Children with Social and Emotional Disurbance: Health Focus Area 6

Excerpted from Component A of *The Rhode Island State Health Improvement Plan*

July 28, 2017

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Definition

For the purpose of this *Health Assessment Report*, Rhode Island defines children with social and emotional disturbance as individuals younger than age 21 who have one or more emotional, behavioral, or developmental conditions including autism, developmental delay, depression, anxiety, attention deficit disorder/attention deficit with hyperactivity disorder, and behavioral/conduct disorders.

Children with serious emotional disturbance (SED) represent a sub-set of the population of children with social and emotional disturbance. Children with SED have been diagnosed as having an emotional, behavioral, or mental disorder under the current edition of the Diagnostic and Statistical Manual 5 (DSM-5) or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3). Furthermore, this definition reflects that: (1) the disability has been ongoing for one year or more or has the potential of being ongoing for one year or more; (2) the child is in need of multi-agency intervention(s); and (3) the child is in an out-of-home placement or risks placement because of the disability.[1]

Prevalence across the Life Span

Using the broader definition of social and emotional disturbance, 43,000 Rhode Island children age 2-17 have an emotional, behavioral, or developmental condition.[2] According to the Rhode Island Executive Office of Health and Human Services (EOHHS) claims data, in State Fiscal Year (SFY) 2015, 22% (26,930) of children younger than age 19 enrolled in RIte Care (the Rhode Island State Children's Health Insurance Program also known as SCHIP) had a mental health diagnosis, including but not limited to anxiety, alcohol/drug dependence, psychoses, as well as depressive, mood, and personality disorders. Of those children with a mental health diagnosis, 29% were age 6 and younger, 34% were age 7-12, and 37% were age 13-18.[3]

The RI Department of Children, Youth and Families (DCYF) serves 4,514 children and youth; 1,166 (26%) of whom are age 16-21. Of these, 417 (36%) meet the criteria for SED. Rhode Island ranked sixth highest among all states for the prevalence of SED among school students with an Individual Educational Program: 15.48/1,000 students, much higher than the national average of 8.08 students/1,000.[4]

Adverse Childhood Experiences

Adverse childhood experiences (ACEs), such as abuse, neglect, household presence of mental health problems, domestic violence, substance use, divorce, or incarceration of relatives can increase the risk for health problems and diseases throughout the lifecourse.[5] The number, severity, chronicity, and individual response to adversities ultimately determine whether the experiences result in toxic stress. Toxic stress describes the physical changes in the brain and other organ systems that result from prolonged and

significant ACEs. Absent protective factors, early identification of these stressors and the provision of evidence-based interventions, a significant number of children living in Rhode Island are at risk for adopting maladaptive behaviors (such as substance use) and developing chronic health and behavioral health conditions in adulthood.

Research studies have shown that 48% of children in Rhode Island report experiencing at leastone1 ACE and 23% report experiencing at least two ACEs. The Rhode Island Behavioral Health Project (also referred to as the *Truven Report*) concluded that children living in Rhode Island are at risk of experiencing toxic stress through ACEs.[6] This exposure may explain the high rates of behavioral health disorders among children and adolescents, as shown in Figure 1 and Tables 1 and 2 below.

Figure 1: Prevalence of Adverse Childhood Experiences (ACEs) in Rhode Island Children, 2011-2012.

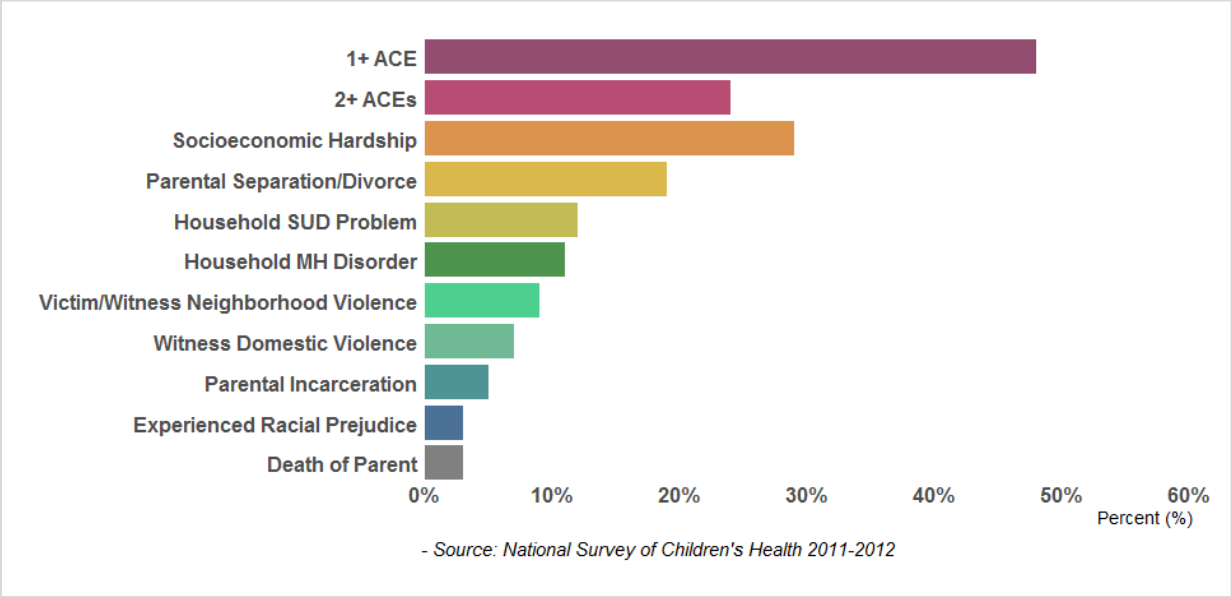

Table 1: Rates of Attention Deficit Hyperactivity Disorder (ADHD) in Children Age 4–17, 2011.[7]

State	Rate of ADHD
Rhode Island	9.4%
Connecticut	5.5%
Maine	7.3%
Massachusetts	8.0%
New Hampshire	7.2%
Vermont	7.8%

Source: National Survey on Children's Health

Table 2: Rates of Behavioral Health Disorders in Adolescents Age 12–17, 2012- 2013.[8,9]

State	Moderate to Severe ADD or ADHD*	Major Depressive Episode (MDE)*	Illicit Drug Use or Dependence
Rhode Island	**7.2%**	**11.3%**	**5.0%**
Connecticut	5.2%	9.4%	3.5%
Maine	6.2%	11.2%	3.3%
Massachusetts	7.1%	8.6%	3.6%
New Hampshire	7.2%	10.3%	4.4%
Vermont	5.6%	9.5%	3.8%
National Average	**5.6%**	**9.9%**	**3.8%**

** Adolescents were assessed as having moderate to severe ADD or ADHD based on parental perception. Source - National Survey of Children's Health, 2011/12. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Retrieved 05/09/17 from http://childhealthdata.org/learn/NSCH.*

Adolescents were assessed as having MDE if they had a period of 2 weeks or longer during which they had either depressed mood or loss of interest or pleasure in usual activities, as well as at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-worth. Source - National Survey on Drug Use and Health, 2012 and 2013. Substance Abuse and Mental Health Services Administration Data Center.

Adolescents were assessed as having illicit drug use if they reported use in the past month or dependence if their survey responses met DSM criteria. Source - National Survey on Drug Use and Health, 2012 and 2013.

Children Experiencing Bullying

According to national data collected from the 2015 Rhode Island Youth Risk Behavior Survey (RI YRBS), which represents grades 9-12, 20.2% of high school students reported experiencing school-based bullying.[10] In addition, 15.5% of students reported being a victim of cyber-bullying. According to the 2015 RI YRBS, Rhode Island high school students reported bullying at a rate of 15.5% while at school and 12.4% electronically (which is lower than the national average). Vulnerable sub-populations of Rhode Island high school students reported even higher rates of bullying.

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth:

- 44.7% reported experiencing bullying either at school or electronically, more than twice the rate of their heterosexual peers.

Youth with disabilities:

- 33.8% reported experiencing bullying either at school or electronically, twice the rate of students without a disability.

Not only are those who experience bullying impacted, but the entire student population can also be affected in negative ways. Table 3 illustrates some of these negative effects on both those who are bullied and those who observe bullying.[11]

Table 3: Effects of Bullying on Children.

Students Who are Bullied	Observers of Bullying
Long-term effects of being bullied: • Depression • Suicidal thoughts • Low self esteem • Health problems • Poor grades	Effects on students who witness bullying: • Fearful • Powerless to act • Guilty for not acting
Students Who Bully Others	**Schools with Bullying Issues**
Students who bully are also more likely to: • Get into frequent fights • Drink alcohol and smoke • Steal and vandalize property • Report poor grades	Effects on climate when school does not act: • Environment of fear and disrespect • Students have difficulty learning • Students feel insecure • Students dislike school

Adapted from Violence Prevention Works; How Bullying Affects Children

Being bullied during childhood and adolescence has been linked to depression, anxiety, and substance use in adulthood. A longitudinal study on Adult Health Outcomes of Childhood Bullying Victimization, reported by Takigawa et al,[12] studied victims who had been exposed to bullying between the ages of 7-11. Follow-up at age 23 and age 50 found these victims experienced higher rates of depression, anxiety disorders, and suicidality than their counterparts who had not been bullied. In addition, the childhood bullying was associated with the victims' lack of social relationships, economic hardship, and a poor perception of quality of life at age 50.[13]

Data from the Rhode Island Department of Education (RIDE)'s SurveyWorks! indicate that Rhode Island students in elementary, middle, and high school report experiences of bullying well above the national average as assessed by the YRBS, perhaps because the YRBS collects only a random sample of high school students, while SurveyWorks! data represent all students who choose to respond to the survey.

The table below uses this source to identify the statewide average of students reporting experiences of bullying by school type, and the Community Mental Health Catchment Areas identified as having the highest rates of bullying experiences reported by students for each indicator.

Table 4: Percent of Rhode Island Students Who Report Experiences of Bullying, by School Level.

	Elementary School	Middle School	High School
One or more types of bullying			
Statewide rate	47.3%	56.9%	47.5%
Catchment area with highest reported rate	Providence 53.7%	Warwick 59.8%	Woonsocket[14] 52.7%
Two or more types of bullying			
Statewide rate	28.3%	N/A	N/A
Catchment area with highest reported rate	Providence 33.4%	N/A	N/A
Three or more types of bullying			
Statewide rate	N/A	31.9%	24.9%
Catchment area with highest reported rate	N/A	Warwick 35.1%	Woonsocket 29.0%

Source: SurveyWorks!, 2010 – 2014

More than half of Rhode Island middle school students statewide, reported experiencing one or more types of bullying, and almost half of elementary and high school students reported experiencing at least one type of bullying. In the SurveyWorks! survey, bullied is defined as experiencing one or more of the following in the past 12 months: purposeful exclusion from activities; being teased at school; being pushed, shoved, tripped or spit on; threatened with harm; having property destroyed on purpose; experiencing coercion; having rumors being spread about oneself; or experiencing cyberbullying.

This concern is further heightened by the rates of exposure to multiple types of bullying. More than one in four elementary school students in Rhode Island reported experiencing two or more types of bullying. Almost one in three middle school students, and one in four high school students, reported experiencing three or more types of bullying.

Given the behavioral health, physical health, and social consequences of exposure to bullying by recipients, perpetrators and observers, without increasing protective factors, prevention programs, early identification, and treatment options, bullied children and youth are at higher risk for poor behavioral health, physical health, and social outcomes as adults.

Access to Behavioral Health Treatment

The availability of, and access to, behavioral health treatment varies for children in Rhode Island. Currently, early childhood evidence-based practices, which can reduce the emergence of social and emotional disturbance in children, are funded through a federal grant and are predominantly available in

targeted geographic areas. Only 8% of children/families served by the Maternal, Infant, and Early Childhood Home Visiting Program lived outside of Rhode Island's four core cities.[15]

There is evidence of disparate access to care for mental health treatment. The Truven Report found that 34% of children in Rhode Island were not able to access mental health services when needed. There were significant disparities between populations of children who were unable to access mental health services: 75% of African American/Black and 74% of Hispanic children did not receive treatment when needed, as opposed to 17.2% of White children.

In 2014, there were 2,744 hospitalizations of children with a primary diagnosis of mental disorder at Bradley, Butler, Hasbro Children's Hospital, Newport, and Memorial Hospitals, a 53% increase from 2005. Of the Rhode Island children hospitalized in 2014, 74% were age 13-17, 50% had Medicaid/RIte Care coverage and 47% had commercial coverage, and 39% lived in one of the four core cities (Central Falls, Pawtucket, Providence and Woonsocket) where 33% of the child population lives.[16]

Co-Morbidities

There is a high degree of comorbidity in young children with mental disorders; of those with one disorder, approximately 25% have a second disorder. The proportion of children with comorbidity increases about 1.6 times for each additional year from age 2 (18.2%) to 5 (49.7%).[17]

A number of studies further support co-morbidities in children:

- The results of the ACE Study found a dose-response relationship between ACEs and numerous health problems: the more ACEs a child has, the higher the risk of developing chronic illnesses such as heart disease, chronic obstructive pulmonary disease (COPD), and cancer.[18]

- Bullying is associated with both physical and emotional disorders among children and youth who are victims, as well as perpetrators, of acts of bullying. Both are likely to report headaches and stomachaches, having difficulty falling asleep, depression, and significant anxiety. These symptoms tend to appear in a cluster, requiring an integrated treatment approach.[19]

- Some SEDs are found to occur at higher rates in adolescents with serious health conditions. One study found a significant association between the adolescent-onset diagnosis of bipolar disorder (age 13 and older) and the diagnosis of preexisting obesity, hypertension, migraine headaches, intellectual disability, endocrine disorders, and substance use disorders.[20]

Young children with behavior problems, such as lack of impulse control, restlessness, and poor attention are twice as likely to be diagnosed with alcohol dependence at age 21. Aggressiveness in children as young as age 5-10 has been found to predict substance use in adolescence. Childhood antisocial behavior is associated with alcohol-related problems in adolescence and alcohol abuse or dependence in adulthood.[21]

Adolescents with conduct disorders, ADHD, anxiety, and depression were found to have higher levels of alcohol abuse than their counterparts in the general population.[22] Excessive drinking in teens can result in physical, social, and legal consequences. Physical impairments include:

- Delayed puberty and/or negative effects on the reproductive system;
- Lower bone mineral density; and
- Higher levels of liver enzymes that indicate liver damage.

In addition, impaired judgment and thinking can lead to harmful consequences including:

- Criminal records that cannot be expunged;
- Car accidents;
- Physical and sexual assaults;
- Sexually transmitted diseases;
- Unplanned pregnancies; and
- Lost academic opportunities.

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