

Final Project Report
Admission of Young Children
to State Hospitals
in the Kansas Mental Health System

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Table of Contents

1. Background	1
2. Psychiatric Hospital Utilization: National and State Data	3
2.1 Characteristics of Children and Youth in Inpatient Facilities: National Data	4
2.2 Young Children in Kansas State Hospitals	5
3. Children in the State Hospital -- A Qualitative Multiple Case Study	8
3.1 Methods	8
3.1.1 Access	8
3.1.2 Data Sources and Data Collection	9
3.1.3 Analysis	10
3.1.4 Stakeholder Feedback	11
3.2 Findings	12
3.2.1 Participant Demographics	12
3.2.2 Appropriateness of Admission to the State Hospital	13
3.2.2.1 Acute Child Behaviors leading to Admission	14
3.2.2.2 Context of Acute Behaviors	15
3.2.3 Crisis Services and Crisis Response	16
3.2.3.1 Initial Contact at the Time of Crisis	16
3.2.3.2 Crisis Hotline	17
3.2.3.3 Crisis Walk-In Clinic	18
3.2.3.4 Overnight Crisis Stabilization Services (“Crisis Beds”)	18
3.2.3.5 Crisis Plans	18
3.2.3.6 Mobile Crisis Response	19
3.2.3.7 Police Involvement	19
3.2.4 Services Received Prior to Hospitalization	20
3.2.4.1 Previous Psychiatric Hospitalizations	21
3.2.4.2 Community Mental Health Services	22
<i>Psychiatry and Medication Services</i>	23
<i>Case Management</i>	23
<i>Psycho-Social groups</i>	24
<i>Therapy</i>	24
<i>Attendant Care (AC) or Individual Community Support (ICS)</i>	25
<i>Parent Support</i>	25
<i>Wraparound and Natural Supports</i>	26
<i>Respite Care/Beds</i>	26
3.2.4.3 Child Welfare Services	26
3.2.4.4 School Services	27

3.2.4.5 Community Developmental Disability Organization (CDDO) Services	28
3.2.5 Common Factors Affecting Service Quality	29
3.2.5.1 Turnover	29
3.2.5.2 Accessibility of Services at Critical Points	29
3.2.5.3 Communication and Collaboration with other Service Providers and Systems	29
<i>School-Mental Health Collaboration</i>	29
<i>Child Welfare - Mental Health Collaboration</i>	30
<i>CDDO - Mental Health Collaboration</i>	30
3.2.5.4 Lack of Transportation and Financial Resources	31
3.2.5.5 Not Feeling Taken Seriously	31
3.2.6 Screening and Admission	31
3.2.6.1 Location of Screening	31
3.2.6.2 Time and Duration of Screening	32
3.2.6.3 Who was Involved in the Screening Process?	32
3.2.6.4 Perceived Effectiveness of Screening to Prevent Unnecessary Hospitalization	32
3.2.6.5 Satisfaction with Screening and Admission Process	34
<i>Transportation</i>	34
<i>Delays -- "It was a long day"</i>	37
3.2.7 Screener Background and Training	40
3.3 Stakeholder Feedback	41
3.4 Summary of Qualitative Study Findings and Areas for Improvement	43
3.4.1 Possible Improvements for Community Based Services	43
3.4.1.1 Crisis Prevention through timely Access to Services	44
3.4.1.2 Child and Family-Centered Crisis Response	45
3.4.1.3 Access and Quality of Medication Management	46
3.4.1.4 Improving the Screening	46
4. Implications for Development of Regional Private Hospital Bed Capacity	46
5. Recommendations	50
6. References	52
7. Appendices	54
Appendix A. Coding Guide	
Appendix B. Medication Management--No Easy Solutions	

EXECUTIVE SUMMARY

In order to guide future directions of state policy and practice, the Kansas Department of Social and Rehabilitation Services (SRS) commissioned this inquiry which explores reasons for the admission of children age twelve and younger to state hospitals, experiences of families and professionals, and possible alternatives to the use of state hospitals through development of local and regional resources.

Two state hospitals in Kansas currently serve young children under 13 years of age: Rainbow State Hospital (RSH) in Kansas City and Larned State Hospital (LSH) in Western Kansas. In FY 2004, the majority of children at both hospitals were male Caucasians between the ages of 10-12. RSH admitted 49 children (mean length of stay was 24 days) and LSH admitted 43 children (mean length of stay was 38 days). These figures compare to a total of 148 children admitted in FY 2002 (mean length of stay 73 days) indicating a **downward trend in utilization**.

Analysis of a multiple case study (n=12) and data from local/regional hospitals who admitted children with psychiatric disorders in FY2004 shows that **state hospitals fulfill a distinct function and role in the current system: State hospitals provide an intermediate length of inpatient treatment between the short acute psychiatric programs in local hospitals and much longer stays in Level VI residential treatment**. Acute hospitals are designed for stays between 3-7 days (mean 5.28 days) and longer stays than Level VI placements (length of stay ranged from 82-180 days for children and adolescents).

An **in-depth multiple case study** of a sample of twelve typical children residing at or admitted to either state hospital between November 2004 and January 2005 highlights reasons and circumstances of their admission, the screening process, and services received prior to admission. (This study did not evaluate services received at the state hospitals.) In order to explore potential capacity of utilizing local regional psychiatric hospital beds instead of state hospitals for young children, data from the Kansas Hospital Association were collected and examined.

Qualitative analysis of 67 interviews with families and service providers of these 12 children indicates that **admissions to the state hospital were appropriate** given the resources available to families and providers at the time. Children admitted to state hospitals displayed **acute harmful behaviors** and psychiatric symptoms at the time of admission, were **in need of medication adjustment** and evaluation, and had experienced **significant life changes or transitions in recent months**. Their **history of serious emotional and behavioral difficulties** left them in frequent if not chronic crises.

Most often children were admitted or transferred to state hospitals because **(1) short-term treatment in local hospitals had been attempted and was deemed insufficient to stabilize the child and/or adjust medications or (2) short-term treatment in local hospitals was not available due to a shortage of beds at the time**. State hospitals offer a longer-term treatment option currently unavailable in local hospitals.

Services families received prior to hospitalization included many services from mental health and other service systems (including child welfare, schools and disability organizations). ***It is surprising, however, that these young people with very severe and chronic mental health issues did not receive the full array of mental health services at the time of admission: only seven received mental health services using the Home and Community-based Services waiver, and of those only two received the full range of services at the time of admission; only eight of the 12 children had IEPs at school at the time of admission to the state hospital.*** The most consistently received mental health service was the administration of medication but families voiced strong concerns about the accessibility and quality of medication management and psychiatric consultation. Families were most satisfied with case management services and had mixed impressions about the quality of Attendant Care/ICS, Therapy, and Psycho-Social Groups. The effectiveness of previous local inpatient services, especially for adjusting and monitoring medications, seemed limited by the short-term nature of local hospital programs. Although areas for improvements in community-based services were identified, it is not clear to what extent such improvements could have prevented the hospitalization of any of the children in this sample.

Common barriers affecting service quality across systems included high turnover, lack of accessibility of services at critical points in children's lives, lack of communication and collaboration within and between systems, lack of transportation and financial resources, and families' sense of not being taken seriously.

Another common concern was that ***current crisis services and response systems frequently failed to adequately assist families with young children in psychiatric crises.*** Hotline responders were unprepared for the questions and needs of families whose definition of "crisis" is different from adult psychiatric categories of being homicidal or suicidal. Individual crisis plans lacked details and specificity to assist families or responders in de-escalating the child or divert from hospitalization. Concerns about worker safety kept Mobile Crisis Response Teams from assisting families at their homes and instead require families to transport their child to a safe location for screening. The lack of adequate on-site crisis services contributed to the frequent use of law enforcement officers to assist with crisis intervention and transportation. Walk-in crisis clinics and local crisis beds were appreciated and utilized by families but these service options are not available in all parts of the state.

The effectiveness of the screening process as a way to prevent unnecessary hospitalizations is influenced by screeners' experience and comfort level with children and children's services, as well as availability of and access to diversion services at the time. For the safety and convenience of workers, most screenings were conducted in agency settings making it necessary for families to arrange for safe transportation. ***The screening and admission process can take an extraordinary length of time*** especially when the child welfare system is involved and requires collaborative planning, or court orders, or when families access services through an emergency room.

Screener background and training varied widely. Screeners often lacked specific experience and training in working with children and families, or familiarity with children’s services. Currently, screener training is not standardized across the state. Training occurs on-the-job through shadowing and supervision, and is usually not specific to work with children and families.

Analysis of **data from local/regional hospitals** shows that five hospitals account for more than 90% of psychiatric admissions of children in community hospitals statewide: Coffeyville, Stormont Vail, KU Medical Center, Prairie View, and Kaw Valley Center.

Recommendations

(1) Do not close State Hospital beds for children age 12 and younger because:

- Current admissions of this population seem appropriate, given the current status of the system of care.
- State mental hospitals serve a need for mid-range inpatient care (20-30 days on average) that cannot be filled by local/regional hospitals even if solutions to programming and staffing barriers could be found. The number of children needing this type of psychiatric inpatient service (100 per year statewide) is not enough to justify more than two regional centers, the same number as the two state hospital facilities that exist now. Thus, the problem of families needing to bridge geographic distance would persist.

Recommendations for the improvement of the existing system include:

(2) Prevent acute crises by assuring timely access to the full range of community based services:

- Provide training and quality assurance for crisis plans to be specific, relevant and updated to anticipate crises in the advent or wake of significant life transitions (plans should address transportation questions)
- Further improve availability, accessibility and/or quality of the full range of services under the HCBS waiver
- Foster and improve communication and collaboration of CMHCs with local law enforcement, child welfare providers, school systems, and CDDOs.
- Consider creating liaison positions between CMHCs and private hospitals, as well as hospitals and child welfare contractors.

(3) Build a more effective, child and family-centered crisis response system:

- Train hotline responders to understand, respond and assist families in crisis.
- Explore the option of a statewide warm-line for families with children in crisis whose responders are trained to coach and assist families in how to de-escalate their children, and which local resources to access.
- Educate families on the use of crisis plans, crisis hotlines and/ or warm-lines (Utilizing local parent support workers)
- Enable mobile teams go to families’ homes safely: consider the development of joint teams of law enforcement, mental health crisis and family workers.

Foster collaboration, co-training and co-deployment with community law enforcement officers.

- Explore current technology to allow more screener mobility

(4) Improve psychiatric diagnosis and medication management:

- Do NOT consider the development of “algorithms” as a way to guide medication management for children because of the significant difficulties in ascertaining accurate diagnoses for children, and the absence of psychotropic medications that have been empirically tested and approved for the use by children. [See Appendix B for full discussion of this issue.]
- Improve accuracy of psychiatric diagnoses for children and reliability across providers.
- Improve availability and access to psychiatric medication services through recruitment of child psychiatrists and ARNPs.
- Explore if and how other states successfully improve availability and access to medication services for children.
- Provide families with information about psychiatric medications

(5) Improve the screening process and training for screeners:

- Establish basic standard training for screeners that includes assessing children, interviewing families and knowledge about CBS services for children.

Hospitalization of Children in the Kansas Mental Health System

1. Background

In Kansas and throughout the U.S., policy initiatives for children and adolescents with serious mental disorders have focused on building a community-based services system as an appropriate and preferred alternative to hospitalizations (Pottick et al., 2002). Various stakeholders in the state of Kansas, have raised questions about the role of State Psychiatric Hospitals on the continuum of care for children and adolescents with serious emotional disorders (SED), and wondered about the reasons for and alternatives to the admission of children who are 12 years of age or younger to state mental hospitals.

In March 2001, the Hospital Stakeholder Task Force, established by SRS in December of 1999, recommended that “the state of Kansas establish a goal to eliminate state institutions for the treatment of mental illness for children 12 and under by developing alternative services.”

In May 2002, a Statewide Children’s Hospital Committee began to meet to discuss this recommendation and to make recommendations for improving the coordination of care and appropriate utilization of psychiatric hospitalization for children and youth in Kansas. This group’s recommendations were forwarded to a third task force on the Future of Kansas State hospitals. The Steering Committee Report, issued December, 2003, did not specifically endorse the above goal from the 2001 Hospital Stakeholder Task Force, but did make recommendations that were germane to children’s mental health services:

- Renewed assessment of the reimbursement system for state-funded inpatient psychiatric services provided outside of state hospitals.
- Increased outreach to inform families having youth with mental health needs about CMHC services.
- Enhanced crisis service plan development and implementation by CMHCs.
- Additional inpatient service availability regionally, with implementation in FY 2005 of a regional model for inpatient psychiatric services for children
- Continued exploration of alternative models of state hospital service delivery.

Similarly, the Subcommittee on Children’s Mental Health of the Governor’s Mental Health Services Planning Council has questioned whether children twelve or younger could or should be maintained in the community, and if current Medicaid reimbursement structures result in children being admitted to state hospitals when private

1.
Background

hospitals could no longer obtain reimbursement for their services (Governor's Mental Health Services Planning Council, Draft Report 2004).

In an effort to avoid unnecessary hospitalizations of children and youth, current policies in the state of Kansas mandate that a screening be done before any admission to state hospitals. Screenings are provided through licensed mental health professionals from the local Community Mental Health Center and are available 24/7 as part of the crisis services. In an attempt to identify possible gaps in services and initiate possible diversion from hospitalization, screeners conduct a risk assessment of child behaviors, and complete an inventory of mental health services the child has received. Diversions are initiated if outpatient services can be accessed and are deemed sufficient to keep the child safe. Otherwise, children are hospitalized.

In order to guide future directions of state policy and practice, the Kansas Department of Social and Rehabilitation Services (SRS) commissioned the following inquiry, conducted by the School of Social Welfare at the University of Kansas, to explore reasons for the admission of children age 12 and under to state hospitals, experiences of families and professionals with the current screening process, and possible alternatives to the use of state hospitals through development of local and regional resources.

Study Questions:

The research questions for this study were:

1. What are the characteristics of children age 12 and younger who were admitted to state hospitals in terms of age, race, gender, socioeconomic status, diagnosis, address, and other demographic variables?
2. What were the circumstances that led to their admission to a state hospital?
3. What were the processes and conclusions of the Screening?
4. What services had the child received from their local CMHC or local hospital prior to admission, if any? Was state hospital admission prompted by Medicaid rules for reimbursement of community hospitals?
5. What was the array, intensity, duration, and quality of those CMHC and hospital services? Was safety an issue, and the need for a secure facility the reason for admission?
6. Prior to admission, what was the nature and quality of family involvement in the array of services?
7. Given the results of the above, how many of the admissions could, or should, have been prevented, and how?
8. As an alternative to the use of state hospitals for children 12 and younger, how feasible is the development of local/regional hospital resources?

In order to best answer these questions, the two state hospitals, which serve children, (Rainbow State Hospital and Larned State Hospital) shared relevant statistical data from FY 2004. In addition, a qualitative multiple case study was undertaken to allow for an in-depth picture of children admitted from October 2004 to January 2005 and their circumstances prior to hospitalization. (This study did not investigate the quality of care at the state hospitals nor the situation upon discharge.) In order to explore potential capacity of utilizing local/regional psychiatric hospital beds instead of state hospitals for young children, data from the Kansas Hospital Association were collected and examined.

2. Psychiatric Hospital Utilization: National and State Data

2.
Psychiatric
Hospital
Utilization

Penetration rates and length of stay. The federal government's Center for Mental Health Services (CMHS), a division of Substance Abuse and Mental Health Services Administration (SAMHSA), collects data from states via the CMHS Uniform Reporting System (mentalhealth.samsha.gov/cmhs/mentalhealthstatistics). According to this data base, in FY 2002, Kansas served 148 children and youth aged 0-17 in state psychiatric hospitals, a penetration rate of 0.21 per 1,000 children. The length of stay for those discharged during FY 2002 was 73 days. Nationally, the average penetration rate was 0.29, and the average length of stay was 66 days. Thus, Kansas served a somewhat smaller percentage of children in state hospitals, but they stayed slightly longer. These rates varied widely from state to state: Vermont reported no children in state hospitals; South Carolina served 514 children (.51 penetration rate) with discharged length of stay only 37 days; Nebraska admitted only 65, (0.14 penetration rate), with length of stay 30 days; California served only 162 children (.02 penetration rate), but those discharged from the state hospital in 2005 had stayed an average of 238 days.

Changes in the utilization of mental health services. Compared to estimates for 1986, the overall number of youth who entered into any type of mental health services in 1997 rose by 87.1% indicating greater access to services (Pottick, et al., 2002). Youth admitted to inpatient care were far outnumbered by youth served outpatient in both 1986 and 1997. (Only about 21% of youth received services in inpatient facilities). ***Still, the relative increases for inpatient versus outpatient services developed contrary to policy intentions: A comparison of inpatient versus outpatient care shows that the utilization of outpatient care increased by 64.6%, while admissions to inpatient facilities increased by 142.7% from 1986 to 1997*** (Pottick, et al., 2002). Calculating admission rates per 100,000 youth in the U.S., the outpatient service rate rose by 48.7%, while the admission rate for inpatient services rose by 119.2%. Thus, despite reforms youth were not diverted from hospitals but were hospitalized more. The authors (Pottick, et al.,

2002) caution against conclusions that reforms have failed and point to changes in the insurance system during the 11-year time frame including the threat of liability suits may have led insurance companies to make inpatient care more accessible to seriously disturbed and potentially dangerous youth.

2.1 Characteristics of Children and Youth in Inpatient Facilities: National Data

The most recent available national data from the Substance Abuse and Mental Health Services Administration (SAMHSA) about the characteristics of children and youth utilizing inpatient mental health services draw upon the 1997 Client/Patient Survey Sample (CPSS) (Pottick, et al., 2002). The CPSS consists of a sample of over 4,000 children and adolescents, and provides information of their socio-economic background, prior services, and family situation.

Socio-demographic data. CPSS data indicate that of youth admitted to all types of inpatient services in 1997 32.5% were children age 12 or younger, while the majority (67.6%) were adolescents. Gender was distributed almost evenly with 50.8% male and 49.2% female patients. A majority of youth in inpatient facilities were Caucasian (67.4%), 16.1% were African-American, and 14% Hispanic (2.6% other). In contrast to youth admitted to residential care, far more young people admitted to inpatient facilities lived with a parent (72.5% as opposed to only 53% of residential youth), and only 18.4% of inpatient youth had ever lived away from relatives prior to admission (compared to more than 40% of residential youth). The two main sources of payment for hospitalization were private insurance (48.3%) and Medicaid (37.6%) (Pottick et al., 2002).

Functioning and diagnoses. Youth admitted to inpatient facilities showed significant impairments of functioning (54.7% had GAF scores of 60 or below and 79.4% had GAF scores of 60 or below). Forty-three percent had two psychiatric diagnoses. The largest number of diagnoses fell into the mood disorder category (44.3%) followed by disruptive disorders (17.4%). Other disorders included psychotic (7.2%), personality (5.6%), anxiety (4.9%), alcohol or drug use (4.9%) or developmental disorders (4.3%).

Presenting problems. Inpatient youth most often presented with anxious or depressed mood (64.5%), suicidality (55.4%), aggression (48.7%), family problems (47.3%) and difficulties coping at school (44.4%). A substantial number also presented with drug and alcohol use (25.7%), delinquent behaviors (24.5%) and a history of being abused or neglected (20.3%) (Pottick et al., 2002).

Prior services. Eighty-four percent of youth in inpatient facilities had received mental health services prior to hospitalization: 55.4% had seen a private doctor; 42.4 % had been admitted to

inpatient treatment before, 33.3% had received outpatient services, and 13.2 % had been in residential treatment (4.2% other/ unknown services) (Pottick et al., 2002).

2.
Psychiatric
Hospital
Utilization

2.2 Young Children in Kansas State Hospitals

Unlike national data about the utilization of hospitals, the recent trend of children's admissions to State Hospitals in Kansas shows a considerable reduction of admissions and shortening lengths of stay. While in FY 2002 a total of 148 children age 12 and younger were admitted to Kansas State Hospitals, only 92 children were admitted in FY 2004. The mean length of stay dropped from 73 days in FY 2002 to 31 days in FY 2004.

In FY 2004, *Rainbow State Hospital (RSH)* admitted 49 children age 12 and younger to its facility. The majority of children were boys (77.6%), Caucasian (69.4%), and between ages of 10 and 12 (63.3%). Most lived either with parents or other family members (79.6%), and 77.6% of them carried multiple psychiatric diagnoses. The mean length of stay was 24 days.

In the same time frame, *Larned State Hospital (LSH)* admitted 43 children age 12 and younger to its facility. The majority of the children were boys (72.1%), Caucasian (79.1%), and between the ages of 10 and 12 (59.5%). Most lived either with parents or other family members (65.1%), and 90.3% carried multiple diagnosis. The mean length of stay was 38 days. (See Tables 1 and 2).

Tables 1. and 2. Demographics of Young Children admitted in FY 2004 by hospital

Larned State Hospital FY 2004	
Admissions Total	43
Gender	72.1 % male 27.9% female
Ethnicity	79.1% Caucasian 9.3 % African-American 6.9 % Hispanic 4.7% other
Age	2.3%: 0-6 39.5%: 7-9 59.5%: 10-12
Living	With parents (or kinship):65.1% Adoption: 34.9% Foster care: not available JJA: 2.3%
Multiple diagnoses	90.3% yes
Mean LOS	38 days

Rainbow State Hospital FY 2004	
Admissions Total	49
Gender	77.6% male 22.4% female
Ethnicity	69.4 % Caucasian 16.3% African-American 6.1 % Hispanic 4.1 % Native American 4.1 % other
Age	0%: 0-6 36.7%: 7-9 63.3%: 10-12
Living	With parents (or kinship): 79.6% Adoption: 6.1% Foster care: 14.3 %
Multiple diagnoses	77.6% yes (of 7-9 year olds: 83.3 %) (of 10-12 year olds: 74.2%)
Mean LOS	24 days

2.
Psychiatric
Hospital
Utilization

Most frequently recorded diagnoses for children admitted Rainbow State Hospital in FY 2004 were Bipolar Disorder (27%), ADHD¹ (18%), Mood Disorder NOS² (14%), and PTSD³ (10%). RSH reported only the primary diagnoses for its children.

Larned State Hospital reported all diagnoses on record for children admitted in FY 2004. The 43 children had a total of 116 diagnoses between them. The most frequent diagnoses assigned to children were ADHD¹ (44%) Oppositional Defiant Disorder (42%), Bipolar Disorder (21%), Intermittent Explosive Disorder (16%), and Impulse Control Disorder (14%). Table 3. provides an overview of children's diagnoses at the two facilities.

Table 3. Most Frequently Assigned Diagnoses for Children admitted to State Hospitals in FY 2004

	STATE HOSPITAL	
	Rainbow	Larned
# OF TOTAL ADMISSIONS	49	43
DIAGNOSES	(total provided: 49)	(total provided: 116)
ADHD	9 (18%)	19 (44%)
Bipolar	13 (27%)	9 (21%)
ODD	2 (4%)	18 (42%)
Mood Disorder NOS	7 (14%)	5 (12%)
Conduct Disorder	0 (0%)	6 (14%)
PTSD	5 (10%)	4 (9%)
Psychoses	2 (4%)	1 (2%)
Other	11 (22%)	54 (46%)
<i>Most Frequent Others</i>	Major Depressive Disorder 3 (6%) Disruptive Behavior Disorder 2 (4%) Adjustment Disorder w/ disturbance of emotions or conduct 2 (4%)	Intermittent Explosive Disorder 7 (16%) Impulse Control Disorder 6 (14%) Depressive Disorder NOS 5 (12%)

NOTE: Table indicates number and percentage of children diagnosed with a given disorder, which maybe a secondary or tertiary diagnosis for LSH.

Notably, there is a wide variation of assigned diagnoses. Comparisons between the two state hospitals are somewhat skewed because LSH reported all diagnoses on record while RSH reported only the primary diagnoses. Still the prominence of different

¹ ADHD: Attention Deficit/Hyperactivity Disorder

² NOS: Not otherwise specified

³ PTSD: Post-Traumatic Stress Disorder

diagnoses in different hospitals is apparent. [See Appendix B. for a discussion of regional diagnostic patterns and questions regarding reliability and accuracy of diagnoses].

2.
Psychiatric
Hospital
Utilization

Regional referral patterns for FY 2004 can be gleaned from the Tables 4 and 5 for Rainbow and Larned Hospital respectively. The highest number of referrals for Rainbow State Hospital came from the main urban areas in the eastern part of Kansas together accounting for 28 of 49 admissions: Family Service and Guidance Center in Topeka (11 referrals), ComCare in Wichita (8), and Johnson County in the Kansas City area (6). Notably, relatively few referrals came from Wyandot County Mental Health Center located in a comparatively poor county in the same county as Rainbow State Hospital (3).

The highest number of referrals (accounting for 25 of the 43 admissions) for *Larned State Hospital* came from five areas in close proximity to the state hospital: Area Mental Health (Dodge City area ;8 referrals), Center for Counseling and Consultation (Great Bend and Larned areas; 6 and 3 referrals respectively), Horizons Mental Health (Hutchinson and Pratt; 4 referrals each).

Table 4. Rainbow--Number of Young Children by Community Mental Health Centers for FY 2004

Community Mental Health Center	Total	By Age		
		0 - 6	7 - 9	10 - 12
Central Kansas Mental Health Center	1	0	0	1
Community MHC of Crawford County	3	0	2	1
Four County Mental Health Center	1	0	0	1
Franklin County Mental Health Center	2	0	0	2
Johnson County Mental Health Center	6	0	3	3
Kanza Mental Health & Guidance Center	1	0	0	1
Mental Health Center of East Central Kansas	3	0	2	1
Miami County Mental Health Center	3	0	0	3
Pawnee Mental Health Services	3	0	1	2
ComCare of Sedgwick County	8	0	3	5
Family Service and Guidance	11	0	3	8
South Central Mental Health Counseling Ctr	3	0	3	0
Southeast Kansas Mental Health Center	1	0	1	0
Wyandot Ctr for Community Behavioral Health	3	0	0	3
Total:	49	0	18	31

Table 5. Larned-- Number of Young Children by Community Mental Health Centers for FY 2004

Community Mental Health Center	Total	By Age		
		0 - 6	7 - 9	10 - 12
Area Mental Health	10	0	7	3
Central Kansas	1	0	0	1
Center for Counseling and Consultation	10	1	3	6
Comcare of Sedgwick County	1	0	1	0
High Plains	6	0	2	4
Horizons	9	0	3	6
Iroquois Center for Human Development	1	0	0	1
Prairie View	2	0	1	1
South West Guidance Center	2	0	0	2
Juvenile Intake	1	0	0	1
Total	43	1	17	25

3. A
Qualitative
Multiple
Case Study

3. Children in the State Hospital -- A Qualitative Multiple Case Study

In order illuminate the circumstances surrounding the admission of children to state mental facilities, this multiple case study took an in-depth look at a convenience sample of twelve children age 12 and under who were admitted to or residing at one of the two state mental hospitals in the months of November 2004 through January 2005.

3.1
Qualitative
Study --
Methods

3.1 Methods

3.1.1 Access

Access to potential study participants was gained through Rainbow and Larned State Psychiatric Hospitals. A letter to parents or guardians, which outlined the basic purpose and procedures of the study, became part of the admission packet at state hospitals at the beginning of November 2004. State hospital staff alerted families to the study and to the fact that KU researchers would contact them. Rainbow Hospital staff also mailed copies of the letter to families of children who were already at the hospitals at November 1st allowing the inclusion of these children in the study for the RSH site. Designated staff at state hospitals forwarded families' basic contact information to the researchers who then called potential family participants to explain the project in detail, and asked their consent to participate in the study.

3.1.2 Data Sources and Data Collection

3.1
Qualitative
Study --
Methods

When families agreed to participate, formal consent forms were signed by families and the two researchers met with family participants at a time and location of the families' choosing (usually their residence) to conduct a 90-120 minute face-to-face interview. Families also consented to give researchers access to information on file at the hospitals. Family participants identified community mental health service providers, school personnel, child welfare workers or other sources able to offer additional insights into the situation prior to and leading up to hospital admission, and granted written consent for these sources to release information to researchers.

The total sample for this study consisted of 12 cases. In the time period from November 1st, 2004 through January 30th, 2005, *Rainbow State Hospital (RSH)* referred 19 cases to researchers. These cases were either at RSH on November 1st, or were admitted thereafter. Ten of the 19 families could either not be contacted, declined participation, or no-showed for the interview. Nine RSH families participated in the study. *Larned State Hospital (LSH)* referred four cases who were admitted between November 1st, 2004 through January 2005. Of these four cases, one family declined participation. Three LSH families agreed to participate in the study.

Each researcher took primary responsibility for six cases. While family interviews were conducted jointly, each researcher individually approached community providers identified by "their" families, obtained providers' consent to participate, and conducted either face-to-face or phone interviews. If children were transferred from a private hospital setting to the state hospital (five cases), researchers also contacted the private hospital to obtain information about reasons for the transfer.

All family interviews were audio-taped and transcribed for analysis. Interviews with service providers were audio-taped whenever possible. To expedite the analysis, researchers utilized a evaluation-focused method (Patton, 1997) to transcribe key quotes and information given by providers. In addition to interview data, hospital case records, including demographic information, a psycho-social history and assessment, and screening forms were main sources of information for this study.

For the 12 cases, a total of 67 interviews were conducted (see Table 6.): Thirteen interviews with family members, 50 interviews with professionals directly or indirectly involved in providing services for the child, and four interviews with intake staff at LSH and RSH (the latter are not listed in the case matrix below because they covered several cases and general information related to admission processes).

Table 6. Case Matrix

	<i>Family</i>	<i>Screeners</i>	<i>MH Case Manager</i>	<i>Other MH provider</i> ¹	<i>School personnel</i> ²	<i>Child Welfare</i>	<i>Regional Hospital</i>	<i>Police officer</i>
1	X	X	X	XX				
2	X	X		X				
3*	X	X	X	XX	X	X	X	
4*	X	X		X	X	X	X	
5*	X	X	X	X	X		X	
6	X	X			XX			
7* ³	X	X	X	X	X		See ³	
8	X	X	X		X			
9* ³	X	X	XX	X	X		See ³	
10	XX	X	X		X	X		
11	X	X	X		X			X
12	X	X	X	X	X			

¹ Includes 5 therapists, 3 ICS or Attendant Care workers, 2 parent support specialists.

² includes 8 teachers or principals, 3 school counselors or school psychologists

³ interviews 7 and 9 indicated the same reasons for transfers and children had come from the same regional hospitals as earlier cases. To avoid unnecessary redundancies, regional hospital staff were not interviewed a second time.

* = Transfer from local hospital to state hospital

X = number of Xs represents number of interviews

Questions posed to families elicited their recollection of the main crisis that led to the child's hospitalization (child behaviors, crisis response etc.), the sequence of events (such as who did they contact first, how did they transport the child etc.), experiences with the screening and admission process, changes and transitions in the child's or family' life within the past year, and the range and quality of services received from mental health providers (including previous hospitalizations), schools, and other service systems (such as child welfare providers). If children were transferred to the state hospital, interviewers inquired about reasons for the transfer.

Akin to the family interviews, questions posed to service providers focused on their involvement with the family, the type and quality of services delivered prior to and during the crisis, communication and collaboration with other providers, and precipitating factors. If children were transferred to the state hospital, interviews inquired about reasons for the transfer.

Questions posed to screeners focused on the initial impression of the child, diversion attempts, screeners' professional background, training, and more general questions about the perceived effectiveness of screenings. If children were transferred to the state hospital, interviewees inquired about reasons for the transfer. Staff at state and local hospitals were asked to identify reasons for transfers, and related barriers and challenges. All participants were asked to make recommendations for the improvement of services.

3.1.3 Analysis

Coding and interrater agreement. All transcripts were entered into an Atlas.ti qualitative data base for coding and data management. In order to maximize consistency between

researchers' coding, each researcher independently analyzed one pilot case for which she had taken primary responsibility, and coded all interviews concerning this case. Researchers then met to discuss their respective codes and developed a joint coding guide, consisting of a total of 32 codes, used to code all interviews. After coding all of their respective cases, researchers swapped cases, serving as a second rater for already coded interviews. Again, questions about codes were discussed as they emerged in the process, and the shared coding scheme was finalized (see appendix A).

Data was analyzed using *constant comparisons* in three main ways:

- (1) Within case: Which main themes emerge within each case? Which key information is shared by all sources for the case, which information diverges?
- (2) Across case: Which themes emerge across all cases? How are they similar or different? Which themes are unique to particular cases?
- (3) Within source: Grouping interviews by their source (such as all family interviews, all case manager interviews etc.) which common themes emerge? Which information is unique to a particular source?

3.1.4 Stakeholder Feedback

In order to establish if the sample was similar to typical hospital populations beyond the FY 2004 comparison group, and to assure credibility and confirmability of the data (Lincoln & Guba, 1985), preliminary findings were presented to a group of stakeholders who represented the major respondent groups (family representatives, staff from state hospitals, community mental health services and crisis services, and screeners). Feedback was also solicited from stakeholders unable to attend the meeting, namely school staff, law enforcement, case managers, regional hospital staff, child welfare contractors, and the Governor's Mental Health Services Planning Council. A summary of stakeholder feedback can be found on pages 41-43, Section 3.3.

3.2 Findings

3.2.1 Participant Demographics

Two thirds of the *RSH* sample were boys (66.7%), and all but one were Caucasian. One child was younger than 7 years old, one was between 7 and 9 years of age, and all others were between 10 and 12 years (77.8%). Most children lived with parents or family members (77.8%), one was adopted, and one in foster care at the time of admission. Primary diagnoses of the *RSH* sample included Mood Disorder, Bipolar disorder, Posttraumatic Stress Disorder (PTSD), Reactive Attachment Disorder (RAD), Oppositional Defiant Disorder (ODD), Attention Deficit Disorder (ADD/ADHD), Psychotic Disorder, Obsessive Compulsive Disorder (OCD), and Autism/Pervasive Developmental Disorder (PDD). All of the children carried multiple psychiatric diagnoses.

Of the *LSH* sample, two children (66.7%) were male, and all were Caucasian. One was between 7 and 9 years of age, and two (66.7%) between 10 and 12 years old. One child was adopted, two lived with parents or family members. Their primary diagnoses included Bipolar Disorder, ADD/ADHD, PTSD, and ODD, and all of them carried multiple psychiatric diagnoses.

In terms of their basic demographic characteristics these convenience samples appear similar to the population admitted to the respective state hospital in FY 2004. Stakeholder feedback from hospital staff also confirmed that the samples are indeed characteristic of the typical population of children admitted to each of the state hospitals. [Table 7. represents the sample demographics.]

Table 7. Sample demographics by Hospital

	Rainbow Sample	Larned Sample
Total	9	3
Gender	66.7% male 33.3% female	66.7% male 33.3% female
Ethnicity	88.9% Caucasian 11.1% African-American	100% Caucasian
Age	11.1%: 0-6 11.1%: 7-9 77.8%: 10-12	0%: 0-6 33.3%: 7-9 66.7%: 10-12
Living	With parents (or kinship): 77.8% Adoption: 11.1% Foster care: 11.1%	With parents (or kinship): 66.7% Adoption: 33.3%
Multiple diagnoses	100% yes	100% yes

3.2.2 Appropriateness of Admission to the State Hospital

Overall, analysis of the data indicated that **children's admission to the state hospitals was appropriate given the resources available to families and providers at the time**. As will be explicated in more detail below,

- all children had a history of serious emotional or behavioral difficulties, and exhibited significant self-harming or aggressive behaviors at home, at school or in both or more areas immediately prior to admission;
- all children in the sample already received some type of mental health service in their community at the time of admission (one had only received crisis services);
- less restrictive community-based services to divert from the hospitals were either not available at the time of crisis or were deemed insufficient to keep the child safe.
- While areas for improving community-based services were identified, none of these respondents indicated that such improvements would or could have prevented the need for hospitalizing these children.

Overall, **reasons for children to be admitted to state hospitals instead of local/regional psychiatric hospitals** fell into five main categories⁴ although it was often difficult to discern a single reason for admission. Frequently, multiple reasons applied to a given case:

- (1) Previous local hospitalization appeared insufficient or unsuccessful. Several children had been previously hospitalized in one or more local/regional psychiatric hospital units and their hospitalization was viewed as unsuccessful or too short by families and/ or providers.
- (2) Transfers. Five of the 12 children in the sample were transferred from a private local hospital to the state hospital because the child was not deemed stable enough to be released after spending several days at the local/regional hospital. Local hospital providers concluded that these children's needs extended beyond the short-term (3-7 days) design of regional hospital programs, and required longer term treatment, which led to a transfer to state mental facilities.

Three related reasons for transferring children were discussed:

- Some children may not suit the group milieu at a private hospital (such as age groups, behaviors, or group dynamics) at a given time leading local/regional hospital staff to transfer or not admit a child;
- Private local hospital programs do not have staff to provide school services, thus children in need of longer term inpatient treatment may be missing schoolwork;

⁴The need for a "secure facility" was not cited in these cases. Interview data suggest that this factor is more likely to apply to an adolescent population.

3.2.2
Findings--
Appropriateness of
Admission

- For some children the days allotted by private insurances for inpatient treatment may be running out before the child is deemed stable enough to be discharged to outpatient services. Interview participants from private hospitals insisted that most of the children admitted to their services are Medicaid recipients (as in the cases in this sample), and that children's needs, not DRGs, determined the transfer or discharge of a given child. Structurally, however, it stands to reason, that insurance (and Medicaid) reimbursement policies that clearly favor short-term stays (3-5 days) played a role in the design of psychiatric programs at private hospitals. In other words, the standard reason given for transferring a child to a state facility--"needs longer term treatment than our program is designed to provide"—is at least an indirect result of current reimbursement structures and policies that favor short-term program designs.

- (3) Availability of beds. At the time of the screening no hospital beds in local/regional hospitals were available.
- (4) Medication adjustment or re-evaluation. The need for significant medication adjustments or re-evaluations, including the need to monitor behaviors and side effects after changing medications, required a longer-term inpatient stay than the time-limited design of local/regional hospital programs could provide.
- (5) Family circumstance or choice: In some cases, families' circumstances or explicit preferences for the state hospital because of prior experiences or geographic location led to a direct admission in Rainbow or Larned.

3.2.2.1 Acute Child Behaviors Leading to Admission

All of the children showed some kind of violent action directed at self or others or made threats to harm themselves and/or others leading to initiation of screening and admission to the hospital. Yet, the need for a secure facility was not given as a reason for transferring children from regional to state hospitals. Examples of behaviors include:

- stabbing self with sharp objects,
- threatening to kill teachers or family members,
- running in front of moving cars,
- destroying property,
- punching and kicking adults or peers,
- trying to suffocate self
- running away from home or school etc.

Variations of behaviors typically occurred both at home and at school. In three cases critical behaviors occurred almost exclusively in the school setting, and in one case the child's most explosive behaviors occurred primarily in the family setting. In

seven cases families indicated that difficulties at school were directly related to the most recent hospitalization. In one case the child's threats against school personnel triggered hospitalization, although the child otherwise appeared to exhibit more internalizing than externalizing behaviors.

3.2.2
Findings—
Appropriate-
ness of
Admission

3.2.2.2 Context of Acute Behaviors

Children's acute behaviors occurred in the context of already existing emotional and behavioral difficulties for the child and/or for the family resulting in ***frequent if not chronic crises***.

- In all cases, participants reported a history of psychiatric difficulties in the child.
- In seven cases, data indicate a history of child abuse or neglect or a strong suspicion thereof.

In addition, difficulties adjusting medications and life changes/transitions appeared to contribute to the current crisis:

Difficulties adjusting or monitoring psychotropic medications

All children in this sample received prescribed psychotropic medications before they were admitted. Adjustments of medication were cited as one of the reasons for hospital admission in nine cases. Participants specifically identified that the following factors influenced the decision to admit the child to the state hospital instead of local/regional hospitals:

- the need for longer-term medication adjustments;
- wanting to take a child off all medications ("med wash out"); or
- the need to monitor behaviors and side effects after changing medications

The time-limited design of local/regional hospital programs did not provide an opportunity to titrate medications slowly, watch medication effects over a longer period of time, or for taking a child off all medications.

[See page 22 for further findings on medication services previously received.]

Life changes/ transitions during the past 12 months.

In all cases, participants reported that the child and/or family had undergone significant life changes or transitions in the months prior to hospitalization. It remains unclear, however, to what extent some of these changes may have occurred in response to escalating behaviors.

- In seven cases the child had recently changed schools.
- Seven children had moved.
- Three had changed main caregivers.

Other losses or changes included:

- loss of family members to death, separation or divorce, or final termination of parental rights (five cases)

3.2.2
Findings—
Appropriate-
ness of
Admission

- changes in schedule and availability of key caregivers (due to entering school, new stepparent, new siblings, foster sibling leaving home, illness in the family etc.) (six cases).

In summary, admissions were appropriate given the resources available to families and providers at the time. ***Children admitted to state hospitals*** displayed acute harmful behaviors and psychiatric symptoms at the time of admission, were in need of medication adjustment and evaluation, and had experienced significant life changes or transitions in recent months. Their history of serious emotional and behavioral difficulties left them in frequent if not chronic crises. Most often children were admitted or transferred to state hospitals because short-term treatment in local hospitals

- had been attempted and was deemed insufficient to stabilize the child and/or adjust medications
- was not available due to a shortage of beds at the time.

State hospitals offer a longer-term treatment option currently unavailable in local hospitals.

3.2.3
Findings--
Crisis
services
and Crisis
Response

3.2.3 Crisis Services and Crisis Response

Aside from the screening, which is a mandatory part of crisis services preceding any hospitalization to state hospitals, most families had used one or more of the crisis services prior to hospitalization. Crisis services at Community Mental Health Centers (CMHCs) include such services as

- crisis hotline/1-800 number
- walk-in crisis clinic
- crisis beds (overnight crisis stabilization services)
- mobile crisis response
- individualized crisis plans

3.2.3.1 Initial Contact at the Time of Crisis

At the time of the crisis that eventually led to hospitalization, families most often contacted (or attempted to contact) a specific mental health provider with whom they had an existing relationship. Other contacts were initiated through hotlines, walk-ins, or in the context of already scheduled meetings. In one case school personnel initiated the crisis call.

- two contacted their therapist
- four contacted or attempted to contact case manager
- two called the on call crisis line/team
- one had meeting scheduled with psychiatrist
- two walked into a crisis services clinic
- one was in a scheduled school meeting

- one walked into the hospital emergency room
- one school called the police

3.2.3
Findings--
Crisis
services
and Crisis
Response

3.2.3.2 Crisis Hotline

Ten families reported they had used a hotline number either in the crisis leading to the most recent hospitalization or during prior crises. Overall, their experience with hotline services called for improvements.

- Hotline services worked well in situations with behaviors in which parents could transport the children to the CMCH or other locations for a screening but were not helpful in resolving an immediate crisis with a child's out-of-control behaviors.
- Some families reported that hotline responders told them to "call back during business hours", or promised to have CMHC providers call back but that these call-backs never occurred.
- Some parents indicated that hotline responders dismissed their immediate crisis because the child was not deemed homicidal or suicidal. It appeared as though the families' definition of what constitutes a crisis did not match the definition held by responders.

Well, those people say, "Is he homicidal?" "No." "Is he suicidal?" "No." ... "We aren't going to do anything about". So I always felt like my hands were tied and I felt stupid most of the time. I didn't know who to turn to, what to do. [Family]

- Some parents indicated they needed "coaching" about how to handle a child's behaviors and did not receive such help.
- Parents reported being irritated by hotline responders frequently telling them to call the police.

The center has a crisis line that is a joke. You call it and you get someone who does not know your child asking you all these questions that are not relevant. In addition you can tell the person on the other end knows nothing about kids. They tell me to call the police. I am not going to call the police I need some coaching. Is more useful just to call my parents ...and this is what I do. They come to help when I need them to. [Family]

Say you call and have been with the [children] all weekend and need help and they basically relay, "Well, what do you want us to do? Call the police!" I am sorry, I don't want to call the

police. They will take a totally different approach. Besides we have had the police out here before and word in town gets around real fast in this rural community. [Family]

3.2.3.3 Crisis Walk-In Clinic

Two families used a walk-in clinic and found the easy access helpful.

[The school] told me I could go through the crisis clinic that they have there and get some help.....and I've lived in this county my whole life, but never knew that existed to get help. [Family]

They want to know what's going on and... it's kind of a quick fix. "What's going on? Is there something we can do to make this better for you?" It's not like a full appointment. It's more like a 15 minute kind of thing usually. [Family]

3.2.3.4 Overnight Crisis Stabilization Services ("Crisis Beds")

Three families had utilized local crisis beds for crisis stabilization/ respite or for diversion from the hospital before with some success. Some CMHCs provide local crisis beds usually staffed by attendant care workers to provide emergency respite options when children and families need time away from each other to de-escalate a growing crisis situation. These facilities are not staffed or equipped for youth with acutely violent or self-harming behaviors nor to address medication issues.

A client can be there up to 72 hours, [it] provides respite for the family, kind of a long time-out. There are four beds but they will only have two kids at a time, staffed 24-hours. The [crisis beds] are used when parents are at wits end and they all need a break from each other but if the kid voices threats to harm self or others, or has attempted anything like that than a screen for the hospital is indicated. [screener]

3.2.3.5 Crisis Plans

When asked about crisis plans, participants' responses indicated that crisis plans were most often vague. Rarely could any participant, provider or family, recall concrete details of a crisis plan other than calling the case manager, the hotline or the police. Only in two cases did respondents indicate that plans included warning signs for escalating behaviors and individualized ideas for taking action.

There wasn't a lot of meat to it. Potential crisis was "harm to self or others". The actions steps were for her parents to call [mental health center] or Law Enforcement if they needed to. [mental health provider]

Calling the police is on every kid's crisis plan. [mental health provider]

Oh, there was always discussion of crisis plans in court, in wraparound. Let me just say: I've never seen one. [Family]

[These crisis plans are] response plans at best. It takes repeated major crisis before we develop a strong crisis plan. [child welfare provider]

3.2.3.6 Mobile Crisis Response

Although mobile crisis response is considered a regular component of CMHC's services, only in one case did providers come to the family's home to try and assist in the immediate crisis leading to hospitalization.

I used to tell people that there are mobile crisis units but I do not any more. I do not know of any mobile services who will really come to the home. [hospital provider]

In four cases, CMHC providers met the family at the location of the screening. (For more details about the screening process, see pages 30-35.)

3.2.3.7 Police Involvement

In eight of the 12 cases police officers were involved as part of the crisis response to homes or schools (five children threatened to hurt self or someone else and three children were considered to have run away). While the use of law enforcement officers was common practice some respondents voiced uneasiness with the appropriateness of police involvement:

I couldn't get a hold of anybody and so I called the police to get him, they tried to talk to him and he wouldn't talk to them so they had to restrain him and take him [family]

3.2.3
Findings--
Crisis
services
and Crisis
Response

What is the purpose of arresting special needs children?... They need to start working with them more intensively in the schools. The paras don't know what to do they don't have directions so they call the police. That is not right.[family]

I had never really dealt with a kid that age that wouldn't do what we wanted him to do. I was kinda green. [police officer]

In summary, current crisis services and response frequently fail to adequately assist families with young children with serious psychiatric symptoms. Hotline responders are unprepared for the questions and needs of families whose definition of “crisis” is different from adult psychiatric categories of being homicidal or suicidal. Individual crisis plans lacked details and specificity to assist families or responders in de-escalating the child or divert from hospitalization. Concerns about worker safety keep Mobile Crisis Response Teams from assisting families at their homes and instead require families to transport their child to a safe location for screening. The lack of adequate on-site crisis services contributes to the frequent use of law enforcement officers to assist with crisis intervention and transportation. Walk-in crisis clinics and local crisis beds are appreciated and utilized by families but these service options are not available in all parts of the state. Despite these inadequacies, responses did not indicate if better crisis services would or could have prevented hospitalization in a given case.

3.2.4
Findings--
Services
Received Prior
to
Hospitalization

3.2.4 Services Received Prior to Hospitalization

Aside from crisis services (described above), children in this sample received a wide range of services prior to hospitalization, including community-based mental health services, services from child welfare contractors, schools or Community Developmental Disability Organizations. (see Table 8. for a matrix of services received). Satisfaction with services varied widely among cases.

Table 8. Services Received

Case	1	2	3	4	5	6	7	8	9	10	11	12
Mental Health												
HCBS Waiver	x				x		x		x	x	x	x
Previous inpatient	x		x		x	x	x	x	x	x	x	x
Medication Services	x	x	x	x	x	x	x	x	x	x	x	x
Case management	x		x		x		x	x	x	x	x	x
Psycho-Social Gr. Therapy	(x)		x	(x)	x		(x)	(x)	x	x	x	x
Attendant Care/ ICS	x	x	x	x	x		x	x		x	x	(x)
Parent Support	x			(x)	x		(x)		x	x	x	x
Wraparound	x		x	x	x		x		x	x	x	x
Respite Care/Beds	(x)		x		x		x			x		x
Child Welfare (active)			x	x						x		
School: IEP	x		x	x	x			x	x	x		x

x received service at time of admission; (x) received service in the past but not at time of admission

3.2.4.1 Previous Psychiatric Hospitalizations (including state and local/regional hospitals).

Children's significant history of difficulties was reflected in the number of previous psychiatric hospitalizations. Ten of the 12 children had been hospitalized before. Only two children were a first time admission to a psychiatric hospital.

- Seven cases had at least three previous admissions (1: 7; 1: 6; 2: 5; 3: 3)
- Three cases had one or two previous inpatient admissions.
- Four children had been admitted at least one other time to the state hospital.

Respondents most often critiqued the short-term nature of acute hospitalizations as having limited the effectiveness of prior hospital stays.

The only thing they ever do is every time we took her into [the local hospital], they keep her for a couple of days, then they turn around and say they say "we don't see anything wrong with her," then they turn around and send her right back home.[family]

I was [at the local hospital] discharge meeting, reports were that everything was "just wonderful." Things fell apart as soon as she got back. [mental health provider]

- In seven cases, acute inpatient experiences were viewed as not useful because medications were quickly changed without informing parents/providers of potential side-effects or monitoring results.

They might increase her medicine, might decrease, I mean once they even put her on Ritalin don't even ask me what it's for... We didn't even find out until the day they discharged her. So, that didn't help us any either [family]

[It] would be useful to know what they have done....is what we are seeing a side-effect of the recent medication changes. [School staff]

Each hospital stay has been 3-7 days, they change her meds, they send her home and when she gets home everybody has to deal with the med changes and that has been a huge frustration. [Case manager]

3.2.4
Findings--
Services
Received Prior
to
Hospitalization

- Five families singled out Prairie View Hospital as having been a helpful experience because it put an emphasis on family involvement.

Prairie View really set the bar. And, I have not found another facility that has, you know, passed it. They really encourage parents to stay with their children to take part in a lot of educational videos. That's where I got, started my passion to find out more about this. [family]

3.2.4.2 Community Mental Health Services

All 12 children had *some* contact with Community Mental Health Centers (CMHCs) prior to state hospital admission, however only ten were active cases at the time of hospitalization.

- Ten families received an array of services immediately prior to state hospitalization.
- One family left to get private services a year prior to hospitalization citing dissatisfaction with services.
- One family had only contact with crisis services several weeks prior to this hospitalization and was waiting for community-based services to begin. Due to poor coordination and staff turnover there was no follow-up appointment.
- Seven children were served under the Medicaid Home and Community-based Services (HCBS) waiver at the time of admission. Of those, only two reported receiving the full array of services. Most frequently missing in the remaining five cases were parent support services, attendant care/ICS, and respite care at the time of admission.
- Among the five children who were served at the CMHC but not under the HCBS waiver at the time of hospitalization, two were in state custody, one child was served at the local CMHC but not under the waiver, one child had private insurance and received services from a private mental health provider, and one was not yet in the local CMHC system (on the waiting list).

In five of the ten cases served by CMHCs, the intensity of mental health services (# of hours provided) increased just prior to hospitalization.

- Case managers provided extra coaching to parents, went to schools, called other providers involved, or spent more face to face time with children.
- Attendant care was utilized more when available and appeared more effective in crisis situations with two children who had longer term relationships with their provider.
- One family reported more contact with psychiatrist.
- However, higher intensity of service did not always translate into better quality.

Child Welfare provider decided the family needed a lot of support, so we put all that in and I think, it did not really help. When behaviors ... increased and got worse, we put more support in. [mental health provider]

3.2.4.2
MH Services
Received Prior
to
Hospitalization

I mean, [the child] had the case management, I had the case management, and the in-home [therapy], I think they were just saying: this is too much. I mean it was very overwhelming. We had five, six, seven appointments in one week. And it was just too much. [family]

Psychiatry and Medication Services

All (100%) of the 12 cases received prescribed psychotropic medication. In all cases, at least one of the respondents in the case, most often the family, voiced concerns about

- the management of medications;
- side effects;
- lack of timely access to psychiatric consults, especially in rural areas;
- lack of information about medication interactions;
- and inconsistent or conflicting recommendations from different providers regarding the appropriateness of given medications.
- Two parents also expressed that psychiatrists did not validate their experience or listen.

Case Management

Aside from medication services, case management was the most utilized service. Nine families received case management, (one family did not receive case management because providers thought the parent “had it all so together”.)

- Families felt supported, listened to, and children related well with case managers.

She was a real good support to us, which, you know as parents you're going: “what the hell do you do?” [family]

I couldn't handle my kids, finances, house work, cooking, shopping... I couldn't take care of anything...it pretty much was the only thing holding my family together. [family]

She was outstanding...She was a go-getter to get things done. [family]

3.2.4.2
MH Services
Received Prior
to
Hospitalization

When she is here she is 100%. [family]

- Interviewed case managers were generally positive about families' involvement in services and commitment to their children.

Very involved, Mom was 100% involved, wants what is best, does good job advocating, step-dad also involved. [case manager]

Mother has been extremely involved every step of the way. [case manager]

Psycho-Social Groups

Ten of the children were involved in psycho-social groups (four sometime in the past; six at the time of hospitalization). Interview data indicated that psycho-social groups provided families with some respite, structured time for the child, and were a generally good experience according to family respondents. Still, in some cases difficult behaviors exhibited in psycho-social group led to removal or suspension of the child from the group.

Through the summertime, it was more like a vacation for us. [family]

They had an incident where he was a bit out of control and he banged his face on the floor, made his nose bleed. They suspended him for a day... he is going there to get help with his behavior and when he shows the behavior they suspend him. What good is that? So I took him out of that. [family]

[He] ran away from it and tried to get in a fight so our approach was that he could not come back to psycho-social. We tried to give him another chance and drew up a contract with him... [He] had some real big explosions at school and home so we felt like it really wasn't safe for the other kids or him cause he would just probably run if he got upset. [mental health provider]

Therapy

Nine children received individual therapy. Responses indicated that:

- generally, there was good rapport with most therapists, and parents worked to keep the connection even if it put extra demands on them.

[he] seems to relate pretty good... we decided not to change midstream [family]

- Three parents conveyed being unsure if therapy was effective.

I believe everything was in place before he left. He was going to therapy, but in talking to his therapist, he didn't talk about anything with her. [family]

I'm just wondering if a change may be needed. Just to get another set of eyes on what's happening...you know we tell [therapist] what is going on and it's almost like they have to display it right in front of them for them to say, "Oh yeah"... It's frustrating. [family]

Attendant Care (AC) or Individual Community Support (ICS)

Seven children received Attendant Care or Individual Community Support services. Data show that, overall,

- children liked providers and activities, and
- providers generally enjoyed their work.

However,

- families also noted limited availability, access, and continuity of providers;
- some AC/ICS workers felt ill prepared to deal with highly demanding behaviors.

I do not really see what ICS would do for him. We are just college kids. This was such a critical case I did not understand what they wanted us to do. ...I don't know. It brought us workers closer together but I really do not know what they wanted us to do. [AC/ICS provider]

Parent Support

Four families received parent support (two at the time of hospitalization; one sometime in the past; one PRN; another family had been offered parent support but opted not to use it). Interviews showed that

- mothers felt supported by the service, but one father felt alienated/ left out;
- an added benefit of grant funded parent support is that the service could be utilized when funding for other services was unavailable.

3.2.4.2
MH Services
Received Prior
to
Hospitalization

- Four families and two professional staff respondents indicated that parent support groups and family training on concrete behavioral interventions are needed and useful.

Families learn along side the professionals how to handle crisis. Provide services but also require that families learn skills like Mandt have the siblings participate too. So that they don't always have to rely on professionals. [Hospital Intake Staff]

Wraparound and Natural Supports

In nine cases, respondents mentioned some elements of wraparound services being delivered, and at least one family specifically called a meeting in response to critical behaviors.

In terms of natural support systems,

- grandparents were mentioned by four families as providing respite when needed or being present during the hospitalization process;
- one minister attended wraparound meetings regularly and was a supportive positive presence;
- two families had no natural support systems.

Respite Care/ Beds

In six cases, respondents mentioned they had received some type of respite care.

- Three children went to licensed foster homes for respite and had a generally positive experience (two were coordinated through child welfare system, one through the mental health center)
- Three children stayed in a 24 hour center staffed facility where children may stay up to 72 hours (crisis/respite beds)

In addition, three respondents conveyed

- a need for accessible respite care for children who are not in state custody

Respite needs to be available to a family like [this]... [But it is] just not readily available to kids in biological homes... Sometimes we can get a therapeutic placement through SRS during the week where kids can retain biological parent placement. But this is very infrequent and families are reluctant to involve SRS. [Case manager]

3.2.4.3 Child Welfare Services

Seven of 12 children had some involvement with the Child Welfare System:

- two were active foster care cases working toward re-integration;
- one was in foster care with adoption to be finalized soon;
- two Children had been adopted;
- one had abuse and neglect report pending;
- one had a sibling in foster care

3.2.4.3
Findings—
Child Welfare
Services Prior
to
Hospitalization

Two cases had private contract foster care social workers who

- were present for screens in the study;
- developed the goals on the case plan;
- provided feedback to SRS and courts;
- and one accompanied a parent to the state hospital.

Interview data reflected a wide range of perspectives on the quality of involved child welfare services.

I always felt like I could call them [Child Welfare Contractor] and ask them questions or if there was a problem at school, they would be the first people I'd call. [family]

It was just a nightmare trying to get a hold of anybody. And they change hands so often there that nobody knew what was going on. [Family]

With the Foster Care system being privatized it has become really difficult. We have to have permission to see that kid on call. Sometimes we are working with new people who have recently been hired and they don't quite know what I am talking about. [Screener]

It's been better, but not to my expectations. I think [the Child Welfare Contractor] needs to maybe provide a little bit more services than hound, hound, hound, you know. "You need to do this" and "You need to do that." "Well, why don't you help me do this?" and "Why don't you help me do that?" [Family]

3.2.4.4 School Services

Eight of the children in the sample had an IEP, three of them were in structured special education programs with mental health supports for part or all of the school day. Notably, the quality of relationships between families and schools seemed either highly supportive or quite contentious. Even in supportive relationships,

3.2.4
Findings—
Services
Received Prior
to
Hospitalization

the quality of educational services and training of personnel was frequently questioned.

- Seven of the 12 families indicated that difficulties at school were directly related to the most recent hospitalization; Parents also were concerned about
- teachers and paras being overwhelmed, and lacking appropriate training;

The poor teachers, they don't have any training for kids that are ADHD, ODD, OCD. They don't have any training for that. None whatsoever....I think that's probably one of our biggest complaints.[family]

- frequent use of seclusion;

He ends up spending the whole day in seclusion.[family]

- a lack of options for different classrooms;

This classroom is not working for her. [We] tried getting her into a different classroom... They said it was not a good fit and that maybe we would have more options next year. I don't feel like we can wait that long. She needs to be in a place where they acknowledge her strengths. I feel like no one is listening to me. [family]

- and difficulties getting evaluations and IEPs done in a timely manner.

3.2.4.5 Community Developmental Disability Organization (CDDO) Services

One youth had a CDDO case manager in addition to mental health providers.

In summary, although children received many services from mental health and other service systems, ***it is surprising that these young people with very severe and chronic mental health issues did not receive the full array of mental health services at the time of admission.*** This is particularly perplexing for children served under the HCBS waiver (only five of the seven HCBS children received all services). Also, ***only eight of the 12 children had IEPs at school.*** Overall, medication appears to be the most consistently received mental health service whereby families have strong concerns about the accessibility and quality of medication management and consultation. Families are most satisfied with case management services and have mixed impressions about the quality of Attendant Care/ICS, Therapy, and Psycho-Social Groups. The effectiveness of previous local inpatient services, especially for adjusting and monitoring medications, seems limited by the short-

term nature of local hospital programs. Given the severity of children's behaviors at the time of their admission, it is unclear if the provision of additional services, or improvements in service quality would have prevented the necessity of an admission to the hospital.

3.2.5
Findings--
Common
Factors
affecting
services

3.2.5 Common Factors Affecting Service Quality

3.2.5.1 Turnover of mental health, child welfare, CDDO, or school staff was cited as having had a negative effect on seven cases:

- It complicates/delays crucial communications across involved systems;
- families lose support and stability of the provider, feeling they *"have to start over"*;
- it often constitutes another loss and transition for children.

Participants indicated that

- providers left due to poor pay, because they felt uncomfortable with child's aggression, or because of natural life circumstances (maternity leave, marriage, relocation, etc.).

3.2.5.2 Accessibility of Services at Critical Points

Interview data indicated that services were not always accessible at critical point in time. For instance,

- five children were in process of assessment for special education services, or experienced major difficulties in mainstream classrooms;
- children leaving a previous inpatient stay, or those coming into or out of foster care had to wait for therapy, attendant care or case management to begin;
- in two cases the lack of available/trained attendant care was a barrier to quality services;
- children who already had case management were more easily assisted because case managers could accelerate internal agency communication about the needs of families.

3.2.5.3 Communication and Collaboration with other Service Providers and Systems

In the absence of consistent communication and collaboration, the involvement of multiple service systems appeared detrimental to effective service provision. In cases of consistent collaboration parents seemed better informed and confident about overcoming the crisis.

School-Mental Health Collaboration. Respondents highly valued communication between parents, mental health and school providers and appreciated regular updates.

- In several cases school staff attended wraparound meetings.

3.2.5
Findings--
Common
Factors
affecting
services

- In-class use of attendant care requires re-adjustment of turfs, mindsets, and building rapport

It has taken a loooooong time for things to get to this. First when Attendant Care got in, the school said: "Oh you're here to tell us how to do our job??" And I explained: "No I am free work, I am an extra time out for you guys when you are banging your heads against the wall, I may bring ideas that you guys can try when I am not here". It got to the point that they were very appreciative about extra help.[Mental health provider]

Child Welfare - Mental Health Collaboration. Child welfare and mental health providers made efforts to collaborate but at times goals and strategies remained contentious.

We had wraparound only after crises started to happen. We were somewhat lucky because CMHC was involved with family already so there was easier access to supports. [child welfare provider]

There has not been therapeutic work on any issues it was all focused on de-escalating him to get him through each day. [child welfare provider]

Community Developmental Disability Organization (CDDO) - Mental Health Collaboration. CDDO and mental health providers for the one case in this sample made efforts to collaborate but contacts and connections were inconsistent. Respondents also voiced concerns that available CDDO services focus on adolescents and adults, not on children.

For some time, we had a very collaborative [CDDO case manager], who had regular contacts [and the mental health case manager] attended monthly CDDO staffings.... However,... the [CDDO] case manager suddenly disappeared and another CM took over. There was little to no contact after the change and monthly staffing fell apart. [case manager]

...Most of CDDO's stuff is, more of their services are geared toward when the child reaches adulthood as far as living skills and

training skills and helping them to transition from childhood to adulthood.[family]

3.2.5
Findings--
Common
Factors
affecting
services

3.2.5.4 Lack of Transportation and Financial Resources posed a barrier to consistent services.

Transportation is a big issue for people in this community. Transportation requires time to arrange. [Mental health provider]

3.2.5.5 Not Feeling Taken Seriously. Several parents relayed that providers or hotline responders did not seem to “believe them” or “take them seriously” regarding the extreme behaviors children were exhibiting.

In summary, common barriers affecting service quality across systems include turnover, lack of accessibility of services at critical points in children’s lives, lack of communication and collaboration within and between systems, lack of transportation and financial resources, and families’ sense of not being taken seriously. While improvements in these areas are useful and necessary it is not possible to ascertain that such improvements would have necessarily prevented admission to the hospital.

3.2.6 Screening and Admission

3.2.6
Findings--
Screening and
Admission

3.2.6.1 Location of Screening

Interviews with screeners indicated that screens were typically conducted in agency settings such as the community mental health center (CMHC), juvenile intake at the jail, or emergency rooms (ER):

- In seven cases initial screens were done in the CMHC,
- three occurred at the ER of a local hospital,
- and two at juvenile intake.

(Note: In the five transfer cases children were re-screened at the local hospital for the state hospital. For the purpose of this section, their initial screening locations as described by families were included).

Notably, screeners reported differing agency policies for the locations of screens. Some respondents reported it was agency policy not to screen children at families’ homes. Others stated that while they could go to family residences for screens, they preferred not to do so. In both cases, the reasoning was similar: Institutional locations for screens were preferred because of

- concerns about screener safety

[If the child is] aggressive or out of control...[it is] not our job to go into he home and restrain them or calm them down. We have parents call the police.

Once they have calmed down we go wherever the police brings them. [Screener]

- the need for access to communication devices like fax machines and phones to arrange for admission;
- and easier access to existing records of the child at local CMHCs if screens occurred there.

3.2.6.2 Time and Duration of Screening

Seven of the screenings that brought children initially into the local/regional or state hospital were conducted during office hours (8 a.m. to 5 p.m.) while five screenings were conducted after hours (ranging from as early as 7:30 p.m. to as late as midnight).

According to interview accounts of screeners, screenings can--generally speaking--take anywhere from 30 minutes to three hours depending on the client's presentation, screener's previous knowledge about the case, and available information through collateral sources. Screening records of the sample indicate an average length of 1:20 hours for a screening. Recorded times for screenings ranged from 60 minutes to 2:50 hours (one screening form lacked duration of screen information).

3.2.6.3 Who was Involved in the Screening Process?

At least one family member was always present at the screening. In five cases, only family members met with the screener. In seven cases other professionals, aside from the screener, were involved in the screening process.

- In four cases providers from the community mental health center, most often case managers, were involved.
- In two cases police or JJA workers were involved.
- In one case as many as seven service providers (from mental health and child welfare) made an appearance at the location of the screening, even though not all of them were directly involved in the screening process.

3.2.6.4 Perceived Effectiveness of Screening to Prevent Unnecessary Hospitalization

Because the sample for this study consisted solely of children screened *into* the hospital, not surprisingly all screeners deemed hospitalization necessary at the time. When asked about the overall effectiveness of screenings, providers stated they thought screens did help prevent unnecessary hospitalizations:

- screens emphasize hospitalizations as last resort;

At the center there are several layers of services. But sometimes, when kids become explosive even with all the supports they can not be calmed and need hospitalization. So I assume everything had been in place outpatient

and he just could not be maintained. [Screener]

3.2.6
Findings--
Screening and
Admission

Some parents when they figure out the system and how it works, they are just real quick to jump the gun and say you got to put him in the hospital, instead of that being the last choice they want to make it the first choice. In these situations, the screen becomes and intervention of diversion/reassessment of services. I'll say "Have you talked with the Doctor? Are you doing something with Medications? Have you just taken the kid out of the situation to calm down, that may be just for a few minutes or a day or so?" I think this happens more with people who have medical cards. It is a real quick and easy in. As a screener my thought is that we should use hospitalization as a last resort instead of a first choice. [Screener]

- screens help identify and initiate community-based services needed for the child.

I see that a person just needed follow-up care or they needed to get plugged into something that was missing to keep a person out of the hospital. The follow-up plans on the screen are helpful. [screener]

Statistically of the 10-15 screens per month, 30-40% or so are diverted to maybe [crisis beds], or natural resources respite. If they do not have services we may set them up first even if some may still go to the hospital later. It depends on how severely they present in terms of safety. Usually the primary provider makes referrals to other possible services. I may ask them to explore that. [screener]

Participants also identified contextual factors that affect screening results:

- the experience of the screener and amount of work involved in diversion;

Sometimes new screeners at CMHCs are intimidated by alternative care plans (diversion plans). If you decide to go with alternative plans you know you will be there for a while setting up

3.2.6
Findings--
Screening and
Admission

plans, getting transportation, calling people. With kids there are even more entities involved. So the tendency is to admit them and let the hospital sort it out. My role is then too to tell screeners that we need to find the least restrictive environment. That is the idea. Diversion packages, there is this long list of 30-40 items on the screen, you have to go through them. Not all, but you have to make some calls. Diversion plans take a lot of time, and if you do not know the system, the resources, you may not do it, or not do it right. [screener]

- time of screening and availability of alternatives;

If it is done at 4 AM, they are coming here first. No diversion just because everyone is closed. In defense of the screener, I can't blame him for sending a kid here, if the kid is saying to his mom, "I'm gonna kill myself, I'm gonna kill myself". [hospital staff]

Sometimes you admit kids because they seem to be unsafe where they are at, in danger, not because they are actively suicidal or homicidal. [screener]

- erring on the side of caution

Sometimes you have to intuit, and err on the side of caution. Of course you always get pressures from various sides to decide one way or another but you are independent in your decision even from your own agency to do what you believe is right because you will be the one liable. [screener]

3.2.6.5 Satisfaction with Screening and Admission Process

When asked about their experiences of the screening and admission process, most family respondents indicated that the process was lengthy, exhausting, and often frustrating. Challenges they frequently encountered included:

Transportation

Transportation to the screening location and/or to the hospital was provided by families themselves, by CMHC or child welfare providers, by secure transport companies, or by police.

In eight cases respondents stated that safely transporting the child posed a problem. For instance, transportation was deemed problematic when families either did not have own means of

transportation or felt uncomfortable transporting an out-of-control child.

3.2.6 6
Findings--
Satisfaction
with screening
and admission

we called them the night before, the crisis team. And they said well until we could send the police to pick her up but you're going to have to find your own way there. And this is like 11:30 at night, you know, half the people in here were already asleep, at least the ones with cars [family]

I believe they called the crisis team and there was a problem because they had no transportation so they had no way to get to the place where the screening was going to happen. So then apparently the screening happened the next morning.[Mental health provider]

It took us,... maybe an hour and a half just to get him to the car. [family]

So they gave her a shot. There was more Atavan. They promised me that she would be asleep in twenty minutes. Well, she finally went to sleep 40 minutes later. And every time you would move her or anything like that, she would wake up and she would fight. So at that point, I was still unsure if I had a bump in the road or something, if I wanted to take her in my car. [family]

Mental health or child welfare professionals provided transportation in several cases even if policies about who may transport with which vehicles (company or private cars) occasionally complicated the issue

Normally I do not transport but I had gotten permission [parent support worker]

[The welfare worker] had to carry [the child] downstairs, and transport in her own car. Mother assisted by restraining [the child]. While in the car he was trying to bust out the windows, kicking driver's seat. [screener]

3.2.6.6
Findings--
Satisfaction
with Screening
and Admission

I cannot transport, the casemanager can. [child welfare contractor] would tell us they could not transport. In order to transport..., ICS workers would have to come in with company cars. [therapist]

Private companies for "Secure Transports" were another means to transport children, occasionally leading to additional waiting times.

Usually depending on insurance we can do secure transports, or [use specific private company] which accepts medical cards. Others accept medical cards but will not transport out of town. You use whatever is available. Transportation is often an issue to get to [state hospital]. If the kid is out of control we use secure transport because their vans are set up for it. [screener]

It was the secure transport. They will not authorize secure transport until they hold the screen in their hands even though we knew it was clear he would screen in. So you seem to have to wait in a circular pattern to get one thing taken care of before the other can start for 1.5 hours. And because the screener had another call we had to wait outside in the parking lot. It was cold out that night. By this time [the child] was very tired and calm. Mom had taken him to McDonalds for some food and given him his night meds. But it was just long. [child welfare worker]

Calling the police to assist with transportation is not an unusual practice but did not necessarily guarantee a successful experience:

Both officers arrived in patrol cars with cages and said they were not allowed to transport children under age 10 in caged cars. The other, non-cage car, was on another duty. Basically we got no assistance from them. [child welfare worker]

We had to intertwine the cuffs otherwise he could slip his hands through. He started to kick us .We cuffed him behind his back. ... [eventually] we talked on the way over there [to

screening location] and he had never been in a patrol vehicle before and was fascinated with the truck. I didn't have any problems going over there. [police officer]

3.2.6.6
Findings--
Satisfaction
with Screening
and Admission

Delays -- "It was a long day"

According to state hospital staff admission procedures regularly take 2-3 hours. In a majority of cases respondents stated that their process of screening and admitting the child took a significant amount of time beyond this timeframe. Several study participants described lengthy waiting periods and additional delays because

- the screener on-call was busy with other screens;
- there were miscommunication between players;

We were [at the hospital ER] for like about an hour and a half before [the screener] even showed up because nobody had informed him that we were there yet. [family]

- or the need to wait for hospital to confirm admission after screening was completed.

Screening was already done when I checked in with them. We sat there for four hours waiting to hear back from Rainbow, waiting for permission, lot of people out of office, nobody would call back. It was really quite ridiculous. .. It is not usually that way. [parent support worker]

there was a shift change and the psychiatrist who was on call took an exceptionally long time to call back, 1.5-2 hours, which was not helping. [screener]

- Using the ER as an entry point tended to lengthen the process further because ER paperwork, priority of incoming emergency cases, and procedures such as required doctor-to doctor calls before transferring a child out of a medical facility added extra waiting periods.

Our instructions were to go to the emergency room, and, um, we had papers, and that's what we were told to do, ...we did not realize we were supposed to go straight upstairs [during business hours], ... So we wasted about three hours in the emergency room. [family]

3.2.6.6
Findings--
Satisfaction
with Screening
and Admission

I waited for up to seven hours to get things arranged. That is not the most efficient way unless it is the kind of crisis where you tell people to call the police and get the kid to the ER. When you have time to arrange for things, the ER is not efficient.[child welfare worker]

Since we had to go through the emergency room, there was a long wait in the emergency room. ... We went up there at, it was between 8 and 9 a.m. And we didn't get out of there until about 2 or 3 in the afternoon. [family]

- In four cases families stated that the child returned home for the night after being screened, most often because difficulties transporting a child over a long distance and/or late at night appeared too much of a problem at the time. Children were transported and admitted to the hospital the following day.

For children in SRS custody the admission process was further complicated because

- Mental health and child welfare providers need to communicate about the need for screening, admission, and procedures;
- policies to coordinate admissions between the two systems can vary by agency or are unclear to the persons involved;

With the Foster Care system being privatized it has become really difficult... Sometimes we are working with new people who have recently been hired and they don't quite know what I am talking about. It is more of a process, I have to get permission, find out where they want them to be sent, who is providing transportation, who will be there to sign them in. Many hospitals will not take them without someone in that Foster Care system being there to sign them in. Whenever we get a foster care child we are always kind of groaning cause we know it can take forever....[screener]

We first have to call our placement people to locate an acute placement, because some placements pick and choose, do not want sexual offenders, or whatever. They found [a local hospital] who wanted to have more information from me, then agreed to take him around 8:30 p.m. and then we got to arrange for transportation. [child welfare worker]

- depending on funding sources CMHCs need to follow extra procedures for pre-certifying a child in order to get reimbursed

We are constantly reminded, sending us memos telling us we need to get the pre-certs for Medicaid kids from the consortium or the center does not get paid. [screener]

- child welfare agency workers need to be available to arrange for signatures on hospital admission paperwork;

I filled out five hours worth of papers. And I did all that. And then it came down to "wait, you're not his guardian, this is all null and void". So they had to send the papers or fax them, we were actually there on campus and they had to fax the papers out to the director of [child welfare agency] to get them signed, no, SRS, to get them signed. So I spent all that time and it frustrated me, I was thinking: SRS knew that. Why weren't they there? [family member]

- court orders are needed and may not be easily arranged for.

It does cause delays a lot with [local county SRS contractor] because with them a transfer requires a court hearing because guardians cannot sign them into a state hospital. And [local county] will not pursue the proceedings without getting a petition first which then leads to discussions about who will write the petition: [Our hospital county] because that is where the kid is now or [the county] where the kid is from? So they bicker back and forth and that can take several days. [The kid's local county] always ends up doing it, but then there is still discussion about who will write [the petition] the [case manager from the mental health center or the case manager of the SRS contractor]? [local hospital provider]

In summary, the effectiveness of ***the screening process*** as a way to prevent unnecessary hospitalizations is influenced by screeners' experience and comfort level with children and children's services, as well as availability of and access to diversion services at the time. For the safety and convenience of workers, most screenings are conducted in agency settings making it necessary for families to arrange for safe transportation. The ***screening and admission*** process can take an extraordinary length of time especially when the child welfare system is involved and requires collaborative planning or court orders, when families access services through an

emergency room, or when safe transportation is not readily available.

3.2.7 Screener Background and Training

All nine screeners in this sample (several were responsible for multiple cases in this study) held Master's degrees in social work or psychology.

- Six respondents indicated that screening and/or crisis response was their primary job responsibility, one was an administrator of crisis response, and two indicated they primarily worked as clinicians.
- Two screeners also served as liaisons to the state hospital.
- Their experience working as a screener ranged from four months to seven years, with an average of about 3 years.
- Seven screeners indicated they serve children and adults, whereby the majority of their cases are usually adults; two screeners belonged to a crisis team exclusively set up to serve children.
- Familiarity with children's services ranged from extensive clinical experience with children community-based services to "*knowledge by association*" for a screener who is primarily working in the substance abuse field.

When asked about the **training** they received screeners indicated

- There is no standardized training offered for screeners across the state; each CMHC regulates their own training procedures.
- They received on-the-job training through shadowing experienced screeners, and supervision for their first screens.
- Occasionally, a one-time presentation about the screening forms would be held.
- Generally, screening requires
 - knowledge and experience assessing risk for suicide/homicide
 - knowledge and experience with diagnoses
 - familiarity with screening forms and procedures
 - knowledge and experience with crisis intervention, de-escalation
- On-the job training was usually not specific to screening children or adolescents; thus unless screeners come with a background in clinical work with children, they are not well prepared to screen youth.
- Screening children is different from adult screens in that it requires
 - knowledge about and symptoms and diagnoses of children

- knowledge about children’s ways of being suicidal/homicidal
- knowledge and experience in observing and interviewing children
- far more reliance on multiple collateral sources for information, especially families and case managers, because children are not always verbal or willing participants
- knowledge and experience with interviewing families
- awareness that children who have experience with welfare or mental health systems may know how to give the “right” answers
- knowledge and experience with community-based services in the local area in order to assess gaps and initiate options for diversion
- awareness that children in custody require additional contacts and arrangements with child welfare contractors before screening or arranging for admission.

3.2.7
Findings--
Screener
Background
and Training

In summary, screener background and training vary widely. A majority of screeners predominantly serves adults in crisis. Screeners’ experiences in working with children and families, and their familiarity with children’s services, range from extensive to little. Screener training is not standardized across the state leaving training to local mental health centers. Training occurs on-the-job through shadowing and supervision, but is usually not specific to work with children and families.

3.3 Stakeholder Feedback

Preliminary findings of this study were presented to a group of stakeholders who represented the major respondent groups (family representatives, staff from state hospitals, community mental health services and crisis services, and screeners). Feedback was also solicited from stakeholders unable to attend the meeting, namely school staff, law enforcement, case managers, regional hospital staff, child welfare contractors, and the Governor’s Mental Health Services Planning Council.

3.3
Qualitative
Study—
Stakeholder
Feedback

Overall, stakeholders indicated the findings of the study were an accurate representation and fit with their experiences of children admitted to state hospitals. Demographic characteristics of children in the sample appeared typical for children age 12 and younger admitted to the state hospitals. Stakeholders also agreed with the four main categories of reasons to admit children and added that lack of insurance coverage may leave families with the state hospital as the only option for inpatient treatment. In regard to the low number of admissions for Larned State Hospital, stakeholders

3.3
Qualitative
Study—
Stakeholder
Feedback

indicated there was “*no rhyme or reason*” to explain the low numbers during the time of the study.

Stakeholders confirmed that current Medicaid and private insurance reimbursement structures favor shorter lengths of stay (3-7 days) in acute private psychiatric inpatient programs and emphasized the continued need for longer-term inpatient treatment options for children with more complex or chronic difficulties including more intricate medication stabilization and adjustment. In the current system, only the state hospitals offer such services on the continuum of care. Without an option for longer term treatment children may need to be admitted frequently and repeatedly to acute hospital programs within a short time-frame for medication stabilization. Stakeholders recommended exploring options that would allow for longer lengths of stay at local/regional hospitals as well as minimizing transfers from local/regional to state hospitals for children who can be identified early as needing longer than acute hospital treatment.

Stakeholders confirmed that families in crisis prefer to contact someone they know and that, if CBS providers are able to respond, they are usually effective. Still crisis response services appear in need of improvements through more training on individualized crisis planning as well as establishing family friendly crisis response hotlines and safe mobile crisis response mechanisms. Warm-lines and information sheets for parents about the best use of hotlines could be among the options to explore.

In regards to prior services stakeholders identified attendant care, respite care and parent support as valuable services to this population but pointed out that respite care and parent support services are reimbursable only through the Home and Community Based SED Waiver. Thus lack of funding can present a barrier for developing and accessing these services. Stakeholders confirmed that availability of and access to child psychiatry services is very limited across the state. While nurse practitioners (ARNP) and general practitioners try to fill in the gaps for families lack of timely access and strong differences between providers in regards to medication contributes to repeated inpatient admissions.

Stakeholders from the State Hospitals clarified that children in SRS custody must be signed in by a legal guardian and, if parental rights are severed, there must be a court order. Delays in the admission process occur when child welfare contract workers are not aware of this information and assume they have the right to sign a child into the state hospital as in the case of a child welfare respondent in the study who during interviews indicated that SRS had given her the authority to sign children into the hospital. Stakeholders agreed with interview participants that “*one side of SRS is not communicating with another effectively,*” and recommen-

ded additional training for child welfare contractor or a handbook from the state to provide assistance for these instances.

Stakeholders agreed with findings regarding collaborations with schools and pointed to the barriers posed by differing diagnostic labels between systems. Often children identified by mental health as SED are not designated ED in the school systems. Stakeholders also expressed concerns about how impending budget cuts with affect children's services in schools and wondered if and how mental health systems may need to compensate for a lack of services through the educational system.

Although no cases in the study exemplified this point, stakeholders indicated that screening outcomes are affected by time of day and screener experience. According to stakeholders, the screening process could be improved by offering standardized training for screener that incorporates knowledge of child/family interviewing techniques and understanding child services available in the community mental health system. Experienced child and family screeners and families could provide input on the development of training for screeners and crisis services workers.

3.4 Summary of Qualitative Study Findings and Areas for Improvement

Overall, children's admission to state hospitals was appropriate given the resources available to families and providers at the time. All children had a history of serious emotional or behavioral difficulties, and exhibited significant self-harming or aggressive behaviors. All children already received some type of mental health service in their community at the time of admission, and less restrictive services to divert from the hospitals were either not available at the time of crisis or were deemed insufficient to keep the child safe. Some children were transferred from local/regional to state hospitals because local hospital programs are not designed to provide the longer term care needed to stabilize the child. Although areas for improvements in community-based services were identified, it is not clear to what extent such improvements could have prevented the hospitalization of any of the children in this sample. Thus, the state cannot confidently consider closing state hospital beds for children age 12 and younger, unless resources and services in the communities are consistently available and of high quality, and unless local/regional hospital programs are available and flexible enough to accommodate longer term stays beyond the current 3-7 day time frame.

3.4.1 Possible Improvements for Community Based Services

Possible improvements for community based services fall into four main areas: (1) the prevention of acute crises by assuring

3.3
Qualitative
Study—
Stakeholder
Feedback

3.4
Qualitative
Study—
Summary

timely access to the full range of community based services; (2) a more effective, child and family-centered crisis response system to de-escalate a given crisis situation; (3) improvement of accessibility and quality of psychiatric medication management; and (4) improving the screening process through child and family specific training to maximize diversion from hospitalization whenever possible. Together, these improvements may result in fewer hospital admissions of young children.

3.4.1.1 Crisis Prevention through timely Access to Full Array of Services

While all of the children in this study had a long history of multiple emotional and behavioral difficulties, and experienced frequent if not chronic crisis, not all of them received the full range of community based services at the time of admission to the hospital. The only mental health service provided to all children prior to admission was the administration of medication (see also section 3.4.1.3 Access and Quality of Medication Management below). Not all of these children were served under the HCBS waiver, and even those on the waiver did not receive the full array of services most often lacking parent support services, attendant care/ICS, and respite care. It should be noted that families may have chosen not to participate in these services at the time either because they did not see the need or because previous experiences made them doubt the usefulness. Nonetheless, it appears important to assure that (1) all children with such severe and chronic difficulties are assess for their eligibility for services under the HCBS waiver, and (2) that all services purported to be available under the waiver are in fact available, accessible, and of sufficient quality to fulfill the purpose of keeping children in the community whenever possible.

When faced with an acute crisis, most families turned to those mental health providers with whom they had an existing relationship, most often case managers or therapists.

Case managers, generally rated highly by families, served as a nexus of mental health services in that they eased access to additional services, communicated with families, and collaborated with other providers. Turnover, miscommunication, strained relations with families, or a lack of communication and collaboration between providers posed common barriers to effective service provision. Case managers were usually aware of changes and transitions in children's lives, such as moving, changes in schools, or losses in the family. It was not entirely clear, however, how case managers attempted to anticipate and curtail an escalation of difficulties in response to these changes and transitions. In several cases it appeared that hospitalization served as a catalyst for all involved parties to come together and provide the comprehensive planning that--if initiated earlier--may have prevented a deterioration of the situation.

The effectiveness of case management to prevent crises seemed limited when other services, such as attendant care, respite, or parent support were not available or accessible at critical points. There is a need to increase the availability of respite care for children with severe psychiatric difficulties, especially for those who are not in SRS custody. In the absence of formal respite care, other services such as daily psychosocial groups, attendant care, or crisis beds appear to be used to provide the child with supervised time.

Attendant care was used frequently but there is a continued need for available, accessible, and well-trained providers to assist families effectively. Parent support was highly valued but not consistently provided to all families. Most children received individual therapy, but only few received family therapy or in-home family therapy. Given the age and high needs of these children, family therapy seems like an important ingredient to resolve and prevent crises.

3.4.1.2 Child and Family-Centered Crisis Response

There is a need to make crisis services more responsive to the particular needs of families and children.

Crisis plans, as currently implemented, did not appear to be a useful instrument to prevent or de-escalate a crisis. They lacked specificity, were not individualized, and all too often seemed to consist of standard items like “call the hotline” or “call the police”.

Hotline responders appeared unprepared to offer specific, hands-on advice to parents on how to deal with children’s behaviors. It seems that typical hotline responses are geared toward helping adults in crises. As a result, hotline responders revert to rote advice, such as “call back during business hours” or “call the police” when families’ descriptions of difficulties do not fit adult mental health definitions of suicidal or homicidal behaviors.

Mobile crisis teams frequently did not meet with families at families’ homes because of concerns about provider safety. While these concerns are legitimate and need to be addressed, the practice of asking families to somehow transport an out-of-control child from their home to an agency setting places undue burden on already stressed families. Having families call the police to intervene or provide transportation may be legitimate in some cases but cannot replace the need for having mobile mental health provider teams willing and able to go to family residences to assist in times of crisis.

Crisis beds or walk-in clinics were viewed as useful resources but are not available at all mental health centers.

Relying on or deferring to law enforcement as a crisis response service is an insufficient practice to assist children and families in mental health crises. Police officers are a valuable resource to help keep children and providers safe but too often

officers are unprepared and not trained to deal with children in mental health crises. Thus, there is a need to initiate collaborations between law enforcement and mental health providers to maximize efficient and appropriate use of law enforcement personnel.

3.4.1.3 Access and Quality of Medication Management

All of the children in this study received psychotropic medications. While medications were generally viewed as necessary and helpful, medication management was also among the most frequently cited reasons for admission to the hospital. There were considerable concerns about adequate management of medications and their side effects on an outpatient basis, about the lack of timely access to psychiatric consults, the lack of information about medications or conflicting advice from different professionals.

3.4.1.4 Improving the Screening

The screening process was generally viewed as effective in that it emphasizes hospitalization as a last resort, and helps identifying and initiating needed community-based services. Still, screeners' ability to divert children from hospitalization appears somewhat dependent on screeners' confidence in assessing children and families in crisis, their relative experience with children's services, and availability and access to services at the time of the screening. Thus, there is a need for basic statewide training standards for screeners that require knowledge about diagnosing and interviewing children and families, and familiarity with children's services.

4. Implications for Development of Local/Regional Bed Capacity

One of the central questions of this study is to explore the feasibility of closing state mental hospital beds for children 12 and under, by replacing them with some expanded role for local or regional private hospitals. The state hospital admission statistics and the qualitative study of the twelve children admitted in the winter of 2004-2005, discussed in the report above, indicate that current state hospital admissions of this population are appropriate, given the current status of the system of care.

One of the clear functions or roles of the state mental hospital in the current system is to provide a length of stay that is intermediate between the short term stays of local community hospitals and the long term stays of Level VI residential treatment. Table 8. below depicts the admissions and length of stay in Kansas for the private community hospitals, state mental hospitals, and Level VI residential treatment facilities.

Table 9. Utilization Data by Facility Type FY 2004

TYPE OF FACILITY	# SERVED	LOS
Community Hospital	683	5.33
Larned State Hospital	43	38
Rainbow State Hospital	49	24
Level VI Residential	<i>Not available</i>	<i>(range: 82-180 days for children and adolescents)</i>

4.
Implications
for
Local/Regional
Bed
Capacity

Table 10. on page 48 presents additional information about local/regional hospitalizations. Five local/regional hospitals account for about 90% of these admissions statewide: Coffeyville, Stormont Vail, KU Medical Center, Prairie View, and Kaw Valley Center. Males account for 70% of admissions, and the average length of stay is 5.33 days. About 60% of the children are age 10-12, and 40% are under 10.

It stands to reason that, if the state mental hospital beds are closed, then some system for expansion of local/regional resources to cover the intermediate time period of 10-40 days would be needed. Although the above study indicates that current admissions are not inappropriate, most of the children admitted to state mental hospitals have to travel far from their communities, being uprooted from family and other sources of support. Assuming that the treatment children receive in the state hospitals is appropriate and beneficial (an assumption that was not tested in this study), services and treatment for these children would still be enhanced by ready access and involvement of parents, siblings, extended family, local community mental health center professionals, local school personnel, and other community collaborators.

Closure of state mental hospital beds for children 12 and under is NOT recommended at this time, for the following reasons:

1. Current admissions of this population seem appropriate, given the current status of the system of care.
2. A small reduction in the number of admissions could be accomplished by improving the community system of care in the ways outlined above.
3. Currently, the state mental hospitals serve a need for secure, mid-range inpatient care (20-30 days on average) that cannot be filled by local/regional hospitals for two related reasons. First, expanding program treatment models from a focus on 5-7 days to 20-30 days would require additional, expensive resources in the form of different types of therapy,

Table 10. Kansas Local/ Regional Hospital Admissions for Mental Health Diagnoses for Children 12 and younger, FY 2004

HOSPITAL	# ADMITTED	AGE											SEX		LOS (days)	
		2	3	4	5	6	7	8	9	10	11	12	Male	Female	Mean	Range
Coffeyville	67				2	3	6	5	13	15	17	6	50	17	6.95	1-13
Salina	2										1	1	1	1	6.50	1-10
Shawnee Mission	12											12	6	6	5.00	1-11
St. Catherine, Garden City	19					1	2	1	2	4	6	4	11	8	5.42	4-8
Stormont Vail Topeka	113			2	1	5	3	8	11	26	32	29	80	33	5.05	2-11
KU Med Kansas City	158		1	4	7	11	19	20	25	18	34	18	118	40	4.94	0-15
Via Christi Wichita	15					1						14	10	5	4.20	1-7
Wesley MC Wichita	3	1				1						1	1	2	3.66	1-7
Prairie View Newton	228				12	15	13	15	42	44	40	42	164	64	4.97	NA
Kaw Valley Center	65				4	5	4	8	13	4	19	8	42	23	6.8	1-11
TOTALS	683	1	1	6	26	42	46	57	106	111	149	135	483	199	5.33	0-15

[Note: All data was provided by the Kansas Hospital Association, except data for Prairie View Hospital and Kaw Valley Center, which was provided directly by these hospitals.]

4. more therapists and other staff, enhanced educational programming, and improved safety and security. Major barriers to be overcome would include finding hospitals interested in providing such services and funding the programs. Second, even if solutions to those barriers could be found, the number of children needing this service (100 per year statewide) is not enough to justify more than two regional centers, the same number as the two state hospital facilities that exist now. Thus, the problem of distance would remain.

4.
Implications
for
Local/Regional
Bed
Capacity

If both young children and adolescents are included in the population, it is more likely that a regional private hospital system would be cost effective. Next year's planned study of state mental hospital utilization for adolescents will further clarify this issue. The policy choice will then be to either close all of the state hospital beds for children and adolescents in favor of a regional, private inpatient system, or keep all of the state hospital beds for this population open. The conclusion of this study is that it is not advisable to close state hospital beds only for children age 12 and under, because no feasible alternative exists in the local community to provide the kind of care that is needed and that the state hospital currently provides.

5.
Recommendations

5. Recommendations

(1) Do not close State Hospital beds for children age 12 and younger. At the current time it is not feasible for local/regional hospitals to perform the unique role and function of state hospitals serving young children.

Improvements for the existing system include:

(2) Prevent acute crises by assuring timely access to the full range of community based services:

- Provide training and quality assurance for crisis plans to be specific, relevant and updated to anticipate crises in the advent or wake of significant life transitions (plans should address transportation questions)
- Further improve availability, accessibility and/or quality of the full range of services under the HCBS waiver
- Foster and improve communication and collaboration of CMHCs with
 - Local law enforcement
 - Child welfare providers
 - School systems
 - CDDOs
- Consider creating Liaisons positions between
 - CMHCs – private hospitals
 - Hospitals – child welfare contractors

(3) Build a more effective, child and family-centered crisis response system:

- Train hotline responders to understand, respond and assist families in crisis.
- Explore the option of a statewide warm-line for families with children in crisis whose responders are trained to coach and assist families in how to de-escalate their children, and which local resources to access.
- Educate families on the use of crisis plans, crisis hotlines and/ or warm-lines (Utilizing local parent support workers)
- Enable mobile teams go to families' homes safely: consider the development of joint teams of law enforcement, mental health crisis and family workers. Foster collaboration, co-training and co-deployment with community law enforcement officers.
- Explore current technology to allow more screener mobility

(4) Improve reliability and accuracy of psychiatric diagnosis of children; and accessibility and quality of subsequent medication management:

- Do NOT consider the development of “algorithms” as a way to guide medication management for children because of the significant difficulties in ascertaining accurate diagnoses for children, and the absence of psychotropic medications that have been empirically tested and approved for the use by children. (See appendix B. for discussion.)
- Improve accuracy of psychiatric diagnoses for children and reliability across providers.
- Improve availability and access to psychiatric medication services through recruitment of ARNPs.
- Explore if and how other states successful improve availability and access to psychiatric services for children.
- Provide families with information about psychiatric medications.

(5) Improve the screening process and training for screeners:

- Establish basic standard training for screeners that includes assessing children, interviewing families and knowledge about CBS services for children.

6.
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APPENDICES

APPENDIX A.
Coding Guide
3/29/2005

[PRIOR SERVICES]

1. services and supports received (includes perceived quality)
2. services and supports needed
3. communication/collaboration (between system players)
4. family involvement in services
5. length of involvement (of provider with family)
6. turnover
7. school (helpfulness, behaviors at school etc.)
8. previous inpatient admits

[ADMISSION]

9. Screener background (prior experiences, tasks and role in agency, working w/ adults etc.)
10. Screening duration (length of screen)
11. Screening location
12. People at the screen (who attended screening)
13. Initial impression (of the screener re. child's behavior, see screen records)
14. Involvement in decision to admit (who was involved in decision, agreement/disagreements etc.)
15. From screen to hospital (process between screening and actual admission, such as doc-to-doc calls etc.)
16. Delays/duration of admission (time elapsing at various points, or other delays in getting services prior to admission)
17. Reasons for transfer (if directly admitted from other psych hospital)
18. Why state hospital (reasons to choose state hospital over local)

[CRISIS RESPONSE]

- 19. Child Behaviors leading to admission
- 20. Initial Contact (initial attempts of family to get help in crisis)
- 21. Crisis plan (anything related to crisis plan/ lack thereof)
- 22. Diversion attempts (crisis hotline, mobile teams, crisis beds etc.)
- 23. Transportation (to and from screening and /or hospital)
- 24. Police involvement

[OTHER]

- 25. Diagnoses
- 26. Medication (concerns, management of, number of meds etc.)
- 27. Life changes/ transitions (major changes in year prior to admission)
- 28. Family/child history (other background information)
- 29. Screening to prevent (general feedback on screening effectiveness)
- 30. Training for screeners (recommendations re. training)
- 31. Recommendations (other recommendations for system improvement)
- 32. Post hospital developments

APPENDIX B

Medication Management: No Easy Solutions

This study has added support to what many families and professionals have voiced in recent years: medication management is a serious issue that is a primary factor in the admission of many children to state and local hospitals.

One possible approach to responding to this problem is to establish standardized, statewide protocols (often termed medication algorithms), an approach that has been endorsed for adults with mental illness by the President's Freedom Commission on Mental Health. The general idea of these medication algorithms is to provide specific guidelines for the proper type and dosage of medications for all common psychiatric diagnoses. However, such algorithms are relevant and effective only if two conditions have been met, and to date, neither condition has been sufficiently met for children:

The first condition is that there must be an accurate diagnosis. Medications are targeted to specific diagnoses, so an inaccurate diagnosis will inevitably lead to prescription of the wrong medication. With children, families have long complained that diagnosis often varies from one professional to another, and that obtaining an accurate diagnosis can be a long and arduous process. These complaints were echoed by the parents of children in this study. The problem is illustrated by the diagnostic data from the state hospitals (see Table 3. on page 6) and from the local/regional hospitals (depicted in Table 11. below).

As Table 11. depicts there appear to be clear differences in the way admitting physicians diagnose the mental health problems of children admitted to state hospitals. The primary diagnosis of Bipolar Disorder is made frequently in Coffeyville (78%), Prairie View (55%) and Kaw Valley (58%), but quite infrequently at Stormont Vail in Topeka (1%) and the KU Medical Center in Kansas City (15%). Likewise, ADHD is diagnosed infrequently at Coffeyville (7%) and Stormont Vail (1%), but much more frequently at KU Med (28%), Prairie View (30%), and Kaw Valley (62%).

One implication of this differential pattern of diagnoses is that it is difficult, if not impossible, to describe the "typical" mental health problems of young children who need to be hospitalized in the state. Around Coffeyville and Newton (Prairie View), the typical problem appears to be Bipolar Disorders, but this disorder is not prominent in Topeka or Kansas City (except for Kaw Valley Center).

Table 11. Frequency of Mental Health Diagnoses for Children 12 and Under at Kansas Local/Regional Hospitals, FY 2004

	HOSPITALS				
	Coffeyville	Stormont Vail	KU Med	Prairie View	Kaw Valley
# OF TOTAL ADMISSIONS	67	113	158	228	65
DIAGNOSES				(376 diagnoses)	(143 diagnoses)
Bipolar	52 (78%)	1 (1%)	23 (15%)	125 (55%)	38 (58%)
Mood Disorder NOS*	0 (0%)	67(59%)	49 (25%)	71 (31%)	3 (5%)
ADHD*	5 (7%)	1 (1%)	45 (28%)	68 (30%)	40 (62%)
Other	8 (12%)	32 (28%)	35 (22%)	122 (32%)	62 (95%)
<i>Most Frequent Other</i>		Depressive Disorder 18 (16%)	Conduct Disorder 11 (7%)	PTSD 34 (15%) *	Oppositional Defiant Disorder 19 (29%)

NOTE: The first 3 hospitals reported one primary diagnosis per child; Prairie View recorded up to 4 primary diagnoses, with an average of 1.65 diagnoses per child; Kaw Valley Center also reported multiple diagnoses averaging 2.2 diagnoses per child.

* ADHD=Attention Deficit Hyperactivity Disorder; NOS= Not Otherwise Specified; PTSD=Post Traumatic Stress Disorder.

Attention Deficit Hyperactivity Disorder (ADHD) appears to be a big issue at KU Med, but not in Coffeyville or Stormont Vail in Topeka. Mood Disorder, NOS, is rarely diagnosed in Coffeyville or at Kaw Valley Center, but is fairly frequently diagnosed at the other hospitals.

The variation in frequency of diagnosis is rather dramatic, and warrants some attempt at explanation and understanding. One possible explanation is that certain disorders cluster in certain parts of the state (e.g., bipolar around Coffeyville and Newton), but this is implausible. A second possible explanation is that certain hospitals specialize in treatment of certain disorders, so that, for example, children from around the state with bipolar disorder travel to Coffeyville or Prairie View for specialized treatment of that disorder. This too is unlikely. A third possible explanation is that inpatient treatment for a certain disorder is needed in certain regions because that disorder is not effectively treated by the outpatient and community based system. Although this situation is possible (e.g., the communities around Coffeyville and Newton may not deal with Bipolar disorder in the community as well as the communities of Topeka and KCK do), this explanation is also implausible.

If we assume that mental health disorders in children are fairly evenly distributed around the state, the most likely explanation for the differences in admitting diagnoses is that the difference lies with those who do the diagnosing—that, perhaps, different theoretical orientation, training, experiences or biases of admitting physicians and mental health professionals result in different ways to view and categorize children's behavior and symptoms. Relatively little research attention has been paid to the validity of diagnostic criteria for children (Surgeon General's Report to Congress, 1999) or to the reliability of diagnostic evaluations (Armstrong, 2004; DelBello, 2002; DelBello et al., 2001; Sanchez, et al., 1999; Cogan, 1996).

The data above would support parent's reported experience that the mental health diagnosis that a young child receives may be highly dependent on which person is doing the diagnosing. Thus, the remedy to the problem of medication management that was identified above would appear to rest, at least in part, on somehow achieving more accurate, reliable diagnoses.

The second condition is that the effectiveness of medications has been scientifically established through clinical trials. For children's psychiatric diagnoses, this condition has not been met for most diagnoses. Only few medications (mostly stimulants) are listed as approved for children under age 12 by the National Institute of Mental Health (NIMH) (for list of medication currently approved for children see NIMH website: <http://www.nimh.nih.gov/publicat/medicate.cfm#ptdep10>).