system for sharing records facilitates joint planning and improves efficiency and quality of care.[69]
- **Fund and apply consistent use of effective treatments and supports.** A range of effective treatments exist to help children and youth with mental health problems to function well in home, school, and community settings.[70]
- **Engage families and youth in their own treatment planning and decisions.** Family support and family-based treatment are critical to children and youth resilience. Reaching out to community stakeholders to increase their awareness and knowledge regarding EBPs will enhance youth and family engagement, which fosters treatment effectiveness.[71]
- **Provide culturally and linguistically competent services.** Attention to providers' cultural and language competence leads to improved mental health outcomes and greater adoption of effective practices.[72]
- **Finance and implement concrete strategies to identify and prevent mental health problems and intervene early.** Empirically-supported prevention and early intervention strategies support children and youth resilience and ability to succeed.[73]
- **Ensure that the implementation of health reform recognizes the need to support a comprehensive array of benefits from prevention to treatment.** Health insurance expansion is associated with increases in access to mental health services.[74]

Endnotes

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