

A woman with blonde hair in a bun, wearing a white short-sleeved shirt and tan trousers, is pushing a child in a wheelchair. The child has blonde hair and is wearing a pink top. The wheelchair is silver with large rear wheels and a smaller front wheel. A white blanket is draped over the back of the wheelchair. The background is a plain, light-colored wall.

# A Review of Acute Child and Adolescent Mental Health Services

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## Main Messages

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- ☞ There are multiple inequities in the mental health resources available to rural and remote communities compared with metropolitan areas.
- ☞ A triage assessment tool has proven beneficial in assisting nurses in the determination, prioritization and assessment of risk for child and youth mental health patients.
- ☞ Community is much preferred by patients over hospital care.
- ☞ Randomized controlled studies comparing community-based with hospital care for patients with severe mental illness who present for acute treatment (as opposed to longer-term care) have shown no advantages for hospital-based services in terms of clinical symptom and social function outcome.
- ☞ Lengths of stay for psychiatric hospitalization for children and adolescents have shortened over the past two decades, yet hospital based care continues to constitute a major segment of youth services.
- ☞ The focus of psychiatric hospitalization has shifted from comprehensive evaluation and treatment to brief intensive intervention.
- ☞ More research is needed to improve our understanding of acute mental health care for youth so that new strategies and policies can enhance the system of providing mental health services to children and adolescents.
- ☞ Psychiatric consultation and liaison have demonstrated improved efficacy of service delivery and cost reduction, yet it remains relatively non-existent as a model in the vast majority of programs.
- ☞ Home based acute care treatment for mental health issues is cost effective, reduces loss to follow up, decreases family strain, and results in greater consumer satisfaction.
- ☞ The rates and use of aftercare services and evidence of their effectiveness has not been well documented or critically examined.
- ☞ The emergency department is often the first healthcare setting to view manifestations of mental health problems in youth. Emergency department use is often the direct result of inadequate availability of outpatient services in the community.

- ☞ Routine standardized screening is needed for mental health conditions in children presenting for emergency care.
- ☞ Specific interventions are required to increase coordination between the emergency department and the larger mental health system.
- ☞ It is imperative to consult users of psychiatric services (family members and young people) and involve them in all aspects of the development and delivery of mental health care.
- ☞ If in-patient units are to survive, it will be necessary to demonstrate what they offer over and above community-based care, and why they are an essential part of child mental health provision.
- ☞ Several models of community-based care that have generated empirical support in the literature, including wraparound, therapeutic foster care, intensive case management, crisis response, and day treatment.
- ☞ Acute care models are challenged due to bias toward addressing emergencies and crisis in a centralized location to where the child and family must be brought for assessment, intervention, or triage.
- ☞ Mental health nurses can be useful for integrating existing mental health knowledge into health care settings.
- ☞ Outcome research of residential treatment in child psychiatry has been plagued by methodological limitations and lack of funding, and has also been limited by the paucity of controlled studies, with the majority of investigations to date being descriptive, having small numbers of children, and being of short term duration.



## Executive Summary

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Psychiatric hospitalization for children and adolescents has shortened significantly over the past two decades, however, hospital care constitutes a major segment of services. Accompanying this has been the shift from comprehensive evaluation to brief intensive treatment. Although inpatient treatment is viewed as one of many services a young person might need or receive for their acute mental health issues, several recent studies indicate that psychiatric hospitalization can be avoided for some children and youth when there is a rich continuum of less restrictive services available in the community.

Review of the peer reviewed literature revealed major thematic areas of study that comprise the essence of this report. These areas include: acute care in rural settings, acute care and mental health nursing, acute care and the mental health liaison team, acute care versus community based treatment, aftercare services and transitions, acute care and the emergency department, and acute care and consumer perspectives.

A range of models and theoretical frameworks are reported in the literature for application of liaison mental health nursing. The common feature of these models is the ability to integrate existing mental health knowledge into new health care settings using advance nurse practitioners. The role of liaison mental health nurse combines elements of mental health consultation, liaison psychiatry, education, supervision, research and clinical care. They operate autonomously as consultants to other nurses within a nursing hierarchy, or as members of a multidisciplinary liaison psychiatry team. Located primarily in acute general care hospitals, there are advantages to the roles they can play in community-based teams. For instance, community mental health nurses are reported to have considerable flexibility in managing their own caseloads so that they can be available for consultation and client assessment when required.

The mental health liaison team is another model of acute care that brings a multidisciplinary approach to mental health services. There is a growing body of literature that supports the importance of consultation and liaison in improving the efficacy of service delivery as well as in reducing costs associated with mental health

care. In spite of this, there is evidence that such liaison is non-existent in the vast majority of programs

There is evidence for the advantage of home-based acute treatment for mental health issues that include cost-effectiveness, reduced loss to follow-up, lower family burden, lower use of inpatient care and greater consumer satisfaction. Certain types of intensive family-based services have been shown to serve as alternatives to hospitalization with clinical outcomes at least equal to hospitalization. Randomized controlled studies comparing community-based with hospital care for acute psychiatric issues have shown no advantages for hospital-based services in terms of clinical symptoms or social functioning.

The literature on hospital discharge in general addresses the critical importance of multidisciplinary collaboration, specifically linkage between hospital and community in the establishment of networks. It has been shown that post-discharge outcomes are significantly improved when planning begins at time of admission. The majority of young people who are hospitalized in psychiatric settings receive at least some mental health services following discharge, however, the lag between hospital discharge and aftercare is rarely studied and it remains unclear how quickly these young people enter services after hospital care.

This review demonstrates that, with respect to all thematic areas identified, a great deal more research is required in order to improve our understanding of acute mental health care for young people. In this manner, new and innovative strategies can be designed to enhance the system of provision of mental health care.



## Scope of the Review & Methodology

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The Central East Regional offices of the Ministries of Children and Youth Services and Health and Long-Term Care jointly support a Hospital Working Group that is charged with developing recommendations for new acute child and adolescent hospital mental health services in the region. This review of the peer-reviewed published literature in acute child and adolescent mental health care was commissioned to assist in the development of the aforementioned recommendations. Specific topics for investigation in this review included the following:

- Roles of acute inpatient and associated outpatient hospital units in a comprehensive child and adolescent mental health system
- Clients requiring and benefiting from admissions to acute inpatient units
- Program and client objectives for acute hospital inpatient units
- Acute hospital lengths of stay in child and adolescent inpatient units
- Variations in lengths of stay and any analysis developed of the implications for practice of lengths of stay
- Staffing models and use of multi-disciplinary teams in acute hospital inpatient units
- Models for outpatient services needed to support inpatient units, including emergency/urgent care services, day treatment/intensive ambulatory services, and transition services
- Client groups, staffing models, program and client objectives for outpatient services
- Models for coordinating and integrating hospital and community based children's mental health services
- Transitioning clients from inpatient to community services
- Options for implementing the transition function

### Review Methodology

The following databases were searched using selected terms: PsycINFO (1985 - October Week 4 2005); EMBASE (1980 to 2005 Week 43); Ovid MEDLINE (1966 to October Week 2 2005); and CINAHL (1982 - October Week 3 2005). Search terms are

reported in Appendix A. Article citations and abstracts identified through electronic database searches and selections were further pared down to those of relevance to this commission. Reference lists of all relevant articles were searched for further relevant studies. Selected articles were read and citations, abstracts, and main messages entered into Endnote software. This comprised the annotated bibliography found in Appendix B of this report. A reference list is also provided at the back of this report that includes additional citations not included in the annotated bibliography. Themes were identified in the literature and are presented in the body of this report.



## Introduction: Acute Child and Adolescent Mental Health Services

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Psychiatric disorders affect a significant number of children and youth across North America, yet most young people with these problems do not receive care (Reder & Quan, 2004). In the epidemiological literature, prevalence rates of at least one psychiatric disorder in community samples of children and adolescents range from 15 to 25 percent. In an internationally recognized study of the prevalence of mental health problems among children in Ontario, Offord and his colleagues (1989) demonstrated that 18.1 percent of children and youth (452,500 individuals) suffered from diagnosable psychiatric disorder in the years 4 to 16, and that two-thirds of those suffered from more than one disorder. Serious emotional disorders are highly disruptive to the child or youth's ability to interact effectively with family, at school, and in the community. These children are diverse: they live in cities, suburbs and rural areas; come from wealthy, middle-class and poor families; and represent every race and culture. The World Health Organization predicts that, by the year 2020, child neuropsychiatric disorders will become one of the five most common causes of morbidity mortality and disability in children (Murray & Lopez, 1996).

Psychiatric in-patient units for children were first created in the United States following World War I, in the wake of the panencephalitis epidemic (American Psychiatric Association, 1957). In 1923, Bellevue Hospital in New York opened the first child psychiatric in-patient unit. Following the epidemic, units became the setting of choice for children with emotional problems who could not be effectively treated on an out-patient basis (Hersov & Bentovim, 1985). In the 1930s, units operated on therapeutic orientations without a medical base, typically inspired by the work of Aichorn (1935) who had applied psychoanalytic principles to the treatment of delinquent boys in Vienna circa 1920. In the 1960s, Redl (1966) emphasized the primary treatment of children by child care workers in the residential environment through the 'life space interview,' a set of verbal interventions initiated in response to events in the child's daily life (O'Loughlin, 1996). This was followed by Whittaker's (1979) child guidance model which emphasized the importance of the treatment team, comprising a psychiatrist, psychologist, and social worker. During this era, both individual and group psychotherapy were perceived to be the primary focus of treatment. Over time, residential treatment programmes based on the principles of

learning theory became more popular as psychoanalytic concepts became more generally challenged within mental health (O'Loughlin, 1996). Behaviourally-oriented programmes shared a focus on the child's overt behaviour rather than inner personality states or intra-psychic conflicts. Behavioural approaches and psychodynamic approaches share an emphasis on the importance of child and family relationships (Johnson, 1982). The psychoeducational model (Hobbs, 1966), stressing the importance of teaching more appropriate behaviours and coping skills to children and adolescents, has also been influential for in-patient psychiatric treatment. This model emphasized community involvement and continued contact between child and family so as to generalize treatment effects to the home environment (O'Loughlin, 1996).

Prior to the 1980s, psychiatric hospital beds for severely disturbed children or adolescents were hard to come by (Nurcombe, 1995). Patients who were successful in finding inpatient care had to contend with limited, restrictive choices: state hospitals (USA), general hospital units, or more rarely, specialized psychiatric units. The aim of long-stay hospital treatment was essentially reconstructive, sometimes custodial. Long-stay hospital treatment has been criticized for leading to stigmatization of psychiatric inpatients, for being over-restrictive, causing disruption to families and estrangement between children and their parents, who were often encouraged not to visit (Nurcombe, 1995).

Since 1980, there has been a rapid increase in the number of hospital psychiatric units for children (O'Loughlin, 1996). Some have speculated that this is due, in part, to changes in funding and an increased reluctance on the part of health care insurers to fund treatment in non-medical settings. There has also been increasing disillusionment with the results of long term residential treatment (Jemerin & Philips, 1988).

The lengths of psychiatric hospitalization for children and adolescents have shortened over the past two decades (Daniels et al, 2004). Also, the focus of psychiatric hospitalization has shifted from comprehensive evaluation and treatment to brief intensive intervention, with discharges from hospitals often occurring as soon as psychiatrically disturbed youths are thought to be stable and to no longer represent an immediate danger to themselves or others. *Brief* hospitalization has been defined as lasting 3 to 5 weeks, with *ultrabrief* hospitalization lasting 1 to 21 days. Most hospital populations today mix brief and ultrabrief lengths of stay (Nurcombe, 1997).

Brief psychiatric inpatient treatment serves the following purposes:

1. Protection
2. Diagnosis and treatment planning
3. Stabilization
4. Preparation for discharge
5. Reintegration to home, school, and community

These aims can usually be achieved in many cases with a length of stay of about one month.

Specific criteria for admission ensure inpatient care is provided to those truly in need because it is expensive, restrictive, and disruptive. The following criteria exemplify inpatient units that typically operate today (Nurcombe, 1991):

1) General Criteria:

- a) The patient is of an age appropriate to a hospital program - typically 4 to 18 years
- b) The patient suffers from a psychiatric disorder for which inpatient treatment is potentially effective;
- c) The patient has had an adequate trial of outpatient treatment, or outpatient treatment would be clearly inappropriate in view of the acuity of the problem;
- d) The patient is physiologically stable (no delirium, coma, stupor).

2) Special Criteria:

- a) The patient is dangerous to him- or herself or others by virtue of suicidal, self-injurious, reckless, interpersonally provocative, assaultive, destructive, or homicidal behaviour;
- b) The patient is unable to protect him- or herself from common dangers or attend to his or her basic needs unless under close observation (e.g., psychosis or organic brain dysfunction);
- c) The patient refuses, or is afraid of taking, adequate fluids or nourishment (i.e., eating disorders, somatoform disorders, dissociative disorders, or paranoid schizophrenia);
- d) The patient refuses to comply with medical treatment for a potentially lethal or deleterious medical condition (e.g., brittle diabetes mellitus, sickle-cell anemia, hemophilia, epilepsy, paraplegia, or cerebral palsy - some patients refuse drugs, diet, or catheterization);

- e) The patient would deteriorate unless he or she were receiving close observation and intensive medical and nursing care.

In North America as in other jurisdictions, such as the United Kingdom, child psychiatric in-patient treatment is subject to scrutiny to a greater extent than ever before. In a review of British child in-patient psychiatric units, Chesson and Chisolm (1996) argue that if in-patient units are to survive, it will be necessary to be clear regarding that which they offer, and why they are an essential part of child mental health provision. Unless arguments for units' survival are supported by detailed, up-to-date information on their functions, treatment processes and outcomes, then purchasers may not be prepared to support these seemingly costly facilities. At the same time, there is a cry for an increase in the availability of acute in-patient care and a concomitant sense of frustration felt by community agencies and emergency room physicians in gaining access to services for urgent and emergent cases (Parker et al, 2003).

It has been suggested that with increased emphasis on shorter periods of hospitalization and no definitive evidence suggesting that there are clear advantages accruing to intensive out-patient treatment (Blotcky, Dimperio & Gosset, 1984; Braun et al., 1981; Hoult et al., 1983), in-patient treatment must be seen as just one of the many services that a child might need or receive throughout childhood and adolescence (O'Loughlin, 1996). It is also clear that the efficacy of in-patient and residential treatment is in doubt (Malluccio & Marlow, 1972, Pumariega & Winters, 2003). More research is need to improve our understanding of the benefits and acute mental health care and the circumstances under which it is the recommended treatment so that new strategies and policies that enhance the system of providing mental health services to children and adolescents can be developed and implemented.

One of the major changes in the delivery of mental health services to children and youth in the last two decades has been the introduction of the system of care model (Stroul & Friedman, 1986). The idea of an integrated and comprehensive continuum of care is thought to address problems with the availability and delivery of mental health services to children and youth. The model envisions the provision of a full range - a continuum -of mental health services, including residential, intermediate, and nonresidential services. A second key principle of the continuum model is that services be provided in the least restrictive environment. Restrictive

services are reserved for when the child/youth or community is in danger (Pumariega & Winters, 2003). Hospitalization is noted to be a key component of this continuum (Stroul and Goldman, 1980), however, there are strong ideological pressures to avoid hospitalization (MacDonald, 1994).

There are several models of community-based care that have generated empirical support in the literature. The *wraparound approach* is a planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes (Burns, Goldman, Faw, & Burchard, 1999). This approach emphasizes individualized and strength-based services, family empowerment, cultural competence, unconditional care, and achievement of outcomes (VanDenBerg, & Grealish, 1996). The use of flexible funding achieves a balance of formal and informal interventions, and an emphasis on nontraditional services such as in-home providers, respite care, therapeutic foster care, and services provided by paraprofessionals (Burchard, Bruns, & Burchard, 2002). With respect to demonstrated effectiveness, studies suggest that nontraditional services (especially case-management, home-based services, and therapeutic foster care) are effective in altering service use outcomes, including change in placements and use of high intensity services such as hospitals (Jensen et al., 1999). A review of several uncontrolled studies of case management using a wraparound approach found emerging evidence for the effectiveness of wraparound, especially in achieving placement stability (Burns et al., 1999).

*Intensive case management* has been demonstrated to be effective for crisis-prone, high risk youth populations (Evans et al., 1994; Evans et al., 1998). Family-centered intensive case management is a team case management approach developed by Evans et al., 1998). This approach uses parent advocates and flexible funding to purchase economic and social supports, along with in-home respite care. The case manager works to support the skills of family members in functioning as the natural case managers for the child or youth. When compared to case management, family case management demonstrated that a greater number of children approved for foster care remained in their homes and had better clinical and functional outcomes than the group placed in foster care (Evans et al., 1998).

*Crisis service models* typically include rapid evaluation and assessment services, crisis intervention services, and follow-up services (Pumariega & Winters, 2003). Crisis service averts the use of emergency room and inpatient services by

intervening immediately and providing intensive treatment for child and family, and linking them with community support services. Traditional crisis services - hotlines, walk-in clinics, and emergency room services, have been replaced by three models of crisis service: mobile crisis team, short-term residential services (often in therapeutic foster home settings), and home-based crisis services.

Mobile crisis services have the advantage of meeting the child and family where the crisis is occurring. Evaluation of mobile crisis in one jurisdiction in the United States has demonstrated a dramatic decrease in inpatient admissions (Kamradt, 2000). In New York, one study has demonstrated prevention of emergency room visits and out-of-home placements (Shulman & Athey, 1993).

Several home-based interventions specifically address the ecological content of children's mental health crisis (Pumariega & Winters, 2003). Such interventions include multisystemic therapy and are reviewed in greater detail further in this report (p.22).

Therapeutic foster home care is a form of foster care that provides intensive support and treatment services in a foster home placement that provides a nurturing environment (Pumariega & Winters, 2003). In this model, foster parents are trained in the emotional and behavioural management of children and youth with severe emotional and behavioural problems. Settings usually taking on only one to two children, and case managers have low caseloads as well. Four randomized controlled studies of therapeutic foster care programs have demonstrated improved behaviour, decreased use of institutional care, and lowered cost compared with other settings for previously hospitalized youth (Chamberlain & Reid, 1991; Chamberlain & Moore, 1998; Clark et al., 1998) Kutash and Rivera (1995) reviewed 18 reports of uncontrolled studies and found that 60% to 90% of youth treated in therapeutic foster homes were discharged into less restrictive settings, and most youth were able to remain in these settings for substantial periods of time.

Day treatment programs are designed as a more intensive option than traditional outpatient services, while less restrictive than inpatient care (Pumariega & Winters, 2003). Often located in schools, hospital, clinics, or other community settings, they offer a range of services including individual, family, and group therapies, behavioural programming, and educational interventions. Frequently, they are used as alternatives to hospitalization for children and youth in crisis who require a significant intervention but can be managed outside of the hospital. Sometimes, day

treatment serves as a transition step from the hospital back to the community setting. Although most studies on day-treatment show positive results, most are uncontrolled (Pumariega & Winters, 2003). Uncontrolled studies show an improvement in youth behavioural symptoms and family functioning, as well as a reduction in the use of more costly and restrictive services (Grizenko et al., 1993; Grizenko et al., 1997).

There are identified barriers and challenges to community-based approaches in child crisis and emergency services. Some of these barriers and challenges stem from practitioners, where there is a noted inertia or bias toward addressing emergencies and crisis in a centralized location to where the child and family must be brought for assessment, intervention, or triage (Pumariega & Winters, 2003). This is due, in part, to real world fears around risks and liabilities. Other resistance stems from lack of practitioner skills in crisis intervention or inability in mobilizing the most experienced clinicians to the field to deal with the most difficult situations. Some of this can be resolved through phone or video consultation, but better training is needed.



## Theme One: Acute Care in Rural Settings

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Families with mental illness who live in rural settings are disadvantaged in accessing tertiary mental health inpatient services (Tan et al, 2004). There has been increasing recognition and political attention to the unmet mental health needs of rural and remote communities (Blackmon & Ranseen, 1997). The inequities of mental health resources available to rural and remote communities compared with metropolitan areas, along with the corresponding maldistribution and shortage of psychiatrist workforce has prompted innovative alternatives within rural health care delivery (i.e., telepsychiatry), but more acute and standard mental health services are needed in rural and remote areas (Anecdotal account, participant, CMHO Summit, 2005).

Habibis et al (2003) suggest that in rural and regional areas characterized by limited resources, community treatment teams cannot be expected to have a measurable impact on consumer outcomes. In these settings hospital care remains at the heart of the service. This means that regions such as these need to focus their community services on what is achievable given the level of resources and social ecology. For example, they may need to consider offering either crisis intervention or rehabilitation services and to rely on innovations, such as telepsychiatry or strategic alliances with other service providers to fill the gap. There are particular challenges to service delivery in the far north where service providers may serve a number of fly-in communities that do not have local acute or standard mental health care.

Telepsychiatry is the use of communications technology to provide psychiatric services from a distance. Telepsychiatry can be used clinically for both assessment and treatment, is effective for case conferencing and consultation-liaison work, and can be incorporated into a range of service delivery models (Hilty et al, 1999). Telepsychiatry can enable rural and remote communities to gain access to psychiatric services as well as provide support for health care professionals in rural and remote locations (Kennedy & Yellowlees, 2000). It has also been shown to be highly satisfactory to both clients of service and practitioners in rural locales (Boydell et al, 2004; Blackmon & Ranseen, 1997).

In addition to the role of telepsychiatry in providing valuable support for the rural and remote GPs and the general nursing staff in their care of psychiatric patients admitted to a distant service, telepsychiatry can also be used for patients admitted to distant, city-based hospitals. For instance, rural patients admitted to a metropolitan hospital can use videoconferencing to link back to their family and health professionals in the rural community for discharge planning, for assessment or for social support. Hoyle and White (2003a) noted that some organizations have utilized a psychiatrist to screen patients by telephone, which effectively increases the geographical area covered by one specialist.

Rural and remote communities face significant barriers in acute and standard mental health care. Expansion of telepsychiatry is but one solution currently being applied, but more research is needed to determine whether it is effective in meeting the acute and standard mental health needs of children and families in Ontario's rural and remote communities.



## Theme Two: Acute Care and Mental Health Nursing

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The role of the nurse within child and family psychiatry has developed since the first residential psychiatric unit for children opened in 1947 and nurses were the major staff group at the time (Paice, 1996). Child and adolescent psychiatric nursing is a recognized nursing specialty, requiring more advanced training (Paice, 1996). Today, there are a range of models and theoretical frameworks reported in the literature for application of liaison mental health nursing (Webster & Harrison, 2004). The common feature of these models is the ability to integrate existing mental health knowledge into new health care settings using advance nurse practitioners (Patterson & Haddad 1992). The role of liaison mental health nurse combines elements of mental health consultation, liaison psychiatry, education, supervision, research and clinical care (Regal & Davies, 1995; Chase et al., 2000). They operate autonomously as consultants to other nurses within a nursing hierarchy, or as members of a multidisciplinary liaison psychiatry team (Egan-Morriss et al., 1994; Minarik & Neese 2002).

Located primarily in acute general care hospitals, there are advantages to the roles they can play in community-based teams (Chase 2000). For instance, community mental health nurses are reported to have considerable flexibility in managing their own caseloads so that they can be available to other services for consultation and client assessment when required (Webster & Harrison, 2004).

Ayliffe and colleagues (2005) have reported on the benefits using a triage assessment tool to assist Ontario-based pediatric tertiary care nurses in the determination, prioritization and assessment of risk for child and youth mental health patients. In-service education was provided for staff to teach them how to use the Triage Tool and to increase their skill and confidence when encountering mental health patients. The emergency clinical instructor taught a core group of RNs and they then provided in-service education for other team members. Crisis intervention workshops were held to help staff feel more confident in handling abusive patients. Printed on the back of the standard triage assessment form, the Mental Health Triage Assessment Tool is conveniently at hand, and when completed when a patient arrives in the unit. It provides information regarding patient risk, which is imperative in providing safe care while the patient waits to be seen by the crisis intervention

worker or physician. Because patients observe the triage nurse completing information on a pre-designed form for patients with *medical* problems, they may feel less threatened when the same is done for them. The Triage Tool has also been found to facilitate the asking of personal questions by nurses who may be reluctant to do so.



### Theme Three: Acute Care and the Mental Health Liaison Team

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The mental health liaison team is another model of acute care that brings a multidisciplinary approach to mental health services. There is a growing body of literature that supports the importance of consultation and liaison in improving the efficacy of service delivery as well as in reducing costs associated with mental health care (Campo et al, 2000). In spite of this, there is evidence that psychiatric liaison teams are virtually non-existent in the vast majority of programs (Campo et al, 2000; Mrazek, 2000).

In the liaison model, psychiatrists and mental health nurses form the core of the team that is further complimented by social workers and psychologists (Shahinpour et al., 1995; Schofield & Amodeo, 1999). In this model, the nurse's role becomes that of a generic mental health worker (Thorncroft, 1999) with the same level of practice and responsibility as the other professional disciplines.

The liaison team functions as a specialized mental health service within non-mental health services, working in close consultation with health professionals in hospital, the community, general practice, and community support services including police. The pediatrician as a key point of care has been identified as an essential component for success (Kanapaux, 2003). The liaison teams provide assessment and co-management of clients, and education of non-mental health staff (Sharrock & Happell, 2000).

We are aware that other children's mental health systems, most notably in British Columbia, are focusing on providing supports for the provision of child and adolescent mental health care from primary care physicians (Jayne Barker, Director Child and Youth Mental Health Policy and Program Support - Ministry of Children and Family Development British Columbia, Personal Communication, 2005). Some investigators recommend that the role of family physician in delivering mental health care can be enhanced if productive and collaborative relationships can be established (Kates et al., 1997). Though not exclusively focused on provision of acute services this initiative acknowledges the fact that physicians have access to a vast majority of children and youth, yet have little knowledge in the area of children's mental health. To actualize this additional support, the British Columbian government has developed tear-off notepads that list evidence-based parenting books to support children and

youth with mental health issues. These pads are made available to all physicians in the province, and the government has ensured that each book is available in all public libraries in the province. In addition, they have provided physicians with a workbook designed for adolescents with depressive symptoms that is based on cognitive behavioural treatment (CBT). This is done with the recognition that CBT is the primary evidence-based approach for depression and anxiety in children and youth, and yet primary care physicians are not trained to provide this method of intervention. With use of the booklet, physicians can provide CBT based support to the patient.



#### Theme Four: Acute Care versus Community-Based Treatment

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Current psychiatric services seek alternatives to hospitalization wherever possible. For example, key decision makers in a community oriented service were able to identify further alternatives to acute ward hospitalization for 29 percent of admissions and for 42 percent of those with admission duration of over 60 days (Beck et al, 1997). Psychiatric hospitalizations are associated with substantial costs and are more restrictive than other forms of care. As such, they are traditionally used when all other kinds of care are unavailable, unsuccessful or when safety is an issue (Arnold et al, 2003). Of critical importance is that community rather than hospital care is much preferred by patients (Tyrer et al., 1998).

There is great potential for intensive treatment programs to provide economical alternatives to inpatient psychiatric treatment for children and adolescents (Blumberg, 2002). Blumberg (2002) evaluated the impact of a crisis intervention program as an alternative use of psychiatric treatment beds for children using a multidisciplinary community-based intervention that included family therapy, psychiatric intervention and school consultations. Findings demonstrated that the program resulted in a 23 percent reduction in the use of psychiatric treatment beds. Tyrer et al., (1998) compared patients randomized to two models of care (aftercare by community teams and hospital based aftercare) and found that outcomes were similar in both treatment modalities. What was different was that those who were involved with the community aftercare teams had fewer admissions to the hospital.

Cost-effectiveness evidence from the United Kingdom also supports home-based acute treatment for mental health issues (Ford et al, 2001). Advantages include reduced loss to follow up, lower family strain, greater consumer satisfaction and lower use of inpatient care. Ford and his colleagues reported on a home-based acute psychiatric treatment service wherein the treatment team was completely integrated with both inpatient and community services and, most importantly, was available to all people requiring acute treatment. Team members were on duty 24 hours a day and on call at night. They were available to visit individuals in their own homes at any time. This home treatment service was developed in an ordinary setting and has been widely implemented in the Birmingham area. Although more people received acute

care when it was available in any location, including people's own homes, the total impact on mental health services was cost neutral. Clearly, the balance of care shifted with an increase in community costs coupled with a corresponding decrease in inpatient costs.

The Daily Living Program (DLP) described by Knapp et al (1994) offered a problem oriented home-based care for individuals facing emergency admission to hospital. The DLP team acted as a direct provider and liaised with other services, with each patient having a key worker. The costs of providing DLP were compared with standard inpatient care in an randomized controlled trial and found to be significantly less costly than standard treatment in both the short and medium term.

In a time of increasing demand on mental health services and continued fiscal constraints, the search for clinically and cost-effective family-based alternatives to institutional placements for children with behavioural and emotional problems and serious mental illness are being sought by a multitude of stakeholders, including decision- and policy-makers, families, and service providers. Several recent studies indicate that psychiatric hospitalization can be avoided for some children and youth when a there a rich continuum of less restrictive services is made available in the community (Bickman et al., 1996), and for children and youth not perceived by hospital personnel as a danger to themselves or others (Evans et al., 1997).

Several published studies have shown that intensive family-based services can reduce rates of hospitalization for children and adolescents presenting serious clinical problems (Amini et al., 1982; Flomenhaf, 1974; Langsley et al., 1968; Winsberg et al., 1980). These studies support the viability of community-based alternatives to hospitalization under certain community conditions and / or for some proportion of those children and youth who are traditionally hospitalized (Schoenwald et al., 2000).

Pediatric mental health literature (Amini et al., 1982; Henggeler et al., 1999) suggests certain types of intensive community-based mental health services can serve as alternatives to hospitalization with clinical outcomes at least equal to hospitalization. Henggeler and Santos (1997) reviewed such models and concluded that effective treatments assume social ecological models of behaviour, provide individualized and comprehensive services in patients' natural environments, are pragmatic and goal-oriented, and include rigorous quality assurance mechanisms.

One can conclude from this literature that an effective alternative to psychiatric hospitalization must be capable of engaging and mobilizing families and

other indigenous resources to address the multiple needs of both the youth and the family (Henggeler et al., 1999). A study of MST (multi-systemic therapy), modified for use with a sample of youths presenting with psychiatric emergencies, found it to be more effective than emergency hospitalization at decreasing youths' externalizing symptoms and improving their family functioning and school attendance.

Hospitalization was more effective than MST at improving youths' self-esteem, and consumer satisfaction scores were higher in the MST condition (Henggler et al., 1999).

Although published randomized trials have demonstrated the capacity of MST to achieve long term (2.5 to 4 years) outcomes with youth with serious antisocial behavior, a more recent study (Henggeler et al, 2003) failed to demonstrate such lasting treatment differences. Although MST was initially more effective than emergency hospitalization and usual services in terms of decreasing youth symptoms and out of home placements, and increasing school attendance, favorable outcomes dissipated, at best, by one year post treatment. As such, time limited interventions are questioned and instead, more intensive evidence based services in addition to less intensive services are posited to meet ongoing needs of youth and their families.

Despite system- and service-level innovations that have increased the array and accessibility of children's mental health services and satisfaction with such services (Bickman, 1996a), hospital-based care continues to constitute a substantive segment of child and adolescent mental health services (Lyons et al., 1997), both in the United States and Canada. Schoenwald and colleagues (2000) surmise that this is likely due to increasingly large number of youths in custody (Glisson, 1994; Lyons et al., 1997; Schoenwald et al., 1996) and the failure of system level reforms (e.g., Stroul & Friedman, 1994) to provide child outcomes that are superior to those delivered by traditional service systems (Bickman, 1996b; Bickman et al., 1997). As such, use of restrictive placement settings will continue to be justified on the basis of their ready availability and the lack of data supporting clinically and cost-effective alternatives. Schoenwald and Henggler's work (1999; 2000) has shown MST to be clinically effective, and, in some communities where in-patient length of stay is longer, also a cost-effective alternative. More research into other alternatives is needed in the field.

#### Outcomes and Re-hospitalization Rates

There has been growing interest in mental health outcomes in the last decade, and with this focus has come particular attention to treatment outcomes for community-based and in-patient mental health care, and to the prediction of re-

hospitalization rates, in part because of the high cost association with hospitalization (Frederick, Caldwell & McGartland Rubio, 2002).

Two types of variables have been identified as predictors of re-hospitalization. Pathway variables are those that “propel” the potential patient toward the hospital and include such variables as age, sex, and social class. Gateway variables are those existing within the hospital environment such as type of diagnosis, hospital admission policies, and previous admission history.

Science and practice has looked long and hard at the issue of reducing hospitalization through the provision of community aftercare. A growing body of research suggests that readmission rates are reduced by aftercare services, including medication, community support and outreach, assertive community treatment (adult literature), case management, and psychotherapy. Frederick et al 2002 for citations, p 467

Because outpatient follow-up has been found to be a strong predictor of re-hospitalization, a number of interventions have been instituted to try to improve outpatient follow-up rates (Frederick et al., 2002). Reducing delays in appointments has been found to be an effective means to reduce failure to keep appointments at a psychiatric day treatment program and public health department (Miyake et al., 1985; Benjamin-Bauman et al., 1984). Telephone prompts also have been found to improve the percentage of initial attendance at a hospital-based outpatient clinic and a community mental health centre (Boswell et al., 1983; MacDonald et al., 2000).

Frederick et al., (2002) sought to identify the rate of ambulatory follow-up after discharge and discharge rates among individuals 6 years of age and older (mean age 22.1 years) who were hospitalized for treatment of mental health disorders in Missouri, USA. Their findings showed that clients who received in-home treatment were 22 times more likely to follow-through with aftercare treatment of more than one visit than were those who did not receive in-home treatment. In-home treatment, age, gender, or previous hospitalization did not significantly predicted the odds of re-hospitalization. They concluded that providing services within the home (i.e., licensed clinician going to the home of the recently discharged patient for purposes of an initial assessment of need and ongoing counseling visits) has the potential to increase attendance in aftercare services among Medicare managed care recipients.

Alternatives to Psychiatric In-Patient Care

Concerns about the cost and effectiveness of psychiatric hospitalization have led to research on alternative models of care. One of these alternative models is crisis intervention. The literature points to three key studies: Systemic Crisis Intervention Program (SCIP; Gustein, Rudd, Graham & Rayha, 1988), Emergency-Room Follow-Up Team (ERFUT: Greenfield, Hechtman & Tremblay, 1995), and Multisystemic Therapy (MST; Henggeler et al., 1999). These interventions were similar in their use of multidisciplinary teams, rapid response to referrals (assessment within 24 hour period), and brief hospitalization was used in two of the programs. All of the programs focused on psychotherapy (individual or family) and all were judged to be effective. In Blumberg's (2002) study of a crisis intervention program in Delaware, USA, for 465 children 2 to 11 years of age (mean age 8 ½ years), only 2.4% were referred for psychiatric hospitalization and 5.8% were referred for residential treatment on the conclusion of the crisis intervention. The remainder of children in the sample were referred for outpatient treatment (78%), or other nonrestrictive services (4.8%), or day treatment services (9%). Comparison of bed use for 1993 and 1998 data yielded a 23% decrease in utilization of psychiatric beds. Economic analysis further showed that the crisis intervention program successfully diverted approximately 2.5 children per day from psychiatric treatment beds during 1996-98. This was equivalent to a cost savings of \$519,840 per year, compared to the cost of the crisis intervention program which was approximately \$500,000. Thus, the program saved approximately \$20,000.

#### In-Patient versus Community-Based Mental Health Care

Randomized controlled studies comparing community-based with hospital care for patients with severe mental illness who present for acute treatment (as opposed to longer-term care) have shown no advantages for hospital-based services in terms of clinical symptom and social function outcome (Fenton et al., 1979; Stein & Test, 1980; Houtt et al., 1983; Muijen et al., 1992). Some of these studies have included an estimate of cost, which reflects the increasing pressure on health care resources and the importance of financial accountability.

Merson et al., (1996) conducted a randomized controlled trial to compare outcome and cost of treatment by hospital and community-based services over a 3-month period in the United Kingdom. They found that ratings of psychopathology improved significantly in both groups over the treatment period, and there were no significant differences in social functioning between the two services. They did find,

however, that the use of in-patient and day-hospital services was greater in the hospital group, whereas patients treated in community settings had no greater use of other medical services. The pattern of service use was also different; whereas all but one of the community group received further clinical contact, only 37 of the 52 allocated to the hospital group did so, as many of them failed to attend out-patient appointments. Fewer patients in the community group received in-patient psychiatric care (15% vs. 31%) and the in-patient stay for those admitted was less than in the hospital group (5 days versus 24). Reduced costs were associated with community treatments for patients representing a range of psychiatric disorders. Both total cost and average cost per patient were considerably less for the community service than for hospital service.

Outcome research of residential treatment in child psychiatry has been plagued by methodological limitations and lack of funding (Quay, 1986). Research has also been limited by the paucity of controlled studies (Curry, 1991), with the majority of investigations to date being descriptive, having small numbers of children, and being of short term duration. There has also been a lack of definitional clarity regarding residential care and in-patient psychiatric treatment (Irwin, 1982). Problems have been rampant in comparing different treatment approaches, settings, and groups (Hersov & Bentovim, 1985).



## Theme Five: Aftercare Services and Transitions

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In the United States, the mean length of stay for hospitalized adolescents decreased from 44 days to 11 days between 1987 and 1997 (National Association of Psychiatric Health Systems, 1987, 2001). Shorter lengths of stay for youths undergoing psychiatric hospitalization are predicated on assumptions that patients and families will have access to and benefit from outpatient mental health and related services in the community. Aftercare services should, in theory, (1) provide a continuity of care for former inpatients, easing the transition from intensive inpatient services to community-based services; (2) assist patients and their families in maintaining and building upon gains made in hospital; and (3) serve a preventive function in reducing the likelihood of additional hospitalization (Goldston et al., 2003).

Yet, discharge from hospital remains one of the most difficult areas for health care professionals to get right (Simons and Petch, 2002). Moreover, inpatient clinicians identify the lack of adequate support and placement opportunities post discharge and its contribution to unnecessary extended lengths of hospital stay (Corrigall & Refaat, 2004). The rates of use of aftercare services and evidence for the effectiveness of these services have not been well documented or critically examined (Daniel et al, 2004). Discharge policies have been developed in certain jurisdictions to assist with this difficult function. For instance, the United Kingdom has developed a number of policy directives over the last decade pertaining to hospital discharge. In particular, a Department of Health (1989) Circular identified three areas considered generic to effective discharge planning: a multidisciplinary approach, discharge planning to be started soon after admission, and involvement of patients and caregivers. More recently, discharge has been accorded a higher profile by the National Service Framework for Mental Health in the United Kingdom (Department of Health, 1999), which states: "each service user who is assessed as requiring a period of time away from their home should have...a copy of a written care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care coordinators, and specifies the action to be taken in a crisis."

Scotland has mirrored these policy directives, creating The Circular on the Discharge of Patients from Mental Illness and Mental Handicap Hospitals (Social Work

Services Group, 1988). This directive stresses the need for close cooperation and good working practices to be maintained between hospital-based workers and those in the community to ensure a smooth transition.

The literature on hospital discharge in general speaks to the importance of multidisciplinary collaboration, linkage between hospital and community and the establishment of networks (Closs, 1997). In fact, Blader (2004) demonstrated that postdischarge outcomes are improved when planning for discharge begins at admission. It has also been recommended that an assessment of patients' needs could aid the discharge planning process and provide health professionals with the specific information relating to individual patients about their needs. Clinicians should examine the risk of rehospitalization before discharge, particularly for younger patients and those with depression (Arnold et al, 2003). Nurses, both hospital- and community-based, are thought to be key players in this process.

Simons and Petch (2002) reporting on the needs of *adult* patients discharged from acute psychiatric wards, as assessed by the Camberwell Assessment of Need (CAN), found that the needs of patients discharged from acute psychiatric units are more complex than first thought, and that the non-psychotic group report a higher number of needs and higher level of unmet needs. The types of needs identified by patients in this study included psychological distress and psychotic symptoms; daytime activities and company; food and transport; budgeting and benefits. It appears more attention is paid to health needs and less to social and functional needs of patients as they leave hospital care. Findings from their needs assessment indicated strongly that family and friends should be involved in the care planning process wherever possible. This suggestion is reiterated in Hospital Report 2004 Mental Health for Ontario (Lin et al., 2005), stating that a discharge plan is a critical component of inpatient care and that patient and family participation in the development of the discharge plan is highly recommended.

Extant studies suggest that a majority of youth who are hospitalized in psychiatric settings may receive at least some mental health services following discharge. Figures from these studies are, however, varied (Daniel et al, 2004; (Goldston et al., 2003). At least two-thirds of children and youth who are hospitalized for suicidality concerns (Cohen-Sandler et al. 1982; Granboulan et al., 2001; King et al., 1997; Pfeffer et al., 1992), depression (Asarnow et al., 1988; Cohen-Sandler et al., 1982), conduct disorder (Zoccolillo and Rogers, 1991), and schizophrenia spectrum

disorders (Asarnow et al., 1988) have been noted to receive mental health services after hospitalization. The same is noted among diagnostically heterogeneous youths in state psychiatric institutions (Parmelee et al., 1995; Solomon and Evans, 1992) and among adolescent suicide attempters in mixed emergency room and inpatient psychiatric settings (Spirito et al., 1992). Although the majority receives some aftercare services, many youths and families have been found to be noncompliant with aftercare recommendations (Daniel et al., 2004).

The lag between hospital discharge and aftercare service has been rarely studied (e.g., Pfeffer et al., 1992), and few studies have examined actual treatment records to establish aftercare service use (e.g., Pfeffer et al., 1992). As such, it is not clear how quickly these youths enter services after hospital care. In addition, it is not clear which factors are related to initial aftercare service use and earlier discontinuation of service use. Although there is at least one model of variables predictive of aftercare service use, it has been rarely studied. Anderson and Newman (1973) described a conceptual model consisting of three classes of variables that are predictive of service access: (1) severity of illness factors - the perception of the patient, family, or experts as to the severity of the illness and need for treatment; (2) enabling factors - the resources of the patient, family, and community that increase the likelihood that patients or families in need of services will be able to seek and access them; and (3) predisposing factors - such as demographic characteristics that may increase or decrease the likelihood that treatment will be considered as a viable option or alternative when the patient faces illness.

In terms of severity of illness factors, we know that internalizing problems such as depression and anxiety often are related to less parental burden and perception of needs than other problems (Angold et al., 1998). Also, youths in the community with depressive disorders but no disruptive disorders have less lifetime use of mental health services than youths with disruptive behaviour disorders (Wu et al., 1999). Suicide attempters are notable for their severe levels of distress and functional impairment (Goldston et al., 1996; Walrath et al., 2001), but it is not clear whether their level of need is associated with greater use of aftercare services (Goldston et al., 2003). Psychiatric comorbidity also has been related to increased treatment use in epidemiological studies of youths (Bird et al., 1993; Rohde et al., 1991) but has not been examined in relation to aftercare service use (Goldston et al., 2003).

Ethnicity is an identified predisposing factor predictive of aftercare service access. African-American and Latino families have been found to have less previous help-seeking for mental health problems, prior to intake in a mental health clinic, compared to Caucasian families (McMiller and Weisz, 1996). Older youths have been found to have more negative help-seeking attitudes than younger youths (Garland and Zigler, 1994) and they may be less likely to remain in services.

Goldston et al., (2003) studied rates of aftercare services and duration of services among 180 adolescents (mean age 14.8years) and found that most adolescents eventually received aftercare services, particularly individual psychotherapy, pharmacotherapy, and family therapy. Moreover, most youths continued to receive aftercare services for several months to years after the services were first accessed. There were, nonetheless, a subset of youths who do not receive timely aftercare services or who discontinue their service use after relatively brief periods of treatment. . Similarly, Arnold and her colleagues (2003) reported that 73 percent of youth in their study received aftercare services within the first month following hospitalization, and 92 percent received aftercare overall. This finding underscores the fact that some youths and families fail to receive needed outpatient services even after a crisis.

Goldston et al.'s (2003) study also found psychiatric comorbidity, repeated suicide attempts and depressive disorders to be related to initial use or length of use of aftercare services. Psychiatric comorbidity in particular was one of the strongest predictors of initial service use and overall length of service use, and it was related to higher levels of initial treatment with medication and longer duration of pharmacotherapy. . Given this, it is alarming that comorbid psychiatric illness has received little attention in the literature on children and adolescents and rehospitalization (Arnold et al, 2003).

With respect to enabling factors, Goldston et al (2003) found that prior treatment and the presence of a biological parent or grandparent in the home were predictive of initial aftercare service use, but not to length of outpatient services. Age of the youth was found to be a predisposing factor such that younger adolescents were more likely to receive pharmacotherapy in the first month after hospitalization and were more likely to remain in their initial outpatient services than older adolescents. It is thought that older adolescents who are initially seen in an emergency room setting are more likely than younger adolescents to have their

subsequent therapy terminated because of non-attendance. Daniel and colleagues (2004) documented that previous recent mental health service use and decreased family dysfunction appeared to be related to aftercare service use.

In a review of 21 studies of outpatient aftercare use among youths, Daniel et al (2004) found that none demonstrated that aftercare services reduce the likelihood of rehospitalization or increased the time between hospitalizations. In addition, findings were mixed regarding whether aftercare use is associated with better outcome in terms of psychiatric symptoms. Aftercare services did appear to be related to substance abuse among youth who have been in substance abuse treatment.

The issue of aftercare for suicidal adolescents has also received some attention in the literature. King et al., (1997) contend that little is known about which patients actually obtain which recommended treatments after brief inpatient hospitalizations. They claim that the relatively low rate of treatment compliance previously documented among adolescent suicide attempters (e.g., Spirito et al., 1989) suggests that the existing array of recommended treatments, or the way in which they are delivered, may not match the needs or resources of many suicidal adolescents and their families.

With respect to rates of follow-up care for suicidal adolescents, Spirito et al., (1992) noted that 9% of suicidal adolescents initially treated in a psychiatric hospital failed to participate in any outpatient treatment. Only 59% of the suicidal adolescents in their psychiatric hospital sample were participating in psychotherapy visits on a regular basis at 3-month follow-up.

King et al., (1997) claim that rapid dropout from treatment may be the rule rather than the exception for suicidal adolescents. They point to the findings of Trautman et al., (1993) on outpatient clinic attendance patterns of 112 suicide attempters (10-18 year-olds) referred for follow-up services during an 18-month period. They report an overall dropout rate of 77%, with a median three visits before dropout. King et al., (1997) reported that two thirds of suicidal adolescents and their parents/guardians reported complete follow-through with recommended medication follow-up sessions, one half reported complete follow-through with recommended individual therapy, and only one third reported complete follow-up with recommended parent guidance/family therapy. Thus, it appears that a small subset of suicidal adolescents obtain no treatment after hospital discharge, while a large subset initial obtain aftercare services but then dropout or discontinue within a relatively short

period of time. One possible explanation, offered by King, is that greater complexity if associated with less follow-through; it is easier to take a pill than it is to travel to an office and discuss personal matters.

Some research has attempted to identify family predictors of suicidal adolescents' post-hospitalization follow-up. Among 66 13 to 17 year-olds who had been hospitalized on an adolescent psychiatry inpatient unit with significant suicidal thoughts, intents, or behaviours, King et al., (1997) found no relationship between SES and follow-through with individual therapy or parent guidance/family therapy recommendations. SES was, however, related to medication follow-through, with lower and lower-middle SES families having higher rates of medication follow-through. Family caregiver structure was unrelated to treatment follow-through. This area of literature points to the importance of understanding how to provide service and work with suicidal adolescents and their families after the crisis is over and hospital discharge has occurred.



## Theme Six: Acute Care and the Emergency Department

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Psychiatric hospitalization for children and adolescents is often necessary when it is determined that their behaviors are acutely dangerous to themselves or those in their environment (Breslow et al, 2000). This is particularly true in communities where intensive, alternative outpatient treatment services are not available (Meunier-Sham; 2003; Causey et al., 1998). In fact, emergency department use is often the direct result of inadequate availability of outpatient services. The number of youth facing mental health issues is increasing, and the emergency department (ED) is often the first healthcare setting to see the manifestation of those issues in youth (Feiguine et al, 2000; Hoyle & White, 2003a; Reder & Quan, 2004). It has also been noted that parents frequently feel that their children must deteriorate prior to receipt of services, rendering their options limited to restrictive levels of care such as hospitals and residential care (Kapanaux, 2003). Feiguine and colleagues (2000) have documented the steady upward trend in pediatric crisis service utilization in the last two decades and suggest that such utilization will continue to increase. It has also been suggested that the actual number of pediatric psychiatric emergencies is underestimated (Hoyle & White, 2003a). In addition, it has been noted that this increase is disproportionately represented by disruptive behavior disorders (Sullivan & Rivera, 2000).

The need to develop beyond the model of basic psychiatric consultation to the medical emergency room was identified in 1980 (Gerson & Bassuk, 1980) with the idea to develop a separate space for the handling of psychiatric emergencies. Before this time, it was routine for a consultant to be summoned from other duties to assess and treat an emergency. This practice was often thought to be a nuisance and frequently was relegated to the most junior member of the team. Common challenges included time pressures and the lack of private space in order to conduct an evaluation. Consequently, separate psychiatric emergency rooms were developed with their own attending staff, separate nursing staff, and space allocated to properly interview a patient (Oldham et al, 1990).

An ED department in Boston responded to the increased volume and length of stay for pediatric mental health patients with a collaborative effort to establish a

system of care and provide a safe environment during the ED visit. This effort produced the identification of emergency guidelines for the management of psychiatric patients in the ED that included a mental health flow sheet (Meunier-Sham, 2003). This resulted in a greater comfort level experienced by nurses vis-à-vis working with this group of patients.

When faced with a pediatric psychiatric emergency, it is critical to immediately assess and intervene to secure the safety of the child or adolescent and address the concerns of the adults who have accompanied the individual (Feiguine et al, 2000). Hoyle and White (2003a) note that assistance from adequately trained clinicians is sometimes unavailable, and patients fail to receive the comprehensive emergency mental health evaluation they need. This may result in scheduling the evaluation at a later date. If the child and family are not engaged, the crisis frequently passes and adequate resolution is forfeited. This is followed by a return to previous status, which can be potentially life threatening. Other issues specific to hospital ED include lack of sufficient social work and mental health staff, lack of mental health and behavioral screening tools, lack of knowledge of available mental health services, and lack of clarity in the ED's role in identification of mental health issues (Reder & Quan, 2004). Consequently, intervention systems should be specifically dedicated to focusing on pediatric psychiatric emergencies.

Hoyle and White (2003a) reported on a multidisciplinary panel examining the issue of pediatric psychiatric emergencies and identified that many obstacles to the effective treatment of pediatric and adolescent mental health emergencies currently exist. Primary among the barriers is the use of widely variable age ranges for the description of mental health problems in the pediatric population. Naturally, the problems of preadolescents are considerably different from those of older adolescents. Data regarding mental health problems in these age groups are grouped together, making it difficult to accurately describe the mental health needs of a specific subgroup of children. One exception is the work of Rice et al (2002) who identified the differences in younger, middle and older children admitted to child psychiatric inpatient services. They found that the family environment is a significant discriminating variable between younger and older children.

Privacy issues and the lack of data linkage across treatment settings also thwart efforts to define, with any degree of accuracy, the scope of mental health problems for these children. Routine screening for mental health conditions in children

presenting for emergency care and effective tools with which to accomplish this screening are missing. A coordinated system for mental health care including emergency medical services, emergency department, and inpatient/outpatient care is sorely lacking. The body of research that does exist is descriptive in nature.

Sullivan and Rivera (2000) detailed the busy inner city Comprehensive Psychiatric Emergency Program located in New York City. The psychiatric emergency department is located adjacent to the medical ED and a psychiatrist is available on a 24 hour basis to evaluate patients. For extremely agitated or violent patients, a trauma team approach is taken, that provides quick evaluation and behavior control. Post evaluation, patients may be delegated to an extended observation unit for up to 72 hours, to mobile crisis unit follow up, or to crisis residence beds. Within this program, the development of a Partial Hospital Program specifically for children and adolescents emerged. This intensive 6 week full day program accommodates young people seen in the emergency who could be stabilized with intensive treatment and not require inpatient admission. The young people served in this program demonstrated an extremely high level of violence to self or others. The program treats 10 to 16 year olds with an intensive behavioral and family focused approach.

A twenty-four hour psychiatric emergency service for children, adolescents and families in north Manhattan described by Feiguine and colleagues (2000) consists of a half time child psychiatrist, a child psychologist, a social work coordinator, social work assistant and masters level psychologist. This crisis service provides emergency assessment and short term treatment services for the targeted population. Same day urgent evaluations are provided for patients referred by local schools and pediatricians, other psychiatric and medical clinics within the hospital, and local community agencies.

In the only Canadian study identified in the area of acute mental health care for children and adolescents, Parker and his colleagues (2003) describe a rapid response model (RRM) developed in order to provide psychiatric services to children and adolescents. In a naturally occurring experiment, the RRM was introduced, withdrawn and restarted. When RRM was withdrawn at one site, it was implemented at another. The RRM reduced night time emergency consultations and inpatient admissions from the ED, while it increased daytime consultations and daytime admissions. The RRM provided timely, organized emergency psychiatric services.

It has been suggested that expanded school programs focused on mental health issues can help to reduce the burden placed on ED's by youth presenting with mental health concerns (Chrsitodulu et al, 2002).

Some attention is now focused on the stresses on clinicians and administrators of working in pediatric crisis services. It has been acknowledged that crisis services represents a highly stressful service delivery system that requires an understanding of psychopathology family systems, crisis intervention strategies, environmental and cultural factors, and requires an acceptance of highly charged situations that are often not easily solved (Feiguine et al, 2000).

Not surprisingly, there is a need for more research to identify the needs of psychiatric patients who present to these crisis services and the development of specific programs to meet those needs. With the exception of the models described above, few studies or models of care are described in the literature, and there are currently no data on their efficacy (Hoyle & White, 2003a). Research efforts that evaluate treatment methodologies for emergency setting application would enhance the knowledge base in the arena of pediatric emergency mental health. In addition, there is a need for additional and improved training for health care professionals in the field of pediatric mental health emergencies (reference).

There is no question that the role of psychiatric emergency services will continue to expand in the future. It is predicted that psychiatric emergency services will become distinct entities in the same way that emergency medical services have. What is critical here is that there is an accompanying system (whether local, provincial or regional) that facilitates coordination between emergency services and mental health communities to ensure the suitable local resources are in place (Hoyle et al, 2003a). This is particularly pertinent as the two disciplines of mental health and emergency care do not communicate effectively between themselves due to lack of a common language and lack of regular interaction. Specific interventions are required to increase the coordination between the ED and the larger mental health system that includes methods for increasing ED staff knowledge of available and accessible mental health services for youth. It has been suggested that this could be facilitated through an online system (Reder & Quan, 2004). Further, increased awareness and education of primary care physicians could lead to earlier mental health referrals, thus avoiding acute presentation to the ED. The availability of pediatric trained mental health workers and social workers for ED consultation have also been identified (Hoyle &

White, 2003a). Cross training of both mental health and emergency service staff in issues of pediatric mental health poses a potential solution. In addition, it is critical to employ some type of a brief screening tool to identify emergency mental health concerns. Without this tool, the mental health needs of many young people will remain unidentified and they may be left untreated and without referrals.



## Theme Seven: Acute Care and the Consumer Perspective

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There is a great deal of work needed to extend the knowledge base regarding the factors that facilitate and impede the identification of mental health issues and the use of mental health services from the perspective of the service sectors and the youth and their families (Hazen et al, 2004). The imperative to consult users of mental health services has been an important theme in efforts to improve a wide range of services in recent years.

### *Family Involvement*

Families have expressed their desire to be involved in all aspects of care for their children, including the formulation, planning, implementation and evaluation of services. They are often responsible for carrying out interventions and require a voice in the identification of what and how services are provided (Singh et al, 2000). Parents want and need to know what to expect at, during and following the psychiatric hospitalization of their child (Scharer, 2003). Unfortunately, families have complained that many mental health services for children fail to be family friendly (Friesen et al, 1992).

Three basic elements characterize family friendly services: family involvement, family empowerment and respect for the cultural characteristics of the family (Singh et al, 1997). These principles also apply to child and youth friendly services. Family involvement in the mental health system has many benefits. It has been identified as a key component in successful outcomes for children with mental health problems (Baker et al, 1995), increased satisfaction with services (DeChillo et al, 1994), and increased family empowerment (Curtis & Singh, 1996).

The ongoing work of the Research and Training Center for Family Supports in Portland, Oregon<sup>1</sup> has contributed largely to best practice in consumer involvement. Despite this remarkable program wherein families are involved in meaningful ways in all aspects of planning, implementation and evaluation, there is relatively little family involvement on inpatient child and adolescent psychiatric units (Singh et al, 2000).

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<sup>1</sup> The Center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders. This goal is accomplished through collaborative research partnerships with family members, service providers, policy makers, and other concerned persons.

Singh and his colleagues (2000) posit that acute services have been less facilitative of family involvement and empowerment. They assessed the family friendliness of the admissions treatment team process at an inpatient child and adolescent psychiatric hospital and found it of variable quality. Overall ratings were low and much room for improvement was identified.

#### *Youth Involvement*

Current developments indicate a burgeoning interest in consulting with young people and involving them in a meaningful way in the development and delivery of mental health services (Street, 2004). As with families, young people themselves can offer significant insights into the services they receive as well as suggest what they want and need from services. While the views of young people are only one factor which must be considered in order to develop effective programs for the assessment and management of mental health problems, they are central as it is likely that young people will not attend or actively participate in programs that they consider irrelevant to their needs. As a result, mental health and other related services can develop in ways that are 'younger person' friendly.

One area where the focus on the 'voice' of young people has been featured is regarding their perspectives on being in hospital for mental health reasons. Causey and his colleagues (1998) highlighted the fact that young people experience a great deal of stress associated with their psychiatric hospital stay. The most stressful issues related to being away from friends and family, not being able to exercise, play or go outdoors, not enough time to visit with others while in hospital, and the fact that doors are often locked. These stresses were shown to act as recovery inhibitors. The authors highlight that involving children in identifying their feelings and understandings of psychiatric hospitalization have important implications for how they respond to treatment.

The report *Turned Upside Down* (Smith & Leon, 2001) highlighted the results of a baseline research project, the goal of which was to develop conceptual models of community-based crisis services for young people aged 16-25. It was carried out in four stages: 1) the identification of existing crisis services, 2) interviews with service providers, 3) an exploration of the views of young people with experience of a mental health crisis, and, 4) identification of a way forward in involving young people with mental health problems in the development of community-based crisis services. A unique feature of this research has been the involvement of 45 young people with

experience of mental health crisis, in sharing both their experiences of crisis and their ideas for new services.

Young people identified a variety of different models of involving users in the development of a community-based crisis service. An important component was the need to have some kind of peer support. This would involve users, or former users, of the services in befriending, advising and supporting young people in crisis. Participants were confident about the capacity of users and former users to do this. They also felt that some support would be necessary, in order not to feel overwhelmed. Another model they identified was to involve users and former users in the actual operation of the services. In this manner, they would cover different roles, depending on their capacity, ability and interests. Ongoing consultation with users was also cited as a way of finding out what young people would like, in order to integrate their views into the development and delivery of services. Participants felt they could be involved in the running of the service in a number of different ways. Ideas included being involved in the recruitment and selection of staff as well as asking young people who are already using the service directly. This would be achieved using a number of activity-based events, alongside focused meetings - and running a support group for young people to discuss issues and suggestions. They were very clear that not all young people would want to be involved, but felt they should be offered the choice. By being involved in these ways, it was felt that self-esteem would be enhanced; experience and knowledge acquired.

Another innovative model of user involvement is the development of a self advocacy resource for young people in adolescent psychiatric units called The Headspace Toolkit. It is available at [www.headspacetoolkit.org](http://www.headspacetoolkit.org) and the aim is to equip young service users with the information and skills needed to express their wishes and feelings and to be able to challenge and make informed decisions about their care and treatment.



## Conclusions

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Research in the area of acute psychiatric inpatient care for children and adolescents is both modest and diffuse, touching on the several theme areas reported within this report. In particular, there is very little Canadian literature in this area, and perhaps one or two Ontario-based studies. Future research in child and adolescent acute psychiatric treatment should rely on more powerful designs, employ more sophisticated measures of children's problems and competencies, and focus on specific treatment components and outcome over time (Curry, 1991). Such research should also bear in mind the evidence that post discharge services are more significantly related to eventual outcome than the degree of disturbance at the point of admission or discharge (Maluccio & Marlow, 1972).

Others have called for research to inform the placement process and to test relationships between child characteristics, treatment experiences, and outcomes (Wells, 1991). Particular emphasis is needed on how children and adolescents are functioning after discharge, and what experiences, once hospitalization is complete, promote and maintain adaptation (O'Loughlin, 1996).

Ontario's system of care for child and youth mental health needs to consider the application and implementation of the evidence-based models of community-based care reviewed in this report. Although they may not result in cessation of inpatient care, their use stands to reduce costs, improve outcomes, and represent a more ecological approach to the mental health treatment of our children and youth. Some of these models are currently in use, i.e., mobile crisis, while others have not been fully taken up in areas where they could be useful. The efficacy and effectiveness (outcomes and cost) of these community-based models will require evaluation as they are applied, or 're-invented' in different regions and communities, and with different types of clinical populations. Multisystemic therapy is in use in particular areas of the province, in selected service provider organizations, and stands to be a good evidence-based intervention for further dissemination, implementation, and uptake for severely disturbed children and youth.

Beyond the themes covered and main messages reported, there is little in the body of literature to assist in the making of recommendations for acute inpatient care

delivery in Ontario. More research is needed, and certain evidence-based models provide good service delivery models for implementation in Ontario.



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## Appendix A - Search Strategies

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### **PsycINFO**

1985 to October Week 4 2005

Search Strategy:

- 1 mental health services/ or exp mental health/ or exp mental health programs/ or psychiatric patients/ or exp mental health personnel/ (56504)
- 2 exp hospitalization/ or hospitalized patients/ or exp hospitals/ (16710)
- 3 1 and 2 (4700)
- 4 exp psychiatric hospital programs/ or exp psychiatric hospital staff/ or exp psychiatric hospitalization/ or exp psychiatric hospitals/ or psychiatric units/ (9591)
- 5 3 or 4 (11306)
- 6 case management/ or discharge planning/ or organizational structure/ or exp decentralization/ or exp work teams/ or exp community services/ or exp community facilities/ or independent living programs/ or outreach programs/ or exp health care delivery/ or "continuum of care"/ or exp health care administration/ or exp health care policy/ or professional consultation/ or consultation liaison psychiatry/ or posttreatment followup/ or aftercare/ or social casework/ or exp policy making/ (56870)
- 7 5 and 6 (1941)
- 8 limit 7 to ((100 childhood <birth to age 12 yrs> or 200 adolescence <age 13 to 17 yrs>) and yr="1995 - 2006") (113)
- 9 from 8 keep 1-113 (113)

### **CINAHL - Cumulative Index to Nursing & Allied Health Literature**

1982 to October Week 3 2005

Search Strategy:

- 1 Mental Health Services/ or Social Work, Psychiatric/ or psychiatry/ or adolescent psychiatry/ or child psychiatry/ or Psychiatric Care/ or exp Psychiatric Nursing/ or exp Psychiatric Patients/ (19086)
- 2 exp hospital units/ or exp hospitals/ or hospitalization/ or transfer, intra-hospital/ or patient admission/ or exp patient discharge/ or adolescent, hospitalized/ or child, hospitalized/ or inpatients/ (74133)
- 3 collaboration/ or multi-institutional systems/ or exp organizational development/ or hospital policies/ or case management/ or exp "continuity of patient care"/ or exp multidisciplinary care team/ or patient centered care/ or After Care/ or exp "Referral and Consultation"/ or Community Mental Health Services/ or management theory/ or models, theoretical/ or exp nursing models, theoretical/ or organizational theory/ or organizational change/ or exp organizational development/ or exp organizational structure/ or shared services, health care/ (60748)
- 4 1 and 2 and 3 (555)
- 5 limit 4 to (infant <1 to 23 months> or preschool child <2 to 5 years> or child <6 to 12 years> or adolescence <13 to 18 years>) (73)
- 6 from 5 keep 1-73 (73)

**EMBASE**

1980 to 2005 Week 43

Search Strategy:

- 1 exp mental health care/ or exp mental health/ or exp Mental Disease/ or exp psychiatry/ or mental patient/ or mental hospital/ or psychiatric department/ (563344)
- 2 hospital organization/ or inter-hospital cooperation/ or multi-hospital system/ (1622)
- 3 1 and 2 (75)
- 4 from 3 keep 1-75 (75)

**Ovid MEDLINE(R)**

1966 to October Week 2 2005

Search Strategy:

- 1 \*mental health services/ or \*emergency services, psychiatric/ or \*social work, psychiatric/ or \*Psychiatry/ (26615)
- 2 adolescent, hospitalized/ or child, hospitalized/ (4949)
- 3 \*adolescent psychiatry/ or \*child psychiatry/ (2766)
- 4 Psychiatric Department, Hospital/ or exp Hospitals/ or exp Hospitalization/ or inpatients/ (212692)
- 5 Hospitals, Pediatric/ (4919)
- 6 patient care management/ or patient care planning/ or case management/ or progressive patient care/ or exp patient care team/ or "continuity of patient care"/ or patient-centered care/ or Aftercare/ or "Referral and Consultation"/ or Comprehensive Health Care/ (113385)
- 7 organizational innovation/ or program development/ or "Process Assessment (Health Care)"/ or regional health planning/ or community health planning/ or regional medical programs/ or exp Multi-Institutional Systems/ or og.fs. (241778)
- 8 (((1 and 2) or (3 and 4)) and 6 and 7) or ((1 or 3) and 5 and 6 and 7) (25)
- 9 \*mental health services/ or \*emergency services, psychiatric/ or \*social work, psychiatric/ or \*Psychiatry/ or \*adolescent psychiatry/ or \*child psychiatry/ (29245)
- 10 adolescent, hospitalized/ or child, hospitalized/ or Hospitals, Pediatric/ (9572)
- 11 \*adolescent psychiatry/ or \*child psychiatry/ (2766)
- 12 Psychiatric Department, Hospital/ or exp Hospitals/ or exp Hospitalization/ or inpatients/ or adolescent, hospitalized/ or child, hospitalized/ (216547)
- 13 patient care management/ or patient care planning/ or case management/ or progressive patient care/ or exp patient care team/ or "continuity of patient care"/ or patient-centered care/ or Aftercare/ or "Referral and Consultation"/ or Comprehensive Health Care/ (113385)
- 14 organizational innovation/ or program development/ or "Process Assessment (Health Care)"/ or regional health planning/ or community health planning/ or regional medical programs/ or exp Multi-Institutional Systems/ or og.fs. (241778)
- 15 ((9 and 10) or (11 and 12)) and 13 and 14 (25)
- 16 9 and 12 and 13 and 14 (233)

- 17 limit 16 to "all child (0 to 18 years)" (48)
- 18 15 or 17 (49)
- 19 limit 18 to yr="1995 - 2005" (22)
- 20 ((9 and 10) or (11 and 12)) and (\*patient care management/ or \*patient care planning/ or \*case management/ or \*progressive patient care/ or exp \*patient care team/ or \*"continuity of patient care"/ or \*patient-centered care/ or \*Aftercare/ or \*"Referral and Consultation"/ or \*Comprehensive Health Care/) (66)
- 21 limit 20 to "all child (0 to 18 years)" (64)
- 22 limit 21 to yr="1995 - 2005" (16)
- 23 \*organizational innovation/ or \*program development/ or \*"Process Assessment (Health Care)"/ or \*regional health planning/ or \*community health planning/ or \*regional medical programs/ or exp \*Multi-Institutional Systems/ (17396)
- 24 ((9 and 10) or (11 and 12)) and (23 or og.fs.) (82)
- 25 limit 24 to "all child (0 to 18 years)" (76)
- 26 limit 25 to yr="1995 - 2005" (24)
- 27 ((1 and 2) or (3 and 4)) and (\*patient care management/ or \*patient care planning/ or \*case management/ or \*progressive patient care/ or exp \*patient care team/ or \*"continuity of patient care"/ or \*patient-centered care/ or \*Aftercare/ or \*"Referral and Consultation"/ or \*Comprehensive Health Care/ or 23 or og.fs.) (117)
- 28 limit 27 to yr="1995 - 2005" (31)
- 29 (1 or 3) and 5 and (\*patient care management/ or \*patient care planning/ or \*case management/ or \*progressive patient care/ or exp \*patient care team/ or \*"continuity of patient care"/ or \*patient-centered care/ or \*Aftercare/ or \*"Referral and Consultation"/ or \*Comprehensive Health Care/ or 23 or og.fs.) (24)
- 30 limit 29 to yr="1995 - 2005" (5)
- 31 8 or 19 or 22 or 26 or 28 or 30 (60)
- 32 mental health services/ or emergency services, psychiatric/ or social work, psychiatric/ or Psychiatric Department, Hospital/ (21920)
- 33 exp hospital administration/ or exp hospitals/ or Psychiatric Department, Hospital/ (253289)
- 34 \*regional health planning/ or \*community health planning/ or \*regional medical programs/ or exp \*Multi-Institutional Systems/ or og.fs. (230039)
- 35 32 and 33 and 34 (1374)
- 36 limit 35 to "all child (0 to 18 years)" (182)
- 37 limit 36 to yr="1995 - 2005" (62)
- 38 37 not 31 (53)
- 39 31 or 37 (113)
- 40 from 39 keep 1-113 (113)



Appendix B - Annotated Bibliography

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**Ayliffe, L., Legace, C., & Muldoon, P. (2005). "The Use of a Mental Health Triage Assessment Tool in a Busy Canadian Tertiary Care Children's Hospital." Journal of Emergency Nursing 31(2): 161-165.**

In an ongoing climate of reorganization and downsizing in Canada, government restructuring dictated that Children's Hospital of Eastern Ontario serve a larger population of child and youth mental health patients. As a result, nurses needed a triage assessment tool to assist in determining priority and risk for these patients. The guidelines on the Mental Health Triage Assessment Tool form helped to assess, prioritize, and direct patients to the most appropriate care provider. Asking personal questions at a busy triage desk is difficult, and yet there is no other way to assess the risk of a psychiatric patient. For confidentiality, when it is crowded at the triage desk or when the patient is agitated or aggressive, the initial assessment is conducted in a nearby assessment room. Patients see the triage nurse completing information on a pre-designed form for patients with medical problems and may feel less threatened when the same is done for them. The Triage Tool also makes it easier for the nurse who is hesitant to ask these personal questions. With this form, the RN is legally covered by properly charting the patient's risk. High-risk patients are marked either "emergent" or "urgent" and are further flagged with an orange dot to indicate priority and to quickly track the patient to the ED physician or crisis intervention worker. These categories include patients with active hallucinations, agitation or violence on arrival, or any current attempts of "self-harm" or suicide.

Main Messages:

- ☞ A tool developed to help the nurse triage the patient as a possible psychiatric patient versus a crisis intervention patient was successful in assessing, prioritizing, and directing patients to the most appropriate care provider.
- ☞ There is no other way to assess risk of a psychiatric patient other than asking personal questions at busy triage desk - triage tool makes it easier for nurse who is hesitant to ask these personal questions.

**Beck, A., Croudace, T. J., Singh, S., & Harrison, G. (1997). "The Nottingham Acute Bed Study: Alternatives to Acute Psychiatric Care.[Article]." The British Journal of Psychiatry 170(3): 247-252.**

Background: Although modern psychiatric services seek alternatives to hospitalisation wherever appropriate, the national trend toward higher bed occupancies on acute psychiatric wards has refocused attention on community-based alternatives and methods of assessing need for acute care.

Method: We surveyed key decision-makers in a community-oriented district service with a low acute psychiatric bed to population ratio, in order to examine alternatives to hospitalisation in a cohort of consecutive admissions over a six-month period.

Results: Alternatives to acute ward hospitalisation were identified for 29% of admissions, and for 42% of those with an admission duration of more than 60 days. Residential options were chosen more often than intensive community support. Simulated bed day savings were considerable.

Conclusions: In a community-oriented service, key decision-makers could identify further alternatives to acute ward hospitalisation, although relatively few non-residential, community support options were chosen. Although this methodology has limitations, data based upon key worker judgments probably have greater local 'ownership', and the option appraisal process itself may challenge stereotyped patterns of resource use.

Main Messages:

- ☞ There is lack of evidence-based guidelines on the appropriateness of admission or discharge decisions.
- ☞ A considerable number of in patients could be cared for in alternative facilities (intensive community support & residential care) to an acute ward.
- ☞ Participation by key decision-makers may constructively stimulate self review and service wide reviews of current hospitalization practices.

**Beecham, J., Chisolm, D., O'Herlihy, A., & Astin, J. (2003). "Variations in the costs of child and adolescent psychiatric in-patient units. British Journal of Psychiatry 183(3): 220-225.**

Background Child and adolescent in-patient care is a highly specialised service, ideally requiring planning at a national level, but there are no routine data collections specifically for these services. Aims To estimate unit costs for child and adolescent psychiatric in-patient units and to analyse the variations in costs between units. Method Data collection alongside a national survey with cost estimations guided by principles drawn from economic theory. Bivariate and multivariate analyses are employed to identify cost influences. Results Fifty-eight units could provide sufficient data to allow calculation of the cost per in-patient day; mean=£197 (s.d.=71.6; 1999-2000 prices). The management sector, type of provision, number of rooms, capacity and location explained nearly half of the cost variation. Conclusions Child and adolescent psychiatric in-patient units are an expensive resource, with personnel absorbing two-thirds of the total costs. Costs per in-patient day vary fourfold and the exploration of cost variations can inform commissioning strategies.

Main Messages:

- ☞ Per diem cost information for specific child and adolescent psychiatric in-patient units can be generated.
- ☞ Higher costs associated with child and adolescent psychiatric units in London are likely to reflect the higher prices paid by providers for staff and other inputs.
- ☞ Child and adolescent psychiatric in-patient services are high-cost, low-volume services for which specific facility-based costs are rarely estimated.

**Bickman, L., Foster, M. E., & Lambert, W. E. (1996). "Who gets hospitalized in a continuum of care:." Journal of the American Academy of Child & Adolescent Psychiatry 35(1): 74-80.**

Objective: To compare children and adolescents hospitalized under a continuum of care with those hospitalized under traditional insurance coverage.

Method: With comprehensive data, logistic regressions were used to predict hospitalization and to identify its determinants.

Results: As expected, the probability of being hospitalized was much higher under traditional care. In addition, the predictors of hospitalization differed by

site. Accuracy of predictions was high.

Conclusions: Different kinds of children were hospitalized under a continuum of care than under a traditional insurance system. Hospitalizations under both systems were highly predictable.

Main Messages:

- ☞ The probability of being hospitalized was much higher under traditional care versus continuum of care model.
- ☞ Different kinds of children were hospitalized under a continuum of care than under a traditional insurance system.
- ☞ Hospitalizations under both systems were highly predictable

**Blackmon, L. A., Kaak, H. O., & Ranseen, J. (1997). "Consumer satisfaction with telemedicine child psychiatry consultation in rural Kentucky." Psychiatric Services 48(11): 1464-1466.**

Forty-three rural Kentucky families who obtained child psychiatry consultation during the initial eight months of the University of Kentucky's telemedicine program completed questionnaires assessing their satisfaction with telemedicine. Respondents were 46 parents and nine children. All respondents reported that they were very satisfied with the consultation; all of the children and 98 percent of the parents reported that they were as satisfied with the telemedicine consultation as with an in-person visit. Few respondents reported nervousness about using the equipment. These results suggest that child psychiatry consultation via telemedicine provides high levels of satisfaction for both children and adults.

Main Messages:

- ☞ The process of psychiatric consultation via video technology in rural communities has met with great child and parent satisfaction
- ☞ The assumed discomfort level with the technology specifically was unfounded

**Blader, J. C. (2004). "Symptom, Family, and Service Predictors of Children's Psychiatric Rehospitalization Within One Year of Discharge." Journal of the American Academy of Child & Adolescent Psychiatry 43(4): 440-451.**

Objective: To investigate predictors of readmission to inpatient psychiatric treatment for children aged 5 to 12 discharged from acute-care hospitalization.

Method: One hundred nine children were followed for 1 year after discharge from inpatient care. Time to rehospitalization was the outcome of interest.

Predictors of readmission, examined via the Cox proportional hazards model, were symptom and family factors assessed at admission, aspects of psychiatric treatment, and demographic variables.

Results: The Kaplan-Meier rehospitalization risk within 1 year of discharge, taking into account known readmissions and censored observations, was 0.37.

Most readmissions (81%) occurred within 90 days of discharge. Four variables contributed simultaneously to predicting readmission risk. More severe conduct problems, harsh parental discipline, and disengaged parent-child relations conferred a higher risk for rehospitalization; these risks were attenuated when parents disclosed higher stress in their parenting roles.

Conclusions: Findings showed that psychiatric rehospitalization of children is common, most likely in the trimester after discharge, and highly related to both child symptoms and family factors measurable at admission. Results

suggest that efforts to improve postdischarge outcomes of children should target the initial period following inpatient care, address vigorously the complex treatment needs of those with severe conduct problems, and aim to improve parent-child relations.

Main Messages:

- ☞ Postdischarge outcomes are improved when planning for discharge begins at admission

**Blanz, B., & Schmidt, M. H. (2000). "Practitioner Review: Preconditions and outcome of inpatient treatment in child and adolescent psychiatry." J Child Psychol. Psychiat. 4(6): 703-712.**

Inpatient care is expensive and should be ideally provided for children and adolescents with the most serious psychiatric disorders. However, only little is known about inpatient treatment, e.g. the factors influencing hospital admission, the content of care in the hospital, the appropriate norms for the duration of inpatient stays, the inpatient arrangements that result in the best outcomes, or connection with necessary aftercare services. There are many methodological problems with existing research. However, it can be cautiously concluded that psychiatric hospitalisation of children and adolescents is often beneficial, particularly if special aspects of treatment are fulfilled (e.g. good therapeutic alliance, treatment with a cognitive-based problem-solving skilled training package, or planned discharge) and aftercare services are available. The continuum-of-care model is promising because it provides opportunities to achieve better integration between inpatient interventions and aftercare services.

Main Messages:

- ☞ Extreme pessimism concerning the response of psychiatrically disturbed children and adolescents to inpatient care does not appear warranted. All follow-up studies reported some positive treatment outcomes, with more than half demonstrating positive long term outcome.
- ☞ Inpatient care is the most expensive component of mental health services and accounts for most mental health expenditure. Compared with adults, children and adolescents have longer hospital stays and cost more to treat.

**Blumberg, S. H. (2002). "Crisis Intervention Program: An Alternative to Inpatient Psychiatric Treatment for Children." Mental Health Services Research 4(1): 1-6.**

This study evaluated the impact of a Crisis Intervention program as an alternative to use of psychiatric treatment beds for young children. A multidisciplinary community-based intervention was utilized, including family therapy, psychiatric intervention, and school consultations. The impact of the service was evaluated in relation to the use of psychiatric treatment beds by the population of children eligible for Medicaid or uninsured. In comparison to an historical control group, the program resulted in a 23% reduction in the use of psychiatric treatment beds. A cost-minimization analysis indicated that in addition to the program reducing the use of psychiatric treatment beds, the cost of treatment was also slightly reduced.

Main Messages:

- ☞ There is great potential for intensive treatment programs to provide economical alternatives to inpatient psychiatric treatment.
- ☞ Data provides support for the use of multidisciplinary community-based

interventions as an alternative to hospitalization.

- ☞ The crisis intervention program provided an effective means of safely treating high risk children while reducing the number of psychiatric treatment beds utilized.
- ☞ For the population served (uninsured children and children with Medicaid), the per capita use of psychiatric treatment beds decreased 23% after the implementation of the crisis intervention program.
- ☞ Treating a child in the crisis intervention program cost 28% of the cost of hospitalizing a child.

**Breslow, R. E., Erickson, B. J., & Cavanaugh, K. C. (2000). "The Psychiatric Emergency Service: Where We've Been and Where We're Going." Psychiatric Quarterly 71(2): 101-121.**

The Psychiatric Emergency Service (PES) has evolved into a separate service with its own space and staff specialized for the handling of psychiatric emergencies. A study of trends in our PES reveals increased need for children's services, issues with managed care and an expansion in the use of the PES as a filter for the mental health system in dealing with substance abuse. Education and research have been added to the missions of the PES and there is strong potential for future development in this area. PESs of the future may be very different, with advances in communication, safety, computerized records and databases. New dilemmas in balancing the patient's right to confidentiality and autonomy against the potential of these advances are bound to occur.

**Main Messages:**

- ☞ The scarcity of resources available to deal with psychiatric problems of children often results in an emergency room visit.
- ☞ The development of a psychiatric emergency service separate from the general emergency service is that it allows staff to become more specialized. This in turn, leads to a 'critical mass' of professional staff that is much better at rendering services to patients in the midst of an emergency.
- ☞ The psychiatric emergency service has strong potential as a locus of education and research.

**Brewer, T., & Faitak, M. T. (1989). "Ethical guidelines for the inpatient psychiatric care of children." Professional Psychology: Research and Practice 20(3): 142-147.**

Recommends concrete procedures for implementing APAs *Ethical Principles* during each phase of psychiatric hospitalization: admission, assessment, treatment planning, intervention and discharge. The multiple needs of parents, child and treaters within the hospital setting are examined. The benefits that derive from meeting clients' ethical rights are reviewed, and procedures for resolving conflicts between treaters and clients are suggested.

**Main Messages:**

- ☞ Children's rights should be addressed at all phases of hospitalisation. Children as young as 9 years can make responsible decisions about uncomplicated treatment issues.
- ☞ Even though children do not have the legal authority to obtain or refuse treatment, knowing what is planned for them and why provides increased respect and a sense of control.

**Campo, J. V., Kingsley, R. S., Bridge, J., & Mrazek, D. (2000). "Child and**

**Adolescent Psychiatry in General Children's Hospitals." Psychosomatics 41(2): 128-133.**

This article characterizes the academic, administrative, clinical service, and fiscal characteristics of departments of psychiatry in traditional children's hospitals to determine the characteristics of fiscally successful programs. A survey of chairs of psychiatry from short-term general children's hospitals was conducted based on 38 questions addressing the descriptive characteristics of their respective departments. The characteristics of psychiatry programs identified as fiscally successful were compared to those of programs that required subsidy. Nine of 45 eligible children's hospitals (20%) did not have a department or section of psychiatry, and surveys were returned by 35 of 36 department chairs (97% response). Considerable variation exists in the academic, administrative, clinical services, and fiscal characteristics of programs, although over half are operating at a deficit. Fiscal success was associated with availability of inpatient and intermediate levels of psychiatric care, better integration of the psychiatry program within the children's hospital, and adequate fiscal information being provided to the psychiatry chair. Additional research regarding the potential of psychiatric services to generate clinical success and cost savings is warranted. Pediatric health care professionals and third-party payers should be educated regarding the relevance of psychiatric services within children's hospitals and in physically ill children.

**Main Messages:**

- ☞ Systematic descriptions of psychiatric services in US hospitals are lacking
- ☞ Approximately 1 in 5 short-term general US children's hospitals do not provide accessible pediatric psychiatric services.
- ☞ Education is needed for administrators and other health care professionals regarding the medical training background of child and adolescent psychiatrists.
- ☞ Growing body of literature highlighting the importance of psychiatric consultation in improving efficiency of service delivery and reducing health care expenditures.
- ☞ C-L services are in deficit in the vast majority of programs.
- ☞ Children's hospitals where there is a broad institutional interest and commitment to a vision of pediatric care based on the biopsychosocial model are more likely to offer comprehensive, integrated and fiscally successful psychiatric services.

**Causey, D.L., McKay, M., Rosenthal, C., & Darnell, C. (1998). "Assessment of hospital-related stress in children and adolescents admitted to a psychiatric inpatient unit." Journal of Child and Adolescent Psychiatric Nursing 11(4): 135-145.**

**Problem.** The assessment of hospital-related stressors experienced by child and adolescent patients on a psychiatric inpatient unit.

**Subjects.** Child and adolescent inpatients (n = 40) admitted to an acute, short-term psychiatric unit.

**Methods.** A newly developed stressor survey was administered to subjects to identify the most problematic stressors. Correlation analyses were used to assess associations between hospital-related stress and adjustment variables.

Findings. Broad domains and specific items of the most problematic hospital-related stressors were revealed. Also, higher levels of hospital-related stress were consistently associated with poorer hospital based adjustment.

Conclusions. Implications for treatment include identifying hospital-related stressors for individual patients and providing interventions to enhance coping.

Main Messages:

- ☞ The stress that young people may experience as a result of psychiatric hospitalization has been largely overlooked or underemphasized as well as the concomitant significant issues that could ease patients' adjustment to the inpatient unit and potentially increase the effectiveness of hospitalization.
- ☞ The most stressful issues related to hospital stay are being away from and missing friends and family, not being able to exercise, play or go outdoors for fresh air, not enough time to visit or talk to friends and family while in hospital, not knowing how long hospitalization will be, locked doors, lack of personal items from home, and being watched. These stresses may inhibit recovery. Children's understanding of psychiatric hospitalization has important implications for how they respond to treatment.

**Chadbra, A., Chavez, G., Harris, E., et al (1999). "Hospitalisation for mental illness in adolescents: risk groups and impact on the health care system." Journal of Adolescent Health 24(5): 349-356.**

**PURPOSE:** To determine the extent and cost of hospitalizations for mental illness among adolescents and to identify differences in acute care hospital use by gender and between racial/ethnic groups. **METHODS:** Analysis of discharge data for adolescents, 10 to 19 years of age (n = 27,595), with a principal diagnosis of mental illness from acute care hospitals in California in 1994. Relative risks (RRs) were calculated by race/ethnicity and gender and stratified by race/ethnicity and payment source. **RESULTS:** Mental illness accounted for 14.8% of hospitalizations in this age group; the mean length of stay was 10.9 days. Total charges exceeded \$300 million. Overall, adolescent boys had a slightly lower risk of hospitalization for mental illness than did adolescent girls (RR = 0.90, 95% confidence interval [CI] = 0.87, 0.92) but a higher risk for certain diagnoses. Overall, nonwhite adolescents had a lower risk of hospitalization for mental illness than did white adolescents: African-Americans (RR = 0.77, 95% CI = 0.74, 0.81), Latinos (RR = 0.32, 95% CI = 0.31, 0.33), and Asians/others (RR = 0.27, 95% CI = 0.26, 0.29). These differences remained significant after stratification by payment source. **CONCLUSIONS:** The risk of hospitalization for mental illness among adolescents varies by specific mental illness and by race/ethnicity. In light of the significant human and financial costs associated with hospitalization for mental illness, further research into the determinants of illness and the options for care is warranted.

Main Messages:

- ☞ Clear disparities exist in psychiatric inpatient utilization by different racial/ethnic groups.
- ☞ There is lower use of inpatient mental health services by minority adolescents.

**Christodulu, K. V., Lichenstein, R., Weist, M., Shafer, M. E., & Simone, M. (2002). "Psychiatric emergencies in children." Pediatric Emergency Care 18(4): 268-270.**

**Objective:** To examine the demographic and clinical characteristics of children using the pediatric emergency department (ED) in a medical center in

Baltimore, Maryland. The rate of admission and length of stay for children who were evaluated in the ED were also examined.

Setting: A large, urban medical center with approximately 15,500 visits per year.

Results: During a 13-month period, more than 600 visits to the ED were made for mental health concerns for children aged 2 to 18 years, with psychiatric visits constituting more than 5% of total visits to the ED. Psychiatric visits averaged more than 5 hours' duration in the ED and involved significant effort by medical staff, with approximately one half of visitors undergoing psychiatric admission. Interviews conducted with the ED staff revealed that addressing psychiatric problems in children is a considerable burden and that there is a general lack of resources within the ED and the surrounding community to respond to the needs of children with psychiatric emergencies.

Conclusion: The challenge in most communities is to build a true system of care that involves proactive and more preventive care in natural settings, such as schools, and coordination and improvement of care for youth with more serious problems.

Main Messages:

- ☞ Among frequent emergency service users, a portion of these patients were seen on multiple occasions within 2 months of their initial visit, suggesting that patterns of recidivism are high within the first 2 months after discharge
- ☞ Pediatric patients with psychiatric concerns visit EDs, many of which have inadequate staff well trained and comfortable with the care of children
- ☞ By providing more preventive and treatment services in the schools, expanded school mental health programs can help reduce the burden placed on EDs by youths presenting with mental health concerns

**Cohen, N., Gantt, A. B., & Sainz, A. (1997). "Influences on fit between psychiatric patients' psychosocial needs and their hospital discharge plan." Psychiatric Services 48(4): 518-523.**

**OBJECTIVE:** The study examined factors that help determine a good or poor fit between the psychosocial support needs of hospitalized patients and the hospital's discharge plan. **METHODS:** The Mount Sinai Discharge Planning Inventory was completed weekly for 494 consecutive admissions to the hospital's adult inpatient psychiatric units. The resources that patients brought with them into the hospitalization in the areas of housing, entitlements, daily activities, and psychiatric treatment were recorded as well as the resources that would constitute an optimal discharge plan. Good or poor fit was operationally defined by the match between the optimal, first-choice plan and the implemented discharge plan. **RESULTS:** One-third of admissions were found to have an optimal fit on admission in all resource categories studied. For patients who entered the hospital with suboptimal resources, discharge planning was significantly more likely to establish clinically relevant psychiatric treatment options and to strengthen daily living activities than to change housing resources. Certain diagnoses and a history of drug abuse, criminality, violence, and treatment noncompliance were associated with poorer fits with first-choice disposition options. **CONCLUSIONS:** The Mount Sinai Discharge Planning Inventory provides a method to systematically evaluate discharge planning by tracking progress toward securing relevant posthospital care and support.

Main Messages:

- ☞ Use of a discharge inventory to identify resources patients bring with them to hospitalization (e.g., housing, entitlements, daily activities, psychiatric treatment) provides a useful method to systematically evaluate discharge planning.

**Corrigall, R. & Refaat, R. (2004). "Integrated in-patient adolescent services [letter]." The British Journal of Psychiatry 184: 455.**

- ☞ It is possible to provide an integrated and comprehensive adolescent in-patient services that includes emergency access.

**Corrigall, R., & Mitchell, B. (2002). "Service innovations: rethinking in-patient provision for adolescents A report from a new service." Psychiatric Bulletin 26: 388-392.**

**AIMS AND METHOD** To evaluate the first 2 years of a new adolescent unit.

**RESULTS** One-hundred and eighteen cases were admitted, with a broad range of diagnoses. Median length of stay was 33 days and 82% of admissions were urgent, of which 70% were admitted on the day of referral. A later study of 27 consecutive cases showed a mean improvement of 25% in the Children's Global Assessment Scale and 40% in the Child and Adolescent version of the Health of the Nation Outcome Scales scores.

**CLINICAL IMPLICATIONS** It is possible to provide an in-patient service for adolescents that includes all-hours emergency access, as well as catering for the full range of severe mental illness and a wide variation in length of stay.

Main Messages:

- ☞ Three main barriers identified to an accessible service: i) overly restrictive admissions criteria - overzealous criteria can readily create an inaccessible service that denies hospital care to those most in need; ii) over reliance on reassessment - no firm evidence that reassessments make any difference to outcome and they delay admission; iii) lack of emergency admission service.
- ☞ Flexible treatment planning around individual need is essential.
- ☞ The lack of adequate support and placement opportunities post discharge is a frequent complain of inpatient providers and contributes to unnecessary prolonged inpatient stays.
- ☞ Contracts with local health authorities with specified bed numbers is a helpful way of providing an adolescent inpatient service.
- ☞ An all hours emergency admission service is a viable model for delivering care.

**Daniel, S. S., Goldston, D. B., Harris, A. E., Kelley, A. E., & Palmes, G.K. (2004). "Review of Literature on Aftercare Services Among Children and Adolescents." Psychiatric Services 55(8): 901-912.**

**OBJECTIVE:** Psychiatric hospital lengths of stay have decreased for children and adolescents, in part because of the presumption that aftercare services in the community are effective and accessible. This review critically examines the literature that pertains to the rates of aftercare service use, the effectiveness of aftercare services, and predictors of aftercare service use. **METHODS:** Studies were selected on the basis of MEDLINE and PsychINFO computer searches, covering the period between January 1992 and August 2003. Reports that were selected (N=21) included data on outpatient aftercare service use among youths who were aged 18 years and younger and who were discharged

from child and adolescent inpatient facilities. RESULTS AND DISCUSSION: A majority of youths received aftercare services after hospitalization, but many youths and families were not fully compliant with aftercare recommendations. Many youths and families continued to receive services up to three months after hospitalization. The literature documents only a small amount of evidence about the effectiveness of aftercare services, but the evidence suggested that aftercare services for youths with substance use problems may have beneficial effects. Few studies examined predictors of aftercare service use and discontinuation, but previous recent mental health service use and decreased family dysfunction appeared to be related to aftercare service use.

Main Messages:

- ☞ In a review of 21 reports, it was found that none demonstrated that aftercare services reduce the likelihood of rehospitalization or increase the time between hospitalizations.
- ☞ Mixed findings exist about whether aftercare service use is associated with better outcomes in terms of psychiatric symptoms.
- ☞ Aftercare service does appear to be related to substance abuse among youth who have been in substance abuse treatment.

**Feiguine, R. J., Ross-Dolen, M. M., & Havens, J. (2000). "The New York Presbyterian Pediatric Crisis Service." Psychiatric Quarterly 71(2): 139-152.**

This paper outlines the structure of the Pediatric Psychiatry Crisis Service at New York Presbyterian Hospital, a service that provides twenty-four hour emergency psychiatric evaluation and intervention to children, adolescents and families in northern Manhattan. Structure and staffing of the service, usage of the service and the presentation of three cases addressing high, moderate and low risk crisis patients are discussed. Finally, future challenges facing the Crisis Service are addressed.

Main Messages:

- ☞ There is a need for systems of intervention specifically dedicated to address pediatric psychiatric emergencies.
- ☞ There has been a steady upward trend in pediatric crisis service utilization.
- ☞ Clinicians must be keenly sensitive to subtle situations, with patient and family, in order to make the appropriate triage disposition.
- ☞ The failure to appropriately assess a pediatric psychiatry crisis situation can result in life threatening situations.
- ☞ Pediatric crisis service clinicians and administrators must always be aware of the stress of their working environment and have appropriate systems in place.

**Ferguson, A. (1997). "Discharge Planning from A to E: Part I." Accident and Emergency Nursing 5(4): 210-214.**

The discharge of patients from hospital has always been a vital part of the nurse's role. The government recognized the need for health personnel to plan effective discharge of patients from hospital and guidelines were produced by the Department of Health in 1989. While these were aimed more at the inpatient than the Accident and Emergency (A & E) attender, many of the recommendations can be applied to the emergency setting. Nowhere more than A & E does this create a management problem for patients, carers and colleagues alike. Those patients that belong to vulnerable groups, the elderly, the homeless, children and the mentally ill require a comprehensive discharge

programme, utilizing the skills and knowledge of a number of community care personnel. Current practices are explored and recommendations made for future management. Part 2 of the study, covering appropriate discharge advice for patients who do not need to reattend the department, will be published in 1998.

Main Messages:

- ☞ A true multi-professional approach must be taken - the quality of discharge management should not rest on one individual.
- ☞ Patients presenting at A and E with a mental condition were unlikely to receive a proper acknowledgement of their need for help (Bell et al, 1991; BJP, 158:554-557)

**Ford, R., Minghella, E., Chalmers, C., Hout, J., Raftery, J., & Muijen, M. (2001). "Cost consequences of home-based and in-patient-based acute psychiatric treatment: Results of an implementation study." Journal of Mental Health 10(4): 467-476.**

Home treatment for acute mental illness is known to have advantages for some service users over hospital-based approaches. Generalisation from short term research studies to sustainable services in ordinary settings has been difficult. A service level and individual matched pairs ( n =58 x 2) study in North Birmingham indicated that home treatment can be developed with neutral cost-consequences. During the 6-week and 6-month follow-up periods users from the implementation team area had higher use of community-based care and lower use of hospital-based care compared to matched users from the control area. The combination of adding a home treatment team and halving the number of inpatient beds was, when compared to a control area, associated with (a) additional numbers of people receiving acute care (b) a lower cost per individual and (c) no difference in overall service cost.

Main Messages:

- ☞ Crisis resolution teams were used indicating that home treatment can be developed with neutral cost consequences.
- ☞ The combination of adding a home treatment team and halving the number of inpatient beds was (when compared to control area) associated with additional people receiving acute care, lower cost per individual, and no difference in overall service cost.

**Foster, E. M., & Connor, T. (2005). "Public Costs of Better Mental Health Services for Children and Adolescents." Psychiatric Services, 56(1): 50-55.**

OBJECTIVE: This study evaluated how improved community mental health services for youths affect public expenditures in other sectors, including inpatient hospitalization, the juvenile justice system, the child welfare system, and the special education system. METHODS: Participants were youths aged six to 17 years who received services through a mental health agency in one of a matched pair of communities. One community delivered mental health services according to the principles of systems of care (N=220). The comparison community delivered mental health services but did not provide for the interagency integration of services (N=211). The analyses are based on administrative and interview data. RESULTS: Preliminary analyses revealed that mental health services delivered as part of a system-of-care approach are more expensive. However, incorporating expenditures in other sectors reduced the

between-site gap in expenditures from 81 to 18 percent. This estimate is robust to changes in analytical methods as well as adjustments for differences between the two sites in the baseline characteristics of participants.

**CONCLUSIONS:** These findings suggest that reduced expenditures in other sectors that serve youths substantially, but only partially, offset the costs of improved mental health services. The full fiscal impact of improved mental health services can be assessed only in the context of their impact on other sectors.

Main Messages:

- ☞ Mental health services delivered as part of a system of care approach are more expensive

**Frederick, S., Caldwell, K., & McGartland-Rubio, D. (2002). "Home-Based Treatment, Rates of Ambulatory Follow-Up, and Psychiatric Rehospitalization in a Medicaid Managed Care Population." Journal of Behavioral Health Services & Research 29(4): 466-475.**

This study reports on the effect of home-based mental health treatment following psychiatric hospitalization on ambulatory follow-up rates and readmission rates in a Medicaid managed care population. Logistic regression models were used to predict the odds of ambulatory treatment after hospitalization and to predict rehospitalization. A consumer who received in-home treatment was 22 times more likely to follow-through with aftercare treatment of more than one visit than were those who did not receive in-home treatment. However, in-home treatment, age, gender, and previous hospitalization did not significantly predict the odds of rehospitalization. While home-based services did not reduce the incidence of rehospitalization, providing services within the home has the potential to increase attendance in aftercare services by Medicaid managed care recipients.

Main Messages:

- ☞ Patients (aged 6-57 years of age) (in managed-care) who received in-home treatment were 22 times more likely to follow-through with aftercare treatment of more than one visit than were those who did not receive in-home treatment.
- ☞ In-home treatment, age, gender, and previous hospitalizations did not significant predict the odds of rehospitalization.

**Gavidia-Payne, S., Littlefield, L., Hallgren, M., Jenkins, P., Coventry, N. (2003). "Outcome evaluation of a statewide child inpatient mental health unit." Australian and New Zealand Journal of Psychiatry 37(2): 204-211.**

**Objective:** To assess the impact of inpatient intervention, provided by a child mental health unit in Victoria, Australia, on a number of key child and family variables.

**Method:** Pre-post test design with a four-month follow up was applied to assess changes across time. Twenty-nine parents, 42 teachers, and 37 referrers provided reports on a series of child, parent, and family functioning measures.

**Results:** Significant improvements in child behaviour and functioning, parenting competency and efficacy, parenting practices, and reduced parental depression were observed over time. Changes in family functioning scores were not significant; however, univariate analysis indicated improvements in two

individual subscales.

Conclusions: There is a lack of studies of the outcome of inpatient interventions of children in psychiatric settings. However, as shown in the present study, improvements in functioning can be detected and obtained with short-term interventions that focus on both children and families.

Methodological shortcomings (i.e. absence of comparison groups) and lack of specificity in intervention variables, however, are difficulties yet to be overcome in evaluation research of inpatient treatment.

Main Messages:

- ☞ There is a need for additional research exploring the outcome of child psychiatric inpatient treatments.
- ☞ Interventions that incorporate both child- and parent-level goals yield desirable outcomes.

**Goldston, D.B., Reboussin, B. A., Kancler, C., Daniel, S. S., Frazier, P. H., Harris, A. E., Kelley, A. E., & Reboussin, D. M. (2003). "Rates and Predictors of Aftercare Services Among Formerly Hospitalized Adolescents: A Prospective Naturalistic Study." Journal of the American Academy of Child & Adolescent Psychiatry 42(1): 49-56.**

Objective: To examine rates and predictors of aftercare use, lengths of service use, and predictors of the duration of aftercare service use among 180 adolescents monitored for up to 8.1 years after discharge from an inpatient psychiatry unit.

Method: Drawing upon the Anderson-Newman model of service use, severity of illness, enabling, and predisposing factors assessed during the hospitalization were examined as potential predictors of service use. Information about outpatient mental health specialty services after hospitalization was assessed repeatedly and verified with treatment records.

Results: Seventy-three percent of adolescents received aftercare within the first month after discharge, and 92% eventually received outpatient services. Fifty-seven percent of adolescents remained in treatment 6 months after initiation of services. Psychiatric comorbidity, prior service use, and presence of a biological parent or grandparent in the home were related to initial service use. Psychiatric comorbidity and history of repeated suicide attempts were related to longer duration, and older age and minority group status were related to shorter duration of aftercare service use.

Conclusions: Most adolescents receive aftercare services, but there are certain groups that are relatively less likely to access or remain in services.

Interventions to decrease the barriers to care in such groups may be beneficial.

Main Messages:

- ☞ Most youths receive outpatient mental health specialty services after hospitalization, and more than half remain these services after initial access.
- ☞ Certain youths, such as those without a biological parent or grandparent in the home and those who were not already in services prior to their hospitalization, were less likely to receive treatment in the first month after discharge.
- ☞ Older youths and minority youths did not remain in services as long as other youths.
- ☞ Research is needed regarding the barriers to care among such groups and ways of reducing these barriers.

**Goren, S. (1997). "Pursuit of the ordinary: Short-Term Inpatient Treatment." Archives of Psychiatric Nursing 11(2): 82-87.**

Short-term inpatient care creates tension between administrative mandates to reduce costs through shortened lengths of stay and staff members' commitment to the philosophy, treatment strategies, and milieu organization associated with extended inpatient care. The attempt to practice as usual within the shortened stay, that is, to do long-term treatment quickly, is bound to fail. Effective short-term care is possible, but only when the culture and treatment approach of the unit are radically altered from those of the traditional model. Short-term inpatient treatment can be understood as the pursuit of ordinary behavior during the inpatient stay. This article offers a set of norms and expectations appropriate for this pursuit.

**Main Messages:**

- ☞ Ten "commandments" of brief inpatient treatment:
  - Staff are the culture carriers - expected to stay longer than the patients
  - Change is expected, recognized and supported -
  - Crossing unit boundaries is facilitated - rapid return to ordinary life
  - Family/Hospital Boundary: The child and family integrated into treatment team as full participants in decision making and discharge planning
  - Hospital/Aftercare Boundary: staff see the unit as part of an interdependent system of services. Contact with follow up services initiated at the time of admission and maintained throughout the inpatient stay.
  - The exclusive therapist/patient relationship is discouraged - as they encourage dependence on the therapist and interfere with recognition of the potential for expertise and support within the family and social network.
  - Enactment of the long term patient role is prevented -
  - Treatment goals are limited to symptom relief and planning aftercare -
  - Intervention is aimed at changing current behavior -
  - The language of change is spoken -
  - Treatment is culture sensitive -
  - Time is valued -
- ☞ Excellent inpatient work can be performed in a brief time period

**Gowers, S. G., & Cotgrove, A.J.(2003). "The future of in-patient child and adolescent mental health services." The British Journal of Psychiatry 183: 479-480.**

This editorial identifies the need for a national plan for in-patient child and adolescent mental health services. It should include a full needs assessment, address as a priority gaps in current provision, and a closer working relationship between service sectors.

**Main Messages:**

- ☞ Models of service provision need to be developed that allow for high levels of cooperation and joint planning between agencies
- ☞ Staffing levels of inpatient services should reflect the training role they currently fulfill and allow for the regular movement of staff into community services
- ☞ Further research is needed to provide an evidence base for different models of

service provision

**Gowers, S. G., & Rowlands, L. (2005). "Inpatient services." Current Opinion in Psychiatry 18(4): 445-448.**

Purpose of review: Inpatient services constitute the most highly specialized child and adolescent mental health provision and cater for the most severe disorders in this age group. In view of a number of mapping and audit initiatives in the UK in recent years and changing influences on admission policies worldwide, it is timely to review their function and effectiveness. Recent findings: Recent attention has focused on describing service configurations and auditing against standards. National surveys of cost, referral processes and patient satisfaction are in progress in the UK. There seems to be an international trend toward a more severe, comorbid and aggressive patient group being admitted to inpatient services. There is a shortage of quality research into clinical outcomes of inpatient treatment, but controlled trials comparing hospital treatment with intensive community management are emerging.

Summary: Inpatient descriptive studies and uncontrolled outcome studies predominate in the literature. Although many children and adolescents benefit from admission to mental health inpatient facilities, the specific advantages of admission over intensive community management are uncertain.

**Main Messages:**

- ☞ Although reports from inpatient services show increasing evidence of good clinical outcomes and family satisfaction with increasingly sophisticated methodologies, uncertainties remain about the benefits of hospital admission over good quality assertive community-based interventions. Little attention is given to possible adverse effects.

**Green, J., Kroll, L., Imrie, D., Frances, F., Begum, K., Harrison, L. & Anson, R. (2001). "Health Gain and Outcome Predictors During Inpatient and Related Day Treatment in Child and Adolescent Psychiatry." Journal of the American Academy of Child and Adolescent Psychiatry 40(3): 325-332.**

Objective: To investigate health gain and its predictors during inpatient and associated day patient treatment.

Method: Consecutive admissions to two inpatient units for children and young adolescents in northwest England were studied (N = 55). Ascertainments were made from multiple perspectives, including family, teacher, clinician, and an independent researcher. Measures were taken at referral, admission, discharge, and 6-month follow-up; health gain was inferred from change scores on measures. Recruitment lasted from late 1995 to 1997; follow-up was completed during 1998. Independent variables tested as predictors included assessments of presenting symptoms, therapeutic alliance, and family functioning.

Results: Significant health gain during hospitalization was found on most measures and sustained to follow-up. There was no symptom change during the waiting-list control condition. Health gain was predicted independently by child and parental therapeutic alliance with the unit early in hospitalization and by preadmission family functioning. Externalizing problems did well if accompanied by good alliance.

Conclusions: Assessment of health gain from multiple perspectives is possible

and valuable. Inpatient treatment has significant therapeutic effect. Predictors for health gain lie in process variables of therapeutic alliance and family functioning rather than presenting symptoms. The results are discussed in relation to clinical practice and future research.

Main Messages:

- ☞ Main treatment gains may often take place during the early weeks of hospitalization, a finding that echoes other findings that length of stay has only a modest association with health gain during hospitalization itself
- ☞ It is practicable to undertake assessment of health gain of child inpatient and related day care from multiple perspectives and that these provide useful additional information to single ratings alone.

**Green, J., Kroll, L., Imrie, D.M.A., Frederica, F.M., Begum, K., Harrison, L., & Anson, R. (2001). "Health Gain and Outcome Predictors During Inpatient and Related Day Treatment in Child and Adolescent Psychiatry." Journal of the American Academy of Child & Adolescent Psychiatry 40(3): 325-332.**

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Conclusions: Assessment of health gain from multiple perspectives is possible and valuable. Inpatient treatment has significant therapeutic effect. Predictors for health gain lie in process variables of therapeutic alliance and family functioning rather than presenting symptoms. The results are discussed in relation to clinical practice and future research.

Main Messages:

- ☞ Significant health gain during hospitalization was found on most measures and sustained to follow-up.
- ☞ There was no symptom change during the waiting-list control condition.
- ☞ Health gain was predicted independently by child and parental therapeutic alliance with the unit early in hospitalization and by preadmission family functioning.
- ☞ Externalizing problems did well if accompanied by good alliance.

**Harbour, A. (2003). "Commentary on the Characteristics of the Detained and Informal Child and Adolescent Psychiatric In-Patient Populations." Child and Adolescent Mental Health 8(3): 135-135.**

**Background:** This project surveyed the use of the Children Act and the Mental Health Act in in-patient child and adolescent mental health services in England and Wales.

**Methods:** Data were collected as a day census from child and adolescent psychiatric inpatient units, questionnaire forms completed by consultant psychiatrists or key-workers. Returns were received from 71 of the 80 units.

**Results:** One hundred and twenty-seven of the 663 patients had been admitted formally, the great majority under a section of the Mental Health Act. Compared with those admitted informally, those admitted formally were older, contained a higher proportion of males and had 'adult-type diagnoses', mainly schizophrenia, mood disorders and personality disorder. The clinical and psychosocial characteristics of formal and informal patients were consistent with these differences.

**Conclusions:** This study provides a timely and useful snapshot of the use of the Acts in this population.

Main Messages:

- ☞ The use of compulsion on young people who have contact with the secondary mental health services is fraught with ethical and practice difficulties and this study does further our understanding of a part of that group.

**Harrington, R., Peters, S., Green, J., Byford, S., Woods, J., McGowan, R. (2000).** "Randomised comparison of the effectiveness and costs of community and hospital based mental health services for children with behavioural." *BMJ* 321(7268): 1047-1050.

**Objective:** To test the hypothesis that a community based intervention by secondary child and adolescent mental health services would be significantly more effective and less costly than a hospital based intervention. **Design:** Open study with two randomised parallel groups. **Setting:** Two health districts in the north of England. **Participants:** Parents of 3 to 10 year old children with behavioural disorder who had been referred to child and adolescent mental health services. **Intervention:** Parental education groups. **Main outcome measures:** Parents' and teachers' reports of the child's behaviour, parental depression, parental criticism of the child, impact of the child's behaviour on the family. **Results:** 141 subjects were randomised to community (n=72) or hospital (n=69) treatment. Primary outcome data were obtained on 115 (82%) cases a year later. Intention to treat analyses showed no significant differences between the community and hospital based groups on any of the outcome measures, or on costs. Parental depression was common and predicted the child's outcome. **Conclusions:** Location of child mental health services may be less important than the range of services that they provide, which should include effective treatment for parents' mental health problems.

Main Messages:

- ☞ There was no difference between community and hospital based care for children and adolescents based on outcome measures or on costs.
- ☞ Community based child mental health services are not necessarily more effective or cheaper than hospital based services

- ☞ The outcomes of children's mental health problems are determined by many other factors, such as parental mental health
- ☞ Child mental health services should provide effective treatment for parental mental health problems
- ☞ The range of mental health services available is more important than where the service is given

**Harrison-Read, P., B. Lucas, B., Tyrer, P., Ray, J., Shipley, K., Simmonds, S., Knapp, M., Lowin, A., Patel, A., & Hickman, M. (2002). "Heavy users of acute psychiatric beds: randomized controlled trial of enhanced community management in an outer London borough." Psychological Medicine 32(3): 403-416.**

Background. Heavy users of psychiatric services, often defined as the population that uses the most beds, consume a large part of the resources used by the whole service, despite being relatively small in number. Any intervention that reduces heavy use is therefore likely to lead to significant savings, and enhancement of standard care using a form of intensive case management akin to assertive community treatment was thought to be a pragmatic strategy for testing in this group.

Methods. The effectiveness of enhanced community management (ECM) was compared with standard care alone in heavy users, who represented the 10% of patients with the highest number of hospital admissions and occupied bed days over the previous 6.5 years in an outer London borough. One hundred and ninety-three patients (aged 16 to 64 years) were randomly assigned to ECM or standard care and their use of services was determined after 1 and 2 years, with assessments of costs, clinical symptoms, needs, and social function made before entry into the study and after 1 and 2 years.

Results. Despite a 2.4 fold increase in community contacts in the study group, there were no significant differences between the two groups in any of the main outcome measures. Small savings on in-patient and day-hospital service costs were counterbalanced by the increased costs of outpatient and community care for the subjects assigned to ECM. Clinical outcome data derived from interviews in two-thirds of the subjects were similar in both groups.

Conclusions. Providing additional intensive community - focused care to a group of heavy users of psychiatric in-patient services in an outer London borough does not lead to any important clinical gains or reduced costs of psychiatric care.

Main Messages:

- ☞ Among heavy users of psychiatric services (ages 16-64 years), there were no differences between an enhanced community management (ECMN) group compared to standard care along with respect to main outcome measures.
- ☞ Savings on in-patient and day-hospital service costs were counterbalanced by the increased costs of outpatient and community care for the subjects assigned to ECM.
- ☞ Clinical outcome data were similar for the two groups.
- ☞ Providing additional intensive community - focused care to a group of heavy users of psychiatric in-patient services in an outer London borough does not lead to any important clinical gains or reduced costs of psychiatric care
- ☞ These findings may not be applicable to pediatric samples.

**Hazen, A. L., Hough, R. L., Landsverk, J. A., & Wood, P. A. (2004). "Use of Mental Health Services by Youths in Public Sectors of Care." Mental Health Services Research 6(4): 213-225.**

The present paper examined the lifetime rates of mental health service use in a representative sample of youths identified as receiving services in at least one sector of care in a publicly funded service system of a large, metropolitan area. Service use was examined in relation to age, gender, mental health diagnostic status, and service sector involvement. Participants were 1,706 youths ages 6-17 years who were active in at least one of the following service sectors: alcohol and drug services, child welfare, juvenile justice, mental health, and special education services for serious emotional disturbance. Structured service use and diagnostic interviews were administered to youths and their caregivers. High lifetime rates of mental health service use were found. Eighty-seven percent of the sample used at least one outpatient service, 45% used at least one inpatient service, and 71% reported use of a school-based service. Youths involved with the mental health and special education sectors had the highest rates of service use. In contrast, youths enumerated from the juvenile justice system tended to have the lowest rates of use. Additional research is needed to refine our understanding of the factors associated with the observed patterns of service use.

Main Messages:

- ☞ Older youth more likely to use inpatient services than younger counterparts who were more likely to have used specialty outpatient services.
- ☞ Additional work needed to extend knowledge regarding factors that facilitate and impede the identification of mental health problems and the utilization of mental health services - from the perspective of the service sectors and youth and their families.

**Henggeler, S., Rowland, M. D., Randall, J., Ward, D. M., Pickrel, S. G., Cunningham, P. B., Miller, S. L., Edwards, J., Zealberg, J. L., Hand, L.D., & Santos, A. B. (1999). "Home-Based Multisystemic Therapy as an Alternative to the Hospitalization of Youths in Psychiatric Crisis: Clinical Outcomes." Journal of the American Academy of Child & Adolescent Psychiatry 38(11): 1331-1339.**

**Objective:** The primary purpose of this study was to determine whether multisystemic therapy (MST), modified for use with youths presenting psychiatric emergencies, can serve as a clinically viable alternative to inpatient psychiatric hospitalization.

**Method:** One hundred sixteen children and adolescents approved for emergency psychiatric hospitalization were randomly assigned to home-based MST or inpatient hospitalization. Assessments examining symptomatology, antisocial behavior, self-esteem, family relations, peer relations, school attendance, and consumer satisfaction were conducted at 3 times: within 24 hours of recruitment into the project, shortly after the hospitalized youth was released from the hospital (1-2 weeks after recruitment), and at the completion of MST home-based services (average of 4 months post recruitment).

**Results:** MST was more effective than emergency hospitalization at decreasing youths' externalizing symptoms and improving their family functioning and school attendance. Hospitalization was more effective than MST at improving youths' self-esteem. Consumer satisfaction scores were higher in the MST condition.

Conclusions: The findings support the view that an intensive, well-specified, and empirically supported treatment model, with judicious access to placement, can effectively serve as a family-and community-based alternative to the emergency psychiatric hospitalization of children and adolescents.

Main Messages:

- ☞ An intensive, well-specified, and empirically supported treatment model, with judicious access to placement, can effectively serve as a family-and community-based alternative to the emergency psychiatric hospitalization of children and adolescents
- ☞ MST was more effective than emergency hospitalization at decreasing youths' externalizing symptoms and improving their family functioning and school attendance.
- ☞ Hospitalization was more effective than MST at improving youths' self-esteem. Consumer satisfaction scores were higher in the MST condition.

**Henggler, S. W., Rowland, M. D., Halliday-Boykins, C, Sheidow, A. J., Ward, D. M., Randall, J., Pickrel, S. G., Cunningham, P. B., & Edwards, J. (2003). "One-Year Follow-up of Multisystemic Therapy as an Alternative to the Hospitalization of Youths in Psychiatric Crisis." Journal of the American Academy of Child & Adolescent Psychiatry 42(5): 543-551.**

Objective: This study presents findings from a 1-year follow-up to a randomized clinical trial comparing multisystemic therapy (MST), modified for use with youths presenting psychiatric emergencies, with inpatient psychiatric hospitalization.

Method: One hundred fifty-six children and adolescents approved for emergency psychiatric hospitalization were randomly assigned to home-based MST or inpatient hospitalization followed by usual services. Assessments examining mental health symptoms, out-of-home placement, school attendance, and family relations were conducted at five times: within 24 hours of recruitment, shortly after the hospitalized youth was released from the hospital (1-2 weeks after recruitment), at the completion of MST (average of 4 months post recruitment), and 10 and 16 months post recruitment.

Results: Based on placement and youth-report measures, MST was initially more effective than emergency hospitalization and usual services at decreasing youths' symptoms and out-of-home placements and increasing school attendance and family structure, but these differences generally dissipated by 12 to 16 months post recruitment. Hospitalization produced a rapid, but short-lived, decrease in externalizing symptoms based on caregiver reports.

Conclusion: Findings suggest that youths with serious emotional disturbance might benefit from continuous access to a continuum of evidence-based practices titrated to clinical need.

Main Messages:

- ☞ Four published randomized trials have demonstrated the capacity of MST to achieve long-term (i.e., from 2.4 years to 4.0 years) outcomes with youths with serious antisocial behavior. In contrast with expectations, this first MST study with a predominantly mental health population did not achieve such lasting treatment differences. At best, favorable outcomes dissipated by 12 months post treatment.
- ☞ Based on the hospitalization rate of youths in the MST condition, it is fair to say

that home-based MST alone will not be sufficient.

- ☞ In light of the chronicity and complexity of the problems experienced by the youths and key family members, time-limited interventions will not often be adequate.
- ☞ More intensive evidence-based services, as well as less intensive (e.g., an outpatient model) services, are required to meet the ongoing mental health needs of these youths and their families.

**Ho, T.-P. & Luk, C. (1997). "Comparison of Child Psychiatric Patients in Hospital and Community Clinics in Hong Kong." General Hospital Psychiatry 19(5): 362-369.**

This is a prospective study comparing a consecutive sample of child psychiatric patients at a community child mental health clinic (N = 56) and hospital clinic (N = 42) in Hong Kong. The subjects and their parents were studied with standardized questionnaires and semistructured interviews at their first visits to the clinics. A review of the treatment received was conducted 15 months later. Across settings, subjects were similar in sociodemographic profile, degree of social adversity, number of preceding life events, duration of chief complaints, maternal psychopathology, parental explanatory models of the child's problems, and expectations in treatment. Community clinic attenders had more disruptive behavioral problems, received shorter treatment, and less inpatient care than hospital clinic attenders. Subjects in both settings had very similar previous help-seeking behaviors. The findings suggested that the community clinic attracted disturbed children of similar backgrounds. The community child mental health clinic appeared to be a viable alternative in providing psychiatric care to children in Hong Kong.

**Main Messages:**

- ☞ In a pediatric population in Hong Kong, community clinic attenders had more disruptive behavioral problems, received shorter treatment, and less inpatient care than hospital clinic attenders.
- ☞ Subjects in both settings had very similar previous help-seeking behaviors.
- ☞ The findings suggested that the community clinic attracted disturbed children of similar backgrounds.
- ☞ The community child mental health clinic appeared to be a viable alternative in providing psychiatric care to children in Hong Kong.

**Hoyle, J. D., & White, L.J. (2003a). "Pediatric mental health emergencies: Summary of a multidisciplinary panel." Prehospital Emergency Care 7(1): 60-65.**

The World Health Organization has estimated that by the year 2020, neuropsychiatric disorders will become one of the five most common causes of morbidity, mortality, and disability among children (U.S. Department of Health and Human Services. HHS Fact Sheet on Mental Health Issues. www.hhs.gov. 2001). This is a distressing statistic, particularly when many of the mental health disorders are preventable and/or treatable with good prognosis. Children's mental health services and access to them are inconsistent within the United States. The National Institute of Mental Health reports that although 10% of our nation's children currently suffer from mental illness, only one-fifth of these children receive necessary treatment. (National Institute of Mental Health. Brief notes on the mental health of children and adolescents. Bethesda, MD: National Institute of Mental Health, 1999). The purpose of this

article is to present summary information from a national consensus conference regarding the current state of emergency mental health resources for children and adolescents. The intended audience includes community health care providers, emergency care workers, and researchers. Major issues explored in this paper include the questions: Are emergency mental health services for children and adolescents readily available in communities? Is access to care possible for all children? Are resources and services in place to ensure that the mental health needs of this vulnerable population are not neglected? The authors would like to see the development of local, regional, and national systems that facilitates coordination between emergency medical services (EMS), emergency medicine, and mental health communities to ensure appropriate local resources are in place and to allow the emergent identification and treatment of mental health needs in the pediatric and adolescent population. Key words: pediatrics; mental health; children; adolescents.

**Hoyle, J. D., & White, L.J. (2003b). "Treatment of pediatric and adolescent mental health emergencies in the United States: Current practices, models, barriers, and potential solutions." *Prehospital Emergency Care* 7(1): 66-73.**

Mental illness significantly impairs the lives of 10% of all children and adolescents in the United States (National Institute of Mental Health. Brief Notes on the Mental Health of Children and Adolescents. Bethesda, MD: National Institute of Mental Health, 1999). Of the myriad mental health problems afflicting children, an alarming number are known to have grim outcomes. Some illnesses continue into adulthood, while others may culminate in death during adolescence. Despite the serious consequences of children's mental health problems, early treatment can improve or control these conditions. Even with this knowledge, seemingly little effort is geared toward removing barriers to treatment for these diseases that plague our children. As a part of its five-year plan, Emergency Medical Services for Children (EMSC) has collaborated with the National Association of EMS Physicians (NAEMSP) to examine childhood and adolescent mental health emergencies-particularly their presentation and management within the emergency medical services system. This document presents a critical review of current practices and models for treatment of children and adolescents that includes identification of barriers to mental health treatment and recommendations for their resolution.

Main Messages:

- ☞ There are a considerable number of children and youth with mental health problems who make their first connection to medical treatment through the emergency medical services system.
- ☞ Adolescents more frequently use prehospital care than younger pediatric patients.
- ☞ The actual number of psychiatric emergencies is likely underestimated.
- ☞ There is a paucity of published material regarding the emergency management and treatment of pediatric psychiatric emergencies. Lack of definition of the extent of the problem.
- ☞ The index emergency department visit is a primary opportunity for intervention with a child at risk for major depression or suicide.
- ☞ Few studies or models of care are described in the literature. Nothing on their efficacy...

- ☞ In a program described by Sullivan and Rivera (Psychiatr Q, 2000, 71,123-8), the psychiatric emergency department is located adjacent to the medical ED and a psychiatrist is available on a 24 hour basis to evaluate patients. For patients who are extremely agitated, or violent, a trauma team approach is taken which provides rapid evaluation and control of such behavior. Following a thorough evaluation, patients may be assigned to an extended observation unit for up to 72 hours, to mobile crisis unit follow up, or to crisis residence beds.
- ☞ The ED practitioner frequently relies on a consultant (psychologist, social worker, psychiatrist) to perform evaluation. When assistance from adequately trained personnel not available, many patients do not receive the thorough emergency mental health evaluation they need. Patients are often scheduled for evaluation at a later date which may not be best practice for these patients.
- ☞ Need to recognize the importance of pediatric mental health emergencies by emergency care practitioners is key to improving treatment, availability, accessibility of resources.
- ☞ Treatment of pediatric emergency mental health disorders would benefit tremendously from enhancement of research efforts designed to elucidate and an evaluate treatment methodologies for application in the emergency setting.
- ☞ Improved training for health care professionals regarding pediatric and adolescent mental health emergencies is needed.

**Jaffa, T., & Percival, J. (2004). "The Impact of Outreach on Admissions to an Adolescent Anorexia Nervosa Inpatient Unit." European Eating Disorders Review 12(5): 317-320.**

Patients from outside the local South Cambridgeshire area are, on discharge, referred back to their own local Child and Adolescent Mental Health Services (CAMHS). This caused problems of lack of continuity of care. Complaints from patients and families were frequent. Local services at times found it difficult, for resource or other reasons, to continue the work started at the Phoenix Centre, a UK National Health Service facility for teenagers with eating disorders. Too often, patients appeared to manage with the high level of support received at the centre but deteriorated quickly on discharge. The development of an outreach services from a UK National Health Service inpatient unit for teenagers with anorexia nervosa seems to contribute to a reduced need for admission. This finding may have implications for other eating disorder services.

Main Messages:

- ☞ Inviting referrers, local professionals, patients, their families, and relevant members of the Phoenix Centre team to review meetings held every 4 weeks throughout the inpatient unit were useful but not sufficient to address the problem.
- ☞ They instituted a program of progressively increasing home leaves. Beginning a few weeks after admission and extended until such time leading up to discharge patients were spending much of their time at home and school and could also attend appointments at their local CAMHS. Still these measures were not enough.
- ☞ New monies were used to develop an outreach service that would serve to improve linkages with local CAMHS.
- ☞ A growing number of cases on the waiting list and supported by the outreach

resource team in the interim, have not required the bed when it becomes available.

- ☞ Outreach staff can, in bridging the gap between inpatient unit and community services, help prevent the need for admission in some cases referred for this purpose.
- ☞ Why does this work? It can be argued that outreach service brings resources and skills of the highly specialized inpatient unit/centre, to the patients, their families, and the local services.
- ☞ This outreach approach is likely to be relevant where inpatient care is provided separately from local outpatient services and where the inpatient unit works to a defined catchment area.
- ☞ Once a patient has one admission, it becomes all too easy for this to set the pattern for subsequent relapses.
- ☞ Although inpatient admission does result in distancing from school, friends, family and other aspects of normal life, there does remain a place for inpatient treatment. We should, however be developing and evaluating initiatives to reduce the need for these and to help patients avoid that first step into the world of inpatient care.

**Johnson, A., & Sandord, J. (2005). "Written and verbal information versus verbal information only for patients being discharged from acute hospital settings to home: systematic review." Health Education Research 20(4): 423-429.**

This article presents the results of a Cochrane review which was conducted to determine the effectiveness of providing written and verbal health information compared with verbal information only to patients being discharged from acute hospital settings to home. Only two trials met the review inclusion criteria. In both trials the participants were parents of children being discharged from hospital to home. The two outcomes measured in both trials were knowledge and satisfaction. The review confirms that providing written and verbal health information is more effective in improving knowledge and satisfaction than providing verbal information only for parents of children being discharged from hospital to home. There is no evidence of effectiveness of the intervention in adults who provide their own care after discharge from hospital. Further research is required which involves adult patients being discharged from hospital to home, and research which measures a range of outcomes which include readmission rates, recovery times, patient/carer knowledge, complication rates, service utilization and costs (community, outpatient, and inpatient), confidence in one's own care management, stress and anxiety levels, satisfaction with services provided prior to discharge, and adherence to recommended care.

**Main Messages:**

- ☞ Providing information to parents (or significant others) on discharge from hospital to home is an essential component of quality care provision for the majority of clinical staff and is the fundamental right of all patients being discharged.
- ☞ Providing written and verbal health information significantly increases knowledge of parents of children who have been discharged as compared to verbal information alone.

**Kanapaux, W. (2003). "Responding to an Emergency for Children's Services:**

**Innovative Program Seeks Cure for Over-reliance on Crisis Care." Behavioral Healthcare Tomorrow 12(5): 12-17.**

**Not available**

Main Messages:

- ☞ Some children are unable to access services any other way, so they go to emergency room.
- ☞ The pediatrician as the primary point of care is a critical component for success. This should be accompanied by immediate phone access to expert consultation by a child psychiatrist or psychiatric nurse practitioner.
- ☞ Child psychiatry specialists should be co-located within primary care settings in order to encourage informal discussion and maintain a consultative role.
- ☞ Medical settings can be traumatic for children - as emergency rooms are brightly lit - not equipped to handle emotional and behavioral disorders.
- ☞ Parents often feel that their children must deteriorate before they are able to receive services and their options are then limited to restrictive levels of care, namely, hospitals and residential facilities.

**Kaplan, S., Busner, J., Chibnall, J., & Kang, G.. (2001). "Consumer Satisfaction at a Child and Adolescent State Psychiatric Hospital." Psychiatric Services 52(2): 202-206.**

**OBJECTIVE:** This study examined satisfaction with services among patients in a child psychiatric hospital and their parents, and assessed the relationship between consumer satisfaction and the perception of improvement in the problem that led to hospitalization. **METHODS:** A consumer satisfaction survey developed by the investigators was administered to three sampling waves of child and adolescent psychiatric inpatients (N=157) and their parents or guardians (N=111). Ninety-five percent of patients contacted and 97 percent of their parents or guardians agreed to participate in the study. The survey provided data about the children's and parents' satisfaction with inpatient care and their perceptions of the children's clinical improvement. **RESULTS:** Most parents and children reported high satisfaction with patient care. Twenty-eight percent of children and 21 percent of parents reported some form of abuse by the staff during the hospital stay. Those who reported abusive behavior were significantly less satisfied with the hospital experience than those who did not report abuse. The participants' perception of clinical improvement was only weakly related to their satisfaction. **CONCLUSIONS:** Most child psychiatric patients and their parents will participate in consumer satisfaction surveys about inpatient care. Consumers are critical of a hospital if specific prompts in the survey are provided. An unexpectedly high level of consumer-reported abuse was found. Consumer-perceived clinical improvement was only weakly related to satisfaction.

Main Messages:

- ☞ There may be clinical utility in performing surveys at multiple time points, as problems identified can be addressed and solutions later evaluated.

**King, C. A., Hovey, J. D., Brand, E., & Ghaziuddin, N. (1997). "Suicidal Adolescents After Hospitalization: Parent and Family Impacts on Treatment Follow-Through." Journal of the American Academy of Child & Adolescent Psychiatry 36(1): 85-93.**

**Objective:** To help determine optimal strategies for treating suicidal adolescents, the authors studied family predictors of compliance with

recommended psychotropic medication monitoring, individual therapy, and parent guidance/family therapy sessions.

**Method:** Sixty-six hospitalized, suicidal adolescents participated in a comprehensive diagnostic evaluation and depression/suicidality assessment. Family/parental assessment measures were the Family Assessment Device, Social Adjustment Inventory for Children and Adolescents (parent-adolescent subscales), Symptom Checklist-90-Revised, and Social Adjustment Scale-Self Report. Follow-up evaluation, 6 months post hospitalization, consisted of structured telephone interviews assessing treatment follow-through.

**Results:** Compliance with recommended medication follow-up (66.7%) and individual therapy (50.8%) was better than compliance with parent guidance/family therapy (33.3%) sessions. The most dysfunctional families and those with the least involved/affectionate father-adolescent relationships had the poorest follow-through with parent guidance/family therapy. Mothers' depressive and paranoid symptoms were linked with less adolescent individual therapy and family therapy follow-through. Mothers' hostility was associated with less medication follow-up.

**Conclusions:** Follow-through was best for medication and individual therapy. Multiple family/parental predictors of poor follow-through suggest the need for alternative or supplemental treatment strategies.

Main Messages:

- ☞ Follow-through was best for medication and individual therapy.
- ☞ Multiple family/parental predictors of poor follow-through suggest the need for alternative or supplemental treatment strategies.

**Knapp, M., Beecham, J., Koutsogeorgopoulou, V., Hallam, A., Fenyo, A., Marks, I.M., Connolly, J., Audini, B., & Muijen, M. (1994). "Service use and costs of home-based versus hospital-based care for people with serious mental illness." Br J Psychiatry 165(2): 195-203.**

**BACKGROUND.** The Daily Living Programme (DLP) offered problem-oriented, home-based care for people aged 17-64 with severe mental illness facing emergency admission to the Bethlem-Maudsley Hospital. The multidisciplinary DLP team acted as direct provider and link with other services. Each patient had a key worker. Cost-effectiveness was assessed. **METHOD.** The comprehensive costs of DLP and standard in-patient care were compared within a randomised controlled trial. Cost measures ranged over all service inputs and living expenses. The costs of informal care and lost employment were also considered. Assessments of service use, costs and outcomes were conducted at referral, 4, 11 and 20 months. **RESULTS.** The DLP was significantly less costly than standard treatment in both short and medium term ( $P = 0.000$ ). Cost savings accrued almost exclusively to the NHS, with no other agency's costs being higher. **CONCLUSIONS.** Coupled with mildly encouraging outcome results over the 20 month period, the DLP was clearly cost-effective in this medium term.

Main Messages:

- ☞ Home based care was less costly than standard care for individuals with severe mental illness.

**LeCuyer, E. A. (1992). "Milieu therapy for short stay units: A transformed practice theory." Archives of Psychiatric Nursing 6(2): 108-116.**

Milieu therapy is an interdisciplinary treatment approach widely applied in psychiatric settings. Current short stay inpatient trends indicate a need to adapt the approach so that it remains useful for nursing practice in those settings. This report presents basic historical milieu concepts with their relationships to patient outcome; current short stay patient needs, outcomes, and nursing actions are developed and linked with the historical concepts. The resulting transformed theory can be seen as an adaptation of the classic approach, tailored to short stay settings, with short-term goals and a clarified role for the nurse in the milieu.

Main Messages:

- ☞ Updated milieu therapy (to be applicable to short stay is useful for nursing practice.

**Lyons, J. S., O'Mahoney, M. T., Miller, S., Neme, J., Kabat, J., & Miller, F.. (1997). "Predicting Readmission to the Psychiatric Hospital in a Managed Care Environment: Implications for Quality Indicators." The American Journal of Psychiatry 154(3): 337-340.**

**Objective:** This study examined predictors of hospital readmission to determine whether readmissions can serve as a quality indicator for an inpatient psychiatric service. **Method:** A series of 255 patients consecutively admitted to any of seven psychiatric hospitals in a regional managed care program were followed to determine whether they were readmitted within 6 months of discharge. Case managers assessed patients with the use of a reliable outcome management/decision support system designed for acute psychiatric services. **Results:** Patients with greater impairment in self-care, more severe symptoms, and more persistent illnesses were more likely to be readmitted than other patients. Suicidal patients were less likely to be readmitted. There was no evidence to suggest that poor hospital outcome or premature discharge was associated with readmission either within 30 days or within 6 months. **Conclusions:** Although patients at risk for hospital admission can be identified, it does not appear that the success of the hospital intervention per se influences the likelihood of readmission. Use of readmission rates as quality indicators for hospital care providers is not recommended.

Main Messages:

- ☞ There was no evidence to suggest that poor hospital outcome or premature discharge was associated with readmission either within 30 days or within 6 months.
- ☞ Although patients at risk for hospital admission can be identified, it does not appear that the success of the hospital intervention per se influences the likelihood of readmission.
- ☞ Use of readmission rates as quality indicators for hospital care providers is not recommended.

**Madianos, M. G., & Econom, M. (1999). "International update: The impact of a community mental health center on psychiatric hospitalizations in two Athens areas." Community Mental Health Journal 35(4): 313-323.**

**ABSTRACT:** This paper explores the impact of a Community Mental Health Center intervention activities on the inpatient psychiatric morbidity of two areas served by this center. Athens University established this Center, the first of its kind in the Greater Athens area. A comparison among the utilization rates

of inpatient psychiatric services by community residents during the years 1979, 1985, 1991 and 1995 is made. The results of the 1995 survey show a significant reduction in the number and days of hospitalization and a remarkable cut in compulsory admissions when compared with those in 1979. It is concluded that medication monitoring, outreach, domiciliary care for patients in crisis, and day care are effective and robust principles of mental health services.

Main Messages:

- ☞ Medication monitoring, outreach, domiciliary care for patients in crisis, and day care are effective and robust principles of mental health services.

**Merson, S., Tyrer, P., Carlen, D., & Johnson, T. (1996). "The Cost of Treatment of Psychiatric Emergencies: A Comparison of Hospital and Community Services."**

**Psychological Medicine 26(4): 727-734.**

**SYNOPSIS** This study aimed to compare the costs of treatment by community-based and hospital-based psychiatric services. The design entailed random allocation of patients presenting with psychiatric emergencies over a subsequent 3-month period to one of two services, followed by retrospective quantification of service use and its cost for each group. One hundred patients with emergency presentations to the psychiatric service via the Accident and Emergency Department, liaison psychiatrist and approved social worker were included in the study. Their use of a range of items of service was recorded and disaggregated costings of these items of service was calculated. The use of non-psychiatric services was similar for both groups, but the use of psychiatric services differed, with the hospital group making greater use of in-patient beds and the community group employing more frequent home-based interventions. The total cost of treatment for the community group (Pounds Sterling56000) was much lower than for the hospital group (Pounds Sterling130000), although the median patient cost was 50% higher in the community group (Pounds Sterling938 v. Pounds Sterling610), and a greater proportion of the community service expenditure (10% v. 2%) was due to failed contacts. Taken together with clinical outcome, which showed no advantages for the hospital-based service over the community-based service, our findings suggest that this form of community psychiatric service is a cost-efficient alternative to hospital-based care for this group of patients.

Main Messages:

- ☞ Psychiatric in-patients make greater use of in-patient beds while community-based patients make greater use of home-based interventions.
- ☞ Cost of community treatment was much lower than for hospital treatment.
- ☞ Community-based mental health treatment is a cost-effective alternative to hospital-based care for children with severe mental illness.

**Meunier-Sham, J. (2003). "Increased volume/length of stay for pediatric mental health patients: One ED's response." Journal of Emergency Nursing 29(3): 229-239.**

The increased volume and length of stay for pediatric mental health patients inspired a new collaborative effort in the emergency department. The need for increased communication across disciplines drove this effort. Informally, staff reported an increased sense of communication and satisfaction resulting from these interventions. Patients were previously seen as belonging to Child Psychiatry, and now there is an increased sense of shared responsibility.

Main Messages:

- ☞ Because the availability of outpatient services is inadequate, children and adolescents whose behavior is deemed unstable or dangerous often are directed to emergency departments to await psychiatric evaluation.
- ☞ ED response - a collaborative effort in emergency department - Boston - Providing a safe environment during the ED visit is a major treatment priority for these children
- ☞ Identified emergency guidelines for management of psychiatric patients in pediatric emergency department - helped nurses feel more comfortable with these patients -
- ☞ Developed a mental health flow sheet
- ☞ Working to establish a system of care and a safe environment for this patient population should be a priority of every emergency department.

**Minds, Y. (2000). "Whose Crisis? Meeting the Needs of Children and Young People with Serious Mental Health Difficulties."**

This YoungMinds study, completed in 2000, examines the difficulties often encountered by professionals working in the community trying to refer young people for admission to in-patient units. It looks at who is often referred and the different routes by which young people may become known to mental health services. Through a number of case studies, the report also looks at how access to in-patient services might be improved.

The report provides an overview of key findings from a range of other studies into mental health services that were ongoing in 1999 and 2000. These include the Royal College of Psychiatrists' National In-patient Child and Adolescent Psychiatry Study (NICAPS). There is also a summary of national statistics on prevalence rates for mental health problems amongst children and young people and about national policy initiatives relevant to CAMHS.

Overall, the research findings highlight a range of serious issues about a lack of beds, long wait times in many units and about a general mismatch between what in-patient units offer and the types of needs presented by the children and young people that community-based professional wish to refer. In particular, the study highlights concern about many units only being operational on a five day per week basis when the needs of young people are such that provision every day of the week is required.

Throughout the report, the issues are discussed from a multi-disciplinary and multi-agency perspective. The pressures facing social service departments and education authorities are considered - including the problems of agreeing diagnoses and appropriate treatment; the barriers to referral pathways and the problems caused by long CAMHS waiting lists. The study also provides data on the use of inappropriate resources when no CAMHS bed is available - notably social services secure provision and adult psychiatry and paediatric hospital beds.

The final chapter of the report sets out eleven key actions for improving access to in-patient CAMHS. There is also an appendix giving contact details for the other research studies described in the report and the case studies.

**O'Herlihy, A., Worrall, A., Lelliott, P., Jaffa, T., Hill, P., & Banerjee, S. (2003). "Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales." *The British Journal of Psychiatry* 183: 547-551.**

Background Little is known about the current state of provision of child and

adolescent mental health service in-patient units in the UK.

**Aims** To describe the full number, distribution and key characteristics of child and adolescent psychiatric in-patient units in England and Wales.

**Method** Following identification of units, data were collected by a postal general survey with telephone follow-up.

**Results** Eighty units were identified; these provided 900 beds, of which 244 (27%) were managed by the independent sector. Units are unevenly distributed, with a concentration of beds in London and the south-east of England. The independent sector, which manages a high proportion of specialist services and eating disorder units in particular, accentuates this uneven distribution. Nearly two-thirds of units reported that they would not accept emergency admissions.

**Conclusions** A national approach is needed to the planning and commissioning of this specialist service.

Main Messages:

- ☞ Child and adolescent inpatient care is a necessary function of a comprehensive child and adolescent mental health service.

**Pandiani, J. A., Schacht, L. M., & Banks, S. M. (2001). "After children's services: A longitudinal study of significant life events." Journal of Emotional and Behavioral Disorders 9(2): 131-138.**

This article examined the long-term (3 year) treatment outcomes of all adolescents who received services in a statewide system of care. The outcomes included rates of hospitalization, incarceration, and maternity. Because the outcome measures were derived from existing administrative and public health data, outcome data were available for all participants. Results indicate that recipients of services had substantially elevated rates of incarceration and hospitalization (compared to the general population) but that maternity rates in the treatment groups were not different from other young women in the same age group. Interestingly, the amount of elevation of incarceration and hospitalization rates decreased over time.

Main Messages:

- ☞ Compared to other young people, young men and women who received services in Vermont's system of care for children and adolescents when they were 17 years of age were much more likely to be hospitalized for behavioural health care (8 times as likely to be hospitalized).
- ☞ Young men who had received services were incarcerated at almost five times the rate of other males.
- ☞ Maternity rates in the treatment groups were not different from other young women in the same age group.
- ☞ The amount of elevation of incarceration and hospitalization rates decreased over time.

**Parker, K.C.H., Roberts, N., Williams, C., Benjamin, M., Cripps, L., & Woogh, C. (2003). "Urgent adolescent psychiatric consultation: from the accident and emergency department to inpatient adolescent psychiatry." Journal of Adolescence 26: 283-293.**

The Rapid Response Model (RRM) provides psychiatric services to children and adolescents seen at the Accident and Emergency (A&E) department or at the Urgent Consultation Clinic of the Child and Adolescent Psychiatry Division the next day. In a naturally occurring experiment, the RRM was introduced,

withdrawn and restarted. When RRM was withdrawn at one site, it was implemented at another. The RRM reduced nighttime Emergency Consultations and inpatient admissions from A&E, while it increased daytime consultations and daytime admissions. The RRM provided timely, organized emergency psychiatric services. A&E staff expressed satisfaction with the service.

Main Messages:

- ☞ CANADIAN STUDY
- ☞ Overview of a rapid response model (RRM) that provides psychiatric services to children and adolescents
- ☞ When the RRM was available, the proportion of inpatient admissions coming from the A and E dropped, when it was suspended, the proportion rose. When RRM reintroduced again, the proportion reduced again. There was also less middle of the night admissions in crisis.
- ☞ Educational components necessary at all levels to ensure the appropriate use of various components of the service.

**Pumariega, A. J., & Winters, N. C. (2003). Trends and shifting ecologies: part II. Child and Adolescent Clinics of North America, 12, 779-793.**

The paper discusses contextual perspectives of child mental health emergencies, application of community systems of care principles to address these emergencies, and reviews several evidence-based interventions (wraparound approach, intensive case management, crisis service models, mobile crisis services, home-based interventions, therapeutic foster homes, partial hospitalization and day treatment). Also discussed are barriers and challenges to community-based approaches to child crisis and emergency services at the level of the practitioner and the system.

Main Messages:

- ☞ The organization of emergency mental health services may influence the outcome of the crisis.
- ☞ Noncompliance is a substantial problem for patients referred to outpatient follow-up from hospital emergency departments.
- ☞ There is little evidence that psychiatric hospitalization itself lowers the risk for subsequent crises.
- ☞ There is little support in the literature for the use of either inpatient or residential treatment programs.

**Reder S., & Quan, L. (2004). "Emergency Mental Health Care for Youth in Washington State: Qualitative Research Addressing Hospital Emergency Departments' Identification and Referral of Youth Facing Mental Health Issues." Pediatric Emergency Care 20(11): 742-748.**

**Objectives:** The purpose of this formative research was to gain a better understanding of how Washington State hospital emergency departments (EDs) identify and refer children and adolescents with mental health concerns. Increased understanding of emergency mental healthcare for youth will lead to the development and implementation of strategies and policies that enhance the system of providing mental health services to children and adolescents.  
**Methods:** We conducted structured group interviews, a form of qualitative research, with ED, social work, and mental health administrators and providers in 9 hospitals in Washington State.  
**Results:** Interviews reflected a system wide lack of emergency mental health

services for youth, as well as a lack of coordination between the larger mental health system and hospital ED. In addition, we identified issues specific to the hospital/ED such as insufficient availability of social work and mental health staff, lack of mental and behavioral health screening tools, lack of knowledge of available mental health services, and lack of clarity about the ED's role in identification of mental health concerns.

Conclusions: Specific interventions should be developed, implemented, and evaluated to increase coordination between the ED and the larger mental health system. This should include methods for increasing ED staff knowledge of available and accessible mental health services for youth, perhaps through an online system. In addition, the role of the ED in identifying youth facing mental health issues should be clarified, and a brief, nonintrusive screening tool for identifying emergency mental health concerns should be developed.

Main Messages:

- ☞ There is a system wide lack of emergency mental health services for youth
- ☞ There is a lack of coordination between the larger mental health system and hospital ED.
- ☞ Knowledge of existing public and nonprofit and private mental health resources should be increased among ED and hospital social work staff.
- ☞ EDs ability to identify youth in need of mental health services would be greatly enhanced by a simple mental health screening tool.
- ☞ The increasing volume of mental health ED visits among youth indicates that without such a tool, many of the mental health needs of youth are not being identified, or youth are being left untreated and without referrals.

**Reynolds, W., Lauder, W., Sharkey, S., Maciver, S., Veitch, T. & Cameron, D. (2004). "The effects of a transitional discharge model for psychiatric clients." Journal of Psychiatric and Mental Health Nursing 11: 82-88.**

This pilot randomized control trial was motivated by the discovery that many individuals with mental health problems are re-hospitalized within a year, with many being unable to fully adjust to community living. A solution was proposed in the form of an intervention called transitional discharge. The transitional discharge model included: (1) peer support, which is assistance from former patients who provide friendship, understanding and encouragement; and (2) overlap of inpatient and community staff in which the inpatient staff continue to work with the discharged patient until a working relationship is established with a community care provider. The overall aim of this study was to test the discharge model designed to assist patients discharged from acute admission wards to adjust to community living. This aim was tested through a number of related hypotheses, which suggest that, 5 months following discharge from an acute admission ward of a psychiatric hospital, individuals participating in a transitional discharge model: (1) report fewer symptoms; (2) report better levels of functioning; (3) have better quality of life; (4) are less likely to have been re-admitted to hospital. The study used a randomized experimental design with two conditions: experimental and usual treatment. In general, both control and the experimental group demonstrated significant improvements in symptom severity and functioning after 5 months. Usual treatment subjects in the control group were more than twice as likely to be re-admitted to hospital. This study needs to be replicated in Scotland with a larger sample and with a modified variation of the intervention called the Transitional Care

Intervention.

Main Messages:

- ☞ The transitional treatment model maintained patients in the community who would otherwise be re-admitted in usual arrangements.
- ☞ The findings are supportive of the importance of interpersonal relationships in the treatment of psychiatric patients post discharge.

**Scharer, K. (2003). "What parents of mentally ill children need and want from mental health professionals." Issues in Mental Health Nursing 23(6): 617-640.**

Child psychiatric hospitalization is a time of crisis for the parents of a child with a mental disorder. Prior to hospitalization, the child's problematic behavior has escalated. Parents have various types of contact with mental health professionals prior to, during, and after the hospitalization, which influence their ability to care for their child. This paper reports a qualitative descriptive study of what parents need and want from mental health professionals during this time frame. During the study, parents spontaneously talked about what they needed and wanted from mental health professionals, including nursing personnel. The perspectives of 38 parents of 29 hospitalized children were obtained through interviews. Parents identified needing informational, emotional, and instrumental support most often in the interviews. Specific examples from the data are included in this report.

Main Messages:

- ☞ Parents want and need to know what to expect at, during and following the hospitalization of their child.

**Schoenwald, S. K., Ward, D. M., Henggeler, S. W., & Rowland, M. (2000). "Multisystemic Therapy Versus Hospitalization for Crisis Stabilization of Youth: Placement Outcomes 4 Months Postreferral." Mental Health Services Research 2(1): 3-12.**

Hospitalization and out-of-home placement data for 113 youth participating in a randomized trial comparing home-based multisystemic therapy (MST; n = 57) with hospitalization(n = 56) for psychiatric crisis stabilization were analyzed following the completion of MST treatment—approximately 4 months post approval for emergency psychiatric hospitalization. Analyses showed that MST prevented any hospitalization for 57% of the participants in the MST condition and reduced the overall number of days hospitalized by 72%. Importantly, the reduction in use and length of hospitalization was not offset by increased use of other placement options, as MST reduced days in other out-of-home placements by 49%. The cost implications for the viability of MST as an alternative to hospitalization for youth presenting psychiatric emergencies are discussed.

Main Messages:

- ☞ MST was successful in preventing a significant proportion of adolescents from being hospitalized.
- ☞ Use of MST to treat children and youth with serious emotional disturbance referred for psychiatric hospitalization is 52% more costly than use with serious juvenile offender populations. Increased costs were associated with (i) reduction in caseload per therapist; (ii) resources need to build 24-hour availability of psychiatric and case worker support on the team; and (iii) increased clinical supervision from a psychiatrist trained in MST.

- ☞ MST would prove to be more cost efficient in communities that have longer average length of stay in hospital, so the context needs to be considered.

**Simons, L. & Petch, A. (2002). "Needs assessment and discharge: a Scottish perspective." Journal of Psychiatric & Mental Health Nursing 9(4): 435-445.**

Discharge from hospital remains a difficult area for health services and it is unclear how much impact policy directives have had on discharge outcomes. The recent National Service Framework for mental health has highlighted discharge as a key area with Standard Five indicating minimum requirements at discharge from hospital. In order to aid this process this paper discusses the findings of a needs assessment of patients following discharge from psychiatric inpatient care in Scotland. The needs and unmet needs as assessed by both patients and mental health community staff on the Camberwell Assessment of Need (CAN) are presented. The CAN seeks to identify needs in a range of domains addressing basic, health, social, functioning and service issues. The sample comprised 173 patients recently discharged from acute psychiatric units in eight health board areas of Scotland and 98 community staff identified as providing key support to 98 of the patient sample. The findings indicate that the needs of patients discharged from hospital are complex and that the targeting of mental health services according to diagnostic criteria may not be the best way of ensuring support reaches those in most need. The range of needs identified suggests that fully integrated multidisciplinary care is essential to meet needs at discharge. The period initially after hospital discharge is one of vulnerability and incorporating a needs assessment into the discharge planning could aid the care planning process required by the Framework.

**Main Messages:**

- ☞ The needs of patients discharged from acute psychiatric units are more complex than first thought.
- ☞ The non-psychotic group report a higher number of needs and higher level of unmet needs.
- ☞ The types of needs identified by patients in this study included psychological distress and psychotic symptoms; daytime activities and company; food and transport; budgeting and benefits. It appears more attention is paid to health needs and less to social and functional needs of patients as they leave hospital care.
- ☞ Family and friends should be involved in the care planning process wherever possible.

**Singh, N. N., Wechsler, H. A., & Curtis, W. J. (2000). "Family friendliness of inpatient services for children and adolescents with EBD and their families: Observational study of the treatment team process." Journal of Emotional and Behavioral Disorders 8(1): 19-26.**

Family-friendly services in child mental health include those that are aligned with the needs of families and are delivered in a manner that values professionals and shows respect for family involvement, empowerment, and cultural differences. We used the Family Assessment Planning Team (FAPT) Observation Form (Inpatient Version) to assess the family friendliness of the admissions treatment team process at an inpatient child and adolescent psychiatric hospital. This instrument is divided into five sections that reflect

the general process of a typical admissions treatment team meeting in inpatient child and adolescent psychiatry: Introduction, Meeting Management, Case Presentation and Discussion, Service Plans, and Tact and Technicalities. Each of the 46 items in this form represents a behavior or event that may occur during a typical children's mental health services planning meeting, and each incorporates some part of the key conceptual components of family friendliness. Use of the forms also allows for the collection of data on relevant characteristics of the meeting participants, as well as demographic information on the children and their families. We observed 35 case presentations of new admissions to a child or adolescent treatment unit in an inpatient setting. Although there were variations between the two treatment teams and among the 35 case presentations, the overall rating across all case presentations was moderately family friendly (72%) and showed marginally higher family friendliness than comparable service planning teams in the community (63%). As with community service teams, improvements in the treatment team process in child and adolescent inpatient psychiatric services are needed in order to ensure increased family friendliness in the planning of services for children with EBD.

Main Messages:

- ☞ Parent education about EBD, the mental health service delivery system, and parent rights regarding services for their children should be an important component of services provided in child and adolescent psychiatry.
- ☞ Increased knowledge assists parental empowerment, increases parent-professional collaboration, and enhances the quality of services provided to children and adolescents with EBD.
- ☞ Treatment team members must be culturally competent, sensitive to the values of families, and unbiased in the delivery of services, regardless of the psychiatric disorders of the children or adolescents.

**Street, C. (2004). "In-patient mental health services for young people - changing to meet new needs?" Journal of the Royal Society for the Promotion of Health 124(3): 115-118.**

There is currently considerable interest in consulting with young people and involving them in the development and delivery of mental health services- both at the local and national level. This is a welcome development since, as various studies have highlighted, young people can offer both valuable insights into the services they receive and suggestions for what they want from services. In 2003, YoungMinds, a national charity that works to promote children's mental health, completed a two-year, in-depth qualitative study focused on a sample of in-patient units drawn from across England and Wales. Such units, found at Tier 4 (the most severe or complex problems) within Child and Adolescent Mental Health Services (CAMHS) provide highly specialist care and treatment to some of the most seriously ill and vulnerable children and young people. A key aim of the study was to give a 'voice' to these young people in order to help in-patient services develop their provision in ways that are possibly more 'young-person friendly'. Alongside this, information from staff working both within in-patient units and the community was gathered, to provide an important contrasting perspective and to build up understanding of the current pressures and challenges that face service providers in this area. In total, data was gathered from 107 young people, 35 parents and 169 staff. Information from a

number of other services was also compiled to provide case study illustrations of some new models of in-patient care now emerging. Multi-centre Research Ethics Committee approval was gained for the study, with considerable attention being paid to the design of clear 'young person' friendly information sheets, consent forms and questionnaires. Much attention was also paid to explaining how information would be used and confidentiality respected. The study findings reveal a picture of considerable change- of improvements but also continuing service gaps. Most importantly, there was a high level of consistency amongst young people as to the areas of greatest concern and many highly realistic, practical suggestions and requests for how in-patient provision for young people should be improved. This article outlines some of the issues raised by young people and in particular highlights the importance of information sharing and of inpatient units being properly staffed. The need for inter-agency links and coordination between inpatient and community based mental health services is also emphasized.

Main Messages:

- ☞ There is a need to consult with young people to involve them in the development and delivery of mental health services. Young people can offer valuable insights into the services they receive and suggestions for what they want from services.
- ☞ Need for interagency links and coordination between inpatient and community based mental health services.

**Sullivan, A. M., & Rivera, J. (2000). "Profile of a comprehensive psychiatric emergency program in a New York City Municipal hospital." Psychiatric Quarterly 71(2): 123-138.**

This paper profiles the services provided, and the patient population treated, in a busy inner city Comprehensive Psychiatric Emergency Program (CPEP) located in Elmhurst, Queens, New York City. For each CPEP component, including the emergency room, extended observation unit and crisis services two years of data are reviewed. A diagnostic profile of patients seen, description of services, patient referrals and dispositions are presented. The children and adolescents treated in the CPEP are described in more detail, focusing on the high frequency of violence to self or others seen in their presenting problems. The CPEP's role in providing comprehensive community based services is discussed.

Main Messages:

- ☞ Innovative comprehensive wraparound services need to be linked to psychiatric emergency program to further ensure patients linkage to the next level of care.

**Tan, E., Hannah, D., Chant, C., & Martin, G. (2004). "Gundhu Adolescent Wing: providing adolescent beds in a rural acute mental health unit." Australasian Psychiatry 12(4): 396-400.**

**Objective:** To describe the evolution, structure and outcomes of Gundhu Adolescent Wing, Toowoomba, Queensland, which comprises six dedicated beds set aside during development of a new rural acute mental health unit.

**Methods:** All adolescents discharged from Gundhu in its first 7 months were included in the study. Data pertaining to patient characteristics, model of service delivery, length of inpatient stay and outcome at 7 months were

obtained.

Results: Thirty-three adolescents with mental illness living in the rural area were discharged from Gundhu in the first 7 months. For the 23 adolescents who stayed on the unit <14 days, outcome at 7 months after discharge was generally favourable. Six adolescents with length of stay of 30 days did less well, but made similar progress to patients in tertiary units.

Conclusions: From the authors' experience, designating a small number of beds as adolescent within a rural acute mental health unit is an effective intervention for short-stay patients and is valued by adolescents and their families. Keeping the adolescent unit separate is beneficial even at the expense of foregoing access to space and facilities enjoyed by adult patients. Involving families early to provide off-ward fun, exercise and socialization with peers is important. Rural services tend to have high staff turnover. Involving rural general practitioners in follow-up plans may ensure better continuity of care after discharge.

Main Messages:

- ☞ Designating a small number of beds as adolescent within a rural acute mental health unit is an effective intervention for short-stay patients and is valued by adolescents and their families.
- ☞ Keeping the adolescent unit separate is beneficial even at the expense of foregoing access to space and facilities enjoyed by adult patients.
- ☞ Involving families early to provide off-ward fun, exercise and socialization with peers is important.
- ☞ Rural services tend to have high staff turnover.
- ☞ Involving rural general practitioners in follow-up plans may ensure better continuity of care after discharge.

**Tyrer, P., Evans, K., Gandhi, N., Lamont, A., Harrison-Read, P., Johnson, T. (1998). "Randomised controlled trial of two models of care for discharged psychiatric patients." British Medical Journal, 316(7125): 106-109.**

Objective: To compare the clinical outcome and costs of care of psychiatric patients allocated to community multidisciplinary teams or to hospital based care programmes after discharge from inpatient care. Design: Randomised controlled trial. Setting: Inner London (Paddington and North Kensington) and outer London (Brent) psychiatric services. Subjects: 155 patients with severe mental illness with a previous admission within the past 2 years. Main outcome measures: Ratings of clinical psychopathology, depression, anxiety, and social functioning; comprehensive costs of health care. Results: Clinical outcomes were available for 133 patients and cost data for 144 patients after 1 year. The clinical outcomes of the two models of care were essentially similar, but admission to hospital was more likely in the hospital based care group and the costs of health care were 14% greater per patient than in the community group. This difference, however, was dwarfed by a twofold difference in the costs of care in the outer London services compared with those in inner London. This was explained largely by greater inpatient care for outer London patients (58 median bed days v 18 for inner London patients), more of which was provided by extracontractual referrals to other psychiatric hospitals as Brent had only 0.28/1000 beds available for acute adult patients compared with 0.82/1000 in Paddington and North Kensington over the period of the study. Conclusion: Aftercare by community teams for psychiatric patients with severe mental

illness has a similar outcome to hospital based aftercare but with fewer admissions to hospital. When psychiatric bed requirements are insufficient for a population, however, neither form of aftercare is effective as greater use of hospital beds elsewhere swamps any advantage of community care programmes, with disintegration and discontinuity of psychiatric services leading to escalating costs. Key messages Community psychiatric care has generally been shown to require fewer beds than more hospital focused care Clinical outcomes in psychiatric patients with recurrent psychotic illness randomised to community focused or hospital focused care after discharge from hospital and followed up for 1 year were similar Costs were lower for patients in the community group, which had fewer admissions to hospital Costs were twice as high in one of the areas covered by the study, mainly because of the insufficient number of beds in the area, with great reliance on psychiatric beds outside the catchment area When the number of psychiatric beds in an area becomes too low there is no advantage in providing better community care because the impact of this is swamped by the disintegrating effects of inpatient care outside the catchment area

**Webster, S. & Harrison L. (2004). "The multidisciplinary approach to mental health crisis management: an Australian example." Journal of Psychiatric and Mental Health Nursing 11(1): 21-29.**

Changes within the Australian health care system have led many people with mental health disorders to use emergency departments as the point of access to mental health services. Staff in emergency departments are not necessarily equipped to assess the needs of such clients. This paper briefly describes the development of a multidisciplinary mental health liaison team, within the emergency department of one hospital in Sydney, which was designed to assist both staff and clients. A quality assurance audit was undertaken to assess the involvement of the team with the ED, using data obtained from the ED Information System (EDIS) on 406 clients presenting within 6 months, with an identifiable mental disorder (ages 17-65 years). Available evidence suggests the implementation of the team has been a success, however, more research is required to confirm the effectiveness of this approach. Questions are raised about appropriate referral and follow-up for some clients. The study also found deficiencies in the method of routine data collection (Emergency Department Identification System), which makes formal auditing of the team and the services it provides a difficult task.

Main Messages:

- ☞ The presence of liaison mental health team members in the Emergency Department (ED), when requested by ED staff, in an effective way of ensuring that mental health services are available when and as required and that ED staff are supported and care provided to clients.
- ☞ Other functions of Liaison teams include education and destigmatization. As educators, they work to inform, encourage, and facilitate skill transference. They hold on-site sessions for ED staff that are designed to meet the need to develop more effective strategies to encourage collaboration with psychiatry consultants, to facilitate problem solving, crisis assessment and treatment.
- ☞ Liaison teams engage in health promotion through the education and counselling of clients families and carers, and advancing a more positive community perspective.

- ☞ In the area of destigmatization, liaison teams work to change the well-documented negative attitude of many health professionals towards people with psychiatric disorders. For instance, clients presenting to an ED may engage in behaviour that is not in keeping with the 'sick role' and can, consequently, be negatively labelled or seen as not being in need of immediate care.
- ☞ Literature suggests that feelings of fear and powerlessness, and an acknowledgement of the increased length of time required to care for clients with mental health problems, can result in ED nurses avoiding clients with mental illness (see Gillette et al., 1996). This can contribute to the perpetuation of extreme measures to control such behaviour (Trexler, 1996).
- ☞ Audit revealed that while GPs are the primary care providers, there is little evidence that this group is fully involved because only 3.9% of clients were referred to their local GP. The concern is that GPs are meant to function as case managers and primary health providers for the majority of people, and yet they are not filling this role in mental health.
- ☞ Audit data suggest that lack of follow up is a major problem that needs to be addressed by the liaison team; only 20% of clients under acute case management were followed up, and overall, only 35.5% of clients received extensive and supervised professional care. Access to follow-up services is a critical component of mental health services and the apparent lack of strategies to monitor and identify clients who are at risk of relapse should be addressed as a priority for service planning.
- ☞ Findings are unclear as to whether liaison team is more cost-effective than care as usual.
- ☞ Liaison team presence, and the availability and accessibility of specialized expertise and skill appears to have improved the confidence and knowledge level of the ED team in dealing with mental health clients.

**Worrall, A., & O'Herlihy, A. (2001). "Psychiatrists' views of in-patient child and adolescent mental health services: a survey of members of the child and adolescent faculty of the College." *Psychiatr Bull* 25(6): 219-222.**

**AIMS AND METHOD** To obtain a prioritised list of psychiatrists' concerns relating to in-patient child and adolescent mental health services. Four-hundred and fifty-four members of the child and adolescent faculty of the Royal College of Psychiatrists were asked to list their main concerns. **RESULTS** Two-hundred and seventy-four members responded. The most reported themes included lack of emergency beds; lack of services for severe or high-risk cases; lack of beds in general; poor liaison with patients' local services; lack of specialist services; and poor geographic distribution of services. **CLINICAL IMPLICATIONS** The range of themes identified from this survey have served to focus the National In-patient Child and Adolescent Psychiatry Study (NICAPS) and several design changes have been made to NICAPS as a result.

**Main Messages:**

- ☞ There is a lack of services for those aged 16-18 in particular.
- ☞ There is a need for better coordination of services and joint working.
- ☞ Psychiatrists concerned about the admission of young people in crisis to pediatric or adult psychiatric wards.