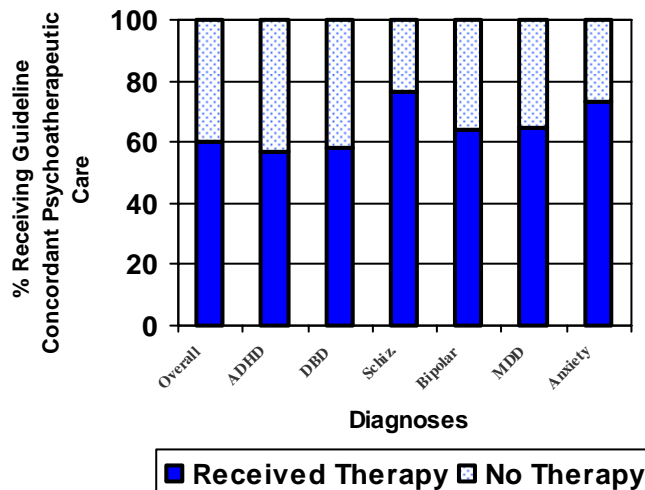


**Children and Adolescents: Access to Psychotherapy**

The prevalence of mental disorders among children and adolescents in the United States has been estimated between 14% and 26% yet only 20 to 30% of youths who require mental health services receive the needed care (1). Little is known, however, about the quality of care provided to youth recipients of mental health services.

When defining quality based on current available evidence, we have found unequivocal support for the provision of psychotherapy as an important component of psychiatric treatment for children and adolescents (2-7). Psychotherapy has been shown to be effective in: 1) improving symptoms for specific disorders (i.e., schizophrenia, bipolar, anxiety and depressive disorders), 2) managing confounding psychosocial factors, and 3) improving treatment compliance by promoting therapeutic alliance.

**Figure 1: Conformance Rates with Evidence-based Psychotherapeutic Care among Children and Adolescents with Psychiatric Disorders**



\*p<0.05 \*\*p<0.01 \*\*\*p<0.001

Using the *APIRE PRN 1997 and 1999 Study of Psychiatric Patients and Treatments* national data, we have examined rates of guideline consistent psychotherapeutic care in a sample of 393 children and adolescents receiving treatment from a psychiatrist in a full range of practice settings. We found that 40% of children and adolescents did not receive psychotherapy as recommended in evidence-based guidelines. Highest rates of psychotherapy were observed among youth being treated for schizophrenia (76%), followed by anxiety (73%), major depressive (64%) and bipolar disorders (64%). Over one-half of the youth with disruptive behavioral disorders (DBD) and ADHD also received psychotherapy (59% and 57% respectively). The next issue of this datagram series will discuss the health plan and financial barriers to the provision of psychotherapy in this population.

**Data Source:** The 1997 and 1999 American Psychiatric Practice Research Network (PRN) Study of Psychiatric Patients and Treatments (SPPT). Results are preliminary and not for citation. In 1997, 417 of 531 (78.5%) PRN members completed the SPPT. In 1999, 615 of 784 (78%) PRN members completed the SPPT.

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### **Limitations:**

Results of this study should be interpreted with the following limitations in mind. First, exclusive reliance on psychiatrist-reported data may have resulted in an under-estimation of psychotherapy, if the treating psychiatrist did not have information about psychotherapy provided by other providers. Second, rates of psychotherapy may have been underestimated since provision of psychotherapy was examined within 30 days of index visit, youths who received psychotherapy outside of this time frame were not enumerated in this study. And finally, we relied exclusively on psychiatrists' definition of what they considered as a psychotherapeutic session, and are limited in our ability to discern the specific types of psychotherapeutic interventions (e.g., CBT or IPT) provided. Notwithstanding these limitations, this study is unique in providing a snap-shot of real world psychiatric practice for children and adolescents treated in a broad range of clinical settings nationwide.

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