

**Kids, Crisis & Care:**  
**Families' Experience with Emergency Services**



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## **Executive Summary**

This report represents the voice of families concerning crisis care. Many families of children with mental health needs find themselves in crisis at various times and often seek the help of Emergency Services Programs (ESPs). Unfortunately, the wait for a mental health evaluation and subsequent outpatient services can result in delayed access to appropriate care. The shortage of psychiatric beds, well documented in recent press releases, has resulted in many families waiting days for treatment. The families in this survey reflect a growing concern around appropriate and available mental health services for children and adolescents.

### **Key findings:**

- Less than 25% of families said a child-trained evaluator was available and more than 60% of families were unsure if the evaluator was experienced or had training in children's mental health.
- Overwhelmingly, families end up feeling that mental health concerns are not a priority in the ER.
- About half of all families reported waiting 1-4 hours before their child receives a mental health evaluation and 35% waited 4-8 hours. These waits occurred after their child had been triaged.
- Almost 30% of families reported that emergency services suggested filing a CHINS.
- 43% of respondents said that they were not linked to services if hospitalization was not required.
- Nearly half of respondents reported that their children were asked to "contract for safety" yet only 9% felt that this was an effective practice.

**Recommendations:**

- 1) Child-trained mental health clinicians must be available to provide developmentally appropriate evaluations of children with mental health needs. Sound knowledge of child development is essential, as children's mental health presents differently than adult mental health.
- 2) Children need access to psychiatric beds if hospitalization is necessary. The presence of additional community supports will allow more children to be moved from hospital placements and housed within their communities, helping to alleviate the current strain for psychiatric hospital beds.
- 3) Children and families in crisis need to receive services in a timely fashion. This can be accomplished by prompt and smooth transitions from initial intake evaluations to behavioral health teams.

## **Introduction**

Emergency Service Programs (ESPs) represent the first stop for many families of children going through a mental health crisis. While many hospital emergency rooms and ESPs who evaluate children do an excellent job, a misstep or protracted wait often multiplies problems for children and families with mental health needs. Periodically, Parent/Professional Advocacy League (PAL) receives a surge in calls and concerns around crisis care and one such surge prompted this study. This survey sought to capture the concerns of families and mental health professionals who have had experience with children's mental health emergency services and highlight areas which need improvement in those settings.

## **Methodology**

This survey was developed with input from several Family Support Specialists in the PAL network who work with families trying to access crisis care. A series of topics and questions were designed which targeted the concerns most often expressed by families. The survey was initially sent out in email form in December 2006 and posted online using a commercial survey product (SurveyMonkey) in January 2007. The survey was sent to a wide range of individuals, including parents, family support group facilitators and mental health professionals, who could speak to their experiences with crisis care for children with mental health needs throughout Massachusetts. The survey consisted of 8 questions focusing on the following issues:

- the use of child trained evaluators in crisis centers;
- length of wait for a mental health evaluation;

- contracting for safety and its perceived effectiveness;
- links to services and the wait for such services;
- recommendations to file a CHINS petition;
- threats to file a 51A;
- and experience with hospital security and staff.

PAL received 67 survey responses from every geographic region of the state, all of which were used for analysis. Over half of all respondents provided comments within the survey.

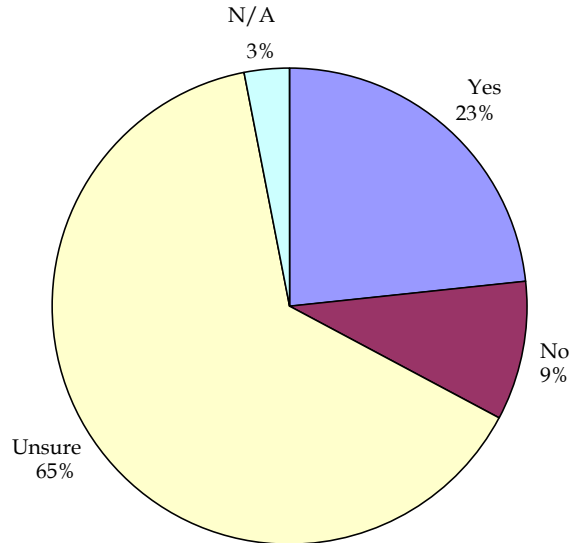
## Results

### *Mental Health Evaluators*

Less than one-quarter of all respondents reported that there was a child-trained clinician available to perform mental health evaluations for children in crisis. In the cases where there a child trained evaluator was on staff, he/she was not always be able to see the child in crisis.

More than 60% of individuals are unsure as to whether or not their ESP employs a child trained evaluator, indicating a lack of communication regarding evaluator qualifications and training. The presence of a child trained evaluator is critical to ensure appropriate treatment, as children’s mental health presents differently than adult mental health. Many of the recommendations for further treatment should stem from an understanding of the children’s mental health service delivery system. Experience and training in children’s mental health ensures that clinical decisions are developmentally appropriate. As one parent reported, “In only 2 of 7 encounters did I feel that the crisis evaluator was aware of how to work with a child to assess his needs and not strictly act as a liaison between the insurance company and the hospital.”

*Does the ESP in your area have a child trained evaluator?*

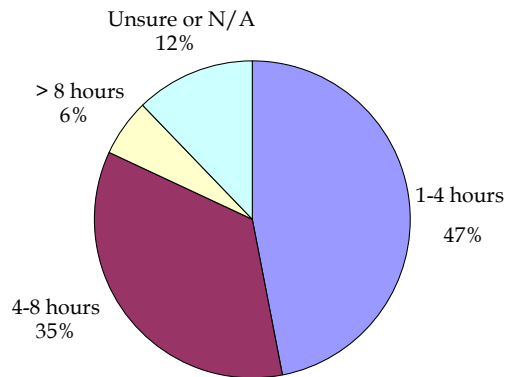


### *Delay of Service*

The overwhelming perception resonating from the data indicates that mental health is not a priority in the ER and that patients with mental health needs are treated differently than patients with other ailments. Treatment time seems to vary with the number of incidents at the ER when the family arrives, and the ability of the family to navigate the system and demand services. As one individual reported, “(Much depends) upon staffing and the number of patients. I have known of highly traumatized children left out on gurneys for 24 hours.”

In the majority of cases, families reported that children with mental health needs are not being evaluated in a timely fashion. Nearly half (47%) of the individuals surveyed typically wait between 1-4 hours for a mental health evaluation. An additional 35% wait 4-8 hours and 6% have had to wait over 8 hours.

**Length of time for an evaluation**



Of particular concern are the two individuals surveyed who have had to wait over 14 hours for an evaluation. In the few instances where this question did not apply, individuals reported being taken by ambulance. The wait time for an evaluation is inconsistent and, in many cases, unreasonably long across areas.

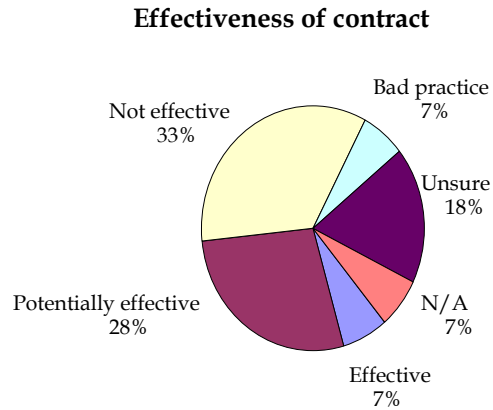
Many individuals reported that patients with physical injuries and other ailments take precedence over patients in need of mental health services. One respondent reported, “Once in there you are a prisoner and in the room you are treated differently than if you were in for other medical needs.” 50% of individuals reported that other people were often serviced before the child with a mental health crisis. Of these children and adolescents, the majority had to wait between 4-8 hours to be seen by a mental health evaluator. One parent reported, “Many patients came and went, most of which were not real emergencies, before our son was evaluated by a mental health specialist (and he even had ties to the hospital since his therapist and psychopharmacologist were on staff there!)” After a child is triaged, it often becomes a low-priority for many emergency rooms to ensure that a mental health evaluation is done. Protocols are often not in place to ensure that the transition to behavioral health teams takes place promptly.

### *Contracting for Safety*

The concept of “contracting for safety” continues to be a controversial issue for families and health care providers. Clinicians need to be closely attuned to both “cries for help” and the threat of imminent self-harm. Often the doctor-patient relationship plays a key role in the effectiveness of safety contracts. According to Dr. Ren J. Muller, “I have come to see these contracts, made in the heat of crisis with a clinician whom the patient does not know, as intrinsically unreliable and essentially different from the agreement often made in outpatient therapy. Outpatient contracts, struck with a clinician when a therapeutic alliance is already established, have proved effective in containing the self-destructive impulses of suicidal patients” (Psychiatric Times, 2002). The presence of

a child-trained clinician is a critical component in both assessing a child’s needs and taking appropriate preventative measures to ensure child safety.

Despite the best intentions of evaluators and crisis team workers, contracts for safety may not be the best way to protect children in crisis. While 49% of respondents reported that children were often asked to “contract for safety”, only 9% of this group felt that this was an effective practice.



28% of total respondents thought that the practice of contracting for safety was potentially effective, depending on the mindset and age of the child and his/her relationship with the evaluator. 33% reported that the practice was not effective and 7% went so far as to report that contracting for safety was a bad practice. Overall, only 7% of individuals reported that the practice of contracting for safety was effective, indicating a strong need to re-think the contracting process to make it successful for children and families.

Many parents align themselves with Dr. Muller’s viewpoint, citing that the degree of contract effectiveness depends on the individual child and the sensitivity and empathy of the evaluator. There is often the feeling that “the kid says what people want to hear” or “the child will say whatever is needed not to go inpatient.” In this sense, the practice appears to be an ineffective aspect of protocol. One individual stated, “It’s common practice, although research has said it’s not particularly effective. However, there’s little

else they can do or offer if the child is going home.” Another said, “I’m not sure how effective it is to ask a potentially suicidal person to contract for safety.” These comments demonstrate the ineffectiveness of current contracting procedures for children, which needs to be reassessed by the ESPs. The presence of child trained clinicians is critical in evaluating imminent harm for the child and family.

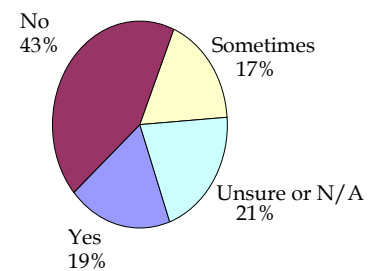
### *Links to Services*

Results from the survey indicate a major gap in service delivery for children not screened for hospitalization. 43% of respondents indicated that crisis center staff did not link the child to services if hospitalization was not required,

leaving the family to either find services on their own or await their child’s next crisis. 19% of individuals reported that the child was linked to services, and 17% indicated that this occasionally occurred. One parent referred back to whether the clinician was trained in children’s mental health and commented, “This varies also - you get whomever you get and that person may or may not be helpful in your situation.”

When services are recommended, the wait for delivery varies tremendously. Individuals reported wait-times for children who are experiencing a mental health crisis ranging from less than 24 hours to 3 weeks. Of those individuals who cited a precise time frame for services, only 3% waited less than 24 hours for services. 8% waited 1-2 days and 27% waited up to 3 weeks for services. Another 9% of individuals reported that there were no links to services.

**Links to services**



The data indicate that when services are recommended at home, service delivery is not manufactured in a timely fashion or simply not delivered at all. Despite the best intentions when making service recommendations, oftentimes the family is left in crisis due to the inability of providers to expedite services. When families seek the help of a crisis team, it is due to the urgent nature of their needs; they cannot wait 3 weeks to receive FST services. Results demonstrate the need for additional supports, whether they be FSTs or community-based programs, to provide efficient, quality services to families in crisis.

### *Filing a CHINS petition*

Child in Need of Services (CHINS) petitions were initially designed to address behaviors that were seen to be contrary to the youth's own self-interest. These youth often committed "status offenses", including running away, truancy, stubbornness, and other behaviors which would not bring an adult to court. The CHINS process is being increasingly used to address the unmet mental health needs of children. While the CHINS process appears to offer parents a way to access services, it can be both complicated and risky. Many parents and service providers, especially those not working in the children's service delivery system, do not fully understand what the CHINS system is, or that the potential outcomes of filing a CHINS can include loss of custody. While the CHINS system was designed to assist children displaying high-risk behaviors, there are a number of problems within the system that need to be addressed before it is an effective tool for families of children with mental health needs to utilize. Current legislation seeks to amend CHINS so that families needn't go to court to acquire services for their children.

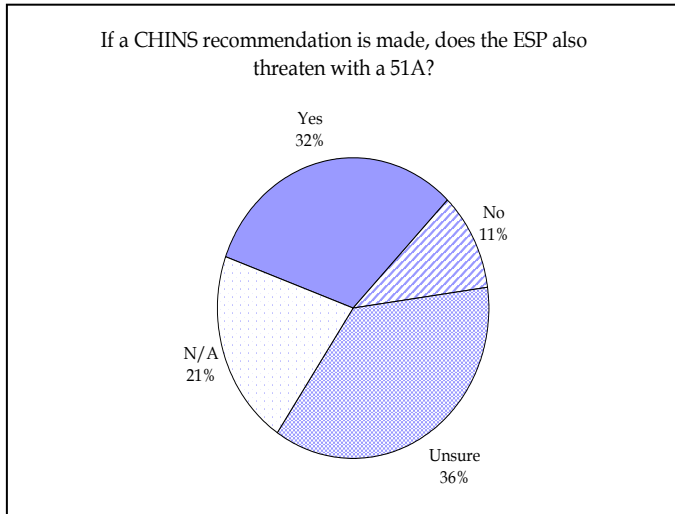
Senator Spilka and Representative Donato filed Bill 3466, an act regarding children and families requiring assistance, in an effort to reform the CHINS system and make it a more effective tool for families.

Even though the CHINS process can be an inappropriate choice for families whose children have mental health needs, 29% of the individuals surveyed reported that the ESP had recommended filing a CHINS petition. One parent was told by her evaluator that “the insurance company is going to ask why I hadn't filed a CHINS - my son was 9 at the time.” This information is misleading to families, as insurance companies are not affected by CHINS petitions and would have no reason to question a family for filing a CHINS. 46% of individuals reported that the ESP had not recommended filing a CHINS, and 14% were unsure. Evaluators need to receive better training and inform families of all treatment options. CHINS petitions should not be the mechanism by which families receive mental health services. ESPs need to connect families to appropriate, available services instead of using the court system as a vehicle for assistance.

*Threats to file an allegation that the child is at substantial risk of harm (51A)*

23% of respondents reported that the ESP in their area had threatened to file a 51A they decided against waiting and left with their child. An additional 38% of individuals were unsure as to whether or not the ESP had threatened parents with a 51A and 17% reported that the ESP had not told parents they would file if they left. For 24% of individuals, the question did not apply. Comments suggest that threats to file a 51A may stem from parent/caregiver frustration concerning the lack of efficiency in crisis centers. “I have been told when my son wasn’t being hospitalized for his crisis that we

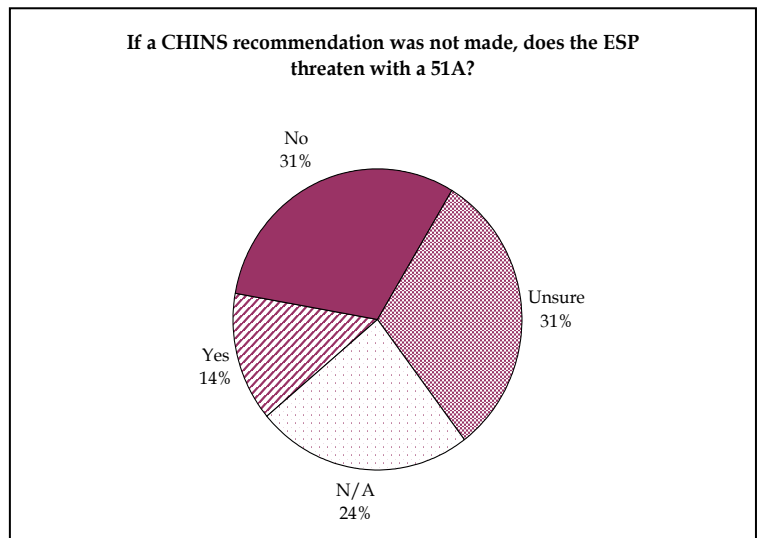
needed to stay to get medically cleared to go. After waiting 10 hours for this process I left and was threatened with a 51A.” An analysis of this data in conjunction with the CHINS results follows to ascertain any emerging trends in patient treatment.



As previously reported, 29% reported that the ESP had recommended filing a CHINS petition. Of this group of respondents, 32% reported that the ESP had also warned parents they would file a 51A if they planned to leave with their child. 11% of this

group reported that the ESP had not threatened parents with a 51A. The remaining respondents were unsure as to whether parents had been notified of this, or the question did not apply.

46% of individuals surveyed reported that the ESP had not recommended filing a CHINS petition. Of this group of respondents, 31% reported that the ESP had not threatened parents with a 51A if they planned to leave with



their child. Only 17% reported that the ESP had notified parents that they would file a

51A. The remaining respondents were unsure as to whether parents had been threatened, or the question did not apply.

The data suggests a possible correlation between filing a CHINS and being threatened with a 51A. In cases where parents were told to file a CHINS, nearly a third of them were also threatened with a 51A. In cases where parents were not told to file a CHINS, nearly two-thirds were not threatened, or could not recall being threatened, with a 51A. Further analysis and follow-up research are needed to ascertain the cause of this trend.

### *Hospital Security*

Survey results indicated mostly positive or neutral experiences with hospital or building security; very few respondents gave negative accounts. 24% reported positive experiences: “The security guard went to the cafeteria and bought my son food, since it was closed.”; “Security has been patient, respectful and very watchful but not intrusive. They kept the situation low key.” 27% reported neutral experiences with security: “Hospital security has been minimal – not direct interaction – just monitoring when I had to leave the room for a moment.” 13% reported negative experiences: “A client of mine was restrained inappropriately by hospital security.” 24% reported that they had not had experience with hospital security: “I haven't addressed it in one way or another per se. If you mean the staff who are there when we come and how they coordinate with us, then they are fine, but we haven't had to deal with actual security staff at the times we brought out son in.” There were not any striking trends from this data, which may be due to the

wide range of care centers and the accessibility and/or prevalence of security staff in those areas.

## **Conclusion**

The data generated from PAL's survey indicates that emergency service providers and crisis teams tend to view children in isolation instead of as members of a family. This common approach to health care also illustrates one of the major flaws within our mental health system. This theoretical viewpoint often ignores or dismisses one of the best sources of information in relating to the child – the family. This perspective also overlooks the needs of the remaining family members, who need support and assistance during the crisis as well. This lack of empathy may have deleterious effects and result in families not accessing services during a crisis. “The disrespect and lack of compassion towards adults and others living in the home often discourages us and other families we know from accessing help, even when it is so clearly indicated... just because a child is stabilized in 3 days does not mean a sibling who has witnessed the utter lack of control is ready in 3 days.”

Children are not receiving necessary supports when they leave the crisis center, leaving parents feeling despondent and the child in turmoil. Once a child leaves the ER or crisis center, supports need to follow the child into the community. Immediate access to services is a key component of family stabilization. Contracting for safety is not an ironclad assurance that the child will remain stable. However, such an effort may be successful in conjunction with other supports, such as case management and links to therapy and FST services.

It is clear from our survey that families are the experts when it comes to caring for their children; they research symptoms and diagnoses, seek the best medical care available, and in some cases, end up going to court for assistance. Unfortunately, instead of capitalizing on this valuable resource, some ESPs continue to treat families insensitively and disrespectfully. This issue resonates in one individual's experience with an ESP: "I have had an ESP argue with me about my child's diagnosis, it was disheartening and uncalled for. I have chosen my doctors carefully and trust their judgment when I am in crisis. I don't need someone being condescending." Another individual wrote, "The children are kept in beds in the hallway and interviewed by hospital personnel in front of everyone... It is very disrespectful of a patient's privacy to be asked about suicide and self-injury in front of onlookers." This respondent went on to report that the family did not receive crisis team services until hours after their initial arrival and interview. These issues need to be addressed by hospital and crisis centers administration to ensure better care of children and families in need of mental health services.

## References

Muller, R. (2002). Renegotiating the “contract for safety” in the ER. *Psychiatric Times*, 19 (5).

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