

# INTRODUCTION

---

## **Background of Child and Adolescent Mental Health**

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

*Serious Emotional Disturbance*

### **Providing Optimal Treatment**

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

*Benefits of Evidence-based Treatments*

*Limitations of Evidence-based Treatments*

### **Using the *Collection 4<sup>th</sup> Edition***

### **Conclusion**

## **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 physiologic factors.

Research conducted in the 1960's 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 who are at greatest risk due to other factors. These include physical problems, intellectual disabilities, 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 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 young 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% 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 were 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), based on the 2000 U.S. Census Report and the Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA) Study, 8.4 million children ages nine to 17 have had a diagnosable mental or addictive disorder associated with at least minimal impairment. This translates to a prevalence of almost 21%, or one in five children. These estimates would suggest that 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 ages one to 17. 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:

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 their mental health disorders, in that they reduce the need for mental health and related services. Further, such interventions can result in improvements in school readiness, health status, and academic achievement and reduce 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***

Federal regulations define a sub-population of children and adolescents with more severe functional limitations, known as 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% of youth ages nine to 17 meet SED criteria, depending upon how the criteria are defined (Costello, Messer, Bird, Cohen & Reinherz, 1998). Definitions of SED are bound by federal legislation and regulation, although 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 85,129 and 104,046 Virginia children and adolescents have SED, with between 47,294 and 66,211 exhibiting extreme impairment (2009). In addition, 71,526 Virginians (age six and older) have intellectual disability and 18,495 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 three steps which must be taken to improve services for youth 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 and 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. To complicate matters, the field of child and adolescent mental health is multi-disciplinary, with a diverse service system. Today there is 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 emerged from a conviction 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. Thus, those who level this criticism suggest 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. It has been noted that some commonly-used treatments are not deemed to be evidence-based treatment because they have not been tested.

### Using the *Collection 4<sup>th</sup> Edition*

With these criticisms in mind, the *Collection 4<sup>th</sup> Edition* editors updated it to reflect the current state of the science. The publication is intended to provide information to families, clinicians, administrators, policymakers and others seeking information about evidence-based practices for child and adolescent mental health disorders.

The revised *Collection* 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 4<sup>th</sup> Edition*

Levels of Scientific Support	Description
What Works	Meet all of the following criteria: <ol style="list-style-type: none"> <li>1. Tested across two or more randomized controlled trials (RCTs);</li> <li>2. At least two different investigators (i.e., researcher);</li> <li>3. Use of a treatment manual in the case of psychological treatments; and</li> <li>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).</li> </ol>
What Seems to Work	Meet all but one of the criteria for "What Works."
What Does Not Work	Meet none of the criteria above while also meeting either of the following criteria: <ol style="list-style-type: none"> <li>1. Found to be inferior to another treatment in an RCT; and/or</li> <li>2. Demonstrated to cause harm in a clinical study.</li> </ol>
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 4<sup>th</sup> 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.

## 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 4<sup>th</sup> Edition* is designed to encourage use of these treatments by professionals providing mental health treatments. The *Collection 4<sup>th</sup> 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.).

## Sources

American Psychiatric Association (APA). (2002). *Childhood Disorders*. [Online]. Available: [www.psych.org/public\\_info/childr~1.cfm](http://www.psych.org/public_info/childr~1.cfm). Not available August 2005.

Costello, J., Messer, S., Bird, H., Cohen, P., & Reinherz, H. (1998). The prevalence of serious emotional disturbance: a re-analysis of community studies. *Journal of Child and Family Studies*, 7 (4), 411-432.

Donald, A. (2002). A practical guide to evidence-based medicine. *Medscape Psychiatry & Mental Health eJournal*, 9 (2).

Fonagy, P. (2000). *Evidence Based Child Mental Health: The Findings of a Comprehensive Review*. Paper presented to "Child mental health interventions: What works for whom?" Center for Child and Adolescent Psychiatry.

National Alliance for the Mentally Ill (NAMI). (2005). *About Mental Illness*. [Online]. Available: [http://www.nami.org/Content/NavigationMenu/Inform\\_Yourself/About\\_Mental\\_Illness/About\\_Mental\\_Illness.htm](http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm). Not available June 2007.

National Institute for Health Care Management. (2005). *Children's Mental Health: An Overview and Key Considerations for Health System Stakeholders. Issue Paper*. [Online]. Available: <http://www.nihcm.org/pdf/CMHReport-FINAL.pdf>. [October 2010].

National Institute of Mental Health (NIMH). (2001). *Blueprint for Change: Research on Child and Adolescent Mental Health*. Report of the National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention.

National Institute of Mental Health (NIMH). (2005). *Mental Illness Exact Heavy Toll, Beginning in Youth*. [Online]. Available: <http://www.nih.gov/news/pr/jun2005/nimh-06.htm>. [October 2010].

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.

Nock, M., Goldman, J., Wang, Y., & Albano, A. (2004). From science to practice: the flexible use of evidence-based treatments in clinical settings. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43 (6), 777-780.

Sturm, R., Ringel, J., Bao, C., Stein, B., Kapur, K., Zhang, W., & Zeng, F. (2001). National estimates of mental health utilization and expenditures for children in 1998, in *Blueprint for Change: Research on Child and Adolescent Mental Health*, Vol. VI, Appendices. Washington, DC: National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention, Development, and Deployment.

Ringel, J., & Sturm, R. (2001). National estimates of mental health utilization and expenditures for children in 1998. *Journal of Behavioral Health Services and Research*, 28, 319-333.

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD.

U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, Ethnicity—Supplement to Mental Health: Report of the Surgeon General*. Rockville, MD.

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services.

Virginia Department of Behavioral Health and Developmental Services (DBHDS). (2009). *Comprehensive State Plan 2010 to 2016*. [Online]. Available: <http://www.dbhds.virginia.gov/documents/reports/opd-StatePlan2010thru2016.pdf>. [October 2010].

Woodruff, D., Osher, D., Hoffman, C., Gruner, A., King, M., Snow, S., et al. (1999). The role of education in a system of care: effectively serving children with emotional or behavioral disorders. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume III*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

### **Organizations**

#### **American Association of Child & Adolescent Psychiatry (AACAP)**

[www.aacap.org](http://www.aacap.org)

#### **American Psychiatric Association (APA)**

[www.psych.org](http://www.psych.org)

[www.parentsmedguide.org](http://www.parentsmedguide.org)

#### **American Psychological Association (APA)**

[www.apa.org](http://www.apa.org)

#### **Center for Effective Collaboration and Practice**

#### **National Resource Network on Child and Family Mental Health Services**

<http://cecp.air.org>

#### **American Academy of Family Physicians**

#### **FamilyDoctor.org**

<http://familydoctor.org/online/famdocen/home.html>

#### **Medscape Today Resource Centers (from WebMD)**

[www.medscape.com](http://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](http://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](http://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](http://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>

**Richmond**

701 East Franklin Street, Suite 807 — Richmond, Virginia 23219

**Northern Virginia**

4031 University Drive, Suite 200 — Fairfax, VA 22030