Part 1: Earlier Evaluations and the Current Situation

Chapter 2

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INTRODUCTION

Services for children[1] with mental health problems have long been a focus of national concern. This chapter summarizes the work of several major policy-related studies and commissions, giving their conclusions about the prevalence of mental health problems in children and their recommendations for services. The chapter also presents available information pertaining to trends in the availability and use of children's mental health services. Although data to assess the current situation are limited, it is nevertheless clear that several key policy recommendations of past studies and commissions have yet to be implemented.

[1] Throughout this background paper, the term "children" is used to refer generally to all infants, children, and adolescents under age 18. Where necessary, further distinctions are drawn among children of various ages and developmental stages.

EARLIER EVALUATIONS OF CHILDREN'S MENTAL HEALTH NEEDS AND SERVICES

Estimates of the Prevalence of Children's Mental Health Problems

Estimating the prevalence of mental health problems among children is hard for several reasons. Distinguishing between distinct mental health problems and normal changes during a child's development, for example, is often difficult. Also, some children without a diagnosable disorder may require mental health services because of problems in their social and physical environment (see ch. 4). These factors complicate the task of enumerating specific disorders and identifying children in need.

To complicate matters further, various panels that have tried to estimate the prevalence of children's mental health problems in the past have varied in the age range of children and the types of problems included in their estimates. Also, because of changes in psychiatric nomenclature, prevalence estimates used in individual studies or reports cannot be reliably replicated by subsequent groups. Nevertheless, all of the various panels' estimates have been roughly similar (see table 1), and the panels have all agreed that the need for children's mental health services exceeds the availability of services.

Joint Commission on the Mental Health of Children (1969)

One of the most detailed assessments of the magnitude of children's mental health problems was conducted by the Joint Commission on the Mental Health of Children (324). Established in 1965 (Public Law 89-97), the Joint Commission on the Mental Health of Children was specifically mandated to develop a coordinated study of the diagnosis, prevention, and treatment of "emotional illness" in children and adolescents. An earlier commission whose work had led to the 1963 act establishing community mental health centers throughout the country had not dealt explicitly with children (324).

In defining and estimating the prevalence of emotional disorders in children, the Joint Commission was hindered by a lack of specific diagnostic criteria. The Joint Commission adopted a rather broad definition of an "emotionally disturbed child" based on its synthesis of research and expert opinion:

> . . . one whose progressive personality development is interfered with or arrested by a variety of factors, so that he shows an impairment in the capacity expected of him for his age and endow-

Table 1 .—Estimates of Children With Mental Health Needs[a]

	Children under 18 years of age with mental health needs	
	Percent	Number[b]
All mentally disturbed children:		
Joint Commission on the Mental Health of Children (1969)	13.6%	8.8 million
President's Commission on Mental Health (1978)	5% to 15%	3.0 to 9.6 million
Gould, et al. (1981) .	11 .8%[c]	7,5 million
Severely mentally disturbed children:		
National Plan for the Chronically Mentally Ill (1980)	8%	9.1 million
Knitzer/CDF (1982) ., .,	5.0%	3 million

[a]Estimates differ because inconsistent definitions of children's mental health needs have been used The U S Department of Health and Human Services is currently evaluating the validity of a diagnostic interview schedule for use with children in order to conduct an epidemiological study of the presence of mental disorders
[b]The number of Children in need of services is calculated as a percent Of the 1980 population of 638 million individuals under 18 years of age
[c]Subsequent analyses concur with this estimate See text

SOURCES Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health Challenge for the1970's* (New York Harper & Row, 1969); President s Commission on Mental Health *Report to the President From the President's Commission on Mental Health*, vol 1 (Commission Report) and vol 3 (Task Panel Reports) (Washington DC U S Government Prmtmg Office, 1978), M S Gould, R Wunsch-Hitzig, and 8 Dohrenwend, "Estlmatmg the Prevalence of Childhood Psychopathology A Critical Review," *Journal of the American AcadernyofChddPsycfr/airy 20462, 1981*, L Salver, "Chronic Mental Illness m Children and Adolescents Scope of the Problem, " paper for the National Conference on Chronic Mental Illness in Children and Adolescents, sponsored by the American Psychiatric Association, Dallas TX, March 1985 J Knitzer *Unclaimed Children* (Washington, OC Children's Defense Fund 1982)

> ment; (1) for reasonably accurate perception of the world around him; (2) for impulse control; (3) for satisfying and satisfactory relations with others; (4) for learning; or (5) for any combination of these.

Using this definition to interpret available research, the Joint Commission on the Mental Health of Children estimated that up to 13.6 percent of children were "emotionally disturbed. " This included a small percentage (0.6 percent) of children who were considered psychotic, 2 to 3 percent who were severely disturbed, and an additional 8 to 10 percent who suffered from emotional problems serious enough to require mental health services.

U.S. Department of Health, Education, and Welfare: Project on the Classification of Exceptional Children (1975)

The issues of classifying children's mental health problems were also of concern subsequent to the Joint Commission's report. In 1972, a project was initiated by the Secretary of the U.S. Department of Health, Education, and Welfare (DHEW), now the U.S. Department of Health and Human Services, to consider issues in the classification of "exceptional" children, including but not limited to those with mental health problems. Supported by a consortium of DHEW agencies and directed by Hobbs, the Project on the Classification of Exceptional Children brought together a group of experts to develop a better understanding of the issues involved in classification and a rationale for policy and services for "exceptional" children.

The final report of the project cited a DHEW Bureau of Education (298,299) estimate that there were about 7 million children aged O to 19 in various "exceptional" categories (physically handicapped, retarded, and emotionally disturbed), but it did not estimate prevalence for specific disabilities. Another 1 million children (2.9 percent of children aged 10 to 17) had been in trouble with the law in 1972, and 10 million poor and 10 million nonwhite children were also of concern to the advisors to DHEW.

The report concluded that although there were significant problems associated with labeling children, categorization was often necessary to establish policy and to ensure that services were delivered. The report noted, however, that the classification of emotional disorders was particularly difficult and therefore recommended the development of multidimensional classification systems. A central feature of this recommendation was that such systems classify disorders, rather than children.

President's Commission on Mental Health and Its Task Panel on Infants, Children, and Adolescents (1978)

The President's Commission on Mental Health was established in 1977 to undertake a broad-based review of national mental health needs and to make recommendations to the President as to how those needs might be met (514). One of the principal "task panels" of the Commission addressed the mental health needs of children. Using studies conducted since the time of the Joint Commission on the Mental Health of Children, this task panel estimated that from 5 to 15 percent of children aged 3 to 15 had handicapping mental health problems. The panel's lower estimate corresponds to estimates of the number of psychotic

and severely disturbed children; its higher estimate corresponds to the number of children with "neuroses" and behavior problems for whom mental health intervention may be useful.

The Commission as a whole stated that the country's mental health problems could not "be defined only in terms of disabling mental illnesses and identified psychiatric disorders. " Mental health problems "must include the damage to mental health associated with unrelenting poverty and unemployment and the institutionalized discrimination that occurs on the basis of race, sex, class, age, and mental or physical handicaps, " and "conditions that involve emotional or psychological distress which do not fit conventional categories of classification or services" (514).

Recent Estimates of the Prevalence of Children's Mental Health Problems

Epidemiologic research on mental health problems needed in order to estimate prevalence has continued to develop. Over two dozen studies of the prevalence of mental disorders in children and adolescents have now been conducted (229,248, 389,609).

Some of the most important research on prevalence, conducted in the United Kingdom by Rutter and colleagues (562,566), is believed to be relevant to the situation in the United States. On the basis of a convergence of identifications by mental health professionals, parents, and teachers, Rutter estimated that 13.2 percent of children in the United Kingdom were in need of mental health services.

In a detailed 1981 review, Gould, et al., concluded that the percentage of children and adolescents in need of mental health services in the United States was probably "no lower than 11.8 percent" (248). Later reviews, by Gilmore, et al. (229), and Silver (609), concur with the 11.8-percent figure.

Gould and her colleagues' estimate that about 12 percent of the children in the United States—7.5 million—are in need of mental health services seems to be one on which there is general concurrence. This estimate, however, reveals nothing about the severity of disturbances and levels of care children need—distinctions that are essential for the development of comprehensive public policy.

Increasing interest is being directed to children with severe mental health disturbances, both in terms of identification and for developing appropriate treatment options (396). Estimates of the number of severely disturbed children, however, differ substantially. In comparison to the findings of the President's Commission on Mental Health (514), for example, the 1980 National Plan for the Chronically Mentally 111 (609) estimated that about 9.1 million (8 percent) children are severely disturbed and in need of services.

Recommendations About Mental Health Services for Children

Concern about the inadequacy of mental health services for children is not a recent phenomenon. As long ago as **1909,** a White House Conference on Children recommended new programs to care for mentally disturbed children **(324).** A White House Conference in 1930 echoed the earlier recommendation and maintained that mentally disturbed children have the "right" to develop the way other children do. A similar conclusion has been reached by nearly every subsequent commission or panel (324). These panels and study commissions have made numerous detailed and specific recommendations conceiving policy relevant to the mental health needs of children. Only the flavor of their recommendations can be provided here. Selected conclusions and recommendations of various commissions and panels are summarized in table 2, and the work of the more recent groups is discussed in detail below.

Joint Commission on the Mental Health of Children (1969)

The Joint Commission on the Mental Health of Children **(324),** in its 1969 report *Crisis in Child Mental Health,* stated that large numbers of emotionally, physically, and socially handicapped children did not receive necessary or appropriate services and that the mental health service system for children and youth was wholly inadequate. Although the most disturbed and disrup-

Table 2.—Mental Health Services for Children: Selected Findings and Recommendations of Past National Study Panels

Selected conclusions	Selected recommendations	Subsequent Federal actions
White *House Conference on Children (1909):*		
	Develop new programs to care for emotionally disturbed children	
White House Conference on Children (1930):		
Emotionally disturbed children have the "right" to develop like other children,	Develop new programs to care for emotionally disturbed children	
Joint Commission on the Mental Health of Children (1969):		
Large numbers of emotionally, physically, and socially handicapped children do not receive necessary or appropriate services,	Establish a child advocacy system to coordinate Federal, State, and local action, Establish community services focused on prevention and remediation Expand prevention services to include family planning, prenatal care, nutrition, and other physical health care, Deliver treatment in settings resembling normal living conditions Increase research on diagnosis and treatment	
Project on the Classification of Exceptional Children (1975):		
Services for all kinds of children remain a tangled thicket of conceptual confusions, competing authorities, contrary purposes, and professional rivalries, leading to the fragmentation of services and the lack of sustained attention to the needs of Individual children and their families,	Classify disorders, not children Coordinate and plan services, Educate all children; make public schools advocates for all services for all children,	Education for All Handicapped Children Act (Public Law 94-142) passed in 1975.
President's Commission on Mental Health or its Task Panal on infants, Children, and Adolescents (1978):		
A delay in the delivery of mental health services is no more justifiable than a delay in the delivery of physical health services, Adolescents are one of the most underserved groups in Nation, Mental health commissions have to date garnered little action for minority group programs	Provide prevention services (e. g., prenatal care) to all families with children. Services should "respect ethnic differences, be adapted to children's specific needs, treat significant others. Incorporate mental health services (e.g., developmental assessments, diagnostic services) into general health care. Involve parents m development of treatment, educational, and service plans, Develop a network of psychiatric, pediatric, counseling, special education, and occupational training services Organize mental health services along a continuum of intensiveness Increase residential and outpatient care. Make mental health care available at reasonable costs to all who need it. Address adolescent suicide, teenage pregnancy, delinquency, and substance abuse. Increase the number of mental health professionals trained to work with children, Fund more basic and evaluation research,	Mental Health Systems Act (1980) authorized programs to improve the delivery and coordination of services for severely emotionally disturbed children and adolescents (repealed in 1981)
Select Panel for the Promotion of Child Health (1981):		
Public Law 94-142 (the Education for All Handicapped Children Act) has wrought significant Improvements, but substantial variations exist m the availability of services,	Develop better means of Identifying and evaluating children with handicapping conditions, including serious emotional disturbance. Require delivery of health and mental health services to handicapped children, Improve Federal and State monitoring, technical assistance, and enforcement of Public Law 94-142. Expand mental health services to include early detection and treatment of developmental problems, other preventive services for children and families, high quality residential treatment services, and community support mechanisms, Develop new means of coordinating physical and mental health services, and mental health services with educational and social services, Involve families in delivery of mental health services.	
Knuitzer/Children's Defense Fund Survey of State **Mental** *Health Programs:*		
All services (residential and nonresidential) are inadequate Inpatient psychiatric care is the most accessible, but also the most costly and restrictive, States do not monitor children's progression through mental health system. Service systems (juvenile, educational, child welfare, mental health) are uncoordinated, Seriously emotionally disturbed children appear to be underserved under Public Law 94-142.	Increase efforts to Identify children and adolescents in need of services or who are inappropriately served Develop incentives for creating coordinated services. Coordinate juvenile justice, education, child welfare, and mental health services by means of a child advocacy system, Target Federal Alcohol, Drug Abuse & Mental Health (ADM) block grant funds for children's services,	Child and Adolescent Service System Program (CASSP) was funded to promote coordination of mental health services within States, Ten percent of ADM mental health block grant funds was set aside for children or other underserved populations,

SOURCES Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health Challenge for the1970's* (New York Harper & Row, 1969). N Hubbs,*The Futures of Children Categories, Labels and Their Consequences* (San Francisco, CA Jossey-Bass, 1975), President's Commission on Mental Health, *Report to the President From the President's Commission on Mental Health*, VOl 1 (Commission Report) and VOl 3 (Task Panel Reports) (Washington, DC U S Government Printing Off Ice, 1978), Select Panel for the Promotion of Child Health, *Better Health for Our Children A National Strategy*, presented 10 the U S Congress and the Secretary of Health and Human Services, Washington, OC, 1981, J Knitzer, *Unclaimed Children* (Washington, DC Children's Defense Fund, 1982)

tive children could receive treatment services, the Commission found that treatment provided to them very often was inappropriate and ineffective. The Joint Commission was particularly concerned that severely disturbed children were being institutionalized in State mental hospitals and that such facilities provided custodial rather than treatment services for children. The Joint Commission was also concerned about the "corrosive" effects of poverty and the fact that mental health problems were more acute and services less available among poor children.

A principal recommendation of the Joint Commission on the Mental Health of Children was that a child advocacy system be established to coordinate Federal, State, and local actions. The Commission believed that advocacy was essential for development of a comprehensive network to meet children's mental health, physical, and social needs.

The Joint Commission also recommended the establishment of community services that focused on prevention and "remediation. " Recommended prevention services included family planning, prenatal care, and mental health services associated with schools. Remedial mental health services, which the Commission estimated would be required for 10 percent of children, were to be based on children's functional level, rather than on legal or clinical classification systems.

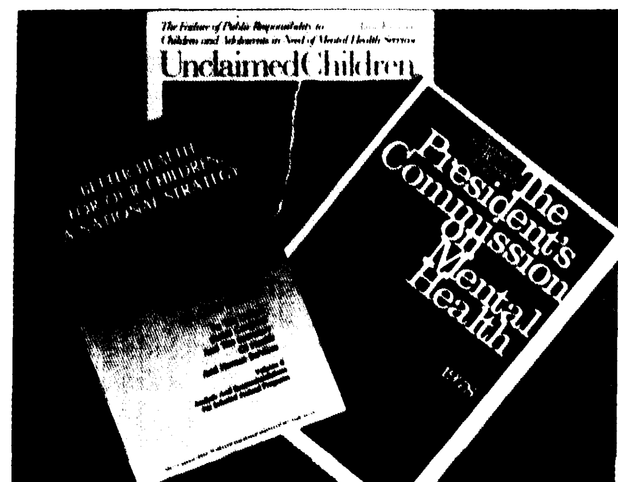
The Joint Commission further recommended that children (particularly the severely handicapped) be cared for in settings that most closely resembled normal living situations. An additional recommendation was for increased research on diagnosis and treatment of children's mental health problems. The Joint Commission believed that both basic and applied research was essential and suggested a variety of research priorities, both for the National Institute of Mental Health (NIMH) and for the National Institutes of Health.

U.S. Department of Health, Education, and Welfare: Project on the Classification of Exceptional Children

Perhaps because it was concerned with "exceptional" children of several kinds (handicapped, disadvantaged, and delinquent), the Project on the Classification of Exceptional Children was perhaps even more concerned than the Joint Commission on the Mental Health of Children with the coordination of services across agencies and categories of children. Thus, the Project's final report **(298,299)** recommended that the U.S. Congress and the legislative bodies of each State and community establish an agency to serve a planning and coordinating function for all programs bearing on families and children. The Project report also suggested that at every level, citizens' councils advise the planning agencies on program development and agency operations. The Project also made recommendations concerning specific programs which might be implemented under the purview of the legislative bodies, and noted several needs that should be given priority attention:

- support for parents,
- improved residential programs for children,
- fairness to disadvantaged and minority group children,
- improved classification systems,
- better organization of services, and
- new knowledge to inform policy.

One of the Project's recommendations, that all children including the handicapped have access to education, was implemented with the passage of Public Law 94-142, the Education for All Handicapped Children Act. Public Law 94-142 also implicitly made the public schools the primary



A number of national studies and commissions have concluded that mental health services for children are inadequate.

source of advocacy for children, another recommendation of the Project on the Classification of Exceptional Children.

President's Commission on Mental Health and Its Task Panel on Infants, Children, and Adolescents (1978)

The President's Commission on Mental Health (514) found that many of the Joint Commission's 1969 recommendations had not been implemented. Children and adolescents, the President's Commision found, continued to receive inadequate mental health care:

> Services that reflect the unique needs of children and adolescents are frequently unavailable. Our existing mental health services system contains too few mental health professionals and other personnel trained to meet the special needs of children and adolescents. Even when identified, children's needs are too often isolated into distinct categories, each to be addressed separately by a different specialist. Shuttling children from service to service, each with its own label, adds to their confusion, increases their despair, and sets the pattern for adult disability.

The Commission's subtask panel on infants, children, and adolescents recommended preventive services for all children, not only those identified as mentally disturbed. Services such as developmental assessments and access to diagnostic mental health services, it suggested, should be incorporated within children's general health care.

The subtask panel also recommended a network of "psychiatric, pediatric, counseling, special education and occupational training services" for children with severe psychiatric disorders. These services were necessary, according to the panel, because no matter how successful prevention efforts were, some children would always require special help. The services provided, the panel recommended, should be adapted to children's specific needs and should include counseling with parents and others significant in a child's life. In addition, the panel believed, it was essential that services "respect ethnic differences. "

The subtask panel on infants, children, and adolescents emphasized that children's mental health services should be provided within a system of care that "insofar as possible maintain a continuing relationship between child and family." To prevent disruption in the relationship between children and their families, the panel recommended that health insurance plans eliminate barriers to reimbursement for outpatient treatment services. The panel also recommended that parents be involved in the development of special education and other treatment plans, especially for intensive services provided for severely disturbed children.

Another recommendation of the subtask panel was that children's mental health services be organized along a continuum of intensiveness, so that children could move along the continuum as their needs changed. Good residential facilities specializing in the treatment of severely disturbed children and adolescents, the panel suggested, were urgently needed. The panel supported the Joint Commission calling for development of a better research and evaluation base, characterizing the tendency to reduce research funding in order to provide treatment services as "penny wise and pound foolish" (514). Noting that without more research and evaluation, "the potential for waste of resources is great, " the panel recommended a lo-percent set-aside of total program funds for research, demonstrations, and evaluation.

The subtask panel called the mental health system for adolescents "woefully inadequate, " noting that adolescents were one of the most underserved groups in the Nation. This panel urged that services be provided to address such problems as adolescent suicide, teenage pregnancy, delinquency, and substance abuse. The panel's recommendations focused on development of an integrated network of mental health services in schools, juvenile courts, neighborhood centers, and occupational training facilities.

One impact of the work of the President's Commission was the development and enactment of the Mental Health Systems Act. The act authorized programs to improve the delivery and coordination of services for severely emotionally disturbed children and adolescents. The act became law in 1981, but was repealed before it became effective and was replaced by the Alcohol, Drug Abuse, and Mental Health (ADM) block grant (Public Law 97-35; see ch. 10).

Select Panel for the Promotion of Child Health (1981)

Established at about the same time as the President's Commission on Mental Health was the Select Panel for the Promotion of Child Health established under Public Law 95-626. The Select Panel had a broad mandate; it attempted to develop recommendations that:

> . . . reflected] hardheaded analysis of serious unmet needs in child and maternal health . . . and a sober and pragmatic assessment of the capacity of our institutions to provide parents, professionals and . . . others working to improve child health with the scientific, financial and organizational support they need.

The Select Panel reported its findings in December 1980 (595). The general recommendations of the Panel, much like those of its predecessors, emphasized the interrelationships among services provided by health care agencies, schools, families, and social service institutions. The Select Panel's analysis suggested changes to a wide range of Federal programs affecting children. With respect to mental health needs, the Panel focused on implementation of the Education for All Handicapped Children Act (Public Law 94-142, enacted in 1975) and mental health service systems that were to be affected by the Mental Health Systems Act (enacted in 1980, but then repealed in 1981).

Public Law 94-142 mandates that handicapped children be provided access to a free and appropriate public education. Public Law 94-142 authorizes a program for States to receive Federal funds, but it also "guarantees" the right to education for handicapped children without regard to the provision of Federal funds to support such services. Although the Select Panel found that significant improvements had resulted from Public Law 94-142, particularly in changing attitudes about the handicapped, it was concerned that substantial variations existed across States in the availability of services. The Panel stressed the need for better methods of identifying and evaluating children with handicapping conditions and more stringent requirements for delivering health and mental health services to these children. To ensure compliance with the law, it recommended Federal and State monitoring, technical assistance, and enforcement.

The Select Panel also considered the role of community mental health centers and other mental health service systems and recommended that these systems expand mental health services for children. Although children's mental health services had been mandated earlier (Part F of the 1970 Amendments to the Community Mental Health Centers Act), direct Federal support specifically for children's programs had been withdrawn in 1975. The Select Panel believed that developmental assessment and other preventive services, as well as high-quality residential treatment services and community support mechanisms, were necessary components of all comprehensive mental health programs.

As had the President's Commission on Mental Health in 1978, the Select Panel for the Promotion of Child Health recommended that mental health services be coordinated with general health care. The Select Panel also recommended coordination of education and social welfare programs that serve children. Other recommendations of the Select Panel were that community mental health programs provide services in schools, Head Start programs, and juvenile justice institutions, and that families be involved in the delivery of mental health services.

Knitzer/Children's Defense Fund (1982)

Concern about the adequacy of services for mentally disturbed children remained, despite the convergence of recommendations by the Joint Commission, the President's Commission, and the Select Panel. In 1982, the Children's Defense Fund (CDF) published an elaborate and highly critical study of how children and adolescents in need of mental health services are treated **(358).** That report, Unclaimed *Children,* by Jane Knitzer, described a survey of mental health services for severely disturbed children and adolescents in 50 States and the District of Columbia. Unlike the reports of earlier commissions and panels, the Knitzer/CDF report is based on systematically collected original data and is one of only a few efforts to comprehensively assess State, *as well* as Federal, programs.

The Knitzer/CDF report concluded that there were 3 million seriously disturbed children (based on the estimate of the President's Commission on

Mental Health in 1978), but that 2 million (two-thirds) of these children were not receiving needed treatment services. The report also suggested that many children who received services received inappropriate care and that poor and minority group children were most likely to receive no care or inappropriate care.

Using data from State and county hospitals, Knitzer concluded that the most restrictive and costly level of care—inpatient hospital treatment—was also the most accessible. Although the data Knitzer collected suggested that as many as 40 percent of such hospital placements were unsuitable, alternatives to hospital services for severely disturbed children were found to be either nonexistent or rudimentary in many States. One-third of the States responding to Knitzer's survey indicated a need for more long- or short-term beds. According to Knitzer **(358):**

> . . . those States with the fewest alternatives to inpatient care were generally the ones that wanted more beds. Those with a number of alternative programs saw less need to fund more hospital placements . . .

Knitzer suggested that Federal funds had been used disproportionately to provide medically oriented inpatient care, while Federal resources available for community services had declined.

Responsibility for seriously disturbed children, according to Knitzer, lies with public agencies. The Knitzer/CDF report strongly recommended increased efforts to identify children and adolescents who are either in need of services or are being inappropriately served. It also urged the development of incentives to create a coordinated set of services appropriate to the child. As did the reports of each of the government panels described earlier, the Knitzer/CDF report recommended increased coordination among agencies that deal with children, including educational, juvenile justice, and child welfare agencies. A specific recommendation of the report was that ADM block grant funds be targeted for children's services.

THE CURRENT AVAILABILITY AND USE OF CHILDREN'S MENTAL HEALTH SERVICES

Despite general agreement among experts about the magnitude of children's mental health problems, it is difficult to specify precisely the number of children with mental health problems and the types of services they need. The National Institute of Mental Health (NIMH), which recently conducted a nationwide study of the prevalence of adult mental health disorders (533), plans a parallel survey of children's problems. At the time this background paper was being written, NIMH was studying the reliability and validity of the instrument it plans to use in the survey—the Diagnostic Interview Schedule for Children (DISC). DISC is based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders.* The NIMH survey represents an important step toward more precise assessment of children's mental health problems **(664).**

A serious problem in attempting to assess the extent to which mental health services for children are available, and the degree to which the mental health service system has changed in recent years, is the lack of precise epidemiologic data. The information available at the time this background paper was being prepared was quite dated. The most recent systematically collected information on inpatient, residential, and outpatient mental health care pertained to utilization for 1981 (665). These data do not reflect the impact of recent policy changes such as Medicare's Part A prospective payment system, the limitation by the Civilian Health and Medical Program of the Uniformed Services on inpatient treatment, the lo-percent set-aside in the mental health portion of the ADM block grant, and the Child and Adolescent Service System Program (see ch. 10). Nevertheless, they do allow the identification of several noteworthy trends. For the most part, the continuation of these trends has been confirmed by individuals consulted during the preparation of this background paper.

The most dramatic trend in recent years has been a decline in the number of children treated as inpatients in State and county mental hospi-

tals (665). This trend has been accompanied, however, by increases in children's admissions to private psychiatric hospitals and to facilities such as psychiatric units of general hospitals, for a small net increase in children's admissions to psychiatric hospitals.

In 1970, as shown in table 3, the rate of children's admissions to private psychiatric hospitals (9.3 per 100,000 children under 18) was one-fourth the rate of children's admissions to State and county mental hospitals (37.8 per 100,000 children under 18). During the 1970s, children's admissions to State and county mental hospitals declined 30 percent and admissions to private psychiatric hospitals increased almost 200 percent, so that in 1980, the latest period for which systematic data are available, the rates of children's admissions were about the same for both types of institutions. The rates of children's admissions to non-Federal general hospitals with inpatient psychiatric services increased slightly from 63.3 per 100,000 population in 1970 to 68.5 per 100,000 population in 1980, for a total net increase in the rate of psychiatric hospitalization of children of about 10 admissions per 100,000 population. There may be significant regional variations (589).

Some evidence suggests that the length of treatment episodes in State and county mental hospitals is declining, although the evidence on the length of stay for children in private psychiatric hospitals is unclear (458,665). As can be seen in table 4, data from NIMH indicate that the median length of stay of children in State and county mental hospitals dropped from 74 days in 1970 to 54 days in 1980, while the 1ength of stay in private psychiatric hospitals remained constant at 36 days (665). A survey of National Association of Private Psychiatric Hospitals members, however, found that the median length of stay for children in 1985 in the private hospitals surveyed was twice NIMH's number for 1980 (458). Data from NIMH indicate that the length of stay in non-Federal general hospitals with inpatient psychiatric services increased from 9 to 17 days between 1970 and 1975, then decreased to 14 days in 1980. The evidence just cited clearly shows that general hospitals are used for short-term care, and the length of stay in State and county mental hospitals has declined. It does not allow conclusions about the length of treatment in private psychiatric hospitals.

As shown in table **3,** NIMH data suggest that there has been an increase in utilization of residential treatment centers for emotionally disturbed children (RTCs). Such facilities can provide an alternative form of treatment for children who require residential treatment but who do not require constant medical supervision (see ch. 6). There was a substantial increase in the number of admissions to RTCs between 1969 and **1981.** According to NIMH data, the rate more than doubled, from 11.4 admissions per 100,000 population under **18** in 1969 to 28.3 admissions per 100,000 pop-

Table 3.—Admissions of Children Under 18 Years of Age to Hospital Inpatient Psychiatric Facilities and Residential Treatment Centers, 1970, 1975, and 1980[a]

	1970b		1975		1980C	
	Rate[d]	Number	Rate[d]	Number	Rate[d]	Number
Hospital inpatient facilities						
State and county mental hospitals	37.8	26,352	38.1	25,252	26.1	16,612
Private psychiatric hospitals	9.3	6,452	23.3	15,426	26.3	16,735
Non-Federal general hospitals with inpatient psychiatric services	63.3	44,135	64,4	42,690	68.5	43,595
Total hospital inpatient admissions	110.4	76,939	125.8	83,368	120.9	76,942
Residential treatment centers for emotionally disturbed children (RTCs)	11.4	7,596	18.8	12,022	28.3	17.703

[a]Includes new admissions and readmission during the year, SO is not an unduplicated count
[b]Data for RTCs are fOr 1969
[c]Data for RTCs are for 1981.
[d]Rate per 100,000 children under 18 Years of a9e
[e]Includes St Elizabeth's Hospital in Washington, DC

SOURCE National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U S Department of Health and Human Services, *Mental Health, United States,1985.* C A. Taube and S A Barrett (eds), DHHS Pub No. (ADM) 85-1378 (Rockville, MD 1985), tables 221 and 23.

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Table 4.—Median Length of Stay in Hospital Inpatient Psychiatric Facilities Among Children Under 18 Years of Age, 1970, 1975, and 1980

	1970	1975	1980
State and county mental hospitals ... .,	74 days	66 days	54 days
Private psychiatric hospitals	36 days	36 days	36 days
Non-Federal general hospitals with inpatient psychiatric services ,	9 days	17 days	14 days

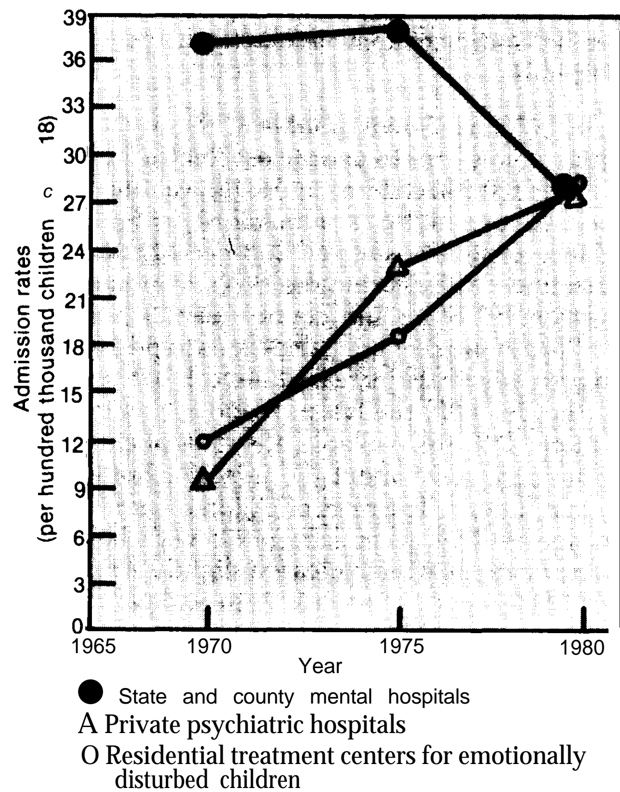
SOURCE NationalInstituteof Mental Health Alcohol, Drug Abuse and Mental Health AdministrationPublic Health Service U S Department of Health and Human Services. *Mental Health United States 7985* C A Taube and S A Barrett (eds) DHHS Pub No (ADM) 85-1378 (Rockville MD 1985)

ulation under 18 in 1981. The declining use of State and county mental hospitals and increasing use of RTCs is shown dramatically in figure **3.**

Partial hospitalization or day treatment in other facilities is another increasingly accepted way to treat some children. It may be appropriate for those who require mental health care that is more intensive than outpatient care but less intensive than inpatient or RTC care (see ch. 6). Data on children's admissions for partial hospitalization comparable to the data on other settings are not available, but the increasing use of partial hospitalization can be inferred from NIMH's 1983 end-of-year census data. These data indicated that **20,000** individuals under 18 were receiving a planned program of mental health treatment services generally provided in visits of 3 or more hours to groups of patients/clients in various settings (665).

The use of outpatient treatment mental health services by children is difficult to determine. The 1980 National Medical Care Utilization and Expenditures Survey found that 3.2 percent of children under 18—and 4.3 percent of all age groups combined—had had a mental health visit in **1980, (665).** Some observers have suggested that these figures probably underestimate the number of individuals who receive outpatient mental health treatment and that the treatment rate for individuals of all ages may be as high as 6 percent (178). The 1980-82 NIMH epidemiologic catchment area survey of adults in urban areas found that 6 to 7 percent of those surveyed had had a visit for a mental health problem, not necessarily a diagnosable disorder, in the 6-month period preceding the survey (599). Without specifying precise percentage increases by age, a 1985 NIMH report (665) noted that the use of outpatient mental health services had greatly increased for all ages. Careful assessment of the use of mental health services by children awaits conduct of the NIMH epidemiologic survey of children.

Figure 3.—Admission Rates for Children Under 18 Years to Psychiatric Hospitals and Residential Treatment Centers, 1970, 1975, and 1980a



● State and county mental hospitals
A Private psychiatric hospitals
O Residential treatment centers for emotionally disturbed children

[a]Data for residential treatment centers are for years 1969, 1975, and 1981

SOURCES 1970 to 1980 admission **rates** to State and county mental hospitals and private psychiatric hospitals. and 1969, 1975, and 1981 admissions for residential treatment centers National Institute of Mental Health, Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services, *Mental Health United States, 1985*, C.A Taube and S.A Barrett (eds.), DHHS Pub No. (ADM) 85-1378 (Rockville, MD 1985) 1969, 1975 and 1980 population **under** 18 (used to calculate admission rates for residential treatment centers) U.S. Department of Commerce, Bureau of the Census, Washington, DC, unpublished data for 1969, 1975, and 1980.

CONCLUSION

There appears to be a significant gap between the number of children identified in epidemiologic assessments as requiring mental health services and the number receiving services. There is general agreement that at least 12 percent of the Nation's children—7.5 million—are in need of some type of mental health treatment. Available evidence suggests that only a small number (fewer than one-third) of the children who have mental health problems receive treatment. An unknown number of other children maybe at risk for mental health problems and in need of preventive services (see ch. 4). The problems of a lack of treatment and inappropriate treatment for children's mental health problems have long plagued those responsible for providing services to children. Subsequent chapters of this background paper examine the current state of knowledge about diagnosable mental disorders and the environmental risk factors that can cause or exacerbate children's mental health problems.