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Improving the Transfer of Children and Adolescents to Hospitals for Psychiatric Treatment

By John M. Diamond, M.D.

Imagine your daughter is starting high school. She has a fight with her boyfriend. She becomes despondent and begins to cut herself. Her grades decline. She is moody.

It doesn't stop. She keeps to herself. She even stops using Facebook.

One evening, you see an open bottle of her mother's Xanax. Your daughter has taken 20 of the prescription pills, and she is out cold on the floor.

You dial 911, and an ambulance takes her to the emergency room (ER).

Twelve hours later, she wakes up.

In the ER, you wait for a psychiatric evaluation for many hours. Your daughter is not stable. She doesn't want to live anymore, and she will not say that she won't try to commit suicide again.

She is involuntarily committed to a hospital, but the only open child psychiatry bed is hundreds of miles away.

The sheriff is dispatched, but it is many hours before he arrives. She is transported by the sheriff in shackles and handcuffs because she is potentially dangerous or may hurt herself or others.

She ends up far from home. Because the sheriff picks her up at 2 am, you do not get to say goodbye to her before she leaves.

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Rowan County

The N.C. Center for Public Policy Research recommends that the Joint Legislative Oversight Committee on Health and Human Resources of the N.C. General Assembly study different methods of transporting children needing mental health treatment instead of relying on our sheriffs.

We conducted an informal survey of 50 states. We randomly picked two hospitals in each state and asked the emergency department, "How are kids transported to the psychiatric hospital?"

Although this method may not lead to completely valid results, they are illustrative nonetheless. Eight states use the police, sheriff, or other law enforcement for transportation. Twenty-seven states use an ambulance or other emergency medical service (EMS) transportation. Thirteen states use a combination of law enforcement or EMS. Two states outsource transportation to a private provider.

For example, Virginia uses EMS, Tennessee uses the police, South Carolina uses the sheriff, and Mississippi uses ambulances. Based on discussions with colleagues in other countries, Finland, Holland, and Norway use ambulances. Sweden uses the police.

The model used in North Carolina begs several questions. Why does hospitalization often occur 90 miles or more away? Why is the expense of a hospital needed? Safety can be found in less expensive, community-based settings where the family can be involved in treatment.

In Kentucky, for example, crisis stabilization units are used. Most regions of the state have had these units for at least 15 years. Some are for adults, but the state has 10 units for children. The units have eight to 12 beds. The length of stay varies, but recent data indicates the average length of stay is 5.85 days. Only 2.88 percent of the kids are readmitted within seven days, 8.83 percent are readmitted within 30 days, and 15.17 percent are readmitted within 90 days. Psychiatrists visit the unit two to three times a week. Therapists provide crisis intervention up to 24 hours a day.

North Carolina can do better. We need different methods to transport children needing treatment that are cost effective and that keep them closer to home. We can learn a lot from other states and nations without reinventing the wheel.

Source: John M. Diamond, "Concepts for Improving Mental Health Services for Children and Adolescents," PowerPoint to the Mental Health Subcommittee of the Joint Legislative Oversight Committee on Health and Human Services, Raleigh, NC, February 24, 2014. On the Internet at *http://www.ncleg.net/documentsites/committees/JLOCHHS/HHS%20Subcommittees%20by%20Interim/2013-14%20HHS%20Subcommittees/Mental%20Health%20Subcommittee%20Folder/2-24-14%20MH%20Subcom%20Meeting/IVd-Diamond%20Concepts%20for%20Improving.02.14.14.pdf*, accessed on July 8, 2014.

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