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Focus on Children's Behavioral Health

Childhood is the best of times. Children are spared the stresses that plague most adults. Or so we used to think. Recent recognition that infants, children and adolescents suffer from mental illness has shattered this long-held myth.

Even without mental illness a child is subject to wild emotional swings, experiencing dramatic physical, cognitive and social changes and pressures. A successful childhood, marked by achieving developmental milestones, secure attachments, good social interactions and effective coping skills, helps a child become mentally healthy. Mentally healthy young people function well at home, in school and in the community. Depending on its severity, a childhood mental disorder, addiction disorder or emotional disturbance can cause a minor struggle or a major upheaval.

Understanding Childhood Mental Illness or Behavioral Problems

Attempting to determine what constitutes a childhood mental illness or behavioral problem is particularly challenging given the fast pace of each child's development. During childhood, change is more common than stability, making assessment difficult. Many signs of normal development are eerily similar to many symptoms of mental and behavioral disorders. Small differences occur between normal and abnormal behavior. Assessment requires clinicians to determine whether usually normal childhood behaviors, such as shyness, fearfulness, inattentiveness or food fads, occur unreasonably, unexpectedly, too frequently or last too long.

Mental illness in children requires assessment that is different from assessment undertaken for adults. Typically a child is more suggestible than an adult, requiring additional vigilance in ferreting out particular symptoms. Even more than is true for adults, understanding childhood mental health and illness requires unraveling the individual child's particular history, both normal and abnormal, including development, biology, genetics, relationships, behavior, environment and more. Effective assessment requires an adequate understanding of that specific child's ability to adapt to their environment. More than for adults, a child's behavior may reflect a pathological or severely disordered environment. Age and timing achieves exaggerated importance. Normal behavior for one age may be a symptom of mental illness at another. The same stressful event may have little impact at one age and a profound impact at another. Children are commonly unable to verbalize their thoughts and feelings, requiring greater dependence on parents, teachers and others involved with a child to facilitate assessment of mental and emotional problems.

Good mental health requires that a child's first relationships be trusting and caring to provide a "secure base" from which they can begin exploring the world. The emerging field of infant mental health focuses on those relationships to explain the social-emotional development of infants and toddlers from birth through age five. Relationships that are formed during this period provide the foundation for a child's mental development. When an infant feels secure and is reassured by kind and nurturing relationships, they feel valued, growing into adults who care about others.

When an infant feels insecure and lacks healthy nurturing relationships, a lifetime of poor mental health begins. A baby can experience serious depression or develop an eating disorder as early as four months of age. They often appear lethargic, displaying a "flat affect." Many try to nurture themselves, rocking back and forth. Some become aggressive and hostile, rejecting any comforting because past relationships have failed to be nurturing.

Prevalence

A very large number of Oklahoma children and teens, almost ninety thousand (89,278 ages 9 through 17 in 2005), suffer from mental or behavioral impairments. One of five (20.9%) children over age 8 and teens under age 18 have a diagnosable mental illness or addiction disorder associated with at least some impairment. Mental disability is the most common developmental disability among Oklahoma children. See the 2003 Oklahoma KIDS COUNT Factbook and the 2005 Oklahoma KIDS COUNT Factbook for further data and analysis related to developmental disability and childhood health.

Of Oklahoma's children and teens suffering from mental or behavioral impairment, over fifty-five thousand (55,532 ages 9 through 17 in 2005) suffer from a Serious Emotional Disturbance (SED). While not tied to any particular diagnosis, SED refers to this estimated thirteen percent (13.0%) of Oklahoma children with diagnosable mental health problems that severely disrupt their ability to function socially, academically and emotionally.

Mental Disorders in Children

There is much parental and professional disagreement about whether specific childhood problems are accurately described as mental disorders, developmental delays or biological disorders. An increasing consensus links biological factors to pervasive developmental disorders, autism, early-onset schizophrenia, social phobias, attention-deficit/hyperactivity disorder (ADHD) and other disorders, including obsessive-compulsive disorders and Tourette's Syndrome. Nevertheless, such childhood problems remain listed as "mental disorders" in publications such as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), used to categorize childhood problems in medical records.

The DSM-IV organizes childhood mental disorders into a number of broad categories. Most occur across a person's entire life span, but typically have their onset during childhood. It is not uncommon for a child to have more than one disorder or to have disorders from more than one of the following categories listed on the following page.

Primary Disorders of Childhood and Adolescence

CATEGORY	EXAMPLES	CHARACTERIZED BY
ANXIETY DISORDER	separation anxiety disorder; generalized anxiety disorder; post-traumatic stress disorder; obsessive-compulsive disorder; panic disorder; phobias	unreasonable fear, uneasiness and anxiety over a period of months or years; commonly co-occurs with depression, learning disorders and addiction disorders
ATTENTION-DEFICIT & DISRUPTIVE BEHAVIOR DISORDERS	attention-deficit disorder, disruptive disorder; oppositional defiant disorder; conduct disorder	inattentive, impulsive, hyperactive and/or aggressive behavior; commonly co-occurs with learning disorders and addiction disorders
AUTISM & OTHER PERVASIVE DEVELOPMENTAL DISORDERS	pervasive developmental disorders, autism; Asperger's disorder; Rett's disorder	disordered cognition or thinking, difficulty understanding and using language, understanding others and the environment, repetitive behavior; commonly co-occurs with learning disorders and addiction disorders
EATING DISORDERS	anorexia nervosa, bulimia nervosa, binge eating disorder	self-starvation, binge eating, purging and/or excessively exercising; obsession with food and being thin or compulsive overeating; commonly co-occurs with depression, learning disorders and addiction disorders
ELIMINATION DISORDERS	enuresis (bedwetting not caused by a physical medical condition); encopresis	repeated, involuntary inability to control elimination commonly co-occurs with learning disorders and addiction disorders
LEARNING & COMMUNICATION DISORDERS	dyslexia, dysphasia, aphasia, dyscalculia, dyspraxia	lack of functional ability to process or organize information, to learn or to communicate; commonly co-occurs with addiction disorders
MOOD DISORDERS	major depressive disorder; dysthymia; bipolar disorder	severe depression, hopelessness, low self-esteem, manic periods, lack of motivation or dramatic emotional swings lasting over a period of months or years; commonly co-occurs with anxiety, learning disorders and addiction disorders
SCHIZOPHRENIA	schizophrenia, paranoid schizophrenia, hebephrenic schizophrenia	impairment in perception of reality, hallucinations, delusions, disorganized speech and thinking, withdrawal, inability to experience pleasure, flattened affect; commonly co-occurs with learning disorders and addiction disorders
TIC DISORDERS	Tourette's disorder	sudden, rapid, nonrythmic, involuntary movements; commonly co-occurs with learning disorders and addiction

Addiction Disorders in Children

Taking risks is a normal part of growing up and getting through high school. Taking risks with alcohol and drugs can lead to addiction before high school is even over. Youth exposure to drugs and alcohol is very common. Young people don't start drinking or using drugs to develop an addiction, most begin casually without fully understanding the consequences. Adolescent substance abuse substantially alters behavior, creates preoccupations and changes relationships.

The Youth Risk Behavior Survey (YRBS) monitors risky behaviors such as alcohol and drug use and abuse among young people. In 2003 and 2005, the Centers for Disease Control and Prevention (CDC), the Oklahoma State Department of Health (OSDH) and local public high schools collaborated to randomly administer surveys to provide data representative of all state public high school students in a manner that can be compared to other students around the nation.

Alcohol use is common among Oklahoma children and youth. Three of every four (76.5%) Oklahoma high school students have already tried alcohol (lifetime use). Two of every five (40.5%) high school students currently drink alcohol (at least one drink within the last month). One in four (26.6%) engages in episodic heavy drinking (binging on five or more drinks in a row within the last month). Rates of binge drinking among Oklahoma high school students are higher than comparable rates around the nation.

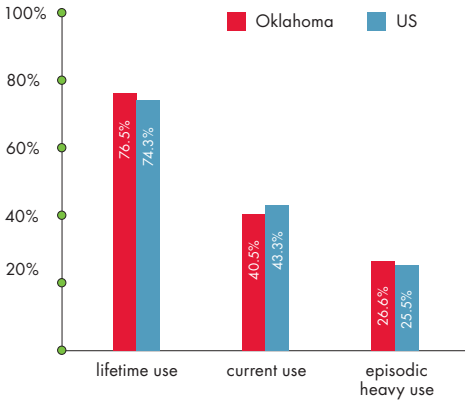
Marijuana is one of the most popular drugs among teenagers because of the common misconception that it is harmless. Two of every five (39.3%) Oklahoma high school students have already smoked marijuana. One of those (18.7%) is a current user.

Experimenting with a wide variety of drugs is not unusual. Oklahoma youth are more likely than others around the nation to have tried cocaine, methamphetamines and ecstasy. The use of illegal drugs is associated with problems like depression and anxiety. It is not clear whether such problems are the consequence or the cause of substance abuse.

Youth Risk Behavior Survey

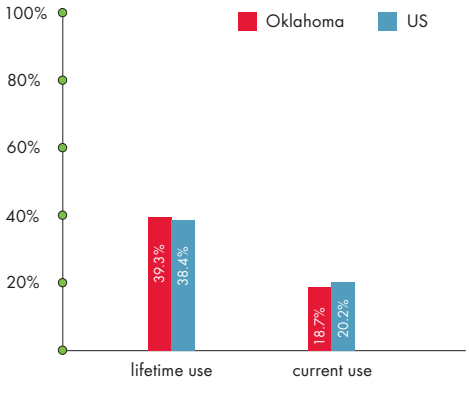
Alcohol Use Among High School Students

Oklahoma & US
2005



Marijuana Use Among High School Students

Oklahoma & US
2005



Oklahomans start young. Before the age of 13, one in four high school students drank alcohol (25.2%). One in ten (9.4%) tried marijuana. The younger people are when they begin to drink alcohol and use illegal drugs, the more likely they are to become addicted. One out of every ten young Oklahomans (ages 9 through 17) may have a substance disorder.

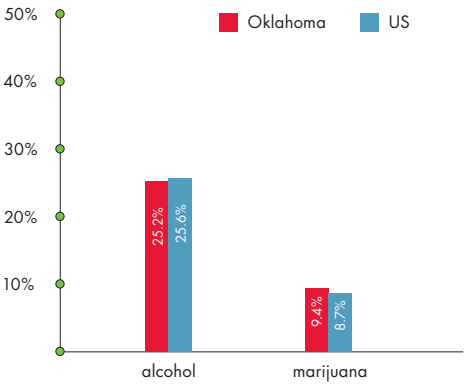
Risk Factors

Mental disorders among Oklahoma children may be influenced by biological factors, environmental factors, exposure to trauma and access to effective care. While not necessarily "causing" mental disorders, risk factors provide a framework for assessment and understanding. Whether or not a disorder is induced in an individual child depends on their age, the frequency of exposure to adverse experiences, their personal resiliency, their biological vulnerability and many other factors.

Risk factors typically used to predict or identify possible childhood mental illness, addiction disorders or severe emotional distress include birth/genetic/biological factors, environmental factors, exposure to childhood trauma and access to effective treatment. Risk factors do not occur in isolation, but are interrelated and appear in clusters. For example, if a child is a victim of abuse or neglect (thereby being exposed to childhood trauma), it is likely that the dysfunctional abusing parent suffers from depression or a mental psychosis (thereby subjecting the child to an inherited predisposition to mental disorders). Considering each factor in isolation results in a limited understanding of a child's risk for mental illness and behavioral disorders.

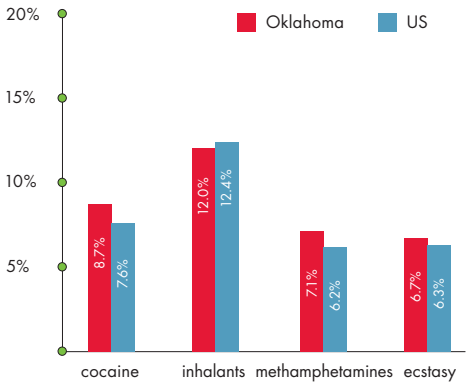
First Use Among High School Students Before Age 13

Oklahoma & US
2005



Lifetime Use of Selected Illegal Drug Among High School Students

Oklahoma & US
2005



Birth/Genetic/Biological Factors

Biology exerts pronounced influence on several childhood mental and behavioral disorders. Birth, genetic and biological risk factors for childhood mental illness, addiction disorders, behavioral disorders or serious emotional disturbance include very low birth weight, diagnosed genetic or chromosomal disorders, inherited predisposition to mental disorders, abnormalities of the central nervous system, prenatal damage from trauma or malnutrition, and prenatal exposure to drugs, alcohol and tobacco.

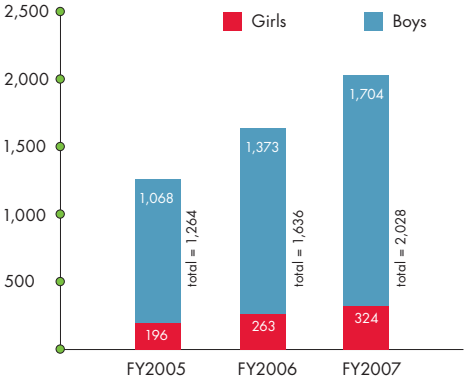
Very low birthweight often predicts later mental, developmental and behavioral difficulties for Oklahoma babies. Many infants who begin life weighing less than 3 pounds, 5 ounces, face childhoods marked by depression, anxiety, hyperactivity and aggression. Representing 1.3% of all Oklahoma births, each year almost seven hundred (665 average annual, 2003-2005) Oklahoma babies are born very, very tiny (weighing less than 3 pounds, 5 ounces). See State Benchmark Topics, County Benchmarks and the Data Tables in this 2007-2008 KIDS COUNT Factbook for further data and analysis related to very low birthweight in Oklahoma.

Genetics and family history can influence whether a child develops a mental or behavioral disorder. Children of depressed parents are more than three times as likely than children of nondepressed parents to suffer depression themselves. Having parents who suffer from depression also increases a child's risk of anxiety disorder, conduct disorder and alcohol dependence. While the consequences of maternal depression vary with her child's developmental stage, depressed mothers are less able to prevent out-of-control behavior, often leading to later conduct disorders and childhood aggressiveness.

Children afflicted with disabilities on the autism spectrum have extreme difficulty understanding the world around them. They suffer through a wide variety of obsessions and repetitive actions, making their behavior difficult for people unfamiliar with autism to understand. In Oklahoma, more than two thousand (2,028 on October 1, 2006) children and youth (ages 3 through 21) with a primary disability of autism (or on the autism spectrum) are enrolled in special education. Most (84.0%) are boys. Autism is the fastest growing developmental disability in the United States. The number of children receiving special education in Oklahoma schools with autism spectrum disorders recorded as their primary disability increased more than sixty percent (60.4%) during the most recent three-year period (FFY2005 through FFY2007) on record.

Children with Primary Disability on the Austim Spectrum Receiving Special Education

Oklahoma, Ages 3–21



Environmental Factors

Environmental risk factors for childhood mental illness, addiction disorders, behavioral disorders or serious emotional disturbance include poverty and all that accompanies poverty-related deprivation: unemployment, welfare dependence, poor nutrition, exposure to environmental hazards, poor health care, and more.

Mental health challenges disproportionately affect poor children and youth. Even so, poverty remains one of the most difficult risk factors to judge independently. Poverty-related deprivation is part of a cycle that impairs the ability of a young person to succeed in school and places them at risk for involvement in Oklahoma's child welfare and juvenile justice systems. Is it the deprivation itself, the resulting trauma or the inability to finance or access treatment which increases a poor child's risk of mental or behavioral impairment? Regardless of the answer, poor children are more commonly victims of mental illness than non-poor children, allowing risk to be measured by lack of income.

One in every five (20.2% in 2004) Oklahoma children, more than one hundred seventy thousand (171,495), lives in poverty. Oklahoma's poverty rate for children is higher than that for all children in the United States (17.8%), placing Oklahoma near the bottom (39th) of the national rankings. Only eleven states (New York, South Carolina, Arizona, Kentucky, West Virginia, Alabama, Texas, Arkansas, New Mexico, Louisiana and Mississippi) have a larger share of children living in poverty than Oklahoma. Among Oklahoma counties the proportion of children living in poverty ranges from the lowest and best rate found in Canadian County (11.9%) to the highest and worst rate (almost three times higher) found in Choctaw County (31.5%).

Unemployment — sometimes periodic, sometimes entrenched — causes hardship when the family breadwinner is out of work. Unemployment-related deprivation increases the likelihood that the youngest members of the family will suffer from mental illness and behavioral disorders. Average annual (2003-2005) unemployment rates for Oklahoma reach 5.0%. The highest and worst unemployment rates (11.5%) are found in Coal County; the lowest and best (2.4%) is in Roger Mills County.

Exposure to Childhood Trauma

The relationship between a child's exposure to trauma and their risk for developing a mental illness, addiction disorder or behavioral disorder is well established. As discussed above, the same stressful event may have a profound impact at one age and little impact at another. For example, parental death or divorce can increase a very young child's risk for major depression but may result in less impact during adolescence.

Oklahomans are not strangers to the devastation caused by trauma. On April 19, 1995, the bombing of the Alfred P. Murrah Federal Building in Oklahoma City became what, at the time, was the most egregious act of terrorism ever carried out within the borders of the United States. The aftermath left one hundred sixty-nine fatalities, eight hundred people injured, almost five hundred people homeless, more than three hundred buildings and two thousand vehicles damaged or destroyed. No one was more affected than the children: nineteen were murdered, fifty were injured or maimed, thirty-nine were orphaned, two hundred nineteen were left with only one parent. A community of children was left afraid. In the years that followed, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) funded services for over five thousand (5,430 from 1995 to 2001) Oklahoma children left traumatized by the tragedy.

Typically, Oklahomans face more ordinary traumas, albeit in large numbers. According to the Federal Emergency Management Agency (FEMA), Oklahoma ranks first per capita in federal disaster declarations. Between November 27, 2000, and August 31, 2007, FEMA designated various Oklahoma counties as federal disaster areas over six hundred (615) times because of Oklahoma tornadoes, fires, floods and winter storms. On average FEMA declares eight Oklahoma counties as federal disaster areas every month. Between November 27, 2000, and August 31, 2007, the highest and worst disaster rate (24.2 disaster declaration per 1,000 county children) is found in Tulsa County; the lowest and best (0.1 disaster declaration per 1,000 county children) is in Roger Mills County.

The 2006-2007 Oklahoma KIDS COUNT Factbook focused on the Adverse Childhood Experience, or ACE, Study, one of the largest investigations of trauma ever conducted. The ACE Study, a collaborative research project between the Centers for Disease Control and Prevention (CDC) and the Department of Preventive Medicine at Kaiser Permanente (KP) in San Diego, documents a direct correlation between the traumas and family dysfunction suffered in childhood with poor adult health status and premature death decades later. The ACE Study produces remarkable insight into how childhood experiences evolve into risky behaviors, which, in turn, evolve into disease and premature death.

The ACE Study demonstrates that adverse childhood experiences have a powerful relationship to adult health status half a century later. The same adverse childhood experiences place a child at risk for mental illness, addiction disorders and behavioral problems.

For example, child maltreatment (abuse and neglect) increases a child's risk of suffering from various psychological disorders (attachment, post-traumatic stress, conduct), depression and impaired social

and cognitive functioning. The Oklahoma Department of Human Services (OKDHS) substantiates over thirteen thousand (13,167) incidents of child abuse and/or neglect each year (Fiscal Year 2004 - Fiscal Year 2006). These young victims are left to deal with the very real trauma of being mistreated by people responsible for their care.

Similarly, having a member of their household incarcerated increases separation anxiety and depression among children and teens. Oklahoma ranks first in the nation (and the world) in its rate of incarceration of women. As of June 29, 2007, Oklahoma incarcerated over twenty-five hundred (2,566) female offenders. Over 80% of these inmates are parents, with an average of 3 children each, leaving over six thousand Oklahoma children to deal with the elevated trauma of having their mother incarcerated.

State and county ranking of key indicators of adverse childhood experience in Oklahoma, first reported in the 2006-2007 Oklahoma KIDS COUNT Factbook, are summarized for use to help assess the risk of mental illness, addiction disorders and behavioral problems among Oklahoma children and youth. Each Oklahoma county is ranked based on the likelihood a child residing in that county would experience adversity during their childhood. The worse the county rank, the more likely children living there will accumulate ACEs. One half of each county's ACE Index is comprised of indicators measuring Child Maltreatment (confirmed child abuse and confirmed child neglect). The other half of each county's ACE Index is comprised of indicators measuring Household or Family Dysfunction (divorce, index crime, psychological distress, substance abuse and protective orders). Based on these indicators, Cimarron County is best, Coal County is worst. See the 2006-2007 Oklahoma KIDS COUNT Factbook for details and data for each indicator.

Adverse Childhood Experience (ACE)

- Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Emotional Neglect
- Physical Neglect
- Mother Treated Violently
- Household Substance Abuse
- Household Mental Illness
- Parental Separation or Divorce
- Incarcerated Household Member

Access to Effective Treatment

Mental health treatment for children is slow to emerge. Most (60.6%, FY2005-2006) Oklahoma children (ages 9 through 17) suffering from mental illness or addiction disorders are unserved by Medicaid (OHCA), the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) or the Office of Juvenile Affairs (OJA). Currently, the highest and worst rate (87.4%) of mentally ill or substance abusing children and youth (ages 9-17) unserved by Medicaid, ODMHSAS or OJA is found in Cimarron County; the lowest and best (2.7%) is in Coal County. Two-fifths (40.3%, FY2005-2006) of Oklahoma SED children and youth (ages 9 through 17) are unserved for their severe emotional disturbances by these public agencies. Currently, the highest and worst rate (81.3%) of SED children and youth (ages 9-17) unserved by Medicaid, ODMHSAS or OJA is found in Beaver County; the lowest and best (0.0%) is found in 9 Oklahoma counties (Atoka, Beckham, Blaine, Bryan, Choctaw, Coal, Custer, Greer and Pushmataha).

The most frequently diagnosed mood disorder diagnosed in children and adolescents is depression. Depression substantially increases the risk of suicide. While suicide itself is not a mental disorder, most children and adolescents who commit suicide have some level of

diagnosed mental disorder. The death of a child by their own hand is, perhaps, the most compelling evidence of inaccessible treatment. On average, seventy-five (75) young Oklahomans (ages 5-24, 2003-2005) take their own life each year. Currently (2003-2005), the highest and worst rate (43.9 suicides per 100,000 children and youth ages 5-24) is found in Roger Mills County; the lowest and best (0.0 suicides per 100,000 children and youth ages 5-24) is found in twenty-six (26) Oklahoma counties (Alfalfa, Atoka, Beaver, Cimarron, Coal, Craig, Custer, Dewey, Ellis, Garfield, Grant, Greer, Harmon, Haskell, Hughes, Jefferson, Kingfisher, Kiowa, LeFlore, Major, Murray, Noble, Nowata, Okfuskee, Tillman and Woodward).

The cost of treatment for behavioral health services for children and youth is high and going higher. Garnering an accurate picture of how Oklahoma families pay for such treatment is a complex prospect. Some care may be available without cost or at reduced cost to some children through publicly-funded initiatives (such as Medicaid, ODMHSAS or OJA). Where available, these publicly-funded initiatives supplement or replace private treatment that would otherwise require payment or insurance coverage. Unfortunately, such initiatives often have limited eligibility, services and locations.

Mental health disorders must be covered by private health insurance policies due to Oklahoma's "parity" laws. Parity laws provide little help to the almost half (44.4%) of Oklahoma's children who have no private insurance coverage. Oklahoma children are more likely to be uninsured than others around the nation. Oklahoma is the 35th worst state in the nation with one in eight (12.5%) children totally uninsured. One hundred fourteen thousand (114,000) Oklahoma children have neither private nor public insurance.

Treatment of Childhood Mental Illness, Behavioral Disorders, Addiction Disorders or Severe Emotional Distress (SED)

Traditional treatments used with adults, such as psychotherapy and pharmacology or some combination, are also used with young people. Much of the treatment research is conducted on adults with results extrapolated and tailored for use with children and adolescents. While it is well documented that children and adolescents improve more with treatment than with no treatment, less is known about what therapy works best for each childhood condition.

Research also lags behind the surge in use of medication therapy for children and adolescents with mental disorders. Most of what is known about dosage, effectiveness and how a particular drug affects a person's body comes from studies of adults. Widespread "off-label" use has resulted, prescribing pharmaceuticals to children and adolescents which have only been tested and approved for adults.

State and County Childhood Stress Index

Key indicators, reported here for the State of Oklahoma and by county in the benchmark section of this 2007-2008 Oklahoma KIDS COUNT Factbook, can be grouped together and compared, allowing each Oklahoma county to be ranked based on the likelihood a child residing in that county would experience mental illness, an addiction disorder or a severe emotional disturbance (SED) during their childhood. Each Oklahoma county is ranked on eight indicators, selected to represent county rates for birth/genetic/biological factors (very low birthweight, autism spectrum disorder specified as the primary diagnosis on IEPs), environmental factors (childhood poverty, unemployment), childhood exposure to trauma (FEMA disaster declarations, Adverse Childhood Experiences), and access to effective treatment (mentally ill/substance abusing/SED children unserved by Oklahoma's publicly-funded treatment system & child/youth suicide). The worse the county rank, the more likely children living there will grapple with mental illness, addiction disorders or SED. All measures are given the same weight, with no attempt to judge relative importance. Based on these indicators, Cimarron County is best, Adair County is worst.

Now, more than ever before, there is hope. In the midst of dealing with the despair of a child with mental illness, addiction to drugs or alcohol or behavior problems it is easy to forget that such diseases are increasingly treatable. Today, with timely and appropriate assessment, treatment and support, emotionally distraught, addicted and mentally ill young people can feel better and get better: staying in school, maintaining healthy relationships and staying out of trouble. The first step is understanding.

Childhood Stress Index, Oklahoma & Counties, using data from 2000–2007