Psychiatric Community Crisis Services for Youth

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KEYWORDS

• Community • Child • Family • Psychiatry • Crisis • Emergency • Services • Interventions

KEY POINTS

- Epidemiologic data reflect increasing numbers of children and families presenting to emergency services for psychiatric care; however, standard emergency departments are often under-resourced to effectively meet their needs.
- A variety of care models have been devised to better support youths and families in psychiatric crises; these include mobile crisis services, phone triage lines, and observation and brief residential services.
- Key tenets to implementing such services include coordination with community stakeholders, leverage and collaboration with existing agencies, assessment and application for funding sources, evaluation and education around staffing needs, and continued quality improvement.
- Data reflect improved outcomes clinically and financially when communities implement a continuum of crises services.

INTRODUCTION

Children and families are seeking behavioral health care in record numbers, often with severe symptoms, including suicidal ideation, aggression, high risk–taking behaviors, and psychosis. In most communities, children and families in crisis present to emergency departments (EDs), which are often ill prepared and/or underequipped to provide adequate psychiatric evaluation, stabilization, and discharge planning. Given the challenges faced by our traditional medical systems in meeting these needs, communities can greatly benefit from developing and expanding psychiatric crisis care services for youths and families.

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In this article, the authors highlight 2 crisis care models that have been successfully implemented at the community and state level. The authors review the development, implementation, as well as the clinical and financial outcomes of these models.

Data reflect what many health providers anecdotally observe: a continuous increase in children and families seeking care for psychiatric crises, including suicidal ideation, aggression, psychosis, substance intoxication, and severe family conflict. National data between 2006 and 2011 indicate a 50% increase in hospital admissions for mental health conditions, a 21% increase in ED visits for primary psychiatric concerns in children 10 to 14 years old, and a total of $11.6 billion spent on mental health in hospital settings during this time frame.[1] With nationwide shortages of child psychiatric providers (particularly in rural and poor, urban areas[2]), a decrease in number and availability of inpatient and residential beds, and insufficiently developed community-based treatment systems, children and families often face limited options for crisis care outside of standard emergency services.[3] Unfortunately, EDs often lack appropriate space and/or professionals with psychiatric training; so youths and families often face long wait times and limited options for intervention and follow-up. Children who are directed to inpatient admission may spend days boarding in EDs and inpatient medical floors, which occupies prized medical space and can be disruptive and stressful for youths and families.[1] Furthermore, there is limited evidence that inpatient treatment is the most effective treatment of many conditions, such as conduct disorder; other models of care are more effective for many children and families.[3] With these considerations in mind, it is clear that thinking outside the box to consider a continuum of crisis care services can better meet community needs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines crisis services as a "continuum of services provided to individuals who experience a psychiatric emergency, with goals of stabilizing and improving psychological symptoms of distress, and engaging individuals in an appropriate treatment service to address the problem that led to the crisis."[4] Crisis services generally involve screening, evaluation and risk assessment, brief solution-focused interventions, and referral and linkage to ongoing care. Many communities have adult crisis services, such as assertive community treatment and crisis intervention teams, which engage with individuals in their community setting and interface with law enforcement to provide care; however, such services are less prevalent for children and adolescents.[4]

Additional examples of core crisis services include phone triage and warm lines that help with assessment and referral of youths to appropriate services; mobile crisis units that "go out into the community to begin the process of assignment and definitive treatment outside of a hospital or health care facility";[4] and psychiatric teams embedded within EDs that respond to psychiatric needs or incorporate short-term observation and residential beds.[4]

Several communities have implemented psychiatric crisis services for youths; this article describes the development and integration of programs in Ventura County, California and in Connecticut. The development and implementation of these crisis services share several themes: teamwork with community stakeholders; leverage and development of current services; expanded hiring and training for staff; and ongoing evaluation and collection of outcome measures, including psychiatric admission rate, repeated use of the ED, and linkage to ongoing treatment.

The Ventura County Non–Hospital-Based Continuum of Care Model for Youths in Mental Health Crisis

Ventura County, California is situated along the Pacific Coast between Los Angeles and Santa Barbara counties; it has a population of approximately 850,000.[5] Ventura