Pediatric Mental Health and Emergency Psychiatric Resources: A Path Toward Accessibility

A Literature Review

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Abstract

A review of current literature reveals the tragic disparity between increasing rates of serious emotional/behavioral disturbances among children and adolescents in the U.S. and a lack of available resources. Inaccessible and limited resources have resulted in higher rates of mental health related visits to the emergency department (ED) and increasing psychiatric hospital admissions even as the actual number of available inpatient psychiatric beds continues to decline. I aim to provide a comprehensive, yet succinct review of the complex factors contributing to the systemic problem of scarce and inadequate pediatric mental health and emergency psychiatric resources. In the wake of recent changes in U.S. healthcare policy, service delivery, and reimbursement, the role of the ED remains vital along the spectrum of available emergent pediatric mental health care. In concert with existing crisis services and various systems of care, the ED has the potential to treat the biopsychosocial needs of the individual through evidence-based interventions, competent assessment, referral to the most appropriate level of care, and innovative care coordination.
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Inadequate Pediatric Mental Health and Emergency Psychiatric Resources:

A Path Toward Accessibility

The broad, macro-level problem of inadequate and scarce pediatric psychiatric resource availability has, over time, resulted in a cascade of interrelated smaller scale problems described within the literature. By providing a succinct foundational description of the macro and interrelated micro level problems evident in the reviewed literature, the author aims to inform or inspire more viable solutions to the problem of inappropriate pediatric psychiatric ED utilization. It is one thing to dissect and understand the nature and consequences of smaller scale problems. It is another to propose solutions that consider the root causes of the problem and the resulting interrelated systemic factors that reinforce it.

The problem, simply stated, is that inadequate resources exist to care for pediatric patients presenting to the emergency department with mental health diagnoses. Unfortunately the causes of this inadequacy are less clear, with complex and wide-ranging systemic implications. Even more obscure are viable solutions that can address issues of funding, efficient service delivery, and efficacy in mental health treatment. By reviewing and synthesizing existing research relevant to the stated problem, the author seeks to provide a comprehensive, yet succinct description of the current problem, analysis of the systemic context of the problem, and a path toward viable solutions.

Current State of Affairs

Examining Relevant Statistics

In general, research points to an increasing prevalence of diagnosable mental health symptoms among children and adolescents in the U.S. Approximately one in five individuals under the age of 18 experience symptoms that lead to clinically significant impairments in
functioning during any given year (Brown & Schubert, 2010). It is unclear whether this rising statistic reflects an actual increase in prevalence or is due to other factors (i.e. early childhood screening methods, greater use of mental health resources, or increased use of diagnostic codes to obtain reimbursement for services). Whatever the cause, according to the United States Department of Health and Human Services, “preliminary work indicates that less than 20% of pediatric clients who suffer from mental disorders are receiving appropriate treatment” (Brown & Schubert, 2010, p. 413).

Given these startling trends, it is no surprise that recent research also revealed a general nationwide increase in pediatric mental health-related visits to the ED. Over the past 30 years, such visits have increased considerably, in some cases, up more than 50% (Brown & Schubert, 2010). One study, which analyzed nationally representative data between 1995 and 2001 from the National Hospital Ambulatory Medical Care Survey (NHAMCS), found statistically significant visit increases when comparing first to last year data for mental health related pediatric visits to the ED, but found only modest evidence of a yearly time trend increase (Grupp-phelan, Harman, & Kelleher, 2007). An even more recent review of NHAMCS by Pasic et al. (2009) found that youth are presenting to the ED for psychiatric complaints with rising frequency (1.6% of all pediatric visits in 1999 and 2.3% in 2006), while exhibiting a high percentage of severe psychiatric complaints (13.6% reported a recent suicide attempt and 10.8% reported psychosis).

This increase is more starkly evident when compared to the relatively stable visit statistics for similarly resource intensive children with chronic medical conditions. From 1995 to 2001, pediatric psychiatric visits to the ED increased with mental health diagnoses accounting for roughly 5% of all visits, while visits among children suffering with chronic medical
conditions remained stable at 5.3% (Grupp-phelan et al., 2007). For both of these groups approximately 15% of visits resulted in hospitalization.

ED as the Access Point

The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) mandates that hospital EDs must provide care to anyone needing emergent treatment regardless of citizenship, legal status, or ability to pay. Thus, it has become the de facto entry point for many individuals seeking services that are often inaccessible through other systems of care. The statistics provided in the previous section illustrate how the ED also serves as a bellwether, highlighting our nationwide deficiencies in pediatric mental health resources.

Various stakeholders (i.e. states, counties, cities, and hospitals) have, up until now, implemented their own innovative approaches to locally manage the burgeoning demands within emergency pediatric psychiatric care. In many cases, these stakeholders have operated and innovated independently, resulting in redundancy, repeated mistakes, and a systemic absence of communication or collaboration. In addition, widespread variation in ED structure, process, and quality of care exists, especially when comparing urban to rural locations.

Emergency pediatric visits are remarkably resource intensive. Often these patients require a lengthy safety assessment, beyond the requisite medical staff (i.e. MD, RN), from specialized licensed staff such as: social workers, clinical counselors, marriage and family therapists, drug and alcohol counselors, psychiatrists, or psychiatric residents. In addition to medical care, they often require on-the-spot therapy, medication evaluation and prescriptions, hospitalization, or a wide variety of outpatient referrals; not to mention, staff and security that are adequately trained to handle disruptive or unsafe behavior within the unit.
Whether we choose to acknowledge it or not, across this nation the ED has become the point of entry and part of the standard continuum of mental health care for many children and adolescents. In addition to providing care for pediatric patients in acute psychiatric distress, the ED has now taken on additional roles as mental health triage, treatment, and referral service. Heavy reliance on the ED for these purposes is inappropriate for such costly resources; it is reactive as opposed to preventative; and is often ineffective since most EDs are ill-equipped to handle this burden.

**Systemic Context of the Problem**

Without first surveying the broader context of contributing factors, it is difficult to fully grasp the connection between these broad statistics and the emergence of the ED as a main point of pediatric mental health access. This problem did not mysteriously arise over night. Several major questions came to the foreground as I reviewed the literature for answers: (1) what are the main individual and family characteristics that contribute to overutilization of the ED? (2) What are the main systemic factors (inside and outside the healthcare system) that have reinforced inappropriate utilization of the ED over time and created barriers in access to appropriate use of community-based mental health resources? (3) Given the recent paradigm shift in healthcare reform, how do we make the best use of emergency and community based mental health resources? First, I will look at how these questions relate specifically to the ED environment, and secondly I will examine how the answers to these questions impact our society as whole.

**Examining Question One**

Question number one goes straight to the heart of the issue. A critical step in optimizing ED treatment access, adherence, and outcomes is to analyze the relationship between service use and patient characteristics (i.e. presenting problem, diagnosis, gender, age, treatment history).
The existing research revealed a plethora of statistics related to these characteristics, but provided no simple answers to the question at hand. A true measure of how much individual characteristics effect ED utilization is difficult to ascertain given the myriad of possible contributing factors. However, the research did provide the necessary contextual foundation for framing informed long-term solutions for the larger issues of resource inadequacy and scarcity.

**Complex Risk Factors**

Analyzing ED utilization among pediatric patients requires an understanding of the complex interrelated factors that contribute to psychiatric pathology. According to The United States Department of Health and Human Services (as cited in Geller & Biebel, 2006):

Assumptions regarding children’s and adolescents’ mental health and illness are composed of complex, multilayered interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations), systems issues (including community factors and the larger social-cultural context), and the interaction of these factors over the course of a child’s development. (p. 243)

Lapointe, Garcia, Taubert, and Sleet (2010), found that many frequent users of psychiatric hospitalization are in some form of surrogate care (separated from their biological parents) as a result of untimely death, abuse, neglect, incarceration, homelessness, physical disability, or psychiatric disorder. It remains unclear exactly how these complex, multilayered, interacting variables impact pediatric ED utilization patterns.

Geller and Biebel (2006), found that youth with serious emotional disturbances are more likely to face a myriad of risk factors among family members, such as prior mental health
disorders, felony convictions, multiple family disruptions or separations, and foster care placement. According to the Center for Mental Health Services (1999):

Research indicates that the majority of children and adolescents with serious emotional disturbances come from single-parent households (53%), live in poverty (61%), and experience at least one family risk factor such as a family history of substance abuse (62%), or violence (54%). (as cited in Geller & Biebel, 2006, p. 277)

Additionally, the offspring of a parent with psychiatric pathology have a greater likelihood of receiving public sector mental health services and are more likely than the general child population to have their own psychiatric diagnosis (Geller & Biebel, 2006).

Other notable risk factors highlighted by Geller and Biebel (2006) include analyses of data from the SAMHSA Comprehensive Community Mental Health Services for Children and Their Families Program, which found that:

Over 60% of children with serious emotional disturbance entering systems of care services had a history of one or more risk factors. These data indicated that 30% had histories of running away, 26% had a previous psychiatric hospitalization, 24% had been physically abused, 18% had been sexually abused, and 20% had a history of substance abuse. (p. 274)

Existing research also points to a strong comorbid relationship between mental health and substance abuse disorders among children, adolescence, and young adults.

The National Comorbidity Study found that 41% to 65% of individuals with a lifetime substance abuse disorder also had a lifetime history of at least one psychiatric disorder, and that 51% of those with at least one lifetime psychiatric disorder also had at least one
substance abuse disorder; these rates were highest among 15 to 24 year olds. (Geller & Biebel, 2006, p. 275)

While the exact nature of the relationship between all these aforementioned risk factors and pediatric psychiatric ED utilization remains unknown, the impact these factors have on the healthcare system are certainly significant. We must also consider how these risk factors relate to the families, employers, schools, religious institutions, legal systems, healthcare providers, long-term care facilities, and various other social service providers that comprise our core social institutions. Especially, when considering possible solutions to the problem of inadequate or inaccessible, emergent, pediatric psychiatric resources.

**Consistent Findings in the Literature**

There were a few findings that consistently appeared in the research when looking at children and adolescents who frequent the ED. According to Brown and Schubert (2010), “The most frequent pediatric behavioral health presentations are by children displaying behaviors dangerous to others and children with diagnoses of adjustment, conduct, and oppositional disorders” (p. 414). Secondly, youth presenting with these behaviors are more likely to have had a prior history of ED visits, inpatient hospitalizations, and be engaged in current or past mental health treatment (McCulloch, Frosch, & Dosreis, 2008; Frosch, McCulloch, Yoon, & Dosreis, 2011).

According to Lapointe et al. (2010), the two most common reasons for psychiatric admission are aggression and suicidality, whereas individual risk factors most associated with repeated hospitalization are noncompliance with psychotropic medications, oppositional/defiant behavior, a learning disability, developmental delay, and a diagnosed psychotic or major affective disorder. Another study found that youth presenting frequently with dangerous behaviors are
made up mostly of younger males, while strictly suicidal presentations (with suicidal ideation or an actual suicide attempt) consist mainly of females and older youth (McCulloch et al., 2008).

Finally, visit rates tend to increase with age among all patients presenting with mental health conditions under age 18 (Grupp-Phelan et al., 2007).

General consensus was also evident within the reviewed literature that poor follow-up appointment attendance increased ED visit frequency among child and adult psychiatric patients discharged from the ED or inpatient ward. Authors Simakhodskaya, Haddad, Quintero, and Malavade (2009) stated that:

In a study of risk factors and strategies to improve follow up rates, Boyer and colleagues found that only 35% of discharged inpatients attended their scheduled or rescheduled initial outpatient appointment. Similarly, a study of psychiatric ER patients revealed that only 41.8% of these patients completed their referral. Noncompliance with aftercare plan often leads to high rates of readmission or repeat presentation to the ER. (p. 60)

More specifically, Simakhodskaya et al. (2009) indicated through clinical observation that higher rates of non-compliance, related to follow-up appointments made in the ER, exist among homeless individuals and active substance users demonstrating a higher level of illness severity.

Differences in rates of admission, rehospitalization, and ED utilization along racial lines were also revealed within the literature. In a study conducted by Lapointe et al. (2010), an unusually high percentage of African American youth had multiple hospitalizations. The authors further stated that, “this finding is consistent with reports from the Surgeon General that African Americans are overrepresented in psychiatric inpatient settings” (Lapointe et al., 2010, p. 169). Unfortunately, the causes underlying these differences are less clear and likely very complex.
Socioeconomic status, limited access to quality outpatient or preventative care, fear of stigma, or lack of knowledge about available mental health resources may all be contributing factors.

An in-depth look at how child and adolescent demographics, psychiatric histories, and presenting problems relate to ED visit frequency, revealed further complex relationships between these variables. A study authored by Mcculloch et al. (2008) categorized visits into groups based on year and presenting problem, “(1) Suicide Attempt (SA), (2) Suicidal Ideation (SI), (3) Behavior Problems, (4) Both Behavior Problems and Suicidal Ideation, and (5) Other (e.g., substance abuse, psychosis, mood, anxiety, etc. without any of the previously mentioned presenting problems (1-4))” (p. 2). Interestingly, the most common presentation to the ED (behavioral problems without SI), was correlated with a lower likelihood of a past SA, but also a higher likelihood of previous ED visits, hospitalization, and active psychiatric treatment (Mcculloch et al., 2008). Furthermore, behavioral patients presenting with SI were equally as likely as other groups (1, 2, 3, and 5) to have a history of active psychiatric treatment, but had a higher likelihood of a prior SA, a prior ED visit, and a history of hospitalization. Non-behavioral patients presenting with a SA or SI showed a higher likelihood of a prior SA, but a lower likelihood of prior psychiatric treatment, hospitalization, or visit to the ED (Mcculloch et al., 2008).

A broader study that examined non-psychiatric specific ED overcrowding and excessive service use over time among adults revealed some interesting conclusions. Weber et al. (2008) stated “Major contributors to increasing ED utilization appear to be disproportionate increases in use by nonpoor persons and by persons whose usual source of care is a physician’s office” (p. 108). The study further revealed that from 1996 to 2004, ED visit totals among uninsured adults remained stable, but they increased among adults with a usual source of primary care and among
adults whose family income was greater than 400% of the federal poverty line (Weber et al., 2008). However, it is still unclear as to whether this is more a result of inappropriate use among patients and referring providers, or due to systemic factors that have decreased the accessibility and affordability of resources at more appropriate levels of care.

Uncertainty remains in the research as to which factors have the greatest impact on the frequency of ED utilization. Ultimately, individual or family characteristics should be viewed as one of many possible factors influencing statistics related to ED utilization patterns and the overarching problem of inadequate pediatric mental health services. It would be shortsighted to place undue emphasis on individual patient characteristics, in light of all the other possible external or systemic factors that will be examined throughout this literature review.

**Examining Question Two**

Instead of focusing on individual characteristics, let’s take a step back and examine the systemic factors that contribute to inappropriate utilization of the ED. On a more macro level, we will examine how, policy, healthcare reform, Medicaid, deinstitutionalization, inpatient hospitalization, tort law, workforce shortages, inadequate funding, managed care, and cost-shifting among core social institutions affect the problem of inadequate pediatric psychiatric resource availability and overutilization of ED resources. Let us begin by more closely examining access to primary care, main sources of mental health referral to the ED, and existing crisis or emergent community-based resources.

**Access to Primary Care**

Close ties exist between pediatric psychiatric utilization of the ED and timely accessibility to quality primary care. According to Leininger and Meurer (2011), “whether fighting communicable diseases, providing behavioral health services to at-risk adolescents, or
managing chronic physical conditions (such as asthma) achieving key pediatric health goals is crucially dependent upon the presence and accessibility of high-quality health care services” (p. 161). In addition to prevention and wellness, primary care serves as a significant source of referral to specialty or emergency care. As of 2007, the nationally representative Medical Expenditure Panel Survey found that 71.3% of children (between the ages of 1-17) visited at least one medical provider within the previous year, while 89.6% had an established non-ED source of primary care. This is an alarming indicator that a significant proportion of youth (roughly 30% in 2007) lack access to basic, annual, preventative medical examinations, especially among families with low socioeconomic status (Leininger & Meurer, 2011).

Broad systemic factors such as primary care workforce shortages, expanded publicly-funded insurance programs, and low reimbursement rates have converged over time to disrupt access to primary care. Despite per capita growth in the number of active physicians from 115 per 100,000 people in 1965 to 190 in 1992, the specialist-to-population ratio ballooned by 120%, while the primary care physician-to-population ratio grew by a mere 14% (Bodenheimer & Pham, 2010). The vast majority of primary care practices function on a fee-for-service basis and exist in small settings with only one or two physicians.

As a result of managed care practices, physicians see increasingly higher volumes of patients, while decreasing the amount of time they spend with each one. Consequently, this limits their ability to build trust, discuss health related issues, and develop a working alliance that can enhance treatment outcomes (Halfemeister, Mclaughlin, & Smith, 2013). In contrast to relatively high reimbursement rates for specialty procedures and imaging services, primary care physicians receive far less compensation for: cognitive services (i.e. counseling on lifestyle and
medications), care coordination (i.e. specialty consultation and referral), and administrative costs (billing and other insurance related activities).

In addition to primary care physician shortages, child and adolescent psychiatrists have also become difficult to find; especially within many rural and low income communities. Prescribing privileges are typically limited to physicians (MD), physician assistants (PA), and nurse practitioners (DNP, CNP, CNS), which excludes the majority of children’s mental health providers (PhD, PsyD, LP, LPC, LPCC, LMFT, LICSW). “A national study found that from 1993 to 2009 the percentage of visits to office-based physicians in which antipsychotic medications were provided increased over sevenfold for children, almost fivefold for adolescents, and slightly less than twofold for adults” (Halfemeister et al., 2013, p. 64). Despite continued growth and reliance upon psychopharmacological treatments, there are only about 8.7 pediatric psychiatrists available for every 100,000 youth in the U.S. (Holzer & Thomas, 2006).

Psychiatrists must also contend with relatively low reimbursement rates (especially among patients with Medicaid and Medicare) and limited compensation for case management, care coordination, and administrative related activities. Consequently, a significant number of psychiatrists limit care based on insurance type or only see patients who can afford to pay out of pocket for services.

Over time, eligibility thresholds for Medicaid and CHIP (Children’s Health Insurance Program) have expanded to include poor older children, teenagers, and near-poor younger children. Data from 2008 revealed that 10% of all children remained uninsured, despite the majority actually being eligible for publicly subsidized coverage (Leininger & Meurer, 2011). Of those who had coverage, “31% of children were enrolled in Medicaid or CHIP, 55% were enrolled in employer-sponsored plans, and 4% were enrolled in private non-group plans”
Policy efforts, including the 2010 passage of the Patient Protection and Affordable Care Act (PPACA), have continued to facilitate enrollment with the ultimate aim of universal coverage for children.

Unfortunately, expanded publicly-funded insurance coverage has not immediately translated into improved access to primary care. Numerous additional barriers to access exist depending upon the unique characteristics of families. For example, many low-income families struggle to afford premiums or copayments, locate providers available in their area, and obtain transportation to scheduled appointments. Many of the same barriers described throughout this research review as limiting access to mental health resources, also limit access to primary care. Finally, “low reimbursement rates coupled with onerous paperwork requirements deter physicians from caring for publicly insured patients; as a consequence, approximately 15% of pediatricians are not accepting any new patients” (Leininger & Meurer, 2011, p. 164).

The influx of publicly-insured individuals has exacerbated existing primary care workforce shortages, while Medicaid enrollees continue to disproportionately utilize the ED for nonemergent purposes. A study by Gandhi, Grant, and Sabik (2014), examined a nationally representative sample of hospital-based ED visits over time (2000 - 2009) to reveal trends in nonemergent utilization patterns based on insurance status. On average, uninsured visits were most likely to be nonemergent when compared to other insurance types. However, when accounting for total visits and population size, the authors revealed, “that nonemergent ED visit rates per person were relatively stable within each insurance group, but that Medicaid enrollees had far more nonemergent visits per person than the privately insured, Medicare enrollees, or the uninsured” (Gandhi et al., 2014, p. 505). It remains to be seen whether the passage of the PPACA will decrease nonemergent utilization of the ED over time.
Main Sources of Referral to the ED

**Primary care.** Mental health services are increasingly in high demand within primary care settings, which often serve as a main source of pediatric psychiatric referral to the ED. Since pediatricians provide the majority of primary care to children, they are often the first point of contact for youth suffering with mental health symptoms. Pediatricians report reluctance in addressing these issues for a variety of reasons: (a) inadequate mental health training and expertise, (b) they lack collaborative relationships with specialized community-based mental health providers, (c) insurance related barriers to care or reimbursement, and (d) excessive demands on limited clinic resources (Valleley et al., 2007; Pfferle, 2007; Burka, Van Cleve, Shafer & Barkin, 2013). However, pediatrician responses to a questionnaire regarding access to mental health care reveal that, “on average, respondents treated 40% of children with mental health disorders themselves, either with supportive counseling or medications” (Pfefferle, 2007, p. 427). Additionally, “pediatricians described treating children themselves, hiring mental health practitioners to work in their practices, training themselves on mental health issues, and gaming on diagnostic codes in order to receive payment” (Pfefferle, 2007, pp. 429-430). Out of necessity and fear of liability, many pediatricians refer complex cases or patients in crisis to the ED; especially if it will help them obtain faster access to prescriptions or referrals to more appropriate levels of care.

**School.** Nationwide, there has been an increase in the number of youth referred from schools to the ED for nonemergent mental health issues (Shah & Donise, 2014). Statistical variations in the pattern of pediatric ED utilization have been shown to vary depending on hours of school operation (Brown & Schubert, 2010; Pasic, Zarkowski, & Hilt, 2009). Contributing factors include risk averse, zero tolerance policies regarding aggressive behaviors and difficulties
related to triaging mental health issues or arranging appropriate outpatient services (Shah & Donise, 2014). Beyond the monetary costs of emergency psychiatric evaluation (often $2000 or more), children and families also face emotional costs from: (a) the often humiliating spectacle of being placed on a stretcher and taken via ambulance in front of peers, (b) lengthy wait times in the ED, and (c) potential trauma related to experiencing or witnessing forcible restraint within the ED environment (Pasic et al., 2009). ED evaluation provides only a brief glimpse into existing psychopathology, especially when communication is limited between school and ED staff before, during, and after the visit. Sadly, many EDs are ill-equipped to manage psychiatric emergencies beyond a basic evaluation for inpatient hospital admission and do not have any better access to outpatient mental health appointments than the referring school.

**Juvenile justice.** Over time, changes in juvenile law and deficiencies in the child mental health system have contributed to a situation where approximately two-thirds of incarcerated youth meet criteria for one or more mental disorders (Grisso, 2008). “Youth with mental disorders frequently have symptoms involving impulsiveness, anger, and cognitive confusion that can make them less manageable and a greater risk to themselves or others, especially under the stress associated with their offense and arrest” (Grisso, 2008, p. 151). Consequently, it is not surprising that these youth have more frequent contact with police, are detained for longer periods of time, and are overrepresented within the juvenile justice system (Grisso, 2008). As a society, we run the risk of criminalizing mentally ill youth by over relying on the juvenile justice system to compensate for inadequacies within the mental health system.

Similar to the ED, police are available to the community 24 hours a day, 7 days a week. Depending on the severity of the offense, police must make the difficult decision to either detain children within the juvenile justice system, take them to a shelter (if such resources exist), or
transport them to the ED for psychiatric evaluation. Police are often reluctant to arrest mentally ill and/or behaviorally aggressive youth that, for one reason or another, cannot remain at home. In many cases, they are responding to juveniles engaged in long-standing parent-child conflicts, where no laws have been broken or offenses are not serious enough to warrant arrest. Detaining “out of control” youth is not an appropriate use of law enforcement resources and is often not in the best interest of children either. Police simply have very few placement options at their disposal that function as safe alternatives to the ED or juvenile detention.

**Existing Crisis or Emergent Resources**

In response to increased utilization of psychiatric emergency services, many communities have developed a variety of supports such as: “24-hour observation units, mobile assessment teams, emergency department consultation, law enforcement, telephone crisis hotlines, crisis residence, and disaster response teams” (Brown, 2005, p. 141). Typically, extended observation units are 24-hour, hospital-based programs aimed at reducing unnecessary inpatient hospitalization by stabilizing patients and providing for their basic needs. Mobile assessment teams usually consist of mental health professionals who respond to crises (on location) by providing immediate assessment and referral. To some degree all communities rely on law enforcement and other first responders to appropriately de-escalate, prescreen, and temporarily detain individuals in psychiatric crises. Typically, crisis hotlines utilize trained mental health staff to provide free counseling, crisis management, and referral over the phone. Crisis residences reduce unnecessary inpatient hospitalizations by stabilizing crises within the community through a variety of services (e.g. temporary shelter, referral, medication education, psycho-education, counseling, etc.). Disaster response teams utilize mental health professionals to provide crisis counseling and debriefing services following disaster situations (Brown, 2005).
Wide variation exists in the funding and administration of these services, with the bulk of responsibility falling on the shoulders of public providers at the city and county level. Many of these services are not reimbursable through insurance; thus they are financially unsustainable without reliable sources of public funding. The availability of public funding often depends upon a variety of factors such as: geographic location, population size, local politics, and the overall health of the surrounding community. “Crisis services have been largely unable to assume the roles of the hospital ER because the capacity of crisis programs has been limited to small numbers of youths” (Geller & Biebel, 2006, p. 256). While many of these services share a common goal of reducing unnecessary hospital admissions, they also function as significant sources of referral to the ED, where youth are likely to be evaluated for possible psychiatric admission.

Without further consistency and standardization of care, research into the structure, process, and outcomes of psychiatric emergency services will likely remain limited, non-generalizable, and mostly descriptive in nature. “Twenty years of research into psychiatric emergency services has led to the identification of areas that need further development including: cost-effective resource allocation; service innovation; integration and specialization; and refinement of assessment tools” (Brown, 2005, p. 153). Quality psychiatric emergency services, built on a foundation of robust empirical evidence, is of vital importance since they often serve as a measure of integrity of the health care system as a whole.

**ED Function**

It is difficult to grasp an accurate understanding of the current or ideal function of the ED in relation to other core social institutions and the broader continuum of existing mental health services without further, in-depth description of the history and process surrounding pediatric
psychiatric hospitalization in the U.S. In addition to immediate medical attention and psychiatric crisis-stabilization, one main function of the psychiatric ED is to determine whether or not a patient requires and/or meets criteria for inpatient admission. Logic would follow that people presenting to the ED are actually seeking admission, but that is not always the case.

In reality, the role of the ED has strayed quite far from the previously stated primary functions. “According to the New York National Alliance for the Mentally Ill, psychiatric emergencies in children have reached epidemic proportions. Emergency room doctors report seeing a large number of children whose parents have run out of options for care” (Geller & Biebel, 2006, p. 256). For many referring providers and institutions it serves as mechanism for minimizing risk, reducing liability, and obtaining a referral to a more appropriate level of care. For many patients (especially the uninsured) it is perceived as the only immediately accessible resource during a time of crisis. Most often, the psychiatric ED serves as a gateway for people who are unable obtain a scarcely available resource, lack the necessary knowledge to navigate the intricacies of the mental health system, or simply do not know what they are looking for - except that they need help.

**Psychiatric ED Structure and Process**

A review of the literature revealed a startling nationwide lack of consistency in the structure and process surrounding the evaluation and treatment of pediatric psychiatric symptoms within the ED environment. At this point it is unclear whether enough standardization in assessment and treatment processes exists to make cross-facility comparisons. Consequently, much of the research is focused on describing case examples (Brown & Schubert, 2010). In general, the research reflects significant qualitative differences in psychiatric care when comparing standard medical ED environments to more specialized psychiatric EDs, where
separate but parallel processes are often delineated for patients that present with psychiatric symptoms as their chief complaint. Typically, these specialized processes are only found within large metropolitan communities, while hospitals without inpatient psychiatric services may be least likely to provide adequate pediatric psychiatric emergency evaluation. “Psychiatrists worry that children with serious emotional disturbances aren’t getting appropriate care in emergency room settings, and few hospitals have units dedicated to pediatric emergencies or wards specific to child psychiatric cases” (Geller & Biebel, 2006, p. 256).

In standard medical ED environments physicians are primarily focused on providing medical clearance prior to hospital admission or further evaluation by a mental health professional if such resources exist. Physicians typically obtain a brief history, examine both physical and mental status, and perform medical tests when necessary. This ensures appropriate identification and treatment of any underlying medical illness that might cause or contribute to psychiatric symptoms (Kohen, Farahani, Veksman, & Manu, 2010). Ordering of urine analysis or laboratory testing is not uncommon since substance abuse is frequently found among psychiatric patients presenting to the ED (Kohen et al., 2010). However, clear standards regarding the components or appropriate depth of evaluation for medical clearance have not yet been established, resulting in highly variable and potentially inadequate evaluation (Kohen et al., 2010; Brown & Schubert, 2010).

Depending on the availability of resources, standard medical EDs or specialized psychiatric EDs may include a number of additional supports for the evaluation, treatment, and referral of pediatric psychiatric patients. The ED physician may enlist the services of one or more additional professionals such as a: psychiatrist, psychiatric resident, licensed mental health specialist, or social worker. “Despite literature that identifies the unique complexities of
psychiatric and pediatric populations and recommends evaluation by specialty personnel, most general EDs do not have regular staff who are behavioral health specialists or pediatric specialists” (Brown & Schubert, 2010, p. 414).

Interview structure and reliance on collateral information from parents may be altered in accordance with the child’s age, willingness to participate, and cognitive abilities. Some ED’s encourage assessors to obtain a release of information from parents so they can collaborate and share documentation with the patient’s existing providers (e.g. primary care physician, established mental health providers, probation officer, teacher, etc.). Primarily evaluation is aimed at stabilizing the patient and referring them to the most appropriate level of care. “In pediatric patients, dispositions are determined based on the severity of the presenting symptoms, and the strength of the safety plan, support system, and community follow-up” (Pasic et al., 2009. p. 217). The decision for against inpatient admission is primarily based upon an overall assessment of the risk of potential harm to self or others.

There is significant variation in the degree of accommodation when comparing standard medical EDs to psychiatric EDs, especially when accounting for hospital size. Larger hospitals typically have greater access to resources and place more emphasis on establishing safe and therapeutic surroundings. Typical environmental considerations for pediatric psychiatric patients are: close supervision and formal security; food and drink; separation from adult patients; reduced noise; sensory toys, video games, or audio/video equipment; and removal of potentially hazardous materials. Physical restraints are used as a measure of last resort for patients in severe risk of harming themselves or others, while chemical restraints are either used in addition to physical restraints or given on a voluntary basis to reduce severe agitation (Pasic et al., 2009).
Due to a general lack of available ED resources and inpatient psychiatric beds, long waiting periods for admission or even psychiatric evaluation are not uncommon; so much so that many patients and families leave without being seen (Pasic et al., 2009). The training and availability of nonclinical support staff (nurses, psychiatric technicians) also varies significantly between ED facilities (Brown & Schubert, 2010). For those not admitted, referral to community providers is not uncommon, but actual scheduling of a follow up appointment prior to ED discharge is rare.

**Legal Complexities**

**Consent, confidentiality, involuntary treatment, and mandatory reporting laws.** Legal issues surrounding consent, confidentiality, involuntary treatment, mandatory reporting laws, and duty to warn laws add to the inherent complexity of emergency pediatric psychiatric evaluation. First, consent for care requires that the patient is capable of making medical decisions. Such capacity is presumed for most adults, while consent from a legal guardian is almost always required for minors. Second, informed consent requires that the patient is given and understands all the relevant information regarding the risks and benefits of treatment options (including alternatives to the proposed treatment). Lastly, the patient must voluntarily communicate their decision to accept the treatment without coercion or duress (Pasic et al., 2009).

However, informed consent may be bypassed in emergency situations, where delay in care could potentially result in death or undue risk to health. Additionally, depending on state law and context-specific cases, minors may be able to provide their own consent. For example, emancipated minors or adolescents seeking treatment for certain substance abuse or mental health related services can, in some cases, provide their own consent (Pasic et al., 2009).
Obtaining consent for the treatment of minors may be especially challenging if: youth are brought to the ED alone, they refuse to divulge legal guardian names or contact information, parents are divorced, or children are placed under the physical custody of Child Protective Services (CPS).

Maintaining patient privacy and confidentiality is of the utmost importance within emergency pediatric psychiatric care. “The Health Insurance Portability and Accountability Act (HIPPA) prohibits the disclosure of clinical information, with exceptions for treatment, payment, or when mandatory reporting laws supersede (e.g. when child abuse is suspected)” (Pasic et al., 2009, p. 216). Protections (and exceptions) under HIPPA must be explained to the patient and consent from a legal guardian must be obtained before confidential information can be released. However, in cases of emergency, where clinicians can prevent potential abuse, neglect, self-harm, or violence, they may selectively gather or disclose clinical information without consent. Every potential consideration must be made to prevent the unnecessary disclosure of sensitive information.

State specific differences in the laws regarding involuntary psychiatric admission, mandatory reporting, and duty to warn can be confusing for both patients and providers. All states require mandatory reporting of suspected child abuse or neglect to CPS, but the people and professionals who are mandated to report varies depending on the state. While the majority of states maintain duty to warn laws, wide variation exists as to: whether such laws are mandatory or permissive, which professionals are required or permitted to warn potential victims of violence, and how potential victims are to be warned. In general, state laws are in agreement that patients should always be placed in least restrictive settings that provide for appropriate care and safety. Involuntary hospitalization is only indicated in situations where patients cannot safety
care for themselves or are at imminent risk of harming themselves or others. However, differences in state law exist regarding: the minimum age of consent for voluntary inpatient hospitalization; whether a legal guardian’s consent for involuntary inpatient hospitalization supersedes a minor’s nonconsent; or whether a physician’s consent for hospitalization supersedes a legal guardian’s nonconsent.

**Tort law.** Tort law, as it relates to defensive medicine, has had an increasingly significant impact on patterns of ED utilization and the availability of pediatric mental health resources. Since timely access to appropriate, community-based levels of care are often limited, healthcare providers frequently avoid potential malpractice by making unnecessary referrals for psychiatric evaluation to the ED. Mental health patients are often subject to unnecessary inpatient hospitalization as a result of inadequate: psychiatric training in the ED, care standardization, resources for mental health consultation, and access to timely follow-up appointments. Over time, unnecessary inpatient psychiatric admissions and referrals for emergency psychiatric evaluation have had the effect of driving up healthcare costs and decreasing the availability of funding and reimbursement for community-based mental health resources.

Historically, a general lack of legal advocacy and standardization in mental health treatment has insulated mental health professionals from malpractice claims in comparison to other healthcare specialties (Hafemeister, Mclaughlin, & Smith, 2013). Most medical malpractice claims fall under a subcategory of civil law known as tort law. These are cases where no contractual relationship exists and one person does something to another that resulted in harm. The prosecution must establish that: (1) the defendant had a duty to provide reasonable care to the injured party (as in a doctor-patient relationship), (2) reasonable standards of care were not met, (3) failure to provide appropriate treatment resulted in physical or emotional
injury, and (4) the plaintiff should be awarded compensation as a result of their injury (Hafemeister et al., 2013). The inherently complex nature of mental health diagnosis and treatment has made establishing a standard of care (typically via expert witness testimony) and proving the existence and degree of harm (in the absence of physical evidence) exceedingly difficult.

However, standards of care have become more clearly delineated through the development of evidence-based diagnosis, treatment guidelines, and psychopharmacological interventions. A shift has occurred where providers are increasingly being held to these evidence-based standards, as opposed to standards based on customary, or jointly agreed upon practices within the profession. This is especially concerning for mental health professionals, who prefer to utilize non-pharmacological treatment interventions or adhere closely to a therapeutic theoretical orientation that is in the minority. “A failure to obtain a needed referral or consult when treating a client can constitute a breach of the standard of care and result in liability for the provider” (Hafemeister et al., 2013, p. 54). Unfortunately, the combination of pressures imposed by managed care, limited financial incentives, and increased professional liability have likely done more to reinforce existing mental health provider shortages than deter malpractice.

Additionally, malpractice claims have increased where primary care providers have failed to appropriately prescribe or monitor psychotropic medications for pediatric patients. According to Hafemeister et al. 2013:

Several factors make primary care providers likely, at least initially, to attempt to resolve their patients' mental health problems by prescribing a treatment regime of psychotropic medications: their training and background consist primarily of a biological approach to treating mental illness, the treatment options readily available to them are typically
limited to medications, their ‘gatekeeping’ responsibilities restrict referrals to mental health specialists, and they have a desire to personally assist their patients - which also typically reflects the expectations of their patients. (p. 59)

Consequently, it is not surprising that primary care providers often end up referring youth in mental health crisis, or in need of psychiatric prescriptions, to the ED for psychiatric evaluation.

The increased liability associated with assessing patient risk of harm to self or others in the community has exacerbated existing clinician tendencies toward defensive medicine. “At present, many providers—often the most talented and credentialed—are simply unwilling to subject themselves to the perceived legal vulnerability and potential economic risks that come with serving those patients at highest proclivity for self-harm” (Appel, 2012, p. 529). Critical provider shortages enable psychiatrists to fill their practices with carefully selected, low-risk patients, while creating practically no incentives to take on greater liability.

Instead of deterring malpractice, increased litigation has contributed more to: a pervasive fear of patient self-harm among clinicians, reduced access to care among high-risk individuals, and unnecessary inpatient psychiatric admissions that may actually discourage high-risk patients from seeking help (Appel, 2012). “Concern over liability also leads providers to adopt overinclusive hospitalization policies that favor involuntary commitment at the first signs of possible Suicidality” (Appel, 2012, p. 530). It is unknown whether the short-term, harm-reducing benefits associated with forced hospitalization outweigh the potential long-term harms affecting patient mortality or provider practices.
A Brief History

Medicaid, deinstitutionalization, and LRA. A brief review of U.S. history related to policy, rising healthcare costs, managed care, and inpatient psychiatric hospitalization will reveal the broader overlying context that has led to the current function of the ED and the existing state of pediatric mental health resource scarcity. During the latter half of the 1960’s and early 1970’s, policies aimed at deinstitutionalization and accountability led to the creation of Medicaid as a means for regulating mental health service delivery and reimbursement. Medicaid was designed as a jointly funded (state/federal) insurance program that gave coverage to low-income, Temporary Assistance for Needy Families (TANF) or State Children’s Health Insurance Program (CHIP) eligible families and Supplemental Security Income (SSI) eligible elderly, disabled, or severely mentally ill individuals (Frank, Goldman, & Hogan, 2003). State funded mental hospitals or IMD’s (institutions of mental disease) were no longer eligible to receive Medicaid payments for individuals between the ages of 22-64, while general and private hospitals could still obtain reimbursement for inpatient psychiatric admissions. Thus, Medicaid served as the main catalyst for deinstitutionalization, trans-institutionalization of people between custodial/long-term care facilities, and implementation of the least restrictive alternative to treatment (LRA).

Original proponents LRA sought to collectively manage and treat deinstitutionalized individuals within the community to the fullest extent. LRA policy was aimed at respecting the dignity, value, and freedom of the individual, while encouraging tolerance and productive engagement within the community. For decades, highly restrictive, state funded psychiatric facilities provided treatment and custodial care for people suffering with a variety of ailments such as: dementia, developmental disability, chemical dependency, chemical dependency, and mental illness. The
judicial commitment process, as well as the quality and availability of care, varied widely within these institutions across the U.S. Over time, widespread reports of abuse and neglect began to garner public attention. Public opinion also changed as major advances in psychopharmacology led to an increase in the level of functioning for many patients; especially among those suffering from psychotic symptoms.

The vast majority of funding was cut for state operated inpatient psychiatric facilities. “During 1955 - 1965 the populations of public mental hospitals fell by about 1.5 percent per year. Following the introduction of Medicaid, they fell at a rate of 6 percent per year” (Frank et al., 2003 p. 107). Also, deinstitutionalization was hastened by new laws that prohibited the use of unpaid labor as a source of revenue within IMD’s. What followed was a gradual nationwide decline in psychiatric bed totals, a decrease in the average length of admission, and a dramatic shift in bed operation from state facilities to private and general hospitals. From 1970 to 2000 the total number of psychiatric inpatients steadily declined, even as the number of admissions gradually increased from 1969 to 1998 (Geller & Biebel, 2006). According to Lapointe et al. (2010), “Between 1996 and 2004 there was a 40% increase nationwide in the number of youth referred for psychiatric inpatient treatment (p. 162).

Minority and low-income access to Medicaid. Medicaid has played a significant role in redefining how mental health care is delivered in the U.S. However, as total inpatient psychiatric bed numbers dwindle and admission numbers continue to rise, it has become increasingly evident that pediatric mental health resources within the community are either inappropriate, ineffective, or inaccessible. According to Geller and Biebel (2006):

Studies show significant numbers of children and adolescents in need of treatment do not receive behavioral health services; this is particularly true of low-income and minority
children who experience disparities in access to, and availability of, quality behavioral health services. (p. 252)

Additionally, the authors state that the strongest demographic correlate of a psychiatric diagnosis in children is poverty and that unmet needs for many behavioral health services have remained high for the past 30 years. (Geller & Biebel, 2006).

In line with eligibility requirements, Medicaid disproportionately serves, poor people, minority groups, and people with severe mental disorders, which has resulted in increased utilization of mental health resources among Medicaid reimbursable services. “The growth in access, as measured by utilization rates, for Medicaid and Medicare enrollees was particularly notable, increasing from 10.5 percent in 1977 to 17.7 percent in 1996” (Frank et al., 2003 p. 106). As noted by Frank et al. (2003), results from a ten-state study of mental health and substance abuse spending within Medicaid in 1994 revealed that, “53 percent of enrollees treated for an MH/SA condition were white, 38 percent were African American, and 3 percent were Hispanic” (p. 103). After adjusting for inflation, total mental health spending in Medicaid grew by a factor of 2.6, or $10.3 billion, by 1997 (Frank et al., 2003 p. 103).

**Coverage gaps and cost shifting.** Through matching contributions, Medicaid has effectively served as a mechanism for the federal government to help states cover the heavy costs associated with psychiatric care. According to Frank et al. (2003):

Medicaid provides 18 percent of state mental hospital revenues, 27 percent of general hospital psychiatric services revenues, and 24 percent of revenues for community-based providers such as community mental health centers (CMHCs). Nursing homes also receive substantial payments for mental health care. (p. 104)
When comparing between the states, several factors have influenced the variety and availability of mental health services such as: (a) federal Medicaid rules and matching rates; (b) the existing availability of state funded hospitals or other publicly funded providers; (c) the availability of private insurance; and (d) the amount of state income (Frank et al., 2003 p. 106). Based on these, or other state-specific factors, states often allocate funding in a way that capitalizes on services that provide the highest federal matching rates for their particular economic circumstances.

Both intended and unintended consequences have occurred as a result of deinstitutionalization, Medicaid, and the implementation of LRA. As states shifted costs to capitalize on federal matching, some existing state-grant-funded community mental health resources (aimed at serving low-income, unemployed, and non-Medicaid or SSI eligible individuals) sustained significant reductions in funding. According to Timmermans, Orrico, and Smith, (2014):

Health policy makers and social scientists have established that the 48 million uninsured children and nonelderly adults in the United States are at risk for negative health outcomes and downward social mobility because of gaps in health insurance and problems accessing health care delivery. (p. 361)

In particular, a significant gap in accessibility has persisted for those who do not qualify for publicly funded insurance or cannot afford private health insurance, either on their own, or through their employer.

The utilization of disproportionate-share hospital (DSH) payments, is another example of how policy, shrewd politics, and state specific factors have influenced the availability of mental health resources when comparing between states. “The Omnibus Budget Reconciliation Act
(OBRA) of 1981 required states to take account of the situation faced by hospitals with a disproportionate share of low-income patients with special needs” (Frank et al., 2003 p. 108).

Several states utilized DSH payments as a way to circumvent the IMD Medicaid exclusion and continue funding state mental health institutions. In some states this, “gaming” of the system to obtain DSH payments, resulted in arguably unfair allocations of aid.

In order to control spending, state Medicaid programs often set Medicaid reimbursement rates below private market levels. In principle, Medicaid eligible individuals have access to a variety of covered services such as: prescription drugs, physician services, inpatient care, nursing home care, laboratory services, psychologists’ services, case management, clinic services, personal care, and rehabilitation (Frank et al., 2003). In reality, the number of providers that offer these services in exchange for low Medicaid reimbursement rates are often insufficient to meet demand, especially within outpatient care. A familiar pattern has emerged, where states reduce spending by lowering reimbursement rates, which further constrains the supply of outpatient providers and ultimately results in greater reliance on emergency and/or inpatient services.

**Rising costs.** As states adjusted their budgets to accommodate deinstitutionalization, the expansion of Medicaid, and the implementation of LRA, the U.S. concurrently experienced rapid nationwide growth in healthcare costs overall. A report from The Henry J Kaiser Family Foundation describes the following statistics:

1. In 2010, the U.S. spent $2.6 trillion on health care, an average of $8,402 per person.
2. The share of economic activity (gross domestic product, or GDP) devoted to health care has increased from 7.2% in 1970 to 17.9% in 2009 and 2010.  
3. Health care costs per capita have grown an average 2.4 percentage points faster than the GDP since 1970.
Since 2002, the rate of increase in national health care spending has fallen from 9.5% to 3.9%. Half of health care spending is used to treat just 5% of the population. (p. 7)

Several key contributing factors are linked to cost increases such as: (a) the growing population of aging Americans, (b) the treatment and management of chronic diseases, (c) increased utilization and reliance on technological innovation in healthcare, and (d) administrative costs associated with billing and other insurance-related activities (The Henry J Kaiser Family Foundation, 2009).

**Managed care.** In this climate of rising costs, state and federal government officials were looking for new ways to contain MH/SA healthcare related costs. During the late 1990’s, managed behavioral health care (MBHC) became a central institutional feature of Medicaid in the U.S. (Frank et al. 2003). MBHC differs from the more traditional, fee-for-service (indemnity) model of financing care by managing the integration of both the financing and delivery of MH/SA care separately from general medical services. States generally contracted directly with one vendor to manage these risks or allowed health plans to subcontract with a vendor of their choice. As a result of the inherent complexity in administering MH/SA benefits, MBHC was devised as a way to save money, while offering greater flexibility in the mix of available services and improving overall quality and access to care.

There is evidence that MBHC led to savings, mainly through the expansion and utilization of residential and day treatment programs as an alternative to inpatient care. “Studies of the implementation of MBHC arrangements in Colorado, Massachusetts, North Carolina, Tennessee, and Utah all show the ability of such programs to reduce Medicaid spending on MH/SA care” (Frank et al., 2003, p. 109). However, in many cases, reduced fees paid to
providers and reduced duration of outpatient treatment did little to advance the aim of improving access and quality of care.

Existing research reveals ample evidence of reduced funding, inaccessibility, and scarcity of mental health resources in relation to cost shifting (from state to federal funding through Medicaid) and MBHC. According to Geller and Biebel (2006):

In 2002, 29 states cut funding for mental health agencies or mental health services under Medicaid. Forty-nine states instituted cost control measures in 2002 including cutting provider payment rates, reducing benefits and services, instituting preferred medication lists, and reducing eligibility levels for Medicaid. In FY 2003, every state froze or reduced rates to Medicaid, 46 states employed prescription medication cost controls, 25 states restricted Medicaid eligibility, 18 states restricted or reduced Medicaid benefits, and 17 states imposed cost sharing measures for Medicaid recipients. (p. 279)

The unfortunate coincidence of both public (federal and state) and private (MBHC contracted third party payer) funding cuts coupled with ever increasing expansions to Medicaid eligibility, has left many mentally ill without adequate access to care. “States have been reducing spending on behavioral health and rates of private insurance coverage have been decreasing” (Voursney et al., 2012, p. 34). The National Alliance on Mental Illness (NAMI) reported that between 2009 and 2012 states cut approximately $1.6 billion in funding for mental health services (Ciha, 2013).

**Juvenile justice.** Over time, several factors such as: increased adjudication of youth, MBHC related barriers to care, mental health spending cuts, politically motivated cost-shifting, inpatient psychiatric bed reductions, and decreased availability of mental health resources all converged in such a way that the juvenile justice system began to compensate for the
inadequacies within the mental health system. In response to an upsurge in violent crime among adolescents in the 1980s, most states revised their laws in the 1990s to mandate harsher penalties for youth regardless of their criminal history or mental health status. Decreased discretion was given to police officers, probation officers, prosecutors, and judges with regard to arrest and penalty. Indirectly, this had the effect of further limiting the availability of public funds for community-based mental health resources by shifting them into the juvenile justice system.

In many communities, the juvenile justice system began to play a much larger role in detaining, treating, and mandating referral for youth in mental health crisis (Grisso, 2008). Youth were often limited in their options for treatment during incarceration. In comparison to more voluntary, community-based mental health settings, therapeutic bonds were more difficult to maintain within correctional facilities. According to Grisso (2008), “Considerable evidence indicates that rehabilitation methods in secure settings, such as behavior modification, effectively change behavior within the setting but do not retain their effect when youth return to the community” (p. 154). Unfortunately, criminalizing children and adolescents in need of mental health care may actually increase the likelihood that they will reoffend; thus decreasing the potential benefits of treatment resulting from adjudication (Grisso, 2008).

**Inpatient hospitalization.** Over time, MBHC has continued to gain momentum as the primary method for managing mental health benefits among most insurance plans. In particular, MBHC has impacted the utilization and function of inpatient pediatric psychiatric care. In its current form, hospitalization is often a short affair, focused mostly on stabilization of acute psychiatric symptoms, ensuring safety, group activity and interaction, medication management, and psychological testing. Due to time constraints, less emphasis is placed on time-intensive family therapy, individual therapy, or ongoing case management. Debate continues over the
appropriate length of stay, degree of restriction, and overall efficacy of child inpatient psychiatric hospitalization.

Research suggests that frequently admitted, behaviorally aggressive and defiant youth have consumed the largest amount of inpatient pediatric resources, while likely obtaining the least amount of benefit. These admissions have typically served as an expensive form of respite for older, behaviorally dysregulated youth, who are less likely to adapt any lasting change in behavior. There is statistical evidence within the literature that pediatric psychiatric hospitalization has done little to lower the risk of future crises and does not prevent future hospitalizations. Roughly 40% of all pediatric admissions result in readmission usually within the first year following discharge (Lapointe et al., 2010). Unfortunately, most inpatient hospital settings are ill-equipped to adequately treat oppositional defiant disorder, conduct disorder, or the often underlying parent – child conflict.

In line with MBHC cost saving measures, many behaviorally or emotionally deregulated youth have been shuffled between inpatient and outpatient levels of care. Schools, families, and outpatient resources have been ill-equipped to handle these youth within the community as acute symptoms remerge following hospital discharge. “Although a reduction in hospital stay length lowers the cost of inpatient services, it also contributes to more high-risk youth being discharged before adequate supports are in place” (Lapointe et al., 2010, p. 163). Ironically, the immediate cost savings garnered from expedited hospital discharges may have actually increased costs over time as youth were frequently readmitted to the hospital or were ultimately adjudicated.

_Lack of community-based pediatric resources._ While the total number of specialized, community-based, child and adolescent mental health resources have actually increased since deinstitutionalization, Medicaid expansion, and the nationwide trend toward MBHC, there is
ample evidence within the literature that youth in need of these services are still vastly underserved. “More vulnerable populations may not be well served by a behavioral managed care system, and the costs of serving the severely ill may discourage HMOs from providing high-quality mental health services at all” (Geller & Biebel, 2006, p. 280). In fact, many health plans (both privately and publicly funded) have provided little to no coverage for many intensive community-based services such as: crisis services, intensive in-home services, day treatment, substance abuse counseling, social and daily living skills training, case management, behavioral aid services, and various other long-term services (Geller & Biebel, 2006). In general, coverage and reimbursement for mental health patients and providers have declined or remained stagnant. Meanwhile, pharmaceutical and health insurance companies have enjoyed record breaking profits.

In a study focused on pediatrician perspectives on children’s access to mental health services, Pfefferle (2007) stated that “both the quantitative and qualitative data showed that pediatricians are concerned about access to mental health treatment for children” (p. 430). Pediatricians reported issues of affordability of care and availability of mental health providers, regardless of insurance type, but especially among children seeking access to resources with publicly funded insurance (Pfefferle, 2007). “Pediatricians overwhelmingly identified insurance issues as primary in accessing care for children with mental disorders” (Pfefferle, 2007, p. 428). These insurance issues were further described as: (a) managed care companies providing patients with limited or outdated lists of approved/in-network providers; (b) lengthy wait times for community-based services that often forced patients to either resolve symptoms within the family unit or rely more heavily on emergency psychiatric services; (c) limited benefits or reimbursement for treatment not otherwise imposed on physical healthcare services; and (d)
premature or inappropriate referral back to primary care for complex psychiatric medication management (Pfefferle, 2007).

Across the U.S. in both rural and urban locations, pediatric patients (and their families) struggle to find providers for therapy, medication management, psychological testing, support groups, chemical dependency treatment, residential treatment, day treatment, partial hospitalization, shelters for crisis-stabilization or runaway youth, and inpatient hospitalization. According to Geller and Biebel (2006):

The trend in the health insurance arena toward managed care may be problematic for children and adolescents with severe emotional and behavioral difficulties as managed care organizations often lack the specialized resources, e.g., day treatment and long-term services, required for high-need children and adolescents. (p. 280)

In general, there are shortages of all these services, but the actual degree of provider scarcity depends on a variety of factors such as: service type, geographic location, availability of public funding, etc. Even when pediatric providers are geographically available, wait times and cost barriers further limit access.

According to Grupp-phelan et al. (2007), “children with recognized mental health problems often have difficulty accessing mental health services due to inadequate numbers of providers, poor mental health service coverage, and inconvenient hours of service” (p. 56). The authors also attribute the nationwide increases in pediatric psychiatric ED visits to reduced availability of public mental health funding, shortages in child specialists, and a notable increase in pediatric mental disorders within primary care and educational settings (Grupp-phelan et al., 2007, p. 61).
Increased complexity in mental healthcare delivery. A system-wide lack of uniformity in policy, funding, and health plan administration has exacerbated the complexity of mental healthcare delivery within the U.S. Children and their families must rely on a patchwork of providers and payers with various forms of organizational structure (i.e. public, private, nonprofit, private nonprofit, etc.) that operate under inconsistent federal and state funding and regulation. For example, Medicaid is funded through state and federal matching funds, while actual plan administration and provider networks are often managed by privately owned health insurance corporations (i.e. Blue Cross Blue Shield, Medica, Preferred One, Health Partners, etc.). Even though Medicaid is mandated by federal law to cover the costs of most medically necessary services for children, it is still up to the states (in partnership with private insurance companies and contracted MBHC vendors) to actually define these services. Such inconsistency has led to confusion among providers as to which services are reimbursable and how to bill Medicaid (Geller & Biebel, 2006).

Over time, the expansion of Medicaid, and a nationwide trend toward MBHC has resulted in privatization of the management of publicly funded MH/SA resources. The role of government-based mental health agencies in altering provider networks, restructuring provider organizations, defining mental health programs for low income people, and maintaining Medicaid or public mental health information systems has become increasingly limited. According to Frank et al. (2003):

If the mental health care buying power and managerial responsibility are shifted to the state Medicaid program, the fit between program design and population treatment needs may be misaligned. This may be reflected in part by the vast variation in state-level
mental health care policies in Medicaid and the tenfold differential in psychiatric hospitalization rates across states. (p. 111)

Despite having specialized expertise related to MH/SA disorders, state agencies are now functioning more as contractors and regulators instead of directly funding and administering local services to meet the unique needs of their population.

Administrative costs associated with MBHC (and healthcare in general) also add to the complexity of healthcare delivery. According to the Institute of Medicine, the U.S. spends roughly $361 billion every year on health care administration, of which half of these costs are unnecessary (as cited Cutler & Basch, 2012). Examples of administrative costs are: (a) interacting with health plans regarding payment, formularies, authorization for treatment, and treatment plans (b) employment of staff to code, submit, and monitor the billing and reimbursement process, and (c) credentialing processes that establish contracts between providers and health plans (Cutler & Basch, 2012). Costs are compounded as providers struggle to accommodate the differing administrative rules and processes set forth by third party payers. Finally, wide variation in the process for determining the value of healthcare services and reimbursements among providers and payers has resulted in extremely inconsistent pricing.

**Lack of care coordination and continuity.** As we can see, various systemic factors have converged and compounded over time to increase the complexity of the healthcare system, while hindering care coordination among patients, providers, and third party payers. The prevailing climate of privatized, risk averse, managed care offers little incentive for providers to work together to improve patient outcomes and overall quality of care. Low reimbursement rates and relatively high administrative costs make it difficult for pediatricians and mental health clinicians to make available the time and resources necessary to adequately manage youth within the
community. This has been especially detrimental for pediatric MH/SA patients, who benefit most from evidenced-based, comprehensive, interdisciplinary models of care.

Politically motivated cost shifting has resulted in cuts to MH/SA spending, while vulnerable populations continue to be shuffled between core social institutions (i.e. juvenile justice, education, and healthcare systems, etc.). Inconsistent funding, regulation, and health plan administration has resulted in gaps in insurance coverage and decreased access to specialized MH/SA resources. Care has become increasingly compartmentalized based on specialty, restrictive provider networks, and limited health plan benefits. All too often referrals are difficult to obtain and vital information is not shared between pediatricians and clinicians.

A descriptive study conducted by Pfefferle (2007), surveyed and analyzed questionnaire responses from a nationwide sample of pediatricians in relation to mental health screening and care coordination. A majority of respondents reported that they disagreed or strongly disagreed that: (a) they had easy access to mental health referral or consultation (65%); (b) there were enough mental health clinicians near their practice (83%); or (c) mental health providers routinely communicated with them regarding referrals (70%) (Pfefferle, 2007). Private insurance panels were described as restricting children’s access to mental health services, while limiting opportunities for consistent communication between pediatricians and mental health specialists (Pfefferle, 2007). Additionally, pediatricians reported a lack of knowledge about community-based treatment options due to gaps in communication with the public sector agencies that coordinate mental health resources.

Healthcare Reform

Politics. There are many competing perspectives on the role of government in healthcare. The more liberal perspective argues that the public-private interplay underlying the current
system prioritizes profits before the overall health of the American people. They view mental healthcare as an integral and necessary entitlement because all people require healthcare at some point in their life. In their view, the current system discourages coordination among payers and providers, lacks administrative efficiency, and does not provide equal access to quality care. This perspective is more apt to rely on government regulation to create nationwide equal access to quality care regardless of employment, socioeconomic status, or place of residence.

Conversely, the more conservative perspective seeks to capitalize on the inherent benefits of the free market, where the consumer has greater freedom of choice and quality care is preserved though healthy competition and innovation. The question remains whether the costs associated with systemic segmentation and inconsistency outweigh the benefits associated with a market-based system that encourages competitive innovation. Historically, conservatives have been less likely to support any policy reforms related to mental healthcare. However, over the years, there have been many legislative attempts at reforming healthcare in the U.S. The following is a brief recap to highlight some notable legislation that has (either directly or indirectly) impacted the ongoing issues of inadequate/inaccessible pediatric psychiatric resources and increased psychiatric-related utilization of the ED.

**Policy.** While many attempts at comprehensive reform have failed over the years, a few key pieces of legislation have passed into law to address specific aspects of healthcare. As referenced earlier, the passage of the Social Security Act (1935) and Social Security Amendments Bill (1935) have hugely impacted how healthcare benefits are funded and delivered to the elderly, disabled, severely disordered, unemployed, and impoverished. Some of the most impactful programs created under these laws are the Federal Old-Age, Survivors, and Disability Insurance (OASDI), TANF, Medicare, Medicaid, CHIP, and SSI. Also of note, the Community
Mental Health Centers Act of 1963 (CMHA) provided states with federally funded grants that encouraged the creation of less restrictive, community-based alternatives to institutionalized mental health care. The CMHA explicitly stipulated that emergency psychiatric treatment was included as an essential service within these organizations (Klein, 2010).

Several other key reforms were also accomplished through the passage of The Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments: (1) the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), (2) the Health Insurance Portability and Accountability act of 1996 (HIPPA), (3) The Mental Health Parity Act of 1996 (MHPA), (4) the Newborns’ and Mothers’ Health Protection Act of 1996, and (5) the Women’s Health and Cancer Rights Act of 1998. Among other things, ERISA set minimum operational and appeals processing standards for employer self-funded health plans that fully assumed the risks associated with financing and directly paying for employee healthcare costs. COBRA gave many employees the ability to maintain health coverage for a limited period of time after leaving employment. HIPPA outlined several important provisions such as: (a) standards for protecting the privacy, confidentiality, and security of protected health information, (b) access to group health insurance coverage for workers and their families regardless of previous health status or knowledge of genetic disease, and (c) opportunity for employees to join other group plans or purchase individual insurance after losing their existing coverage.

The other aforementioned amendments to ERISA (listed above as 3, 4, and 5) further regulated private insurance products by requiring more robust coverage for specific conditions. These amendments outlined minimum benefit standards that: (3) provided coverage for at least a forty-eight hour hospital stay following childbirth, (4) required that annual and lifetime dollar limits on coverage for mental illness be the same as the limits associated with medical or surgical
benefits, and (5) ensured coverage for certain post-mastectomy complications and reconstructive surgery. In addition to the MHPA, the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed in 2008 to supplement the initial legislation and enact stronger protections.

In large part, the MHPA and MHPAE did not reach their intended aims since many insurance providers bypassed protections by imposing coverage capitations for inpatient care and limits on outpatient visits. Fortunately, the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA) legislated new provisions, where “insurers are required to charge similar deductibles and copayments for mental health treatment, refrain from applying more stringent preauthorization rules, and stop limiting the number of provider visits or hospital days” (Walker, 2014, p. 3). It is unclear exactly how much of an impact parity will have on the availability and accessibility of mental health resources in the future.

**Patient Protection and Affordable Care Act.** As of March of 2010, incremental implementation of comprehensive healthcare reform has begun, adding to the complexity already inherent in this system. The Patient Protection and Affordable Care Act (PPACA) in concert with the Health Care and Education Reconciliation Act has marked major shifts in healthcare policy. The implications of this legislation are numerous and broad, so I will focus my synopsis on the provisions that are of clear importance to the topic at hand. Overall, the PPACA seeks to achieve sustainable savings over time through patient-centered, quality-focused, outcomes-based measures that move away from episodic care and closer to coordinated care management (Panning, 2014).

The following are key aspects of the PPACA. Medicaid was expanded to 138% of the federal poverty level, making publicly subsidized insurance more widely available to many who
previously did not qualify based on income or other factors. Starting in 2014, all U.S citizens and legal residents are required to obtain qualifying health insurance, get an exemption, or pay a monetary penalty. Coverage can be purchased through state, federally, or jointly operated online Insurance Exchanges for those people that are not already covered through qualifying, privately held, or employer-based coverage. These exchanges provide a marketplace where private insurance companies can compete and offer comparable plans to individuals and small business that meet the coverage standards set forth by the PPACA. Expanding the common risk pool to include a larger proportion of younger, lower risk, previously uninsured individuals also serves to offset the heavy costs associated with less healthy or aging populations.

In addition to mandating coverage, the PPACA sets a minimum standard for essential coverage that encourages preventative, as opposed to reactive or volume based care models. For example, coverage cannot be denied and must be renewable regardless of health status, pre-existing condition, or gender. Insurers must provide coverage to dependents until they reach the age of 26 (Panning, 2014). Additionally, insurers must provide coverage for at least ten preventative essential benefits without placing dollar limits on their use. Minimum standards include coverage for at least 60% of out-of-pocket costs on required services, while employer-based plans must cover at least 60% of total allowed costs after deductibles, copays, and coinsurance. Limits are placed on the amount someone can be charged based on their age, tobacco use, family size, and geography (Panning, 2014). Finally, insurance companies must provide rebates to consumers if they spend less than 80-85% of premiums on care or efforts to improve care quality.

Prevention, wellness, and quality provisions are evident throughout the PPACA. For example, co-payments for many preventative care services are eliminated and incentives are
offered for the completion of behavior modification programs for Medicare and Medicaid eligible individuals. Additionally, personalized prevention planning and yearly comprehensive risk assessments are authorized under Medicare (Panning, 2014). Employers are offered grants to establish wellness programs and are permitted to offer premium discounts to employees based on participation. A federal council will be created to coordinate prevention and public health wellness activities (Panning, 2014). Finally, the newly created Patient-centered Outcomes Research Institute (PCORI) encourages continued quality care improvement through, “comparative effectiveness research [that] is designed to inform health care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options” (Panning, 2014, p 110).

The PPACA extends the life of the Medicare trust fund until 2029 and contains many provisions aimed at long-term Medicare reform and cost containment. This includes a major emphasis on the reduction and prevention of fraud and waste. Cost sharing and containment reforms include: reduced subsidies for Medicare Part D premiums for individuals with an annual income over $85,000; limitations on the amount of revenue that Medicare Advantage Plans can keep as profits; and reduced annual market-basket adjustments that effectively lower reimbursement rates for many Medicare providers and services (Panning, 2014). It seeks to reduce unnecessary hospital readmissions through improved care coordination among providers and closes the Medicare Part D prescription coverage gap over time. Finally, the PPACA also establishes several new entities such as: (1) an Independent Payment advisory Board to reduce the annual growth in Medicare spending, (2) Accountable Care Organizations (ACO) that continually encourage equitable cost sharing, and (3) a Center for Medicare and Medicaid
Services (CMS) Innovation Center that develops improvements in payment structures and methodologies (Panning, 2014).

In addition to expanding Medicaid to cover more Americans, the PPACA encourages improved primary care management and coordination. It contains provisions to improve reimbursement for primary care services and improves coordination of care for dually eligible Medicare and Medicaid recipients (Panning, 2014). Individuals diagnosed with (or at risk for) an eligible combination of chronic medical and/or severe mental health conditions will be given the option to utilize a medical home model of care. This is a comprehensive, patient-centered, interdisciplinary approach to primary care, aimed at improving care accessibility and collaboration among patients and providers. Care quality is improved through: Health IT innovations that increase communication and decrease wait times; increased patient participation in healthcare decision making; and coordinated primary care that addresses the needs of the individual as a whole.

Other notable PPACA provisions include: improvements to the training and development of the healthcare workforce, tort reform, and the development of new payment structures. Healthcare workforce improvements include targeted scholarships, loans, workforce training programs, and Graduate Medical Education positions that redistribute resources to underserved populations, encourage upward career mobility within nursing, enhance workforce diversity, and develop team-based models of primary care. Additionally, grants will be available to states that choose to test new and innovative strategies that accomplish tort reform effectively. Finally, innovative bundled payment structures and value-based purchasing programs will be developed and/or piloted to encourage care coordination, cost containment, outcomes measurement, and quality improvement in healthcare delivery.
The PPACA builds upon the original policies underlying Medicaid and Medicare that emphasize least restrictive or community-based care. It provides grant money for the creation of community-based collaborative care networks, increases funding for community-based healthcare centers, and strengthens emergency department and trauma care capacity. It provides coverage for new home and community-based care options for Medicaid eligible individuals, as well as community-based attendant services for disabled individuals requiring an institutional level of care (Panning, 2014). In addition to developing programs that further incentivize non-institutional care, it requires standardized reporting for all skilled nursing facilities and creates an optional, national insurance program for assisted living (Panning, 2014). The absence of more restrictive levels of care (i.e. inpatient psychiatric care) coupled with increasing emphasis on non-institutional care, may place continued stress on other core social institutions. Only time will tell whether these, or other PPACA reforms, will adequately provide for the mental health needs of the most vulnerable mentally ill populations within the community.

The consequences resulting from this reform remain highly politicized and hotly contested among leading political parties. Some view it as a good balance between government regulation and free market principles. Some think reform should have gone further by creating universal coverage, where private enterprise would be further limited or totally removed from healthcare. Others believe the PPACA, in its current state, is already a costly government takeover of healthcare. Finally, there are those who advocate for a voucher system, where the existing role of government in healthcare is either scaled back or removed completely. Given the highly contentious debate over healthcare reform, it is entirely possible that major modifications to PPACA could occur in the near future.
Costs to Society

Cost benefit analysis. As a nation, we have shifted from one extreme to the other in our efforts to care for the mentally ill among us; from primarily state-funded, long-term, restrictive, one-size-fits-all hospitalization; to deinstitutionalization, Medicaid, managed care, widespread healthcare privatization, community-based resources, and integrated service delivery. “Public sector beds have declined in response to deinstitutionalization, privatization and a value system that community-based care and treatment is better than institution-based care and treatment, even when neither is adequately defined” (Geller & Biebel, 2006, p. 284). Reliance on less restrictive and more integrated treatment settings is evident within policy and judicial findings as well (Geller & Biebel, 2006).

Before examining the societal costs of inadequate pediatric mental health care, it is important to note that, compared to the situation prior to deinstitutionalization, there is little doubt within the existing research that Medicaid has resulted in net improvements to overall mental health care quality and accessibility within the community. Research supports an association between Medicaid and a general increase in mental health resource use from 1970 to 2000 (Frank, Howard, & Goldman, 2003). Major advances in the treatment and diagnosis of MH/SA disorders have occurred since the inception and expansion of Medicaid. In terms of resource expansion since the 1960’s, the areas of highest growth are private and general psychiatric inpatients, outpatient mental health clinics (free-standing and community-based), partial hospitalization programs, and prescription drug use (Frank et al., 2003). Those who have access to private insurance or qualify for publicly-funded healthcare are now more likely to be able to choose from a broad continuum of more specialized, community-based, MH/SA treatment options, which simply did not exist prior to deinstitutionalization.
Nearly half a century has passed since the inception of Medicaid, yet we are far from fully realizing the laudable aims that underlie LRA policy; especially as it relates to the uninsured and the pediatric mental health population. According to Geller and Biebel (2006):

There is sufficient evidence at this time that the dismantling of state-run, long-term psychiatric beds for children and adolescents increases the criminalization of youth, exacerbates the morbidity of services and emotional disorders, and contributes to higher mortality through suicide, drug overdoses, and “kids just doing really crazy things. (p. 286)

Despite reports of limited success among widely implemented admission diversion programs, community-based crisis services, and prescreening practices, a majority of states still maintain publicly funded inpatient psychiatric facilities. At present, many report overcrowding, as well as long waiting lists for admission. Within private and general hospitals, rates of inpatient psychiatric admission often outpace their total bed capacity, leading to shorter lengths of stay compared to state run facilities (Geller & Biebel, 2006, p. 253).

As publicly owned and operated resources have been defunded, the private sector has also been less available to meet the mental health needs of the population. “While overall healthcare spending increased by 15.7% between 1992 and 1999, mental health and substance abuse spending decreased by 17.4%. Behavioral healthcare spending went from 7.2% of total private health insurance spending to 5.1% over this same time period” (Geller & Biebel, 2006, p. 254). Over time, reimbursement rates for mental health services have remained stagnant or fallen to the extent that they often do not cover the total costs of care or treatment. Meanwhile, costs associated with mental health care have risen, “due to workforce shortages, skyrocketing
professional liability insurance, escalating pharmaceutical costs and progressively increasing regulatory requirements” (Geller & Biebel, 2006, p. 254).

Prior to the passage of the PPACA, many low income people who did not qualify for Medicaid, or other government assistance, had inadequate access to affordable care. Even with expanded access to MH/SA benefits through Medicaid, these vulnerable populations still struggle to gain access to these resources. In summary, the following factors are primarily responsible for the current scarcity of pediatric mental health resources and the related problem of inappropriate utilization of the ED: past and present healthcare reform (or lack thereof); deinstitutionalization coupled with inadequate or insufficient community supports; rising healthcare costs; politically motivated cost shifting (aimed at capitalizing on federally-matched Medicaid funds); tort law and regulatory inconsistencies between states; and widespread privatization in the allocation and administration of MH/SA resources through MBHC. In particular, youth and other vulnerable populations are not be receiving adequate access to MH/SA resources as a result of MBHC practices.

Prioritizing mental healthcare. Caring for the mentally ill is a complex and costly endeavor. Gradual reforms to policy and law increasingly reflect that, as a society, we find value in providing quality, efficient, and effective mental health care that respects the dignity of the individual. However, an enduring and pervasive lack of available public and private funding continues to call into question the true order of our social priorities. The business of financing social services is not particularly profitable within the system of capitalism, yet we still find room in our public coffers to more adequately fund education, prisons, and defense. To date we have mostly seen reactive, politically shrewd funding decisions, and business practices that have shifted around the responsibility for mental health care amongst the families, employers, schools,
religious institutions, legal systems, child welfare services, crisis/homeless shelters, healthcare providers, long-term care facilities, and various other social service providers that comprise our core social institutions. This shifting of responsibility typically results in temporary solutions that ultimately reinforce larger systemic problems within the healthcare system.

Savings garnered from limiting MH/SA resources translates into more spending on inappropriate utilization of services and nonemergent referrals to the ED. Unfortunately, many families wait until problems turn into crises before seeking help; thus, over-utilizing the ED for services that could more appropriately be managed on an outpatient basis through primary medical and mental health care. Mental health related referrals to the ED come from a wide range of sources such as: self-referral, the education system, outpatient mental health agencies, primary care clinics, group homes, nursing homes, crisis line agencies, and the judicial system. ED utilization patterns among these referral sources illustrate the state of interdependency that exists between systems of care.

As a society we are moving closer to a collective understanding that healthcare is not an expendable commodity that can easily be lived without. All children and adolescents, regardless of their demographics or socioeconomic status, need access to healthcare to be well. Mental health is an integral and essential element of healthcare, just as the mind cannot be separated from the body. Providing youth with mental health care how, when, and where they need it, increases the likelihood they will lead healthier, happier, and more productive lives.

Various sources within the literature emphasize that individuals and society collectively suffer profound and lasting consequences from neglecting to properly treat pediatric mental health concerns. “Emotional and behavioral problems in children and adolescents that go undetected and untreated can lead to negative outcomes including school failure, family
disruption, unplanned pregnancies, out-of-home placements, poor employment opportunities, incarceration, and poverty in adulthood” (Geller & Biebel, 2006, p. 252). Undertreated youth are placed at higher risk for social isolation, increased severity of psychopathology (in both late adolescence and adulthood), economic costs throughout life, and even suicide in some cases (Pailler & Feiln, 2009; Fein et al., 2012). “When children’s mental health services are unavailable, unaffordable, or inappropriate, many young people end up caught in the child protection or, juvenile justice systems” (Lapointe et al., 2010, p. 169). By neglecting the young and ill among us, we ultimately pay a larger price through decreased productivity, increased poverty, lower graduation rates, higher rates of incarceration, and increased strain on the social safety net.

Examining Question Three

Emerging Frameworks and Models of Integrated Care

Now that we have reviewed the individual characteristics and systemic factors most related to the availability of pediatric mental health resources and ED utilization, it is time to outline a path forward in line with existing healthcare reform. Truly viable and sustainable solutions to the problem of inappropriate ED utilization will not be realized unless there are significant increases in funding for, access to, and efficacy of community-based, pediatric mental health resources. The literature revealed several emerging frameworks and models for delivering integrated medical and mental health care within the community such as: Systems of care (SOC or “wraparound” services), Comprehensive Community Mental Health Services (CMHI), Family support programs, Diversion Programs, Patient Centered Medical Homes (PCMH), Community Health Centers (CHC), and School-Based Health Centers (SBHC). A full description of each of
these care delivery models is beyond the scope of this paper, therefore I will provide a brief
description of each, while highlighting points of intersection and potential benefits.

**SOCs, CMHIs, family support programs, and diversion programs.** SOCs serve as a
guiding framework for systemic change that has evolved over the course of two decades. SOCs
can vary widely in how they are structured and what wraparound services are provided
depending on the unique needs of each community. Originally, SOCs were mostly aimed at
providing coordinated, individualized, community-based mental health care for youth with
severe emotional disturbances across major service sectors (i.e. mental health, primary care,
juvenile justice, and child welfare) (Kilmer & Cook, 2012). According to Stroul, Blau, and
Freidman (2010) SOCs are now more inclusively defined as:

> A spectrum of effective, community-based services and supports for children and youth
> with or at risk for mental health or other challenges and their families, that is organized
> into a coordinated network, builds meaningful partnerships with families and youth, and
> addresses their cultural and linguistic needs, in order to help them to function better at
> home, in school, in the community, and throughout life. (p. 6)

Wraparound services actuate the guiding values and principles of the SOC into practice through
appropriate, individualized, evidence-informed, community-based supports (Stroul et al., 2010).
The SOC framework and wraparound practices have been broadly implemented within nearly all
50 states and blend well with other efforts promoting medical and behavioral health integration
and colocation within the community (Kilmer & Cook, 2012).

Under the larger umbrella of SOC, is a widely implemented Community Mental Health
Services for Children and Their Families Program (CMHI), which primarily serves youth from
birth to age 22 that have a Serious Emotional Disturbance (SED). According to Miech et al. (2008)

CMHI has five primary goals: (a) expand community capacity to serve children and adolescents with serious emotional disturbance; (b) provide a broad array of effective services, treatments, and supports; (c) create a case management team with an individualized service plan for each child; (d) deliver culturally and linguistically competent services for racial and ethnic populations represented in the communities; and (e) promote full participation of families and youth in service planning and development of local services. (p. 255)

Like other SOC approaches, CMHI seeks to provide coordinated, individualized, culturally sensitive, family-oriented, least restrictive, community-based supports and services across multiple agencies (Miech et al., 2008).

A variety of community-based, family support programs have also emerged nationwide working to assist, advise, and advocate for children and families engaged in mental health care. According to Kilmer and Cook (2012),

Family support programs, designed to increase family strengths, stability, and well-being, have used diverse means to accomplish these goals, including parent education, social and emotional support, counseling or referral to services and case management, other support services (e.g., transportation, respite, play groups), health care for parents and children, center-based early childhood education, leadership/advocacy training, and adult basic education and/or job skills (p. 582).

Typically, these are grass-roots funded, family-driven, para-professionally guided groups that build on families’ strengths, provide additional natural supports, enable informed decision
making in mental health care, and assist in setting goals, designing, implementing, and evaluating programs within SOCs.

Diversion programs have also emerged nationwide as a way to reduce high rates of juvenile of incarceration. “Substantial evidence suggests that systemic, well-functioning diversion programs have reduced the census of juvenile pretrial detention centers in many communities, often by half” (Grisso, 2008, p. 156). Following arrest and arrival at pre-trial detention, many youth charged for minor offenses are screened for mental health issues and diverted accordingly to various systems of care (e.g. home, shelter, foster care, community-based mental health center, etc.). Screening and referral methods have evolved to incorporate evidence-based practices. Unfortunately, communities vary widely in their availability of mental health crisis resources, systems of care collaborations, diversion programs, and police training for psychiatric-related juvenile encounters.

**Outcomes and evidence-based care.** In addition to all of the evidence I outlined earlier that points to the inaccessibility and scarcity of pediatric mental health resources, there is also growing concern within the literature regarding the effectiveness of existing community-based mental health resources. “Data from several studies utilizing different methods and sampling from a variety of community-based service systems reinforce serious concerns about the ineffectiveness of usual mental health care for children” (Garland et al., 2013, p. 7). The built-in structural adaptability and multi-service complexity of the SOC framework has made implementation, research, and comparative evaluation especially challenging. According to Kilmer and Cook, (2010), “the extant literature includes notable gaps regarding the ‘active’ components of SOCs, strategies for attending to families’ larger contexts, and the qualities, characteristics, and practices that are necessary and sufficient to support positive child and
family outcomes” (p. 584). Additional barriers to conducting mental health outcomes research include, “ideological and methodological challenges, limited research funding for practice-based research, and minimal representation of research conducted in routine care practice settings in high impact mental health journals” (Garland et al., 2013, p. 9). What is most troubling is that there simply is not enough convincing empirical evidence that supports the overall clinical efficacy of existing child and adolescent community-based mental health care (Garland et al., 2013).

Given the emphasis on outcomes measurement within the PPACA, ongoing state and federal budgetary challenges, and the major gaps in SOC-related outcomes and effectiveness research, legislators have insufficient data to use as justification for continued allocation of limited resources toward many SOC initiatives. Successful implementation and evaluation of SOCs is costly and requires multiple levels of change that alter: (1) state and federal policies, funding mechanisms, and workforce training, (2) local and organizational infrastructure development, management of resources, and system evaluation, and (3) wraparound service delivery and outcomes measurement on a provider-patient level (Stroul et al., 2010). “Outcome accountability is needed as it can contribute to program planning at the aggregate level and can improve clinical decision-making at the individual provider-patient level” (Garland et al, 2012, p. 15). An important balance must be struck where there is enough standardization within SOCs to allow for multilevel comparative research without compromising the overall structural flexibility that enables SOCs to meet the unique needs of each community.

Increased measurement of outcomes and utilization of evidence-based-practice (EBP) within community-based pediatric mental health is essential for maintaining and improving treatment efficacy. Additionally, research by Garland et al. (2012), suggests that, “children who
received more intensive treatment techniques consistent with EBP attended more sessions” (p. 12). There is potential for a pattern of positive feedback loops to emerge where: improved treatment leads to improved outcomes; improved outcomes leads to improved funding; improved funding results in expanded access to mental health resources; expanded access results in more preventative care, more appropriate utilization of the ED, and less reliance on costly and restrictive inpatient psychiatric care.

Unfortunately, there are very few incentives for providers to implement EBPs, assess therapeutic progress over time, or measure outcomes on the practice level (Garland et al, 2012). In particular, manualized EBPs are often costly, time consuming, and clinically resource intensive since they require additional supervision, training, and measurement of outcomes (Voursney et al., 2012). Typically, care is provided on a fee-for-service basis and mental health service reimbursement rates are low to being with; thus it make little fiscal sense for providers to use EBPs when they generate the same amount of revenue as any other service and they may contain components that are not billable through many health insurance plans. New and sustainable payment models, as opposed to temporary grant-funded incentives, will likely be necessary before widespread adoption of EBP occurs within community-based mental health care.

**PCMHs, CHCs, and SBHCs.** Following the passage of the PPACA new models of integrated care delivery have emerged such as: patient-centered medical homes (PCMHs), accountable care organizations (ACOs), and primary care and behavioral health integration. According to Korda and Eldridge (2012), “these models rely on interdisciplinary provider teams to coordinate patient care; health information and other technologies to assure, monitor, and assess quality; and payment and financial incentives such as bundling, pay-for-performance, and
gainsharing to encourage value-based health care” (p. 227). These, among many other provisions within PPACA provisions, could trigger the broad changes necessary to address barriers in mental health resource access, as well as redefine the appropriate role and function of the ED. If people are given access to quality, preventative care how, when, and where they need it, then they will be less likely to rely on more reactive or emergent means of care.

Leaders within healthcare, government, and the insurance industry have embraced the PCMH model as a blueprint for enhancing population health management and containing costs within primary care. Passage of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) within the American Recovery and Reinvestment Act (ARRA) in 2009, has created powerful financial incentives for eligible physicians to fulfill Meaningful Use standards by implementing electronic medical records (EHRs). In line with these health information technology (HIT) initiatives, the National Committee for Quality Assurance (NCQA) has outlined the following PCMH standards: (1) enhance access and continuity through team-based care, increased information sharing, and after-hours communication; (2) manage population health through data collection and analysis; (3) utilize evidence-based care guidelines; (4) Support self-care management by providing patients with information tools and community resources; (5) Coordinate and follow up on referrals, tests, and transitions of care; (6) Continuously improve quality by measuring performance, outcomes, and patient feedback (Capko, 2014). In addition, for eligible and participating providers, the government-sanctioned Physician Quality Reporting System (PQRS) links new financial incentives with quality measures aimed at prevention, management, and monitoring of chronic diseases (Capko, 2014).

The question remains as to whether widespread adoption of the PCMH model, NCQA standards, PQRS reporting, and HITECH initiatives will enhance pediatricians’ ability to manage
mental health concerns within primarily care. Preliminary findings in a systemic review conducted by Jackson et al. (2013) suggest that “the PCMH holds promise for improving the experiences of patients and staff and potentially for improving care processes, but current evidence is insufficient to determine effects on clinical and most economic outcomes” (p 169).

In theory, PCMH practices emphasize the patient-clinician alliance and seek to structure care around the unique needs of the patient; however, wide variation exists in how these goals are being accomplished and how payment is being structured (i.e. fee-for-service, enhanced fee-for-service, per-member per-month, capitation, or hybrid) (Jackson et al., 2013).

It is important to note that participation in PCMH model is voluntary for patients and providers, which may have an effect on the speed of implementation and rate of adoption. Additionally, the vast majority of mental health providers are not eligible to benefit directly from the payment incentives underlying adoption of the PCMH model. Unless the payment system is restructured to encourage increased interdisciplinary integration, co-location, and collaboration with community-based, mental health providers, barriers related to resource scarcity will likely persist. Some argue that significant improvements in care quality and cost containment will remain unattainable until traditional, fee-for-service payment structures/incentives are replaced by population health-driven, global payment models (Landon, 2014).

**Integrated colocation.** There is ample evidence within the literature supporting the benefits of increased collaboration between primary care and mental health providers, especially when services are co-located within primary care settings. It is becoming increasingly clear that this model of care improves clinical outcomes, cost effectiveness, and satisfaction for both the client and provider (Airken & Curtis, 2004). It increases opportunities for consultation among providers, while ensuring mental health issues are promptly identified, addressed, and followed
According to Airken and Curtis (2004), “evidence suggests that clients prefer to receive mental health counseling within their primary care setting, report less stigma about receiving mental health services, and feel reassured knowing that their PCP is involved in treatment” (p. 323). Co-location provides a unique opportunity for clinicians to simultaneously and holistically address their patient’s physical and mental health issues, as well as the link between the two.

In response to care inadequacies, school-based health centers (SBHCs) and telehealth school-based health centers (tSBHCs) have emerged in over 2,000 schools nationwide, providing increased access among underserved youth to a wide range of healthcare services (e.g. preventative assessment, treatment of acute and chronic illness, laboratory testing, mental health screening, treatment and referral, etc.) (North et al., 2014). SBHCs provide a more natural and convenient setting for students and educators. Teachers interact with students on a daily basis, thus they are well suited to identify abnormal behavior and make appropriate referrals. Students are able to maintain a greater sense of privacy at SBHCs, since medical and mental health referrals are often indistinguishable within this integrated setting. Convenient access to care minimizes transportation-related disruptions in daily activity for both students and parents, which allows for effective follow-up and case management over time.

Not surprisingly, many youth seem to prefer SBHCs over other community health centers (North, McElligot, Douglas, & Martin, 2014). According to North et al. (2014):

SBHCs have been shown to provide the same quality of adolescent preventative health care as traditional primary care sites, and improvements in health outcomes include: improved access to preventative health care and decreased emergency department use, improved student utilization of mental health services, improved academic outcomes for
high-risk adolescents, and decreased likelihood of dropping out of high school in both the general population and expectant young mothers. (p. e34)

SBHCs increase opportunities to holistically address the biological, behavioral, and social determinants of health through collaborative communication between students, educators, providers, specialists, and parents (Clayton, Chin, Blackburn, & Echeverria, 2010).

Despite the positives associated with establishing SBHCs, several barriers continue to stand in the way of their growth and expansion. Tight budgetary constraints make the task of securing grants or regular sources of funding increasingly difficult within many school districts. The need for a large school population to help an SBHC approach financial viability excludes children in rural communities who are more likely to attend a school with fewer than 500 students, be poor, and have difficulty accessing health care. (North et al., 2014, p. e34)

Additionally, it is not uncommon for SBHCs to be overwhelmed by large caseloads and high demand for mental health resources within underserved communities (Weist, Goldstein, Morris and Bryant, 2003). It is imperative that SBHC staff maintain close and collaborative relationships with primary care providers in the community; otherwise, they run the risk of undermining the underlying goals of the PCMH model.

Community Health Centers (CHCs) function nationwide as a primary healthcare safety net for many underserved populations characterized by have high poverty rates, high infant mortality rates, and low physician-population ratios (Leininger & Meurer, 2011). These are federally funded, non-profit organizations that serve a higher proportion of low-income, minority, and non-English speaking individuals regardless of their insurance status. CHCs aim to deliver a variety of integrated and interdisciplinary support services tailored to meet the
unique needs of the community. These include, but are not limited to: translation, transportation, behavioral health, dental care, case management, health and nutrition education, and home-based visits. According to Leininger and Meurer (2011), “A review of the evidence on the health impact of CHCs finds that they are appreciably reducing racial/ethnic disparities in access to care and are improving a variety of health outcomes for many at-risk populations” (p. 165). CHCs have served as an outstanding example of the patient-centered medical home model (PCMH), which is now an integral component of nationwide trends in healthcare reform.

**Recommendations for the ED**

Now that I have highlighted some innovative ways to make the best use of community based mental health resources, I will turn my attention to improving the ED. As previously stated, noncompliance with aftercare recommendations following ED psychiatric evaluation has been an ongoing problem. As a result, one study by Simakhodskaya et al. (2009) described an innovative method for achieving wraparound follow-up services through the creation of a Comprehensive Emergency Psychiatric Emergency Program (CPEP), which integrated their psychiatric emergency service (PES) with an extended observation unit (EOU), mobile crisis unit (MCU), interim crisis clinic (ICC), and crisis residence. It had a team-based, interdisciplinary approach with a variety of staff ranging from psychiatrists, psychologists, social workers, substance abuse counselors, and nurses. “Essential elements of successful application of this model include providing an immediate appointment, having close follow up, and ensuring a collaborative and interdisciplinary approach that addresses the biopsychosocial needs of patients” (p. 60).

Following evaluation, the patient could be referred for a brief stay in the EOU to undergo short-term interventions such as: supportive psychotherapy, motivational interviewing,
psychoeducation, family meetings, or psychopharmacology. Alternatively, the patient could be sent to the ICC for next-day or rapid outpatient appointment scheduling for outpatient therapy, medication evaluation, medical workup, cognitive screening, or additional long-term community-based mental health resources. Patients could also be directly referred to the crisis residence within the community.

At every step patients were given the guidance they needed to navigate the intricacies of the mental health system, while receiving care at the most appropriate level. The MCU worked collaboratively with the ICC in the community by: checking in on patients who no-showed for appointments, transporting patients to the ICC for appointments when necessary, or making direct and timely referrals to the ICC for outpatient appointments. Hours of operation varied among components. The PES, EOU and ICC components had separate physical spaces that were reachable within walking distance and staff maintained care continuity through dual roles and/or cross-component consultation. Patients could easily be referred back to the PES if necessary following decompensation.

Clearly, it is not realistic to expect that all EDs can implement such innovative and comprehensive solutions. Small hospitals, hospitals without mental health or inpatient psychiatric services, and rural hospitals must utilize more cost effective methods for improving psychiatric care in the ED. Innovations in health information technology have become increasingly useful in overcoming barriers to: identification of undetected mental health symptoms, mental health resource access, and quality psychiatric evaluation within the ED environment.

One study, by Fein et al. (2012) utilized a self-administered, computerized screening tool to identify youth with unmet mental health needs presenting with nonpsychiatric symptoms to an
urban, tertiary care, pediatric ED. The Behavioral Health Screen for Emergency Departments (BHS-ED) “identifies and assesses adolescents for depression, suicidal ideation, posttraumatic stress, substance use, and exposure to violence” (Fein et al., 2012, p, 1112). Items within the BHS-ED went through extensive review by experts and are based off of a combination of well-established sources such as the: Youth Risk Behavior Survey, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and Beck Depression Inventory – Fast Screen (BDI-FS). Initial findings within the research suggest that among adolescents between the ages of 14 – 18, the BHS-ED has led to relatively small, but significant increases in the identification of previously undetected psychiatric problems (Fein et al., 2012).

In particular, this tool could be useful within EDs, where more comprehensive methods of mental health symptom identification or pediatric psychiatric evaluation are simply not financially feasible. Earlier identification of mental health symptoms could enable more timely specialized clinical evaluation and referral for treatment. Additionally, relatively easy integration of the BHS-ED into existing workflow processes through automated administration, scoring, and interpretation could save on limited clinical resources (i.e. assessment time, effort, and costs).

Potential shortcomings of BHS-ED adoption include: (a) resistance to screening among youth and parents due to cultural concerns or mental illness-related social stigma; (b) liability concerns among ED medical providers, where increased identification of previously undetected mental health symptoms are not followed-up with quality mental health evaluation, treatment, or referral; and (c) absence of reimbursement for psychiatric screening. Computerized mental health screening tools may hold potential as effective preventative measures, but underlying barriers must also be addressed if broader adoption is to occur.
Telehealth is also emerging as an innovative and cost-effective method for providing more specialized psychiatric evaluation, treatment, and referral within the ED. According to Yellowlees et al. (2008), “Telepsychiatry has been successfully used to treat mental health patients with limited care access in non-urgent situations for many years, and in recent years there have been reports of its application in psychiatric emergencies.” Through the use of secure, videoconferencing technology clinicians can remotely evaluate patients; effectively increasing rural access to vital care and reducing costs associated with long-distance travel and unnecessary inpatient psychiatric hospitalization. This technology has the potential to improve treatment outcomes by (a) enabling timely, specialized psychiatric assessment, (b) advancing coordination of care with the patient’s providers in the community, and (c) connecting patients to the most appropriate level of care.

There are clinical, technical, and environment barriers that stand in the way of quality, ethical application of telehealth technology. To ensure patient privacy, telehealth sessions must occur in a private, well-lit area and all electronic communication must be encrypted to ensure HIPPA compliance. Clinicians must have access to high bandwidth data connections and high-definition video/audio equipment that can establish a quality connection capable of capturing most of the nuances present in face-to-face communication. Technical difficulties during assessment could be a potential liability, especially when assessing patients with suicidal or homicidal thoughts. The cost of videoconferencing hardware, software, infrastructure, and technical support can be cost prohibitive, especially in cases where third party payers do not provide reimbursement for telehealth services. Finally, the full potential of specialized telehealth psychiatric evaluation may not be realized in settings where there is no mechanism for quality referral to community-based resources following assessment or discharge.
Conclusion

In the wake of recent changes in U.S. healthcare policy, service delivery, and reimbursement, the role of the ED remains vital along the spectrum of available emergent pediatric mental health care. Ideally, the ED will play a smaller role in pediatric psychiatric care as access to health insurance coverage increases, parity laws are enforced, and youth receive more preventative, comprehensive, and integrated primary care. To some degree, there will always be a need for 24/7 access to emergency pediatric psychiatric care and inpatient psychiatric admission for youth in crisis. In concert with existing crisis services and various systems of care, the ED has the potential to treat the biopsychosocial needs of the individual through evidence-based interventions, competent assessment, referral to the most appropriate level of care, and innovative care coordination.
References


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