

Source: Heflinger, C. A., Simpkins, C. G., & Foster, E. M. (2002). Modeling child and adolescent psychiatric hospital utilization: A framework for examining predictors of service use. *Children's Services: Social, Policy, Research, and Practice*, 5(3), 151-171.

An important finding from this study documents the impact that community and mental health service systems have on reducing child and adolescent psychiatric hospitalization. Using a database of over 11,000 youth, the authors compared data on consumer, community, and services characteristics to determine whether any of those characteristics could predict hospitalization usage. The authors found that “when community-based services, whether group home or alternative settings, were available in a county, fewer children were hospitalized, indicating that these resources can be used to reduce hospitalization” (p. 167).

Data were examined for all children and adolescents in custody of the State of Tennessee as of November, 1, 1996 ($N = 11,585$). The mean age of this group was 11.5 years. Over half (58%) of the youth were male, 60% were Caucasian, and 38% were African American. Most youth entered state custody through the child welfare system (80%). Results indicate that, 10.3% of youth ($n = 1,193$) had received (any) psychiatric hospitalization. Males were more likely than females to experience hospitalization, and older youth were more likely than younger children to be hospitalized. Caucasian youth were more likely to be hospitalized than were African American youth. Compared with children who entered into state custody through child welfare, youth who entered through the Department of Mental Health were 7.6 percentage points more likely to experience psychiatric hospitalization.

The authors also found that “five service system and community characteristics at the county level were significant predictors” ($p < .05$; p. 164) of hospitalization. Four of those predictors were found to *reduce* the probability that a child in his or her home county would be placed in a psychiatric hospital anywhere in the state. Those predictors are: (a) the county’s capacity for alternative placements while the child was in state care; (b) the presence of a general or psychiatric hospital in the child’s home county; (c) the total population of the child’s county, and (d) the number of children living below the poverty line in the child’s county. The fifth predictor—the percentage of children in the child’s county who were living in a single parent family—was associated with an increased probability of placement in a psychiatric hospital.

In conclusion, the presence of hospitals in a child’s community may have a mitigating effect on reducing the rates of psychiatric hospitalization among children in state custody. The authors speculate that the availability of outpatient clinics associated with hospitals provides an alternative to hospitalization, and that the presence of group homes and other community settings may also be associated with reduced hospitalization rates. That is, if there were alternative lower-level placements in the county where the child lived, he/she was much less likely to be hospitalized. Other findings of this study also suggest the need for “the development and use of a community-based range of services” (p. 167). For example, the high rate at which boys were served in psychiatric hospitals or residential treatment settings, even though their mental health needs were similar to other adolescents, suggests that “supports geared to meet the needs of boys and other adolescents must be developed so that they can have successful community lives and avoid placement out of the community in residential treatment” (p. 167). These findings have direct implications for further mental health services research.