Concepts for Improving Mental Health Services for Children and Adolescents

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Imagine this…

- Your daughter is starting 9th grade (high school)
- She had a fight with a boyfriend and all of her friends are on his side.
- She gets despondent, and begins some self-cutting.
- Her grades are going down, her mood is irritable

It doesn’t stop…

- She stays to herself, not even on Facebook anymore
- One evening, you see an open bottle of her mother’s Xanax and she has taken 20 pills, and is out cold on the floor
- You phone EMS, and she goes to the ED
- 12 hours later, she is awake

In the ED….

- You wait many hours for medical clearance and a psychiatric evaluation
- Your daughter is not safe, will not say that she won’t try again, and just doesn’t want to live
- They make an involuntary commitment to the hospital

Where?

- Well, if she is in ECU/Vidant (Greenville), where there is no child psychiatry unit, she goes WHEREVER they find an open bed
- From as close as 90 miles, to as far as Charlotte!
- How does she get there?

Our involuntary process….

- The Pitt County Sheriff is dispatched, perhaps again many hours later
- They transport her, often in shackles/handcuffs because she is potentially dangerous to “hurt herself or others”
- She ends up far from home, sometimes leaving 2 AM and doesn’t see her parents before she leaves

In the rest of the USA

- We conducted an informal survey of 50 states
- We randomly picked two hospitals in each state and asked the ED personnel, “how are kids transported to the hospital?”

The Results

- Police/Sheriff/Some form of law enforcement: 8 states
- Ambulance/EMS: 27 states
- Some of both methods: 13 states
- Private outsourcing of transportation: 2 states
- Virginia: EMS
- SC: Sheriff

Tennessee: Police

Mississippi: Ambulance

Other nations?

- Finland: Ambulance
  Sweden: Police
  Holland: Ambulance
  Norway: Ambulance

Why 90 miles or more away?

- Why the expense of hospital?
- Safety could be found in a less expensive setting
- It could be community based
- The family could be involved in treatment and not travel hours

The Kentucky Model:
Use of Crisis Stabilization Units

- Most regions of the state have had these units for at least 15 years; some adult, some for children
- Eight to Twelve beds
- Wide variety of utilization and length of stay
- There are ten of these for kids

Recent Utilization Data

- Average length of stay: 5.85 days
- Readmission rates (implying effectiveness):
  - 7 days – 2.88%
  - 30 days – 8.83%
  - 90 days – 15.17%

Role of Staff

- Psychiatrist may come 2-3 times/week
- Psychiatrist may evaluate, follow-up on interventions, or provide consultation to staff
- Therapist (LCSW or equivalent) provides crisis intervention, potentially 24 hours per day

Conclusion

- From humane methods of transport to methods that are cost-effective and keep kids closer to home, North Carolina can do better!
- From models in other states to other nations, we can learn much and not reinvent an expensive wheel.

Contact Info

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