

CHAPTER 1

The Mental Health Landscape

PURPOSE

This chapter provides an overview of

- demographic characteristics of youth with mental health needs,
- terminology used to describe mental health conditions,
- the two most common identification systems for youth – mental health and special education, and
- common mental health or emotional disorders in youth.

Youth with mental health needs often face unemployment, underemployment, and discrimination when they enter the workforce. Employment data indicate that individuals with serious mental illness have the lowest level of employment of any group of people with disabilities. As a result, large numbers of youth with both diagnosed and undiagnosed mental health needs who are transitioning into young adulthood, to the world of work, and to postsecondary education are likely to experience significant difficulties.

Statistics show that youth with MHN are over-represented in foster care, the juvenile justice system, and among school disciplinary cases and high school dropouts. Table 1.1 provides further statistical data on youth with MHN. The President’s New Freedom Commission on Mental Health’s Report recognizes that schools have a critical role to play in providing early identification of MHN, research-based interventions, and mental health services, as well as in educating families, service providers, and the local community about supporting youth with MHN. Unfortunately, too many youth do not receive the services they need in order to successfully navigate the road to work and meaningful adult lives.

Youth service practitioners in the workforce development system are responsible for supporting vulnerable youth; several of these targeted groups include many youth with mental health needs. Fortunately, there are a growing number of strategies and resources to support youth with MHN in achieving independence, self-sufficiency, and their employment and postsecondary education goals. Youth with mild to moderate mental health needs who are placed in employment often need minimal or no employment supports.

TABLE 1.1

Facts and Statistics for Youth with Mental Health Needs

- According to the National Mental Health Information Center, population studies show that at any point in time, 10% to 15% of children and adolescents have some symptoms of depression. The National Institute for Mental Health found that suicide was the third leading cause of death among 15 to 24 year olds, following unintentional injuries and homicide in 2002.
- Youth with emotional disturbance in secondary schools had the highest percentage (44.8%) of negative consequences for their actions (i.e., were suspended, expelled, fired, or arrested) of any disability group in the National Longitudinal Transition Study-2 (NLTS2).
- Students with emotional disabilities had a higher dropout rate than for any other single disability category in the NLTS2.
- High school youth with emotional disabilities in the NLTS2 were more likely to be involved in bullying or fighting in school (42%) and to initiate bullying (36%) than the general population of youth with disabilities.
- The National Center for Mental Health and Juvenile Justice estimates that on any given day over 100,000 youth reside in juvenile detention and correctional facilities across the country. Existing data suggest that between 65% and 100% of these youth have a diagnosable mental disorder, and that approximately 20% have a serious mental health disorder.
- The Northwest Foster Care Alumni study of over 600 foster care alumni revealed that 54.4% had a mental health disorder, including 25.2% with post-traumatic stress disorder, 20.1% with major depression, and 17.1% with social phobia.
- There is a 90% unemployment rate among adults with serious mental illness, the worst level of employment of any group of people with disabilities according to the President’s New Freedom Commission on Mental Health.

TERMINOLOGY

Youth with mental health needs (MHN) are referred to variously as *emotionally disturbed (ED)*, *antisocial, psychiatrically disordered (PD)*, *behaviorally disordered (BD)*, *socially maladjusted*, or *emotionally and behaviorally disordered (EBD)*. For purposes of this guide, the

category “youth with MHN” refers to the broad population of youth who have been diagnosed with emotional disorders by the public schools and/or the mental health system, as well as those with such conditions that have not been diagnosed. A sizeable proportion of these youth are never formally identified as having mental health disturbances by the educational or mental health systems.

The definitions and terms used to describe youth with MHN vary by system. The terminology used by the two systems — mental health and schools — that deal most directly with youth with mental health needs are described below.

Mental Health System Identification. Two broad and independent dimensions of MHN, internalizing and externalizing disorders, have been identified among children and youth. Externalizing disorders are represented by behavior that is directed outward toward the external social environment. They are characterized by behavioral excesses such as verbal and physical aggression, tantrums, disturbing others, oppositional behavior, noncompliance, and so on. In contrast, internalizing disorders are usually directed inward. They are represented by such problems as social withdrawal and isolation, low self-concept, phobias, and depression.

Both externalizing and internalizing MHN are described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* of the American Psychiatric Association, a publication that presents categories and definitions of disordered behavior and psychopathology for children, youth, and adults. The *DSM-IV-TR* is used primarily by mental health and social service agencies, and by vocational rehabilitation in some states, to determine eligibility for services and treatment, such as pharmacologic or medication interventions, for some diagnoses. Examples of psychiatric disorders (PD) found in the *DSM-IV-TR* include bipolar disorders, schizophrenia, autistic disorder, conduct disorder, oppositional defiant disorder, substance-related disorders, mental retardation, learning disorders, attention deficit/hyperactivity disorder, obsessive compulsive disorder, and personality disorders.

Special Education Disability Identification – Emotional Disturbance. The public education system uses 13 disability categories defined by the Individuals with Disabilities Education Act (IDEA) to identify the students who need special education. These categories are autism, deafness, deaf-blindness, emotional disturbance (ED), hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment (e.g., asthma, leukemia, heart conditions, etc.), specific learning disability (SLD), speech or language impairment, traumatic brain injury (TBI), and visual impairment including blindness.

The most visible label for youth with MHN in the public schools is emotional disturbance, which was previously known as serious emotional disturbance. It is important to note that this classification is based on a student’s *inability to learn due to his or her MHN*, not the mere presence of his or her MHN, as emphasized in the federal special education definition contained in Table 1.2.

TABLE 1.2

Definition of Emotional Disturbance (ED)

The Individuals with Disabilities Education Improvement Act of 2004 defines an emotional disturbance (formerly known as a serious emotional disturbance) as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, and which adversely affects educational performance:

- an inability to learn that cannot be explained by intellectual, sensory, or health factors;
- an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- inappropriate types of behavior or feelings under normal circumstances;
- a general, pervasive mood of unhappiness or depression; or
- a tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes children who are schizophrenic and does not include children who are socially maladjusted unless it is determined that they are emotionally disturbed.

MENTAL HEALTH AND SPECIAL EDUCATION: CONTRASTING IDENTIFICATION SYSTEMS

Public schools and mental health agencies use very different criteria to determine which youth are eligible for receiving special services as a consequence of their MHN. A youth who is classified as having a mental health need in school may not be defined as such by a mental health agency, and vice versa. It is also common, especially with internalizing conditions, for youth not to be identified at all.

As noted above, most youth with MHN in schools are classified as having an emotional disturbance. Youth with autistic disorder, mental retardation, specific learning disability, and attention deficit/hyperactivity disorder are not usually considered to have mental health needs unless they also have an emotional disturbance that impairs their ability to learn. In the *DSM-IV-TR*, however, all of these disabilities are considered mental health disorders regardless of whether they affect a youth’s ability to learn.

It is critical that the correct disability label for a youth’s MHN be used in order for the youth (1) to receive services from the public schools and/or the mental health system, and (2) to be referred from either of those two systems to the adult mental health system and related employment and career services. The correct disability label is the key to receiving transitional services from the schools and mental health agencies. It is entirely possible for a youth to be identified as needing services from the school system because of his or her MHN, but not to be identified by the mental health system as eligible to receive services from that service system. Conversely, the opposite situation also can be true. Some youth with MHN are therefore missed by both of these systems.

At the point of transition from youth to adulthood – and moving from child-based services to the adult service system – it is possible for youth with MHN to fall through the cracks of the unconnected and inadequate network of service delivery systems. In addition, a substantial number of youth with MHN will remain undiagnosed and consequently will receive no services. This is one reason why youth with

disabilities are over-represented in juvenile correctional systems and facilities and, most likely, in a number of workforce development programs.

COMMON MENTAL HEALTH OR EMOTIONAL DISORDERS IN YOUTH

The classification of mental illness is not a simple or definitive process. Unlike the definition of some obvious disability categories (e.g., spinal cord injuries or deafness), definitions of MHN differ among education, mental health, and social service programs; there is no one uniform description, or profile, of youth with MHN. Youth with MHN also may exhibit more than one MHN or disability that will present additional challenges to their transition to adult life. For example, depression may be combined with attention deficit disorder (ADD) or conduct disorders.

Mental health needs may develop in childhood, adolescence, or adulthood. A large number of mental health disorders first occur and are diagnosed in the teen years. One study showed, for example, that about three-fourths of 26-year-old adults were first diagnosed with a mental health disorder as adolescents.

The most common mental health problems faced by youth involve depression, anxiety, and maladaptive behaviors. Other more serious mental health problems, such as schizophrenia, psychosis, and bipolar disorder, are less common. The common mental health needs are defined below.

Depressive Disorders. Young people with clinical depression (defined as a major depressive episode lasting for a period of two weeks or more) often have multiple symptoms, including a depressed mood, irritability, overeating or lack of appetite, difficulty sleeping at night or wanting to sleep during the daytime, low energy, physical slowness or agitation, low self-esteem, difficulty concentrating, and recurrent thoughts of death or suicide. Like many mental health problems, untreated depression can make education or career planning difficult. Fortunately, depression is one of the most treatable of all mental illnesses.

Anxiety Disorders. There are several anxiety disorders that interfere with school performance or attendance and with job training or work. Generalized Anxiety

Disorder (GAD) is characterized by six months or more of chronic, exaggerated worry and tension that is unfounded or much more severe than the normal anxiety most people experience. Youth with GAD also have one or more of the following symptoms in association with the worry: restlessness, fatigue, poor concentration, irritability, muscle tension, or sleep disturbance. People with GAD are often pessimistic and worry excessively even though there may be no specific signs of trouble. These anxieties may translate into physical symptoms such as insomnia, eating problems, and headaches. Young people with GAD may have social anxieties about speaking in public or working in public areas.

Conduct Disorders. Conduct disorders are a complicated group of behavioral and emotional problems in youth manifested by difficulty in following rules and behaving in a socially acceptable way. Youth with conduct disorders may exhibit some of the following behaviors: aggression to people and animals, destruction of property, deceitfulness, lying, stealing, or other serious violations of rules. They are often viewed by other youth, adults, and social agencies as "bad" or delinquent, rather than having a behavioral disorder.

Many youth with conduct disorders often have other conditions affecting mental health, and self-medication (through illicit drugs and alcohol) is common. Early and comprehensive treatment is usually necessary to avoid ongoing problems that impede academic growth or vocational planning. Without treatment, many youth with conduct disorders are unable to adapt to the demands of adulthood and continue to have problems with relationships and with holding a job; many also engage in antisocial or illegal behaviors.

Hidden Disabilities. Some youth systems (e.g., education, mental health, social services, etc.) may base eligibility or service options on a diagnosed disability, and therein lies a potential problem. Up to 75% of youth with disabilities have hidden or non-apparent disabilities, including mental health needs. Hidden disabilities are not readily apparent through observation; in fact, many of these conditions have not been diagnosed or have not been recognized or acknowledged by the individual or his or her parents.

Hidden disabilities include specific learning disabilities (SLD), attention deficit/hyperactivity disorder (AD/HD), attention deficit disorder (ADD), emotional or behavioral problems (such as depression, anxiety disorders, or conduct disorders), and traumatic brain injuries (TBI). Occasionally, young people with mental retardation can be considered to have a hidden disability if, for example, they are socially adept and are able to function without assistance in routine day-to-day activities.

Unfortunately, the frustrations and functional limitations caused by hidden disabilities can lead to harmful, unsafe, or illegal behavior. Unemployment or underemployment, teen pregnancy, drug or alcohol abuse, and involvement with the juvenile or adult justice systems are common outcomes for youth with hidden disabilities. Diagnosing and accommodating the disability are usually necessary prerequisites for good educational and vocational outcomes.

Substance use and learning disabilities may not be the first issues that come to mind as being associated with mental health needs. They are included here, however, because of their high incidence among youth, the frequency of their co-occurrence with other mental health needs, and their symptoms that are typically visible in the behavioral, emotional, and social domains.

Substance Use. Although not always considered a disability, substance use is relatively common among youth with hidden disabilities and can cause serious problems. Substance use is defined as the use of a chemical substance, legal or illegal, taken to induce intoxication or reduce withdrawal symptoms resulting in dependency, abuse, or addiction. Substances may include alcohol, illicit and prescription drugs, paint, household cleaners, plants, and others.

Youth with mental health needs may use alcohol, marijuana, prescription drugs, and other substances to try to reduce or manage their symptoms. Substance use is a significant behavioral health issue that affects education, transition planning, job training, safety, productivity, and other aspects of a youth's life. For example, youth who use alcohol or drugs while undergoing assessment often end up with poor or invalid results.

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports in the findings from the *2004 National Survey on Drug Use and Health* that approximately 39 million adults of working age (18 to 54) experience mental illness, a substance abuse disorder, or both. Over 10% of all full-time and part-time workers abused or were dependent on drugs or alcohol. Youth may therefore need assistance in managing substance use problems, in becoming aware of the consequences of such behaviors, and in learning how to avoid temptation.

Specific Learning Disabilities. Specific learning disabilities (SLD) affect an individual's ability to interpret what he or she sees and hears or to link information from different parts of the brain. These differences can show up as specific difficulties with spoken and written language, coordination, self-control, or attention. SLDs may include developmental speech and language disorders, academic skills disorders, motor skill disorders, and other specific developmental disorders. It is important to note that not all learning problems are necessarily SLDs; some youth simply take longer in developing certain skills.

Such difficulties may affect a youth's ability to learn to read, write, or do math. In some individuals, many overlapping learning disabilities may be present. Others may have a single, isolated learning problem that has little impact on other areas of their lives. *It is important to note that having an SLD does not indicate deficits in intelligence. Many people with SLDs have very high IQs.*

One of the primary concerns for workforce development staff working with individuals with disabilities is the limited usefulness of diagnostic and clinical information in assisting individuals with mental health needs to secure meaningful employment. Clearly, better tools, information, and resources are needed.

In order to achieve improved transition outcomes for youth with mental health needs, youth service practitioners and policymakers must develop a common understanding of the disability-specific needs of youth with mental health needs and the supports those youth will require for successful employment.

Please see Appendix B for the list of references.

Supporting Research

More than half of youth with MHN will drop out of school, with few youth ever accessing treatment services. Except for the small portion (3% to 5%) of youth who are placed in long-term mental health care (Rosenblatt & Rosenblatt, 1999), the majority of youth with MHN demonstrate average or above cognitive abilities (Davis & Vander Stoop, 1997). Due to emotional difficulties, however, many in this broad and diverse population will experience sporadic and inappropriate academic and vocational preparation during their school years (Fredericks, 1995).

Psychiatric disabilities are not directly related to any one special education category — including Emotionally Disturbed — and may or may not play a role in decisions regarding eligibility for special education services (Forness, 2003; Forness, Kavale, King, & Kasari, 1994; Forness & Knitzer, 1992).

The duality of systems and the distinctions in educational and mental health definitions (Achenbach, 1985) mean that youth who receive special education services as a result of their emotional needs may be, and probably are, very different from those youth who receive services from mental health agencies because of their emotional needs. For example, Davis and Vander Stoop found that “schools use the DoED [U.S. Department of Education] definition [of emotional disability] in identifying youth...” and “state mental health agencies use the CMHS [Center for Mental Health Services] definition and a variety of other criteria to define target populations and determine eligibility” (1997, p. 401).

Moreover, many youth with MHN will go undiagnosed and untreated by both the educational and mental health systems (Cohen, Brook, Cohen, Velez, & Garcia, 1990; Compas, Orosan, & Grant, 1993; Lewinsohn, Rhode, & Seely, 1995; Lewis, 1990; Lewis & Miller, 1990). This is of particular concern since several types of mental health conditions develop in adolescence. In one study of 26-year-olds with mental disorders, approximately three-fourths were originally diagnosed in their teens (Kim-Cohen, Caspi, Moffitt, Harrington, Milne, & Poulton, 2003).

Studies differ concerning the percentage of youth in correctional settings who have mental health needs. The National Center for Mental Health and Juvenile Justice (n.d.) estimates that between 65% and 100% have a diagnosable mental condition. Other studies indicate that roughly 40% to 60% of youth in correctional settings have a special education disability, usually learning disabilities or ED (Bullis, Yovanoff, & Havel, 2004; Rutherford, Bullis, Wheeler-Anderson, & Griller,

2002). It is unclear, however, how many of those youth were first identified as having a disability in public school or were identified upon entering the correctional system (Rutherford, Bullis, Wheeler-Anderson, & Griller, 2002).

For more than 30 years, Achenbach and his colleagues have examined the structure of psychopathology (i.e., MHN) among children and youth (ages 5 to 17) (Achenbach, 1966, 1985; Achenbach & Edelbrock, 1981; Achenbach & McConaughy, 1987). They consistently identified two broad and independent dimensions of MHN among this age group: *internalizing and externalizing* disorders. The “broad-band” grouping designated as internalizing mainly involves problems within the self, such as unhappiness and fears. The broad-band grouping designated as externalizing, by contrast, mainly involves conflicts with others, such as aggressive, delinquent, and overactive behavior (Achenbach & McConaughy, 1987, p. 33).

Roughly 10% to 12% of all youth will have some form of mental health problem severe enough to call for short-term special services and treatment during their teenage years (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kauffman, 1997). Of these, less than half (3% to 5% of the total age group) will present MHN of such complexity and seriousness to require long-term educational, mental health, or transition interventions (Kauffman, 1997; Quay & Wherry, 1986).

Less than 1% of all students in the public schools will be identified as having an emotional condition that will qualify them for special education services, a rate that is far below the best estimates of the prevalence of MHN among children and youth cited previously (Forness & Knitzer, 1992; Kauffman, 1997; Kavale, Forness, & Alper, 1986). Estimates also suggest that less than a quarter of youth with MHN will receive any formal services from mental health or social service agencies (Knitzer, Steinberg, & Fleisch, 1990; Stroul & Friedman, 1994). Though some youth identified as having a MHN by the special education system are also served through the mental health system, the percentage of youth served by both systems is not clear (Forness, Kavale, King, & Kasari, 1994; Forness, Kavale, & Lopez, 1993).

As mentioned earlier, youth who exhibit externalizing behaviors predominate among those students labeled as ED in special education (Walker, Colvin, & Ramsey, 1995) and probably also among youth with PD who are served in the mental health system (Quay, 1986). Research conducted by Jessor and Jessor (1977) and Donovan and Jessor (1985) indicate that externalizing behaviors, which are identified in

EXHIBIT 1.1: SUPPORTING RESEARCH

the *Diagnostic and Statistical Manual of Mental Disorders*, tend to be exhibited in a syndrome, or cluster of related behaviors: delinquency/criminality, school failure, pregnancy and high risk sexual behaviors, and alcohol or substance abuse.

Youth with depression may also exhibit attention deficits and/or conduct disorders (Lewinsohn, Rhode, & Seely, 1995). Additionally, the coexistence of learning disabilities, learning difficulties, and emotional disturbance has long been recognized (Lane, 1980; McEvoy & Welker, 2000; Trout, Nordness, Pierce, & Epstein, 2003).

The Substance Abuse and Mental Health Services Administration (SAMHSA) found a strong relationship between substance abuse and mental health problems in youth. Successful treatment for co-occurring conditions requires individualized treatment plans that treat both mental health and substance abuse conditions across a wide spectrum of services and settings, including cross-referrals, cooperation, consultation, collaboration, and treatment modes (Substance Abuse and Mental Health Services Administration, 2002).

The Center for Mental Health Services, in partnership with the National Institute of Mental Health, was a leader in the development of the first Surgeon General's report ever issued on the topic of mental health and mental illness: *Mental health: A report of the Surgeon General* (U.S. Department of Health and Human Services, 1999). The report found that although a great deal was already known about how to treat mental illness, much remained to be learned about ways to prevent mental illness and to promote mental health. The groundbreaking report also found that in spite of the fact that a range of effective treatments existed for most mental disorders, nearly half of all Americans with severe mental illnesses failed to seek treatment.

These and other findings led the Surgeon General to assert that "growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them" (U.S. Public Health Service, 2000, Foreword). An analysis of the impact of mental illness on mortality in children with disabilities by a national workgroup on child and adolescent mental health concluded that "no other illnesses damage so many children so seriously" (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention and Deployment, 2001).

In 2004, ODEP and SAMHSA sponsored a study to identify critical issues, systemic barriers, and policy recommendations for employment and training agencies regarding the provision of services to individuals with psychiatric disabilities. The

study, conducted by the Institute for Community Inclusion (ICI), was intended to provide information and guidance to federal agencies and the workforce development system on effective practices and service implementation for serving people with psychiatric disabilities within local One-Stop Career Centers.

The study (Marrone & Boeltzig, 2004) identified a number of common barriers for the effective employment of young adults and adults with psychiatric disabilities:

- fragmentation and lack of seamless service delivery,
- the tendency to see people with psychiatric disabilities as needing only disability-specific services,
- a lack of understanding of employment as a valuable outcome by mental health systems of care,
- insufficient staff knowledge and skills,
- insufficient understanding of the disability community,
- a lack of access to support services,
- a lack of baseline standards,
- a lack of customer marketing plan,
- a lack of a marketing plan for employers connected to overall business services,
- social isolation,
- a lack of access to health insurance,
- the complexity of existing work incentives, and
- limited skill sets in choice and control.

These barriers have important implications for policy and service reforms, and the barrier related to staff knowledge and skills underscores the need to provide information and resource tools to workforce system practitioners. One of the initial barriers to address with workforce development practitioners is the tendency to underestimate the capacities and skills of people with psychiatric disabilities and to overestimate the risk to employers. The ICI study found that often staff in One-Stop Career Centers indicated a need for consistent baseline knowledge and skills to meet the needs of customers with psychiatric disabilities.

Please see Appendix B for the list of references.

