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Prevalence and Costs of Mental Illness

It is estimated that 1 out of 10 children in the US have a mental illness severe enough to cause significant functional impairment; the incidence is believed to increase to 2 out of 10 when considering mental disorders that cause at least some impairment. However, fewer than one in five of these children receive needed treatment (Greenberg et. al. 2001). Like many other diseases, early diagnosis and intervention is often crucial to minimize further complications throughout childhood and into adulthood.

In 2002, there were nearly 420,000 children in Texas who suffered from mental illness significant enough to impair their social, home, and academic functioning (Mental Health Association in Texas 2005). Of these, 151,000 were eligible to receive mental health services through the Texas Department of Mental Health and Mental Retardation, but only 26% of those that were eligible actually received these services (Mental Health Association in Texas 2005). In 2002, Bexar County had 10,147 children who suffered from mental illness significant enough to impair their social, home, and academic functioning, but only 20% of those who needed services and were eligible and received care, a rate lower than Dallas, El Paso, Harris, and Travis Counties (Mental Health Association in Texas 2005).

Most disorders are diagnosed after the child's sixth birthday but signs of mental health problems may be evident in some children as early as infancy. In a national study of child mental health service recipients, 9% were under 6 years of age, 40% were between the ages of 6 and 12, and 51% were between 13 and 17 (The Annie E. Casey Foundation 2005).

The presence of mental illnesses is often linked to social, academic, and legal problems for many youth. According to the Texas Youth Commission, approximately 50% of adolescents in the judicial system have been diagnosed with a mental illness, and 20% are under the care of psychotropic medication for their illness (Mental Health Association in Texas 2005). Limited access to mental health services causes further burden on the state and families. In 2002, there were 244 children whose parents relinquished custody of them to the state, 82% of these relinquishments were a last resort measure by the parents because they had no other way to access mental healthcare (Mental Health Association in Texas 2005). It is estimated that the cost to care for these children as wards of the state is \$9.7 million as compared to the cost of providing the mental health care these children were unable to access, \$6.3 million (Mental Health Association in Texas 2005). In 1990 alone, it was estimated that mental illness cost the United States 74.9 billion dollars (Greenberg et. al. 2001). Another implication of increased mental illness and a lack of proper treatment are increased rates of suicide among youth. In Texas, there are 1 ½ times more suicides than homicides, and of the suicides carried out, 90% are related to under-treated mental illness. In Bexar County in 2001 alone, 27 young people committed suicide (Mental Health Association in Texas 2005).

Common Diagnoses in Children

One of the most common types of mental illness is disruptive behavior disorder, such as Attention Deficit Hyperactivity Disorder, with 31% of all youth receiving mental health services being diagnosed as such (The Annie E. Casey

Foundation 2005). Between 3 and 5 percent of all youth ages 9-17 are believed to suffer from ADHD; this means that in a typical classroom of 25 to 30 children, it is likely that one or more of those children will be suffering from ADHD (National Institute of Mental Health 2005). ADHD can often be detected as early as preschool. A child with ADHD is often characterized by an inability to stay focused on activity, constant fidgeting, excessive talking, and trouble paying attention and following instructions (National Institute of Neurological Disorders and Stroke 2003). Treatment for ADHD typically consists of behavioral therapy to control impulsive behavior and stimulants, such as Ritalin.

Another of the more common forms of mental illness present in children and adolescents are mood disorders, which include depressive disorders and bipolar disorders. Depressive disorders affect approximately 5% of children, and the number of children suffering from bipolar disorder is unknown (National Institute of Mental Health 2005b, Goldman 2005). Of the children receiving mental health services in the United States, 21% have a mood disorder (The Annie E. Casey Foundation 2005). Symptoms for these disorders include intense sadness and despair, hopelessness, loss of pleasure in activities that had once been enjoyable, and severe mood swings (The Annie E. Casey Foundation 2005). Depression is also highly linked to genetic factors. Between 20% and 50% of depressed children and adolescents have a family history of depression, and children of depressed parents are over three times as likely as children of nondepressed parents to be diagnosed with a depressive disorder (Children and Mental Health). Typical treatment for mood disorders includes medication, such as selective serotonin reuptake inhibitors, mood stabilizers, antidepressants, and psychotherapy for such disorders. However, the use of antidepressants has come under fire due to a possible increase in suicidal behavior seen in children using these drugs. The US Food and Drug Administration and the National Institute of Mental Health have since issued warnings relating to all antidepressants used for depression in children (National Institute of Mental Health 2005). In

fact, the only antidepressants currently allowed for children under age 18 are Anafranil, Luvox, Sinequan, Tofranil, and Zoloft. Most importantly, the hugely popular and widely subscribed SSRIs, Paxil and Prozac are now not approved for anyone under the age of 18 (National Institute of Mental Health 2005c).

The third most common form of mental illness among youth is adjustment disorder, affecting 16% of youth admitted for mental health services in the U.S. (The Annie E. Casey Foundation 2005). Adjustment behavior is characterized as a response to an identifiable psychosocial stressor and includes symptoms such as anxiety, misconduct, and a depressed mood.

Contributing Factors

Both biological factors and personal experiences impact the emergence of mental illness among children. Some of the more common risk factors for mental health problems among children are:

- Prenatal exposure to drug, alcohol, and tobacco
- Low birth weight
- An inherited predisposition to a mental disorder
- Poverty
- Abuse or neglect
- Inadequate parental bonding
- Exposure to traumatic events
- Interpersonal problems
- School problems
- Developmental delays
- Emotional difficulties

(U.S. Surgeon General 1999, Greenberg et al. 2001).

Early Detection and Intervention

The following quote epitomizes the importance of prevention for the field of mental health. "Cancer treatment is more effective when the disease is caught early. Ditto for heart disease that's treated before a stroke or a heart attack. But, in mental health, most patients suffer for months or years before doctors intervene" (Johnson 2005). Over the past decade or so, prevention of mental illness in children has slowly become a priority. This is evidenced by

a paradigm shift of federal agencies in their policy, practice, and research (Greenberg et. al. 2001). To reduce the large number of America's youth with mental illness problems, therapeutic interventions need to begin earlier, and ideally, these interventions should be provided to at risk populations prior to the development of symptomology. As the system stands currently, many children do not become eligible for clinical care until it is mandated by a juvenile court.

There are three categories of prevention. Universal preventative interventions include the general public or a large population group. Selective interventions target individuals or subgroups whose risk of developing a mental disorder is higher than average; and indicated interventions target people who have biological markers and sub-threshold symptoms for mental illness but do not yet meet diagnostic criteria. The following are a few specific interventions that have been tested for their effectiveness (Greenberg et. al. 2001).

The Coping with Stress Program attempted to prevent depression in a sample of high school students. After the 15 session intervention, their analyses through 12 months post intervention indicated that there were significantly fewer cases of Major Depressive Disorder or Dysthymia in the experimental condition compared to the controls. Another promising finding is a study that used two popular suicide prevention programs, a C-CARE group, a C-CARE plus CAST group, and a "care as usual" control group to test these intervention's affects on suicidality. All three groups showed significant decreases in suicide risk behaviors and anger problems, and both groups of interventions reported lower levels of depression and higher self-esteem when compared to the control group. Additionally, subjects that received the CAST intervention along with the CARE intervention evidenced significant improvements in problem solving, self control, and perceived family support (Greenberg et. al. 2001). Another promising program, the Primary Mental Health Project, has a 42 year history of early detection and prevention of young children's adjustment problems; the catalyst to

many mental disorders. PMHP specifically addresses emotional and behavioral problems such as aggression and withdrawal that hinder successful learning. Though screening, PMHP selects students with adjustment problems, who then receive services through an individualized program. This program includes school mental health professionals, the child's family, and the homeroom teacher. Students are seen in groups or individually once or twice a week for short 30 to 60 minute sessions. These training sessions focus on improving both learning and social skills and have yielded promising results. Significant improvements in grades and test scores, a reduction in acting out, shyness, and anxious behaviors, and increased frustration tolerances were shown (Mental Health: A Report of the Surgeon General, Primary Mental Health Project 2005).

Initiatives such as these are on the right track to preventing mental illness. It is imperative that prevention programs and early interventions address universal, selective, and indicated levels of influence to be effective. Making resources available at all levels such as communities, schools, families, and individuals is critical to the progress of prevention and early intervention. Many experts see children more much more resilient with regard to mental health and life circumstances than adults are. However, resiliency requires early and sufficient intervention to reduce the long-term effects of an issue.

Resources for Treatment

Resources for the treatment of mental illness include the Texas Department of Health Services, Medicaid, and CHIP. Over 57% of the children treated for mental health problems in U.S. in 1997 were poor, with 42% having their care paid for by Medicaid, 31% through private insurance, and 10% through some other public insurance (The Annie E. Casey Foundation 2005). The Texas Department State Health Services provides services for children and adolescents ages 3 through 17 years with a diagnosis of mental illness, but only if they exhibit serious emotional, behavioral, or mental disorders (Texas Department of State Health Services 2005). They do not provide for the

treatment of less severe mental disorders and have recently seen some funding cuts as well. Medicaid continues to provide for mental health services, but because it is a program for the indigent, many who do not qualify still go untreated. The Texas Children's Health Insurance Program was intended to pick up those that fell through the cracks of the state mental health system, especially after the cuts to the Texas Department of Health Services program. However, during the 78th Legislative session, all but the most basic mental health care were slashed. However, through a grant from the U.S. Department of Health and Human Services, mental health services have been partially reinstated to include:

- 30 days of inpatient mental health treatment per year;
- 30 outpatient visits for mental health treatment per year;
- Substance abuse detoxification services and 30 days of residential treatment;
- 30 outpatient visits for substance abuse treatment per year.

(Children's Defense Fund 2003).

Other community resources that are available for mental health treatment at a reduced or sliding fee include: Center for Healthcare Services, Alamo Children's Advocacy Center, Benitia Center, Child Guidance Center, House of Neighborly Services, and the Mental Health Association. Given the complexity of the mental health needs of children and their families it is important to emphasize that there is no single solution to address the mental health needs of children. It is through comprehensive prevention and intervention efforts that children's mental health problems can be better prevented and addressed. It is important for communities to offer an array of services and approaches and coordinate them to have improved outcomes for children and families.

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