



**National Resource Center for  
Family-Centered Practice and Permanency Planning**  
*at the Hunter College School of Social Work*

*INFORMATION PACKET:  
Mental Health Care Issues for  
Children and Youth*

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## **Summary**

Problems in mental health affect about 4 million children and youth in the U.S. Only about 1 in 5 of these children, however, actually receive mental health services (U.S. Department of Health and Human Services, 1999). Up to 80% of children who enter foster care have serious problems with mental health (Simms, Dubowitz, & Szilagyi, 2000). The most common entry point into the mental health system is through schools. However, restrictions within legislations such as the Individuals with Disabilities Education Act (IDEA) may prevent some children in need from receiving services. Unfortunately, many youth do not receive mental health services until they enter the juvenile justice system. Limited access to and delivery of mental health services continues to be a pervasive problem. This information packet presents facts and statistics, a review of policies and legislation, best practice tips and identification of model programs, helpful web sites, and a current bibliography. It will be useful for mental health providers, policy analysts, and families of children who use mental health services.

## **Facts and Statistics**

- Current studies show that 18% to 22% of children and youth experience serious difficulty in psychosocial functioning at any given time in the U.S. (Dore, 2005)
- Between 5% and 8% of these children experience difficulties serious enough to be considered a mental illness. (Dore, 2005)
- Therefore, 4 million children and youth in the U.S. are currently in need of mental health services and treatment. (Dore, 2005)
- Only about 1 in 5 children who need mental health services actually receives them (U.S. Department of Health and Human Services, 1999).
- Children who are members of minority groups, who live in poverty, or in rural communities, are even more neglected in terms of receiving needed mental health services. (Owens et al., 2002).
- Only 4 out of the 50 states received a rating of “strength” in regards to the Child and Family Service Reviews (CFSRs), which state that children and youth of the child welfare system must

receive necessary services to meet their mental health needs . Twenty-five states reported a lack of mental health services as a challenge to meeting National standards. (Administration for Children and Families, 2002).

#### Entry points into the mental health system

- Schools are the major entry point to the mental health system for children and youth, while the mental health and general healthcare systems are the second most common providers (Farmer, Burns, Phillips, Angold, & Costello, 2003).
- Among adolescents, serious emotional or behavioral mental health problems are often identified upon entry into the juvenile justice system (Dore, 2005).

A study completed by the Substance Abuse and Mental Health Services Administration (SAMHSA) about School Mental Health Services in the United States, 2002–2003, provides the first national survey of mental health services in a representative sample of the approximately 83,000 public elementary, middle, and high schools and their associated school districts in the United States. The following information is from that study, and can be found at:

(<http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4068/exsum.asp>).

- Nearly three quarters (73 percent) of the schools reported that social, interpersonal, or family problems were the most frequent mental health problems for both male and female students.
- For males, aggression or disruptive behavior and behavior problems associated with neurological disorders were the second and third most frequent problems.
- For females, anxiety and adjustment issues were the second and third most frequent problems.
- All students, not just those in special education, were eligible to receive mental health services in the vast majority of schools (87 percent).

- More than 80 percent of schools provided assessment for mental health problems, behavior management consultation, and crisis intervention, as well as referrals to specialized programs. A majority also provided individual and group counseling, and case management.
- Financial constraints of families and inadequate school mental health resources were the most frequently cited barriers to providing mental health services.

#### Children and youth in foster care:

- Up to 80% of children who enter foster care have serious problems with mental health (Simms, Dubowitz, & Szilagyi, 2000), as compared to 18% to 22% of children diagnosed with mental health problems in the general population (Roberts; Attkisson, & Rosenblatt, 1998).
- Only 23% of children who are in foster care for at least 12 months received mental health services (National Survey of Child and Adolescent Well-Being, 2003).
- According to a recent study by the Urban Institute, foster children tend to have higher levels of behavior and emotional problems, and tend to have more physical, learning, or mental health conditions that negatively impact school performance and psychosocial functioning (Kortenkamp & Earle, 2002).

#### Mental health of youth previously in care

A recent study completed by Casey Family Programs and the Harvard Medical School (Casey Family Programs, 2005) reveals that a disproportionate number of former foster children (“alumni”) have mental health disorders as adults. The following information is from that study.

Case record reviews were conducted for 659 alumni (479 of whom were interviewed) who had been in the care of Casey Family Programs or the Oregon or Washington state child welfare agencies between 1988 and 1998. Compared to the general population, a disproportionate number of alumni had mental health disorders. Within the 12 months prior to being interviewed, their diagnoses included:

- One or more disorders: 54.4%
- Post-traumatic stress disorder (PTSD): 25.2% (a rate nearly double that of U.S. war veterans)

- Major depression: 20.1%
- Social phobia: 17.1%

### Mental Health Treatments and Services

- Some psychopharmacological interventions are established as effective in treating mental health problems in children and youth. Examples include: the use of stimulants (i.e. Ritalin) for the treatment of ADHD and the use of selective serotonin reuptake inhibitors (SSRIs) and clomipramine for obsessive-compulsive disorder in children with children (Greenhill, Halperin, & Abikoff, 1999; Emslie, Walkup, Pliszka, & Ernst, 1999).
- Evidence-based psychosocial interventions for children and youth include:
  - Cognitive-behavioral treatment for anxiety, depression, adjustment disorders, eating disorders, and conduct disorders (Kazdin, 2003),
  - Parent management training for oppositional and aggressive behaviors (McClellan & Werry, 2003).
  - Parent-child interaction therapy (PCIT) for disordered/ disorganized attachment resulting from maltreatment of early separation from birth parent (Brinkmeyer & Eyberg, 2003).
  - Family and community based approaches such as multisystemic family therapy (MST) for conduct disorder and associated comorbid disorders (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Other treatments for this disorder include multidimensional family therapy (MDFT) (Liddle et al. 2001); Pennsylvania's Child and Adolescent Service System Program (CASSP) (Lindblad-Goldberg, Jones, & Dore, 2004); and brief strategic family therapy (BSFT) for Hispanic youth (Robbins et al., 2003).
- Community-based services include intensive case management (ICM) and "wrap-around services". ICM for children collaborates with families to coordinate the provision of community services needed in the least restrictive setting possible (Dore, 2005).

- “Wrap-around services” provide extensive services to each child in all areas of functioning in order to ensure that the child remains in a community setting. A care manager, the child and family, school personnel, community partners, and mental health clinicians all contribute to developing a plan for services to achieve the specified goals.

### **Review of Policies and Legislation**

Before the 1980s, children received mental health services either from long-term care in inpatient settings (ie residential treatment centers and state psychiatric hospitals) or with outpatient treatment in a child guidance clinic, mental health center, or psychiatrist’s office. During the late 1970s and early 1980s, activists and parents of mentally ill children brought on a series of lawsuits, which cast doubt on the level of care provided in state-run institutions for the mentally and emotionally handicapped (Dore, 2005).

In 1982, the federal government initiated the Child and Adolescent Service System Program, (CASSP), designed to assist the states in developing a continuum of mental health care for children (Pumariega, Winters, & Huffine, 2003). CASSP integrated a set of principles that formed a new “system of care”, which still guides today’s services for children’s mental health in the United States. “System-of-care principles include: (1) attention to the individual needs, preferences, and cultural characteristics of the child and family; (2) use of a strengths-based, rather than deficits-based perspective; (3) involvement of families in their children’s care and in programs and system development; (4) cross-agency coordination and collaboration in service system management and service delivery; and (5) use of the least restrictive service setting that is clinically appropriate” (Dore, 2005, p. 163).

In 1992, the federal government began the Comprehensive Community Mental Health Services for Children and their Families program. This program built on CASSP, and developed 67 local systems-of-care across the nation in order to make community-based mental health services more readily available for children and families (Dore, 2005). “By 1999, more than 40,000 children and their families had received services from sites funded under this initiative” (Holden, Friedman, & Santiago, 2001).

Another important piece of federal legislation is the Education for All Handicapped Children Act (P.L. 94-142), passed in 1987 by Congress. This law regulated that children with special educational

needs, and those with mental disorders, would be schooled in their own community, mainstreamed in regular classes with additional support, and in self-contained classrooms only if necessary. The Act also mandated that all children with special educational needs would have an individualized education plan (IEP), detailing how each child's learning needs would be met by the school.

Individuals with Disabilities Education Act (IDEA), passed by Congress in 1990 and revised in 1997, replaced P.L 94-142, while keeping many of its stipulations. Under IDEA, schools may classify a child with a mental disorder either as emotionally disturbed (ED) or as other health impairment (OHI). To qualify as ED under IDEA, a child must exhibit one or more of the following conditions: (1) an inability to learn that is not explained by intellectual, health, or sensory factors; (2) an inability to build or maintain satisfactory interpersonal relationships with peers or teachers; (3) inappropriate relationships with peers or teachers; (4) a tendency to develop physical symptoms or fears associated with personal or school problems (Roberts, Jacobs, Puddy, Nyre, & Vernberg, 2003).

Current findings show that children with certain external mental health disorders may not be covered under IDEA because of the exclusionary provision for children deemed "socially maladjusted" (Dore, 2005). These "socially maladjusted" children display problems in conduct such as a tendency to be oppositional or intentionally break rules (Forness, Kavale, & Lopez, 1993). Recently, there have been efforts to change IDEA so that schools would be able to "exclude from the classroom mentally or emotionally disabled who are disruptive, including those whose diagnostic symptoms include behavioral difficulties" (American Academy of Child and Adolescent Psychiatry 2002b).

### **Best Practice Tips and Identification of Model Programs**

#### 5 Important steps to take:

The Following information is from Dore (2005) and the Academy of Child and Adolescent Psychiatry (2003).

- Offer and/or authorize an adequate assessment and treatment plan, including a full biopsychosocial, psychiatric evaluation, and plan for medication if needed.
- Assemble information from a variety of sources—including the child, family, school/day care center, doctors, other mental health workers, and other members of the community who are significant to the child.
- Maintain a network of qualified, available and licensed children’s mental health professionals, including child and adolescent social workers, psychologists, and psychiatrists.
- Support and encourage the participation of families/primary care providers in the assessment and treatment process.
- Consider the child’s interests, cultural values, strengths, potential, and limitations.

**Model Programs and Components of Best Practice:**

Transition to Independence Process (TIP) for youth with emotional and behavioral difficulties:

Retrieved from: Focal Point’s web site, Best Practices in Transition Programs for Youth with Emotional and Behavioral Difficulties by Nicole Deschenes and Hewitt B. Clark:

<http://www.rtc.pdx.edu/FPinHTML/FocalPointSP01/pgFPsp01BestPractices.shtml>

- Person-centered planning is driven by the young person's interests, strengths, and cultural and familial values.
- Services and supports must be tailored for each youth individually and must encompass all transition domains.
- Services and supports need to be coordinated to provide continuity from the young person's perspective.
- A safety net of support is provided by the young person's team.
- Achieving greater independence requires the enhancement of the young person's competencies.
- The TIP system must be outcome driven.

Guidelines for Family Provider Collaboration:

Retrieved from: The Research and Training Center and Family Support and Children's Mental Health  
Portland State University, Portland, Oregon, Promising Practices in Family-Provider Collaboration

Executive Summary: <http://www.rtc.pdx.edu/pgProjPromisingExec.shtml>

**Definition:** Family-provider collaboration in systems of care is the process that participants (including family coordinators and advocates, therapists, administrators, social workers, and case managers) in systems of care engage in to improve services for children and their families, and requires:

- ongoing dialogue on vision and goals
- attention to how power (administrative, financial, etc.) is shared;
- attention to how responsibilities in planning and decision-making are distributed;
- open and honest two-way communication and sharing of information; and
- that all participants in systems of care are seen as mutually respected equals.

**Components:** Frequently mentioned components of family-provider collaboration include:

- caring, non-blaming attitude toward the family;
- recognition of the family as a key resource;
- recognition of limits and the existence of other responsibilities;
- shared responsibility and power in the relationship, including joint decision-making and problem solving;
- support and understanding;
- practical assistance that improves families' access to services;
- open and clear information sharing; and
- professionals' readiness to alter services based on feedback from parents.
- shared vision and goals,
- shared power in decision-making at all levels, and
- long-term commitment to the process of developing collaboration.

## **Identification of web sites and resources**

### **1. The Child Welfare League of America:**

<http://www.cwla.org/programs/bhd/mhweblinks.htm>

Included is a comprehensive list of links to many top organizations and agencies that focus on child and youth mental health issues. This is a good starting place to research a specific mental health issue.

### **2. National Mental Health Information Center**

<http://www.mentalhealth.samhsa.gov/child/childhealth.asp>

NMHI is a part of the United States Department of Health and Human Services – Substance Abuse and Mental Health Services Administration. Here you will find a description of mental health topics, national government funded mental health programs, resources for more information on mental health of children, publications, and mental health in the news. NMHC is useful for mental health providers, policy makers, and consumers of mental health services and their families.

[www.nmha.org/children/justjuv/index.cfm](http://www.nmha.org/children/justjuv/index.cfm)

This Web site provides information on children with emotional disorders in the juvenile justice system.

### **3. The National Youth Violence Prevention Resource Center**

<http://www.safeyouth.org/scripts/facts/mental.asp>

This fact sheet from the national youth violence prevention resource center provides information on risk factors, prevention, intervention, and treatment of mental health problems. It also includes publications and an overview of federal programs designed to respond to children's mental health issues.

### **4. National Institute of Mental Health (NIMH)**

<http://www.nimh.nih.gov/healthinformation/childmenu.cfm>

The Mission of NIMH is to reduce the burden of mental illness through research on the mind, brain, and behavior. This website includes information of mental health disorders, treatment options, local service providers, publications, and mental health in the news.

<http://www.nimh.nih.gov/publicat/childqa.cfm#readNow>

This publication provides information on the diagnosis and treatment of children with anxiety disorders, depression, bipolar disorders, and other mental disorders. It also includes a medications chart.

#### 5. **Child Trends research brief**

<http://www.childtrends.org/files/K5Brief.pdf>

This publication includes a review of research and a table of treatments that do and do not work for different mental health disorders in adolescents.

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