



Children's Mental Health: Facts for Policymakers

NOVEMBER 2006

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. There are effective treatments, services, and supports that can help children and youth with mental health problems and those at risk to thrive and live successfully. Most children and youth in need of mental health services do not receive them.

Children's Mental Health Problems are Widespread

Mental health problems occur commonly among today's youth¹ and begin at a young age.²

One in five children has a diagnosable mental disorder.

- One in 10 youth has serious mental health problems that are severe enough to impair how they function at home, school, or in the community.
- The onset of major mental illness may occur as early as 7 to 11 years old.³
- Factors that predict mental health problems can be identified in the early years.⁴

Children and youth from low-income⁵ households are at increased risk for mental health problems.

- 21% of low-income children and youth ages 6 through 17 have mental health problems.⁶
- 57% of these low-income children and youth come from households with incomes at or below the federal poverty level.⁷

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

- 50% of children and youth in the child welfare system have mental health problems.⁸
- 67% to 70% of youth in the juvenile justice system have a diagnosable mental health disorder.⁹

Mental Health System Inadequate to Meet Needs of Children and Youth

Most children and youth with mental health problems do not receive needed services.

- 75% to 80% of children and youth in need of mental health services do not receive them.¹⁰

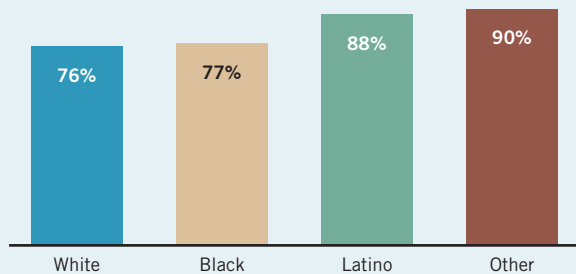
Mental health services and supports vary depending on the state in which a child or youth with mental health needs lives.

- There is a 30% difference between the states with the highest and lowest unmet need for mental health services (51% to 81%).¹¹

Latino children and youth are less likely to receive services for their mental health problems than children and youth of other ethnic groups.

- 31% of white children and youth receive mental health services.¹²
- 13% of children from diverse racial and ethnic backgrounds receive mental health services.¹³
- 88% of Latino children have unmet mental health needs. (See Figure 1.)

Figure 1: Unmet children's mental health needs, by race/ethnicity

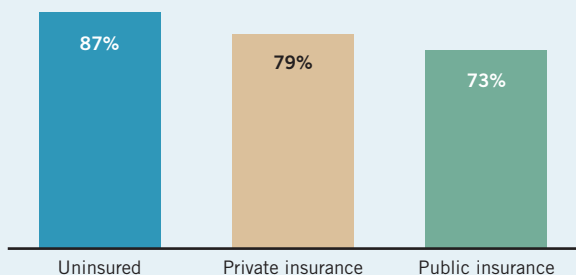


Source: Kataoka, S.; Zhang, L.; & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9), 1548-1555.

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

- 85% of children and youth in need of mental health services in the child welfare system do not receive them.¹⁴
- 79% of children with private health insurance and 73% with public health insurance have unmet mental health needs. (See Figure 2.)

Figure 2: Unmet mental health needs of U.S. children, by insurance status



Source: Kataoka, S.; Zhang, L.; & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9), 1548-1555.

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

- Less than 10% of the over 1.4 million youth between 12 through 17 years of age who needed substance abuse treatment in 2004 received specialty facility-based substance abuse treatment.¹⁵

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

Preschool children face expulsion rates three times higher than children in kindergarten through 12th grade—a factor partly attributed to lack of attention to social-emotional needs.¹⁶

- African-American preschoolers are 3 to 5 times more likely to be expelled than their white, Latino, or Asian-American peers.¹⁷

Children and youth in elementary school with mental health problems are more likely to be unhappy at school, be absent, or be suspended or expelled.

- In the course of the school year they may miss as many as 18 to 22 days.¹⁸
- Their rates of suspension and expulsion are three times higher than their peers.¹⁹
- Among all students, African-American students are more likely to be suspended or expelled than their white peers (40% vs. 15%).²⁰

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

- Up to 14% of them receive mostly Ds and Fs (compared to 7% for all children with disabilities).²¹
- Up to 44% of them drop out of school.²²

Youth in the child welfare and juvenile justice systems with mental health issues do less well than others.

- Children with mental health issues in the child welfare system are less likely to be placed in permanent homes.²³
- They are also more likely to be placed out of home in order to access services.²⁴
- They are more likely to over rely on restrictive and/or costly services such as juvenile detention, residential treatment, and emergency rooms.²⁵

- Young adults leaving the child welfare system experience major mental health problems and drug and alcohol dependence at significantly higher rates than the general population.²⁶

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

- **Improve access to mental health consultation with a specific focus on young children.** Preschools with access to mental health consultation have lower expulsion rates.²⁷
- **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.²⁸
- **Provide mental health services and supports that meet the developmental needs of children.** Treatment and supports designed using a developmental framework are more likely to respond to the changing needs of children and youth.²⁹
- **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.³⁰
- **Engage families and youth in their own treatment planning and decisions.** Family support and family-based treatment are critical to children and youth resilience. Youth and family engagement fosters treatment effectiveness.³¹
- **Provide culturally and linguistically competent services.** Attention to providers' cultural and ethnic competence leads to improved mental health outcomes and greater adoption of evidence-based practices.³²
- **Implement concrete strategies to prevent and identify mental health problems and intervene early.** Empirically supported prevention and early intervention strategies support children and youth resilience and ability to succeed.³³

Endnotes

This fact sheet was prepared by Rachel Masi and Janice Cooper.

1. Children ages 12–17 are classified as youth in this fact sheet.
2. New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration <www.mentalhealthcommission.gov/reports/reports.htm>.
3. Kessler, R. C.; Beglund, P.; Demler, O.; Jin, R.; & Walters, E. E. (2005). Lifetime prevalence and the age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), pp. 593-602.
4. Knitzer, J. & Lefkowitz, J. (2006). *Helping the most vulnerable infants, toddlers, and their families* (Pathways to Early School Success Issue Brief No. 1). New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health.
5. The current federal poverty level for a family of 4 is \$20,000. Low-income families make up to twice that amount. For more information on measuring poverty, see NCCP's state profiles at <www.nccp.org> and the U.S. Department of Health and Human Services <www.aspe.hhs.gov/poverty/06poverty.shtml>.
6. Howell, E. (2004). *Access to children's mental health services under Medicaid and SCHIP*. Washington, D.C.: Urban Institute.
7. Ibid.
8. Burns, B.; Phillips, S.; Wagner, H.; Barth, R.; Kolko, D.; Campbell, Y.; & Yandsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8), pp. 960-970.
9. Skowrya, K. R. & Coccozza, J. J. (2006). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. Delmar, NY: The National Center for Mental Health (NCMHJJ) and Policy Research Associates, Inc. <www.ncmhjj.com/Blueprint/pdfs/Blueprint.pdf>.
10. Kataoka, S.; Zhang, L.; & Wells, K. (2002). Unmet need for mental health care among U.S. Children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9), pp. 1548-1555.
11. U.S. Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Statistics (OAS). (2004). Youth substance use and family income (National Survey on Drug Use and Health). *The NSDUH Report*, Dec 24 <www.oas.samhsa.gov/2k4/youthIncome/youthIncome.htm> and Sturm, R.; Ringel, J. S.; & Andreyeva, T. (2003). Geographic disparities in children's mental health care. *Pediatrics*, 112(4), p. 308.
12. Ringel, J. S. & Sturm, R. (2001). National estimates of mental health utilization for children in 1998. *Journal of Behavioral Health Services & Research*, 28(3), pp. 319-333.
13. Ibid.
14. See Burns et al., in Endnote 8.
15. U.S. Substance Abuse and Mental Health Administration (SAMHSA), Office of Applied Studies (OAS). (2005). *Results from the 2004 National Survey on Drug Use and Health: National findings* <www.drugabusestatistics.samhsa.gov/nsduh.htm#NSDUHinfo>.
16. Gilliam, W. S. (2005). *Prekindergartens left behind: Expulsion rates in state prekindergarten programs* (FCD Policy Brief Series 3). New York, NY: Foundation for Child Development <www.fcd-us.org/PDFs/NationalPreKExpulsionPaper03.02_new.pdf>.

17. Ibid.
18. Blackorby, J. & Cameto, R. (2004). Changes in school engagement and academic performance of students with disabilities. In *Wave 1 Wave 2 Overview* (SEELS) (pp. 8.1-8.23). Menlo Park, CA: SRI International.
19. Ibid.
20. Ibid.
21. Blackorby, J.; Cohorst, M.; Garza, N.; & Guzman, A. (2003). The academic performance of secondary school students with disabilities. In *The Achievements of Youth with Disabilities During Secondary School*. Menlo Park, CA: SRI International.
22. Wagner, M. (2005). Youth with disabilities leaving secondary school. In *Changes Over Time in the Early Post School Outcomes of Youth with Disabilities: A Report of Findings from the National Longitudinal Transition Study (NTLS) and the National Longitudinal Transition Study-2 (NTLS2)* (pp. 2.1-2.6). Menlo Park, CA: SRI International.
23. Smithgall, C.; Gladden, R. M.; Yang, D. H.; & Goerge, R. (2005). *Behavioral problems and educational disruptions among children in out-of-home care in Chicago* (Chapin Hall Working Paper). Chicago, IL: Chapin Hall Center for Children at the University of Chicago <www.chapinhall.org/article_abstract.aspx?ar=1415&L2=61&L3=130>.
24. Hurlburt, M. S.; Leslie, L. K.; Landsverk, J.; Barth, R.; Burns, B.; Gibbons, R. D.; Slymen, D. J.; & Zhang, J. (2004). Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry*, 61(12), pp. 1217-1224.
25. U.S. House of Representatives, Committee on Government Reform, Minority Staff Special Investigations Division. (2004). *Incarceration of youth who are waiting for community mental health services in the United States* (Report prepared for Rep. Henry A. Waxman and Sen. Susan Collins). Washington, DC: U.S. House of Representatives, Committee on Government Reform <www.democrats.reform.house.gov/Documents/20040817121901-25170.pdf>; Pottick, K.; Warner, L. A.; & Yoder, K. A. (2005). Youths living away from families in the US mental health system: Opportunities for targeted intervention. *Journal of Behavioral Health Services & Research*, 32(2), pp. 264-281; and Almgren, G. & Marcenko, M. O. (2001). Emergency room use among foster care sample: The influence of placement history, chronic illness, psychiatric diagnosis, and care factors. *Brief Treatment and Crisis Intervention*, 1(1), pp. 55-64.
26. Pecora, P. J.; Williams, J.; Kessler, R.; Downs, C.; O'Brien, K.; Hiripi, E.; & Morello, S. (2003). *Assessing the effects of foster care: Early results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs <www.casey.org/Resources/Publications/NationalAlumniStudy.htm>.
27. See Gilliam in Endnote 16.
28. See Hurlburt et al., in Endnote 24.
29. Knitzer, J. & Cohen, E. (Forthcoming). *Promoting resilience in young children at the highest risk: The challenge for early childhood mental health* and Horner, R. H.; Sugai, G.; Todd, A. W.; & Lewis-Palmer, T. (2005). Schoolwide positive behavior support. In L. Bambara & L. Kern (Eds.), *Individualized Supports for Students with Problem Behaviors*. New York, NY: The Guilford Press.
30. Yannacci, J. & Rivard, J. C. (2006). *Matrix of children's evidence-based interventions*. Alexandria, VA: Centers for Mental Health Quality and Accountability, NASMHPD Research Institute.
31. McKay, M. M.; Hibbert, R.; Hoagwood, K.; Rodriguez, J.; Murray, L.; Legerski, J.; et al. (2004). Integrating evidence-based engagement interventions into "real world" child mental health settings. *Brief Treatment and Crisis Intervention*, 4(2), pp.177-186 and Christenson, S. L. & Hays, L. H. (2004). Family-school-peer relationships: Significance for social, emotional, and academic learning. In J. E. Zins, R. P. Weissberg, M. C. Wang & H. J. Walberg (Eds.), *Building Academic Success on Social and Emotional Learning: What Does the Research Say?* (pp. 59-75). New York, NY: Teachers College Press.
32. Halliday-Boykins, C.; Schoenwald, S.; & Letourneau, E. J. (2005). Caregiver therapist ethnic similarity predicts youth outcomes from an empirically based treatment. *Journal of Clinical Child and Adolescent Psychology*, 34(5), pp. 808-818 and Schoenwald, S.; Letourneau, E. J.; & Halliday-Boykins, C. (2005). Predicting therapist adherence to transported family-based treatment for youth. *Journal of Clinical Child and Adolescent Psychology*, 34(4), pp. 658-670.
33. Masten, A. S. & Powell, J. L. (2003). A resilience framework for research, policy, and practice. In S. S. Luthar (Ed.), *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities*. New York, NY: Cambridge University Press; Fergus, S. & Zimmerman, M. A. (2004). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annual Review of Public Health*, 26, pp. 399-419; and Greenberg, M. T.; Domitrovich, C.; & Bumbarger, B. (2000). The prevention of mental disorders in school-aged children: Current state of the field. *Prevention & Treatment*, 4(1), unpaginated.