

BRIEF REPORT

Crisis Stabilization Services for Children and Adolescents: A Brokerage Model to Reduce Admissions to State Psychiatric Facilities

Julian E. Ruffin, Ph.D.
H. Randolph Spencer, M.D.
Anne Abel, M.D.
Jeanine Gage, R.N., M.S.
Luanne Miles, M.S.W.

ABSTRACT: There continues to be an increased interest in developing community-based services for children and adolescents as an alternative to inpatient care. However, there has been much more talk than action in creating such alternatives. This paper describes the success of a crisis stabilization program for children and adolescents in a community mental health center which historically over-utilized the State psychiatric facility for youth. The Crisis Stabilization Program consists of three components: (1) a two-person crisis team, (2) a four-person on-call team for after hours crises, and (3) funds which the crisis team utilized to broker for a wider array of community-based services.

INTRODUCTION

The deinstitutionalization movement within the field of mental health resulted in a significant reduction in the number of patients in public psychiatric hospitals during the past thirty years (Stroul, 1986; Geller, 1991). The escalating costs of inpatient care as well as the emphasis on

All correspondence should be directed to Dr. Julian E. Ruffin, Chief of Child and Adolescent Services, Columbia Area Mental Health Center, 1801 Sunset Drive, Columbia, S.C. 29203.

providing treatment in the least restrictive environment have served as an impetus for the development of community-based service alternatives (Goldman, 1988). There is considerable agreement that "community-based care is more humane, more therapeutic, and less stigmatizing" than institutional care (Stroul, 1986, p. 4). There is also evidence that community-based care is as effective and less expensive than inpatient psychiatric treatment (Keisler, 1982; Mosher, 1983; Update, 1987-88). In addition, there is a need for a comprehensive community-based service system to both prevent and treat emotionally disturbed children and adolescents (Friedman, 1985; Keisler, 1982).

Unfortunately, the lip-service which has been rendered regarding the value of community-based alternatives frequently has not materialized into the actual development of new resources. There continues to be a severe shortage of supportive and rehabilitative programs in the community to meet the needs of persons either discharged or diverted from hospitals (Stroul, 1986).

Crisis services have received considerable attention due to their potential to reduce psychiatric admissions, to provide an appropriate alternative in a less restrictive environment, and to be cost effective (Stroul, 1986; Geller, 1991). Although crisis services have been focused primarily on adults, these services are important to children also (Goldman, 1988). However, crisis services have generally "been either totally neglected or approached in a fragmented manner" in the area of child mental health (Stroul & Friedman, 1986, p. 46).

THE PROBLEM

This paper describes the development of a crisis stabilization program within a child and adolescent program at a local mental health center. It is our contention that the various components of this program can be replicated in other community mental health centers and have a significant impact on admission rates to psychiatric hospitals.

This center has had a history of experiencing high admission rates to the state psychiatric facility for children and adolescents. In fact, this center consistently had more child and adolescent admissions than any of the other seventeen community mental health centers in the state. During 1988, there were 117 admissions from this center as compared to 49 from the Center which had the second largest number of admissions. The average length of stay at the State psychiatric facility for these 117 children was 59 days. Sixty percent were hospitalized for less

than thirty days. So it was clear that this Center admitted children and adolescents at a much higher rate than the other community mental health centers, and that the majority of these young people did not receive long term care.

There has also been a glaring absence of a comprehensive system of care which provided a broad range of services. Historically, the service menu has consisted of only two options for those in crisis: outpatient counseling and inpatient care. The alternatives of partial hospitalization, therapeutic foster care, and therapeutic group care were not available on the menu. This is not a situation unique to our center. Friedman (1985) has pointed out that these alternative services are a recent phenomenon in the field of child and adolescent services.

Consequently, the child and adolescent service of the largest community mental health center in South Carolina had more admissions to the State psychiatric facility for children and adolescents than any of the other sixteen community mental health centers in the State. Therefore, the Center developed a new Crisis Stabilization Program with the following two goals:

1. To reduce the number of admissions to the State psychiatric facility for children and adolescents.
2. To utilize more community-based treatment alternatives rather than inpatient treatment alternatives.

GAPS IN OUR CRISIS SYSTEM

Crisis services can be classified on the basis of the three dimensions of timeliness, intensity, and accessibility (Petr & Poertner, 1989; Friedman, 1983). Timeliness refers to how rapidly services are provided once they are requested. Intensity addresses the length and frequency of contact. Accessibility refers to both the location and the hours in which services are available. Prior to 1989 there were some significant gaps in our crisis delivery system for children and adolescents.

First, there were no staff specifically trained and assigned to handle crisis cases. Crises were handled by the same therapists who had ongoing outpatient caseloads.

Second, these therapists rotated responsibility for coverage of crisis cases, and simply had to squeeze the crisis cases into an already full schedule. Since crisis cases often took more than an hour, this system had a negative impact on regularly scheduled clients.

A third gap occurred when a young person in crisis needed to be seen again very soon. As the regular outpatient therapists' schedules were generally filled two to three weeks in advance, it was difficult to find a time to see the child again quickly without impacting a regularly scheduled client.

A fourth gap in the delivery of crisis services occurred after regular working hours. The Center's system provided no assessment by or consultation with a child-trained professional for young people who were in a crisis. Consequently, the State psychiatric facility frequently reported that there were inappropriate admissions during after hours.

A fifth gap was the lack of alternative placements available for children and adolescents who legitimately needed placement, but not necessarily in a hospital. Some children were hospitalized "inappropriately" due to the fact that it would have been even more "inappropriate" to leave them in an inadequate community placement. There were often no reasonably appropriate alternatives available.

THE DEVELOPMENT AND IMPLEMENTATION OF A PLAN

Some of the reasons for the high number of admissions to State psychiatric facilities from this Center was the limited capacity to provide timely, intensive, and accessible intervention in crisis situations by a trained child and adolescent specialist, and the lack of affordable alternative resources. Therefore, the child and adolescent service of the Center proposed to and received from the State Legislature the funding for a Crisis Stabilization Program which consisted of the following three major components:

1. A two-person crisis intervention team which provides timely and intensive intervention. These individuals are available to provide frequent follow-up so as to divert children and adolescents from unnecessary hospitalization, thus addressing the first, second, and third gaps listed above.
2. A four-person team is on call after regular working hours, on weekends, and holidays to consult with the graduate students who work in the emergency room of the community hospital. This team consults on every child or adolescent seen in the emergency room, and makes face to face contact with any young person who is being considered for admission to the State psychiatric facility, thus addressing the fourth gap.

3. Funds are available which the Crisis team can use to contract with and purchase alternative services for children who do not have the financial resources. These funds have allowed the Crisis team to expand the menu of available services for children to include therapeutic foster homes, a residential treatment facility and two private psychiatric hospitals. As the broker, the Crisis team assesses children as to their clinical needs and authorizes the expenditure of the crisis funds if an alternative placement is deemed appropriate and is available. All of the Crisis Stabilization contracts are set up on a space available basis with the provider having the option to accept or reject the referral.

RESULTS

The primary goal of the Crisis Stabilization Program was to reduce the number of admissions from our catchment area to the State psychiatric facility. During the first year of the Crisis Stabilization Program there was a 51% reduction in admissions to the State psychiatric facility for children and adolescents (117 to 58). This reduction was accomplished with only one alternative placement available during the first seven months of 1989 (a private psychiatric hospital). The reduction increased to 60% during the second year of operation (117 to 47). During 1990 the service alternatives increased to include a second private psychiatric hospital, access to therapeutic foster homes, and one residential treatment facility. The second year of operation continued to show an improvement with a 19% reduction in admissions to the state psychiatric hospital (58 to 47). This data clearly indicates the effectiveness of the Crisis Stabilization Program in reducing the admissions to the State psychiatric facility for children and adolescents.

The availability of more community-based alternatives in 1990 allowed us to reduce the utilization of inpatient alternatives by 60% from 1989 to 1990 (35 to 14). In 1989, hospitalization accounted for 85% (35 of 41) of our alternative placements. Whereas in 1990, hospitalization accounted for only 24% (14 of 59) of our alternative placements. Thus, it is clear that the program has been successful in achieving its second goal of utilizing more community-based treatment alternatives and using hospitalization less.

Another pleasant result, which was not a goal of our program, was the cost savings of the crisis program. During 1988 the average stay of our 117 admissions was 59 days at a daily cost of \$400. This translated into

an average admission costing the State \$23,600. However, 69 of these admissions were for less than 30 days with an average length of stay of 12.5 days. So the average cost for our short-term admissions during 1988 was \$5,000. During 1989 the inpatient alternative cost us \$3,058 per admission and the therapeutic foster care cost us \$690.58 per admission. During 1990 the inpatient alternative went up to \$4,047.44 per admission and therapeutic foster care went up to \$904.21. The Residential Treatment Facility cost us \$2,395 per admission. So it is easy to see that the average cost of our admissions to alternatives compared very favorably with the cost at the State Psychiatric Facility.

SUMMARY AND IMPLICATIONS

It is clear that a Crisis Stabilization Program which includes the three major components of (1) a crisis team to respond to day-time crises, (2) an on-call team to respond to crises which occur after regular working hours, and (3) having funds with which to broker for alternatives beyond the traditional outpatient and inpatient options can be very effective in reducing the number of children and adolescents admitted to state psychiatric facilities. Many children and adolescents who are in crisis can be handled effectively in community-based crisis oriented programs when these are available.

It is less clear how each component separately would impact on admissions. Our impression is that each of the three components has been effective and contributed to reducing admissions. Therefore, a community mental health center which does not have the funding to implement all three components at once might consider implementing only one component or implement the components sequentially as funding becomes available. This would have the added advantage of assessing the impact of the various components.

Based on previous reports comparing community-based and inpatient care on the variables of cost and effectiveness, it is not surprising that our crisis stabilization model of short-term treatment proved very cost-effective (Keisler, 1983; Mosher, 1982). However, it seems that insurance continues to pay well for children and adolescents who are hospitalized but not for children in community-based programs. Our experience indicates that many children who are hospitalized can be treated just as effectively in less expensive community-based programs. Thus it might be in the best financial interest of insurance companies to consider reimbursing community-based programs.

Two significant problems in implementing such a crisis program in a community where alternative community-based programs have not been available are: (1) Much education is needed to convince other professionals in the community that a community-based alternative is adequate for "their" child. This has been particularly true of physicians who work in an Emergency Room and mental health professionals who are used to the hospital as a "safe" environment for a client who is suicidal. (2) Even though there is much literature to support that community-based programs are less expensive and as effective as inpatient care, there are still costs in developing new alternatives for children and adolescents. As Friedman (1985) has pointed out, alternative services for children and adolescents are a recent phenomenon. These resources are scarce but are greatly needed; therefore, communities need to promote the development of such programs on the basis of providing care in a less restrictive, more humane and natural environment as well as their cost-effectiveness (Keisler, 1983; Mosher, 1982; Gutstein, 1988; Update, 1987/88).

As Geller (1991) has pointed out, it should not be assumed that hospital diversion is unquestionably positive. Therefore, it would be helpful for us to do follow-up to see how many of the children and adolescents we initially diverted away from hospitalization ended up in the hospital eventually. This would help determine if there is a recidivism problem with regard to the alternative placements. In addition, it would be helpful to do a more thorough assessment of the cost-effectiveness of our Crisis Stabilization Program. These are areas which we plan to study as we continue to assess the merits of our Crisis Stabilization Program.

REFERENCES

- Friedman, R.M. (1983). Planning and developing community-based mental health services for children and adolescents. Article available from the Department of Technical Assistance and Consultation, Florida Mental Health Institute.
- Friedman, R.M. (1985). Serving seriously emotionally disturbed children: An overview of major issues. Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children. Article available from the Epidemiology and Policy Analysis, Florida Mental Health Institute.
- Geller, J.L. (1991). "Anyplace but the State Hospital" Examining assumptions about the benefits of admission diversion. *Hospital and Community Psychiatry*, 42, 145-151.
- Goldman, S.K. (1988). Community-Based services for children and adolescents who are severely emotionally disturbed: Crisis services. Article available from the Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center.

- Guterman, S.E., Rudd, M.D., Graham, J.C., & Rayha, L.L. (1988). Systemic crisis intervention as a response to adolescent crises: An outcome study. *Family Process*, 27, 201-211.
- Keisler, C. (1982). Mental hospitals and alternative care: noninstitutionalization as potential public policy for mental patients. *American Psychologist*, 37, 349-360.
- Mosher, L.R. (1983). Alternatives to psychiatric hospitalization: Why has research failed to be translated into practice? *New England Journal of Medicine*, 309, 1579-1580.
- Petr, C. & Poertner, J. (1989). Protection and advocacy for the mentally ill: New hope for emotionally disturbed children? *Community Mental Health Journal*, 25, 156-163.
- Stroul, B.A. (1986). Crisis residential services: Review of information. Article available from the National Institute of Mental Health, Community Support Program.
- Stroul, B.A. & Friedman, R.M. (1986). A system of care for severely emotionally disturbed children and youth. Article available from the Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center.
- Update. Crisis Emergency Services (Fall 1987/88). Improving services for emotionally disturbed children. Publication of the Florida Mental Health Institute, 3, 10-12.