Service Paths of Children and Youth Who Access Emergency Mental Health Care

Executive Summary

Study Purpose and General Exploratory Approach
Given great concern about youth who need intensive mental health services, the State Mental Health Planning and Advisory Council requested a study be conducted to explore how and why service needs are and are not met for children and youth who access emergency psychiatric services.[i]

Research Questions
The study addresses the following research questions:

1) What are service pathways prior to and subsequent to the mental health crisis?

2) For those young people who are engaged in mental health services, how are their mental health care needs addressed?

Study Areas and Subject Selection Sites
Two study areas were selected: Denver County (The Children's Hospital Emergency Department) and a rural six-county area of southeastern Colorado (Southeast MH Services, and the Emergency Room services of the Arkansas Valley Regional Medical Center).

Data Collection
The study data were collected from four sources: 1) interviews with agency staff;
2) crisis service logs, 3) interviews with a caregiver of a youth who had received crisis services, and 4) review of clinical charts located at the crisis service facility. Emergency service visits occurred from September 2001 through March 2002 and data about these episodes were collected at least two months subsequent to the crisis event.

FINDINGS

Service Paths
This analysis summarizes client characteristics, and some system-level factors, related to service paths. Figures 1 and 2 illustrate these findings in each site.

Examination of the intensity of services throughout the study period indicates a systematic difference. The Denver study participants were much more likely to be engaged in mental health services immediately prior to a mental health crisis (13 of 18 young people) than the study participants in SE Colorado (2 of 10 young people). Furthermore, in the Denver site children and adolescents had received a substantial amount of services.

Also there were disposition differences between the two geographic sites; in Denver, 10 of the 18 young people were admitted to psychiatric inpatient care. Only two of the ten SE young people were placed overnight into an inpatient bed at the time of crisis stabilization and these two inpatient placements were admissions to general regional hospital units and not to psychiatric inpatient care.

It is notable that a majority of the study participants (19) across sites were engaged in specialty mental health care directly after the crisis stabilization.[ii] In Denver, thirteen of the 18 young people received continuous specialty mental health treatment in the eight weeks following the crisis (72%). Six of the ten SE Colorado young people were engaged in post-crisis specialty mental health treatment (60%).

While the rates of such treatment post-crisis were similar in the two areas, in Denver, almost one-half (6 of 13) of the service-engaged young people were provided residential or day treatment subsequent to the crisis evaluation and disposition. Only one of the six service-engaged young people in the SE area was provided day treatment and not one of these study participants was placed into an RTC or into longer inpatient care at a state psychiatric institute.

There were other qualitative differences in the care delivered at each site. At the point of crisis stabilization, the Denver young people were almost exclusively served by mental health professionals in the emergency office venue. In SE Colorado, crisis stabilization took place in a variety of venues and with a variety of professionals. Additionally, in Denver, the police performed a specific role of initial crisis management, i.e., control and ensuring physical safety, prior to the young person's visit to the emergency service. In the SE Colorado area, the police performed a broader role, often accompanying the young person to the evaluation site and contacting the crisis team about the need for on-going care subsequent to the initial need for behavior control.

While we can identify differences between the two areas, we cannot say whether those differences manifest as a result of an urban/rural effect, (either cultural or differential resource availability outside the systems), characteristics specific to the two systems studied, or different populations served by each area. So while we cannot say *why* there are differences, we can examine the different service paths in each area to identify possible exemplary practices for further evaluation. A key question would be how these differences may relate to outcome.

There are some similarities across both sites regarding young people who were not engaged in post-crisis services within the specialty care systems.
One possible determinant of follow-up is age; of the seven young people who did not follow-through with recommended outpatient services five were aged 15-17. This is not unexpected as older teenagers transitioning into adulthood are notoriously difficult to keep engaged in treatment.

Also, pre-crisis mental health service is associated with post-crisis follow-up services. Of the nineteen young people who had post-crisis services, 13 or 68% had received pre-crisis mental health service as well. Conversely, of the nine young people who had NO post-crisis mental health service, only 2 or 22% had received pre-crisis service.

An examination of the entire four-month crisis episode suggests three relationships between post-crisis service engagement and pre-crisis services:

1) Youth who are involved in pre-crisis specialty mental health care are more likely to be involved in post-crisis mental health care.

2) Youth who are involved pre-crisis in one of three other human service sectors are more likely to be involved in post-crisis mental health care.

3) The crisis event functions as a door to Colorado specialty mental health services and this function may be especially key to service access in rural or community-based systems of care (as distinct from urban or hospital-based systems).

Caregivers' Judgments About Recent Service Paths

Caregivers were asked: if different or additional services had been provided for their young people prior to this crisis event, would these services have prevented the crisis? They were also asked, what aspects of the crisis episode had been most difficult and most helpful for them and their young person? The responses to these interview questions provided judgments about how well the service paths addressed the needs of their young people. Caregivers across the sites voiced the following similar negative and positive themes:

- ⇒ Need for greater accessibility to intensive specialty mental health services
- ⇒ Need for better "service" knowledge and availability of adjunct services
- ⇒ Relief and appreciation for recent crisis and follow-up treatment

Issues for Further Study

The findings about the service paths of these young people and their caregiver judgments describe unmet need in both youth not receiving any services and youth receiving some social services, including specialty mental health. As in all empirical studies, the observations reported here lead to intriguing questions. The questions raised include:

- What are the short and long-term consequences of not receiving post-crisis treatment?
- Does the nature of post-crisis care affect outcome?
- What factors relate most directly to positive outcomes?
- What is the rate of other system involvement subsequent to a crisis?
- To what degree does intensity of services affect process and treatment outcomes?

A final observation is that if the numbers and types of emergency service requests could be observed at additional points in time, the function of the emergency service as a barometer of system functioning might be developed to be used as a routine measure of service delivery systems and could be tested as a predictor of potential unmet service need in Colorado.

There are two crucial points to take from these results. First, there are children and adolescents who have experienced a mental health crisis but who STILL do not become engaged in specialty mental health care subsequent to that emergent need.

Secondly, this study documents that there are young people and families who have been engaged in specialty mental health services, but who STILL have had difficulty accessing services that adequately address their needs. This study has identified some possible factors related to post-crisis care, in addition to identifying areas for further investigation. The issue remains of how the needs of youth and families can be met so that crises may be averted.

Pre and Post Crisis Mental Health Engagement – SE Colorado Site

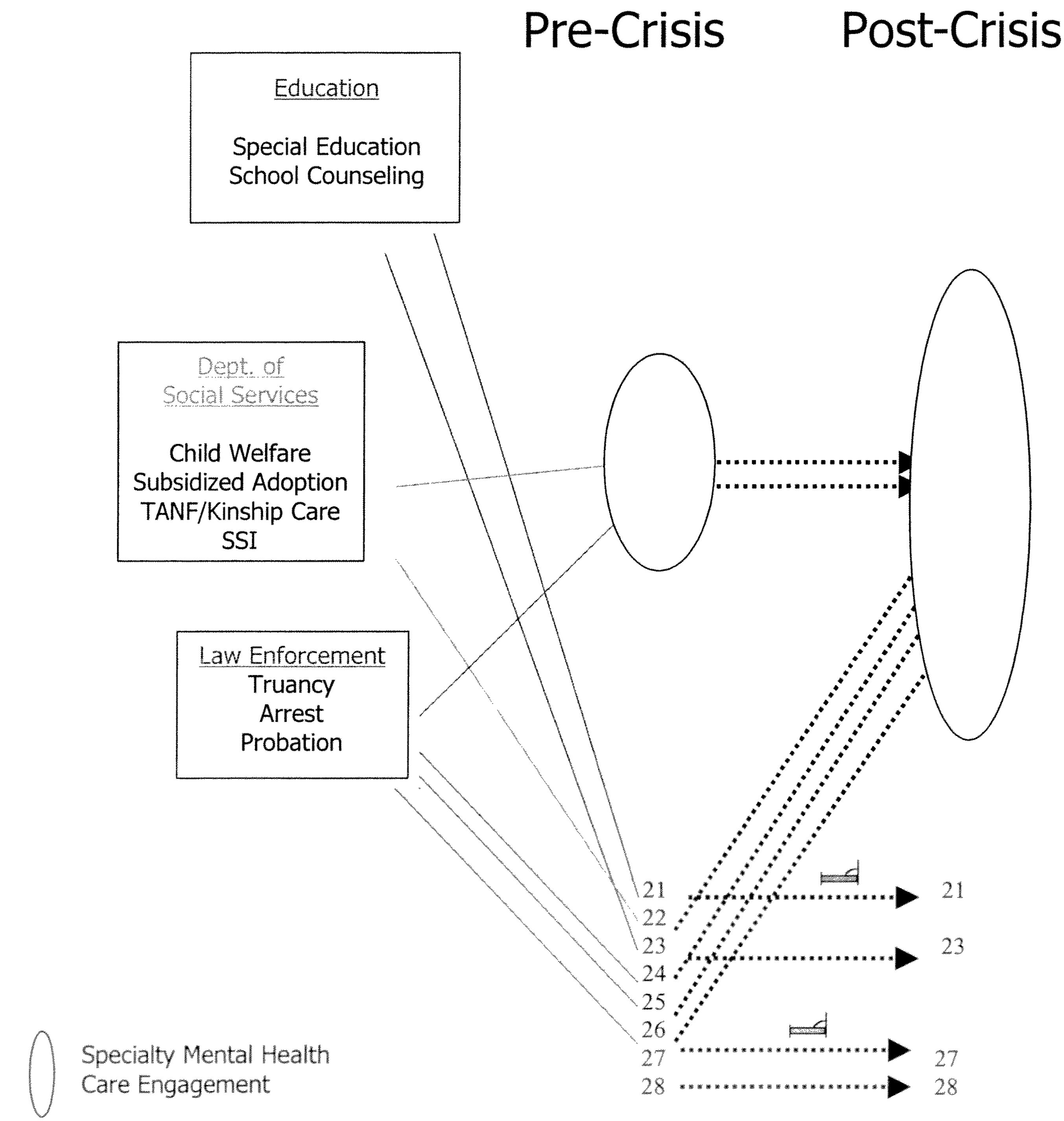
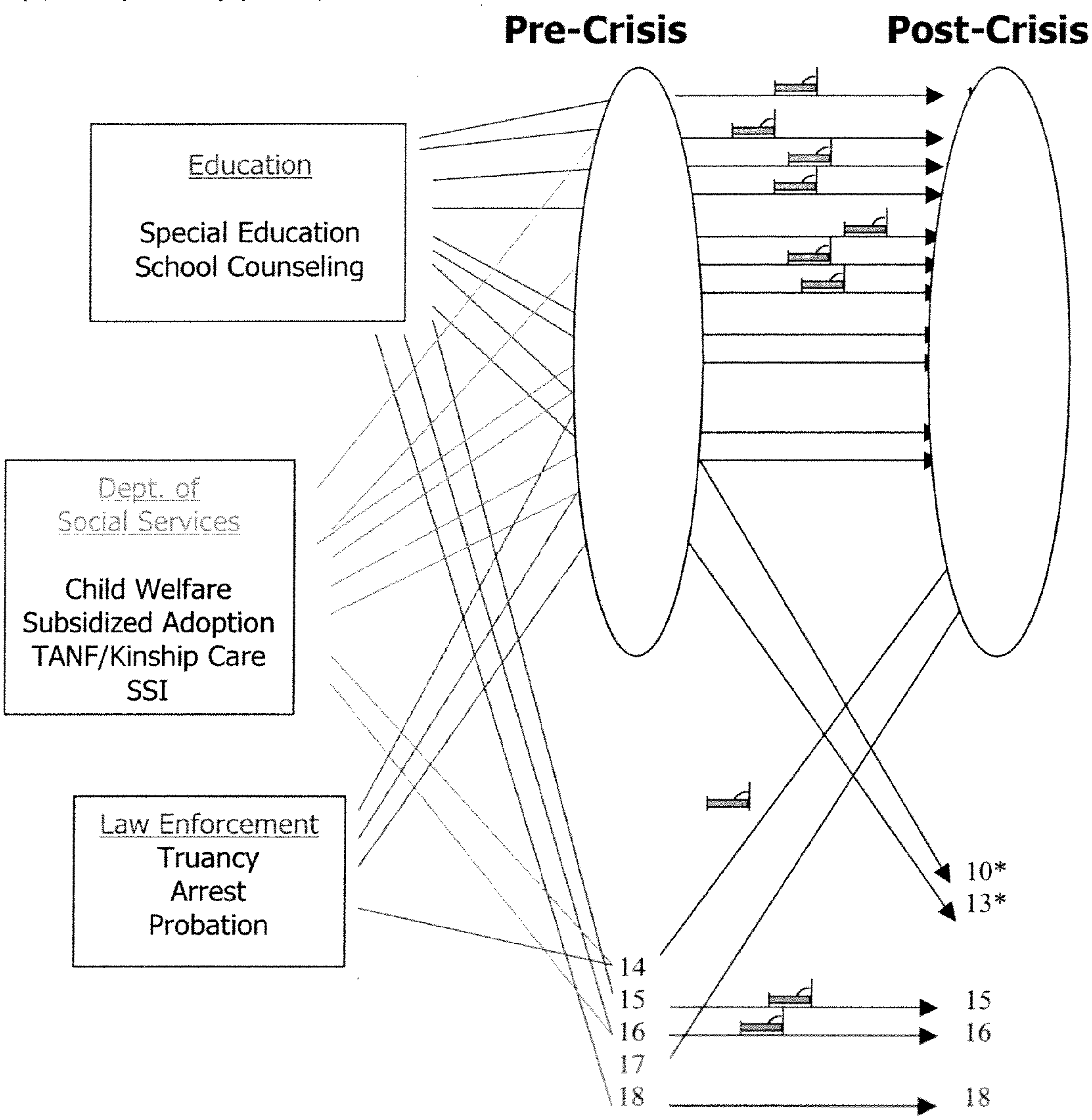


Figure 1

Pre and Post Crisis Mental Health Engagement - Denver Site

Numbers (1,2 etc.)= study participant IDs



Specialty Mental Health Care Engagement

Crisis Disposition = Inpatient Psychiatric Care

Figure 2

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Received Post-Crisis Mental Health
Care "Outside the Clinic Walls"
(pastoral or school counseling)

Numbers (1,2 etc.)= study participant IDs

[i] Initial Request for Study – "Youth in Need of Intensive Services Study" (MHS)

[ii] The method of participant selection could be a factor contributing to this number. Staff of each facility assisted in contacting the potential participants. Families whose young people received post-crisis services might have been more receptive to telephone contact by facility personnel than families who had little contact with the facility after the crisis. Also, contact information may have been updated from the time of the crisis in a client chart if the family had continued to have contact with the facility. Thus, the families subsequently connected tot mental health services may have been more easily contacted than families who had no post-crisis services.