Children, Youth and Families’ Crisis Response and Stabilization

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What’s the Problem?

• Emergency department (ED) visits for non-urgent behavioral health issues are common and among the largest contributors to the increase in ED visits by children (Frosch, Dos Reis, 2011)
• An ED visit, sometimes followed by a hospitalization, is often the default response for a family experiencing a behavioral health crisis
• EDs generally are not equipped to address the behavioral health needs of children, unless the child is suicidal or psychotic
• Some hospitals do not have inpatient beds for children or beds are full, so families may need to wait and/or transfer the child to another site, often after waiting hours to see a doctor at the ED
Defining a Mental Health Crisis

- Pumariega & Winters (2003) Identify six types:
  1. Danger to self or others
  2. Danger to the child from others
  3. The child is unable to maintain his or her own safety
  4. The child engages in serious substance abuse that places them or others at risk
  5. Environmental stressors that leave the child vulnerable
  6. Environmental supports decompensate and are no longer effective

Crises are determined by the timing of the behavior and resources available to adults. They decide when the child needs emergency services.

Caregiver Perspectives

“Rage attacks; Screaming, pounding of walls and doors”

“He was extremely aggressive – Breaking items, putting holes in the wall, threatening to harm the people in the house”

“Threatened suicide, self-injury, threatened siblings, extreme anger”
Caregiver Perspectives

“The waiting is the hardest part”

“One time we were in the ER at least 24 hours — longer than the admission. She was not able to get her current meds or her birth control”

“We were there three days waiting for a bed”

“Children end up in the hospital 24 to 36 hours until a bed opens”

“I sat in the emergency room three nights and three days with him before they found a bed for him”

Caregiver Perspectives

“The ER needs to be more educated and caring. They lack severely in empathy. They stigmatize people a lot. If a child is going through a crisis it is not the parent’s fault”

“I wanted the ER to listen to me since I am the parent and know my child best... You know your child better than anyone and everyone is quick to judge”

“Had to use key words to get help – threatening to commit suicide, a danger to others”

“Once you get past the gargoyle at the gate the care was wonderful”
Rising ED Admission Rates in Maryland

- After adjusting for inflation, costs for treating youth experiencing crises in hospitals increased 25% from FY 2007 to FY 2012 (from $52.3 million to $65.6 million)
- Total admissions by the youth’s county of origin rose 45% from FY 2007 to FY 2012 (from 7,635 total admissions to 11,078 total admissions)

FY 2007 to FY 2012 Trends in ED Admissions and/or Inpatient Hospitalizations
FY 2007 to 2012 Annual Trends in ED Admissions and Inpatient Hospitalizations

Data Source: The Hilltop Institute, UMBC. (2012). CHIPRA Year 3, DATA REQUEST #15: ER and Psychiatric Hospitalizations: Maryland Medical Assistance [Data file.] Provided to the Institute for Innovation & Implementation, University of Maryland School of Social Work under the CHIPRA Quality Demonstration Grant.

Map of Psychiatric Emergency Department Admission Changes: FY 2007 to 2012
Map of the Rate of Psychiatric Emergency Department Admissions, FY 2012, per 1,000 Medicaid Enrollees (Ages 0-21) and the Locations of Admissions by Hospital in FY2012

Crisis Response & Stabilization Redesign Workgroup

- CHIPRA Grant project staff established the Crisis Response and Stabilization Redesign Workgroup (“Crisis Workgroup”) in December 2011
Crisis Response & Stabilization Redesign Workgroup

- Developed a continuum of recommended essential core components of a crisis response and stabilization system, including a review of effective core crisis response and stabilization services within a continuum of care and integration of mental health and substance abuse crisis needs
- Conducted a gap analysis in partnership with the local Core Service Agencies to determine availability of recommended core services in each of the 24 jurisdictions in Maryland
- Assisted in designing a qualitative study to learn from families

Crisis Response & Stabilization Redesign Workgroup

- Overarching goals are to keep children and their families safe and to strengthen service capacity and access to a comprehensive crisis system
- Building a statewide comprehensive crisis system is expected to ultimately reduce:
  - utilization of EDs
  - unnecessary inpatient psychiatric hospitalizations
  - disruption of a youth’s home placements (i.e., family homes, foster homes, group homes)
  - response required by law enforcement

“Crisis services for mental health should be like a fire department with services available in every neighborhood. Anyone can experience a mental health crisis in their family” – Jane Walker
Recommended Core Services

Immediate Triage & Crisis Response Information
- Hotlines & Online Resources

Community-Based Crisis Response Services
- Mobile Crisis Response
- Psychiatric Urgent Care
- ED Diversion
- Emergency Respite
- Crisis Beds

Longer Term Crisis & Stabilization Services
- Care Coordination & Stabilization

Component #1 - Immediate Triage and Crisis Response Information:
- Hotlines and Online Resources
  - First available resource within a continuum of care
  - Provides preventative and initial crisis response resources, as well as triaging to determine if the individual is currently safe or whether further intervention is required
  - Includes technology services (i.e. online chat and support groups)
Component #2 – Community-Based Crisis Response Services:

• Mobile Crisis Response
  – A team of behavioral health qualified and trained clinicians that intervenes at the time of the crisis where the consumer is located (i.e. the youth’s home or school)
  – Evidence suggest that mobile crisis teams can reduce hospital admission by up to 50%, keep more patients in treatment, and mitigate issues of stigma for consumers and families (Joy, et al., 2008)

Component #2 – Community-Based Crisis Response Services:

• Urgent Care Services
  – Non-hospital based walk-in location where rapid access to licensed behavioral health clinicians is available
  – Example: Minnesota’s Mental Health Crisis Alliance, 2013
    • Cost-benefit analysis found that for every one dollar spent on crisis services, there was a savings of $2 - $3 in hospitalization costs
    • Use of outpatient mental health services increased significantly for low-frequency patients following stabilization
    • ED utilization decreased significantly post-crisis stabilization for all patients
Component #2 – Community-Based Crisis Response Services:

• Emergency Respite
  – a safe environment (i.e. residential or group home) designed to provide a temporary break for caregivers of youth with serious behavioral health needs for up to two weeks

• Crisis Beds
  – Hospital-based 23-hour observation beds or non-hospital based overnight beds available to stabilize acute crises and prevent inpatient hospitalizations

Component #2 – Community-Based Crisis Response Services:

• Emergency Department Diversion Programs
  – Clinic or facility-based interventions that divert youth from accessing the ED for de-escalation or initial services
  – Example: Baltimore Child and Adolescent Response System (B-CARS)

  • Lower rates of psychiatric inpatient service use and ED visits in the three months after ED Diversion Program discharge compared to the three months prior to B-CARS ED Diversion enrollment
  • Saved between $4,118 and $12,919 per person in inpatient costs and $407 to $2,146 in ED costs over a 3 month period (B-CARS, 2014)
Component #3- Longer Term Crisis/Stabilization Services:

• Care Coordination and Stabilization
  – longer-term, community-based interventions intended to provide stabilization support and to prevent future crises
  – Based on Wraparound Model and principles
  – Services available for up to 90 days

Case Study: Texas

• In 2007, $82 million were appropriated by the legislature to address gaps in the state’s behavioral health crisis service delivery system
  – Crisis hotlines
  – Mobile crisis teams
  – Psychiatric urgent care
  – Emergency respite
• Findings:
  – More services provided (4.6 services per consumer pre-redesign compared to 6.1 two years later)
  – Declining hospitalization (1 of every 6 crisis episodes resolved via hospitalization pre-redesign, compared to 1 of every 8 post-redesign)
  – Increased access to all types of crisis services
  – Direct and measurable cost savings ($1.16 to $4.51 return on every dollar invested)
Gap Analysis Method

Factors Included:

• Rate of crisis episodes by county of origin: Measured as the number of youth ages 0 to 21 with a psychiatric admission per total population of Medicaid-enrolled youth ages 0 to 21
• Rate of crisis episodes by location of psychiatric admission: Measured as the total number of psychiatric admissions among all hospitals for a given jurisdiction per total population of Medicaid-enrolled children, youth, and young adults, ages 0 to 21
• Number of essential crisis system components available: Measured as the total number (range of 0 to 7) of essential crisis system services serving the jurisdiction
• Ratio of providers of essential crisis services to crisis episodes: Measured as the number of providers serving the jurisdiction to the number of crisis episodes occurring in that jurisdiction (by county of origin of the children and youth)

• A higher Z score indicates greater need for crisis response services relative to other counties, while a lower Z score indicates less of a need for services
• Z-score distribution rescaled 1-10 to rank counties’ relative need for crisis response services
Map of Rank of Relative Need for Crisis Services, by Jurisdiction

Recommendations

• Expand community crisis response and stabilization services, including
  – Immediate triage and crisis response information
  – Community-based crisis response services
  – Longer term services

• While the above services need to be available throughout the entire State, the jurisdictions identified by the gap analysis as having the greatest need could be targeted for more intensive expansion efforts
Recommendations

• Statewide promotion, training and quality assurance of crisis programs
  – Design and execute a statewide crisis response training and coaching model
  – Develop and implement training and coaching program for all system partners to include law enforcement, school, and hospitals
  – Implement a CQI program which ensures collection, analysis and dissemination of key data elements

Recommendations

• Streamline behavioral crisis triage response in MD
  – Using existing or reconfigured hotline call centers, develop a coordinated statewide response system for screening, triaging and dispatching CRTs
  – Explore and test an ED Diversion model that required all psychiatric inpatient admissions first be assessed and authorized by a CRT
  – Work with local jurisdictions to ensure that hotline call centers are able to provide a bridge between triage response and service available in each local community
References


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