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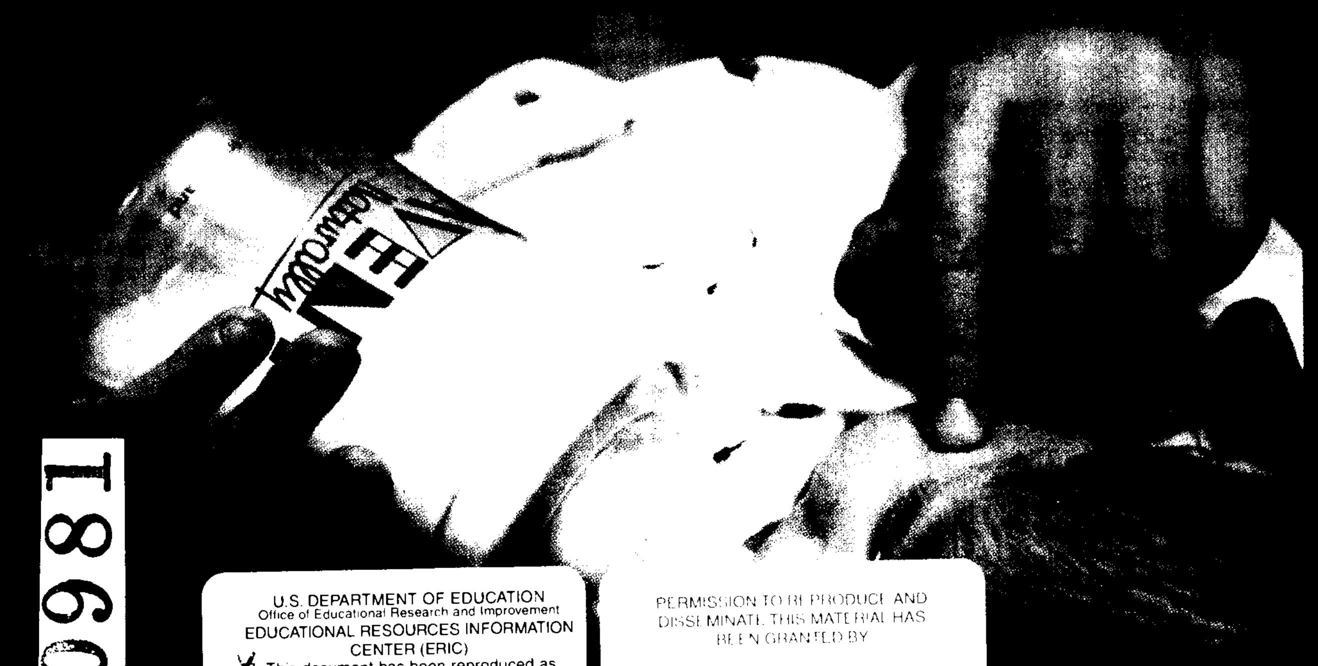
ABSTRACT

This Wiskid special report, the third in a series focusing on areas of child well-being in Wisconsin, focuses on issues related to children's mental health. The first part of the report features the following articles: (1) "Infant Mental Health: From Parenting to Policymaking" (Raquel L. Reyes), introducing the concept of infant mental health and discussing the importance of attachment as a positive basis for brain maturation; (2) "Culturally Competent Care for Children in the Mental Health System" (Pahoua Yang), presenting six essential elements to achieving cultural competence in mental health practice; (3) "Educating Children with Mental Health Needs in the Public School System: Personal Reflections of an Educator" (Lynette I. Fassbender), discussing the needs of students with mental illness and current school services; (4) "May I Have Your Attention Please: ADHD and ADD" (Nan Brien), discussing the use of medication to treat children with ADHD and ADD symptoms; and (5) "Defining Parity" (Shel Gross), outlining the case for legislation to accomplish parity in insurance coverage for mental health and alcohol and other drug abuse disorders. County and statewide data are then presented for the following indicators related to child well-being: (1) 2000 child population; (2) 2000 births; (3) child poverty; (4) Healthy Start participation; (5) Badger Care [state health insurance] eligibility; (6) hospitalization rates; (7) juvenile arrest rate; (8) children in out-of-home care; (9) child Medicaid recipients; (10) percent mothers with high school degree; (11) low birthweight infants; (12) teen mothers; and (13) prenatal care. The report concludes with information on county data sources. (Contains 24 endnotes.) (KB)

A WISKIDS COUNT SPECIAL REPORT • 2002

CHILDREN'S MENTAL HEALTH

FROM PARENTING TO POLICYMAKING



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CHILDREN'S MENTAL HEALTH
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Introduction

In January 2001, Surgeon General David Satcher reported that the nation is facing a public health crisis in mental health for children and adolescents. According to Satcher, "In the United States, one in ten children suffer from mental illness severe enough to cause some level of impairment. Yet, in any given year, it is estimated that fewer than one in five of these children receives needed treatment. The long term consequences of untreated childhood disorders are costly in both human and fiscal terms."

For the last six years the Wisconsin Council on Children and Families' Better Badger Baby Bus has been touring the state presenting scientific facts that support quality parenting and care giving for infants and children. Brain research has verified what our grandmothers knew all along - to be both physically and mentally healthy kids need loving and nurturing home and caregiver environments. Unfortunately, even some children with ideal environments do not escape mental illness. During 2000, in Wisconsin alone 6,810 children were hospitalized as a result of a serious mental illness.

This year, rather than publishing our annual data book covering a broad array of issues affecting children, we have chosen to focus on several areas of child well being in Wisconsin. *Children's Mental Health, From Parenting to Policy Making* is the third in this series. The first, *Affordable Housing, a Crisis for Wisconsin Families* was released in May. *Standardized Testing, One Size Fits All?* was published earlier this fall. At the end of this year, we plan to release a report based on our statewide survey on guns.

In our first essay, Dr. Raquel Reyes, a psychologist with the Child Psychiatry Center at Children's Hospital introduces the concept of infant mental health. The healthy development of babies is directly tied to their mothers' response to them. Therefore, any discussion of infant mental health looks at the kind of environment and relationships that babies have with their parents and caregivers. Dr. Reyes discusses the importance of attachment as a positive basis for brain maturation, and social/emotional development well into adolescence and the negative effects that maternal depression and child abuse and neglect have on infants' mental health.

In *Culturally Competent Care for Children in the Mental Health System*, Pahoua Yang, psychotherapist at the Hmong Mental Health Institute of the Children's Service Society of Wisconsin, writes about the importance of instilling a level of cultural competence at all levels of service delivery systems. Ms. Yang lays out six essential elements to achieving cultural competence in mental health practice:

"valuing diversity, self awareness or the capacity to assess oneself culturally, understanding the dynamics of difference, basic cultural knowledge, adaptation of service delivery, and the instillation of cultural competence within all levels of service." According to Ms. Yang, cultural competence involves a new way of thinking that must be implemented daily.

Lynette Fassbender, Director of Student Services for the Verona Area School District, discusses the disconnect between real students with mental illness and current school services. In *Educating Children with Mental Health Needs in the Public School System: Personal Reflections of an Educator,* Ms. Fassbender acknowledges the tremendous strides that have been taken by school districts as a result of the federal Individuals with Disabilities Education Act (IDEA). However, she points out that experience has shown that many kids still stand little chance of succeeding without an intentional school program designed specifically to meet their needs.

May I Have Your Attention Please: ADHD and ADD, by Nan Brien, associate director of the Council on Children and Families, presents another issue that challenges schools, parents and students. Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder are perhaps the most frequently diagnosed mental health conditions for children, yet they are still not well understood. Controversy continues over the use of medication to treat children with ADD and ADHD symptoms. On average, at least one child in every classroom in the United States needs help for an attention deficit. According to Edward Hallowell, author of Driven to Distraction, the experience of ADHD is "like driving in the rain with bad windshield wipers. Everything is smudged and blurred and you're speeding along, and its reeeeeally frustrating not being able to see very well."

Finally, Shel Gross, policy director for the Mental Health Association in Milwaukee County writes *Defining Parity*. Parity in health insurance coverage for Mental Health and Alcohol and Other Drug Abuse disorders means that coverage for treatment of these disorders should be equivalent to coverage for other medical conditions. Mr. Gross outlines the case for legislation to accomplish parity in insurance coverage. In the last four sessions, the legislature has failed to pass mental health parity legislation. However, according to Mr. Gross, momentum is gaining. Ultimately, it will be an increase in public understanding of the scientific evidence that mental health and alcohol and drug abuse disorders are biological and treatable that will create true parity.

Again, we have been fortunate to have five writers contribute their expertise on matters related to children's mental health and bring clarity to the issue. A publication of this length cannot be truly comprehensive. In a climate of state and national budget woes, children's mental health may easily be ignored. We can not afford to let this happen. It is our intention that these concise essays educate and provoke the interest of the reader and advance the cause of child well being in Wisconsin.

Infant Mental Health: From Parenting to Policymaking

BY RAQUEL L. REYES, Ph.D.

When someone mentions the phrase "infant mental health," people are typically surprised. Visions of babies lying supine on a couch with an analyst taking notes enter our minds, and we do not imagine infants as being "in need of therapy." Yet the concept of infant mental health is much more complex and prevalent than we might think. It is the basis for much of the cutting edge research that has taken place over the past several decades and is increasingly studied as new discoveries around cognitive, social, and emotional development in infancy occur. This article will discuss infant mental health within various significant contexts including attachment theory, brain development, maternal depression, and other risk factors. This article will not be an exhaustive discussion of these areas, but will offer a generalized synopsis of the basics.

The concept of infant mental health is much more complex and prevalent than we might think.

What is infant mental health?

Infant mental health represents a wide range of concepts that have to do with the psychological well-being of the infant and toddler. Because the infant is not able to fend for herself and is, in fact, a silent and helpless member of society, she needs to be viewed within the wider context of those on whom she depends - from parents and caregivers to policy-makers. Therefore, when we consider the idea of infant mental health, our considerations are as specific as how a mother responds to her infant's needs for food, shelter, and comfort, and they are as general as how policies can be developed, supported, and implemented in order to assure the existence of quality care in a variety of environments. The infant develops within a complex system of relationships that are affected by the various levels within his/her environment. The study of infant mental health helps us discover which relationships and experiences foster successful adaptation and health or maladaption and disorder. A discussion of some areas of study that define infant mental follows.

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Attachment Theory

Perhaps the most popular and most studied concept relevant to infant mental health is that of attachment. Attachment is described as an enduring emotional bond with the primary caregiver (usually the mother), and is characterized by behaviors in the infant that typically evoke a caring response from the primary caregiver. These behaviors are quite familiar to many of us and include crying, smiling, calling, reaching, clinging, and protesting when left alone.

Attachment theory emphasizes the importance of the mutual relationship between the primary caregiver and the infant. The impact of secure attachment on healthy personality development and social-emotional well being in later life has been documented. The hallmarks of attachment are that: 1) the infant develops expectations concerning self and others, 2) the infant over time develops a sense of self as worthy or unworthy of care, 3) the infant develops a context for later social relationships, and 4) later experiences build on current experiences.

Whether an infant's attachment will be characterized as secure, avoidant, resistant, or disorganized, will depend on the quality of care provided prior to his reaching seven months of age.

Attachment behavior becomes evident at approximately seven months of age. Therefore, whether an infant's attachment will be characterized as secure, avoidant, resistant, or disorganized will depend on the quality of care provided prior to his reaching seven months of age.

The founder of attachment theory, John Bowlby, believed that the attachment relationship influenced the formation of life-long emotions and the degree to which developmental stages were mastered throughout the life span. His theory has proven correct. Longitudinal studies of toddlers at two years of age demonstrated that securely attached infants showed more autonomy and social confidence in the presence of their caregivers than anxiously attached peers; showed more persistence in handling frustrating tasks; were more likely to ask for help; and were more likely to be cooperative and affectionate with their mothers. Studies also have demonstrated that adults who were securely or insecurely attached to their caregivers were more likely to have children with similar attachment patterns. In summary, satisfying, stress-reduced relationships help develop healthy internal representations of the environment for the infant. On the other hand, a lack of positive caregiver responsiveness can precipitate the development of anxious attachments or other social relational difficulties in later life. Let's examine more specifically the precursors to attachment, which also contribute to the infant's social and emotional development.

The Development of Social Involvement in the Infant

As mentioned earlier, the infant is completely dependent upon others to survive. However, survival during the first years of life is based on both biological and social-emotional interventions. At birth, the infant moves from one ecosystem to another - from the womb to the world. Each system is entirely different from the other. Yet, in both worlds, the infant completely depends upon others to meet his/her most basic needs. A mother's care assures an infant's biological survival. The baby, in turn, has certain characteristics, referred to by Emde as "babyness" that elicit caretaking behaviors by the mother. In addition, soothing an upset infant is in itself a rewarding experience for the caregiver. The quiet that is achieved in the infant after an episode of upset, the caretaker's sense of efficacy in calming her baby, and the caretaker's sense that she is needed or appreciated are all perceived as rewarding experiences by the caretaker. The mother-infant bond develops during these interactions, marked by the infant's gaze evoking mother's gaze, and subsequently leading to sustained facial gazing. This sustained gazing has been described by Schore as the most intense form of communication between a mother and her infant. The connection made in the sustained gaze induces a symbiotic state of pleasure in both the infant and his mother. This unique experience helps the infant to develop knowledge of his own emotional being and sense of self.

At birth, the infant moves from one ecosystem to another – from the womb to the world. Each system is entirely different from the other.

Brain Development

Brain studies over the past decade have yielded remarkable findings: first, the infant's brain continues to develop after birth; second, the implications of this rapid development strongly support the infant's need for an appropriate environment during what we now know are significantly formative years.

Schore discusses four principles of brain growth that markedly impact these formative years. The first principle is that brain growth occurs during critical periods and is influenced by the social environment. Five-sixths of the human brain's growth spurt occurs after birth and continues to about 18-24 months of age. In fact, brain weight increases from 400g at birth to 1000g at 12 months. Based on what we know from the attachment studies discussed previously, a primary brain growth spurt occurs during the period when close mother-infant interactions are most necessary and expected. Social forces influence brain development.

The second principal has to do with the stages during which the brain develops. Basically, the brain achieves greater capacity to perform more complicated functions during growth spurts that occur doing different times in the life of the infant/child/adolescent. Each successive stage builds on the neural structure laid down during the preceding stage and involves increased dominance or control exerted by the later developing structures. Each succeeding developmental stage requires more energy as the neural structures become increasingly complex. Proper nutrition is essential as the energy requirements expand.

The third principal emphasizes how important the infant's postnatal environment is to the regulation of the developing brain. Genetic effects are amplified during these more complex periods of growth. Seventy percent of the brain's final DNA content is added after birth. The synthesis of specific chemicals in the brain occurs during critical periods of development that are especially sensitive to social and environmental stimulation. Maternal behavior is an example of an environmental event that causes the expression of genetic differences. Therefore, a mother or primary caregiver becomes a regulator of the infant's nervous system development. These outside influences have an impact on specific signals in the brain that act as internal clocks to coordinate the timing of these developmental processes.

Brain development continues to undergo sensitive periods that are influenced by the social environment as the infant simultaneously becomes more social.

The fourth principal acknowledges that the infant's social environment changes over the stages of infancy and these changes induce the reorganization of brain structures. In other words, brain development continues to undergo sensitive periods that are influenced by the social environment as the infant simultaneously becomes more social. The role of the mother at this point shifts from primarily care giving to socialization. This can cause stress for both mother and infant, as each member adapts via trial and error until this new behavior of interacting with a social environment has been established.

The brain continues to develop through adolescence. The changes include the migration of cells, the growth of various neurons in the brain, and the formation of connections or synapses. We already know that a 30 percent weight gain occurs in the infant brain between three months and 18 months of age. A five to 10 percent weight gain occurs between two and four years of age. Additional changes and growth spurts occur between six and eight years of age, 10 to 12 years of age, and 14 to 16 years of age. Cognitive changes accompany these periods of brain growth. Substance use/abuse may affect brain development during these sensitive periods (e.g., pre-adolescence, adolescence).

Given the understanding of the profound impact of the quality of the infant's care-taking environment, we will now examine two risk factors and the effect they can have on the infant's developmental well-being.

Maternal Depression

The experiential cycle of discomfort and alleviation of that discomfort leads an infant to the healthy formation of his/her social, emotional, and environmental perceptions. At the same time, the infant develops the notion that the world will indeed be a safe, trusting place in which his/her needs can be met effectively. When there is severe neglect, the infant is likely to exhibit depressive symptomatology and developmental delays including those in the social-emotional realms. If a mother can successfully manage stress and find appropriate outlets for its release, she will be able to maintain the sensitive quality of her responses toward her infant and the infant's self-perceptions of the world will not be impaired. However, if the mother has difficulty containing or appropriately releasing her stress, that stress may be passed to her infant via the diminished or absent responses to her infant.

Parents can pass the effects of their stress to their children, leading to negative developmental outcomes in their children.

Depressive symptoms may interfere with a mother's ability to appropriately read her infant's cues (expressions and behaviors) that indicate the infant is in need. For example, a review of the literature on migrant and refugee families indicates that parents can pass the effects of their stress to their children, leading to negative developmental outcomes in their children. The same can be applied to any families experiencing stress. Although stressful experiences can be offset by the child's interactions with positive individuals in the community or family, infants may be at higher risk because they are likely to spend more time with their mothers. When a mother or primary caregiver experiences depression or other stress-related mood problems, and does not manage her stress appropriately when she is with her infant, the infant is more likely to be directly affected.

The sources of depression are varied and include genetic influences, socioeconomic issues, marginalization, lack of emotional support, and a past history of depression. Another common type of depression is postpartum depression. Postpartum depression has been subject to a surge of attention recently. It is now known that 40 percent of U.S. births are complicated by postpartum depression (PPD). Typically, PPD lasts up to 12 days; however, if it lingers for longer than two weeks, it may turn into a major depression characterized by over-concern or excessive anxiety for the baby, feeling like a failure at motherhood, lack of interest in the baby, and fear of losing control.

Research findings on maternal depression indicated that depressed mothers were more likely to withdraw from their children, responded with little or no emotion or energy, were less positive with their infants, felt less competent during feedings, perceived their children as more difficult, and became intrusive and hostile toward their infants. In turn, infants of depressed mothers tended to be insecurely attached, dysphoric, less positive with their mothers, and had more problematic interactional patterns. In addition, studies found that mothers tended to be more hostile and critical toward their infant children; their children showed more frustration, helplessness, less enthusiasm, less persistence, more fear and more inhibition responses than the children of nondepressed mothers. Brain differences in infants of depressed mothers were also noted. These infants also demonstrated more insecure and disorganized attachments.

Infants of depressed mothers tended to be insecurely attached, dysphoric, less positive with their mothers, and had more problematic interactional patterns.

Affects of Abuse and Neglect

As mentioned earlier, the infant perceives the experience of stress in another. Brain research indicates that there is a biological basis for emotions. There is a specific physiology of stress that impacts periods of rapid brain development. Specifically, research has found that when an infant or young child experiences a traumatic event or events, the result is the abnormal transmission of neurochemicals in the brain. Trauma victims also have extremely high levels of certain hormones and neurotransmitters. These stress hormones, which are typically reserved for survival responses such as the "fight or flight" response, occur in excess amounts in cases of chronic trauma and can become toxic to the young brain. Characteristics of Posttraumatic Stress Disorder (PTSD) become evident and include hypervigilance and a constant state of arousal in the young child.

Brain-imaging studies were conducted on 44 children who, between the ages of one and three years had been exposed to or were the victims of sexual abuse, physical abuse, or had witnessed domestic violence. These children were tested at school age and were, at the time, in stable homes. All of the children met criteria for PTSD and some also met criteria for depression and/or other clinical syndromes. These children were found to have smaller brain volumes, larger lateral ventricles, and smaller areas of connection between the left and right sides of the brain. In addition, the longer the children had been exposed to trauma, the greater the differences when compared to children who had been rescued earlier.

However, a note of caution - it is dangerous to think that, because an infant or young child has been exposed to neglect, trauma, an overly stressed primary caregiver, or other negative events, the infant will have "no hope for the future." In fact, resiliency studies indicate that the opposite is true. With timely intervention and the presence of supportive and nurturing care giving, infants and young children are able, in many instances, to become emotionally healthy children and adults. However, the intervention must be systemic and include family and community systems in order to be holistically effective.

In the world of politics and social advocacy, infants and young children remain the most vulnerable, silent and helpless members of society.

Conclusion

Infants start out in this world value-free; hence the innocence of the earliest years. Their laughter might elicit joy and their tears may elicit a myriad of feelings. No two children share the same environment and no environment is experienced in exactly the same way by two different children. Their primary caregivers have the potential to make the most powerful differences in these early years. Yet, in the world of politics and social advocacy - the realms where support for their general well being should be of the utmost concern - infants and young children remain the most vulnerable, silent and helpless members of society. As policy-makers, educators, providers, and advocates, we can have an impact on alleviating the stressors of poverty, isolation, and non-existent or overcrowded social service programs. This may sound like an old cliché, one that unfortunately has not yet been sufficiently heeded - and that is, infants are the citizens of the future. Their earliest years are indeed integral to their overall well-being as well as to the well-being of the communities of the future.

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Culturally Competent Care for Children in the Mental Health System

By PAHOUA YANG, MSSW, CICSW

Cultural competence in the mental health field can be looked at pragmatically: to be culturally competent helps an agency or individual provide good, efficient service to families, encouraging client satisfaction and utilization. Cultural competency is a moral and ethical duty of practitioners. If we look at the meaning of cultural competence, what develops is the clear integration of the practical with the moral and ethical. Cultural competence is the ability to use academic, experiential, and interpersonal skills to increase understanding and appreciation of cultural differences and similarities within, among, and between groups. This encompasses the desire, willingness, and ability to improve systems by drawing on diverse values, traditions, and customs. It implies working closely with knowledgeable persons from the community to develop interventions and services that affirm and reflect the value of different cultures (Family and Youth Services Bureau, 1994). Although the context of culture is not limited to race and ethnicity, and should be conceptualized to include gender, age, religion, class, sexual preference, for the purposes of this essay, I will be discussing culture mainly within the context of ethnicity and race.

> **If we look at the meaning of cultural competence, what develops is the clear integration of the practical with the moral and ethical.**

Culture influences one's conceptualization of mental health, wellness, and treatment; therefore, cultural competentence is central to our ability to deliver mental health services that are responsive to the needs of our clients. Culture is not limited only to clients, however. It also applies to the practitioners who provide treatment because of the way our own culture and the "culture" of our respective professions integrate to form how we interact with clients and the process of treatment.

There are many levels in the continuum of attaining cultural competence. Most experts agree that at the most restricted level, an individual has a patronizing view of other cultures and perceives one's own culture to be highly superior to that of others. Therefore the goal is often to conquer and change or "save" people of the other culture (often referred to as cultural destructiveness). In the middle of the continuum is a cultural blindness model (the view of "I don't see your color, I only see you"). Although this model purports to "do away" with discrimination and prejudice, it only tries to ignore the big white elephant in the room and does not acknowledge the impact culture has made upon the individual; nor does it recognize the historical, social, political, and individual significance of being a part of that culture. While cultural sensitivity or awareness is a step above cultural destructiveness, it is only a precursor to competence. It's nice to be recognized, but as defined above, cultural competence moves beyond recognition to actual proficiency, which is the desired end of the continuum. It is important to recognize that achieving cultural competence is not a linear process. In fact, the lines between the levels are often blurred. It is normal to constantly shift from level to level depending on the culture, the situation, and many other more complex issues; however, experts agree that most cultural competence models embrace the trajectory described above in some manner.

It is important to realize that achieving cultural competence is not a linear process. In fact, the lines between the levels are often blurred.

There are six essential elements to achieving cultural competence in mental health practice: valuing diversity, self awareness or the capacity to assess oneself culturally, understanding of the dynamics of difference, basic cultural knowledge, adaptation of service delivery, and the instillation of cultural competence within all levels of service.

Valuing Diversity

Before jumping on the bandwagon of diversity or cultural competence, it is important to ask about your own (or agency-wide) values regarding diversity. To value diversity is to be aware of, accept, and respect differences. No matter how much training, how much education, how wonderful a mission an agency or person has, all of us are most strongly influenced by how we really regard diversity. If we do not truly see the value in it, we will be unable to make the commitments necessary to instill and maintain it.

Within this context, it is also important to recognize that while there is diversity regarding culture, class, gender, age, and so forth, there is also great diversity within all of these groups. Because of our individual exposure to many different cultures via the media, education, employment, living situations, and other activities, each of us are shaped uniquely by this integration as well as our culture as defined in the more traditional sense. For instance, if we look at the Hmong as a group, there are some shared characteristics. Depending upon the individual, these may include some aspects of linguistic, religious, physical, cultural, and familial characteristics. However, the Hmong in Laos, Australia, the United States, France, Canada, and China have also integrated and incorporated the distinct cultures to which they have been exposed.

If we look at the Hmong in the U.S., there are people who have been here since 1976 and people who arrived last year. There are also a growing number of young adults and children who have been born in this country and grown up in this society. The degree of their experience, acculturation and assimilation has certainly created a kaleidoscope within the culture itself. These experiences influence how someone views and presents mental health issues and mental health treatment. For example, someone who is more acculturated may view sleeplessness, weight loss, loss of pleasure, withdrawal, irritability, and crying spells in their child as indicators of depression. This person may seek psychotherapy for the child. Someone who may be less acculturated may view this as a "loss of spirit." This person may seek the assistance of a traditional shaman to lead the child's spirit back instead of, or in conjunction with, more traditional western help. Valuing diversity influences how we choose to accept and respect the choices our clients make, their concepts of mental health, as well as how we integrate them into viable treatment plans.

Valuing diversity influences how we choose to accept and respect the choices our clients make, their concepts of mental health, as well as how we integrate them into viable treatment plans.

Self-Awareness/Capacity to Assess Oneself

The second step toward achieving cultural competence is the ability to honestly assess our own culture and that of our agency. Many good intentions have often fallen short of their desired goals because the people behind these intentions have not taken the time to do an assessment of themselves as well as the system from which they come. How we feel about our own culture and ethnic identity and how we feel about others are important aspects of developing awareness for what needs to improve as well as how we practice. For example, buying into the myth that white Americans in this country do not have a culture may cause white service providers to become patronizing either in trying to overcompensate for not being identifiably "ethnic" or by minimizing or over emphasizing the impact of culture and ethnicity upon mental health issues. The most unconscious acts are often the ones we need to be especially cognizant of, such as how we speak and interact with others of the same or different cultures or how an agency defines it's hiring practices (e.g., having practitioners who are reflective of the diverse clientele, but supervisors who are not). Therefore, cultural competency assessments must be formalized and embedded in agency operations and policy. Without these assessments, the development of culturally competent leadership and policy is difficult. Procedural and administrative adjustments may be difficult to attain. Administrators must be willing to engage in regular assessment activities in order to build upon the strengths of the agency as well as to eradicate weaknesses.

Understanding the Dynamics of Difference

There are many factors that affect cross-cultural exchanges. For instance, many marginalized groups in this country have experienced profound discrimination and unfair treatment. These experiences have caused a certain level of mistrust of the dominant culture within oppressed groups. While many folks from the dominant group may feel that they have not personally been responsible for historical and institutional racism, they have benefited because of the privilege dominance affords them in our current day society. These privileges extend not only to education, economic gain, and political power, but also to many other aspects of daily life that may affect the relationship between clients of color and practitioners from the dominant community, such as the fear that individual actions will be used to judge an entire race. I work with Southeast Asian clients who are often unwilling to reveal the full extent of their mental health and familial concerns to white practitioners because they fear that the information will be used to label all Southeast Asians as "crazy" or all Southeast Asian children as "bad" or "gang members."

Understanding how the dominant culture is viewed and how it influences minority groups is crucial to beginning to understand why certain attitudes, behaviors, and fears exist.

Mental health providers must understand these dynamics not only because of the role they play in access to care, but also because of the difficulties that our clients may encounter outside the context of our offices. These concerns also influence how clients perceive their providers. Because people of color are underrepresented in the mental health fields, there is a good chance that a mental health provider will come from a different culture and ethnicity than that of their clients. Understanding how the dominant culture is viewed and how it influences minority groups is crucial to beginning to understand why certain attitudes, behaviors, and fears exist. The ability to understand the dynamics of race and culture in this country are important to forming better relationships with clients and therefore more optimal treatment outcomes.

Basic Cultural Knowledge

Having a basic knowledge about selected cultural characteristics such as history, language, belief systems, and behaviors of the people who make up our community and those who make up our clientele is extremely important if we are to provide better service for our clients. Staff, as well as management, should have continuing training and education opportunities in order to expand basic knowledge and to effectively utilize that knowledge.

Practitioners also must also understand that it may be necessary to seek consultation on behalf of clients. We must not make the mistake of putting our clients in the role of being our teachers. While that might inadvertently happen through the stories and experiences that clients share with us, it is our responsibility to consult the literature, research, and individuals who are part of the community in order to get the most complete and thorough understanding of what our clients face. For instance, most practitioners would never put a sex abuse victim in the position of teaching them what it means to be a sex abuse victim with all of the social, political, and historical issues that have impacted them. Some of this would come out in therapy, but if inexperienced in this area, a practitioner would seek outside consultation. We should treat people of color with the same courtesy and commitment.

Finally, it is vital to remember that even when the client in front of us shares the same culture or ethnicity, we may not automatically be culturally competent in their issues. The assumption that because we share a basic culture, skin color, or belief, we are automatically competent to work with the client can be dangerous because it might hinder our ability to be objective as well as to seek proper consultation and additional training. For instance, although often lumped into one general category of "Hispanic/Latino," the experiences of Americans who come from Puerto Rico may be vastly different from Americans who are of Mexican descent, not to mention the diversity within and between the two groups based upon factors such as class, gender, education and acculturation levels. Mental health issues may not only be expressed differently, but client views of precipitating causes may vary as well. Because of the unique perspective that each of us takes away from shared or similar cultural experiences, consultation and training are crucial for all mental health practitioners.

Finally, it is vital to remember that even when the client in front of us shares the same culture or ethnicity, we may not be culturally competent in their issues.

Adaptation of Service Delivery

The fifth element is adaptation of service delivery. We must look at how treatment options are presented and whether they make sense to clients within their cultural paradigm. As mental health practitioners know, presenting treatment options that clients cannot connect with nor buy into is useless. We must find ways to engage clients so that this process is meaningful for them. For instance, there are many cultures in which the concept of "family" is fairly different from the westernized view of the nuclear family. When we talk about doing family therapy, for example, the client and the family must define that for us, and we must be prepared when extended members such as grandparents, uncles, aunts, cousins, and neighbors show up for family therapy. Or when parents don't show up, but any of the above do!

Another important aspect of adaptation of service delivery is that often times, we also have to help clients build a context within which to begin healing. For instance, many Asian cultures stress modesty. For Asian American children who may be used to the praise and reward systems in the American school system, it is often confusing that this is not repeated within the home. These types of relationships have often caused misunderstandings on the part of practitioners who assume emotional distance and therefore instruct parents to interact in a certain way with their children without first understanding and trying to build upon the strengths of the relationship as well as exploring the context of change.

Instillation of Cultural Competence at All Levels

Cultural competence has historically been seen as an issue for the "line staff" worker. However, building capacity for true cultural competence means a commitment that is strong enough to enable permeation at all levels including service, administration, and policy. It means that multiethnic and multiracial practitioners, board members, and supervisors, particularly those reflective of the community, must be actively recruited and retained. The development of culturally competent assessments and instruments must be nurtured by administration. Services must be accessible to all clients including linguistic, cultural, and physical access. Cultural competence training for all staff must be ongoing. It must be a standard for staff as well as the agency and other contracted services. And all of this must be set in agency policy.

Too often, when cultural competence is only addressed at the service level, it dissipates when practitioners leave or retire.

Too often, when cultural competence is only addressed at the service level, it dissipates when practitioners leave or retire. There has not been institutional change and a lackadaisical attitude permeates the entire organization.

When we work in the mental health field, and particularly with children and families, we are often working with some of the most vulnerable members of our society. Without truly understanding and conceptualizing the importance of providing culturally competent care, we not only do our clients the greatest disservice, we decrease the efficiency and effectiveness of our services. Most importantly, we violate our ethical and moral responsibilities as mental health providers. Cultural competence involves a new way of thinking that must be implemented on a daily basis. In the mental health field, we have too much to loose if we ignore the impact of culture and everything to gain if we don't. In the words of the Surgeon General's 2001 mental health supplement on culture, race, and ethnicity: "Culture counts."

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Educating Children with Mental Health Needs in the Public School System:

Personal Reflections of an Educator

By LYNETTE L. FASSBENDER, Ph.D.

Jerome is a 10 year-old boy in the fourth grade of a public elementary school who receives special education services. He had been diagnosed with a Bipolar Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Post Traumatic Stress Disorder (PTSD). He has been on a number of psychotropic medications with mixed results. Jerome's family background is positive for stress factors and instability. His mother is currently incarcerated and he has not seen her for over three months. Jerome is described by his teachers as being extremely volatile with rapid and unexpected mood changes. During these times, it takes four-to-five adults to contain Jerome in a safe-area so that he does not injure himself or others when restrained.

These three students have something in common - mental illness and unsuccessful school programs.

Michael is a middle-school student who has a mental health diagnosis of Reactive Attachment Disorder Syndrome (RADS) and borderline schizophrenic. Several psychotropic medication trials have not resulted in improved performance. He receives special education services for an emotional/behavioral disability. Michael exhibits many behaviors that result in disciplinary action and school failure including refusing to do homework, disrupting others' learning, disobeying rules, refusing to follow directions, compulsive stealing and kicking others. Michael has been suspended from school numerous times and is not able to attend his regular education classes.

Melissa, a nine year-old third grader with a pending mental health diagnosis, has been referred for a special education evaluation. Melissa's regular education teacher describes Melissa as completely out-of-control. Melissa is lacking in boundaries. She becomes very upset with any changes to her typical routine. Emotional outbursts occur daily. During these outbursts, Melissa swears and threatens others. Kicking, spitting and biting are also common. Melissa has been taken home on numerous occasions.

These three students have something in common - mental illness and unsuccessful school programs.

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Students with mental health illnesses are the most challenging and potentially disruptive students in many public school systems. Despite training for special education teachers and changes in recent IDEA reauthorizations that address the discipline and programming necessary to educate them, these are the students with whom no one-teacher nor administrator is comfortable working. Scientific research suggests a relationship between brain chemistry and misbehavior and indicates that brain development may be impaired as a result of neglect and abuse. However, recent reports on the public's perception of mental illness suggest that many incorrectly believe that children's mental illness is a choice and/or the result of bad parenting. With public perceptions and scientific evidence about mental illness so at odds, how can society create positive outcomes for these children, who so significantly challenge our school systems? This article will address these challenges and suggest how school systems can begin to provide successful services.

With public perceptions and scientific evidence about mental illness so at odds, how can society create positive outcomes for these children, who so significantly challenge our school systems?

What have we learned from our experiences?

Today's special education differs greatly from special education in the past. Previously, special education provided services to students primarily in self-contained, segregated settings and teachers were certified in one categorical area (e.g., specific learning disabilities, cognitive disabilities, emotional-behavioral disabilities).

In some respects, educating students with mental health illnesses was easier when these students were self-contained in a public school (or other facility). A cadre of specially trained adults who chose to work with these students, suffered through their ups and downs mostly out of view of regular education teachers and school administration. Many of these specially trained teachers understood that change would be slow in coming and that the development of a positive and trusting relationship with the student was a necessary piece of a successful program. Surely there were some successes, but were there enough? Would children separately educated from "the norm" ever be prepared for the "real world?" What if there were no appropriate peer models? Who would protect them from themselves and others as they grew older, physically stronger, and unable to adjust to the larger society.

Today, services are provided in mostly integrated (inclusive) settings and teachers receive cross-categorical or multi-categorical certifications. Special education teacher training programs no longer focus on one disability area and offer a more global perspective to pre-service teachers. It is common to find children with emotional disabilities in regular education classrooms with children without disabilities and "at risk" children. Some children with mental illness appear to benefit greatly from these more "normalized" settings with appropriate peer models. Others, however, cannot or will not "fit-in." These few (but mighty) students are the bane of many teachers and administrators who espouse inclusion and success for all students. These are the students who continue to be "shut-out," "put-out," and "written off." Their needs are seemingly outside the expertise of school personnel. No adaptations or modifications of curriculum are going to resolve their emotional issues. As much as school personnel may wish that they could, they cannot change the environmental conditions in which many of these children must learn to survive. What do we do with these "throw-away" children?

Educating children with mental health problems is the responsibility of public schools in partnership with parents and in collaboration with community agencies.

School-Based Mental Health Programs

A few forward-thinking school districts and states have proposed or instituted school-based mental health programs. The theme, to educate students with mental health issues, is the same, but the approaches differ. Some school districts/states provide mental health personnel in each school or district or collaborate with community agencies to address mental health needs as they do physical or cognitive needs. Other school districts have clinics, which include mental health services, in the neighborhood school. Still other school districts, offer separate programs, sometimes in separate buildings, for students with mental health issues. For many school districts, however, these programs may fail to meet the needs of students with mental health issues due to insufficient funding, ineffective services, inappropriate placements of students in inclusive settings, and the continued perception that emotional problems are self-inflicted or caused by "bad" parenting.

Alternatives to Admiring the Problem

Educating children with mental health problems is the responsibility of public schools in partnership with parents and in collaboration with community agencies. If schools are to provide for a 7 1/2 hour school day for these students, they will need innovative programs, constructive ideas, dedicated staff, and the support of parents and the community. If school buildings filled with hundreds of students increase some student's anxiety to levels that result in serious misbehaviors, then instruction can take place in the community. Community-based instruction requires staff who are willing and able to see how to teach traditional academics in non-traditional environments. Community-based instruction with lots of 1:1 adult attention helps a child or adolescent regain self-control through positive, incremental learning experiences. Community-based instruction can occur for all or a small part of a child's school day, based on individual needs. Finding school staff who are willing and able to work with students with mental health needs in community-based environments remains a challenge. Fear of the "what-ifs" and failure to plan adequately for possible misbehavior often result in a denial of services. However, community-based instruction can be a cheaper alternative, in the long run, to suspension, expulsion, institutionalization, and corrections.

While community-based instruction may resolve some student anxieties, many students will require mental health therapy in their school as a related service. Related services are defined as those services necessary for a child to benefit from his or her special education. Schools commonly include occupational and physical therapy for students who have a physical disability or other sensory differences. Few question the efficacy of these therapies. Yet, many question the necessity of providing mental health therapy as a related service in the schools. Students with mental illness need access to mental health therapy in the school environment, so that they too can learn. These students' anxiety attacks and emotionally based misbehaviors do not happen by appointment, so the typical once per-week, 50-minute therapy appointment is not adequate. Daily access to a school-based mental health practitioner will help students with mental illness tear down the barriers to learning. They will assist students with the timely resolution of perceived conflicts, learning effective conflict resolution and proactive social skills, and the use of a "safe-space" where these students may express emotions that are unacceptable in classroom environments.

While community-based instruction may resolve some student anxieties, many students will require mental health therapy in their school as a related service.

Adults who understand the problems that students with mental health issues face, recognize their own power. These adults know beyond a doubt that the only behavior that they can control is their own. Therefore, strategies and interventions revolve around smoothing the fit between the child's environment and the child rather than looking for a child "fix." Careful planning of all aspects of the child's school program and an emergency protocol will more likely lead to a successful experience for student and adult. This can best be accomplished by doing a thorough functional assessment and creating a positive behavioral support plan. This does not mean that there will not be times when it is necessary to call the police, restrain or even suspend for a brief period of time. What it does mean is that we respect the child's disability and we try our best to provide positive, successful experiences. Slowly, but surely the student understands his/her boundaries; fears and anxieties diminish.

Flexible thinking is critical to an effective school program for students with mental health needs. The starting point is with the child's needs, not the adult's. Herein lies one of the major challenges to educating these students - how to be okay with change. How to help school personnel understand and acknowledge that current approaches, allocation, staffing, curriculum, instructional strategies, etc. may, indeed, need to be changed in order to achieve student success. Administrators who operate from a position of "what can we do for this child" rather than from a position of "we don't have the resources to educate these children" will model appropriate thinking and actions. True parent and community partnerships will occur. Yes, additional resources will be needed, but additional money won't be nearly as effective as flexible thinking. We can do this with a creative, heart-felt approach.

There will need to be support the adults who work day-in and day-out with students who have mental health needs. While it is vital to provide consistency and structure in a child's program, it is unwise to expect that one individual can be responsible for an entire school day. Multiple adults need to be trained to work effectively with the individual child. These adults need to understand and respect the child. They need to have an inner strength that allows them to feel good about what they are doing despite what may appear to be abusive behaviors directed towards them. They need to be well aware of the conflict cycle and keep one-step ahead of the emotions and corresponding misbehaviors of the student. They need an acute awareness of the "communicative intent" of behavior - this child is attempting to tell us something about him or herself through these behaviors - and a professional demeanor throughout. This is not a job for inadequately trained adults who work for a meager wage and feel hopeless and helpless. We will need some of our smartest, best, most dedicated teachers to show us the way.

> **While it is vital to provide consistency and structure in a child's program, it is unwise to expect that one individual can be responsible for an entire school day.**

Schools and community agencies need to stop arguing about who is financially responsible for what services during what hours of the day and get their acts together. Right now, no one is winning and our children are failing. Children and families need teams of professionals with wrap-around services who work together to provide supports. They don't need teams of professionals who fear and blame each other for lack of success. Schools can't fix kids and agencies can't fix families. Collaborative teams can adequately solve even some of the most challenging problems. Schools and community can develop mutually beneficial service-learning programs and provide 1:1 mentors for students with mental illnesses. We know that we have to work together and that we have to share the financial burdens.

Jerome, Michael and Melissa stand little chance of experiencing success in today's schools. They are at great risk for complete failure without an intentional school program that is designed to meet their individual needs. This concept is not new; it has been the heart of the special education law since it's inception. Appropriate education for students with mental health needs is the last of special education's great frontiers. Educators have moved mountains for students with physical disabilities, severe cognitive delays, and students with autism. Success for all is a possibility and its time has come.

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May I Have Your Attention, Please: ADHD and ADD

By NAN BRIEN

Controversy continues to swirl around Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)* – is either, or both, a disease; if they are, how do we treat them, etc.? In the January 26, 2001 issue of *Science*, two scientists, Peter R. Breggin (Director of the International Center for the Study of Psychiatry and Psychology) and Fred Baughman (retired neurologist) disputed the categorization of "disease." According to Braughman, "ADHD...appears to be a set of normal behavioral variations." On the other hand, many scientists and physicians agree with a statement from NIMH (National Institute for Mental Health):

About three to five percent of school-age children have ADHD; it is diagnosed three times more often in boys.

> "Children with attention deficit hyperactivity disorder, the most common of the psychiatric disorders that appear in childhood, are often the subject of great concern on the part of parents and teachers. Children with ADHD are unable to stay focused on a task, cannot sit still, act without thinking, and rarely finish anything. If untreated, the disorder can have long-term effects on a child's ability to make friends or do well at school or in other activities. Over time, a child with ADHD may develop depression, lack of self-esteem, and other emotional problems."

Obviously, NIMH considers ADHD to be a disease.

Hyperactivity, impulsivity, and inattention are the three identified symptoms of ADHD; about three-to-five percent of school-age children have ADHD; it is diagnosed three-to-four times more often in boys.

ADHD tends to run in families, so there is likely to be genetic influences. Brain scans also reveal structural brain differences - prefrontal cortex, striatum, basal ganglia, and cerebellum tend to be smaller. However, overall brain size is generally only about five percent smaller in affected children (*Scientific American*, 9/98). The dopamine neurotransmitter system has been linked to ADHD, as will be discussed later. ADD is the term applied to the same disorder without the hyperactivity; this may be a more common diagnosis for girls.

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The stimulant, methylphenidate (Ritalin) is the most common drug used to combat the symptoms of ADHD. A time-release version of methylphenidate, Concerta, is the latest drug to be used. Its effects last 12 to 14 hours instead of the four to five hours for Ritalin. Students do not have to go to the nurses' office for a midday dose, which can be more difficult for youngsters concerned about other students' perceptions. It also avoids some of the mood swings that can occur as Ritalin effects wear off.

Diagnosis continues to be a major issue. Depression, anxiety, bipolar disease, and oppositional-defiant behaviors have been misdiagnosed as ADHD.

Diagnosis continues to be a major issue. Depression, anxiety, bipolar disease, and oppositional-defiant behaviors have been misdiagnosed as ADHD. Ritalin can be the wrong medication in many of these cases. Although not uniformly accepted by his peers, Dr. Daniel G. Amen (CEO-Amen Clinics, Newport Beach & Fairfield, CA) identifies six distinct types of ADD (*Newsweek*, 2/26/01) and suggests varied interventions:

1. Classic ADD (distractibility, disorganization with hyperactivity and impulsivity) - stimulant medication: Adderall or Ritalin.

2. Inattentive ADD (primary ADD symptoms with low energy and motivation; more common in females) - medication: stimulants, plus higher protein diet.

3. Overfocused ADD (primary symptoms with cognitive inflexibility and difficulty shifting attention; often display negative thoughts and behaviors - worry, bear grudges, argumentative; often in families w/addiction problems or obsessive-compulsive tendencies) - medications: antidepressant (Effexor or SSRI, such as Prozac), combined w/a stimulant and a higher carbohydrate diet.

4. Temporal lobe ADD (primary ADD symptoms with a short fuse, periods of anxiety, memory problems and difficulty reading; may be history of head injury or family history of learning or temper problems) - medication: combination of an anti-seizure drug like Neurontin, a stimulant, and a higher protein diet.

5. Limbic ADD (primary ADD symptoms w/mild sadness, low energy, low self-esteem, irritability, social isolation, and poor appetite and sleep patterns) - medication: a stimulating antidepressant such as Wellbutrin, w/aerobic exercise and a balanced diet.

6. "Ring of fire" ADD (primary ADD symptoms w/extreme moodiness, anger outbursts, inflexibility, fast thoughts and excessive talking; sensitive to sounds and lights - intense "ring of overactivity") - medications: an anticonvulsant such as Neurontin, combined with an SSRI or a new antipsychotic medicine such as Risperdal or Zyprexa. Aerobic exercise also seems to help.

According to Amen, "ADD, then, is a multifaceted illness that usually responds to well-targeted treatment. However, without a vast change in the way doctors look at ADD, millions will be left untreated or mistreated by the very people they depend on."

In the same manner that controversy continues to swirl about the definition and treatment of ADD or ADHD, so does controversy surround the proposed causes of the disorder. Probably the most accepted explanation centers on the dopamine system (*Scientific American*, 9/98). Since 80 percent of differences between individuals with ADHD and those without it can be explained by genetic factors, it follows that the deficiency in the dopamine system reflects a genetic disorder of that system. Two studies, one at the University of Chicago and the other at the University of California at Irvine point to deficiencies in the dopamine system. In the former study, the research scientists found that children with ADHD were "more likely than others to have a particular variation in the dopamine transporter gene." In the second study, the scientists found "a variant of the dopamine receptor gene." However, both studies had a small sample of children, so larger studies are needed to replicate these results before they can be uniformly accepted.

In the same manner that controversy continues to swirl about the definition and treatment of ADD or ADHD, so does controversy surround the proposed causes of the disorder.

The results of a recent study at the Massachusetts General Hospital, reported in *The Lancet* (12/16/99) medical journal, show that "ADHD sufferers had 70 percent more dopamine transporters [responsible for reuptake] than their healthy counterparts." However, it was not clear if this effect was the cause or the result of ADHD. "The increased number could either mean not enough dopamine is floating around the system or that too much is being produced."

Most scientists believe that the problem lies with the transporters. Ritalin is thought to shut down the transport system and allow more dopamine to remain in the synaptic cleft and act on the receiving cells. We generate dopamine in the brain when we attempt to pay attention or focus on a difficult task. It shuts out "the noise." ...too little dopamine (for whatever reason), too little ability to concentrate. People suffering from ADHD appear to have too little dopamine. Perhaps Malcolm Gladwell (*The New Yorker*, 2/15/99) states it best:

> Dopamine is manufactured in the brain, [released into the synapse, and binds to] special receptors [on the postsynaptic cell]; each of those receptors has a "transport," a kind of built-in vacuum cleaner that sucks up any excess dopamine floating around and stores it inside the neuron. Ritalin shuts down that transport, so the amount of dopamine available for cognition remains higher than it would be otherwise. In about 65 percent of those who take

> the drug, Ritalin appears to make them "normal," and in an additional 10 percent it appears to bring about substantial improvement.
>
> Cocaine affects the brain in almost exactly the same way. Nicotine, too, is a dopamine booster, although its mechanism is somewhat different [Ritalin is not addictive, however.]. Cocaine was a feel-good drug of a certain kind - a drug that people thought would help them master the complexity and the competitive pressures of the world around them. At the moment of its greatest popularity, cocaine was considered a thinking drug, an achievement drug, a drug for the modern world. Nicotine has a similar profile. Cigarettes aid concentration. There are plenty of data showing that nicotine does exactly what you would expect a dopamine enhancer to do. Ritalin is becoming a safe pharmaceutical alternative to the more dangerous dopamine boosters of the past.

In a further reference to Ritalin, Gladwell says:

We are extending to the young cognitive aids of a kind that used to be reserved exclusively for the old.

> We are extending to the young cognitive aids of a kind that used to be reserved exclusively for the old. It is this reliance on a drug - the idea that children should have to be medicated - that, of course [the critics] find so upsetting. If some children need to take a drug in order to be "normal," they think that the problemis with our definition of "normal." What if Tom Sawyer or Huckleberry Finn were to walk into my office tomorrow? Tom's indifference to school and Huck's 'oppositional' behavior would surely have been cause for concern. But this is just the point. Huck Finn and Tom Sawyer lived in an age where difficult children simply dropped out of school, or worked on farms, or drifted into poverty and violence. Their "childhood" was a ruthlessly Darwinian place, which provided only for the most economically - and genetically - privileged. Children are now being put into situations that demand attention and intellectual consideration, and it is no longer considered appropriate simply to cast aside those who because of some neurological quirk have difficulty coping.

According to many of the scientists and physicians who treat children, the worry is not that Ritalin and other drugs are not useful, but rather that diagnosis and companion therapies are often inadequate.

As Dr. Amen and others have pointed out, ADHD is neither an easy nor simple diagnosis. The disorder itself, according to NIMH, is often co-morbid with other mental health problems like oppositional behavior, bipolar disease, anxiety disorders.

Children also can be diagnosed as having ADHD when, in fact, they suffer from another illness.

Dr. Thomas Brown (*New York Times*,6/20/00), associate director of the Yale Clinic for Attention and Related Disorders, points to two major factors that are crucial to correct diagnosis and treatment.

1. Individuals with ADHD are at very high risk of having or developing other problems such as depression, bipolar disorder, anxiety, learning disabilities, and, in adolescents, substance abuse. **A problem that coexists with ADHD can interfere with Ritalin and other stimulant medications** (emphasis added).

2. Individuals with ADHD often have difficulty with the brain's executive functions - short-term memory, planning and staying on task without being distracted by emotional impulses. **So ADHD does not impair one's ability to pay attention across-the-board, but rather it interferes with the ability to pay attention when frustrated or lacking interest** (emphasis added). Individuals can have difficulty with attention in some situations, but not others.

Individuals with ADHD are at very high risk of having or developing other problems such as depression, bipolar disorder, anxiety, learning disabilities, and, in adolescents, substance abuse.

Regarding diagnosis, Dr. David Fassler (*New York Times*, 6/20/00), chairman of the Council on Children, Adolescents and Their Families of the American Psychiatric Association says: "You can't do this in one or two sessions. A comprehensive evaluation means getting a detailed history of the child's early development, medical conditions and problems in school and with friends, as well as meeting with the child and with the family."

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*In the diagnostic manual, DSM-IV, the definition for what has been commonly referred to as ADD now reads "ADHD, predominantly inattentive type." For purposes of this article, we continue to refer to this diagnosis as "ADD."

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Defining Parity

BY SHEL GROSS

Over two million Wisconsin residents are members of organizations that have declared their support for parity in health insurance coverage for mental health and alcohol and other drug abuse (MH/AODA) disorders.[1] Yet the Wisconsin Legislature has failed to pass a parity bill in four consecutive sessions. This article provides an overview of what MH/AODA parity is and what it is not, its costs and benefits, some of the history and politics surrounding parity legislation and what the future may hold.

Parity in health insurance for MH/AODA disorders means that these disorders should not be more restrictive than coverage for other medical conditions.

What Parity Is

Parity in health insurance coverage for MH/AODA disorders means that coverage for these disorders should not be more restrictive than coverage for other medical conditions. Restrictions can take a variety of forms:

- **Day and Visit Limits:** lower limits on the number of outpatient visits and inpatient hospital days for MH/AODA than for other medical conditions.
- **Lifetime and Annual Dollar Limits:** lower limits on the total payments health plans will make for MH/AODA treatment than for other medical conditions.
- **Copayments and Deductibles: higher copayments** (the share of the cost of a service that the consumer[2] must contribute) and deductibles (the amount the consumer must pay before the insurance begins to make any payments for services) than for other medical conditions.
- **Out-of-Pocket Limits:** Failure of plans to include MH/AODA treatment in calculating the limit on a consumer's annual out-of-pocket payments - the amount the consumer is required to contribute for all care prior to reaching the annual dollar limit. Plans will generally have out-of-pocket limits of $5,000-$10,000 for other medical conditions.

In Wisconsin, state statutes require commercial health insurance policies to provide a minimum level of coverage for MH/AODA disorders.[3] This minimum is $7,000 per year for all treatment. Within this, the plan must provide a minimum of $2,000 per year for outpatient treatment for MH/AODA (if the plan offers outpatient treatment for other disorders) and $3,000 per year for transitional treatment (e.g., residential treatment, community support programs).

While these limits are codified as minimums they have often become maximums and, at the very least, legally allow health plans to offer coverage of MH/AODA disorders at a level significantly below the coverage offered for other disorders.

Thirty-two states currently have some form of parity legislation.

What Parity Is Not

There are other ways that health plans can restrict coverage of care that are not addressed by most parity legislation. These include:

- Failing to faithfully implement the provisions of the parity legislation.
- Failing to have an adequate supply of qualified MH/AODA providers.
- Failing to reimburse providers at a level adequate to ensure the availability of sufficient services.
- Utilizing overly restrictive utilization review or managed care.

Therefore, as Ken Liebertoff has pointed out, "Comprehensive parity cannot succeed without companion legislation that provides consumer protections and anti-discrimination safeguards".[4] Wisconsin, for instance, is in the process of implementing a new statutory requirement for independent external review organizations to which consumers can appeal adverse decisions about their health care. Without such safeguards the promise of parity may well fail to be realized.

"Comprehensive parity cannot succeed without companion legislation that provides consumer protection and anti-discrimination safeguards."

The Premises Underlying Parity

There are two basic premises underlying the effort to achieve parity for MH/AODA. The first is that these disorders are real and treatable. It is beyond the scope of this article to document the current science with regard to MH/AODA disorders. The Surgeon General's Report on Mental Health[5] catalogues the research to date with regard to mental illness. *Managing Managed Care: Quality Improvement in Behavioral Health*, from the Institute of Medicine,[6] provides an excellent review of the knowledge on AODA treatment. Suffice it to say that there is strong empirical support for treatment effectiveness for both disorders.

The second premise is that the most effective and efficient health care system is one that allows the physician and the client to determine the type and amount of care that will best address the health condition without being constrained by arbitrary limits imposed by the insurance plan.

Parity at the Federal Level

One limitation of all state level parity laws is that they cannot regulate companies that choose to self-insure. Federal laws, however, can apply to these companies. Additionally, a federal law can bring some consistency to the wide variety of current state legislation.

One limitation of all state parity laws is that they cannot regulate companies that choose to self-insure. Federal laws, however, can apply to these companies.

The first federal parity law, the Mental Health Parity Act (MHPA), was enacted in 1996. This bill did not cover substance abuse, exempted employers with fewer than 50 employees, applied only to annual and lifetime spending limits and had a cost increase cap of one percent. A General Accounting Office (GAO)[7] study of the impact of the Act found the following:

- Despite the rather weak requirements of the Act, 14 percent of firms surveyed were non-compliant.
- Of those that complied, 87 percent had at least one other plan design that resulted in more restrictive mental health coverage-most generally this was a day or visit limit.
- Only three percent of employers claimed that the MHPA led to increased costs and virtually none requested exemption from the Act.

The MHPA also had a sunset provision for 2001. In preparation for this, Sens. Domenici and Wellstone introduced a more comprehensive bill, the Mental Health Equitable Treatment Act of 2001. This bill would have covered all terms and conditions of coverage and would have eliminated the cost increase cap. The bill, however, would still have applied only to firms of 50 or more employees and excluded AODA. Although the bill passed the Senate it ultimately failed to make it through a conference committee. The committee, however, did extend the sunset on the MHPA for another year.

Although efforts to require health insurance parity for private employees have been only minimally successful, the same is not the case for federal employees. In 1999, the Clinton administration announced that it would provide full mental health and AODA parity for all nine million federal employees and family members covered through the Federal Employees Health Benefit Program (FEHB). This went into effect January 1, 2001. In addition to sending a strong message about the federal government's commitment to parity, the change will also allow for a large-scale test of the impact of parity.

The Costs of Parity

The most significant barrier to the passage of parity has been the business community's belief that removing restrictions on MH/AODA treatment will lead to large increases in premium costs. In fact, over time, the estimated cost impact of parity continues to decline.

A 1998 report from the U.S. Department of Health and Human Services[8] estimated an average 3.6 percent premium increase for MH/AODA parity. However, projected increases were much higher (5 percent) for fee-for-service plans than for managed care plans (0.6 percent). By June 2000, an updated actuarial analysis by the Hay Group had revised the estimated overall impact to 1.4 percent.[9]

The same trend can be seen in Wisconsin, where reports from the Office of the Commissioner of Insurance document a decline in the projected impact of parity legislation from a range of 0.6-1.2 percent in June 2000, to a range of 0.12-1.0 percent in October 2001.[10]

However, the most compelling evidence is from those states that have actually implemented parity. Ronald E. Bachman, FSA, MAAA, a principal with PriceWaterhouseCoopers conducted a comprehensive review of source documents from a number of states and concluded, quite simply, "To date, there are no examples where mental health parity has been enacted in a state and costs have dramatically increased."[11]

Parity opponents continue to bring forward studies that show higher cost increases. However, according to Roland Sturm, a noted health researcher, "incorrect assumptions and outdated data [often lead to] dramatic overestimates."[12] Specifically, he notes that some estimates use data from the 1980s, when MH/AODA costs were exploding, and do not take into account the advent of managed care, which now manages about 75 percent of persons receiving MH/AODA services.

The most significant barrier to the passage of parity has been the business community's belief that removing restrictions on MH/AODA treatment will lead to large increases in premium costs.

Unfortunately, the concerns about the costs of MH/AODA parity are caught up in the larger issue of rapidly escalating health care costs. The share of overall health care costs attributable to MH/AODA has actually declined considerably. MH/AODA services represented 7.8 percent of U.S. health care expenditures in 1997, down from 8.8 percent in 1987. Real spending for MH/AODA disorders by private insurers fell 0.6 percent annually during that period.[13] However, as long as health care premiums increase at a double digit rate any efforts to expand coverage are going to meet with resistance.

The Benefits of Parity

The benefits of parity arise from the ability of increased access to treatment to reduce the high costs associated with untreated MH/AODA disorders.

While businesses focus on the cost of providing parity, they tend not to look at the cost of not doing so.

There are numerous estimates supporting the assertion that MH/AODA disorders cost our society a lot of money. The Surgeon General reported direct treatment costs for mental illness of $69 billion and indirect costs of $79 billion.[14] A more recent report by the National Mental Health Association identified direct treatment costs of $92 billion and indirect costs of $113 billion ($105 billion from lost productivity and $8 billion from social costs associated with crime and welfare) for MH/AODA disorders.[15] Another study that looked at a broader array of indirect costs found costs of $276 billion from AODA disorders.[16] While the specific estimates may vary, it is noteworthy that a large part of the cost relates to lost productivity. While businesses focus on the cost of providing parity they tend not to look at the cost of not doing so. Indeed, the Global Burden of Disease study, conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness ranks second in the burden of disease in established market economies, such as the United States.[17]

A variety of studies point to the ability of treatment to reduce direct and indirect costs of mental illness and substance abuse disorders:

- A 1999 study documented declines in absenteeism rates among employees treated for depression.[18]
- There are marked reductions in job problems such as missing work, making mistakes, completing work and conflicts with supervisors following AODA treatment.[19]
- In an interesting natural experiment, a Connecticut company that reduced its mental health services experienced increased general health care costs, increased use of sick leave and decreased productivity that equaled the money they saved in reduced benefits.[20]
- By providing Employee Assistance Programs for workers with addiction problems General Motors saves $37 million/year, United Airlines estimates a $16.96 return for every dollar spent and Northrop Corporation reports $20,000 savings per rehabilitated employee.[21]

Clearly, evidence of direct benefits to employers is critical in the parity debate. So while the literature is still evolving in this area, the evidence that exists provides some reason to believe that treatment can positively impact performance in the workplace in addition to general well-being.

Parity: It's the Right Thing To Do

Ultimately parity is not about costs and cost offsets. It is about fairness. It is about the understanding and acceptance of conditions that have been long stigmatized. As the science base has increased, as prominent persons who have mental illness and AODA disorders step forward and speak out, as people begin to realize that these are real and treatable disorders, the unfairness of unequal coverage becomes clearer.

Ultimately parity is not about costs and cost offsets. It is about fairness. It is about the understanding and acceptance of conditions that have been long stigmatized.

In his *Report on Mental Health*, the Surgeon General laid out the comparative out-of-pocket costs for persons requiring treatment for mental illness and persons receiving treatment for other medical conditions. A study by Zuvekas et.al.,[22] found that a family with $35,000 in mental health treatment expenses paid an average of $12,000 out-of-pocket. Those with $60,000 in mental health expenses paid an average of $27,000 out-of-pocket. The corresponding out-of-pocket costs for similar levels of medical/surgical care were $1,500 and $1,800 respectively.

This is the underlying discrimination that is inherent in current health insurance coverage. It reinforces the stigma that so many people with these disorders already experience.

The Politics of Parity

As noted at the outset, parity legislation has been introduced in four sessions of the Wisconsin Legislature. The first two times the bill was introduced it would have applied only to persons with certain enumerated serious mental illnesses. The bill did not make it out of committee in either of these sessions. The subsequent bills were comprehensive, covering all MH/AODA diagnostic categories and all size employer groups. In the 1999-2000 legislative session the bill passed the Senate Health, Utilities, Veterans and Military Affairs Committee, but was never taken up on the floor of the Senate. In 2001-2002 the bill passed the Senate but never made it out of the Assembly Health Committee.

Opposition to parity in Wisconsin, as elsewhere, has come primarily from business groups: the National Federation of Independent Businesses and the Wisconsin Manufacturers and Commerce. Additionally, health plan providers have opposed the legislation.

Opponents have raised a variety of concerns about the legislation in addition to the cost concerns addressed earlier. A primary concern is an opposition to mandates. Employers note that the insurance statutes already mandate a wide variety of benefits. They argue that this raises costs, limits flexibility and ultimately reduces the number of persons who have access to any insurance.

However, Bachman's analysis did not find examples of states that implemented parity and, subsequently, had measurable increases in the number of uninsured. Additionally, while employers argue that employees should be able to negotiate these benefits with their employers, employees often have very justified fears regarding discrimination that prevent them from disclosing a MH/AODA disorder in themselves or their family.

Opponents also argue that it is really government's role to provide this treatment.

Opponents also argue that it is really government's role to provide this treatment. This is based in part on the existence of a public system of care for MH/AODA that does not exist for other medical conditions. It is also based on data that suggests that some of the savings from parity will accrue to the public through reduced corrections and welfare costs. However, the public system is overburdened - already serving many individuals who have exhausted their insurance benefits - and the available funds have been declining over the past ten years. An analysis by the Wisconsin Council on Children and Families found that community aids, a critical source of funding for MH/AODA services in Wisconsin, decreased 26 percent in inflation-adjusted value between 1996 and the projected funding level in 2003.[23]

Parity legislation has strong bi-partisan support. Democrats have generally supported parity. But in Wisconsin the lead author of the bill and the lead sponsor in the Assembly are both Republicans. The bill passed the Senate in 2001 by a 22-11 vote with a number of Republicans joining most of the Democrats to pass the bill. However, the strongest opponent of the bill has been Rep. Gregg Underheim (R-Oshkosh) who chairs the Assembly Health Committee and has been very public about his opposition to the bill.

The Future of Parity

Although progress has been slow, each year more states do enact parity legislation, which undoubtedly will provide further impetus to efforts at the federal level. Additionally, the future of parity will be tied to ongoing efforts to seek meaningful reform in the health care industry as costs rise and high numbers of individuals remain uninsured.

Efforts already are underway to move federal parity legislation forward. Following the defeat of the legislation in the conference committee in 2001, Sen. Domenici apparently received a promise from President Bush that the President would help support parity legislation in the future. Early in 2002 a hearing was held in a key House committee for the first time.

In Wisconsin, efforts to change the law will continue. The Coalition for Fairness in Mental Health and Substance Abuse Insurance, which consists of over 80 mental health and substance abuse consumer, family, advocacy and provider groups as well as labor, faith-based groups and others will continue to promote parity legislation. While the failure to pass a bill in 2002 was disappointing, the Coalition is buoyed by the fact that the bill made it much further through the legislative process than in previous years.

However, the future may have been foreshadowed in the legal arena. A recent U.S. District Court decision found that a woman was inappropriately denied disability insurance because her bipolar disorder was not covered as a physical illness. Judge Henry H. Kennedy Jr. noted that bipolar disorder can be inherited, is visible on brain scans and is characterized by chemical imbalances in the brain, so therefore is a physical illness.[24]

While the ruling itself may have limited applicability, and presents some concerns because the physical basis of every mental disorder is not as clear as it is for bipolar disorder, it does reflect the growing awareness of the science underlying our understanding of MH/AODA disorders. Ultimately, it will be this growing knowledge that MH/AODA disorders are real and treatable that will make parity a reality.

A recent U.S. District Court decision found that a woman was inappropriately denied disability insurance because her bipolar disorder was not covered as a physical illness.

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References

[1] A variety of terms are used to refer to disorders involving alcohol and other drug abuse or dependence. In its statutes Wisconsin most typically uses alcohol and other drug abuse (AODA), which we will use here. Other terms are substance abuse and chemical dependency.

[2] Consumers refers to persons receiving treatment for MH/AODA. It is not a term that is popular with all persons receiving these services, but is in wide use in Wisconsin.

[3] See 632.89 Wis. Stats. for complete language.

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[23] *Trends in Funding for County Human Service Programs*, Wisconsin Budget Project, Wisconsin Council on Children and Families, May 16, 2001.

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Children's Mental Health County Data

County	2000 Child Population	2000 Births	2000 % Child Poverty	Healthy Start 12/31/01	Healthy Start per 1,000	Badger Care 12/31/01	Badger Care per 1,000	2000 Hospitalizations per 1,000
Wisconsin	**1,368,756**	**69,289**	**11.2**	**114,073**	**83.34**	**35,506**	**25.9**	**5.0**
Adams	3,883	158	14.6	679	174.9	210	54.1	5.4
Ashland	4,284	224	13.6	930	217.1	357	83.3	6.8
Barron	11,380	466	10.9	1,360	119.5	429	37.7	*
Bayfield	3,700	141	17.0	623	168.4	275	74.3	*
Brown	59,123	3,212	8.2	4,734	80.1	964	16.3	6.7
Buffalo	3,461	163	8.2	291	84.1	102	29.5	*
Burnett	3,465	136	12.2	505	145.7	199	57.4	*
Calumet	11,619	513	4.6	569	49.0	102	8.8	3.3
Chippewa	14,602	673	11.3	1,701	116.5	443	30.3	2.9
Clark	10,038	496	18.6	975	97.1	301	30.0	6.6
Columbia	13,221	616	6.2	778	58.8	244	18.5	3.9
Crawford	4,512	183	13.1	482	106.8	482	106.8	*
Dane	96,255	5,555	7.5	5,214	54.2	5,214	54.2	2.9
Dodge	21,263	994	6.7	1,258	59.2	1,218	57.3	5.5
Door	6,172	232	9.5	519	84.1	177	28.7	3.9
Douglas	10,202	513	13.8	1,233	120.9	419	41.1	*
Dunn	9,305	483	12.1	1,006	108.1	288	31.0	2.5
Eau Claire	21,820	1,116	9.6	2,362	108.2	631	28.9	6.0
Florence	1,164	36	12.4	140	120.3	63	54.1	*
Fond du Lac	24,489	1,151	6.6	1,760	71.9	397	16.2	6.1
Forest	2,536	114	18.7	386	152.2	141	55.6	*
Grant	11,768	540	12.9	960	81.6	271	23.0	4.1
Green	8,908	402	5.2	690	77.5	690	77.5	2.7
Green Lake	4,614	219	9.2	432	93.6	155	33.6	5.4
Iowa	6,171	263	8.1	355	57.5	115	18.6	5.7
Iron	1,334	40	15.6	222	166.4	110	82.5	*
Jackson	4,603	233	10.6	644	139.9	176	38.2	6.3
Jefferson	18,657	931	6.9	1,112	59.6	250	13.4	3.6
Juneau	6,182	275	13.1	716	115.8	198	32.0	7.0
Kenosha	40,502	2,151	9.9	3,358	82.9	862	21.3	6.5
Kewaunee	5,217	224	6.0	347	66.5	85	16.3	4.5
La Crosse	25,261	1,234	9.7	2,350	93.0	554	21.9	5.8
Lafayette	4,389	174	12.5	344	78.4	92	21.0	*
Langlade	5,057	209	13.3	679	134.3	214	42.3	*
Lincoln	7,541	281	8.1	633	83.9	166	22.0	4.4

* han 20 events. No rate is calculated.

Children's Mental Health County Data

Juvenile Arrests per 1,000 children	Out Of Home	Out Of Home (%)	MA 12/31/01	MA per 1,000 children	2000 % Mothers w/o HS degree	2000 % Low Birthwt. Babies	2000 % Teen Mothers	2000 % 1st Trimester Prenatal Care
93.3	**10,677**	**7.8**	**292,584**	**213.8**	**15.9**	**6.5**	**10.2**	**83.9**
18.8	23	5.9	1,390	358.0	23.5	8.2	12.6	74.7
128.9	24	5.6	1,813	423.2	11.1	6.3	14.8	83.5
55.8	57	5.0	2,584	227.1	15.9	7.5	9.6	84.5
94.9	12	3.2	1,215	328.4	5.7	4.3	5.6	85.1
90.8	125	2.1	9,702	164.1	17.2	5.9	10.3	84.9
32.4	12	3.5	632	182.6	8.7	3.1	9.2	80.4
77.9	16	4.6	1,078	311.1	11.8	9.6	13.2	77.9
25.6	17	1.5	959	82.5	5.5	6.6	3.9	87.9
69.9	43	2.9	2,989	204.7	11.6	5.2	10.9	85.9
34.9	22	2.2	1,625	161.9	36.3	4.8	7.4	63.5
120.3	38	2.9	1,533	116.0	10.2	6.8	6.8	85.7
54.3	18	4.0	892	197.7	12.0	8.7	13.6	74.3
91.7	452	4.7	13,551	140.8	10.2	6.0	6.9	88.4
78.2	65	3.1	2,509	118.0	12.0	4.0	10.0	86.8
65.8	7	1.1	925	149.9	9.1	4.3	10.8	85.8
112.8	41	4.0	2,897	284.0	11.1	6.4	12.6	87.1
50.1	52	5.6	2,079	223.4	9.1	5.4	7.1	81.6
137.6	105	4.8	4,577	209.8	10.9	5.8	7.6	83.4
30.1	2	1.7	289	248.3	13.9	11.1	13.9	88.9
86.0	68	2.8	3,468	141.6	12.2	6.4	8.8	85.3
81.6	16	6.3	759	299.3	24.6	7.9	9.7	86.8
61.1	20	1.7	1,735	147.4	13.7	5.2	8.7	79.4
71.6	31	3.5	1,277	143.4	10.5	6.0	6.5	88.8
141.3	17	3.7	831	180.1	12.5	6.8	11.9	69.9
61.7	25	4.1	743	120.4	9.5	5.3	7.2	85.9
61.5	3	2.2	400	299.9	17.5	0	20.0	85.0
60.2	10	2.2	1,103	239.6	16.3	6.0	13.3	78.1
143.1	34	1.8	2,036	109.1	12.5	4.8	8.5	86.7
45.9	22	3.6	1,382	223.6	16.0	6.2	14.2	74.5
94.5	347	8.6	9,132	225.5	16.5	6.5	11.3	82.5
59.8	3	0.6	587	112.5	11.1	6.3	8.5	86.6
160.6	135	5.3	4,656	184.3	8.2	4.6	6.5	83.5
54.9	15	3.4	563	128.3	8.0	5.7	9.2	87.4
85.0	24	4.7	1,328	262.6	16.7	5.3	16.2	84.7
186.6	8	1.1	1,188	157.5	10.7	7.1	8.9	84.0

Children's Mental Health County Data

County	2000 Child Population	2000 Births	2000 % Child Poverty	Healthy Start 12/31/01	Healthy Start per 1,000	Badger Care 12/31/01	Badger Care per 1,000	2000 Hospitalizations per 1,000
Manitowoc	21,101	894	7.8	1,453	68.9	251	11.9	5.2
Marathon	33,716	1,520	8.9	3,241	96.1	678	20.1	3.4
Marinette	10,201	457	10.5	1,208	118.4	317	31.1	6.3
Marquette	3,335	146	9.1	382	114.5	140	42.0	6.6
Menominee	1,776	93	39.9	305	171.7	31	17.5	20.8
Milwaukee	247,825	14,846	23.7	29,710	119.9	7,512	30.3	5.3
Monroe	11,498	602	17.5	1,277	111.1	286	24.9	6.2
Oconto	9,160	383	8.9	737	80.5	255	27.8	4.4
Oneida	8,203	316	8.6	1,048	127.8	374	45.6	6.9
Outagamie	44,527	2,289	5.7	2,133	47.9	484	10.9	4.7
Ozaukee	21,931	869	2.7	480	21.9	145	6.6	3.7
Pepin	1,909	79	13.7	190	99.5	42	22.0	*
Pierce	8,997	412	5.6	473	52.6	128	14.2	*
Polk	10,835	454	8.3	1,090	100.6	395	36.5	*
Portage	16,177	805	8.6	1,461	90.3	401	24.8	3.1
Price	3,770	125	12.3	581	154.1	243	64.5	*
Racine	50,951	2,650	11.9	3,996	78.4	1,019	20.0	7.9
Richland	4,512	201	13.8	454	100.6	141	31.3	6.6
Rock	40,366	2,075	9.5	3,177	78.7	822	20.4	5.2
Rusk	3,803	148	15.4	594	156.2	190	50.0	5.5
St. Croix	17,617	908	9.2	713	40.5	224	12.7	*
Sauk	14,371	755	16.7	1,076	74.9	263	18.3	5.1
Sawyer	3,901	182	10.7	821	210.5	266	68.2	*
Shawano	10,433	470	7.1	1,026	98.3	288	27.6	8.1
Sheboygan	28,775	1,437	4.3	1,828	63.5	275	9.6	7.4
Taylor	5,332	247	12.7	628	117.8	206	38.6	5.8
Trempealeau	6,844	322	9.8	681	99.5	209	30.5	5.1
Vernon	7,696	390	23.0	709	92.1	204	26.5	4.4
Vilas	4,345	155	11.8	384	88.4	182	41.9	6.2
Walworth	22,654	1,102	8.6	1,644	72.6	366	16.2	6.0
Washburn	3,815	163	12.4	645	169.1	209	54.8	*
Washington	31,330	1,490	4.5	1,236	39.5	315	10.1	3.0
Waukesha	94,903	4,357	3.1	2,296	24.2	565	6.0	5.2
Waupaca	13,277	567	8.1	856	64.5	224	16.9	5.0
Waushara	5,444	225	10.9	634	116.5	227	41.7	5.3
Winnebago	37,343	1,926	7.0	2,557	68.5	557	14.9	5.9
Wood	19,385	878	7.8	2,001	103.2	478	24.7	7.5

* than 20 events. No rate is calculated.

Children's Mental Health County Data

Juvenile Arrests per 1,000 children	Out Of Home	Out Of Home (%)	MA 12/31/01	MA per 1,000 children	2000 % Mothers w/o HS degree	2000 % Low Birthwt. Babies	2000 % Teen Mothers	2000 % 1st Trimester Prenatal Care
161.9	86	4.1	2,776	131.6	14.2	5.5	9.5	85.6
74.4	143	4.2	5,799	172.0	11.0	6.8	9.3	78.8
59.9	15	1.5	2,171	212.8	13.7	4.6	11.6	78.6
18.9	12	3.6	739	221.6	22.0	4.1	14.4	74.7
355.3	14	7.9	886	498.9	33.3	2.2	19.3	64.5
112.0	6,077	24.5	107,479	433.7	27.7	9.1	15.7	79.5
129.0	26	2.3	2,446	212.7	26.6	6.6	11.8	75.7
70.2	32	3.5	1,480	161.6	8.6	5.0	7.9	90.6
113.0	53	6.5	2,296	279.9	10.7	6.0	8.6	89.9
103.0	59	1.3	4,025	90.4	9.7	5.5	7.1	85.9
58.8	14	0.6	867	39.5	2.6	5.2	3.4	94.1
21.5	2	1.0	309	161.9	21.5	5.1	8.9	79.7
36.6	23	2.6	848	94.3	5.5	5.6	7.5	82.0
53.5	36	3.3	1,984	183.1	9.7	5.3	9.8	84.8
66.6	33	2.0	2,609	161.3	10.6	4.7	10.5	84.7
67.4	7	1.9	1,091	289.4	8.0	8.0	5.6	89.6
75.6	231	4.5	10,887	213.7	19.6	7.2	13.2	80.8
46.3	9	2.0	904	200.4	13.5	3.0	7.5	75.6
140.9	233	5.8	9,119	225.9	19.2	7.3	12.4	87.7
103.6	18	4.7	1,128	296.6	15.6	3.4	8.2	80.4
39.4	18	1.0	1,394	79.1	6.7	5.5	6.1	84.9
97.3	55	3.8	2,137	148.7	14.9	5.4	8.4	81.1
39.5	14	3.6	1,539	394.5	15.3	7.7	17.5	78.0
101.6	2	0.2	1,835	175.9	14.3	3.8	8.1	82.3
104.2	85	3.0	3,617	125.7	14.4	4.7	9.1	86.8
53.1	17	3.2	1,041	195.2	17.4	5.7	6.8	80.6
49.2	8	1.2	1,246	182.1	11.5	7.1	7.5	86.0
25.5	22	2.9	1,254	162.9	25.1	4.1	9.3	65.9
121.5	15	3.5	789	181.6	15.4	2.6	11.6	83.9
130.7	80	3.5	2,941	129.8	16.5	5.3	9.1	81.2
43.5	28	7.3	1,182	309.8	16.0	7.4	12.2	80.4
103.3	33	1.1	2,322	74.1	5.4	4.7	5.1	91.1
61.6	84	0.9	4,558	48.0	5.8	5.8	4.4	95.1
81.4	29	2.2	1,763	132.8	14.2	4.8	9.9	83.1
26.1	21	3.9	1,313	241.2	26.7	7.1	10.7	72.4
103.7	117	3.1	5,296	141.8	12.7	7.0	8.2	85.8
85.4	75	3.9	3,805	196.3	12.2	5.0	10.5	80.8

County Data Sources

State and County Total Population 2000:

Data are from the U.S. Bureau of the Census, Populations Estimates Program.
Web address: *www.census.gov/populatfon/estimates/county.*

Child Poverty, 2000

Data are from the U.S Bureau of the Census, American Fact Finder.
Web address *http://factfinder.census.gov/servlet/BasicFactsServlet*

2002 FEDERAL POVERTY LEVELS

Group Size	Hourly*	Annual	Monthly**					
			100%	115%	130%	150%	185%	200%
One	$4.26	$8,860	$738	$849	$959	$1,107	$1,365	$1,476
Two	$5.74	$11,940	$995	$1,144	$1,294	$1,493	$1,841	$1,990
Three	$7.22	$15,020	$1,252	$1,440	$1,628	$1,878	$2,316	$2,504
Four	$8.70	$18,100	$1,508	$1,734	$1,960	$2,262	$2,790	$3,016
Five	$10.18	$21,180	$1,765	$2,030	$2,295	$2,648	$3,265	$3,530
Six	$11.66	$24,260	$2,022	$2,325	$2,629	$3,033	$3,741	$4,044
For each add'l person, add:	$1.48	$3,080	$257	$296	$334	$386	$475	$514

• assumes a full-time job for a full year (2,080 hours) ** rounded to nearest dollar

Note: Significance of Indicated Poverty Guidelines:
115% is the maximum income level for participation in W-2.
130% is the maximum income for the food stamp program.
150% is the income level at which premiums are first required for BadgerCare.
185% is the maximum income level for entering the child care, Healthy Start and BadgerCare programs.

Births:

Data are from Wisconsin Births and Infant Deaths 2000, Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, December 2001.

Healthy Start Recipients (per 1,000 children) 2000:

Unpublished data were provided by the Wisconsin Department of Health and Family Services, Division of Health, Bureau of Public Health. Rates were calculated using the child population for 2000.

Badger Care (per 1,000 children)

Data provided by the Wisconsin Department of Health and Family Services, Division of Health. Rates were developed using the estimated child population. These data provide a snapshot of Badger Care eligibility as of December 31, 2000.

Hospitalizations (per 1,000 children)

Data are from the Wisconsin Community Health Profiles 2000, Center for Health Statistics, Department of Health and Family Services. Web address: *www.dhfs.state.wi.us/localdata/*

Total Juvenile Arrests (per 1,000 children) 2000:

Arrest data are from Crime and Arrests, Wisconsin Office of Justice Assistance, Statistical Analysis Center. Rates were developed using the estimated child population for each year. The Office of Justice Assistance provided Child population estimates.

Web Address: *http://oja.state.wi.us/static/crimereports.asp*

Child Abuse and Neglect Substantiations (per 1,000) 2000:

Data are from Wisconsin Child Abuse and Neglect Reports: Annual Reports, Wisconsin Department of Health and Family Services, Division of Children and Family Services, Bureau of Programs and Policies.

Juvenile Placements In Out-of-Home Care:

Data are primarily from the published report Children In Out-of-Home Care in Wisconsin: 1990 through 1999, Mark E. Courtney, Amy Dworsky, School of Social Work, University of Wisconsin – Madison, Wisconsin Department of Health and Social Services, Division of Children and Family Services Office of Policy, Evaluation, and Planning, October 2001. A youth is considered "placed' in an out-of home setting if a facility was paid for his or her care during the calendar year. These data relate only to alleged or adjudicated delinquent youth placed in foster homes, group homes, or child caring institutions.

Child Medicaid Recipients (per 1,000 children):

These data provide a snapshot of Medicaid eligibility as of December 31, 2000. Data provided by the Wisconsin Department of Health and Family Services, Division of Health. Rates were developed using the estimated child population for each year. State totals include recipients whose eligibility may have been determined by an agency other than the county (tribal agencies). Therefore, the state total is larger that the cumulative county totals.

Births to Mothers with Less Than a High School Education (%):

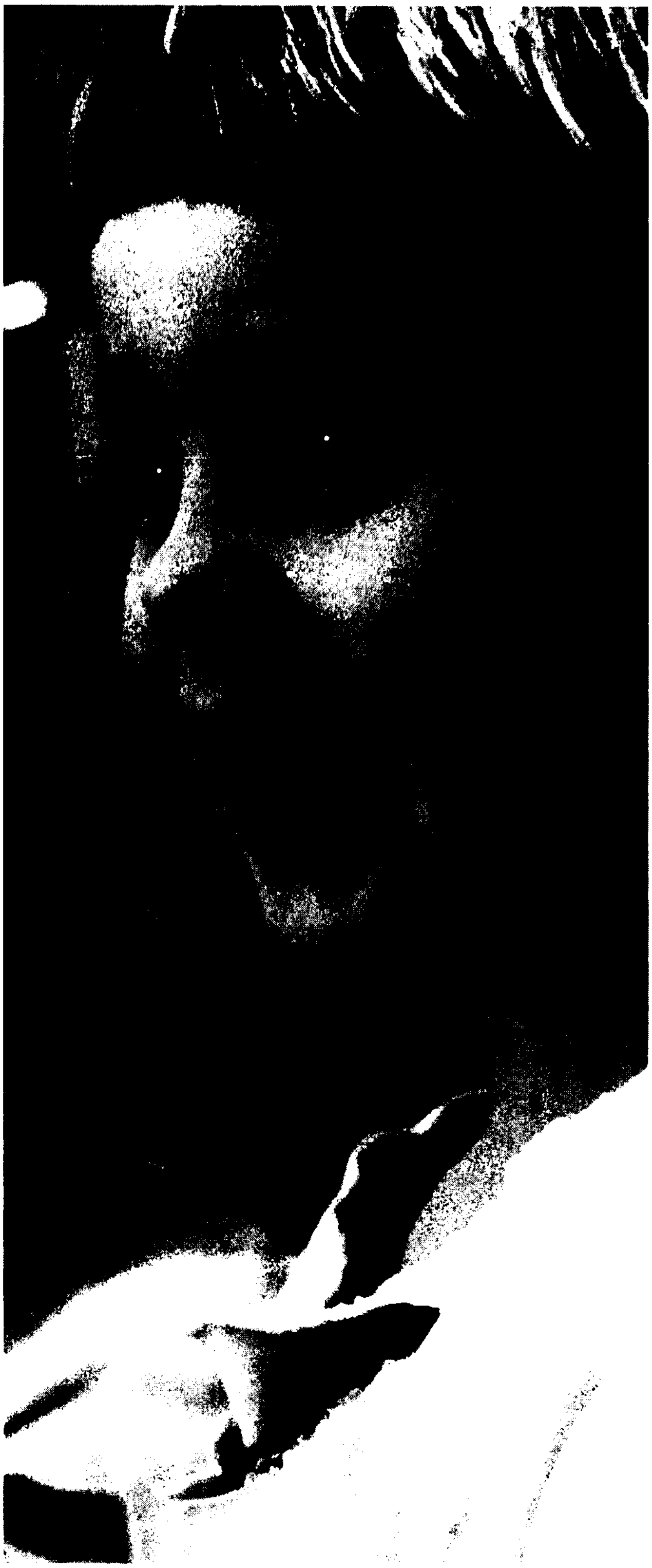
Education of the mother is noted on Wisconsin birth certificates. Wisconsin Births and Infant Deaths 2000, Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, December 200. The percentages were calculated using the number of all births as the denominator.

Low Birthweight Births (% of all live births):

Defined as births in which the newborn child weighs less than 5.5 pounds (2,500 grams). Percentages are from Wisconsin Births and Infant Deaths 2000, Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, December 2001.

Prenatal Care Initiated in First Trimester of Pregnancy (%):

Data are from Wisconsin Births and Infant Deaths 2000, Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information, December 2001.



WISCONSIN COUNCIL ON
**CHILDREN
&FAMILIES**
The Voice For Wisconsin's Children

The Wisconsin Council on Children and Families serves as Wisconsin's leading voice of, and premiere advocate for, children throughout the state.

Emphasizing the core values of fairness, caring, and community, the Council conducts a variety of advocacy activities, including organizing expert research, educating the public, supporting key issues and legislation, and coordinating grassroots activity in communities all across Wisconsin.

In addition to publishing the *WisKids Count Data Book* – which seeks to enrich local, state, and national discussions concerning ways to secure better futures for all children – the Council accomplishes its advocacy through several publications; educational conferences throughout the state; and key projects like the Better Badger Baby Bus Tour, W-2 Watch, the Wisconsin Budget Project, and Advocacy Camp among others.

www.wccf.org

MISSION STATEMENT

The Wisconsin Council on Children and Families is a statewide, multi-issue child advocacy organization. It works to improve the well being of children and families by advocating for effective health, education, justice and human service programs that are accessible and equitable for children.

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