# INTRODUCTION



## Background of Child and Adolescent Mental Health

The recognition that children and adolescents suffer from mental health disorders is a relatively recent development. Throughout history, childhood was considered a happy period. Children were not thought to suffer from mental disorders or emotional distresses, due to the notion that they were spared the stresses that afflict adults (American Psychiatric Association [APA], 2002). It is now well-recognized that these disorders are not just a stage of childhood or adolescence, but are a result of genetic, developmental, and physiological factors.

Research conducted in the 1960s revealed that children suffer from mental disorders (APA, 2002), but it was not until 1980, when the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* was published by the APA, that child and adolescent mental disorders were assigned a separate and distinct section within the classification system (National Institute of Mental Health [NIMH], 2001). The development of treatments, services, and methods for preventing mental health disorders in children and adolescents has also evolved over the past several decades.

The National Alliance for the Mentally Ill (NAMI) defines mental illness as a disorder of the brain that may disrupt a person's thinking, feeling, moods, and ability to relate to others (2005). Mental health disorders appear in families of all social classes and backgrounds. However, there are children at greater risk due to other factors. These include physical problems, intellectual disability, low birth weight, family history of mental and addictive disorders, multigenerational poverty, and caregiver separation or abuse and neglect (U.S. Department of Health and Human Services, 1999). Risk factors and causal influences for mental health disorders in youth vary, depending on the specific disorder.

Child and adolescent mental health has emerged as a distinct arena for service delivery, drawing on the philosophies and practices that characterize other childhood fields, such as early intervention (Woodruff et al., 1999). With the increased attention given to children's mental health and the development of systems of care for children with serious emotional disorders and their families in the last two decades, mental health has emerged as a new focus in the field of early childhood (Woodruff et al.). Family members, practitioners, and researchers have become increasingly aware that mental health services are an important and necessary support for youth who experience mental, emotional, or behavioral challenges and their families.

## Epidemiology and Burden of Child and Adolescent Mental Health Problems

According to the President's New Freedom Commission on Mental Health, childhood is a critical time for the onset of behavioral and emotional disorders (2003). The Center for Mental Health Services estimates that 11 percent of children in the United States have at least one

significant mental health disorder accompanied by impairment in home, school or peer contexts (U.S. Department of Health and Human Services, 2001).

According to the NIMH, half of all lifelong cases of mental health disorders begin by age 14 (Archives of General Psychiatry, as cited by the NIMH, 2005). Moreover, NIMH noted that there are frequently long delays between the first onset of symptoms and the point when people seek and receive treatment. In addition, this study noted that a mental health disorder left untreated could lead to a more severe, more difficult-to-treat illness and to the development of co-occurring mental health disorders. Nearly half of all individuals with one mental disorder met the criteria for two or more disorders (NIMH).

According to InCrisis (2005), the 2000 U.S. Census Report and the Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA) Study found that 8.4 million children ages 9 to 17 have had a diagnosable mental or addictive disorder associated with at least minimal impairment. This translates to a prevalence of almost 21 percent, or one in five children. These estimates would suggest that as many as 4.3 million youth suffer from a mental health disorder that results in significant impairments at home, at school, or with peers and that there are two million who experience severe functional impairments.

There has been little research to measure the financial burden of mental health disorders in children and adolescents. However, a team of researchers analyzed various data sources to locate information on the utilization and costs associated with mental health disorders in youth. This review was conducted using data from 1998, with focus on youth up to 17 years of age. It was estimated that the direct costs for the treatment of child mental health problems, both emotional and behavioral, were approximately $11.75 billion, or $173 per child (Sturm et al. 2001; Ringel & Sturm, 2001). This study pointed to two of many reasons why national health expenditures for child and adolescent mental disorders are difficult to estimate, including:

1. mental health services are delivered and paid for in the health, mental health, education, child welfare, and juvenile justice systems; and
2. no comprehensive national datasets exist in this area.

Child and adolescent preventive interventions have the potential to significantly reduce the economic burden of mental health disorders by reducing the need for mental health and related services. Further, such interventions can result in improvements in school readiness, health status, and academic achievement and reductions in the need for special education services (National Institute for Health Care Management, 2005). These interventions also translate into societal savings by lessening parents' dependence on welfare and by increasing educational attainment and economic productivity (National Institute for Health Care Management).

***Serious Emotional Disturbance***

A particular population of children with more severe functional limitations is identified by federal regulations as suffering from a serious emotional disturbance (SED). The term "serious emotional disturbance" is used in a variety of federal statutes in reference to a diagnosable mental health problem which severely disrupts a youth's ability to function socially, academically, and emotionally. Studies have documented that 4 to 16 percent of youth ages 9 to 17 meet SED criteria, depending upon how the criteria are defined (Costello, Messer, Bird, Cohen & Reinherz, 1998). Definitions of SED are bounded by federal legislation and regulation, though states may provide additional guidance to professionals.

Virginia's Department of Behavioral Health and Developmental Services (DBHDS, 2009) outlines the following criteria for SED:

- problems in personality development and social functioning that have been exhibited over at least one year's time;
- problems that are significantly disabling, based on the social functioning of most children of the child's age;
- problems that have become more disabling over time; and
- service needs require significant intervention by more than one agency.

DBHDS estimates that between 84,978 and 103,861 Virginia children and adolescents have SED, with between 47,210 and 66,098 exhibiting extreme impairment (2011). In addition, 73,890 Virginians (age six and older) have intellectual disability and 18,427 infants, toddlers, and young children (birth to age 5) have developmental delays requiring early intervention services. Recent estimates by the Centers for Disease Control and Prevention's National Center for Health Statistics are that one in 91 children has an autism spectrum disorder (DBHDS).

## Providing Optimal Treatment

The acknowledgment of mental health needs in youth has prompted further study on a variety of disorders and their causes, prevention, and treatments. Child and adolescent mental health represents a major federal public health priority, as reflected in the U.S. Surgeon General's *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (2000). The report outlines the following three steps which must be taken to improve services for children with mental health needs:

1. improving early recognition and appropriate identification of disorders within all systems serving children;
2. improving access to services by removing barriers faced by families; and
3. closing the gap between research and practice to ensure evidence-based treatments for children.

Without appropriate treatment, childhood mental health disorders can escalate. Untreated childhood mental health disorders may also be precursors of school failure, involvement in the juvenile justice system, and/or placement outside of the home. Other serious outcomes include destructive, ambiguous, or dangerous behaviors, in addition to mounting parental frustration. The resulting cost to society is high in both human and financial terms. Identifying a child's serious emotional disturbance early and ensuring that the child receives appropriate care can break the cycle (New Freedom Commission on Mental Health, 2003).

## Identifying and Encouraging the Use of Evidence-based Treatments

There have been more than two decades of research in treating children and adolescents' mental health disorders. However, there are challenges to helping families and clinicians select the best treatments. The field of child and adolescent mental health is multi-disciplinary, with a diverse service system. Today there are a multitude of theories about which treatments work best, making it is very difficult for service providers to make informed choices. Scientific evidence can serve as a guide for families, clinicians, and other mental health decision-makers. Interventions with strong empirical support are variously referred to as empirically validated treatments, empirically supported treatments, evidence-based treatments, and evidence-based practices. All terms attempt to capture the notion that the treatment or practice has been tested and that its effects have been demonstrated scientifically.

### *Benefits of Evidence-Based Treatments*

Evidence-based medicine evolved out of the understanding that decisions about the care of individual patients should involve the conscientious and judicious use of current best evidence (Fonagy, 2000). Evidence-based treatments allow patients, clinicians, and families to see the differences between alternative treatment decisions and to ascertain what treatment approach best facilitates successful outcomes (Donald, 2002). Treatments that are evidence-based and research-driven complement a clinician's experience in practice. Evidence-based medicine has significantly aided clinicians in the decision-making process by providing a fair, scientifically rigorous method of evaluating treatment options.

Evidence-based medicine has also assisted professional bodies in developing clearer and more concise working practices, as well as in establishing treatment guidelines. The accumulated data for these treatments support their consideration as first-line treatment options (Nock, Goldman, Wang & Albano, 2004). With literally hundreds of treatment approaches available for some disorders, it is difficult for clinicians to select the most appropriate and effective intervention

(Nock et al.). The strongest argument in support of evidence-based practices is that it enables clinicians to identify the best-evaluated methods of health care.

Another driving force in the utilization of evidence-based medicine is the potential for cost savings (Fonagy, 2000). With rising awareness of mental health issues and a demand by consumers to obtain the best treatment for the best price, the emphasis on evidence-based practices is both practical and justified. Few people have time to conduct research in order to evaluate best practices. Evidence-based medicine provides a structured process for clinicians and patients to access information on what is effective.

***Limitations of Evidence-Based Treatments***

There are stakeholders in the field of children's mental health who have regarded the evidence-based treatment movement with skepticism. According to Michael Southam-Gerow, Assistant Professor of Clinical Psychology and Director, Graduate Studies at the Department of Psychology at Virginia Commonwealth University, there are several criticisms surrounding the utilization of evidence-based treatments (Personal Communication, December 15, 2009). These include the following:

1. There is too much information, making it difficult for a service provider to choose a treatment among many that may be supported for a particular problem.
2. There is too little information and there are distinct problem areas for which there is still very little known.
3. The evidence is inadequate and it has been argued that there is insufficient supportive data to favor one treatment versus another. Further, the long-term effects of many treatments are unknown. This criticism suggests that more studies are needed before treatments are categorized as being evidence-based.
4. Because a treatment has not been tested does not mean it is not effective. Some commonly-used treatments are not deemed to be evidence-based treatment because they have not been tested.

## Background of the *Collection*

The 2002 General Assembly, through Senate Joint Resolution 99, directed the Virginia Commission on Youth to coordinate the collection of treatments recognized as effective for children and adolescents, including juvenile offenders, with mental health disorders. The resulting publication, the *Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs (Collection)* was compiled by the Commission on Youth with the assistance of an advisory group of experts.

In 2003, the General Assembly passed Senate Joint Resolution 358, requiring the Commission to update the *Collection* biennially. The resolution also required the Commission to disseminate the *Collection* via web technologies. As specified in this resolution, the Commission received assistance disseminating the *Collection* from the Advisory Group and other impacted agencies. This publication, the *Collection 5th Edition,* provides an updated listing of evidence-based practices for youth with mental health disorders. *The Collection 5th Edition* is for parents, caregivers, educators, service providers and others seeking current research on evidence-based practices.

## Using the *Collection 5th Edition*

With the limitations of evidence-based treatments in mind, the *Collection 5th Edition* has been updated to reflect the current state of the science. It has been developed and updated to provide information to families, clinicians, administrators, policymakers and others seeking information about evidence-based practices for child and adolescent mental health disorders. The *Collection 5th Edition* has four categories that represent different levels of scientific support for a particular treatment. These levels are summarized in Table 1. Because research is ongoing, treatments are expected to move around among the categories with time.

*Table 1*

## Treatment Categories Used in *Collection 5th Edition*

| Levels of Scientific Support | Description |
|---|---|
| What Works | Meet all of the following criteria:<br>1. Tested across two or more randomized controlled trials (RCTs);<br>2. At least two different investigators (i.e., researcher);<br>3. Use of a treatment manual in the case of psychological treatments; and<br>4. At least one study demonstrates that the treatment is superior to an active treatment or placebo (i.e., not just studies comparing the treatment to a waitlist). |
| What Seems to Work | Meet all but one of the criteria for "What Works." |
| What Does Not Work | Meet none of the criteria above but meet either of the following criteria:<br>1. Found to be inferior to another treatment in an RCT; and/or<br>2. Demonstrated to cause harm in a clinical study. |
| Not Adequately Tested | Meet none of the criteria for any of the above categories, but have been tested. It is possible that such treatments have demonstrated some effectiveness in non RCT studies, but their potency compared to other treatments is unknown. It is also possible that these treatments were tested and tried with another treatment. These treatments may be helpful, but would not be currently recommended as a first-line treatment. |
| Untested | Occasionally a treatment may be included that, though sometimes used in clinical practice, has not been tested. Treatment meets the criteria for none of the above categories because it is untested. The benefits and risks are unknown and caution (for providers or administrators) is suggested in applying them and or (for families) in receiving such treatment. |

Source: Virginia Commission on Youth Graphic, 2010.

The *Collection 5th Edition* also includes information on assessment in order to emphasize that all clinical decisions should be made in consultation with the data. Accordingly, data should be collected to justify treatment plans, changes in treatment plans, and terminations. Clinicians and mental health treatment organizations are becoming both data-driven and data collectors, allowing for greater opportunities for outcome measures to be collected and reviewed over time.

### *Revisions Made in Collection 5th Edition*

The *Collection* provides information that represents the medical model, the traditional approach to the diagnosis and treatment of medical conditions. This model focuses on the physical and biological aspects of specific diseases and conditions. However, the medical model does not incorporate changes in the language or methods used for communicating and interacting with individuals with developmental disabilities. In interacting with youth with developmental disabilities, a service provider can use "person-centered" planning and approaches to focus on emotional and support needs. Person-centered practices promote individualized treatment and service plans, in addition to emphasizing individualized outcomes and the participation of the individual in their treatment planning. Further, these plans focus on the services needed for the youth to address his or her mental health disorder and to lead successful integrated lives in their community (National Association of State Mental Health Program Directors, 2004).

In response to the above-referenced finding, the Commission on Youth adopted the following recommendations at its November 2011 meeting:

1. The Commission on Youth will revise the Autism Spectrum Disorders and Intellectual Disability sections of the *Collection 4th Edition* and limit these sections to discussion of co-occurring mental health disorders.
2. The Commission on Youth will add a disclaimer to the *Collection 5th Edition* to acknowledge that Intellectual Disability and Autism Spectrum Disorders are developmental disorders.
3. The Commission on Youth will convene the Advisory Group prior to the 2013 biennial update and discuss further modifying the Intellectual Disability and Autism Spectrum Disorders sections to include best practices in service delivery for developmental disabilities.

Accordingly, information included in the "Developmental Disabilities" section of the *Collection 5th Edition* is provided in response to these recommendations. The *Collection 5th Edition* has been modified to classify Autism Spectrum Disorders (ASD) and Intellectual Disability as developmental disorders and to provide information about mental health disorders which may co-occur with these developmental disorders. The disorders included in this and in previous editions are presented as classified in the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (*DSM-IV-TR*) of the American Psychiatric Association (APA): *Disorders usually categorized as disorders first diagnosed in infancy, childhood, or adolescence.*

## Conclusion

Effective mental health treatments which have undergone testing in both controlled research trials and real-world settings are available for a wide range of diagnosed mental health disorders. The *Collection 5th Edition* is designed to encourage use of these treatments by professionals providing mental health treatments. The *Collection 5th Edition* is also designed to inform parents, caregivers, and other stakeholders by providing general information about the various disorders and problems affecting children and adolescents.

Evidence-based treatments have been developed with the express purpose of improving the treatment of child and adolescent mental health disorders (Nock et al., 2004). Clinicians can incorporate these well-documented treatments, while still adequately addressing the individual differences of the patient (Nock et al.).

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## Organizations

**American Association of Child & Adolescent Psychiatry (AACAP)**
http://www.aacap.org

**American Psychiatric Association (APA)**
http://www.psych.org
http://www.parentsmedguide.org

**American Psychological Association (APA)**
www.apa.org

**Center for Effective Collaboration and Practice**
**National Resource Network on Child and Family Mental Health Services**
http://cecp.air.org

**FamilyDoctor.org**
**American Academy of Family Physicians**
www.aafp.org

**Medscape Today Resource Centers (from WebMD)**
www.medscape.com

**Mental Health America (MHA)** (formerly National Mental Health Association)
http://www.nmha.org

**National Alliance for the Mentally Ill (NAMI)**
http://www.nami.org

**National Technical Assistance Center for Children's Mental Health**
http://www.dml.georgetown.edu
**Research & Training Center on Family Support and Children's Mental Health**
http://www.rtc.pdx.edu

**U.S. Department of Education**
**Office of Special Education Programs**
http://www.ed.gov/about/offices/list/osers/index.html?src=mr

**U.S. Department of Health and Human Services**

**Centers for Disease Control and Prevention (CDC)**
www.cdc.gov

**National Institutes of Health**

**Medline Plus**
**U.S. National Library of Medicine and the National Institutes of Health (NIH)**
www.nlm.nih.gov/medlineplus

**National Institute of Mental Health (NIMH)**
http://www.nimh.nih.gov/index.shtml

**Substance Abuse and Mental Health Services Administration (SAMHSA)**
National Mental Health Information Center
Child, Adolescent and Family Branch, Center for Mental Health Services
http://www.mentalhealth.samhsa.gov/child

National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov

## Virginia Resources

**Children's Services System Transformation**
801 East Main Street — Richmond, VA 23219
http://vafamilyconnections.com

**Mental Health America of Virginia**
http://www.mhav.org

**National Alliance for the Mentally Ill Virginia (NAMI Virginia)**
www.namivirginia.org

**Virginia Department of Behavioral Health and Developmental Services (DBHDS)**
P.O. Box 1797 – Richmond, VA 23218-1797
http://www.dbhds.virginia.gov

**Virginia Office of Comprehensive Services**
http://www.csa.virginia.gov

**Voices for Virginia's Children**
http://www.vakids.org
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