

Behind the Numbers



Go to page 46 for
more data analysis

LEVEL OF FUNCTIONING FOR MENTALLY ILL YOUTH

One of the indicators that the FCFC tracks is the percentage of mentally ill youth who report improved functioning after six months of treatment. As you can see on page 46, the trend has consistently been in the desired direction since the 2002-03 reporting period, the first year for which data are available. Going “behind the numbers” of this indicator provides an opportunity to see why it is an important one and to explore some of the issues that it raises in a larger context.

First, in order to gain a better understanding of this indicator, it is useful to start with its associated outcome, Positive Living for Special Populations. (See page 36.) By “Special Populations,” the FCFC means people of any age with significant disabilities who need assistance with basic daily living skills to live in the most appropriate, least restrictive community setting possible and avoid inappropriate institutionalization. This includes, of course, children with mental illness.

By “Positive Living,” the FCFC means that, with support from the community, special populations have the opportunity to participate in every aspect of community living that they desire. Full achievement of this outcome would mean that people with significant disabilities are living, learning, working and participating in typical, accessible community settings and that the community respects and protects their rights and includes them as contributing members.

While embracing a community outcome that recognizes the special challenges faced by these populations, the FCFC empha-

sizes that the ideals of the other community outcomes—health, safety, security, stability and success—fully apply to the members of special populations.

How could it be otherwise? According to the 2000 Census, one in five Americans has some level of disability and one in ten has a severe disability.¹ Therefore, not to seek the participation of special populations in “every aspect of community living that they desire” would be unfair to over 110,000 Montgomery County residents with some level of disability and almost 56,000 County residents with severe disability, based on the national proportions.

Perhaps no one feels this tension between being in a “special population” and being in the mainstream more keenly than do children and adolescents with mental illness. Being isolated from—or stigmatized by—his or her peers can be devastating for anyone, but especially for a young person. Childhood and adolescence are times when important skills in interpersonal relationships are acquired. When untreated, mental health disorders in children and adolescents can lead to school failure, family conflicts, drug abuse, violence, and even suicide. Untreated mental health disorders can be very costly to families, communities, and the health care system.²

It is heartening, then, that this indicator has been steadily moving in the desired direction. Determining its value every year begins with asking youth who are receiving mental health services a number of questions. One set of questions gauges how their “problems might get in the way of your ability to do everyday activities.”

Note that these activities include getting along with friends and family, taking care of personal health and grooming, participating in school and recreational activities, and so forth.

In other words, to the extent that a young person can do—or resume—such everyday activities, he or she is on the way to recovery. He or she is also less likely to be one of the “over 58% of children with mental illness (who) do not graduate from high school.”³

But just how prevalent IS mental illness among Montgomery County’s youth? Analysis of data presented to the Family and Children First Council⁴ suggests that Montgomery County has the highest rate among the eight largest counties in Ohio and that its rate is almost twice as large as the overall rate for Ohio. (Fig. 1.)

While these data are alarming, they must be viewed with some caution. Determining prevalence rates for mental illness is notoriously difficult. The data discussed above are based on reports to the Ohio Department of Mental Health from publicly funded providers of mental health services. Differences across the state in surveillance and reporting mechanisms have to be considered, as well as all of the cases in which the child is receiving private treatment. Whatever the ultimate explanation for Montgomery County’s high rate compared to the other large counties and to the rest of the state, these prevalence data clearly deserve further examination.⁵ They also emphasize the important role that prevention can play.

Mental illnesses are biologically based brain disorders; they are not related to “character” or intelligence and they cannot be overcome through “will power.”⁶ They can strike at any age. While there is no doubt that great advances have been made, especially in the last two decades or so, in the development of programs with proven effectiveness at preventing mental disorders in school-age children,⁷ what about younger children?

Prevention researchers are increasingly aware that the initiation of mental illness, or of processes that can lead to mental illness, can happen even during infancy or early childhood.⁸ As a result, they are

strongly recommending that a mental health perspective be integrated into early childhood, early intervention, child care, and home-visiting programs that provide services to families with young children.⁹

Therefore, by going “behind the numbers” of this indicator, we see that while its positive trend is certainly good news, it is not the whole story. We have identified an issue (an apparent high rate of prevalence) that raises a warning flag, and the discussion has led us to the importance of prevention, especially at an early age. The FCFC looks forward to continuing this community conversation.

PREVALENCE OF MENTAL HEALTH DISORDERS					
	Ohio	Montgomery County	Hamilton County	Stark County	Other 5 Largest Counties
ADJUSTMENT DISORDERS	8,274	511	802	552	2,666
ANXIETY DISORDERS	3,198	229	557	219	1,170
ATTENTION DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS	20,522	2,346	2,192	1,136	8,283
CAUSING SELF-HARM DISORDERS	52,430	4,567	6,161	2,607	17,938
MOOD DISORDERS	11,627	1,118	2,054	487	3,832
PERVASIVE DEVELOPMENT DISORDERS	484	77	78	17	119
SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS	419	48	131	13	153
TOTAL (MAY INCLUDE DUPLICATIONS)	96,954	8,896	11,975	5,031	34,161
POPULATION (AGES 5-18)	2,290,621	108,562	173,884	74,714	750,048
TOTAL AS % OF POPULATION	4.23%	8.20%	6.89%	6.73%	4.55%

Fig. 1 Prevalence of mental health disorders in Ohio’s children ages 5 – 18 for the year 2005. Montgomery County has the highest rate and the counties with the second- and third-highest rates are shown. The remaining five largest counties (Butler, Cuyahoga, Franklin, Lucas and Summit) are aggregated for simplicity.

¹Ohio Access: Governor Taft’s Strategic Plan to Improve Long-Term Services and Supports for People with Disabilities, February 2004. Available at <http://www.ohioaccess.ohio.gov/pdf/ohioaccessrpt2006.pdf>.

²Child and Adolescent Mental Health Fact Sheet, U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, retrieved from <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0004/default.asp>.

³Behavioral Health: Developing a Better Understanding. Issue one (The costs of mental illness when gone untreated). August, 2003. Published by The Ohio Association of County Behavioral Health Authorities.

⁴Youth Mental Health Report: Indicators of Infant, Child and Youth Development for Montgomery County, Ohio. Center for Urban and Public Affairs, Wright State University. July, 2006.

⁵Left out of this discussion, of course, are those children with mental illness who are not getting treatment. For too many, cost or stigma is a barrier.

⁶The Ohio Department of Mental Health, <http://www.mh.state.oh.us>.

⁷See, for example, Greenberg, M.T. et al. Preventing Mental Disorders in School-age Children: A Review of the Effectiveness of Prevention Programs. (1999) Retrieved from <http://www.prevention.psu.edu/pubs/docs/CMHSxs.pdf>.

⁸National Scientific Council on the Developing Child, Excessive Stress Disrupts the Architecture of the Developing Brain. (2005). Working Paper No. 3. Retrieved Jan. 5, 2007 from <http://www.developingchild.net/reports.shtml>.

⁹Cohen, E., and Kaufmann, R. Early Childhood Mental Health Consultation. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.