

PSYCHIATRIC BEDS FOR YOUTH

Experts look for other treatment options

BY ANDY STEINER



A child and adolescent psychiatrist, Shalene Kennedy, MD, is intimately aware of the shortage of hospital psychiatric treatment beds for young Minnesotans. Too many times, she says, she's seen the great lengths parents have had to go to in order to find inpatient care for their struggling children.

"It has been my personal experience to have a 7-year-old placed in inpatient treatment as far as Winnipeg without his parents. I also witnessed a case where a young man in psychological distress had fractured his mother's sternum. She didn't want to abandon her child, but it took three days for him to get a mental health bed. So this mother stayed by his side—and waited three long, painful days to get her sternum fixed."

While Kennedy believes that less-dramatic treatment options, including intensive outpatient and partial hospitalization programs, can work to help young people sta-

bilize their mental health, she understands that there are situations when inpatient psychiatric treatment is the best and only option.

"There are some families that truly do need hospital care for their children," she says. "When those beds aren't available, the situation can be heartbreaking. We have to make sure that Minnesota has enough beds for the kids who truly need this kind of care."

Sue Abderholden, executive director of NAMI Minnesota, says that while there has been a lot of talk at the Minnesota Legislature about the importance of increasing access to children's mental health services, the state still has a long way to go.

"We have waiting lists at all of our hospital and residential facilities," Abderholden says. "Our system has not been built yet, that's for sure."

Abderholden says that NAMI staff often field calls from parents who've struggled

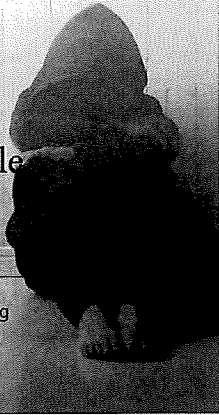
to find hospital beds for children struggling with acute mental illness. "I have heard many stories about families from the Twin Cities having to go drive all the way to North Dakota because there were no beds available here. We've had desperate families bring their child to a hospital emergency room and say, 'This child is not safe at home,' and then they've left. These children then get taken to a youth shelter. When you hear stories like that, you can't say we have enough beds."

"Children's Crisis Residential Services Study," a review of Minnesota's residential psychiatric care options for young people produced by NAMI Minnesota in collaboration with Aspire MN, reported that a dramatic rise in mental health emergency department hospital visits indicated a need for expanded options for families with children in mental health crisis.

Another care option highlighted in the report is short-term residential crisis sta-

“The further you get out of the Twin Cities, the fewer beds exist,” Stein says, adding that in the state’s northern communities, the shortage is particularly acute. “Kids from up north have to come down to the Twin Cities or even further south for care. They could be from International Falls and end up in Rochester at Mayo Clinic because there are no beds available in Duluth. That’s a real hardship for a family.”

— Josh Stein, MD, PrairieCare Medical Office Building



up” visits, but Kennedy decided that there were many other young people who needed a program that was a step up from what she was providing, an option that provided more intensive services without completely removing them from their known worlds.

Kennedy founded Aris Clinic, a Woodbury-based intensive outpatient (IOP) treatment center, where young people ages 5-18 spend an average of six weeks in a combination of full-time psychiatric treatment and grade-appropriate school each day before heading home to their families at night.

“This is an approach that works for many families,” Kennedy says of IOP. “Maybe this is a kid that doesn’t really need to go all the way to inpatient, but his family and he need more service, more intensity. There wasn’t anything that existed. It was either go back to your outpatient providers or are we going to put you in

the hospital?” In an IOP, Kennedy says, children learn to manage school and family stressors while staying embedded in the family system: “This option works as a healthy middle ground.”

“Upstream” advocate

Janna Gewirtz O’Brien, MD, would like to find a way for more kids to get help before they get to the point of needing hospitalization. An adolescent medicine fellow at the University of Minnesota and a board-certified pediatrician, she cares for teens in private practice at Hennepin Healthcare and at Edison High School’s school-based health clinic and the Bridge for Youth, a shelter for runaway and homeless youth.

She advocates an “upstream” approach to care, identifying and treating mental health concerns early, before they spiral out of control and become a problem that requires hospitalization.

“Mental illness doesn’t occur in a vacuum,” Gewirtz O’Brien says. “There are a lot of factors at play. If we could tackle those factors upstream, we could reduce the burden of serious mental illness.”

Often, physical and mental health are linked, Gewirtz O’Brien says. Keeping an eye out and making connections can help patients now and into the future. Take the young woman who came to see her at the Edison High clinic, complaining that her asthma symptoms had been getting worse.

“I said, ‘Do you notice anything that is impacting your asthma? What makes it worse or better?’” Gewirtz O’Brien recalls. “She said, ‘When I get stressed out it makes my asthma worse. That’s one of my biggest triggers.’ That comment opened the door for a conversation about how she was doing from a mental health perspective.”

The student told Gewirtz O’Brien about how troubles at home had been raising her anxiety. “This opened the door to a con-

versation where we could talk about ways she could find both mental and physical health support right in the school.”

This holistic approach to health is supported by a team of care providers.

“There is a school-based mental health provider,” she says. “I can reach out to her about how we can work with this young person on her asthma as her pediatrician and the mental health provider can work with her on her mental health. We can help this young person get to a place where her mental and physical health is thriving. This approach helps us early, before we get to a point where she would require hospitalization.”

Gewirtz O’Brien believes that school-based health centers like Edison’s can help prevent mental health emergencies by identifying and treating potential problems before they grow out of control. Minnesota was one of the first states to implement school-based centers. While there are clinics like Edison’s in schools in St. Paul, Minneapolis, Bloomington, Brooklyn Park and Rochester, their growth has been limited to the state’s urban centers. Minnesota also has an innovative program of school-linked providers in about half of the school buildings in the state, many of them outside the Twin Cities. These are providers who are not school employees but who provide mental health services for students at a school.

“Programs like these work to offset the burden downstream,” Gewirtz O’Brien says. “Unfortunately, though, those systems are not widely available in Minnesota, particularly in rural communities, where the need for mental health care is greatest.”

“I think it’s a both/and thing,” Gewirtz O’Brien says. “It is not one or the other. We need dramatically improved mental health infrastructure that is prepared to meet the acute mental health needs of young people and has sufficient beds to do so. We also need to do what we can to reduce the burden on these systems. We do what we can to support young people’s mental health and well-being so they can thrive in the community and not end up in the hospital.” MM

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bilization services, a facility where a person in mental health crisis can stay for as little as 24 hours under the care of mental health providers. These shorter residential stays can help a person find a way out of crisis at lower cost. Minnesota has created more crisis stabilization programs for adults, but only one exists for youth.

The report advocated that the state invest in creating more of these programs for young people: "Crisis stabilization beds are a critical component to divert youth from higher levels of care, deliver essential screening and treatment, and provide timely intervention. Short-term crisis residential models are uniquely designed to meet these needs." Crisis stabilization services save money, the report concluded, reporting that "resources invested in mental health crisis-stabilization services provide a significant benefit, with a return of \$2.16 dollars for every dollar invested."

Abderholden believes that lawmakers understand the benefits of bolstering residential options for youth, but haven't yet been able to realize their goals. "We've found the things that work, but we haven't fully funded them," she says. The Legislature can provide funds to increase beds for residential treatment, but can't do anything about the number of hospital beds available for children with mental health issues.

Josh Stein, MD, a child and adolescent psychiatrist and clinical director of PrairieCare Medical Office Building, said that while he is confident that the Twin Cities have an adequate supply of inpatient mental health beds for children, the true shortage is in rural Minnesota.

"The further you get out of the Twin Cities, the fewer beds exist," Stein says, adding that in the state's northern communities, the shortage is particularly acute. "Kids from up north have to come down to the Twin Cities or even further south for care. They could be from International Falls and end up in Rochester at Mayo Clinic because there are no beds available in Duluth. That's a real hardship for a family."

Psychiatric hospital treatment for kids ebbs and flows with the season, Stein

says. While programs may have plenty of space in the summer, when school starts in the fall, they begin to fill up and beds become harder to find. Another way Stein measures hospital bed shortages is in the number of stories he hears about young people in crisis waiting in emergency departments until psychiatric treatment beds open up.

"We see kids stuck in EDs across the state just sitting there waiting for a hospital bed," Stein says. "We hear about kids spending the night at HCMC, at Ridgeway and Alexandria hospitals. These kids are spending one, two, three nights in the ED. They are being held for their safety without getting the services they need. It's a sad situation."

When hospitalization is the best choice

Most mental health experts now say that finding alternatives to hospital mental health treatment for young people is needed. Having a treatment option that provides mental health care during the day while a child spends their nights at home is less disruptive and often as effective as inpatient hospitalization.

But there are situations when the best—and only—option for a kid in acute psychological distress is hospitalization treatment. Sometimes a young person's mental illness manifests in violent outbursts that are directed at themselves or at other family members. And when a young person exhibits clear signs of suicidality, parents often feel that hospital-based treatment is the only option.

Abderholden understands those needs. "There are times when families are very worried about keeping their child safe," she says. "Sure, they could be treated in an outpatient program, but if the parent doesn't feel like they can keep themselves, the other children or the child in distress safe at home, then hospitalization is the clearly best option."

Kennedy explains that there are certain situations that call for hospitalization. "Inpatient is for crisis, for large behaviors, for being a danger to yourself or others or very gross impairment in your

functioning, like if you are walking around responding to auditory hallucinations or haven't showered for six weeks."

An inpatient stay, even if it lasts for just a week, can be an option for a child and their family to find an all-important "re-set," Stein says. During these stays, a health care team can safely find medications that stabilize the child, and families can work, through group therapy sessions, to see larger issues and reshape their interactions.

Despite having a lot of other care options, like day treatments, partial hospital treatment and intensive outpatient treatment, Stein says, "we strongly need inpatient facilities because they are a place a child can go to when they are so vulnerable that they need a locked facility that has four walls where they can get the support they need. It's also important for some children to have their environment changed so they can heal."

Middle ground

While inpatient and residential treatment are needed options, mental health providers like Kennedy are working to present ways for young people and their families to find healing without the severe disruption brought about by out-of-home placement. A few decades ago, Kennedy ran her own outpatient pediatric mental health clinic. Too often, she ran into situations when a young patient's mental health had reached a point that twice-monthly visits and medication management weren't enough to help them regain equilibrium.

"There were times when I was like, 'Oh my gosh. My only option is to pull this child from their home take them to an emergency room and then remove them from their family and have them stay overnight with strangers,'" Kennedy says. "How scary is that? You might have a really depressed or a really anxious kid. Two doors down is the psychotic 16-year-old throwing chairs around. It was really hard for the in-between kids who had a breakup or whose parents are in a nasty divorce."

Outpatient programs like hers were helpful for children who could keep their mental health stable with limited "tune-