

COMPdata Monthly Monitor - Montana
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Pediatric Behavioral Health

INTRODUCTION

Mental disorders are an important but often overlooked medical and social welfare problem for children and adolescents in the United States today. Recent estimates suggest that as many as 20 percent of children and adolescents may have a mental health condition that can be identified and treated and at least 10 percent—or as many as six million young people—may have a serious mental health condition.¹

Behavioral health is defined as services for patients with a mental disease or disorder and/or a substance abuse problem. Substance abuse consists of alcohol abuse and/or drug abuse. Along with mental health diseases or disorders and substance abuse problems, suicide is another important issue affecting children and adolescents. In this report, pediatric is defined as individuals aged 17 and younger although some national statistics provided may include other ages groups where stated.

Mental Health

Mental health diseases and disorders fall into a number of broad categories, most of which apply not just to children but across the entire life span. These broad categories are: anxiety disorders, attention-deficit and disruptive behavior disorders, autism and other pervasive developmental disorders, eating disorders, elimination disorders, learning and communication disorders, mood disorders, schizophrenia, and tic disorders.² These disorders are discussed in more detail in the appendix.

Substance Abuse/Dual Diagnosis

Alcohol and other drug abuse and addiction constitute major health and safety concerns in the United States, with costs running into the billions of dollars annually for health care, related injuries and loss of life, property destruction, loss of productivity and more.³

A person who has both an alcohol or drug problem and a mental health condition is said to have a dual diagnosis. To recover fully, the person needs treatment for both conditions. According to a report published by the Journal of the American Medical Association thirty-seven percent of alcohol abusers and fifty-three percent of drug abusers also have at least one serious mental illness and of all people diagnosed as mentally ill, twenty-nine percent abuse either alcohol or drugs.⁴

Suicide

Each year, almost 5,000 young people in the United States between the ages of 15 to 24 take their own lives. The rate of suicide for this age has nearly tripled since 1960, making it the third leading cause of death in adolescents and the second leading cause of death among college-age youth.⁵

According to the U.S. Department of Health and Human Services, in 1980 suicide was the 7th leading cause of deaths for children aged 5-14 years. In 2002, suicide increased to become the 5th leading cause of death for this age group. The number of suicides reported increased from 142 in 1980 to 264 in 2002, an 85.9% change.⁶

Assessment and Diagnosis

Most disorders are diagnosed by their manifestations, that is, by symptoms and signs, as well as functional impairment. A diagnosis is made when the combination and intensity of symptoms and signs meet the criteria for a disorder. However, diagnosis of childhood mental disorders is rarely an easy task. Many of the symptoms, such as outbursts of aggression, difficulty in paying attention, fearfulness or shyness, difficulties in understanding language, food fads, or distress of a child when habitual behaviors are interfered with, are normal in young children and may occur sporadically throughout childhood. Well-trained clinicians overcome this problem by determining whether a given symptom is occurring with an unexpected frequency, lasting for an unexpected length of time, or is occurring at an unexpected point in development.²

BARRIERS TO CARE

In spite of the existence of effective interventions for the care of children and adolescents with mental disorders, a huge proportion of those with these disorders do not have access to care due to a series of barriers. These barriers to treatment are several, but reflect a few dominant themes:

- Lack of resources (financial, practitioners, facilities)
- Stigma
- Other barriers, such lack of the ability to communicate effectively in the patient's native language and lack of public knowledge about mental health disorders in children and adolescents.⁷

Lack of Resources

The system for delivering mental health services to children and their families is complex, sometimes to the point of inscrutability—a patchwork of providers, interventions, and payers. Much of the complexity stems from the multiple pathways into treatment and the multiple funding streams for services.²

Many areas of the United States have a lack of or no doctors (adolescent psychiatrists and adolescent psychologists as well as highly skilled doctors in the pediatric behavioral health field) for children with behavioral health problems to access.

This lack of practitioners is compounded by the lack of facilities and lack of transportation to the facilities that do service pediatric patients.⁷ Families are faced with difficulties because services are provided by so many different public sectors. In addition to problems with coordination, parents and caregivers encounter conflicting requirements, different atmospheres and expectations, and contradictory messages from system to system, office to office, and provider to provider. There is often a gap between what families need and what agencies provide.²

Stigma

Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illness. Stigma is widespread in the United States and other Western nations. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders—especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health conditions internalize public attitudes and become embarrassed or ashamed such that they often conceal symptoms and fail to seek treatment.⁸

Other Barriers to Care

Although lack of resources, transportation and facilities as well as stigma are the main barriers to care, there are other barriers that also lead to decreased care in children and adolescents. Among these other barriers are:

- Lack of ability to communicate effectively in the patient's native language and
- Lack of public knowledge about mental disorders in children and adolescents.⁷

PEDIATRIC BEHAVIORAL HEALTH PATIENTS IN MONTANA

All of the following inpatient statistics exclude newborns – Major Diagnostic Category 15. Pediatric inpatients are 17 years of age and younger. The following Montana hospital statistics illustrate the depth of inpatient pediatric behavioral health patients.

Mental Health (ICD-9 Diagnosis codes: 290-290.9, 293-302.9, 306-319)

In 2003 there were 973 pediatric inpatients discharged with a principal or secondary diagnosis of mental health or 16.9% of all pediatric inpatients. The number of total inpatients with a principal or secondary diagnosis of mental health increased from 945 in 2000 to 973 in 2003, a 3.0% change. Of the 973 inpatients who had a mental health diagnosis, it was a principal diagnosis for 604 or 62.1%.

Pediatric Inpatients With Principal Mental Health Diagnosis

The following statistics explore in more detail the characteristics of the 604 pediatric inpatients that had a principal mental health diagnosis in the year 2003.

- The majority, 79.1%, of pediatric mental health inpatients were diagnosed with a psychoses, DRG 430. Another 6.8% were diagnosed with depressive neuroses, DRG 426, and 4.8% were diagnosed with a childhood mental disorder, DRG 431.
- The principal ICD-9 diagnosis for 22.5% of pediatric mental health inpatients was an “unspecified bipolar affective disorder.” Another 15.1% were diagnosed with a “severe single episode of major depressive disorder” and 7.1% were diagnosed with a “depressive disorder not elsewhere classified.”

With respect to the dual diagnosis of substance abuse and mental health, there were 190 cases with a principal mental health diagnosis and a secondary substance abuse diagnosis or 31.5% of all pediatric inpatients with a principal mental health diagnosis.

Admission and Discharge Patterns

- More than half, 69.0%, of pediatric mental health inpatients were admitted through the emergency room and another 23.2% were admitted through a physician's referral.
- More than four-fifths (80.1%) of pediatric mental health inpatients were considered to be urgent, 10.4% were considered elective and 9.4% were considered emergent.
- The majority (80.8%) of pediatric mental health patients were routinely discharged home, while 13.6% were discharged or transferred to another type of facility.
- The majority (68.4%) of pediatric mental health inpatients were discharged from hospitals in other urban areas. Another 31.6% were from rural hospitals.

Patient Characteristics

- Over 35% of pediatric mental health inpatients were covered under commercial insurance (36.3%). Another 16.9% were covered under Medicaid.
- Slightly more females (52.2%) than males (47.9%) were pediatric mental health patients.
- The average age of a pediatric mental health inpatient was 14.5 years.
- The average total charge for pediatric mental health inpatients was \$7,109 and the average length of stay was 6.4 days.

Substance Abuse (ICD-9 Diagnosis codes: 303-305.93)

In 2003 there were 365 inpatients discharged with a principal or secondary diagnosis of substance abuse. The number of total inpatients with a principal or secondary diagnosis of substance abuse increased from 357 in 2000 to 365 in 2003, a 2.5% change. Of the 365 inpatients who had a substance abuse diagnosis, it was a principal diagnosis for 53 or 14.5% and a secondary diagnosis for 312 or 85.5%. For pediatric inpatients with a secondary diagnosis of substance abuse, 60.9% had a principal diagnosis of mental health.

Pediatric Inpatients With Principal Substance Abuse Diagnosis

The following statistics explore in more detail the characteristics of the 53 pediatric inpatients that had a principal substance abuse diagnosis in the year 2003.

- Just over half, 50.9%, of pediatric substance abuse inpatients had a DRG of “alcohol/drug abuse or dependence with rehabilitation therapy without complications.” Another 45.3% had a DRG of “alcohol/drug abuse or dependence without rehabilitation therapy without complications.”
- Examining specific diagnoses, almost one quarter, 24.5%, of pediatric substance abuse inpatients were diagnosed with unspecified alcohol abuse. Another 22.6% were diagnosed with a continuous combination of drug dependency excluding opioid type drugs and 17.0% were diagnosed with continuous cannabis dependency.
- With respect to the dual diagnosis of substance abuse and mental health, there were just 32 cases with a principal substance abuse diagnosis and a secondary diagnosis of mental health.

Admission and Discharge Patterns

- Over half, 56.6%, were admitted through a physician’s referral, while 43.4% were admitted through the emergency room.
- More than half of these cases, 54.7%, were considered elective; while 32.1% were emergent and 13.2% were considered urgent.
- Over three quarters (81.1%) of pediatric substance abuse patients were routinely discharged home, while another 17.0% were discharged or transferred to another type of facility.
- The majority (94.3%) of pediatric substance abuse patients were discharged from hospitals in rural areas, more than double the percentage of mental health inpatients

discharged from hospitals in these areas. Another 5.7% were from hospitals in other urban areas.

Patient Characteristics

- More than 30% (37.7%) of pediatric substance abuse patients were covered by commercial insurance. Medicaid covered another 17.0% of pediatric substance abuse patients.
- Unlike the distribution of pediatric mental health inpatients, there were more males (58.5%) among pediatric substance abuse patients.
- The average age of pediatric substance abuse patients was 16.0.
- The average charge for these patients was \$7,459 and the average length of stay was 14.0 days.

Suicide (E-codes: E950-E959)

In 2003 there were 69 inpatients discharged with an external cause of injury code (e-code) of suicide. These codes indicate a suicide attempt, not necessarily a suicide death. The number of total inpatients with an e-code of suicide decreased from 77 in 2000 to 69 in 2003, a decrease of 10.4%.

Pediatric Inpatients With Principal E-Code of Suicide

The following statistics explore in more detail the characteristics of the 69 pediatric inpatients that had an e-code of suicide in the year 2003.

- Under half, 43.5%, of pediatric inpatients with an e-code of suicide had a DRG of poison and toxic effects of drugs, DRG 451. Another 34.8% had a DRG of psychoses, DRG 430, and 13.0% had a DRG of depressive neuroses, DRG 426.
- Most, 36.2%, pediatric suicide inpatients had an e-code of “suicide and self-inflicted poisoning by analgesics, antipyretics, and antirheumatics.” Another 26.1% had an e-code of “suicide or self-inflicted poisoning by tranquilizers and other psychotropic agents”, 15.9% had an e-code of “suicide or self-inflicted injury by other specified drugs and medicinal substances” and 14.5% had an e-code of “suicide or self-inflicted injury by cutting and piercing instrument.”
- Over 15% of pediatric inpatients with an e-code of suicide had a principal diagnosis of a “single severe episode of major depressive disorder” (18.8%). Another 13.0% had a principal diagnosis of “poisoning by salicylates” and 8.7% had a principal diagnosis of “poisoning by antidepressants.”

Admission and Discharge Patterns

- The majority, 69.6%, of pediatric suicide inpatients were admitted through the emergency room. Another 23.2% were admitted through a physician referral and 4.4% were transferred from a hospital.
- Over half, 55.1%, of pediatric suicide inpatients were considered urgent, while 40.6% were considered emergent and 4.4% were considered elective.

- More than four-fifths, 81.2%, of pediatric suicide inpatients were routinely discharged home, while 11.6% were discharged or transferred to another type of hospital. No pediatric suicide inpatients died in the hospital.
- The majority of pediatric suicide patients were from hospitals in rural areas (65.2%). Another 34.8% were from urban hospitals.

Patient Characteristics

- Over half, 53.6%, of pediatric suicide inpatients had a principal payer of commercial insurance. Medicaid covered another 13.0% of pediatric suicide inpatients.
- Similar to pediatric mental health inpatients, there were many more females (72.5%) than males (27.5%) among pediatric suicide inpatients.
- The average age for pediatric suicide inpatients was 15.9 years.
- The average charge for pediatric suicide inpatients was \$6,694 and the average length of stay was 5.3 days.

MONTANA STATISTICS FROM COMPdata

All of the Montana patient statistics were derived from MHA's COMPdata. We encourage you to use COMPdata to examine your hospital community area(s) regarding pediatric behavioral health patients so that you might better understand the impact of these patients on your care and treatment of your patient population and the resources needed to diagnose, treat, and manage the pediatric behavioral health population.

The COMPdata graphing feature can be utilized to examine in a pictorial fashion trends in your state and hospital community area(s) regarding pediatric mental health. Click here to obtain a map that illustrates the number of pediatric mental health inpatient cases by county in Montana in 2003: <http://www.ihatoday.org/compdata/mtbhmap.pdf>.

ADDITIONAL INFORMATION

If you would like to develop the COMPdata reports that will provide similar statistics for your hospital or community, a training tool is available to guide you through the process. Click here to obtain the tool: <http://www.ihatoday.org/compdata/mtbhtool.pdf>. For additional assistance on using the COMPdata system, contact the COMPdata Hotline at compdata@ihastaff.org.

The Center for Mental Health Statistics publication Mental Health, United States, 2002 reported that recent estimates suggest that as many as 20 percent of children and adolescents may have a mental health problem that can be identified and treated and at least 10 percent—or as many as six million young people—may have a serious mental health problem. Some of the facts described in this report are:

1. In 2003, nearly one quarter, 24.3%, of pediatric inpatients were discharged with a principal or secondary diagnosis of behavioral health (mental health, substance abuse, or suicide).
2. In 2003 there were 973 pediatric inpatients discharged with a principal or secondary diagnosis of mental health or 16.9% of all pediatric inpatients.

3. The number of total inpatients with a principal or secondary diagnosis of substance abuse increased from 357 in 2000 to 365 in 2003, a 2.2% change.

4. According to the U.S. Department of Health and Human Services, in 1980 suicide was the 7th leading cause of deaths for children aged 5-14 years. In 2002, suicide increased to become the 5th leading cause of death for this age group. The number of suicides reported increased 85.9% over that time period.

Each month COMPdata will focus on the diseases and environmental issues impacting our members. In this issue you will find:

- Readily available information on national and Montana trends on conditions affecting hospitals
- Montana specific information derived from MHA's COMPdata
- References to a variety of background information sources in assembling the reports that hospitals can draw upon for their own community health communication
- Detailed information through COMPdata on how hospitals can prepare the same reports and information for your own community and hospital analysis

Next Month's Topic: Cancer If your hospital has any special services or programs in this area and would like to share information with us about those, please send that by e-mail to Tanya Ternes at tternes@ihastaff.org. If the information is on your web site, you're welcome to point us there. Thank you!

APPENDIX

This section provides additional background information regarding particular mental health conditions that are prevalent among the pediatric population. Typically inpatient hospitalizations are limited to the conditions covered in this report, but many of the conditions listed below are treated on an outpatient basis as well. As the need to treat patients in an outpatient setting is on the increase and patients face the same barriers to care as those seeking inpatient care, it is important to highlight many of the pediatric mental health conditions treated in either setting.

Anxiety Disorders⁹

There are several types of anxiety disorders that affect children as well as adults that are highlighted on the National Mental Health Association website (http://www.nmha.org/children/children_mh_matters/anxiety.cfm). The most common types of anxiety disorders found in children are: generalized anxiety, separation anxiety, social phobia, obsessive-compulsive, and post-traumatic stress disorders.

Children with generalized anxiety disorder have recurring fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. They may be restless, irritable, tense, or easily tired, and they may have trouble concentrating or sleeping.

Children with separation anxiety disorder have intense anxiety about being away from home or caregivers that affects their ability to function socially and in school. These children have a great need to stay at home or be close to their parents.

Social phobia usually emerges in the mid-teens and typically does not affect young children.

Young people with this disorder have a constant fear of social or performance situations such as speaking in class or eating in public. This fear is often accompanied by physical symptoms such as sweating, blushing, heart palpitations, shortness of breath, or muscle tenseness. Young people with this disorder typically respond to these feelings by avoiding the feared situation.

Obsessive-compulsive disorder (OCD) typically begins in early childhood or adolescence. Children with OCD have frequent and uncontrollable thoughts (called “obsessions”) and may perform routines or rituals (called “compulsions”) in an attempt to eliminate the thoughts. Those with the disorder often repeat behaviors to avoid some imagined consequence.

Children who experience a physical or emotional trauma such as witnessing a shooting or disaster, surviving physical or sexual abuse, or being in a car accident may develop post-traumatic stress disorder. Children are more easily traumatized than adults. An event that may not be traumatic to an adult—such as a bumpy plane ride—might be traumatic to a child. A child may “re-experience” the trauma through nightmares, constant thoughts about what happened, or reenacting the event while playing.

Mood Disorders

In children and adolescents, the most frequently diagnosed mood disorders are major depressive disorder, dysthymic disorder, and bipolar disorder. Major depressive disorder is a serious condition characterized by one or more major depressive episodes. Dysthymic disorder is a mood disorder like major depressive disorder, but it has fewer symptoms and is more chronic. Bipolar disorder is another mood disorder in which episodes of mania alternate with episodes of depression.²

Depression

All children “feel blue”, from time to time, have a bad day, or are sad. However, when these feelings persist and begin to interfere with a child’s ability to function in daily life, clinical depression could be the cause. Depression is not a personal weakness, a character flaw, or a mood that one can “snap out of”. It is a serious mental health condition that affects people of all ages, including children. In fact, depression affects as many as one in every 33 children and one in eight adolescents according to the federal Center for Mental Health Services.¹⁰

No one thing causes depression. Children who develop depression may have a family history of the disorder. Family history, stressful life events such as losing a parent, divorce, or discrimination, and other physical or psychological conditions are all factors that contribute to the onset of the disorder. Children who experience abuse, neglect, or other trauma or who have a chronic illness are at a higher risk for depression. Depression in children often occurs along with other mental health conditions such as anxiety, bipolar or disruptive behavior disorders. Adolescents who become clinically depressed are also at a higher risk for substance abuse problems.¹⁰

RESOURCES FOR ADDITIONAL INFORMATION

For Hospitals

A key resource for pediatric behavioral health is the National Mental Health Association website (www.nmha.org). This website contains fact sheets on many different behavioral health topics and has information specifically about children and adolescents.

Another key resource is the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration website (<http://www.mentalhealth.samhsa.gov/>). This website contains information about children's mental health and contains links for current topics in the news.

The American Hospital Association (<http://www.hospitalconnect.com/hospitalconnect/index.jsp>) and the National Association of Psychiatric Health Systems (www.naphs.org) have compiled a series of reference guides to helpful behavioral health materials. The child and adolescent behavioral health reference can be found at: (http://www.hospitalconnect.com/aha/member_relations/content/kidsandadolescents.pdf).

The American Academy of Pediatrics website (www.aap.org) also contains a plethora of information about pediatrics with links to specific behavioral/mental health topics such as ADHD, bipolar disorder, separation anxiety, as well as other topics such as bedwetting, children who bite, and thumb sucking.

For Patients And The Community

The National Mental Health Association (http://www.nmha.org/children/children_mh_matters/promoting.cfm) provides ways to promote children's mental health by building up their strengths, protecting them from risks and giving them the tools to succeed in life. Some tips in promoting children's mental health are:

- Help children relate to others and build their confidence.
- Be a role model.
- Encourage exercise and sports.
- Suggest involvement in after-school activities.
- Encourage strong family relationships.
- High expectations can go a long way.

Tips for parents are caregivers include:

- Spend time with children daily listening to them.
- Talk to them about what is happening in their lives.
- Provide unconditional love and support for your children.
- Education yourself about children's mental health and illness.
- Talk about emotions and feeling with your child.
- Teach and model tolerance and understanding about mental illness.

The National Mental Health Association website (www.nmha.org) contains fact sheets on many different behavioral health topics and has information specifically about children and adolescents. This website also has a link to your local National Mental Health Association affiliate.

The American Academy of Child and Adolescent Psychiatry is another helpful resource (<http://www.aacap.org/>). This website assists parents and families in understanding developmental, behavioral, emotional and mental disorders affecting children and adolescents and contains useful information regarding advocacy, hot topics, and services such as finding a child and adolescent psychiatrist. This website also contains facts for families which provides up-to-date information on issue that affect children, teenagers, and their families— (<http://www.aacap.org/publications/factsfam/index.htm>)

Another key resource for parents and families is the United States Department of Health and

Human Services Substance Abuse and Mental Health Services Administration website (<http://www.mentalhealth.samhsa.gov/>). This website contains resources for parents and families as well as resources for children and adolescents.

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