

Maternal and Child Health Issue Brief

November 2014 №7

Mental Health among Children and Youth in Colorado

Why is mental health of children and youth a concern?

Mental health is important to overall health and well being; it can be affected by chronic disorders that interfere with growth and development. If disorders are not diagnosed or treated early, children and youth can develop problems at home, in school, or with forming friendships. Mental disorders can persist throughout the lifespan, continuing through childhood and adolescence into adulthood.¹

Symptoms of mental disorders usually start in early childhood, but diagnoses sometimes do not occur until the teenage years. A history of depression or other mental disorder along with other factors can lead to suicide, a serious public health issue among youth.¹ Suicide was the leading cause of death for young people ages 15-24 in Colorado in 2013.²



- An estimated one in five children living in the United States experiences a mental disorder in a given year and an estimated \$247 billion is spent annually on childhood mental disorders.¹
- In 2012, Colorado had the 10th highest teen (ages 15-19 years) suicide rate when compared to all other states.³

What is the prevalence of mental disorders among children?

The most prevalent mental disorder among Colorado children ages 4-14 years is current anxiety (7.0 percent) followed by current attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) (6.4 percent). Among Colorado children of the same age, 3.7 percent have current behavioral or conduct problems, and 2.7 percent have current depression (Table 1).

Table 1. Percentage of children ages 4-14 years with specific mental disorders, Colorado, 2013.⁴

Mental Disorders	Prevalence (%)
Current anxiety	7.0
Current ADD/ADHD*	6.4
Current behavioral or conduct problems^	3.7
Current depression	2.7

*ADD/ADHD: Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
^e.g., oppositional defiant disorder or conduct disorder

DEFINITIONS

Anxiety: characterized by persistent, excessive, and unrealistic worry about everyday things.⁵

Attention Deficit Hyperactivity Disorder: characterized by developmentally inappropriate levels of inattention, hyperactivity, impulsivity, or a combination of these, which impair functioning in multiple settings.⁶

Oppositional Defiant Disorder: characterized by a pattern of developmentally inappropriate, negative, aggressive, and defiant behavior that occurs for 6 months or more.⁶

Conduct Disorder: characterized by consistent ignorance of the basic rights of others and violation of social norms and rules.⁶

Depression: characterized by feelings of sadness or hopelessness, a lack of motivation, or a disinterest in life in general.⁵

What is the prevalence of depression and suicide intention among youth?

Among Colorado's high school youth, one in four (24.3 percent) felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. One in seven (14.5 percent) high school youth seriously considered attempting suicide in the past year, 12.0 percent made a plan about how they would attempt suicide, 6.6 percent actually attempted suicide one or more times, and 2.3 percent reported that their suicide attempt resulted in an injury, poisoning, or overdose that needed medical treatment (Table 2).⁷

Table 2. Percentage of high school youth reporting depression and suicide intention, Colorado, 2013.⁷

Depression and Suicide	Prevalence (%)
Felt sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	24.3
Seriously considered attempting suicide during the past 12 months	14.5
Made a plan about how they would attempt suicide during the past 12 months	12.0
Actually attempted suicide one or more times during the past 12 months	6.6
Made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	2.3

In 2013, the hospitalization rate for suicide injury among youth ages 15-19 years was 108.2 per 100,000 teens.⁸ In the same year, the suicide death rate was 13.7 per 100,000 teens (Table 3).² For more information on teen suicide, see the Spotlight on Youth Suicide in Colorado on page 6.

Table 3. Youth (ages 15-19) suicide injury hospitalization rate and suicide death rate, Colorado, 2013. ^{2,8}

Teen Suicide	Rate (per 100,000)
Suicide injury hospitalization rate (per 100,000 teens)	108.2
Suicide death rate (per 100,000 teens)	13.7

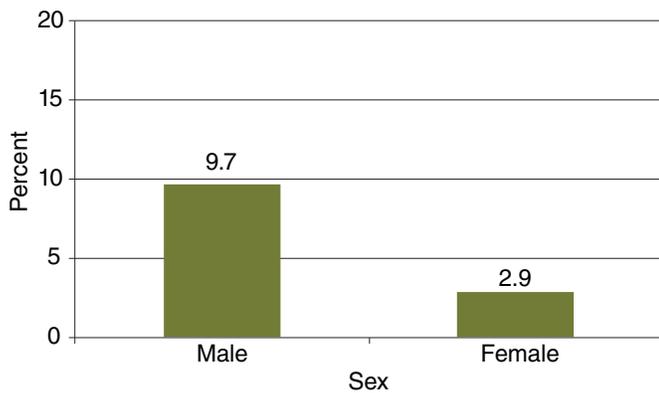


Colorado's Goal⁹

By 2016, reduce to 5.0 percent the proportion of youth (high school students) who report attempting suicide in the previous 12 months.

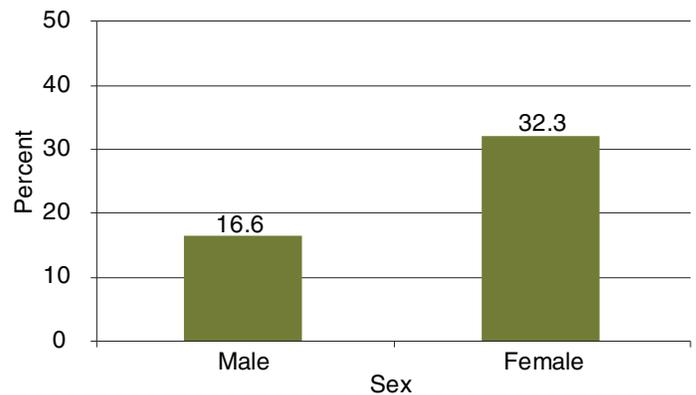
Social disparities

Figure 1. Percentage of children ages 4-14 years with current attention deficit disorder/attention deficit hyperactivity disorder by sex, Colorado, 2013.⁴



In Colorado, one in ten (9.7 percent) males ages 4-14 years was diagnosed with attention deficit disorder/attention deficit hyperactivity disorder. This is significantly different from the 2.9 percent of females diagnosed with attention deficit disorder/attention deficit hyperactivity disorder.⁴

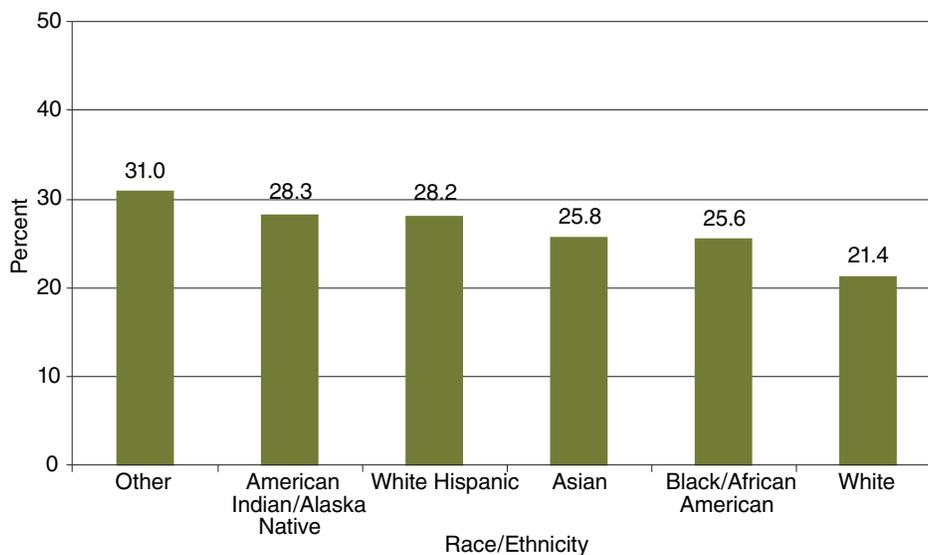
Figure 2. Percentage of high school youth who felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities by sex, Colorado, 2013.⁷



One in three (32.3 percent) females in high school felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities. This is nearly double the 16.6 percent of males in high school, and significantly different.⁷

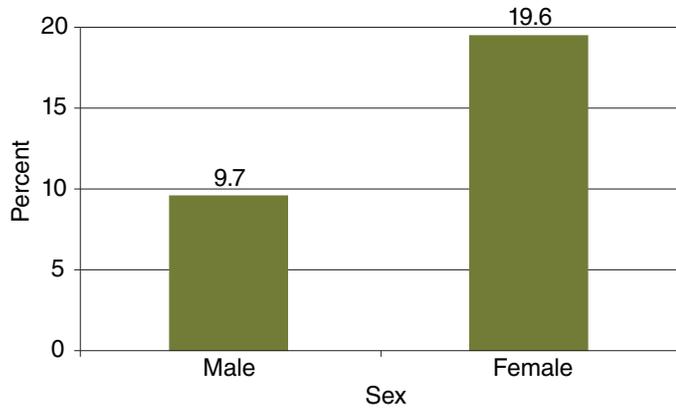
A difference by sex for current attention deficit disorder/attention deficit hyperactivity disorder was the only disparity revealed by the Child Health Survey. Differences by sex, race/ethnicity, or poverty level were not apparent for the other mental disorders shown in Table 1.

Figure 3. Percentage of high school youth who felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities by race/ethnicity, Colorado, 2013.⁷



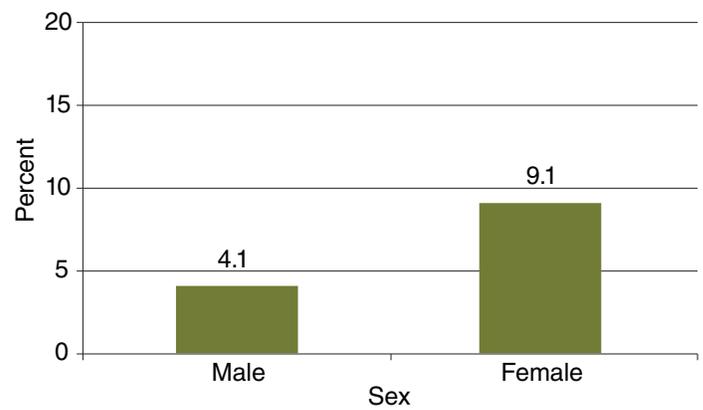
Three in ten youth of other race/ethnicities (31.0 percent) felt so sad or hopeless for two weeks or more in a row that they stopped doing some usual activities compared to one in five (21.4 percent) White high school youth, a significant difference. The prevalence among American Indian/Alaska Native youth (28.3 percent), White Hispanic youth (28.2 percent), and Asian youth (25.8 percent) was also significantly different from White youth.⁷

Figure 4. Percentage of high school youth who seriously considered attempting suicide by sex, Colorado, 2013.⁷



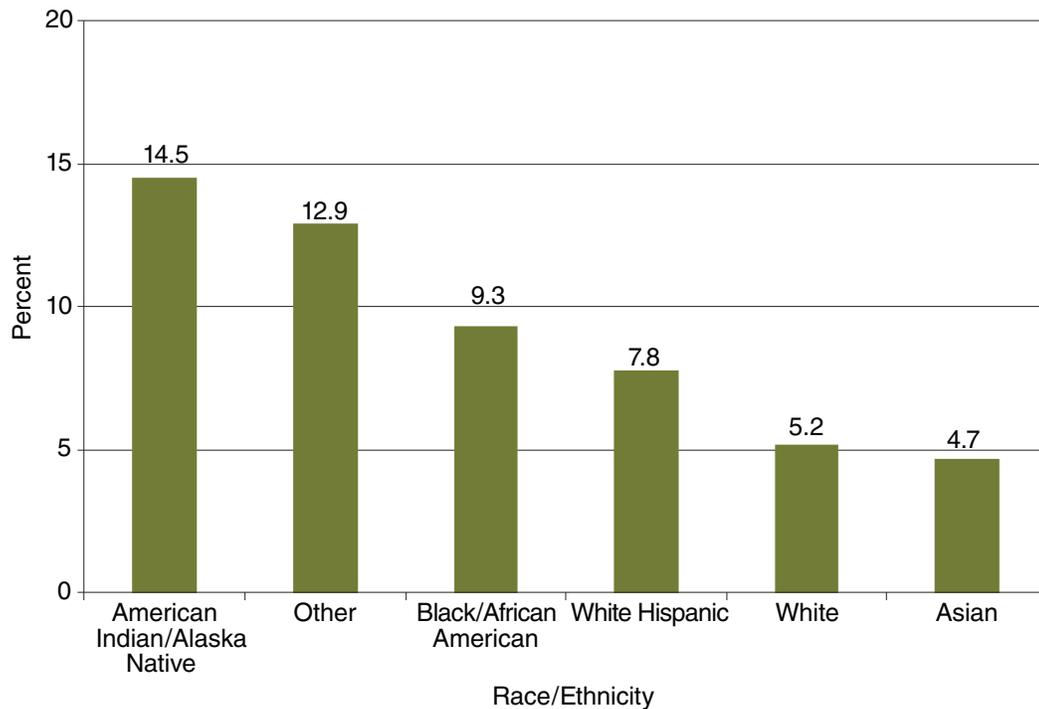
One in five (19.6 percent) females in high school seriously considered attempting suicide; this is significantly different from the 9.7 percent of males in high school.⁷

Figure 5. Percentage of high school youth who actually attempted suicide one or more times by sex, Colorado, 2013.⁷



Almost one in ten (9.1 percent) females in high school actually attempted suicide one or more times; this is double and significantly different from the 4.1 percent of males in high school.⁷

Figure 6. Percentage of high school youth who actually attempted suicide one or more times by race/ethnicity, Colorado, 2013.⁷

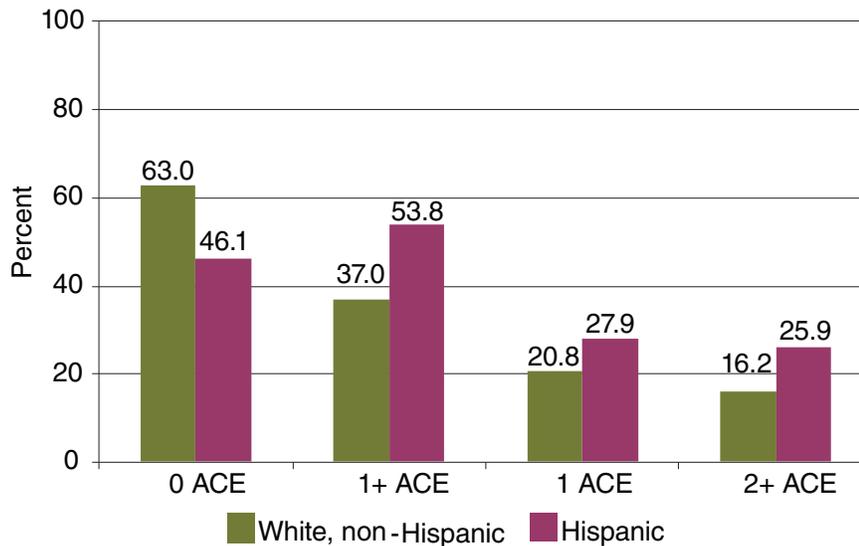


One in seven (14.5 percent) American Indian/Alaska Native youth attempted suicide at least once compared to one in twenty (5.2 percent) White high school youth, a significant difference. The prevalence among youth of other race/ethnicities (12.9 percent), Black/African American youth (9.3 percent), and White Hispanic youth (7.8 percent), was also significantly different from White youth.⁷

What contributes to mental disorders among children and youth?

Family history and biological factors affect the development of mental disorders.¹⁰ Research also indicates that children raised in stressful environments are more likely to develop stress response systems that negatively impact development.¹¹ Toxic stress is repeated intense stress that is not buffered through emotional support,¹¹ and adverse childhood experiences (ACEs) can result in toxic stress. ACEs include household substance abuse, violence, and parental divorce.¹² ACEs and toxic stress may be more likely to occur when families experience trauma and face social, economic, and structural inequalities.^{11,13}

Figure 7. Prevalence of adverse childhood experiences (ACEs) among children and youth ages 0-17 by race/ethnicity, Colorado, 2011-2012.¹²



Four in ten (43.7 percent) Colorado children and youth ages 0-17 experienced at least one ACE; 23.8 percent experienced one ACE and 19.9 percent experienced two or more ACEs (not shown). One in four Hispanic children and youth (25.9 percent) experienced 2 or more ACEs compared to 16.2 percent of White, non-Hispanic children and youth; a significant difference. Hispanic children and youth are more likely to experience an ACE, putting them at higher risk of developing mental and physical disorders.¹¹

Among children living in households at 0-99% FPL, 35.0 percent experienced two or more ACEs, significantly different from the 8.7 percent of children living in households at 400% of the federal poverty level (FPL) or higher.

Among Colorado children and youth ages 0-17 who had one or more emotional, behavioral or developmental issues, over half (57.6 percent) experienced two or more adverse childhood experiences. Among children who did not have emotional, behavioral, or developmental issues, one in four (23.9 percent) had experienced two or more ACEs;¹² this difference is significant. Adverse childhood experiences are associated with emotional issues in adulthood such as anger, depression, or anxiety.¹³

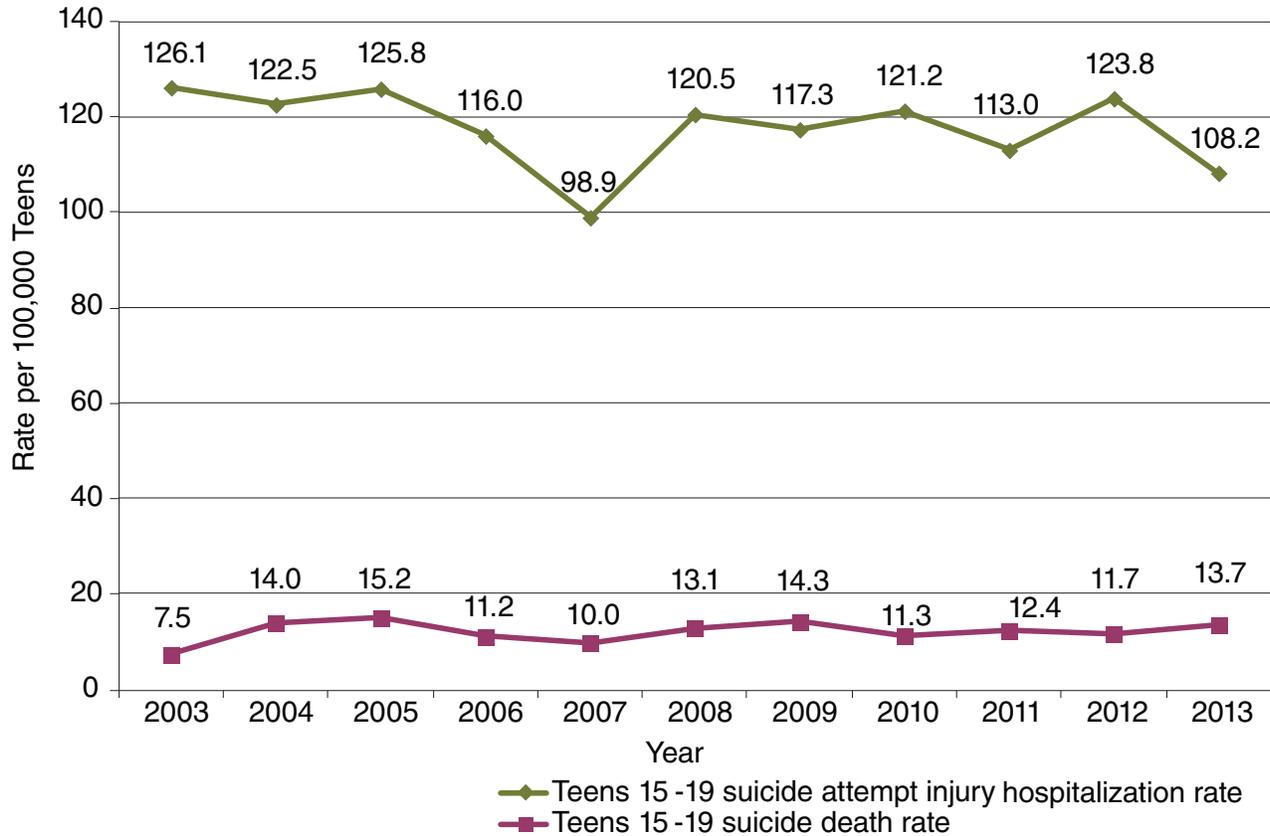
What can prevent mental disorders among children and youth?

Childhood and adolescence are critical periods of emotional, physical, and mental growth and development, making children and youth vulnerable to mental disorders but also capable of building resiliency.¹¹ Individual, family, community and social factors can support children and youth as they develop and protect them from developing poor mental health. Positive influences, such as connectedness, support, and self-efficacy can lessen the effects of stress and trauma, and medication and counseling can be effective treatments for mental health disorders.¹⁰ Data on protective factors such as connectedness and support are quite new. In Colorado, 68.0 percent of high school youth participated in extracurricular activities. Almost half (44.9 percent) of high school youth participated in organized community services as a non-paid volunteer one or more times during the past month. Among high school youth, 81.0 percent reported that they have someone to go to for help with a serious problem.⁷

Spotlight on youth suicide in Colorado.

Adverse childhood experiences, depression, gender, access to lethal means, behaviors considered “high-risk”—such as smoking, drinking, and fighting—and absence of school connectedness are associated with suicide ideation, attempt, or death.^{10,14,15} Resiliency can protect youth from developing mental distress that puts them at higher risk for suicide ideation.¹⁶ Positive peer, parent, or mentoring relationships can build resiliency and provide the emotional support youth need to cope with developmental and life challenges.¹⁶

Figure 8. Youth (ages 15-19) suicide injury hospitalization rates and suicide death rates by year, Colorado, 2003-2013.^{2,8}



Between 2003 and 2013, the suicide attempt injury hospitalization rate among youth ages 15-19 years decreased, but not significantly, and the suicide death rate did not change significantly. The Colorado teen suicide rate in 2013 (13.7 per 100,000) did not meet the Healthy People 2020 target of 10.2 per 100,000.¹⁷

In 2013, the suicide attempt injury hospitalization rate differed significantly between females and males ages 15-19 years (147.3 per 100,000 and 71.3 per 100,000, respectively). Although the hospitalization rate was higher among females, the death rate was higher among males. In 2013, the suicide death rate differed significantly between males and females ages 15-19 years (17.7 per 100,000 and 9.4 per 100,000, respectively).

Data on circumstances and methods for suicides among adolescents is available from the Colorado Violent Death Reporting System. Data from 2008-2011 show that 50.5 percent of suicides among adolescents ages 10-19 involved a current depressed mood and 40.4 percent disclosed intent to commit suicide. Among adolescents, hanging (50.7 percent) was the most common method for suicide followed by firearms (36.3 percent), poisoning (7.9 percent) and other (5.2 percent).¹⁸

Note: Access to mental health screening, referral, and treatment is difficult to measure in Colorado. Some data on access and treatment for the medically indigent population are available from the Office of Behavioral Health at the Colorado Department of Human Services. Data on access and treatment for Medicaid recipients is available from the Colorado Department of Health Care Policy and Financing.



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