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# VOLUNTARY MENTAL HEALTH TREATMENT LAWS FOR MINORS & LENGTH OF INPATIENT STAY

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MPH Thesis: Maternal  
& Child Health

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# INTRODUCTION

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- 1997: Nearly 300,000 children were admitted to inpatient treatment for Mental Health (MH)
- Two-thirds of children do not get the MH treatment they need
- State laws regulate how minor is admitted/consents to, held, and discharged from MH treatment

# LITERATURE REVIEW

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- Much geographic variation in utilization of MH treatment
- Hospitalized children more likely to continue treatment course
- Fewer children being hospitalized or receiving outpatient treatment
- Older children more likely to drop out of treatment

# STATEMENT OF PROBLEM

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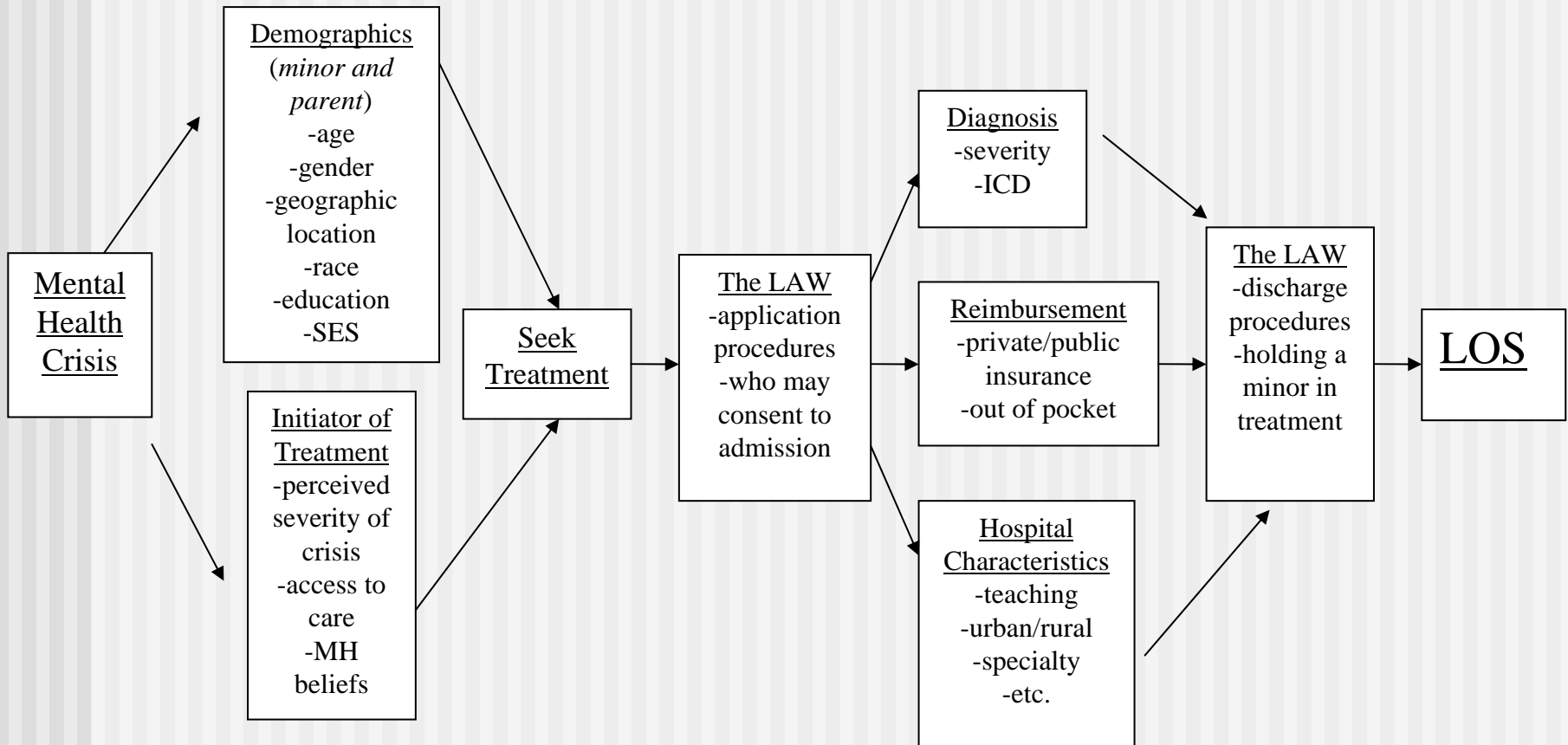
- Law can impact how MH treatment is accessed and utilized
- MH laws giving minors rights to consent to treatment may be at odds with parental rights
- No study has been done to examine effect of conflicting rights—on length of stay (LOS)

# HYPOTHESIS

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- States that grant minors more deference to make MH treatment decisions will have shorter LOS than states that reinforce parental authority in treatment decisions.

# CONCEPTUAL MODEL



# STUDY METHODS

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- Study Design: Ecological
- Evaluate effect of laws on LOS for minors with MH admissions
- Study Population:
  - Ages 12-17 years
  - Admitted to inpatient treatment with psychiatric diagnosis in general hospitals
  - Primary ICD code diagnosis of episodic mood disorder, schizophrenia, other nonorganic psychosis, depressive disorder, adjustment reaction, other neurotic disorders, personality disorders, or other nonpsychotic mental disorder

# DATA SOURCES

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- 50 State Survey of MH Laws
  - Obtained from legal databases, annotated statutory compilations, case law
  - Admission, holding, discharge laws included
- Healthcare Cost and Utilization Project: Kid's Inpatient Database (HCUP KID)
  - 2003 data: 2.9 million discharges of children from 3,438 hospitals in 36 states
  - 69,269 adolescents aged 12-17 with primary MH Diagnosis

# ANALYSIS PLAN

## ■ Evaluate laws in 50 states

- Classify types of laws (admit/consent, hold, discharge)
- Summary variable for strength of parental authority

<b>Strong Parental Deference in Treatment Decisions</b>	<b>Moderate Parental Deference in Treatment Decisions</b>	<b>Moderate Minor Deference in Treatment Decisions</b>	<b>Strong Minor Deference in Treatment Decisions</b>
GA, IA, MD, (NC), (OK), TX, WA, (WY)	(AK), AZ, CA, CT, (DC), IN, KY, (MS), NE, NV, NJ, (ND), OR, SD, UT	(AL), (AR), CO, (DE), IL, KS, MA, MI, (MT), NY, RI, SC, TN	FL, HI, (ID), LA, (ME), MN, MA, (MO), NH, (NM), OH, (PA), VT, VA, WV, WI

# ANALYSIS PLAN

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- Linear regression analysis
- Laws = exposure; LOS = outcome
- Confounders controlled for:
  - Payment source, rural/urban location, diagnosis

# 2003 HCUP KID INPATIENT CHARACTERISTICS FOR ADOLESCENTS 12 TO 17 YEARS WITH PRIMARY MH DIAGNOSIS

<u>Patient Characteristics</u>		<b>Strong Parental Deference State</b> n = 9980	<b>Moderate Parental Deference State</b> n = 16,385	<b>Moderate Minor Deference State</b> n =20,358	<b>Strong Minor Deference State</b> n =22,546
<b>Age</b>	12-13	35.3%	22.2%	21.9%	21.9%
	14-15	23.8%	36.1%	39.6%	39.4%
	16-17	40.9%	41.7%	38.5%	38.7%
<b>Payer</b>	Medicare/Medicaid	43.6%	37.5%	39.3%	36.8%
	Private	45.5%	51.2%	52.5%	51.5%
	Self-pay	2.5%	2.9%	3.9%	7.0%
	No charge/Other	8.1%	8.4%	4.0%	4.3%
<b>Mental disorder</b>	Episodic Mood Disorders	66.1%	54.0%	57.2%	60.0%
	Schizophrenia; Other nonorganic psychosis	5.8%	6.9%	5.9%	4.9%
	Depressive disorder, not elsewhere classified	7.6%	14.1%	8.6%	11.3%
	Adjustment reaction	4.7%	8.0%	8.0%	9.7%
	Other neurotic disorders, personality disorders, and other nonpsychotic mental disorders	15.9%	17.1%	20.3%	14.1%

# LENGTH OF STAY BY SUMMARY CATEGORIES

Type of Law	Adjusted* $\beta$ (95% CI)	Adjusted* $\beta$ including all admit/consent & discharge laws (95% CI)
<b>Strong Parental Deference in Treatment Decisions</b>	(reference)	(reference)
<b>Moderate Parental Deference in Treatment Decisions</b>	1.4 (1.1, 1.8)	2.0 (1.6, 2.3)
<b>Moderate Minor Deference in Treatment Decisions</b>	2.3 (2.0, 2.6)	1.3 (1.0, 1.7)
<b>Strong Minor Deference in Treatment Decisions</b>	<b>-0.9</b> (-1.2, -0.6)	<b>-3.9</b> (-4.2, -3.4)

\* Adjusted for payer, urban/rural location, diagnosis

Median LOS = 6 days

# LENGTH OF STAY BY STATE LAW EXPOSURES

Type of Law	Adjusted $\beta^*$ (95% CI)
<b>Parent Admit/Consent laws</b>	
General Parent admit/consent law	-0.6 (-0.8, -0.3)
Admission of non-consenting minor by parent permitted	-2.7 (-3.0, -2.4)
<b>Minor admit/consent law</b>	0.5 (0.3, 0.7)
<b>Parent discharge law</b>	0.5 (0.3, 0.7)
<b>Minor discharge laws</b>	
Minor permitted to discharge self only if original applicant to treatment	-0.5 (-0.8, -0.3)
Minor has unqualified right to discharge self	-0.2 (-0.4, -0.003)
<b>Parent hold laws</b>	-2.8 (-3.0, -2.5)

\* Adjusted for payer, urban/rural location, diagnosis

# SUMMARY OF MAJOR FINDINGS

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- Strongest minor rights states associated with decreased mean LOS by 0.9 days compared to strongest parental rights states
- Trend for moderate parent/minor rights states have increased LOS compared to strongest parental rights states
- Small association with minor discharge laws and shorter LOS; small association with parent discharge laws and longer LOS

# POTENTIAL CONFLICTING RESULTS

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- Some strong parent rights laws individually associated with shorter LOS
  - 2.8 days shorter LOS if parent can hold minor in treatment; 2.7 days shorter if can admit non-consenting minor
- Need to look at laws together as a whole
  - When include individual laws in summary model, LOS for strong minor rights states dramatically decreases. Possibly picking up on some other effect.
- Need more investigation utilizing additional models

# LIMITATIONS

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- HCUP KID contains data for 36 states
- HCUP KID only has data from general hospitals, no psychiatric hospitals
- ICD codes utilized for billing, inaccuracy in primary diagnosis
  - Could skew results, possibly more adolescents with substance abuse issues included
- May be some residual confounding as unable to control for availability, treatment beliefs, severity, secondary/dual diagnosis

# MENTORS & ACKNOWLEDGEMENTS

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## ■ Thesis Committee

- Melissa Schiff, MD, MPH, Maternal and Child Health, Dept. of Epidemiology
- Anna Mastroianni, JD, MPH, School of Law and Dept. of Public Health Genetics
- Tom Wickizer, PhD, MPH, Dept. of Health Services

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