USE OF EMERGENCY DEPARTMENTS FOR MENTAL HEALTH CARE FOR CONNECTICUT'S CHILDREN

A RISING TIDE

EXECUTIVE SUMMARY

REPORT ONE: CHILDREN ENROLLED IN HUSKY A

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A RISING TIDE

Executive Summary

Pressures on hospital emergency departments (EDs) are mounting as the ranks of the uninsured swell and access to routine preventive care diminishes. This is especially true for the care and management of children with mental health crises. As noted in a recent American Academy of Pediatrics Policy Statement on Pediatric Mental Health Emergencies in the Emergency Medical Services System:

> ***Community mental health resources have diminished and, in some regions, even disappeared through inpatient bed shortages, private and public health insurance changes, reorganization of state mental health programs, and shortages of pediatric-trained mental health specialists. These changes have resulted in critical shortages of inpatient and outpatient mental health services for children. The ED has increasingly become the safety net for a fragmented mental health infrastructure in which the needs of children and adolescents, among the most vulnerable populations, have been insufficiently addressed.***[1]

Hospital EDs have few mechanisms for regulating this demand, since federal law prohibits treatment facilities from refusing care for "walk-ins." Therefore, children who seek treatment in the ED are held for hours or even days before a suitable bed in a treatment facility is found. Despite the growing evidence of a crisis, little has been done to develop strategies going forward.

[1] American Academy of Pediatrics and American College of Emergency Physicians. 2006. "Pediatric mental health emergencies in the emergency medical services system." Pediatrics, vol. 118(4): 1764-1767. p. 1764.

THE PROBLEM IN CONNECTICUT

Connecticut's hospital EDs are reporting similar pressures. To better understand the nature and extent of the problem, the Child Health and Development Institute of Connecticut (CHDI), with funding from the Department of Children and Families, has undertaken an investigation into emergency department use by children and youth with primary psychiatric diagnoses in Connecticut. The three component studies explored the following:

- ED visits for psychiatric purposes made by children and youth enrolled in HUSKY A between 2002 and 2005 (using the Department of Social Services' HUSKY encounter data);
- ED visits for psychiatric purposes by all children to all hospitals in Connecticut between 2001 and 2005 (using the Connecticut Hospital Association CHIME database);
- A qualitative study based on interviews with a sample of parents of children who have used emergency departments for mental health issues and with ED staff who provide care for these children.

HIGHLIGHTS OF THE FINDINGS

Use of Emergency Departments for Mental Health Purposes by Children Enrolled in HUSKY A

- **Volume.** There was a 38% increase in the number of psychiatric ED visits by children enrolled in HUSKY A between 2002 and 2005 (from 3,007 to 4,134). About half the increase was accounted for by an increase in HUSKY enrollment, and half was due to an increase in the actual rate at which children were seen at the EDs.
- **Age.** The greatest proportion of visits were by youth ages 13-15 (32-37%). Younger children (9 and younger) accounted for only 12-13% of ED visits.
- **Gender.** There was little difference in the number of visits by boys as compared to girls (51% vs. 49%).
- **Diagnosis.** Visits for children diagnosed with mood disorders (e.g. depression) were the most prevalent (27-33%), followed by visits for children diagnosed with attention deficit and conduct or disruptive behavior disorders (22-29%).

Are Children Connected to Services Prior to Their ED Visits?

- **Percent.** The majority of ED visits (58-64%) were made by children who were known to the mental health service system at some time during the six months preceding their ED visit. The percent of visits made by children who did not receive any mental health service in the six months preceding their ED visit declined from 42% in 2002 to 36% in 2005.
- **Age.** Older children were less likely to have had a prior connection to the service system during the six-month period. 52% of ED visits by youth age 16 and older had no service contact within the six months preceding the ED visit.
- **Intensity.** Half of the ED visits during 2005 (52%) were made by children who had received services on 13 or more days during the preceding six months.
- **Type of prior service.** Of those ED visits preceded by an outpatient visit, 45% of service contacts occurred within the week prior to the ED visit. For 47% of visits to the ED preceded by an inpatient psychiatric hospitalization, the inpatient stay was from 2-6 months earlier with no intervening service before coming to the ED, indicating the need for more intensive follow-up efforts for children discharged from inpatient settings.

The high percentage of visits by children who are known to the mental health service system (many of whom had relatively extensive contact) suggests a need to examine whether and how providers are working with children and families to develop crisis plans that might divert some portion of these visits.

Are Children Connected to Services Following Their ED Visits?

- **Percent.** The majority of ED visits (76-78%) were followed up with at least one service contact during the subsequent six months, and nearly half of these follow-up service contacts were within one week of the ED visit. However, about one-quarter of visits had no such follow-up during the subsequent six months.
- **Age.** Follow-up service contacts were more frequent for ED visits made by younger children than older children. 85% of visits for those under 12 had a subsequent service contact within six months of being seen in the ED, while 65% of those 16 and older had subsequent contacts.
- **Intensity.** In the majority of cases, visits in which there was any subsequent care were followed up by services on 13 or more days in the six months after being seen in the ED. The proportion of visits with this intensity of follow-up service increased from 59% of visits in 2002 to 63% in 2005. Again, younger children were more likely to have this intensity of contact (73%) than older youth (48%). In fact, one in five visits by older youth (22%) was followed by three or fewer service contacts within the subsequent six months.

ED visits represent critical events that provide an opportunity for follow-up interventions. The majority of visits by children to the ED were followed by fairly frequent service contacts in the ensuing six months, with the rate increasing slightly over time. Visits by youth 16 and older were the exception, suggesting that special efforts to engage this population may be advisable.

Multiple Visits to the Emergency Department

- Over the study period, the proportion of children making multiple ED visits within a six-month period has declined from 22% of all children seen in the ED in 2002 to 19% of children in 2005.
- Children under 12 were more likely to have repeat visits (one in four) across all years than older youth (16%).
- Children with multiple ED visits in a six-month period utilized more services than those children with single visits both before and after the index ED visit. During the six months prior to the index visit, children with multiple visits received services on an average of 12.9 days, as compared to 7.1 days for children with single visits. Similarly, following the index visit, children with multiple visits received services on an average of 30.3 days within the next six months, as compared with 13.2 service days for children with single ED visits.

Conclusion

This study substantiates the increase in the reliance of children enrolled in HUSKY A on EDs. It also tells us that for the majority of children, the ED visit is not an isolated event. Most children were known to the mental health service system at some time during the six months preceding their ED visit. Of greatest concern are those who, before coming to an ED, had no intervening care following an inpatient hospitalization, as well as those children who had no follow-up contact within six months after an ED visit.

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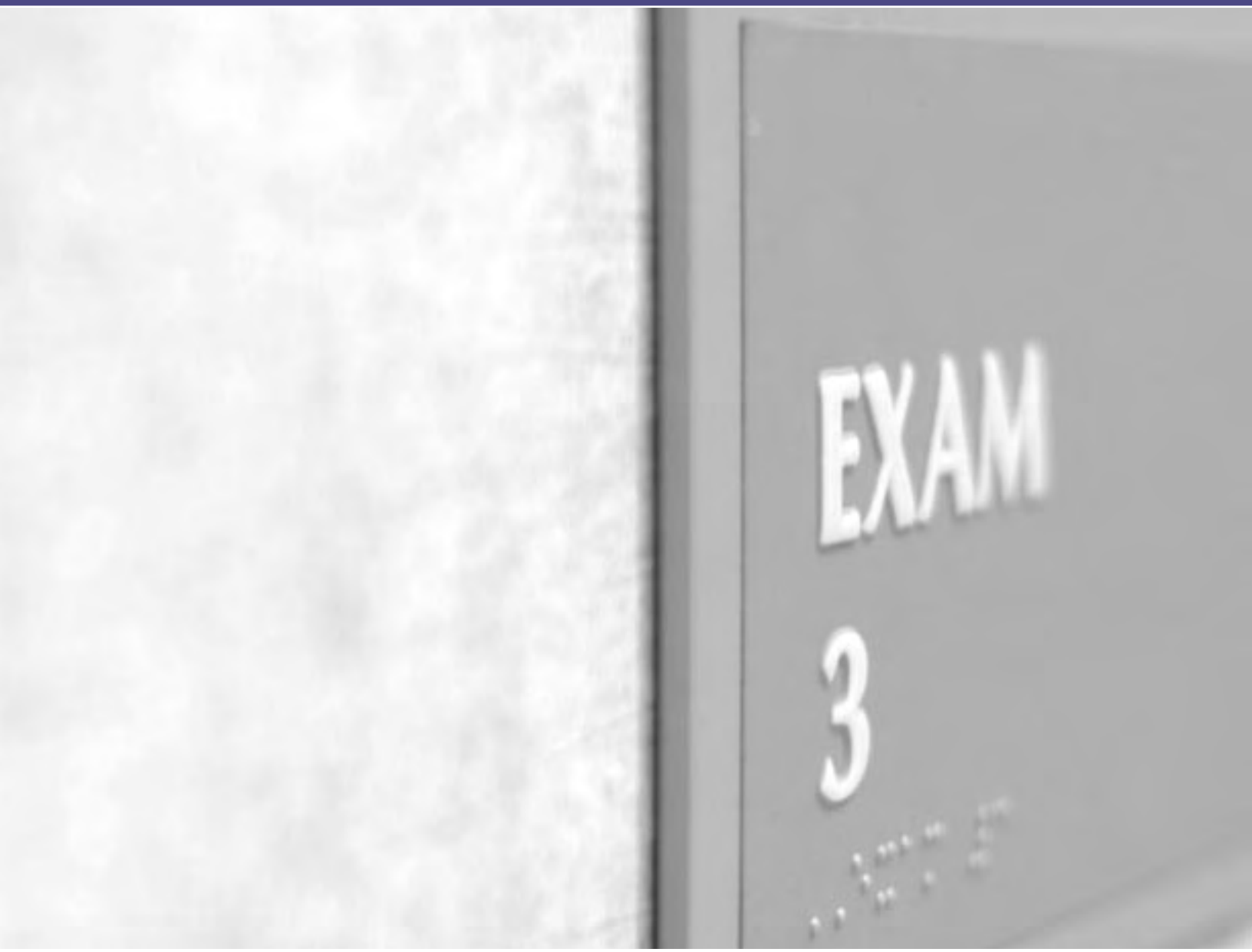

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