INPATIENT PRACTICE

Children as Inpatients: Why the Increase?

In a recent, soon-to-be published analysis of National Hospital Discharge Survey data, Joseph C. Blader, Ph.D., and his colleague, Dr. Gabrielle A. Carlson, found that the rate of psychiatric hospitalization of children increased 53% and the rate for adolescents increased 58% between 1996 and 2004.

During the same time period, psychiatric hospitalizations of adults increased only 3%.

In addition, this analysis indicated a large increase among children and adolescents in the rates with which bipolar disorder was the discharge diagnosis. It also reports a corresponding decrease in the diagnoses of attention-deficit/hyperactivity disorder (ADHD) with a disruptive disorder among inpatient youth. The study is slated for publication in the July 15 issue of Biological Psychiatry.

BY JOSEPH C. BLADER, PH.D.

This month, CLINICAL PSYCHIATRY NEWS explores the implications of these findings with Dr. Blader.

CLINICAL PSYCHIATRY NEWS: What prompted you to review the National Hospital Discharge Data for inpatient hospitalization of children and adolescents, and were you surprised by what you found?

Dr. Blader: I had completed a study that followed up children who were discharged from a single children's inpatient psychiatric unit at 3, 6, and 12 months after they left the hospital, and some of the findings provoked additional questions that a larger study could address. But because mental health services over the last 10 years had, appropriately, emphasized the importance of alternatives to inpatient care to treat children with severe psychiatric illnesses, I first needed to see if the admission of children to acute-care units had declined to the point that there might not be much value in conducting the research.

When I looked at trends from the annual National Hospital Discharge Survey, the rates of children admitted to acute inpatient care had increased significantly. This was somewhat surprising in view of well-publicized projects aimed at buttressing community-based mental health services for children.

What is not clear is whether these services are not yet widely available to affect hospitalization rates, or whether they do not always avoid acute inpatient admissions. Lengths of stay had also become shorter for all age groups.

CPN: The largest increases in inpatient discharges were for patients diagnosed with bipolar disorder. Could this represent upcoding aimed at getting patients admitted to the hospital in an era with tighter insurance restrictions on psychiatric admissions?

Dr. Blader: I certainly don't think that physicians are being disingenuous in their diagnoses for administrative reasons. However, doctors are hearing all the time that the children with the volatile, impulsive, explosive, erratic behavior who have been the mainstay of the child psychiatric inpatient population for many years have some form of bipolar disorder.

For some reason, the diagnoses that accentuate the impulse-control and behavior problem, such as ADHD oppositional defiant and conduct disorders, carry a connotation as being less serious.

It bears emphasizing that these chronic difficulties are major neuropsychiatric problems in their own right. They greatly increase the risk for much impairment that can lead to personal, familial, and social tragedy. It's debatable now in child psychiatry whether a broad conception of bipolar disorder that could include these children is more appropriate than a narrow one.

Discussion about diagnostic boundaries should not obscure the fact that these children suffer from a serious neuropsychiatric condition.

CPN: Are most of the admissions done to start a patient on medication? And is the hospital the best place for these children?

Dr. Blader: Adolescents are more likely than children to have a precipitous onset of major personality or behavior change. So they are more likely than children to have had no prior psychiatric care before they are first admitted for psychiatric observation and treatment. The reasons children are admitted stem from chronic problems evident early in life. These days, it is uncommon that a child is admitted to the hospital without current pharmacotherapy, at least where services are available.

CPN: What medications are these children started on, and is there any reason to think that other medications could be appropriate?

Dr. Blader: In many ways, psychostimulant medications remain the standard of treatment for ADHD, and they often improve the aggressive behavior that develops alongside ADHD and comorbid conduct disturbances. However, the use of stimulant medications is usually contraindicated when a person has "classical" mania. By extension, if clinicians increasingly see major behavioral volatility among children as a symptom of a bipolar-spectrum disorder, they may be dissuaded from adequate stimulant trials with these youngsters. The limited data suggest otherwise.

I recently concluded an outpatient trial that compared adjunctive divalproex sodium with placebo for persistent aggressive behavior among children whose dyscontrol did not improve enough with stimulant monotherapy. We first did an open run-in to optimize stimulant treatment to be certain that the kids' aggression was really stimulant-refractory.

CPN: What did you find?

Dr. Blader: It turns out that even very aggressive, volatile youngsters may have impressive responses to first-line ADHD treatment. About half the kids responded well enough that we could not randomize them to add-on divalproex/placebo. Many of our subjects fulfilled the "juvenile bipolar disorder" phenotype that some investigators use, based on parents' responses to the Child Behavior Checklist.

The largest increase in a family of compounds for this patient group seems to be for antipsychotic medications. Except for clozapine and newly approved paliperidone, every atypical antipsychotic now marketed in the United States has an indication for mania. That probably plays a role in the proliferation of these compounds into the clinical care of these children. So far, though, there are only data for risperidone from large controlled trials for aggressive children.

CPN: It is also clear that a large increase was seen in depression discharges. To what do you attribute that increase?

Dr. Blader: Yes—an increase was seen but that seems more the case among the adolescents and to a lesser extent for adults. It is speculation, but perhaps there is a growing preferential diagnosis of mood disorders over substance use and anxiety disorders. The comorbidity of depression with these other conditions has gained greater appreciation, and the fact that depression precedes these other problems might make them in a sense "primary." Second, perhaps payers are less amenable to supporting inpatient treatment in a psychiatric setting when the principal diagnosis is substance use, anxiety, or dementia.

CPN: As you know, there is currently a shortage of child psychiatrists in this country. Does that shortage play a role here?

Dr. Blader: The uneven availability of high-quality child psychiatric services is still a huge problem. It's hard to say whether or how much that affects hospitalization rates. It definitely makes discharge planning more difficult when it's so hard to locate appropriate clinicians in a youth's home community. ■

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Label Machine Subs for Electronic Medical Records System

BY BRUCE K. DIXON
Chicago Bureau

If you're not ready to invest thousands of dollars in an electronic medical records system, a desktop label writer may be just what the doctor ordered.

"This is a very cost-effective alternative for anyone who doesn't have an EMR system," said Dr. Stephanie Lucas, who equipped her two-physician Detroit practice with several Dymo Twin Turbo label makers at a cost of about $150 apiece.

"I have all my prescriptions on the attached software, so all I have to do to print a label is go to the list on my computer, click on the prescription, and it comes out of the machine," Dr. Lucas said.

'Pharmacists appreciate being able to read the prescriptions without ever having to call.'

DR. LUCAS

She puts one label into the patient's chart and gives a second, signed, copy to the patient to take to the pharmacy. "Or I stick the label or labels on a sheet of paper and fax it to the pharmacy," she said.

The internist and endocrinologist take an extra step to ensure that patients know what their medications are for. For example, in addition to printing "Statin 20 mg #90," the label also says "cholesterol med."

"Patients love it, and pharmacists appreciate being able to read the prescriptions without ever having to call and ask me what I wrote," said Dr. Lucas, whose poor handwriting in grammar school drew a few knuckle raps from a ruler-wielding teacher.

The desktop labeling system also integrates with many software programs such as Outlook and Quickbooks to produce individual labels. "It's nice because it has an optional mailing bar code to facilitate mailing," she added.

The label maker also prints individual postage stamps using the Web site www.stamps.com.

"In addition, the data management software that comes with the machine contains our entire Rolodex file of physicians, so that patients referred to another facility get a legible copy of the name, address, and phone number on a printed label that can be affixed to the lab sheets or tickler file," she said.

Dr. Lucas uses the label maker to print legible, customized instructions for each patient, and puts a second copy into each chart. ■