



A Center Report . . .

Youngsters' Mental Health and Psychosocial Problems: What are the Data?

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Preface

A common request to Centers such as ours is for information about the prevalence and incidence of youngsters' problems. The intent of this report is to provide a synthesis of the best data and to clarify the limitations of what has been gathered so far.

As you will see, available data continue to be quite limited. The synthesis reported here highlights the limitations and underscores major gaps that need filling. It is clear that a great deal more research is needed, and it must be pursued with sufficient resources to enhance and refine the methodology used. At the same time, we all will continue to draw on what has been reported as an essential aid in planning and decision making. In doing so, it is imperative to use that data carefully and wisely – with a full appreciation of its limitations. With all this in mind, we hope you will find our synthesis helpful.

This report reflects the contributions of several staff – particularly DeQuincy Lezine, Angie Mittman, and Perry Nelson, as well as the Center co-directors.

Howard Adelman & Linda Taylor
Center Co-directors

Youngsters' Mental Health and Psychosocial Problems: What are the Data?

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Youngsters' Mental Health and Psychosocial Problems: What are the Data?

Commonly heard these days is the shibboleth:

In God we trust; from all others demand data!

Increasingly, policy makers and others who make decisions are demanding;

Show me the data!

In many arenas, the demand for data has outstripped the availability of good data and has increased the tendency to grab for whatever numbers are being circulated in the literature. As a result, when someone says: "This is the *best* data available," it is essential to remember that *best* does not always mean *good*. This caution is particularly relevant in the mental health field where funding to support data gathering continues to be sparse and sound methodological practices are difficult and costly to implement. It is widely acknowledged that available information on prevalence and incidence of mental health and psychosocial problems and related service provision varies markedly in both quantity and quality.¹ For instance, some youngsters may be counted more than once when they have multiple problems. And, a wide variety of activity may be included in reports of what constitutes a MH service. But the biggest problem remains that too little investment has been made in gathering and aggregating such data. As a result, available data are limited by sampling and methodological constraints, and thus the appropriate generalizability of findings is significantly constricted.

The intent of this report is to provide a synthesis of the best available data and to clarify the limitations of what has been gathered so far. Because of the inadequacies of current data gathering, we must rely on subpopulation survey data and best estimates of mental health (MH) problems in schools, primary health care systems, and juvenile justice systems.

The reality is that the primary sources for widely cited data on mental health and psychosocial concerns represent a relatively small body of studies, each of which makes an important contribution and, at the same time, the researchers are the first to acknowledge the limitations of the reported findings.

¹*Prevalence* data indicate the percentage of a population that is affected at a given time. In contrast, data on *incidence rate* indicate the rate at which new events occur in a population (i.e., the numerator is the number of new events occurring in a defined period; the denominator is the population at risk of experiencing the event during this period). Most of the data reported on the scope of problems are indices of prevalence.

I. A Sampling of Statistical Reports

- A. General Surveys
- B. Special Education Data
- C. Juvenile Justice Data
- D. Specific Problems
 - 1. Attention Deficit/ Hyperactivity Disorder
 - 2. Autism
 - 3. Depression and Suicide
 - 4. Substance Abuse
- E. Cultural and Economic Influence on Prevalence and Service

***I.* A Sampling of Statistical Reports**

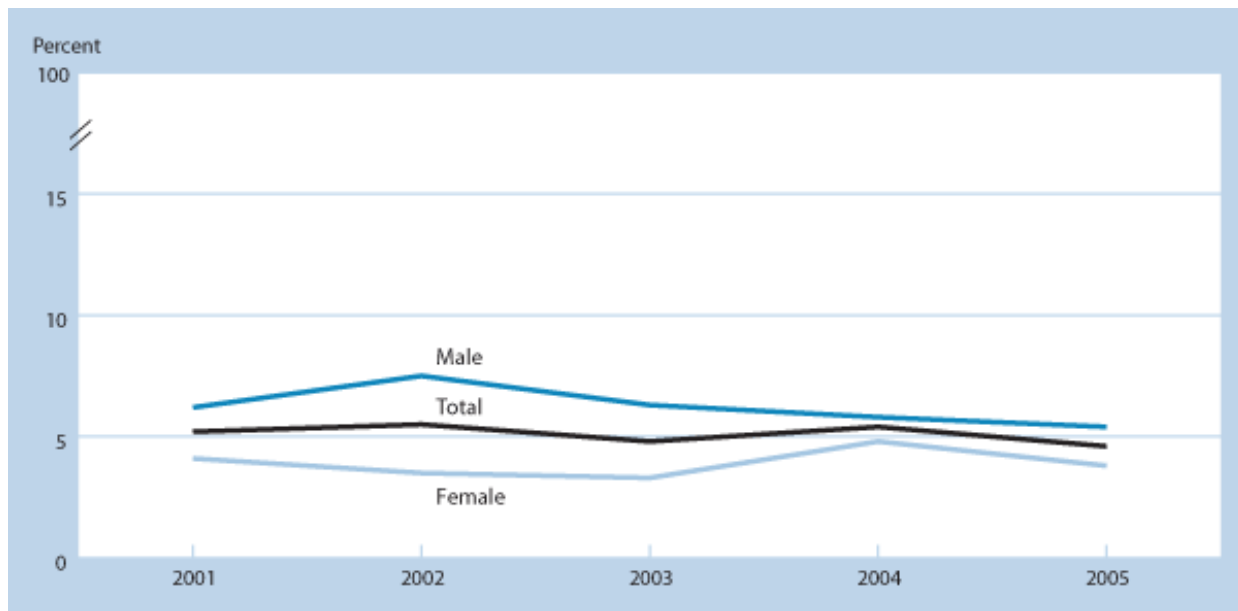
A. General Surveys



Emotional and Behavioral Difficulties

Good emotional and behavioral health enhances a child's sense of well-being, leads to satisfying social relationships at home and with peers, and leads to achievement of full academic potential. Children with emotional or behavioral difficulties may have problems managing their emotions, focusing on tasks, and/or controlling their behavior. These difficulties, which may persist throughout a child's development and can lead to lifelong disability, are usually noticed first by parents. Parents' reports are crucial to alerting doctors about their child's emotional and behavioral difficulties and to obtaining mental health services.

Indicator HEALTH3: Percentage of children ages 4–17 reported by a parent to have serious emotional or behavioral difficulties by gender, 2001–2005



NOTE: Children with serious emotional or behavioral difficulties are defined as those whose parent responded "yes, definite" or "yes, severe" to the following question on the Strengths and Difficulties Questionnaire (SDQ): "Overall, do you think that (child) has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?" Response choices were: (1) no; (2) yes, minor difficulties; (3) yes, definite difficulties; (4) yes, severe difficulties. These difficulties may be similar to but do not equate with the Federal definition of serious emotional disturbances (SED), used by the Federal government for planning purposes.



SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Excerpt Morbidity and Mortality Weekly Report
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5439a3.htm>
October 7, 2005/ 54(39);985-989

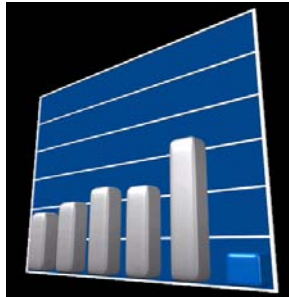
Mental Health in the United States: Health Care and Well Being of Children with Chronic Emotional, Behavioral, or Developmental Problems— United States, 2001

Data on specific diagnoses are not available from the 2001 National Survey of Children with Special Health Care Needs, but estimates from the 2003 National Survey of Children's Health (NSCH) (8) indicate several conditions common to children with EBD problems. According to parent reports of what doctors have told them, 53.5% of children with EBD problems have or have had attention deficit disorder or attention deficit hyperactivity disorder, 51.7% have or have had a learning disability, 43.5% have or have had depression or anxiety problems, 6.8% have or have had autism, and 55.7% have or have had a behavioral or conduct problem (9). Other EBD-related conditions were not addressed by NSCH, but EBD problems as defined in this report also presumably include complex conditions such as Down syndrome and pervasive developmental delay.

The findings in this report are subject to at least three limitations. First, the prevalence estimates of children with EBD problems are lower than certain other estimates of the prevalence of mental and behavioral health problems (6, 10). This lower rate was expected, given that this report limits the prevalence estimate to children whose parents report an EBD problem that is expected to last ≥ 12 months and for which the child currently needs or receives treatment or counseling. Other prevalence estimates do not necessarily apply such restrictive criteria. Moreover, because a delay between the onset of symptoms and diagnosis is common for EBD problems, prevalence estimates for EBD problems might be higher if those estimates are based on reports of symptoms or behaviors rather than reports of conditions for which children require treatment or counseling. Second, these estimates were derived from parent evaluations of their children's health-care needs. Biases in parent reporting might exist, and parents might not recognize certain problems or consider certain problems to be EBD in nature, might not consider various EBD problems to be sufficiently serious to warrant treatment or counseling, or might not be aware of available resources and services for their children. Finally, the data were restricted to the noninstitutionalized population of children living in households with telephones, although weighted estimates reflect the population of noninstitutionalized children living in households with and without telephones.

I. A Sampling of Statistical Reports

B. Special Education Data



The Condition of Education 2007

Indicator 7: Children with Disabilities in Public Schools

Elementary/Secondary Education

Children With Disabilities in Public Schools

The number and percentage of youth receiving special education services have increased nearly every year since 1976—77. From 1976—77 through 2005—06, the percentage receiving services for a specific learning disability increased threefold.

The Individuals with Disabilities Education Act (IDEA), first enacted in 1975, mandates that youth with disabilities are provided a free and appropriate public school education. Data collection activities to monitor compliance with IDEA began in 1976.

Since the inception of IDEA, the number and percentage of youth ages 3—21 enrolled in public schools receiving special education services have increased nearly every year. In 1976—77, some 3.7 million youth were served under IDEA, and these youth made up 8 percent of total public school enrollment. By 2005—06, some 6.7 million youth received IDEA services, corresponding to 14 percent of total public school enrollment. Among these students served under IDEA in 2004—05, about 1 percent were American Indian/Alaska Native, 2 percent were Asian/Pacific Islander, 20 percent were Black, 16 percent were Hispanic, and 60 percent were White (U.S. Department of Education 2006).

Table 7-2. Percentage of youth ages 3—21 served under the Individuals with Disabilities Education Act (IDEA), by disability: Selected years, 1976—77 through 2005—06

Age and disability	1976	1980	1990	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
	—77	—81	—91	—95	—96	—97	—98	—99	—2000	—01	—02	—03	—04	—05	—06
All disabilities	8.3	10.1	11.4	12.2	12.4	12.6	12.8	13.0	13.2	13.3	13.4	13.5	13.7	13.8	13.8
Specific learning disabilities	1.8	3.6	5.2	5.6	5.8	5.8	5.9	6.0	6.0	6.1	6.0	5.9	5.8	5.7	5.6
Speech or language impairments	2.9	2.9	2.4	2.3	2.3	2.3	2.3	2.3	2.3	3.0	2.9	2.9	3.0	3.0	3.0
Mental retardation	2.2	2.0	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.2	1.2	1.2	1.1
Emotional disturbance	0.6	0.8	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Hearing impairments	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Orthopedic impairments	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.1
Other health impairments	0.3	0.2	0.1	0.2	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.8	1.0	1.1	1.2
Visual impairments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Multiple disabilities	—	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
Deaf-blindness	—	#	#	#	#	#	#	#	#	#	#	#	#	#	#
Autism	—	—	—	#	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.5
Traumatic brain injury	—	—	—	#	#	#	#	#	#	#	#	#	#	#	0.1
Developmental delay	—	—	—	—	—	—	#	#	#	0.4	0.5	0.6	0.6	0.7	0.7
Preschool-age disabled ¹	†+	††	0.9	1.2	1.2	1.2	1.2	1.2	1.2	††	††	††	††	††	††

— Not available.

†† Not applicable.

Rounds to zero.

¹Beginning in 1976, data were collected for preschool-aged children by disability type; those data are combined above with data for youth ages 6—21. However, the 1986 Amendments to the Education of the Handicapped Act (now known as IDEA) mandated that data not be collected by disability for students ages 3—5. Accordingly, those data are reported as a separate row for years 1990—91 through 1999—2000. Beginning in 2000—01, states were again required to report preschool children by disability.

NOTE: Detail may not sum to totals because of rounding. Special education services through the Individuals with Disabilities Education Act (IDEA) are available for eligible youth identified by a team of qualified professionals as having a disability that adversely affects academic performance and in need of special education and related services. The total includes youth receiving special education services through IDEA in early education centers and elementary and secondary schools in the 50 states and the District of Columbia, excluding Bureau of Indian Affairs schools. See supplemental note 8 for more information about student disabilities represented here.

SOURCE: U.S. Department of Education, Office of Special Education and Rehabilitative Services (OSERS), Office of Special Education Programs (OSEP), Data Analysis System (DANS), 1976—2005. Retrieved September 22, 2006 from <https://www.ideadata.org/docs/PartBTrendData/B1.xls>.

I. A Sampling of Statistical Reports

C. Juvenile Justice Data



Psychiatric Disorders of Youth in Detention

By: Linda A. Teplin, Karen M. Abram, Gary M. McClelland, Amy A. Mericle,
 Mina K. Dulcan, and Jason J. Washburn

The juvenile justice system faces a significant challenge in identifying and responding to the psychiatric disorders of detained youth. In 2001, more than 104,000 juvenile offenders were in custody in juvenile residential placement facilities. Although epidemiological data are key to understanding the psychiatric disorders of juvenile detainees, few empirical studies exist.

Table 2: Six-Month Prevalence and Odds Ratios of DSM-III-R Diagnoses, by Gender

Disorder	Male (%) (n=1,170)	Female (%) (n=656)	Female-to-Male Odds Ratios
Any of the listed disorders	66.3	73.8	1.43 [^]
Any except conduct disorder	60.9	70.0	1.49 [^]
Any affective disorder	18.7	27.6	1.66 [^]
Major depressive episode	13.0	21.6	1.85 [^]
Dysthymia	12.2	15.8	1.34
Manic Disorder	2.2	1.8	0.81
Psychotic Disorders	1.0	1.0	0.98
Any anxiety disorder	21.3	30.8	1.64 [^]
Panic disorder	0.3	1.5	5.65 [^]
Separation anxiety disorder	12.9	18.6	1.55 [^]
Overanxious disorder	6.7	12.3	1.95 [^]
Generalized anxiety disorder	7.1	7.3	1.03
Obsessive-compulsive disorder	8.3	10.6	1.31
Attention-deficit/hyperactivity	16.6	21.4	1.37
Any disruptive behavior disorder	41.4	45.6	1.19
Oppositional-defiant disorder	14.5	17.5	1.25
Conduct disorder	37.8	40.6	1.12
Any substance use disorder	50.7	46.8	0.86
Alcohol use disorder	25.9	26.5	1.03
Marijuana use disorder	44.8	40.5	0.84
Other substance use disorder	2.4	6.9	3.00 [^]
Alcohol and other drug use	20.7	20.9	1.01

Notes: The odds ratios show the relative likelihood of one group having a disorder compared with another group. For the female-to-male odds ratios, odds ratios greater than 1.0 indicate that females had higher odds of having a specific disorder than males; ratio less than 1.0 show that females had lower odds of having the disorder.

* Attention-deficit/hyperactivity disorder is reported without the criterion of onset before age 7 because caretaker information is not available and self-reporting of symptoms before age 7 is unreliable.

[^] Odds ratios are significant at $p < .05$

I. A Sampling of Statistical Reports

D. Specific Problems

1. Attention Deficit/ Hyperactivity Disorder



***Prevalence of Diagnosis and Medication Treatment
for Attention-Deficit/Hyperactivity Disorder
–United States, 2003.***

(<http://www.cdc.gov/od/oc/media/mmwrnews/n050902.htm>)

*Morbidity and Mortality Weekly Report
September 2, 2005*

This is the first report to estimate national and state-based rates of medication treatment for ADHD using a nationally representative sample of U.S. families. The findings indicate that 7.8 percent (4.4 million) of U.S. youth 4-17 years of age had a reported ADHD diagnosis by 2003. More than half of the youth (2.5 million) with a history of ADHD diagnosis were being treated with medication at the time of the survey. Rates of reported diagnosis and current medication treatment varied by state and socio-demographic characteristic. Questions remain about the long-term health risks and benefits associated with medication as well as other treatments for ADHD. Given the substantial population of youth affected by the disorder, further study of ADHD treatment modalities and associated outcomes is warranted.

Excerpt from...

Evaluating the Evidence For and Against the Overdiagnosis of ADHD

by Mark J. Sciotto and Miriam Eisenberg
Journal of Attention Disorders (2007) 11:106
(<http://jad.sagepub.com>)

Diagnostic inaccuracy. Some studies have shown that, for a significant number of children, an actual or suspected diagnosis of ADHD is disconfirmed after further assessment. For instance, Cotugno (1993) evaluated 92 children previously referred to a specialized ADHD clinic. He found that, after a comprehensive evaluation, only 22% of the children were given a primary diagnosis of ADHD and only 37% were given a secondary diagnosis of ADHD. Similarly, Desgranges, Desgranges, and Karshy (1995) found that 62% of clinic referrals for suspected ADHD were not confirmed as ADHD cases after further evaluation. One potential reason for the diagnostic inaccuracy is the variability in assessment procedures. Studies of assessment practices among psychologist and physicians suggest that a diagnosis of ADHD is often made without a comprehensive assessment. Handler and DuPaul (2005) found that a large majority of practicing psychologists did not regularly follow assessment procedures that are consistent with the best practice guidelines. Similarly, Wasserman and colleagues (1999) found that primary care physicians varied considerably in their assessment and diagnosis of childhood disorders. They found that physicians relied very heavily on interviews and most did not adhere to the DSM criteria or use standardized assessment tools. Although such variability in assessment procedures may provide fertile soil for overdiagnosis, it has not been empirically established that a failure to follow best practices for assessment invariably leads to more false positives than false negatives.

Excerpt from...

Study Raises Questions About Diagnosis, Medical Treatment of ADHD

(www.newsroom.ucla.edu)

(1/22/2008)

A new UCLA study shows that only about half of children diagnosed with attention-deficit hyperactivity disorder, or ADHD, exhibit the cognitive effects commonly associated with the condition.

The study also found that in populations where medication is rarely prescribed to treat ADHD, the prevalence and symptoms of the disorder are roughly equivalent to populations in which medication is widely used.

Part of the explanation may lie in the common method for diagnosing the disorder. ADHD is an extreme on a normal continuum of behavior that varies in the population, much like height, weight or IQ. Its diagnosis, and thus its prevalence, is defined by where health professionals “draw the line: on this continuum, based on the severity of the symptoms and overall impairment.

Researchers also found surprising results regarding the effectiveness of medicine in treating ADHD. In contrast to children in United States, youth in northern Finland are rarely treated with medicine for ADHD, yet the ‘look’ of the disorder—its prevalence, symptoms, psychiatric comorbidity and cognition—is relatively the same as in the U.S., where stimulant medication is widely used. The researches point out that this raises important issues about the efficacy of the current treatments of ADHD in dealing with the disorder’s long-term problems.

“The continuous nature of liability to ADHD requires that we examine more carefully what environmental pressures may be leading to impairment, instead of broadening our diagnostic classifications even further.”

I. A Sampling of Statistical Reports

D. Specific Problems

2. Autism



Excerpt from...

Autism Spectrum Disorders (Pervasive Developmental Disorders)

<http://www.nimh.nih.gov/health/publications/autism/complete-publication.shtml>

Prevalence

In 2007 — the most recent government survey on the rate of autism — the Centers for Disease Control (CDC) found that the rate is higher than the rates found from studies conducted in the United States during the 1980s and early 1990s (survey based on data from 2000 and 2002). The CDC survey assigned a diagnosis of autism spectrum disorder based on health and school records of 8 year olds in 14 communities throughout the U.S. Debate continues about whether this represents a true increase in the prevalence of autism. Changes in the criteria used to diagnose autism, along with increased recognition of the disorder by professionals and the public may all be contributing factors. Nonetheless, the CDC report confirms other recent epidemiologic studies documenting that more children are being diagnosed with an ASD than ever before.

Data from an earlier report of the CDC's Atlanta-based program found the rate of autism spectrum disorder was 3.4 per 1,000 for children 3 to 10 years of age. Summarizing this and several other major studies on autism prevalence, CDC estimates that 2—6 per 1,000 (from 1 in 500 to 1 in 150) children have an ASD. The risk is 3-4 times higher in males than females. Compared to the prevalence of other childhood conditions, this rate is lower than the rate of mental retardation (9.7 per 1,000 children), but higher than the rates for cerebral palsy (2.8 per 1,000 children), hearing loss (1.1 per 1,000 children), and vision impairment (0.9 per 1,000 children).¹ The CDC notes that these studies do not provide a national estimate.

For additional data, please visit the autism section of the [CDC Web site](#).

I. A Sampling of Statistical Reports

D. Specific Problems

3. Depression & Suicide



2006 Fact Sheet on Suicide: Adolescents & Young Adults

The following excerpt is taken from "National Adolescent Health Information Center" and can be found at: <http://nahic.ucsf.edu>

Highlights:

- Suicide is the third leading cause of death for adolescents and young adults.
- Young males are much more likely to commit suicide than their female peers.
- American Indian/Alaskan Native male adolescents have the highest suicide rate.
- The suicide rates for young adult males have fallen sharply in the past decades
- Female adolescents are more likely to attempt suicide than their male peers.

- Suicide is the third leading cause of death for adolescents and young adults.

In 2003, 4,232 adolescents and young adults ages 10-24 took their own lives, resulting in a suicide rate of 6.8 per 100,000. Suicide accounted for 11.2% of all deaths for adolescents and young adults, making it the third leading cause of death for this age group after motor vehicle accidents and homicide.

While adolescent males commit suicide at greater rates, their female peers are more likely to report sad feelings, suicidal ideation and attempts. Female high school students were almost twice as likely to report suicidal ideation and attempts in the past year than male peers. Overall, the percentage of students who reported an attempted suicide in the past year increased slightly from 7.3% in 1991 to 8.4% in 2005.

Female Hispanic students are more likely to attempt suicide than all other students. The suicide attempt rate varies by race/ethnicity: attempts are slightly higher for Hispanic students (11.3%) than for Black-NH and White-NH students (7.6% and 7.3%, respectively). Hispanic students have reported higher rates of suicide attempts than Black-NH and White-NH students since data collection began in 1991.

VITAL STATISTICS

Excerpts from...

Suicide Trends Among Youths and Young Adults Aged 10-24 Years—United States, 1990-2004

MMWR Weekly September 7, 2007 / 56 (35); 905-908
(<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5635a2.htm>)

In 2004, suicide was the third leading cause of death among youths and young adults aged 10--24 years in the United States, accounting for 4,599 deaths (1,2). During 1990--2003, the combined suicide rate for persons aged 10--24 years declined 28.5%, from 9.48 to 6.78 per 100,000 persons (2). However, from 2003 to 2004, the rate increased by 8.0%, from 6.78 to 7.32 (2), the largest single-year increase during 1990--2004. To characterize U.S. trends in suicide among persons aged 10--24 years, CDC analyzed data recorded during 1990--2004, the most recent data available. Results of that analysis indicated that, from 2003 to 2004, suicide rates for three sex-age groups (i.e., females aged 10--14 years and 15--19 years and males aged 15--19 years) departed upward significantly from otherwise declining trends. Results further indicated that suicides both by hanging/suffocation and poisoning among females aged 10--14 years and 15--19 years increased from 2003 to 2004 and were significantly in excess of trends in both groups. The results suggest that increases in suicide and changes in suicidal behavior might have occurred among youths in certain sex-age groups, especially females aged 10--19 years. Closer examination of these trends is warranted at federal and state levels. Where indicated, health authorities and program directors should consider focusing suicide-prevention activities on these groups to help prevent suicide rates from increasing further.

Significant upward departures from modeled trends in 2004 were identified in total suicide rates for three of the six sex-age groups: females aged 10--14 years and 15--19 years and males aged 15--19 years. The largest percentage increase in rates from 2003 to 2004 was among females aged 10--14 years (75.9%), followed by females aged 15--19 years (32.3%) and males aged 15--19 years (9.0%). In absolute numbers, from 2003 to 2004, suicides increased from 56 to 94 among females aged 10--14 years, from 265 to 355 among females aged 15--19 years, and from 1,222 to 1,345 among males aged 15--19 years.

In 1990, firearms were the most common suicide method among females in all three age groups examined, accounting for 55.2% of suicides in the group aged 10--14 years, 56.0% in the group aged 15--19 years, and 53.4% in the group aged 20--24 years. However, from 1990 to 2004, among females in each of the three age groups, significant downward trends were observed in the rates both for firearm suicides ($p<0.01$) and poisoning suicides ($p<0.05$), and a significant increase was observed in the rate for suicides by hanging/suffocation ($p<0.01$). In 2004, hanging/suffocation was the most common method among females in all three age groups, accounting for 71.4% of suicides in the group aged 10--14 years, 49% in the group aged 15--19 years, and 34.2% in the group aged 20--24 years. In addition, from 2003 to 2004, hanging/suffocation suicide rates among females aged 10--14 and 15--19 years increased by 119.4% (from 0.31 to 0.68 per 100,000 persons) and 43.5% (from 1.24 to 1.78), respectively. In absolute numbers, from 2003 to 2004, suicides by hanging/suffocation increased from 32 to 70 among females aged 10--14 years and from 124 to 174 among females aged 15--19 years. Aside from 2004, the only other significant departure from trend among females in these two age groups during 1990--2004 was in suicides by hanging/suffocation among females aged 15--19 years in 1996.

VITAL STATISTICS

Excerpts from...

Youth Risk Behavior Surveillance—United States, 2005

MMWR *Surveillance Summaries* June 9, 2006 / 55 (SS05); 1-108

(<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5635a1.htm>)

Reporting Period Covered: October 2004 - January 2006

Felt Sad or Hopeless

During the 12 months preceding the survey, 28.5% of students nationwide had felt so sad or hopeless almost every day for ≥ 2 weeks in a row that they stopped doing some usual activities. Overall, the prevalence of having felt sad or hopeless almost every day for ≥ 2 weeks was higher among female (36.7%) than male (20.4%) students.

Overall, the prevalence of having felt sad or hopeless almost every day for ≥ 2 weeks was higher among Hispanic (36.2%) than white (25.8%) and black (28.4%) students; higher among Hispanic female (46.7%) than white female (33.4%) and black female (36.9%) students.

Seriously Considered Attempting Suicide

Nationwide, 16.9% of students had seriously considered attempting suicide during the 12 months preceding the survey. Overall, the prevalence of having seriously considered attempting suicide was higher among female (21.8%) than male (12.0%) students.

Made a Suicide Plan

During the 12 months preceding the survey, 13.0% of students nationwide had made a plan about how they would attempt suicide. Overall, the prevalence of having made a suicide plan was higher among female (16.2%) than male (9.9%) students.

Attempted Suicide

Nationwide, 8.4% of students had actually attempted suicide one or more times during the 12 months preceding the survey. Overall, the prevalence of having actually attempted suicide was higher among female (10.8%) than male (6.0%) students.

I. A Sampling of Statistical Reports

D. Specific Problems

4. Substance Abuse



A Day in the Life of American Adolescents: Substance Use Facts

([Http://oas.samhsa.gov/2k7/youthfacts/youth.cfm](http://oas.samhsa.gov/2k7/youthfacts/youth.cfm))

Highlights:

- Facts about substance use among youth aged 12 to 17 are based on data from SAMHSA's 2006 National Survey on Drug Use & Health (NSDUH) and SAMHSA's 2005 Treatment Episode Data Set (TEDS), and for clients under the age of 18 from SAMHSA's 2005 National Survey of Substance Abuse Treatment Services (N-SSATS). Data are presented on first substance use, past year substance use, receipt of substance use treatment, and source of substance use treatment referrals "on an average day."
- On an average day in 2006, youth used the following substances for the first time: 7,970 drank alcohol for the first time, 4,348 used an illicit drug for the first time, 4,082 smoked cigarettes for the first time, 3,577 used marijuana for the first time, and 2,517 used pain relievers nonmedically for the first time.
- Youth who used alcohol in the past month drank an average of 4.7 drinks per day on the days they drank and those who smoked cigarettes in the past month smoked an average of 4.6 cigarettes per day on the days they smoked.
- On an average day in 2005, the number of youth admissions to substance abuse treatment were referred by the following sources: 189 by the criminal justice system; 66 by self-referral or referral from other individuals; 43 by schools; 37 by community organizations; 22 by alcohol or drug treatment providers; and 18 by other health providers.
- On an average day in 2005, active substance abuse treatment clients under the age of 18 received the following types of substance abuse treatment: 76,240 were clients in outpatient treatment; 10,313 were clients in non-hospital residential treatment; and 1,058 were clients in hospital inpatient treatment.

I. A Sampling of Statistical Reports

E. Cultural and Economic Influence on Prevalence and Service



Excerpt from...

New Insights on how Mental Health is Influenced by Culture and Immigration Status

<http://www.nimh.nih.gov/science-news/2007/new-insights-on-how-mental-health-is-influenced-by-culture-and-immigration-status.shtml>
Science Update July 11, 2007

Notable findings from this special issue include:

- Age at immigration appears to affect the onset of mental disorders in Asian Americans. Based on data from more than 2,095 Asian Americans collected for the National Latino and Asian American Study (NLAAS), David Takeuchi, PhD, University of Washington, and colleagues found that those who immigrated during childhood, as well as U.S. born Asians, were much more likely to have a mental disorder in their lifetimes than other immigrant generations. Asian immigrants who arrived at age 12 or younger had a greater risk for psychiatric disorders during childhood than their U.S. born counterparts; this risk, along with risk for substance abuse, increased during adolescence. Asian immigrants who arrived before age 41 also had a greater risk of onset for mood disorders during or shortly after immigration, whereas those who arrived after age 41 were more likely to have experienced onset before immigration.
- Information on more than 2,554 Latinos interviewed for the NLAAS showed that age at immigration was also key in the mental health of this diverse minority population, found Margarita Alegría, PhD, Harvard University, and colleagues. In general, past age 7, the older the person at immigration, the later the onset of psychiatric disorders. Those who arrived later in life had lower lifetime prevalence rates than younger immigrants or U.S. born Latinos. However, after about age 30, the risk of depressive disorders increased among these later-arriving Latino immigrants, whereas risk tended to decrease between ages 30-40 for U.S. born Latinos and immigrants arriving before age 7. Latinos arriving between ages 0-6 had very high risks of onset shortly after immigration, but after several years, their lifetime prevalence rates approached those of Latinos born in the United States.
- Researchers working with Harold Neighbors, PhD, University of Michigan, studied the interactions between culture, race, and ethnicity with depressive symptoms among a subset of participants from the National Survey of American Life, comprising 3,438 African Americans, Caribbean Americans, and white Americans. They evaluated social, group, and individual characteristics related to behavioral responses (such as coping strategies) to life stressors, group and personal identity, ideology, and beliefs about racial relations, and how these factors intersected with symptoms of depression. African Americans in this study did not show a significant relationship between depressive symptoms and high-effort coping strategies, while Caribbean Blacks and white

Americans experienced increasing symptoms of depression linked to increasingly high-effort coping, in relationship to other beliefs and values.

- Nearly 20 percent of Native American middle school students in a single reservation attempted suicide, double the rate for the general teenage population, according to a study led by Teresa LaFromboise, PhD, Stanford University, and funded by the Substance Abuse and Mental Health Services Administration. The researchers evaluated 122 students who belonged to the Metis or Ojibwa tribes living in the Northern Plains and found that a sense of connection or belonging to their school community appeared have a strong, protective effect against suicidal thoughts. Overall, the two strongest predictors for thinking about suicide were depression and substance abuse.
- Data on the mental health of diverse teens in the Houston area suggest few differences in risk for mental disorders based on ethnicity. Robert Roberts, PhD, and Catherine Ramsay Roberts, MPH, PhD, both at the University of Texas, interviewed 4,175 European American, African American, and Mexican American youth and found that, overall, teens of European American descent were at lower risk for anxiety disorders, and African American youth were at lower risk for substance use disorders and having more than one mental disorder. Unlike adults, total family income (or socioeconomic status) was not linked to increased risk for any disorder for any of the three groups; however, the *perception* of lower income was associated with increased risk for all groups.

Reference

Boyce CA, Fuligni AJ. Issues for Developmental Research Among Racial/Ethnic Minority and Immigrant Families. *Res Hum Dev.* 2007 Jun;4(1&2):1-17.

Excerpt from...

Reducing Disparities Beginning in Early Childhood Short Take No. 4

http://nccp.org/publications/pub_744.html

Kay Johnson and Suzanne Theberge

July 2007

Social Emotional Development and Mental Health

- Maternal depression. Low-income and minority women are disproportionately likely to be affected by maternal depression, with rates reaching as high as 40 percent. The effects of maternal depression on children range from poor bonding to lower reading and language scores to higher incidences of later mental health issues and depression.
- Mental health and social-emotional development. Young children from low-income and minority households are at increased risk for mental health and developmental problems.
- Children with multiple risk factors. National surveys indicate that about one-third of U.S. young children (3.1 million) have two or more risk factors for poor health and development. (These are typically indicated by characteristics such as race/ethnicity, maternal education, family poverty, and maternal mental health.) The likelihood of having either poorer health or higher developmental risk increases with each additional risk factor. One risk factor yielded nearly twice the risk, two risk factors over three times the risk, three risk factors nearly five times the risk, and four risk factors 14 times the risk for being in poor health or having a developmental delay.
- Children in the child welfare system. Data from the National Survey of Child and Adolescent Well-Being indicate that both toddlers (41.8 percent) and preschoolers (68.1 percent) who had contact with the child welfare system had high developmental and behavioral needs; however, few children were receiving services for these issues (22.7 percent overall).
- Exposure to family violence. In 2003, violent disagreements were most prevalent among black households (15.1 percent), followed by ““other”” (12.1 percent), Latino (11.3 percent), and white (8.6 percent) households. While demographic and cultural factors may influence disagreement styles, parental stress seems most closely associated with and instrumental to the development of violent disagreements.

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Excerpt from...

Neighborhood Residence and Mental Health Problems of 5 to 11 Year Olds
Yange Xue, PhD; Tama Leventhal, PhD; Jeanne Brooks-Gunn, PhD; Felton J. Earls, MD
Arch Gen Psychiatry. 2005;62:554-563.

Results

The percentages of children above the clinical threshold were 21.5%, 18.3%, and 11.5% in neighborhoods of low, medium, and high socioeconomic status, respectively. A substantial proportion of variance in children's total internalizing scores (intraclass correlation, 11.1%) was attributable to between-neighborhood differences. Concentrated disadvantage was associated with more mental health problems and a higher number of children in the clinical range, after accounting for family demographic characteristics, maternal depression, and earlier child mental health scores. Neighborhood collective efficacy and organizational participation were associated with better mental health, after accounting for neighborhood concentrated disadvantage. Collective efficacy mediated the effect of concentrated disadvantage.

Excerpt from...

An Overview of Selected Data on Children in Vulnerable Families

The Urban Institute and Child Trend Roundtable on Children in Low-Income Families

<http://www.urban.org/url.cfm?ID=311351>

Jennifer Ehrle Macomber

January 12, 2006

Mental Health and Substance Abuse

The share of low-income children living with a parent with symptoms of poor mental health remained relatively stable between 1997 and 2002, fluctuating between 24 and 26 percent. In 2002, approximately 26 percent of children living in low-income families (families with incomes below 200 percent of the federal poverty threshold) lived with a parent with symptoms of poor mental health according to analyses of the NSAF (Vandivere, Gallagher, and Moore 2004). Mental health in the NSAF is assessed based on the frequency in which care givers report feeling very nervous, calm and peaceful, downhearted and blue, happy, and so down in the dumps that nothing could cheer them up. Between 1997 and 2002, between 24 and 26 percent of children in low-income families had a parent who reported symptoms of poor mental health. For children in higher-income families, this share ranged from 10 to 11 percent. It is also notable that in 1999 the proportion of low-income children living with parents with symptoms of poor mental health was significantly higher than the national average in the study states of Alabama (31 percent), Massachusetts (33 percent), and Mississippi (29 percent) (Urban Institute 2000).

Analyses of the NHIS by Child Trends also provide information about parental mental health for poor care givers (Child Trends Data Bank 2005e). These analyses look at the portion of parents reporting symptoms of depression for poor and non-poor families. Results reflect the patterns revealed by the NSAF. The proportion of poor parents reporting depressive symptoms fluctuated between 10 and 13 percent between 1998 and 2003 (Child Trends Data Bank 2005e). For

parents with incomes above the federal poverty threshold, this proportion ranged from 3 to 4 percent during this period.

The share of poor parents who consume five or more drinks at one occasion on a weekly basis fluctuated between 4 and 5 percent between 1998 and 2003. In 2003, approximately 4 percent of poor parents consumed five or more drinks in one occasion on a weekly basis according to analyses of the NHIS by Child Trends (Child Trends Data Bank 2005c). This share fluctuated between 4 and 5 percent between 1998 and 2003 (Child Trends Data Bank 2005c). The share of non-poor parents that fell into this category also ranged from 4 to 5 percent in this period (Child Trends Data Bank 2005c). Looking at this level of consumption on a monthly basis, 7 percent of poor parents consumed five or more drinks in one occasion in 2003 (Child Trends Data Bank 2005c). This share fluctuated between 7 and 9 percent between 1998 and 2003 (Child Trends Data Bank 2005c). The share of non-poor parents in this category ranged from 8 to 9 percent during this period (Child Trends Data Bank 2005c).

These indicators, however, do not provide information on use of illicit substances, which may be more prevalent among low-income parents according to research from the early 1990s (U.S. Department of Health and Human Services 1994). Moreover, in recent years the production, distribution, and use of methamphetamines have increasingly plagued communities nationwide with devastating consequences for families (Hunt, Kuck, and Truitt 2005; Kyle and Hansell 2005). The use and trade of the substance can severely jeopardize the health and well-being of parents and often puts children at risk of abuse or neglect (Hunt et al. 2005; Kyle and Hansell 2005).

Excerpt from...

Children's Mental Health Care: Differences by Race/Ethnicity in Urban/Rural Areas

Embry Howell, PhD; Joshua McFeeters, MPP

Journal of Health Care for the Poor and Underserved 19.1 (2008) 237-247

Abstract

This study examines racial/ethnic disparities in children's mental health and the receipt of mental health services, and whether those disparities differ between urban and rural areas. We find no significant difference between racial/ethnic groups in the prevalence of child mental health problems in either urban or rural areas. However, there are disparities in the use of mental health services. Hispanic children and Black children in urban areas receive less mental health care than their White counterparts, and the disparity persists for Hispanic children in rural areas, even after controlling for other relevant factors. Initiatives to improve access to mental health care for racial/ethnic minorities should recognize these disparities, and address the lack of culturally appropriate services in both urban and rural areas. In addition, outreach should raise awareness among parents, teachers, and other community members concerning the need for mental health services for minority children.

II. In-depth Analysis of Key Reports

- Primary Sources
 - A. How many young people are affected?
 - B. How are data commonly reported?
 - C. Increasing Rates?
 - D. Are they being served?

Table 1. Primary sources for data on prevalence.¹

Mental Disorders

- Lavigne, et al. (1996). *Prevalence rates and correlates of psychiatric disorders among preschool children.*
- Costello, et al. (1996). *The Great Smoky Mountains Study of youth: Goals, design, methods, and the prevalence of DSM-III-R disorders.*
- Shaffer, et al (1996). *The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study.*
- Kessler, et al. (2005). *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication.*

Special Education Labels

- Pastor & Reuben (2002). *Attention Deficit Disorder and Learning Disability: United States, 1997-1998.*
- Moore et al. (2000). *Children's Behavior and Well-Being: Findings from the National Survey of America's Families. Snapshots of America's Families II.*
- Wolraich et al. (1996). *Comparison of Diagnostic Criteria for Attention-Deficit Hyperactivity Disorder in a County-Wide Sample.*
- U.S. Department of Education (2002). *Twenty-fourth Annual Report to Congress on the Implementation of the Individuals with Disabilities in Education Act.*

Psychosocial Problems

- Denton & Germino-Hausken (2000). *America's Kindergartners.* West, J., Project Officer. NCES 2000-070. Washington, DC: U.S. Department of Education, National Center for Education Statistics.
- Angold et al. (1999). Impaired but Undiagnosed. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(2): pp 129-137.
- Grunbaum et al. (2002). Youth Risk Behavior Surveillance - United States, 2001. *Surveillance Summaries, MMWR*, 51, SS-4.
- Kelleher, K.J., McInerney, T.K., Gardner, W.P., Childs, G.E., & Wasserman, G.E. (2000). Increasing identification of psychosocial problems: 1979-1996. *Pediatrics*, 105, 6, 1313-1321.
- Anderson & Smith (2003). Deaths: Leading causes for 2001. *National Vital Statistics Reports*, 52. Hyattsville, MD: National Center for Health Statistics.
- Nansel et al. (2001). Bullying behaviors among US youth. Prevalence and association with psychosocial adjustment. *Journal of the American Medical Association, JAMA*, 285, 2094-2100.
- Johnston, O'Malley & Bachman (2003). *Monitoring the Future Occasional Paper 59.* Institute for Social Research. The University of Michigan, Ann Arbor.

Related Cultural Concerns

- National Highway Traffic Safety Administration (NHTSA) (2002). *Traffic Safety Facts 2002: Children.* U.S. Department of Transportation. DOT HS 809 607
- McLoughlin et al. (2002). Injuries and deaths among children left unattended in or around motor vehicles - United States, July 2000 - June 2001. *MMWR*, 51, 26, pp. 570-572.
- Centers for Disease Control and Prevention. *Web-based Injury Statistics Query and Reporting System (WISQARS)* [Online]. (2002). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer).
- U.S. Census Bureau (2002). *Low Income Uninsured Children by State: 1999, 2000, and 2001.* [online].
- Snyder & Sickmund (1999). *Juvenile Offenders and Victims: 1999 National Report.* Office of Juvenile Justice and Delinquency Prevention.

¹See the Reference list for full citations.

A. How Many Young People are Affected?

As a reference point, it should be noted that data for the year 2000 indicate there were 70.4 million children 17 years old or younger in the U.S. (Federal Interagency Forum, 2001). This represents 26% of the population. (64% were designated as white, non-Hispanic, 16% as Hispanic, 15% as African-American, 4% as Asian-Pacific, and 1% as American Indian/Alaskan Native).

Tables 2 and 3 provide the data reported in the primary sources listed in Table 1. These data come from studies that reflect the most rigorous efforts to gather and report findings. As indicated in Appendix A, each has its limitations. For example, the recent *National Comorbidity Survey Replication* reflects limitations related to the sample and methodology that must be taken into consideration in citing the data. These include widely recognized concerns about volunteer samples and those not represented in the sample, administration of lengthy surveys, the nature and scope of survey items, participant recall of the past, what should be viewed as a symptom rather than a common response to life experiences, limitations related to the statistical analyses, the degree to which the interpretations of the findings are generalizable, and more.

Nevertheless, as the best data available, it is not surprising that the findings highlighted by various studies and reports are widely cited and extrapolated from in order to shed some light on young people's problems.

Table 2. Prevalence data from primary sources related to children and youth in the USA labeled as having emotional, behavioral, and learning problems.

(a) Mental Disorders	Sources		
	Lavigne et al. (1996) % (2-5 yrs) ¹	Costello et al. (1996) % (9, 11, 13 yrs) ²	Shaffer et al. (1996) % (9-17 yrs) ³
Overall Prevalence	21.4	20.3	32.8
Any Anxiety Disorder		5.69	20.5
Separation Anxiety	0.5	3.49	5.8
Overanxious Disorder	0.7	1.38	7.7
Simple Phobia	0.6	0.27	3.3
Agoraphobia		0.07	4.8
Avoidant Disorder	0.7	0.03	
Social Anxiety		0.58	7.6
Any Depressive Disorder		1.52	7.2
Major Depression		0.03	5.6
Depression NOS	0.3	1.45	
Any Behavioral Disorder		6.56	11.5
Oppositional Defiant Dis.	16.8	2.75	6.5
Conduct Disorder		3.32	3.9
ADHD	2	1.94	5.1
Comorbid Emotional / Behavioral	5.4	1.47	

1. Percent based on 510 youngsters aged 2 through 5 years. Diagnostic criteria from DSM-III-R.
2. Percent based on 1,015 youngsters aged 9, 11, and 13 years, weighted by population prevalence rates. Diagnostic criteria from DSM-III-R.
3. Percent based on combined reports of 1,285 youngsters aged 9 through 17 years and their parents with Diagnosis-Specific Impairment Criteria. Diagnostic criteria from DSM-III-R.

The data from Kessler, et al., (2005) is limited to the following categories:

>anxiety disorders	=	28.8%
>mood disorders	=	20.8%
>impulse-control disorders	=	24.8%
>substance use disorders	=	14.6%
>any disorder	=	46.4%

Median age of onset is reported as much earlier for anxiety (11 years) and impulse-control (11 years) disorders than for substance use (20 years) and mood (30 years) disorders. Half of all lifetime cases were reported as starting by age 14 years. Kessler, et al., conclude that: "About half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life, with first onset usually in childhood or adolescence. Interventions aimed at prevention or early treatment need to focus on youth."

(Table continued on next page)

Table 2. Prevalence data from primary sources related to children and youth in the USA labeled emotional, behavioral, and learning problems. (cont.)

(b) Special Education	Sources			
	Pastor & Reuben (2002)	Moore et al. (2000)	Wolraich et al. (1996)	U.S. Dept. of Education (2002)
	% (6-11 yrs)⁴	% (6-11yrs)/ % (12-17yrs)⁵	% (K - 5th)⁶	% (Pre-K to 12th)⁷
Overall Prevalence	12			8.87
Emotional Disturbance		6.3 / 7.4		1
Learning Disability	8			6
Other Health Impairment				0.5
>ADD/ADHD	7		7.3	
Mental Retardation & Developmental Disabilities	1			1
Autism				0.2
Speech & Language Impairment				2.3

4. Percent based on 8,610 youngsters aged 6 through 11 years. Case identification based on previous diagnosis of Learning Disability, ADHD, Mental Retardation, or Developmental Disabilities. Note that 4% of children had comorbid ADD/ADHD and a Learning Disability.
5. Percent based on approximately 36,000 youngsters aged 6-17 years. Case identification based on a cutoff score of 12 or below chosen to represent a high level of problems on the Child Behavioral and Emotional Problems Scale based on the Child Behaviors Checklist.
6. Percent based on 8,528 youngsters enrolled in Kindergarten to 5th grade education in 16 Tennessee schools. Case identification based on teacher reports using DSM-III-R criteria on a version of the Disruptive Behavior Disorders Rating Scale.
7. Percent based on 52,875,000 youngsters enrolled in Pre-Kindergarten to 12th grade education at public or private schools in the 50 states and DC. Case identification based on state reports of the number of students served in federally supported programs for students with disabilities. Among preschoolers aged 3 to 5 years in special education (599,678 children), 55% had speech or language impairments, 3.3% had specific learning disabilities, and 1.4% had emotional disturbances. Among students aged 6 to 21 years in special education (5,775,722 children), 50% had specific learning disabilities, 19% had speech or language impairments, and 8% had emotional disturbances.

(Table continued on next page)

Table 2. Prevalence data from primary sources related to children and youth in the USA labeled emotional, behavioral, and learning problems. (cont.)

(c) Psychosocial Problems			
	Denton & Germino-Hausken (2000)	Angold et al., (1999)	Grunbaum et al., (2002)
	% (Kindergarten)⁸	Weighted % (9-13yrs)⁹	Weighted % (9th-12th grade)¹⁰
Overall Prevalence	15%	14.2%	
Impairment related to subthreshold psychiatric symptomatology		9.4%	
Had gone without eating for more than 24 hours to lose weight or avoid gaining weight			13.5%
Felt sad/hopeless almost every day for more than 2 weeks (in the year)			28.3%
Attempted suicide (in the year)			8.8%
Argue with others often/very often	33%		
Fight with others often/very often	15%		
Physical fight (in the year)			33.2%
Threatened or injured with a weapon on school property (in the year)			8.9%
Dating violence victim (in the year)			9.5%
Make friends never/sometimes	11%		
Comfort others never/sometimes	18%		
Impairment unrelated to psychiatric symptoms		4.8%	
Sibling Relational Problems		1.4%	
Parent-Child Relational Problems		3.6%	
Current frequent cigarette use			13.8%
Episodic heavy drinking			29.9%
Current marijuana use			23.9%
Current cocaine use			4.2%
Lifetime methamphetamine use			9.8%

8. Percent based on parent reports from approximately 22,000 children enrolled in about 1,000 kindergarten programs during the 1998-1999 school year.
9. Percent based on interviewing 1015 youngsters aged 9-13 years and their parent.
10. Percent based on 13,601 questionnaires from students in grades 9-12 in public and private schools in the 50 states and the District of Columbia.

(Table continued on next page)

Table 2. Prevalence data from primary sources related to children and youth in the USA labeled emotional, behavioral, and learning problems. (cont.)

(d) Related Cultural Concerns	
<i>Category</i>	<i>Rate or Percent</i>
Alcohol-related traffic fatalities (0-14 years) ^a	0.76
Children (0-14 years) left unattended in or around motor vehicles - nonfatal injuries ^b	15.14
Children (0-14 years) left unattended in or around motor vehicles - fatalities ^b	0.13
Firearm injuries - nonfatal (Age groups 5 to 9 - 15 to 19) ^c	1.6 - 77.9
BB/Pellet gun injuries - nonfatal (Age groups 5 to 9 - 15 to 19) ^c	8.3 - 32.1
Firearm injuries - fatalities (Age groups 5 to 9 - 15 to 19) ^c	0.4 - 13.1
Children (0-18 years) in families at or below 200% of poverty level ^d	38%
Children (0-18 years) in families at or below 200% of poverty level without health insurance ^d	8%
Youngsters (10-17 years) in custody of the justice system ^e	368

a. NHTSA (2003). Traffic safety facts 2002. Rate per 100,000.

b. McLoughlin et al. (2002). Injuries and deaths among children left unattended in or around motor vehicles - United States, July 2000-June, 2001. Rates per 100,000.

c. Centers for Disease Control and Prevention (2002). WISQARS Injury Mortality Reports. [Rates per 100,000].

d. U.S. Census Bureau (2002). Low income uninsured children by state: 1999, 2000, and 2001. Three year averages.

e. Snyder & Sickmund (1999). *Juvenile Offenders and Victims: 1999 National Report*. Rate per 100,000.

Table 3. Prevalence data by race (Percent unless otherwise specified).

	<i>White Non-Hispanic</i>	<i>Black Non-Hispanic</i>	<i>Hispanic</i>	<i>Asian / Pacific Islander</i>	<i>Native American</i>
<i>Category</i>					
SED / ED	0.7 ^a	1.2 ^a	0.3 ^a	0.2 ^a	0.8 ^a
SLD / LD	3.9 ^a , 7.6 ^b	4.9 ^a , 9.5 ^b	4.1 ^a , 7.2 ^b	1.7 ^a	6.2 ^a
OHI	0.5 ^a	0.4 ^a	0.2 ^a	0.2 ^a	0.5 ^a
ADHD	7.8 ^b	5.9 ^b	3.9 ^b		
MR	0.8 ^a	2.1 ^a	0.5 ^a	0.4 ^a	1.0 ^a
AUT	0.12 ^a	0.14 ^a	0.06 ^a	0.14 ^a	0.08 ^a
DD	0.04 ^a	0.07 ^a	0.02 ^a	0.02 ^a	0.06 ^a
SLI	1.7 ^a	1.7 ^a	1.2 ^a	1.0 ^a	1.9 ^a
PSYSOC ^c	15	17	17	8	19
SAD ^d	27	29	34		
SUIDEA ^d	20	13	19		
SUIATT ^d	8	9	12		
SUICIDE ^e	1.3-9.3	1.2-4.5	1.1-5.2		
ARGUE ^f	10-33	17-33	10-30	6-22	14-34
FIGHT	8-14 ^f , 32 ^d	14-16 ^f , 37 ^d	11-16 ^f , 36 ^d	7-10 ^f	15-18 ^f
ANGER ^f	10-15	15-19	12-21	9-16	13-19
UNSAFE ^f	5.0	9.8	10.2		
BULLIED ^g	8.8	6.7	8.1		
FRIENDS ^f	9-20	13-29	17-26	18-27	13-32
COMFORT ^f	15-45	19-56	24-55	28-50	16-55
CIG	17 ^d , 3-12 ^h	5 ^d , 1-2 ^h	7 ^d , 1-4 ^h		
ALC	34 ^d , 13-34 ^h	11 ^d , 9-12 ^h	30 ^d , 18-27 ^h		
MJ	24 ^d , 15-39 ^h	22 ^d , 13-27 ^h	25 ^d , 21-35 ^h		
DRUG ^h	10-24	4-7	13-18		

- a. U.S. Department of Education (2002). Twenty-fourth Annual Report to Congress on the Implementation of the Individuals with Disabilities in Education Act.
- b. Pastor & Reuben (2002). Attention deficit disorder and learning disability: United States, 1997-98.
- c. Kelleher et al. (2000). Increasing identification of psychosocial problems: 1979 – 1996.
- d. Grunbaum et al. (2002). Youth Risk Behavior Surveillance - United States, 2001
- e. Anderson & Smith (2003). Deaths: Leading Causes for 2001. [Rates per 100,000].
- f. Denton & Germino-Hausken (2000). America's Kindergartners. [Varies by reporter (teacher vs. parent)].
- g. Nansel et al. (2001). Bullying behaviors among U.S. youth: Prevalence and association with psychosocial adjustment.
- h. Johnston, O'Malley, & Bachman (2003). Monitoring the Future. 8th - 12th grade.

Initials:

SED/ED= Severe Emotional Disturbance;
 SLD/LD= Specific Learning Disability;
 OHI= Other Health Impairment (includes ADHD);
 ADHD = Attention Deficit Hyperactivity Disorder;
 MR= Mental Retardation;
 AUT= Autism;
 DD= Developmental Disability;
 SLI= Speech and Learning Impairment;
 PSYSOC= Total clinician identified psychosocial problems;
 SAD= Felt sad or hopeless;
 SUIDEA= Seriously considered attempting suicide;
 SUIATT= Attempted suicide;

SUICIDE= Suicide death (rates per 100,000);
 ARGUE= Argues with others;
 FIGHT= Physical fights;
 ANGER= Easily gets angry;
 UNSAFE= Felt too unsafe to go to school;
 BULLIED= Reported being bullied weekly;
 FRIENDS= Does not make friends;
 COMFORT= Does not comfort others;
 CIG= Current frequent cigarette use;
 ALC= Episodic heavy drinking;
 MJ= Current marijuana use;
 DRUG= Illicit drug use other than MJ

B. How are the Data Commonly Reported?

Drawing on the primary references cited in Table 1, the following statistics are frequently cited in various reports.

- Many reports state the following: Data on diagnosable mental disorders suggest that from 12% to 22% of all youngsters under age 18 are in need of services for mental, emotional or behavioral problems.
- The Surgeon General's 1999 report on *Mental Health* provides one recent example of efforts to highlight available data (U.S. Department of Health and Human Services, 1999). Referring to ages 9 to 17, that document states that 21% or "one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year" – with 11% of all children experiencing significant impairment and about 5 percent experiencing "extreme functional impairment." Of the 5 percent with extreme problems, estimates suggest that 13% have anxiety disorders, 10% have disruptive disorders, 6% have mood disorders, 2% have substance abuse disorders; some have multiple diagnoses. (Using the 21% figure and the 2000 data indicating 70.4 million children 17 or younger, the estimate would be that about 14 million "experiences the signs and symptoms of a DSM-IV disorder during the course of a year.")
- Data from the 1997 Client/Patient Sample Survey conducted by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Service Administration (SAMHSA) Center for Mental Health Services (CMHS) indicate that more than 1.3 million children under the age of 18 – or one out of 50 – received mental health services in the U.S. (Update, 2002).
 - >Over two-thirds of the youth had one of three diagnoses: disruptive behavior disorders (31%), mood disorders (21%) or adjustment disorders (16%). Almost 40% were "seriously emotionally disturbed," using the most stringent definition provided by DHHS. The survey revealed another fact that has significant service implications: one-third (30%) of the youngsters were diagnosed with two disorders; 63% were diagnosed with one, while 7% entered the mental health service system with no psychiatric diagnosis whatsoever.
 - >Half of the youngsters had problems with family (50%); nearly half (46%) had problems such as eating disturbances, sleep problems, grief and loss reactions, or post-traumatic stress – warning signs of depression or anxiety. In addition, 44% had problems coping with school; and 41% had problems with aggression. Nearly one-quarter (24%) threatened or attempted suicide, while fully 20% were victims of abuse or neglect.
 - >Nine percent (119,541) of the children were under six years old
- The Snapshots of America's Families Survey (see The Urban Institute, 2000) provides data from parent reports of behavioral and emotional problems for children ages 6 to 11. In 1999, 6.3% of children ages 6 to 11 were reported by their parents to have behavioral and emotional problems (Moore, Hatcher, Vandivere, & Brown, 2000). Higher percentages are reported for those living in poverty – 9.3% as compared to 4.2% of children living above 200% of the poverty level (Moore, Hatcher, et al., 2000). The same

is true for children living in stressful family environments – 15% vs. 4% (Moore & Vandivere, 2000). For children with multiple risk factors (i.e., three of the following: having a single parent, living in poverty, four or more children in household, parent without high school diploma or GED): 18% of those ages 6 to 11 with at least three risk factors are reported to have behavioral and emotional problems compared to 6% of children who have fewer risk factors (Moore, Vandivere, and Ehrle, 2000).

- Most sources suggest that diagnosis of Attention Deficit-Hyperactivity Disorder (ADHD) is on the rise. However, the estimates generally cited indicate that between 3-5% of school-age children are so-diagnosed. This translates into an estimated 1.5 to 2.5 million children, with boys four to nine times more likely to be so-labeled.
- A ten year review of research on school-based mental health services estimates that from 3-5% of school children have serious behavioral or emotional disabilities (Hoagwood & Erwin, 1997).
- As reported in the U.S. Department of Education 24th annual report to Congress,
 - >over 50% of the 5,775,722 students ages 6 through 21 served in the U.S. under IDEA Section B are diagnosed as having Learning Disabilities (LD)
 - >white students made up 62.3% of the students served; 19.8% were Black;14.5% were Hispanic; 1.9% were Asian/Pacific Islander; and 1.5% were American Indian/Alaska Native.
 - >In 2000-01, the rank ordering of the top five disability categories was nearly identical for all racial/ethnic groups; however, students from some racial/ethnic groups were overrepresented or underrepresented in specific disability categories when compared with the IDEA student population as a whole.
- In 2000, approximately 3 million youths were seen as having been at risk for suicide during the preceding year (NHSDA, 2003).

Note: The picture worsens when one expands the focus beyond the limited perspective on diagnosable mental disorders to the number of young people experiencing psychosocial problems and who are "at risk of not maturing into responsible adults" (Dryfoos, 1990). Several reports have amply documented the problem (Greenberg, Domitrovich, & Bumbarger, 1999; IOM, 1994; NIMH, 1993, 1998; also see fact sheets and reports on the websites for the SAMHSA's Center for Mental Health Services and the USDOE's Safe and Drug Free Schools Program). For general purposes, it is sufficient to note the number of such youngsters in many schools serving low-income populations has climbed over the 50% mark, and few public schools have less than 20% who are at risk. An estimate from the Center for Demographic Policy suggests that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise. The reality for many large urban schools is that well-over 50% of their students manifest significant learning, behavior, and emotional problems. For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult living conditions associated with poverty. All current policy discussions stress the crisis nature of the problem in terms of future health and economic implications for individuals and for society and call for major systemic reforms.

- According to SAMHSA's *National Household Survey on Drug Abuse*:
 - > youth who reported past year alcohol or illicit drug use were more likely than those who did not use these substances to be at risk for suicide (NHSDA, 2002). Hispanic females aged 12 to 17 were seen as being at higher risk for suicide than other youths (NHSDA, 2003)
 - > an estimated 833,000 youths between the ages of 12 and 17 had carried a handgun in the past year (NHSDA, 2001).
 - > In 2000, almost 7 million persons aged 12 to 20 (under the legal drinking age) were binge drinkers. The rate of binge drinking among underage persons (19 percent) was almost as high as among adults aged 21 or older (21 percent). Underage persons who reported binge drinking were 7 times more likely to report illicit drugs during the past month than underage persons who did not binge drink. (NHSDA, 2002).
- The following lifetime prevalence estimates are reported in *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication* (R. Kessler, P. Berglund, O. Demler, R. Jim, and E. Walters, 2005):
 - > anxiety disorders, 28.8%;
 - > mood disorders, 20.8%;
 - > impulse-control disorders, 24.8%;
 - > substance use disorders, 14.6%;
 - > any disorder, 46.4%.
 - > Median age of onset is reported as much earlier for anxiety (11 years) and impulse-control (11 years) disorders than for substance use (20 years) and mood (30 years) disorders.
 - > Half of all lifetime cases were reported as starting by age 14 years.

The authors conclude that: “Whatever else we can say about mental disorders, then, they are distinct from chronic physical disorders because they have their strongest foothold in youth, with substantially lower risk among people who have matured out of the high-risk age range....” “About half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life, with first onset usually in childhood or adolescence. Interventions aimed at prevention or early treatment need to focus on youth.” (See Exhibit 1)

Exhibit 1

National Comorbidity Survey Replication Study

In June 2005, data were reported from the National Comorbidity Survey Replication study, supported by the National Institute of Mental Health and by health research foundations and pharmaceutical companies.

The findings are from a retrospective study of the prevalence and severity of specific mental disorders of children and youth. Data were gathered using a household survey of 9,282 English speaking respondents, age 18 and older. These data are described in four papers in the June 6, 2005 issue of the *Archives of General Psychiatry*.*

As the *New York Times* (6/7/50) notes: “The report comes amid debate about whether adults and children should be screened for mental disorders, and where the line should be drawn. The answers will have an enormous effect on who receives treatment and which disorders are covered by insurance.”

The *Times* also notes: “The new findings are sure to renew the debate about whether [some forms of] mental illness can be reliably distinguished from garden-variety emotional struggles that are part of any life.” For example, Paul McHugh, a professor of psychiatry from John Hopkins University is quoted as follows: “Fifty percent of Americans mentally impaired – are you kidding me? The problem is that the diagnostic manual we are using in psychiatry is like a field guide, and it just keeps expanding and expanding. Pretty soon we’ll have a syndrom for short, fat Irish guys with a Boston accent [like me], and I’ll be [classified as] mentally ill.”

*Note: For purposes of this document, we have extracted the prevalence data from the paper entitled *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication* (Kessler, et al., 2005) and treatment use data from *Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication* (Wang, et al., 2005).

