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ABSTRACT

This document is part of a series of monographs on community-based services for children and adolescents who are severely emotionally disturbed. The series is the product of a national study of community-based service approaches which identified over 200 programs serving emotionally disturbed children and included visits to several programs representing a variety of service delivery approaches. This volume begins with a presentation of a model system of ca~ along with principles for service delivery. A review of crisis services is then presented, focusing on: history; philosophy and goals; characteristics; variables such as hospital affiliation, integration with a larger network of services, and staffing credentials and patterns; specific services such as referrals, intake, evaluation, assessment, crisis intervention, and follow-up; linkages; clients; staffing; resources; evaluation; and major advantages and challenges. Three programs are then described in detail, including: Adolescent Crisis Team and Respite House (Quincy, Massachusetts); Children's Crisis Intervention Service (Sicklerville, New Jersey); and Huckleberry House (Columbus, Ohio.) One-page profiles of 15 other crisis service programs complete the volume. References accompany the first two chapters. (JDD)

Series on Community-Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed

VOLUME II: CRISIS SERVICES

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CASSP Technical Assistance Center
Georgetown University Child Development Center
Funded by the National Institute of Mental Health
Child and Adolescent Service System Program (CASSP)

SERIES ON COMMUNITY-BASED SERVICES FOR CHILDREN & ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED:

VOLUME II: CRISIS SERVICES

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Middlebury, VT

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Lee Mental Health Center
Fort Myers, FL

Homebuilders
Behavioral Sciences Institute
Federal Way, WA

Huckleberry House
Columbus, OH

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The Pressley Ridge Schools
Pittsburgh, PA

Satellite Family Outreach Program
Kaleidoscope
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Ventura County Children's Mental Health Demonstration Project
Ventura County Mental Health Department
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Wake County Juvenile Treatment System
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Family and Children's Services of the Kalamazoo Area
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PREFACE

The system of care for severely emotionally disturbed children and adolescents has been of great interest over the last several years. The conceptualization of this system has been a major focus in the advancement of the availability and appropriateness of services for this underserved population. In 1982, Jane Knitzer estimated in her seminal study, Unclaimed Children, that of the three million children with serious emotional disturbances in this country, two million were receiving no treatment whatsoever and countless others were receiving inappropriately restrictive care because of the lack of community-based service alternatives. Knitzer documented that only 21 states had a child and adolescent administrative unit within their departments of mental health and asserted that this dearth of leadership, lack of appropriate child mental health services, and fragmentation of systems has resulted in literally millions of children with serious emotional problems "falling through the cracks."

In 1986, Leonard Saxe performed a study for the Office of Technology Assessment (OTA) of the United States Congress, which confirmed Knitzer's findings. Saxe introduced this report, Children's Mental Health: Problems and Services, to Congress with the statement: "Mental health problems are a source of suffering for children, difficulties for their families, and great loss for society. Though such problems are sometimes tragic, an even greater tragedy may be that we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available." Saxe presented three major conclusions:

- Many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively.

- A substantial theoretical and research base suggests that, in general, mental health interventions for children are helpful.

- Although there seem to be shortages in all forms of children's mental health care, there are particular shortages of community-based services, case management, and coordination across child service systems.

Even before the OTA study, Congress responded to these problems and to growing calls for change from the field, by funding, in 1984, an initiative to demonstrate the development of better functioning service systems. This effort led the National Institute of Mental Health to develop the Child and Adolescent Service System Program (CASSP). CASSP now supports 42 states in the development of interagency efforts to improve the systems under which the most troubled children and youth receive services. Through state and community level grants, the agencies that serve these youngsters -- mental health, health, social welfare, juvenile justice and special education -- are brought together to develop system change processes.

As states began struggling with system change, a number of critical questions evolved:

- What should a service system for children with serious emotional problems encompass?

- Toward what new configuration or ideal should service system change be directed?

- What are the components of the system?

- What is the ultimate goal of such systems change?

To provide a conceptual framework for the field and to answer these questions, CASSP supported the publishing of A System of Care for Severely Emotionally Disturbed Children and

Youth by Beth Stroul and Robert Friedman in 1986. This monograph has been called a blueprint for action in the child mental health field.

Stroul and Friedman described the various service options required by these youths and the need for continuums of care across all of the relevant child-serving agencies. From these components, they proposed a design for a greater "System of Care" encompassing both the full range of services and the mechanisms required for the assurance of their appropriate delivery.

The System of Care monograph describes a continuum of mental health services for severely emotionally disturbed children and adolescents. This continuum includes a group of important nonresidential service options that have been under-represented in states and communities. In order to assist states and communities that wish to develop a full system of care, CASSP initiated a major study on family-centered and community-based services for children and adolescents with serious emotional disturbance, which has resulted in this series of monographs.

This new series, which includes four volumes focusing on home-based services, crisis services, therapeutic foster care, and systems of care, complements the System of Care monograph as well as an earlier CASSP publication, Profiles of Residential and Day Treatment. Beth Stroul and Sybil Goldman have performed an extraordinary task in reviewing information on hundreds of community-based programs, in synthesizing this information, and in analyzing current treatment practices and service delivery strategies utilized within each of the three service modalities mentioned above. They have produced a truly "state-of-the-art" series on home-based services, crisis services, and therapeutic foster care. In addition, they have described in clear and direct prose three actual communities that have attempted to design and implement well-functioning systems of care for children with serious emotional problems and their families. This series constitutes a major contribution to the field and should be of great interest to program administrators at both the state and community levels, to service providers, to parents, and to advocates -- to all those interested in improving or developing community-based service options for these children and youth.

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INTRODUCTION

This document is part of a series of monographs on community-based services for children and adolescents who are severely emotionally disturbed published by the Child and Adolescent Service System Program (CASSP) Technical Assistance Center at Georgetown University. This series is the product of an extensive national study of community-based service approaches for this population and includes the following volumes:

Volume I: Home-Based Services
Volume II: Crisis Services
Volume III: Therapeutic Foster Care
Volume IV: Systems of Care

There is broad agreement that comprehensive, community-based systems of care for youngsters who are severely emotionally disturbed and their families are needed, and the development of these systems has become a national goal. Many communities offer the more traditional components of the system of care, such as outpatient, inpatient, and residential treatment services. However, there are a growing number of promising and innovative treatment approaches emerging in the field, and there is a tremendous need for information about these service alternatives. The study of community-based services, funded by the National Institute of Mental Health Child and Adolescent Service System Program, was designed to identify and describe three types of services -- home-based services, crisis services, and therapeutic foster care.

The study was conducted from 1986 to 1988 and initially involved a survey of over 650 organizations and individuals requesting that they identify programs providing home-based services, crisis services, and therapeutic foster care to a population of severely emotionally disturbed children. The initial survey resulted in the identification of approximately 200 programs across the nation. An extensive questionnaire then was sent to all identified programs in order to gather detailed information about their organization, philosophy, services, client population, staffing patterns, costs, sources of financing, evaluation results, problems encountered, and other aspects of their programs. Responses were received from more than 80 programs in 36 states, and a one-page profile summarizing major characteristics was prepared for each respondent program.

With the assistance of an advisory committee, several programs in each category were selected for in-depth study through site visits. The programs were selected with the goal of maximizing variation along key dimensions, including different service approaches and treatment philosophies, geographic regions, types of communities, and age groups or minority populations served. Additionally, an attempt was made to select programs that exemplify the core values and guiding principles for the system of care described in Chapter I of this document. The programs selected for site visits were not necessarily considered "model" programs. Rather, they were selected to serve as examples of a variety of service delivery approaches. There are, of course, a great many other programs in the field which are also extremely effective in providing these types of services to troubled children and their families.

In addition to site visits to programs in each of the service categories, the advisory committee recommended visiting three communities that appeared to have a wide array of service components in place as well as effective mechanisms for linking and integrating these services into a coordinated system of care. Three-day site visits were conducted in order to become immersed in the programs in an attempt to determine what makes them successful. The site visits involved observation of program activities and extensive meetings and discussions with

program administrators, staff at all levels, staff from other community agencies, parents, foster parents, and children.

The analysis phase of the project involved synthesizing the information obtained from the survey, site visits, and literature review in each of the service categories. This monograph series represents the major study product, each volume providing a descriptive overview of the service approach, case studies of the programs visited, and profiles of the programs responding to the survey. The monographs are designed to provide information that will be helpful to state and community agencies, advocates, and others who are interested in developing these types of programs.

I. A SYSTEM OF CARE FOR CHILDREN AND ADOLESCENTS WHO ARE SEVERELY EMOTIONALLY DISTURBED

In her book Unclaimed Children, Knitzer (1982) reported that two-thirds of all children and youth who are severely emotionally disturbed do not receive the services they need. Many others receive inappropriate, often excessively restrictive, care. Recently, there has been increasing activity to improve services for children and adolescents who are severely emotionally disturbed. In 1984, with funding appropriated by Congress, the National Institute of Mental Health (NIMH) launched the Child and Adolescent Service System Program (CASSP) to assist states and communities to develop comprehensive, community-based systems of care for emotionally disturbed youth and their families. Coalitions of policymakers, providers, parents, and advocates currently are being forged across the nation to promote the development of such systems.

This chapter presents a model system of care along with principles for service delivery. The model and principles were developed through a project sponsored by CASSP with broad input from the field (Stroul & Friedman, 1986). The model offers a conceptual framework to provide direction to policymakers, planners, and providers. Individual service components, such as those described in this series, should be considered in the context of the overall system of care.

BACKGROUND

Nearly two decades ago, the Joint Commission on the Mental Health of Children (1969) found that millions of children and youth were not receiving needed mental health services and that many others received unnecessarily restrictive care, often in state mental hospitals. The President's Commission on Mental Health (1978) echoed the Joint Commission's conclusions, finding that few communities provided the volume or continuum of programs necessary to meet children's mental health needs. Both Commissions recommended that an integrated network of services be developed in communities to meet the needs of children and youth who are severely emotionally disturbed. Knitzer (1982) asserted that the needs of severely emotionally disturbed children have remained largely unaddressed. She considers these children to be "unclaimed" by the public agencies with responsibility to serve them. Most recently, the Office of Technology Assessment (OTA) of the United States Congress (1986) found that many children do not receive the full range of necessary and appropriate services to treat their mental health problems effectively. The OTA report stated that it is a tragedy that "we currently know more about how to prevent and treat children's mental health problems than is reflected in the care available."

These reports and others have made it apparent that the range of mental health and other services needed by children and adolescents who are severely emotionally disturbed is frequently unavailable. Many children are institutionalized when less restrictive, community-based services would be more effective. Additionally, there have been few attempts to get mental health, child welfare, juvenile justice, health, and education agencies to work together on behalf of disturbed children and youth. This has left children and youth who have serious and complex problems to receive services in an uncoordinated and piecemeal fashion, if at all.

Currently, there is broad agreement about the critical need to improve the range, appropriateness, and coordination of services delivered to severely emotionally disturbed children and their families. The development of comprehensive, coordinated, family-centered, and community-based "systems of care" for children and youth has become a national goal.

The term "continuum of care" has been used extensively in the field to describe the range of services needed by children and adolescents who are severely emotionally disturbed. Throughout this document, the term "system of care" is employed. "Continuum of care" generally denotes a range of services or program components at varying levels of intensity. These are the actual program elements and services needed by children and youth. "System of care" has a broader connotation. It not only includes the program and service components, but also encompasses mechanisms, arrangements, structures, or processes to insure that the services are provided in a coordinated, cohesive manner. Thus, the system of care is greater than the continuum, containing the components **and** provisions for service coordination and integration.

A system of care, therefore, is defined as follows:

> **A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents who are severely emotionally disturbed and their families.**

This chapter describes how these systems of care might look and the values and philosophy that should guide service delivery.

PRINCIPLES FOR THE SYSTEM OF CARE

The system of care concept represents more than a network of service components. Rather, it represents a **philosophy** about the way in which services should be delivered to children and their families. The actual components and organizational configuration of the system of care may differ from state to state and from community to community. Despite such differences, all systems of care should be guided by a set of basic values and operational philosophies.

There is general agreement in the field as to the values and philosophy which should be embodied in a system of care for youth who are severely emotionally disturbed. With extensive consultation from the field, two core values and a set of ten principles have been developed to provide a philosophical framework for the system of care model.

The two core values are central to the system of care and its operation. The first value is that the system of care must be driven by the needs of the child and his or her family. In short, the system of care must be **child-centered**, with the needs of the child and family dictating the types and mix of services provided. This child-centered focus is seen as a commitment to adapt services to the child and family rather than expecting the child and family to conform to pre-existing service configurations. It is also seen as a commitment to provide services in an environment and a manner that enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services.

Implicit in this value is that the system of care is also **family-focused**. In most cases, parents are the primary care givers for children with severe emotional disturbances, but efforts to work with and support families are frequently lacking. Parents often feel blamed, isolated, frustrated, disenfranchised, and shuffled from agency to agency, provider to provider. The system should be committed to supporting parents as care givers through services, support, education, respite, and more. There should also be a strong commitment to maintaining the integrity of the family whenever possible. Recent experience has confirmed that intensive services provided to the child and family can minimize the need for residential treatment, and that residential placements of all types are overutilized (Behar, 1984; Friedman & Street, 1985; Knitzer, 1982; Stroul & Friedman, 1986; United States Congress, 1986).

The second core value holds that the system of care for emotionally disturbed children should be **community-based**. Historically, services for this population have been limited to state hospitals, training schools, and other restrictive institutional facilities. There has been increasing interest and progress in serving such children in community-based programs which provide less restrictive, more normative environments. The system of care should embrace the philosophy of a community-based, family-centered network of services for emotionally disturbed youth. While "institutional" care may be indicated for certain children at various times, in many cases appropriate services can be provided in other, less restrictive settings within or close to the child's home community.

In addition to these two fundamental values for the system of care, ten principles have been identified which enunciate other basic beliefs about the optimal nature of the system of care. The values and principles are displayed on the following page.

SYSTEM OF CARE FRAMEWORK AND COMPONENTS

The system of care model presented in this chapter represents one approach to a system of care. No single approach as yet has been adequately implemented and tested to be considered the ideal model. The model presented is designed to be a guide and is based on the best available empirical data and clinical experience to date. It is offered as a starting point for states and communities as they seek to build their systems, as a baseline from which changes can be made as additional research, experience, and innovation dictate.

The system of care model is organized in a framework consisting of seven major dimensions of service, each dimension representing an area of need for children and their families. The framework is presented graphically on the following page and includes the following dimensions:

1. Mental health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Operational services

The system of care model is intended to be **function-specific** rather than agency-specific. Each service dimension addresses an area of need for children and families, a set of functions that must be fulfilled in order to provide comprehensive services to meet these needs. The model is **not** intended to specify which type of agency should fulfill any of the particular functions or needs. Certainly, particular agencies typically provide certain of these services. Educational services, for example, are provided most often by school systems, and social services generally are associated with child welfare or social welfare agencies. One might assume that the mental health services should be provided by mental health agencies. This, however, is often not the case.

All of the functions included in the system of care dimensions may be fulfilled by a variety of agencies or practitioners in both the public and private sectors. Therapeutic group care, a component in the mental health dimension, often is fulfilled by juvenile justice agencies and social service agencies as well as by mental health agencies. Day treatment is another mental health function that is frequently fulfilled by educational agencies, ideally in close collaboration with mental health providers.

CORE VALUES FOR THE SYSTEM OF CARE

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

GUIDING PRINCIPLES FOR THE SYSTEM OF CARE

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

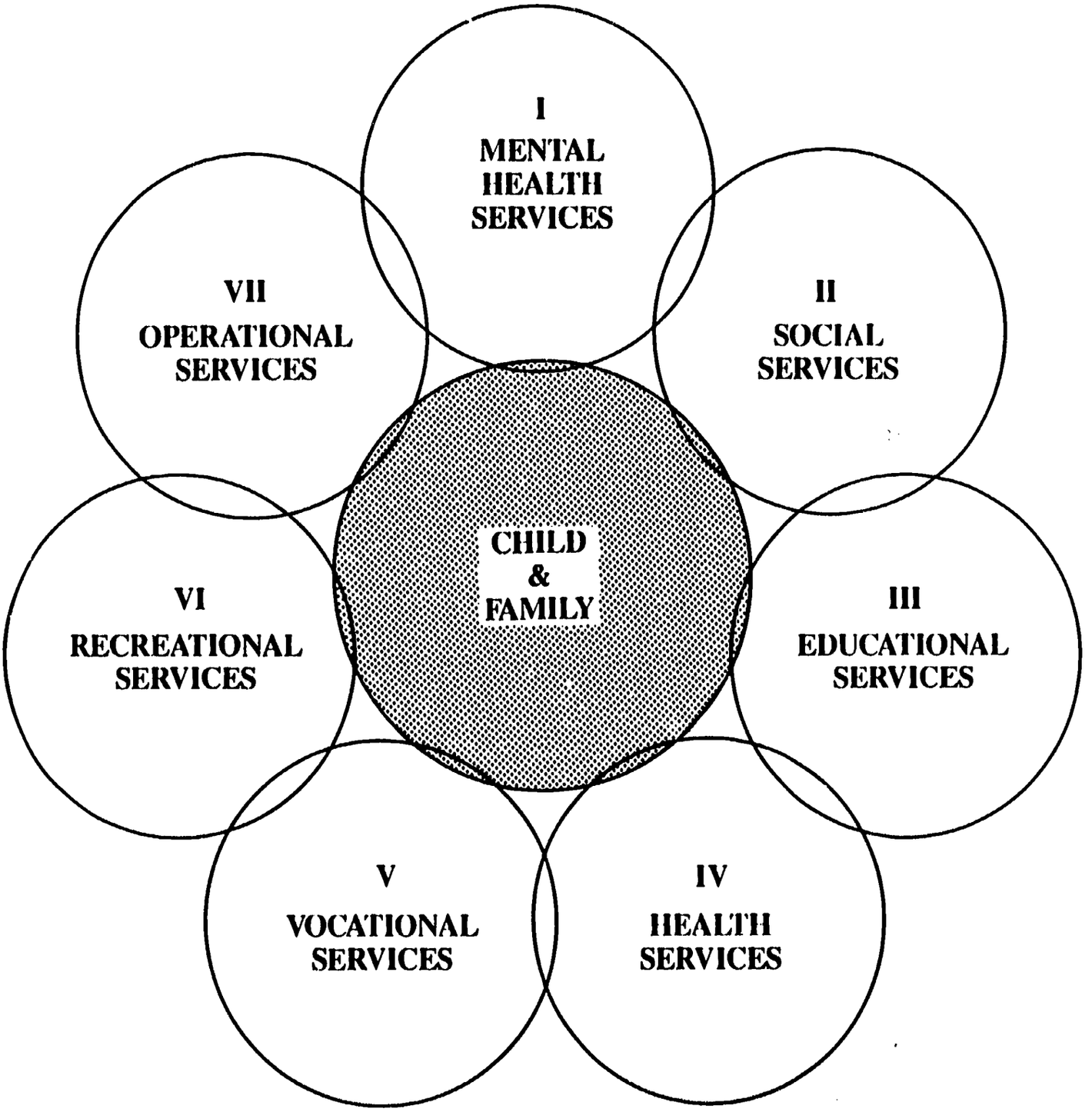
7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Emotionally disturbed children should be ensured smooth transitions to the adult service system as they reach maturity.

9. The rights of emotionally disturbed children should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Emotionally disturbed children should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

SYSTEM OF CARE FRAMEWORK



While the roles and responsibilities of specific agencies are acknowledged, many of the services can be, and are, provided by different agencies in different communities. Furthermore, many of these services are provided not through the efforts of any single agency but through multi-agency collaborative efforts. Such collaborations are important not only in identifying needs and planning services but also in developing, funding, and operating services. It should also be recognized that services are not always provided by agencies. Some functions within the system of care may be fulfilled by families, parent cooperatives, or other arrangements. In addition to public sector agencies and staff, private sector facilities and practitioners can play a pivotal role in the system of care, providing a wide range of services within each of the major dimensions. Additionally, juvenile justice agencies play an important role in the system of care by providing a wide range of services to children and adolescents who have broken the law (Shore, 1985).

An important aspect of the concept of a system of care is the notion that all components of the system are interrelated and that the effectiveness of any one component is related to the availability and effectiveness of all other components. For example, the same day treatment service may be more effective if embedded in a system that also includes good outpatient, crisis, and residential treatment than if placed in a system where the other services are lacking. Similarly, such a program will be more effective if social, health, and vocational services are also available in the community than if they are absent or of low quality. In a system of care, all of the components are interdependent -- not only the components within a service dimension such as mental health, but all of the seven service dimensions that comprise the model.

Within each of the seven service dimensions is a continuum of service components. These dimensions and the components within them are displayed on the following page. Of primary importance is the dimension of mental health services since these are critical services for all children who are severely emotionally disturbed. These services are divided into seven nonresidential categories and seven residential categories. When considering the individual services, it should be recalled that these are component parts of an overall system of care. The boundaries between the various dimensions and components are not always clear, and frequently there is overlap among them. While they are listed individually, the system of care dimensions and service components cannot be operated in isolation. Only when the services are enmeshed in a coherent, well-coordinated system will the needs of severely emotionally disturbed youngsters and their families be met in an appropriate and effective manner.

A critical characteristic of an effective system is an appropriate balance between the components, particularly between the more restrictive and less restrictive services. If such balance is not present, then youngsters and families will not have a chance to receive less restrictive services before moving to more restrictive services. If, for example, within a community there are no intensive home-based services, only 20 day treatment slots and 50 residential treatment slots, the system is not in balance. Most likely, youngsters and families will have no opportunity to participate in home-based or day treatment services because they are relatively unavailable, and the residential components of the system will be overloaded with youngsters, some of whom might have been diverted from residential treatment if there had been more nonresidential services available.

At the present time there are no clear, empirically-based guidelines about the appropriate capacity within each component of a system of care. Implicit within a model system of service, however, is the expectation that more youngsters will require the less restrictive services than the more restrictive ones, and that service capacity, therefore, should diminish as one proceeds through the system. As additional research and field experience are accumulated on systems of care for severely emotionally disturbed children, it may become

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

Nonresidential Services:

Prevention
Early Identification & Intervention
Assessment
Outpatient Treatment
Home-Based Services
Day Treatment
Emergency Services

Residential Services:

Therapeutic Foster Care
Therapeutic Group Care
Therapeutic Camp Services
Independent Living Services
Residential Treatment Services
Crisis Residential Services
Inpatient Hospitalization

2. SOCIAL SERVICES

Protective Services
Financial Assistance
Home Aid Services
Respite Care
Shelter Services
Foster Care
Adoption

3. EDUCATIONAL SERVICES

Assessment & Planning
Resource Rooms
Self-Contained Special Education
Special Schools
Home-Bound Instruction
Residential Schools
Alternative Programs

4. HEALTH SERVICES

Health Education & Prevention
Screening & Assessment
Primary Care
Acute Care
Long-Term Care

5. VOCATIONAL SERVICES

Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement
& Retention Services
Supported Employment

6. RECREATIONAL SERVICES

Relationships with Significant Others
After School Programs
Summer Camps
Special Recreational Projects

7. OPERATIONAL SERVICES

Case Management
Self-Help & Support Groups
Advocacy
Transportation
Legal Services
Volunteer Programs

possible to define the optimal ratios of capacities in the different system components (Friedman, 1987).

The operational services dimension is somewhat different from the other system of care dimensions. This dimension includes a range of support services that can make the difference between an effective and an ineffective system of care but do not fall into a specific category. Instead, they cross the boundaries between different types of services. They are called "operational services" because of their importance to the overall effective operation of the system. The services included in this dimension are case management, self-help and support groups, advocacy, transportation, legal services, and volunteer programs.

Case management is a service within this dimension that can play a critical role in the system of care. Behar (1985) calls case management "perhaps the most essential unifying factor in service delivery." The important role that case management can play in a system of service has been increasingly recognized in recent years but has been operationalized in only a few states.

Case management can be provided to youngsters in both residential and nonresidential programs. It involves brokering services for individual youngsters, advocating on their behalf, insuring that an adequate treatment plan is developed and implemented, reviewing client progress, and coordinating services. Case management involves aggressive outreach to the child and family, and working with them and with numerous community agencies and resources to ensure that all needed services and supports are in place. One important trend in serving emotionally disturbed children is to combine specialized case management with the availability of flexible funds to secure the specific mix of services and supports needed by each individual child and family on a case-by-case basis (Update, 1986).

Advocacy can also play a critical role in the system of care. "Case" advocacy, or advocacy on behalf of the needs of individual children, is needed as well as "class" advocacy, or advocacy on behalf of a group of children. Class advocacy, if successful, can have a greater impact than case advocacy because it can produce changes that affect more children (Knitzer, 1984). Efforts to advocate for improved services are beginning to take the form of coalitions of parent, provider, professional, and voluntary advocacy organizations. These coalitions are forming at community, state, and national levels and are beginning to provide a much needed voice in support of system of care development.

The increased interest in advocacy is one of the more encouraging signs in the children's mental health field in recent years. A key issue affecting the degree to which effective systems of care will be developed is the extent to which strong, persistent, and well-targeted advocacy efforts can be developed.

SERVICE DEVELOPMENT

The model described in this chapter can be used as a guide in planning and policymaking and provides a framework for assessing present services and planning improvements. It can be conceptualized as a blueprint for a system of care which establishes directions and goals. States and communities should revise and adapt the model to conform with their needs, environments, and service systems. The model also must be regarded as flexible, with room for additions and revisions as experience and changing circumstances dictate.

Most important is the acknowledgement that conceptualizing a system of care represents only a **preliminary** step in the service system improvement process. Development of a system of care model is a planning task which must be followed by implementation activities. While

designing a system of care is an essential and challenging task, the real challenge for states and communities is to transform their system of care plans into reality.

Using the framework that the mental health dimension of this model provides, it is apparent that many communities are able to provide the more traditional services to emotionally disturbed children and their families, services such as outpatient services, inpatient services, and services in residential treatment centers. The service gaps generally include some of the more innovative service approaches such as home-based services, intensive day treatment, therapeutic foster care, crisis services, case management, and support services such as respite care.

Because these types of services frequently are lacking in communities, the study of community-based service approaches was initiated by the CASSP Technical Assistance Center at Georgetown University. The intent of the project was to develop and disseminate detailed information about specific service delivery approaches in order to assist states and communities in their efforts to implement similar programs. Thus, this series is designed to provide the tools for policymakers, planners, providers, parents, and advocates to translate their system of care plans into reality.

The three service components selected for study and described in the series are home-based services, crisis services, and therapeutic foster care. Home-based services are counseling, support, and case management services provided on an outreach basis to work intensively with severely emotionally disturbed children and their families in their homes. Many home-based service programs are crisis-oriented, intervening during crisis situations in which the child is in imminent danger of placement in an out-of-home setting. These programs work intensively with families on a relatively short-term basis with the goal of stabilizing the child and family and connecting them with ongoing services as needed. Other programs have developed longer term home-based interventions to work more extensively with families. Some of these programs are based on the assumption that families can benefit from a long and stable association with a professional. Some of the major characteristics of home-based services include the following:

- The intervention is delivered primarily in the family's home.
- The intervention is multifaceted and includes counseling, skill training, and helping the family to obtain and coordinate necessary services, resources, and supports.
- Staff have small caseloads to permit them to work actively and intensively with each family.
- The programs are committed to empowering families, instilling hope in families, allowing families to set their own goals and priorities and assisting them to achieve these.

Crisis services for children and adolescents involve numerous types of agencies, services, settings, and personnel that respond to crisis situations. The range of services includes crisis telephone lines, often specialized for particular types of problems such as suicide or substance abuse; walk-in and outpatient crisis intervention services; mobile crisis outreach services including home-based services and emergency medical teams; and crisis residential services including runaway shelters, crisis group homes, therapeutic foster homes used for short-term crisis placements, and crisis stabilization units. Inpatient hospitalization services of various types are seen as back-up to these other types of crisis services, to be used when other approaches are not adequate for responding to particular situations.

The underlying goals of virtually all of the crisis programs identified in the study were to assist children and adolescents and their families to resolve crises and to avert hospitalization. Despite diverse approaches and settings, there are many similarities among crisis programs for children with emotional disturbances:

- o They intervene immediately.
- o They provide brief and intensive treatment.
- o They focus treatment on problem solving and goal setting.
- o They involve families in treatment.
- o They link clients and families with other community services and supports.

Because crisis services provide brief, intense interventions, they generally are followed by other services. Thus, it is critical for crisis programs to maintain strong and effective linkages with all other components within the overall system of care.

Therapeutic foster care is considered the least restrictive, most normalizing of the residential options within the system of care. There is much controversy over what therapeutic foster care should be called -- foster family-based treatment, special foster care, individualized residential treatment, and other labels. The primary concern is differentiating therapeutic foster care, which is a form of **treatment** for troubled children, from regular foster care. Therapeutic foster home programs report that they successfully serve some of the most severely disturbed youngsters in home settings, some youngsters that could not be managed in the most restrictive, highly supervised institutional settings.

Therapeutic foster care usually involves:

- o Recruitment of treatment parents specifically to work with emotionally disturbed children. Treatment parents are seen as the primary therapeutic agents.
- o Provision of specialized training to the treatment parents to assist them in working with emotionally disturbed children and creation of a support system among the treatment parents.
- o Payment of a special stipend to the treatment parents significantly higher than the rate of payment for regular foster care.
- o Staff who work closely with each child and treatment family and usually assume both clinical and case management roles.
- o Counseling, support, and other forms of assistance to biological families.

Therapeutic foster care programs can be flexible and can easily individualize the treatment approach and program for each child. They can serve both sexes, children of different ages, and children with a wide variety of problems. Some therapeutic foster care programs offer more intensive versions for children with the most severe problems. These involve hiring a human service professional to serve as the treatment parent and provide full-time, one-on-one care for a severely disturbed child or utilizing rotating shifts of foster parent assistants to provide intensive, continuous care and supervision in context of the therapeutic foster home.

While each volume of the series describes a particular service component, the interdependence of all system components should be kept in the forefront. No one service or program can meet the complex needs of emotionally disturbed children and their families. Thus, it may not be wise to devote all available resources to developing one or two services without considering the entire system. Each of the services described in this series must be part of a comprehensive, coordinated system of care which is dedicated to meeting the multiple and changing needs of severely emotionally disturbed youngsters and their families. Volume IV of this series describes the efforts of several communities to link a vareity of service components into well coordinated systems of care.

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II. CRISIS SERVICES

INTRODUCTION

Crisis services, as the name implies, are those services available to an individual who is in crisis. The causes and nature of crises are varied, and, as a result, a number of systems serving children and their families, as well as adults, include crisis services as a part of their service delivery programs. Various types of crisis services and interventions are provided by the following systems: health, public safety, mental health, child welfare, juvenile justice and, to a significantly lesser degree, education.

Because the provision of crisis services is so important and because a number of service systems incorporate such services into their overall delivery system, it would be logical to assume that crisis services would be the most well developed and coordinated component of a system of care. Unfortunately, this is not the case. What has evolved for children and youth in crisis and their families is a fragmented, patchwork set of services cutting across various service systems.

It is difficult to discuss crisis services generically because there are so many variables: the systems involved, the underlying factors that cause individuals to experience crises, the presenting problems and the types of services, programs and settings available to people in crisis. Different terminology such as emergency services, crisis services, crisis intervention and crisis stabilization is also used. In this report the term crisis services is used to encompass all these terms.

The onset of a crisis can be produced by psychological, social, physiological or environmental factors, or a combination of these forces. Individuals can experience a crisis in response to events in the life cycle, such as a change in family structure, or in response to developmental changes and stresses. Some of these events may be part of the normal course of living and others may be of a more extreme nature, such as the death of a parent for a child or adolescent. Some children and families move from crisis to crisis because of chaotic lives marked by poverty, poor health, and other social stresses. Some children are in crisis because they are victims of violence, abuse and neglect. Various types of mental and physical illness can result in, or be exacerbated by, a crisis. According to Stroul and Friedman (1986), youngsters who are basically well functioning as well as youngsters with long term, serious problems may require crisis services for periodic or acute episodes. The presenting problem can manifest itself in various ways and can include suicidal threats or attempts, depression, behavior that is aggressive, hostile or destructive towards others, running away, substance abuse or psychotic behavior.

There are numerous types of agencies, services, settings and personnel that respond to crises. The range of services can include crisis hotlines, often specialized for particular types of problems such as suicide or substance abuse; mobile crisis outreach services, including home-based services and emergency medical teams; walk-in and "outpatient" crisis intervention services; runaway shelters; crisis group homes; therapeutic foster care programs; crisis stabilization units; hospital emergency rooms; and inpatient services in general hospitals or special psychiatric facilities. Treatment approaches of these different services and settings may vary depending on agency auspice, program administration, philosophy and the predominant source of funding. All of these services can be critical to a crisis response system, especially if they are coordinated and linked in an effective manner.

The personnel providing crisis services are also diverse and cut across service systems. Hospital emergency room staff, emergency medical technicians, the police and child welfare

personnel frequently are on the front lines responding to a wide variety of crises, including family crises and crises of a psychiatric nature. The role these personnel play is vital as part of a crisis system. Staff in the different service settings also bring diverse backgrounds, experiences and training to the range of crisis programs.

The focus of this report is on the mental health system and its linkages with other providers and systems to provide crisis intervention and stabilization services to children and adolescents who are severely emotionally disturbed and to their families. In keeping with the principles of CASSP, the focus is also on community-based services. This emphasis is not to minimize the importance of acute hospital inpatient services, only to stress the need for other alternatives as part of a continuum of crisis services so that acute hospitalization is utilized appropriately. Although home-based services and therapeutic foster care are integral components of this crisis continuum, both are more fully discussed in the volumes related to these specific topics.

It is important to note that the information available on crisis programs for children and adolescents is sparse, perhaps reflecting the state of the art in the field. The lack of published and unpublished literature also may be attributed to the reality that those providing crisis intervention services do not have the time to write about what they do. While there are isolated articles describing individual types of services, there is virtually nothing in the literature that examines in a comprehensive way the range of crisis services that are a necessary part of a system for children and adolescents and their families. Additionally, few programs were recommended or responded to the survey for this study. This discussion is a first step in taking a more comprehensive look at crisis services for children and adolescents who are severely emotionally disturbed. It is based on limited survey data, site visits to three different programs, available literature and telephone interviews with selected programs across the country.

HISTORY

Within the field of mental health, crisis services have undergone several major evolutions. The development of crisis services has basically followed two tracks: 1) crisis services as part of an outpatient delivery system, and 2) emergency/crisis care within inpatient hospital settings. This two-track development has exacerbated the fragmentation of services that currently exists. While the focus of crisis services, as with all mental health services, has been primarily on the provision of services for an adult population, the overall trends and development of services for children have been similar.

Traditionally, hospitals -- public mental hospitals, private psychiatric hospitals, and to a lesser degree, community hospitals -- have provided emergency psychiatric services. But while hospitals continue to be major providers, there has been a growing movement and acceptance among mental health professionals working in both hospital and community settings of the importance of "crisis intervention" on an outpatient basis as an effective mental health approach.

Crisis intervention had its roots in the 1940s with the work of Erich Lindemann and his colleagues, who conducted a seminal study of bereavement after a fire in Boston caused the unexpected deaths of a number of young adults (Lindemann, 1944). This and other early studies provided the basis for the mental health profession's understanding and development of crisis theory and practice. In the 1950s and 1960s, there were a number of pioneer programs that provided services and training in crisis intervention (Caplan, 1961; Jacobson, 1980).

In 1963, the Community Mental Health Centers (CMHC) Act established emergency services as one of five essential programs (emergency, outpatient, inpatient, partial hospitalization,

consultation and education) to be provided in order to be eligible for federal funding. As a result, mental health catchment areas developed and implemented plans for the provision of emergency mental health services for their populations. Most CMHCs, however, did not develop adequate services in any of these programmatic areas for children and adolescents, especially youth who were severely emotionally disturbed.

The 1960s also witnessed the development of so-called alternative mental health services such as drop-in centers, runaway shelters, free clinics and hotlines. Most of the early alternative services were founded and staffed by activists and community workers -- both professionals and others without professional credentials -- as a response to the physical and emotional needs of young people who, in the mid to late 1960s, migrated to their communities (Gordon, 1978). A number of elements were characteristic of these alternative programs: immediate access to care with a minimum of bureaucratic restrictions; focus on the individual as part of a larger social system; use of mental health professionals as back-up and "paraprofessionals" as primary deliverers of care; emphasis on the individual's capacity for self-help; avoidance of labels and stigmatization; and, provision of a supportive environment.

The alternative services of the 1960s have had a significant impact on how crisis services are delivered in the 1980s. The deinstitutionalization movement in mental health in the last two and half decades and the development of the NIMH Community Support Program (CSP) are milestones in the development of crisis services. One of the ten essential components of a community support system is 24-hour crisis assistance. Again, while CSP focuses on an adult mentally ill population, the conceptualization of crisis assistance as a "continuum of services and mechanisms that provide quick response and enables the client and family to cope with emergencies while maintaining the client in the community" (Stroul, 1987), is equally germane to children's services and a goal of CASSP.

Concerns about the rapidly escalating costs of inpatient care and the benefits of treatment in the least restrictive, most normal environment have served as an impetus in recent years for the development of community-based service alternatives to hospitalization for emergencies as well as ongoing treatment. In addition to the mental health and health care systems, other service systems such as child welfare, juvenile justice and education have developed policies and programs that recognize the need for young people not to be removed from their homes and families and to be served in their local communities. Although these policies have yet to be fully or adequately implemented, the trend for all these systems is to develop alternative approaches to institutionalization. Different crisis treatment approaches, crisis stabilization units, respite care, therapeutic foster care homes, home-based services and mobile crisis outreach teams, all represent alternatives to hospitalization. During the 1980s, there has been an increased interest in the development of these treatment alternatives and a recognition of the need for a continuum of coordinated crisis services for children and adolescents, including hotlines, home-based services, intensive outpatient crisis intervention services and a range of crisis residential programs with hospital back-up for acute situations (Update, 1987-88).

PHILOSOPHY AND GOALS

The underlying philosophy of virtually all of the community-based crisis programs that either responded to the survey, were site visited, or were contacted by phone, is to assist children and adolescents and their families in resolving crisis situations and to avert hospitalization by enabling youngsters to remain in the community. While it is recognized that hospitalization may be warranted in some cases, the basic belief expressed by most programs was that hospitalization should be avoided because children's lives can be stigmatized and disrupted; it can foster the perception that they are sick; and, it can inhibit them and their families from working through solutions together using natural networks and supports, which can be helpful in developing coping skills to prevent future crises. In the crisis stabilization programs,

shelters, and respite homes that were studied, efforts are made to minimize an institutional feeling. The settings and routines established try to duplicate those of a family-like environment.

In a few cases programs have actually organized to form a system or network of emergency services. The guiding philosophy of these service systems is to provide a continuum of restrictiveness and a continuum of care in order to meet the needs of a child and family in crisis more appropriately.

Despite diverse program approaches and treatment settings, there are many similarities in philosophy, goals and t atment intervention among community-based crisis programs because the treatment approach is grounded in family systems theory and crisis intervention theory. Family systems theory addresses the forces of an entire family on the behavior of an individual family member. The family is viewed as a system and the behavior of individual family members interrelated. The client is the family unit, even though the problem of an individual family member led to the referral for services. A further discussion of family systems theory is included in the volume on home-based services. Crisis intervention is based on an understanding of the nature of crisis. According to crisis theory, a crisis is characterized by the following elements: an individual's psychological equilibrium and functioning is disturbed by an event in the person's social, physical or physiological environment; coping fails and the crisis ensues. The crisis is time limited. New coping efforts, which may be adaptive or maladaptive, are tried. Through these new coping mechanisms, an equilibrium is reached. Crisis intervention is aimed at helping an individual to develop adaptive coping mechanisms and to achieve an optimum level of functioning (Caplan, 1961; Jacobson, 1980).

With these theories as a foundation, most community-based crisis programs have incorporated the following principles or goals in structuring their treatment approach:

- To intervene immediately. Crisis programs are available 24 hours a day, seven days a week. While there may be triaging, there are no waiting lists and treatment begins immediately.

- To provide brief and intensive treatment. Crisis treatment is time limited. Whether in a residential type of setting or in outreach or clinic-based crisis intervention, staff work with the child and family over a brief and defined period of time, usually 3 to 28 days. However, some crisis theorists suggest six weeks is necessary (Jacobson, 1980).

- To focus treatment on problem solving and goal setting. Staff work with the client and family to stabilize the child and the situation, to determine the problem(s) that precipitated the crisis, and to plan the next steps needed to prevent further crises. The goals are limited and focused and next steps immediate.

- To involve families in treatment. Intensive work with the youth and the family is viewed as critical to problem solving, goal development and crisis resolution. The vital role that parents and families play is one of the reasons that home-based crisis services have received such strong support in recent years. But other types of crisis programs also stress the importance of family involvement and empowerment, whenever possible, as an inherent aspect of their treatment approach. In shelters, family reunification is one of the major goals of treatment. Crisis teams usually insist that both parents as well as other family members be part of discussions and treatment, if at all possible. Crisis stabilization units and therapeutic foster care homes can provide respite to parents, enabling families to work through issues and avoid more long-term placements outside the home. Treatment is

not denied, however, to youth who do not have families or whose families are inaccessible or refused to be involved.

- To link clients and families with other community services and supports. Because crisis treatment is short-term, it is important to develop a network of resources -- other service agencies, extended family members, other community services -- to ensure continued support in the community for clients.

The principles of the Akron, Ohio, Emergency Services System, a consortium of several agencies providing a continuum of crisis services, present a useful model for a crisis treatment system (Akron Child Guidance Center, 1987). The principles are outlined on the following page.

COMMON CHARACTERISTICS

Community-based crisis services range along a continuum from mobile outreach teams providing services in homes to crisis stabilization units that are hospital-based. However, despite the diversity of settings, organizational structures and agency auspices, there are a number of characteristics that community-based crisis services have in common.

1. Crisis services are available 24 hours a day, seven days a week.

In order to be responsive to children and families in crisis, staff need to be available at all times to provide screening, evaluation and intervention. Clinics and outreach teams generally have staff on duty during normal clinic hours with staff on call at other times. Shelters and crisis units are staffed 24 hours a day. House or line staff are assigned an evening shift. Clinical staff may be on the premises 24 hours a day, but generally after normal working hours clinicians are available on an on-call basis.

2. Community-based crisis programs have a common purpose to avert hospitalization, if appropriate, and stabilize the child's situation in the most normalized setting possible for the child.

Community-based crisis programs identified in this study have a similar goal and underlying philosophy: to stabilize children and adolescents in the most normalized, least restrictive setting appropriate to that child's needs. While inpatient hospital settings may be warranted in some cases to provide safety and treatment for youngsters who are acutely ill, in the majority of situations children can be stabilized in alternative settings. In addition to being the most expensive treatment setting, hospitals can be disruptive to a child maintaining a normal routine, are stigmatizing, and promote a connotation of being sick in the child's and family's minds.

Community-based crisis services often play a role as gatekeeper to acute inpatient services. Through evaluation and assessment, staff determine if hospitalization is necessary and appropriate. For the most part, programs are designed to offer an alternative to hospitalization. The most preferable setting for a child is to remain at home, receiving intensive home-based or clinic-based interventions from community networks and supports. In some situations, however, an out-of-home placement may be required. Most community-based facilities try to replicate as homelike an environment as possible.

3. Crisis services are short-term.

Time limitations and the increased willingness of individuals and families to make changes are fundamental elements to crisis theory (Caplan, 1961). Crisis services focus on identifying

OPERATING PRINCIPLES

AKRON, OHIO, EMERGENCY SERVICES SYSTEM

1. The system should be visible, understandable, and "user-friendly," so that citizens ar service providers will be able to use it efficiently in times of need.

2. Entry into the system should be user determined, with the system responding to all requests for emergency assistance.

3. The system should be designed to minimize penetration into the mental health system. It should strive to use state institutional settings as a last resort by diverting clients to less restrictive and more appropriate alternatives.

4. The system should operate on a "one stop" principle. Once a client has entered the system, the system should assume responsibility for the client. This responsibility should remain until another responsible service provider, upon referral, has assumed responsibility for care.

5. Services within the system should be time limited and should have as a primary goal connecting a client to an outpatient service (most often at a community mental health center) as expeditiously as possible. There should be no gap between emergency response and follow-up.

6. The system should provide for the maximum appropriate use of existing community resources and services.

7. The system should be designed to respond responsively and flexibly to client needs. Services should be provided as close in location and time to the client's situation as is possible. Disruption to the client's life and to the client's system of social support is to be minimized.

8. The entire operation is to be considered as a total system, with the role and responsibilities of each component delineated and all inter-relationships made clear.

9. Whenever possible, the system should choose voluntary services over involuntary treatment.

10. The system should be structured so as to minimize the conflict-of-interest which may occur when components within the system that have "gate-keeper" responsibilities are in a position to benefit from disposition decisions.

11. The system should be an integral part of the county's mental health system by being included in the county's mental health plan, with safeguards to ensure that it operates consistent with the goals and priorities contained therein.

12. The system should have a strong evaluation component, with explicit performance expectations and outcome indicators and mechanisms for collection and analysis of information to system performance which is directly tied to appropriate management and decision-making functions.

those issues and problems precipitating the crisis and on using the crisis to mobilize the youth and the family to develop new ways to cope and prevent further crisis. Once stabilized, the youth and family can be referred for ongoing, longer term treatment and support. The length of stay or period of involvement with the crisis program, therefore, is brief, usually lasting no more than four to six weeks. Clinic-based crisis staff and outreach teams may meet with a youth and family intensively only three to four times. More frequently, however, the extent and period of involvement of clinic outreach and home-based crisis service teams is about ten sessions over a four to six week period. Initially, staff usually meet more frequently with the youth and family, and the sessions are longer.

The average length of stay for respite homes and for crisis therapeutic foster care programs is approximately seven days. Average length of stay in crisis stabilization units tends to range from approximately 13 to 21 days. Limited data on shelter stays show a wide range--from 4 to 30 days.

4. Crisis programs tend to be small.

Because of the nature of crisis programs, which are based on an intensive relationship between staff, youngsters, and their families and where waiting lists are inherently antithetical, programs tend to be small. In clinic-based settings, staff handle an average of 20 to 30 new intakes and evaluations per month. Depending on the size of the agency or program and number of staff, a larger number of cases may be in crisis treatment at any one time. Crisis therapeutic foster care programs usually will place only one child with a family and respite care homes, one to two youth. Crisis stabilization units on average serve approximately 12 children. Crisis shelters range in their capacity from 8 to 24. One shelter director believed strongly that 20 youth in the shelter at any one time to be an absolute maximum that could not be exceeded if the program were to truly perform its mission.

5. Services provided include evaluation and assessment, crisis intervention and stabilization and follow-up planning.

Although crisis services are provided in a variety of settings, the treatment model in all programs consists of common elements. Upon intake, staff conduct an evaluation and assessment of the youth to determine treatment needs. The focus of the treatment in crisis resolution and stabilization is on problem solving and the development of new coping skills. Programs use the intensity of the crisis as the basis of treatment. The crisis itself enables intervention. Staff work to help the child and family understand the precipitating problem, examine options, and develop more adaptive coping strategies and supports. An intrinsic part of the crisis services is the planning of next steps and linking the client and family to follow-up services and supports.

6. Whenever possible, families are involved in all aspects of crisis treatment.

Community-based crisis programs recognize the fundamental importance of involving families in the treatment of children and adolescents. Programs seek to involve parents in evaluation and assessment, in treatment sessions, and in follow-up planning. Some programs try to involve all family members as well as extended family in the treatment process. Family networks are seen as a vital element to maintaining children in the community. If youth are placed in therapeutic foster care or a crisis stabilization unit, efforts are made to work with families so that children can return home. In crisis shelters serving runaways, one of the initial treatment goals is the call home to begin the family reunification process.

. staff working in crisis programs tend to share certain similar qualities.

While the staff of crisis programs are heterogenous in the types of degrees and credentials held, there are some common elements characteristic of staff. These include the ability to be flexible and adaptable; a high level of skill and competence; a high degree of energy and commitment; an ability to develop relationships quickly and then to let go; and an ability to work in concert with a team. Because of the importance of maintaining this unique staff, all programs make special efforts to support staff and prevent burnout. Such supports include training, good vacation benefits, and an environment that facilitates staff bonding.

8. Crisis programs usually are integrated with other service components.

Because crisis programs are brief, intense interventions that are generally followed up by other services, most crisis programs are part of larger agencies that offer other service components such as inpatient, day treatment or outpatient care, or they have affiliation agreements for the provision of ongoing treatment. Although few crisis programs are linked with a full range of services, there is usually a linkage for inpatient/residential care and/or for outpatient follow-up care.

VARIABLES

While there are a great many similarities among crisis programs, there are differences as well. Some distinctions are agency auspices, financing arrangements, and most notably, the types of settings for providing services, including walk-in clinics, mobile outreach teams and a variety of residential settings ranging from therapeutic foster care homes to crisis stabilization units. Based on the questionnaires, site visits and interviews with key informants, the most significant variables among programs appear to be the following:

- Hospital affiliation;
- Integration of a crisis service with a larger network of services; and
- Staffing credentials and patterns.

It is generally recognized that some youth in crisis may need to be hospitalized or may need to be treated outside the home. One of the major factors distinguishing crisis programs is the reliance on hospital facilities and beds to provide this back-up or inpatient care rather than on establishing other alternatives to hospitalization.

Some crisis programs have an affiliation agreement with community hospitals to provide inpatient care; other programs may be a joint venture. The Crisis Unit/Helpline of the Children's Psychiatric Center and the Riverview Medical Center in Redbank, New Jersey, is an example of a co-sponsored program which offers the full range of medical and psychiatric services provided by these two agencies. Northwest Dade Community Mental Health Center has a contractual arrangement with Jackson Memorial Hospital whereby the mental health center provides screening, evaluation and crisis stabilization, and the hospital provides inpatient beds.

Although these programs stress that youth are hospitalized only when it is indicated clinically, the hospitalization of children and adolescents is a controversial issue in the field. While it is generally agreed that inpatient care is an important and necessary component of a continuum of care for youth who are severely emotionally disturbed, there are valid concerns that hospital care is relied on too heavily and often is not used appropriately (Barach, 1986; Weithorn, 1988). Consequently, there is a growing emphasis on alternatives to hospitalization

for children experiencing a crisis. These alternatives allow hospital beds to be used for those youth most in need and enables a more effective allocation of resources.

Programs such as the South Shore Mental Health Center's Adolescent Crisis Service (Quincy, Massachusetts), the Houston Child Guidance Center's Family Crisis Program and the Philadelphia Child Guidance Clinic's Social Rehabilitation Program place a major emphasis on working with clients in crisis in the community. Both South Shore Mental Health and Houston Child Guidance Centers have crisis teams that work intensively with youth and families at the clinic as well as off site. The Philadelphia Child Guidance Clinic provides an intensive, home-based service to youth and their families to stabilize a crisis situation. Yet all three programs recognize that some youth may require treatment outside the home for a variety of reasons. Both the Philadelphia Child Guidance Clinic and the Houston Child Guidance Center have units with inpatient beds for youth needing more acute care. The South Shore Mental Health Center has established a respite house, a home in a nearby neighborhood staffed by a couple, one of whom is a human service professional.

Placement of youth in crisis therapeutic foster homes where specially trained parents work with usually one youth in crisis represents another alternative to hospitalization. In Trenton, New Jersey, the Youth Emergency Service (YES) is actually located in a hospital but the services provided do not include inpatient hospital beds. Rather, YES relies on a mobile team of crisis workers who provide home-based services and a small network of therapeutic foster homes. A staff member of the program believes, however, that the services would be enhanced if back-up hospital beds were available for those youth who are most acutely disturbed.

New Jersey's Transitional Residence Independence Service (TRIS) Children's Crisis Intervention Service (CCIS) offers another alternative to hospitalization. CCIS treats children in crisis in a community residence providing therapy, medical support, educational services and skill building in a homelike setting. As a result of special legislation (the Baker Act and a special legislative budget request) in the state of Florida, there are 20 crisis stabilization units serving children and adolescents. The majority of these crisis stabilization units, called general units, are mandated to serve all age levels but actually serve few children. Four special units serve only clients 18 and under. Of these units one is in a hospital, one is free-standing, and two have dual locations.

A second major variable among crisis programs is the extent to which the program is part of a larger network of services -- either a continuum of crisis services or a network or agency providing a range of services for referral and follow-up care. Crisis services are frequently the entry point into an agency or service system. Crisis programs providing access to an array of services, as part of an agency or with other agencies through contractual or interagency agreements, have a better capability for making appropriate referrals and triaging at the point of entry and of assuring appropriate follow-up services.

The crisis service may be one component of an agency offering multiple programs. The survey conducted for this study indicated that a number of child guidance and mental health centers such as Houston Child Guidance Center, the Philadelphia Child Guidance Clinic and South Shore Mental Health Center provide a range of services including crisis, outpatient, day treatment, respite, foster care and inpatient. Generally, most of these agencies do not provide a full range, but rather a combination of several services. New Jersey's TRIS also offers a range of services including day treatment and group homes. In Florida most of the crisis stabilization units are affiliated with community mental health centers for follow-up outpatient care. Youth and families served by these agencies can be referred to these service components once a crisis is stabilized.

A few communities such as Ventura County, California, and Kalamazoo, Michigan, have a system of care for emotionally disturbed youth involving multiple agencies. A range of services, including crisis services, are provided to troubled youth and their families. Agencies are linked through interagency agreements or contractual arrangements. Youth who are screened and evaluated can be referred to the appropriate component of the system for treatment.

Akron, Ohio, provides an example of a continuum of crisis services for youth. The Summit County mental health board has organized an emergency services system for children involving a number of agencies each of which provides a different component of crisis care. The lead agency is the Child Guidance Center, which has responsibility for delivering services as well as coordinating the overall continuum. In addition to the crisis intervention and support services provided by the Child Guidance Center, the system includes a children's hospital, providing inpatient and medical care, a crisis shelter, therapeutic foster care homes, and a crisis hotline.

Crisis shelters generally have developed strong interagency relationships in a community, but in most cases the service is focused on providing shelter and counseling to runaways and youth in crisis and not a full array of services. Huckleberry House in Columbus, Ohio, does provide an aftercare counseling program for youth and families seen through the shelter. The Youth Crisis Shelter in Elkins, West Virginia, is a part of the Appalachian Mental Health Center, which offers other programs such as home-based intervention and therapeutic foster care.

A third variable distinguishing crisis programs is the differences in the credentials and staff complements of programs. Generally the type of setting seems to be the major determinant of the staff of a program. Clinic and mobile outreach teams based at mental health and child guidance centers rely heavily on graduate trained clinicians, primarily social workers and psychologists, sometimes psychiatric nurses. Most programs have a psychiatrist on staff or a psychiatric consultant. Programs providing home-based interventions may also use bachelor's level or indigenous workers with special training.

Crisis stabilization units, in addition to psychiatrists, psychologists and social workers, usually have nurses on staff and a cadre of child care staff to cover the various shifts during a 24-hour treatment day. The staff of crisis units in hospitals tend to be more medically oriented in their training and backgrounds.

Crisis shelters tend to put less emphasis on the importance of degrees for their staff. A shelter may have one or more master's or bachelor's level social workers on staff, but the majority of staff are more likely to have experience and strong interest in working with troubled youth. Shelters also often employ high school students as peer counselors.

The use of volunteers and paraprofessionals is another factor which varies by program and setting. Some programs believe it is inappropriate to use volunteers because crisis intervention requires highly skilled, experienced workers. Others, especially crisis shelters, stress the importance of volunteers in working with groups, providing a richer array of activities, and additional support and follow-up.

SERVICES

Crisis services, as has been mentioned previously, include many different types of services and settings, ranging from prevention activities to hospitalization. Stroul (1987), in a recent report for the National Institute of Mental Health on crisis services in a community support

system, categorizes the continuum of community-based crisis services for an adult population into four major components:

- o Crisis telephone services.
- o Walk-in intervention.
- o Mobile crisis outreach services.
- o Crisis residential services.

This categorization provides a useful framework for the delivery of children's crisis services as well. Ideally, a community or an agency will offer a range of services to meet the differing needs of the client population and will provide a means for assisting the client to access the most appropriate service.

Crisis telephone services generally are available 24 hours a day, seven days a week, and usually serve as the entry point to services. Most crisis programs have staff on duty at all times or have an on-call system so that a staff person can be available to take referrals or talk with clients directly, obtaining information over the phone, providing counseling, arranging intakes or making referrals as necessary. In most communities there are a number of crisis hotlines, which may operate independently of an agency or treatment program. Crisis hotlines may employ staff or use volunteers who are trained to provide counseling over the phone and suggest referrals. Crisis hotlines are often specialized, offering support to specific groups, such as substance abusers, youth who are sexually abused, or youth who are suicidal.

Walk-in intervention services are typically associated with mental health centers, child guidance clinics, hospital emergency rooms and other outpatient clinic settings. Staff are usually available during working hours or are on call. In most crisis programs, staff are specifically assigned to handle crisis cases. Some more innovative programs also send a team or individual staff person on site to provide assessment and evaluation as well as crisis intervention.

More and more in communities, crisis services are available on an outreach basis. This usually involves a team of two workers who will go to the site where the crisis is occurring or will meet a client at another site. This meeting could be in a hospital, child welfare office, court, police station, school or in a home. Subsequent meetings may be in the client's home or at the agency providing the service. Staff providing an outreach service usually need to be highly skilled and motivated to work in an out-of-office environment. Training of emergency medical technicians in mental health and psychiatric care to handle these types of emergency cases represents a variation of the outreach teams. Outreach teams also are used to deliver crisis services in rural areas.

Crisis residential services for youth include an increasing number of alternatives: shelters to assist runaways and homeless youth, therapeutic foster care programs using specially trained families or families where one member is a human service professional, small group homes and crisis stabilization units. These programs generally serve as alternatives to hospitalization or juvenile detention centers and are a critical component of a continuum when there is a need for a protective, supervised setting and for placement for youth. Crisis residential services are an important resource for those youth who for various reasons cannot remain with their family or in situations where a short-term placement may be deemed to be therapeutic for the youth and family.

When these crisis services prove inadequate, acute inpatient services may be needed to stabilize the child. Acute hospital care is provided by psychiatric hospitals, private for-profit and not-for-profit psychiatric facilities, and general community hospitals with child and adolescent inpatient units. These services are seen as "backup" to the array of community crisis services that should be available.

The survey conducted for this report provided information on 14 different crisis programs. Because crisis services are often part of a larger agency or service system, it is difficult to classify programs in discrete categories. Programs included four shelters, one a service of a mental health center, and two free-standing crisis stabilization units, one associated with a nonprofit agency providing multiple services for youth. The remaining programs offered an array of crisis services, usually a walk-in or outreach program for screening, evaluation and crisis intervention with various arrangements for inpatient or residential backup, including therapeutic foster care homes, a small community residence for respite, inpatient units and hospital beds. The survey material was supplemented with information gathered on other crisis programs around the country.

In order to gain a better understanding of referral patterns, intake and screening procedures, evaluation and assessment, treatment approaches, duration and intensity of services, and follow-up planning, programs that primarily offer outreach and/or walk-in intervention services will be examined separately from the various types of crisis residential programs available. With a few exceptions, home-based and therapeutic foster care emergency programs will be discussed in the documents devoted to these service components. As noted, most of the outreach programs have a back-up arrangement to provide emergency respite care, residential or inpatient care.

Referrals

Referrals to the child guidance centers and community mental health programs that provide crisis services come primarily from schools, child welfare agencies, courts, and hospitals. A few programs indicate family and other private mental health professionals among their top three referral sources. There are also a few self-referrals. After hours, police are often the source of referrals. Those programs with hospital back-up mentioned physicians as a major referral source. Often in outreach programs the major source of referrals is agencies where mental health workers are located off site to provide crisis intervention services. Programs like the South Shore Mental Health Center in Quincy, Massachusetts, which has staff located at school sites, found the schools not only to be a referral source, but also to provide an opportunity to be available to intervene promptly when a crisis occurred or to prevent a crisis. As part of the Ventura County, California, Mental Health Demonstration Project, the Shomair (meaning "guardian") outreach team screens all children who are placed in foster care as a means of identifying children with significant mental health problems and providing crisis intervention.

Shelters have a much larger percentage of self-referrals than other types of services. Sixty percent of the clients at Huckleberry House in Columbus, Ohio, are walk-ins or referred by friends or family. This referral pattern is similar for other shelters as well. Other major referral sources for shelters include child welfare, human service and correction agencies.

Crisis stabilization units tend to have a slightly different referral pattern. Referrals come from state hospitals and hospital emergency rooms, human service agencies, the juvenile justice system and families. Referral sources for admissions to Florida's crisis stabilization units include 41 percent from various health and mental health professionals, 16 percent from self or relative, 10 percent from human service agencies, 9 percent from the police, 9 percent from schools, and 5 percent from the courts (Scrow, 1988).

Intake, Evaluation and Assessment

The intake process is a critical aspect of crisis services. Crisis services frequently provide entry into a service system. It is at this juncture that an initial screening, evaluation and assessment occurs and a decision made regarding the needs of the youth and the family and the services to be provided. Increasingly, this point of intake is serving a gatekeeping function, restricting referrals and placement in hospitals and more restrictive settings to those youth most acutely in need. Clients may require inpatient hospital care if they have a serious medical or psychiatric condition that cannot be managed within the structure and resources of the program, such as clients who manifest a clear danger to themselves or to others (Stroul, 1987). Most programs use the following criteria to determine if hospitalization is required: harmful to self, harmful to others and unable to provide self care. Making these determinations is obviously a complex process. Some programs indicate they can manage acutely ill clients by providing intensive services in the home, providing one-on-one supervision and staff support, or by mobilizing a network of community supports. The decision to hospitalize is also determined by state commitment and detention laws and requirements of state children's protective services.

While there are different opinions about the professional background and credentials of crisis intake workers, there is general agreement that crisis intake staff require special training, skills and experience so that they can adequately assess an emergency situation and make an appropriate decision for triage. For crisis services, an arrangement needs to be made for staff to provide intake on a 24-hour, seven day a week basis. In some agencies and programs the intake worker plays a screening role, taking basic information and referring the case to the crisis team for further evaluation. Usually, however, the intake is performed by staff who are an integral part of the crisis team or service. The intake worker may continue with the client or the youth may be assigned to another team member for further treatment.

The importance of the intake process is stressed by all crisis programs because it is through this process that information is gathered for evaluation and assessment, and a relationship is developed between the staff and the youth and family. During intake, different levels of evaluation occur. If screening has not already taken place, the nature and seriousness of the crisis needs to be determined to make an immediate decision regarding whether or not hospitalization or placement is required to assure the safety of the youth. At the next level, more information needs to be gathered on the physical and emotional status of the youth, the family situation and the precipitants of the crisis in order to develop an initial treatment plan. The initial intake process usually takes several hours. But evaluation, assessment and relationship building continue throughout the crisis treatment process.

The intake process is handled in a variety of ways, depending on the program. At the South Shore Mental Health Center, the Department of Mental Health may initiate a call about a youth in crisis. The call will go to the agency's main switchboard or directly to the member of the crisis team who is on call. A member of the team will either go to the site of the crisis or arrange to see the youth at the agency. For the initial intake, staff make an effort to have the worker who made the referral present as well as all members of the family, including other individuals who may have a close relationship to either parent. A legal guardian must be present in case hospitalization is required. A typical intake might involve a discussion with all parties to determine the nature of the crisis; then the crisis team member will meet with the child, asking a series of questions to determine the child's mental status, trying to gain as complete a picture as possible at that time. The intake process is also used to give the parents support as well as to connect with the child emotionally. The staff person on call will make recommendations in a written report with respect to areas for further evaluation and treatment interventions. The person on call may stay with the client,

or the case may be assigned to another team member. In some cases the whole team becomes involved.

In Oklahoma a unique program has been initiated to train emergency medical technicians (EMTs) in the assessment and management of mental health crises. EMTs who have completed the training program at Oklahoma City Community College are under contract with community mental health centers and with the Department of Human Services to provide assessment, triage and crisis intervention in local county hospital emergency rooms to youth who exhibit suicidal, homicidal or out-of-control behaviors resulting from emotional problems or drug use. In the second year of this project, EMTs will provide assessment and crisis intervention in other locations such as shelters, schools, or homes (Graham & Richardson, 1988).

In Kalamazoo, Michigan, the Child Guidance Center, which is part of a larger network of mental health services, has on staff a crisis worker to provide crisis intervention in the community, working with courts, social services, schools, the police, mental health agencies and parents. She is available to meet with a client and arrange for intake into the system, if appropriate.

In the Akron, Ohio, continuum of crisis services there are several entry points into the system. During the day, a crisis call goes to staff at the Child Guidance Clinic. After hours, calls are routed to staff in the emergency room of Children's Hospital. Youth can walk into the Child Guidance Center, the hospital, or the shelter, but in all cases coordination occurs through the Child Guidance Center.

In a number of communities, community mental health center staff provide intake services, conducting the initial screening and evaluation to determine the need for hospitalization or placement in a crisis stabilization program. Seventy-five percent of the crisis stabilization units in Florida are affiliated with a CMHC (Serow, 1988). In Dade and Monroe counties in Florida, the Northwest Dade Community Mental Health Center has responsibility for screening, evaluation and case management services. The Center has a contract with Jackson Memorial Hospital for the provision of hospital beds for inpatient services for acutely emotionally disturbed and mentally ill children and adolescents. Diagnostic and screening staff are based at the hospital. Evaluations are also performed off site.

For New Jersey's regional system of community Children's Crisis Intervention Service (CCIS) units, which provide up to 28 days of psychiatric care to stabilize a child in crisis and prevent further hospitalization, the state department of mental health designates and funds local screeners to conduct an initial intake and serve as a gatekeeper to the system. Screeners are usually located at the CMHC or based in an emergency room in a hospital. At TRIS's CCIS, once a referral has been made by the screener, intake usually involves the CCIS intake worker and case manager, the child, both parents, if possible, and any therapists or agency workers involved with the family. The CCIS intake worker and the therapist jointly conduct the social history. The intake worker gathers information from any agencies that the family is involved with and stays involved with the case throughout treatment.

Shelters have staff on duty at all times to conduct intake, which usually entails explaining the rules, policies and services of the shelter, and conducting an initial assessment, including addressing physical needs as well as an emotional assessment. Since the stay at shelters is usually brief, sometimes only one to three days, intake also includes the initial steps in the treatment process. At Huckleberry House, intake may be conducted by the house manager on duty, a crisis counselor, or a volunteer.

Crisis Intervention

The major components of a crisis service are evaluation and assessment, treatment interventions to stabilize the crisis, and planning next steps for youth and family post-crisis intervention -- usually all conducted in a time frame of less than 30 days. In crisis work, the crisis is viewed as a therapeutic opportunity; thus all aspects of treatment are intensified and are part of the overall treatment plan. In most programs evaluation and assessment occur at intake but usually continue throughout the stabilization process. Similarly, the planning for follow-up care is an integral part of treatment and begins early on in the treatment process.

The focus of treatment intervention in crisis resolution and stabilization is on problem solving and the development of coping skills. After the initial evaluation and assessment of the youth and family situation, treatment usually begins by formulating a treatment plan and contract with the youth and both parents, if at all possible. The treatment plan defines the problems, specifies goals that are concrete and immediate, and designates the time frame to attain these goals (Handorf, 1987). Goals usually include recommendations for ongoing supports and services.

Clinical interventions include crisis counseling and support, involving both the client and the family, to relieve stress and to achieve a more stable level of functioning. Counseling can include individual, marital, family and group sessions. Most programs incorporate working intensively with the family as an integral part of treatment and assisting the youth in functioning more successfully in the community. This involves a focus on family dynamics and the roles of different members. Increasingly, crisis programs are emphasizing the importance of case management in the treatment process to assist clients in linking successfully with other community supports.

According to Jacobson (1980), steps in treatment include:

- Determining who is in crisis and what was the precipitating event;
- Establishing rapport;
- Developing a common understanding of goals, limitations and procedures;
- Continuing to clarify the crisis and provide interpretation to the family;
- Helping the child and family to develop alternative coping mechanisms;
- Arranging for follow-up.

At the South Shore Mental Health Center, interventions are designed to create a supportive network, giving the family in crisis a framework for dealing with problems and pulling in other providers as needed. Interventions include intensive counseling sessions with crisis team staff, the youth, and family members.

At the Houston Child Guidance Center, the Systemic Crisis Intervention Program (SCIP) was developed to utilize the opportunity of the crisis elicited by a child's extreme behavior as an experience for families to learn about the potential of their natural networks to help them deal with crises. Treatment involves three components 1) providing an immediate emergency response which serves to maintain family members' anxiety within manageable limits; 2) the mobilization of extended family members (kin) to become involved around the crisis; and 3) the restructuring of kin system relationships to provide successful long-term solutions to the current crisis (Gutstein & Rudd, 1987). Evaluation and treatment are conducted by a six

member multidisciplinary team of therapists that meets with an entire family network to assist in adolescent crisis. The network may extend to as many as 30 members. To target the crisis and teach families to use natural networks for problem solving and improving coping skills, team members go through a complex process which includes the following steps:

- The team works to change the expectations that the professional is the authority figure.
- Team members try to become a part of the family's experience.
- A team member will represent a family member, acting like that member and expressing his or her position within the family.
- The crisis is re-enacted with the potential for a different outcome.
- Supports are determined that will enable the family to sustain new dynamics.

At all times the family maintains ownership of the problem and the solution. On average, treatment consists of one three-hour evaluation, six to ten one-hour preparation sessions with individual family members, and two four-hour extended family sessions. The adolescent and other family members usually are then referred to another service within the agency for ongoing treatment.

As with outreach and walk-in crisis intervention programs, shelters emphasize the development of a plan as an essential part of the treatment process. The treatment approach focuses on relationship building and problem solving. By meeting a youth's physical needs for food, shelter, medical care and safety, shelters can assist a youth to begin the problem solving process. Huckleberry House provides an example of how this process is handled in a shelter setting. At Huckleberry House, after intake, a crisis counselor is assigned. This counselor conducts a full assessment, gathering information about the youth's history and reviewing options. The next step is the development of a plan which consists of concrete goals for the youth to work on during his or her stay at the shelter and plans after leaving the shelter. A critical component of the treatment plan is a phone call home. This step re-establishes communication between children and their families and begins the reconciliation process. Reunification with the family is a critical part of the treatment in all the shelters responding to the survey. During a youth's stay at the shelter, treatment includes individual, group and family counseling. Programs usually offer recreational activities. Other activities such as training in life skills may be a part of the treatment. Youth who are attending schools in the area or who have jobs usually are encouraged to continue to attend.

Crisis intervention provided in other residential settings such as crisis stabilization facilities, therapeutic foster care settings, and group homes have a similar emphasis on problem resolution and planning. Observation and close monitoring of youth are an important part of the treatment process and the ongoing evaluation and assessment. These types of facilities also provide respite or a "cooling off" period in situations where temporary placement may be therapeutic for the child and/or family. This option may be necessary if family reunification is not possible and allows for other more long-term living alternatives to be arranged. A number of programs, such as the TRIS/CCIS in New Jersey, South Shore Mental Health Center's Respite House and Northeastern Family Institute in Vermont, emphasize the importance of creating family-like environments to normalize the experience for the child and to facilitate the transition back to the community.

Services at the TRIS/CCIS in New Jersey and in the crisis stabilization units in Florida tend to be similar. These include:

- o Screening and assessment, including physical examination and psychiatric evaluation, lab work, and medical care;
- o Treatment planning;
- o Ongoing evaluation and observation;
- o Individual, group and family crisis counseling;
- o Recreational and social activity therapy involving a youth in reality oriented events and interpersonal interactions;
- o Educational programming;
- o Referral.

A study of Florida's crisis stabilization units concluded that it was difficult to determine specific services provided to clients since, in most cases, continuous one-on-one interactions between clients and unit staff were as much a part of the therapy as designated counseling sessions (Serow, 1988).

Youth placed in therapeutic foster care homes or a setting such as South Shore Mental Health Center's Respite House, which is a home in a residential neighborhood staffed by a couple, one member of whom is a human service professional, usually follow the normal routine of that family. Family therapy and individual counseling usually are provided by agency staff.

Follow-up

Follow-up to crisis stabilization is an intrinsic part of treatment. The discussion of goals and next steps occurs in the initial stages of crisis resolution. In most cases, whether the child and family have received services through a crisis outreach team, in an outpatient clinic setting, or in a residential setting, a referral is made for follow-up outpatient services through the community mental health center, child guidance clinic or other provider of outpatient services. Crisis staff usually do not continue to work with the family. This transitioning can cause problems since one of the critical components of crisis treatment is the relationship that develops between the client and the crisis staff. At termination there is often a reluctance on the part of the client and the family to engage with another therapist. According to Handorf (1987), the process of transferring a case needs to be done carefully and gradually, through family meetings that include the new therapist as well as the crisis staff.

Crisis staff often remain involved in the provision of home-based services such as those offered through the Philadelphia Child Guidance Clinic or Family Advocate Project of the Counseling Service of Addison County, in Vermont. In these programs, intensive outreach is provided in the home in response to a crisis, but the staff may stay involved with the family, if necessary, after the crisis has stabilized. In the Philadelphia Child Guidance Clinic outreach program, child life staff, who work at the Center's inpatient unit, come to the home and will stay with a child to provide respite to a family. This service is used generally to support the child and family after the crisis has subsided.

Some programs provide case management staff specifically designated to facilitate the transition from crisis intervention and stabilization to other agencies in the community for ongoing treatment and support. Houston Child Guidance Center, Northwest Dade Community Mental Health Center, and TRIS all have designated case management staff. In other programs case management is an integral part of the clinical staff's role.

At the Northwest Dade Community Mental Health Center, which has a contractual agreement with Jackson Memorial Hospital to provide inpatient emergency services, case management is considered to be one of the most important aspects of the program. Case management staff serve with clinical staff on the screening and evaluation team. Linkage with appropriate community resources is considered during the initial evaluation process. The critical function of the case manager is to establish appropriate communication channels so that the treatment team, referral agency, child and family and other agencies involved can collaborate on the resolution of the crisis. The case manager is responsible for assessing individual and social resources and for enlisting the assistance of other agencies in making referrals and monitoring linkages.

At the South Shore Mental Health Center, the Massachusetts Department of Mental Health has assumed responsibility for the provision of case management services. The case manager works collaboratively with SSMHC staff to assist those families who have not been able to engage with the program, where the adolescent continues to be in crisis, and alternative living situations are needed. The case manager becomes engaged when multiple agencies are involved, and there is conflict over different agency roles and financial responsibility. The case manager views his role as involving uninvolved parents, empowering both the parents and the youth, and networking with other agencies.

A study of Florida's crisis stabilization units found that the bulk of therapeutic case management after discharge becomes the responsibility of the community mental health centers. More of the general units (which serve both adults and children) have workers connected with their own facilities who do case management than do the four special units that serve only children. The report speculated that this is probably because these special units are more likely to be affiliated with CMHCs. However, of the children and adolescents served in the crisis stabilization units, only 4 percent of the discharges were designated as having had a case manager. One-fourth (5) of all the sites surveyed indicated that they scheduled follow-up appointments for clients, and another quarter reported linking clients with a case manager; however, only one site indicated subsequent follow-up to determine whether or not the client was actually adhering to the discharge plan (Serow, 1988).

At TRIS/CCIS the therapist and the case manager are involved from the beginning of a child's stay at the home until discharge in planning and arranging the next stage for the child after crisis intervention. The majority of the children return home with continued outpatient counseling. TRIS has affiliation agreements with mental health centers in the same counties it serves. However, in some cases, staff need to be involved in arranging placements in foster care or residential treatment centers. The CCIS may make a referral to one of TRIS's other youth programs, its adolescent interim group home, an after-school day program, or its program that provides intensive mental health counseling to children in foster care.

Shelters typically work with their clients intensively and try to hook up youth and their families with various supports in the community. Increasingly, however, shelters have been providing an aftercare program whereby, following crisis intervention and resolution, youth and their parents are referred to an aftercare component. Both Huckleberry House and the YMCA shelter in Louisville, Kentucky, offer aftercare to those youth served in the shelter program. An aftercare program was established four years ago at Huckleberry House because staff believed that not providing follow-up was a weakness of the shelter's crisis program. About 50 to 60 percent of the youth in the shelter are referred to aftercare. The link with aftercare is made during the last family session in the crisis program. Individual, marital and family treatment are provided in the aftercare program. The staff is separate from the crisis program, but staff of both programs are involved in joint meetings around cases and treatment planning.

Length of Stay

The period of time that a child or adolescent is involved with a crisis program and the level of intensity varies depending on the type of program and setting. However, the common factor in all programs is that treatment is brief and intense. The maximum duration of involvement for programs is four to six weeks. Shelter crisis programs usually have the shortest period of involvement, with a stay in some programs of three to four days.

Mental health and child guidance centers tend to work with clients over a four-to six-week period. At South Shore Mental Health Center, the Adolescent Crisis Team has a fairly high turnover of clients in order to avoid a waiting list, which would be incompatible with an emergency service. Interventions are usually limited to 12 sessions or less. Longer term ongoing treatment, however, is provided by the agency's child and adolescent outpatient team.

Houston Child Guidance Center's family crisis program will work with families for four to six weeks before referring them for follow-up services. Depending on the case, however, the team may meet with a family only three to four times, but each session may be four hours. At Palo Alto's Emergency Treatment Center, where on-call clinicians provide crisis counseling, the average length of service is ten visits.

Crisis home-based services usually extend for four to six weeks, as detailed in the volume on home-based services. Trenton's Youth Emergency Services, which provides a mobile outreach team for evaluation, crisis intervention and management within the home and an emergency foster care program for any necessary placements, is mandated by the state to provide services for a maximum of 28 days. Staff indicate that involvement needs to be longer because once the crisis is stabilized, families need continued support. A period of three to six months was suggested for ongoing involvement. The team generally sees families twice a week for one hour at a time. The Philadelphia Child Guidance Clinic's Social Rehabilitation Program provides intensive outreach into homes for 24-hour emergency service and crisis intervention, but the outreach staff will continue to work with the family for a six-month period; after that a case manager usually is assigned to the family.

The maximum stay at the South Shore Mental Health's Respite House is two weeks; however, during a three-year period the average length of stay was six days. Houston's Family Crisis Unit, a family-centered inpatient unit, has a two-week maximum length of stay. The average length of stay for the Northeastern Family Institute's emergency foster care beds is seven days, and Akron's Parent Therapist Program has a similar length of stay for its crisis program.

As noted previously, New Jersey mandates that the length of stay in its children's crisis intervention facilities not exceed 28 days. At the TRIS/CCIS, the average length of stay is 23 days. About 10 to 15 percent of the children and youth at the TRIS/CCIS have extended stays due to problems in finding placement options following discharge.

In Florida the general crisis units, serving both adults and children, tend to discharge minors much more rapidly than the special units that are solely devoted to a child population. Forty-eight percent of the minor admissions to general units were discharged within three days; 33 percent within four days to a week; and 19 percent within eight days to a month. The special child units had a totally different pattern. Eighteen percent were discharged within three days; 21 percent within four days to a week; 38 percent within eight days to a month; and 23 percent stayed over a month. For the general units the average (median) length of stay was 3.8 days and for the special units 12.8 days (Serow, 1988). These differences were attributed to a number of factors. Special units serve younger children, and a larger percentage of children in the special units are discharged to foster and group homes, which may require more time to arrange placement. In addition, special crisis units appear to be able to handle

more youth that the general units transfer to hospitals. General units discharged almost twice as many of their admissions to hospitals than did the special units. However, staff in both types of units feel that, overall, about half of all minors stay slightly too long and suggest that insufficient discharge placement options cause overstays in crisis units (Serow, 1988).

Length of stay in shelters varies widely, ranging from approximately four days to thirty. Specifically, Huckleberry House's average length of stay is 4.1 days; the Greater Portland Youth Shelter is 12 days; the YMCA in Kentucky is 14 days; and, the Youth Crisis Shelter of the Appalachian Mental Health Center in West Virginia is 30 days.

LINKAGES

Community-based crisis programs interface with multiple agencies and systems. Types of relationships and linkages indicated by crisis programs include referrals to and from the program; information exchanges, particularly around individual cases; funding and service contracts for evaluation and crisis stabilization; affiliation agreements; joint planning; and, consultation and education.

The interdependence of crisis programs with other agencies is especially important in making referrals. Agencies in the community which work with children and families are dependent upon crisis programs that can assist their clients in an emergency and respond promptly to referrals. And, in return, crisis programs need to be able to make referrals to a wide range of community agencies for a variety of services and supports once the crisis is stabilized. Linkages may consist of formal or informal arrangements or affiliations between agencies to facilitate service planning and delivery. These collaborative arrangements may be limited to agencies that are part of a mental health service system, or they may involve other systems: social services, education, juvenile justice, health, and substance abuse. Effective linkages among a broad array of provider agencies result in a service system that is more responsive to children and their families.

The Ventura County, California, Children's Mental Health Services Demonstration Project is an example of one county's efforts to develop interagency linkages between mental health and a number of other systems such as education, child welfare and juvenile justice to ensure an adequate continuum of services, including crisis services, for a severely disturbed population of children.

When there is poor or no communication and coordination between agencies, continuity of care is compromised or may not occur. Referrals for continuing services may be impeded, resulting in children and families not receiving the transition and follow-up services they need, or in children staying longer than necessary in restrictive placements.

A number of crisis programs included in this study stressed the importance of good relationships and interagency linkages with child welfare agencies and staff. In cases where children are dependents of the state or where protective service staff are involved, placement of children after crisis stabilization requires cooperative, joint planning between the crisis program and child welfare staff.

Some crisis programs provide extensive outreach in the community to avert crisis situations, to intervene early, and to provide support and consultation to staff of other child serving agencies. For example, members of the South Shore Mental Health Center Child and Adolescent Team meet with the local Department of Social Services (DSS) two mornings a week to review and discuss cases and accept appropriate referrals. Several contracts between the Department of Mental Health and DSS provide other vehicles for joint staff participation and collaboration. One such project involves a counseling program for victims of sexual

abuse. The South Shore Mental Health Center also has contracts with two local school systems and local community health clinics to provide on-site staff. In one community a clinical team works in the school with all children who are identified as handicapped through the Education for All Handicapped Act. The team provides multiple services, including ongoing consultation to teachers and on-call crisis intervention.

For five years staff of Huckleberry House have been teaching a peer counseling course at two alternative high schools. In this way staff are able to assist and reach youth directly in the schools; the course also serves as a vehicle for recruiting volunteers to work at the shelter.

Directors of crisis programs indicated that they frequently are involved in interagency committees in their communities for joint planning for particular populations or issues. A numbe of communities have interagency committees to address suicide prevention and treatment and the special needs of adolescents.

Interagency linkages also provide a way to establish a network of emergency services, resulting in a more comprehensive range of crisis services and settings. Children and families in crisis often have different needs, depending upon the family's situation and the nature of the crisis. With a range of services available, a more appropriate decision and referral can be made about how best to meet the needs of an individual child and family. A network may include a crisis hotline, a mobile team providing home-based services, a variety of residential alternatives, and inpatient hospitalizations -- all operating under different auspices but linked through interagency agreements. This type of network may require a central intake and screening unit so that an appropriate triage can be made.

In Akron, Ohio, such an emergency services system for children has been established. The system is a cooperative effort of seven agencies. The Akron Child Guidance Center is the agency with overall responsibility for service delivery and coordination of a continuum of services. Other agencies include Support, a 24-hour hotline; the Akron Children's Hospital Medical Center; Youth Residential Services, an agency providing therapeutic foster care emergency beds and home-based services; Safe Landing Youth Shelter and the Summit County Community Mental Health Board. The interagency relationships are specified in contractual agreements. The range of services includes assessment, referral, outpatient services, home-based services, crisis residential care, inpatient care for those children requiring 24-hour medical supervision or a more secure facility, and case management.

A fairly common interagency agreement is one negotiated between a child guidance center or community mental health center and a community hospital to provide a range of outpatient and inpatient services. For example, the Children's Psychiatric Center (CPC) in Red Bank, New Jersey, and the Riverview Medical Center co-sponsor and jointly conduct a crisis unit and helpline. Clients have access to the full range of medical and psychiatric services provided by these two agencies. In addition, the CPC has a comprehensive network of children's services, including outpatient services, therapeutic foster homes, group homes, home-based services, partial hospitalization, a summer camp and two special schools. The Northwest Dade Community Mental Health Center has a contractual agreement with Florida's Department of Health and Rehabilitative Services to provide a program of screening, evaluation and crisis stabilization for children and adolescents in two counties. The Community Mental Health Center has contracted with Jackson Memorial Hospital for the provision of inpatient beds.

CLIENTS

Crisis programs of all types work with a very disturbed population. Studies show that many of these youth would be hospitalized if alternative crisis services were not available. (Barach, 1986; Gutstein & Rudd, 1987). Crisis programs report that the majority of the youth have

made suicidal attempts or threats. Many manifest acting-out, aggressive behavior. Others are seriously depressed. Increasingly, staff of programs report they are seeing youth who have been physically or sexually abused and/or whose parents (either one or both) are addicted to drugs or alcohol. Many of these youth react to severe family dysfunction and developmental stresses in extreme, life threatening ways (Gutstein & Rudd, 1987). Many of these youth are caught in a syndrome involving multiple crises.

While younger children are referred and receive crisis treatment, the population served by crisis programs, not surprisingly, is largely adolescent. This is a period of development where depression and/or hostility can reach extremes, and problems in family, school and the community exacerbate these tensions.

Crisis programs, for the most part, have few barriers to acceptance. In their intake and screening procedures, programs evaluate whether a client requires crisis services so that those who do not need crisis intervention and stablization can be referred to alternative programs, reserving crisis services for those most in need. Agencies/systems that provide a range of services usually establish criteria for the different programs that constitute their system. The criteria set reflect the nature of the program.

As discussed in the volume on home-based services, most home-based service programs will not accept a child and family when the family situation is judged to be dangerous for the child or when a family refuses to be involved. Outpatient or mobile teams will assess whether a youth meets the eligibility criteria for placement in a residential or inpatient setting. Most programs indicate that they try to avoid hospitalization or other residential placement unless absolutely necessary.

Individual state laws dictate admission policies for voluntary and involuntary commitment of minors to state psychiatric hospitals. Many states have adopted similar criteria to determine the need for hospitalization: harmful to self, harmful to others and/or unable to provide self care. The application of these criteria is often a matter of determining degree, i.e., whether the child is **acutely** suicidal, psychotic or violent. Some of the crisis stabilization units and facilities are designed to handle clients who, in the past, could only be treated in hospitals.

Staff of the South Shore Mental Health Center indicate that there is a healthy tension between the consulting psychiatrist and the director of the adolescent team regarding when hospitalization is appropriate. South Shore Mental Health Center's Respite House is a voluntary program which is used when it is clinically indicated that a youth may need to be temporarily removed from his or her environment. The Respite House is a deterrent and alternative to hospitalization. Admission is dependent on an individualized contract stipulating certain conditions such as visits with friends, telephone calls and intensive involvement of families, unless contraindicated.

The Houston Child Guidance Center's Systemic Crisis Intervention Program is not considered to be appropriate for clients who manifest clear-cut psychotic symptoms, have previous heavy institutional involvement or where there is a lack of parental urgency in response to the youth's life threatening behavior (Gutstein & Rudd, 1987).

In Florida the general crisis units, funded under the Baker Act and regulated through the Florida Administrative Code, have more stringent admission criteria than the specialized children's units funded through the Special Children, Youth and Families Program Office and/or through local funding. The special units serve the majority of children in crisis units in Florida. Both special and general units accept voluntary and involuntary admissions. Baker Act criteria specify that a client have a mental illness, be dangerous to self or others, and meet financial eligibility criteria. Primarily behavioral or acting-out problems will not be

accepted unless Baker Act criteria also are met. In a recent study comparing Florida's general and special crisis units, staff of virtually all the centers believed that clients who could be rapidly stabilized and those in need of acute hospitalization were appropriate admissions. Staff reported that admissions to the units were appropriate. Three-quarters of the clients had only one admission during the study time frame.

To be accepted into New Jersey's children's crisis intervention service facilities, clients must meet age and referral criteria, must have a primary psychiatric diagnosis and must be demonstrating an impaired level of functioning that clearly requires the intervention of a residential treatment program. Some programs such as TRIS/CCIS and the Akron Emergency Service System have a non-exclusionary, no-reject policy. Staff of TRIS have worked with children who, in other circumstances, could have been referred to a state psychiatric hospital, but who responded successfully to community-based treatment (Richman, Lynch & O'Brien., 1988).

A few programs, including some of the shelters, indicate that there are certain clients that they do not accept into their programs. These are clients who are actively suicidal, actively homicidal, extremely violent, and/or seriously retarded. Some programs will not accept youth with serious substance abuse problems. The open setting of shelters does not enable these clients to receive the close monitoring which they require. More typically, however, programs assess whether they can assist the youth and make a referral only if the youth, in their view, needs hospitalization or other type of setting.

Those programs providing clinic or outreach services have similar client profiles. For the majority of programs approximately half the clients are male; however, in some cases, over 50 percent of the client population is male. In those programs responding to the survey, there is a racial mix, but it is unclear whether or not the percentages reflect the general population of the community. The majority of the youth are 13 to 18 years of age, with the greatest percentage in the range of 16 to 17. The types of presenting problems include youth who are suicidal and, usually, depressed, compulsive runaways, uncontrollably aggressive, psychotic, and/or youth who are experiencing difficulties with family and school. Most typically, youth are depressed and suicidal. Most diagnoses include emotional and behavioral/conduct disorders. Most programs indicated that 5 to 10 percent of the population served is schizophrenic/psychotic. Northwest Dade Community Mental Health Center indicated that 21 percent of the children served in its crisis program had a primary diagnosis of schizophrenia and other psychotic disorders. For most programs, substance abuse is a major problem for 5 to 10 percent of the children served.

Data from the general and special crisis units in Florida and TRIS/CCIS provide the basis of a client profile of youth being served in these types of facilities. In the crisis units there is a roughly equal distribution of males and females, with a slightly larger percentage of males. Again, as with the clinical outreach programs, racial composition is mixed and appears to reflect general population characteristics.

At the time of the site visit, the majority of TRIS/CCIS clients were between the ages of 13 and 17. Twenty-three percent were 12 and under. Since the time of the visit, a 12-bed facility, Ginger Grove, has been established to serve a younger population of 5- to 10-year olds. In the general crisis units in Florida, 70 percent of admissions are over age 14, with less than 10 percent of admissions for children under 10. For special units, 16 percent are under 10; 40 percent are 10 to 14 years; and 40 percent, 15 to 17 years, resulting in an average age in the general units of 15.3, and in the special units of 14 years (Serow, 1988).

In the crisis stabilization units, the majority of youth are admitted because of suicidal threats or attempts. Increasingly, staff are seeing children with extremely disturbing life experiences.

Major diagnoses of the TRIS/CCIS population were as follows: over one-third of the boys and 60 percent of the girls had been sexually abused; conduct disorders represented 46 percent of the population; adjustment disorders, 20 percent; and schizophrenia, 12 percent. In the Florida units the most common diagnoses were conduct disorders, 29 percent; adjustment disorders, 20 percent; substance induced disorders, 12 percent; and schizophrenia, 11 percent. Most of the Florida programs indicate that they dislike using diagnostic categories for youth. As a result, conduct disorders and adjustment disorders are frequently two "catch-all categories" used (Scrow, 1988).

Another dimension used to describe clients in a setting is their legal status. In Florida's units, 14 percent of youth were dependents of the state; 11 percent were judged delinquent; 6 percent were both; 9 percent were reported to protective services; 35 percent had no previous involvement with the state's human service agency.

Emergency shelters show a slightly different client pattern. For the most part, shelters have a slightly larger number of girls. At Huckleberry House, on average, 60 percent of the shelter population is female. The YWCA Shelter House in Louisville, Kentucky, has a 55 to 45 female to male ratio. These female to male ratios correspond with data provided by the Department of Health and Human Services in its 1985 Annual Report to Congress on Runaway and Homeless Youth. The majority of youth, according to survey data, ranged from 13 to 17 years of age, with most programs having a larger percentage of 13 to 15 year olds. Of the programs responding to the survey, all served a predominantly white population of youth. In two programs, approximately 25 percent of the clients were black. Nationally, the majority of youth served in 293 centers funded under the Runaway and Homeless Youth Act are white, 17 percent black, and 7 percent Hispanic (U.S. Department of Health and Human Services, 1985).

Shelters tend to serve youth who do not seek out traditional agencies. Most shelters were established to serve runaways as alternatives to the juvenile justice system, since runaway juveniles come under the jurisdiction of this system via their status as "ungovernables" or "persons in need of supervision" (Morgan, 1982). Shelters do tend to see youth who have run or are "street kids" who seek out help rather than being referred. Numerous studies have been conducted on the characteristics and symptomatology of runaways (Benalcazar, 1982; Burgess, 1986; Farber & Joseph, 1985; Farber, Kinast, McCoard, & Falkner, 1984; Ferran & Sabatini, 1985; Janus, 1987; Shaffer & Caton, 1984;). A study of children and adolescents in New York City shelters found that mental health problems are present in between 70 to 90 percent of runaway youth. Scores of runaways on measures of behavioral and emotional symptoms were almost identical to youth seen at a child psychiatric clinic (30 percent manifested depressed or suicidal behavior, 18 percent anti-social behavior; and 41 percent a combination). (Shaffer & Caton, 1984).

In shelters the most frequent diagnosis (if diagnostic categories are used) is behavioral/ conduct disorders with emotional disorders, a primary diagnosis for 12 to 30 percent of the youth. Schizophrenic/ psychotic and substance abuse diagnoses fell under 10 percent for each general category. Actively psychotic youth, according to shelter staff, do not do well in shelter environments because they are not able to feel safe.

Huckleberry House does not use DSM diagnostic categories. Staff assess the family and the individual youth to determine whether the crisis is situational or chronic in nature. Using this categorization, 43 percent of the youth seen at the shelter come from chronically dysfunctional families, for 23 percent the presenting problem is more situational for the family; in 10 percent of the cases the individual has problems of a chronic nature, and in 9 percent of the cases the problems are situational or developmental for the individual youth.

Huckleberry House collects extensive data on the population served, providing a useful client profile. Sixty-four percent of the youth have been physically or sexually abused; 46 percent are assessed to have a high to medium rate of suicide lethality, according to a measure designed by Huckleberry House; and 52 percent are involved with substance abuse. The two reasons most frequently cited for running away were rejection or isolation and general family confusion. In 57 percent of these cases, youth have run from their primary family homes; 25 percent have not actually left home but are seeking counseling or other assistance. Three-quarters of the youth served by Huckleberry House are in school. And, for 38 percent of youth, this is the first time they have run. This figure corresponds with national data provided in the 1985 Annual Report to Congress on Runaway and Homeless Youth. On average, the youth who arrives at Huckleberry House has been gone from home less than 24 hours and usually lives within a 15 to 20 mile radius of the shelter. This represents a significantly different change from the 60s and 70s when youth ran long distances to major urban centers. This still may be true, however, for shelters serving large metropolitan areas such as New York, Los Angeles, and Miami.

According to the U.S. Department of Health and Human Services (1985), in the federally funded centers runaways comprised the largest proportion of all clients receiving services (37 percent); 33 percent of the youth were homeless and 30 percent were categorized as youth in crisis. Prior to receiving shelter services, 79 percent of youth were living at home with at least one parent or guardian. Of the youth served, approximately 52 percent returned to families and 22 percent to another stable situation such as a friend or relative's home. Six percent returned to the street. Approximately 60 percent were referred by the shelter to individual, family, or group counseling.

STAFFING

Major variables of the staffing arrangements of crisis programs tend to be dependent on whether the program is primarily a clinic-based or mobile outreach team or whether it is a crisis residential program. The nature of the setting influences the credentials of staff and staffing patterns.

Because of the difficult nature of their jobs, which demand a high level of assessment and treatment intervention skills, crisis staff tend to have extensive experience as well as advanced education and training. But differences do exist, depending on the setting. Clinic and mobile crisis teams usually are made up of staff with graduate degrees at the master's level or higher in clinical psychology, social work and counseling. In addition, most teams or programs have on staff a psychiatrist, at least in a consulting capacity. Programs with larger staffs may also have bachelor's level psychologists, social workers and/or counselors. The Philadelphia Child Guidance Clinic's social rehabilitation team includes staff indigenous to the neighborhood who were trained by the clinic's former director, Salvadore Minuchin, to work intensively with families.

Programs that are hospital-based tend to have staffing requirements that are more medically oriented. The Crisis Unit and Helpline of the Riverview Medical Center and Children's Psychiatric Center in New Jersey includes registered nurses as well as a social worker, a half-time psychiatrist and various paraprofessionals. Trenton's Youth Emergency Services (YES) team, which provides home-based services and operates out of a community hospital, includes psychiatric nurses to adhere to requirements of program funding. Often this is the case, that to qualify for third-party reimbursement or to meet specifications of program funders, the staff complement of a program must include staff with certain professional qualifications.

Staff of crisis stabilization units have similar credentials. However, staffing patterns vary depending on the nature of the facility; for example, whether it is freestanding or associated

with a hospital, or whether it serves only children, or adults and children, as do some of the units in Florida. TRIS/CCIS includes M.S.W.'s, nurses, psychiatric consultants, an educator and paraprofessionals called human service advisors, who serve as line staff. The Florida units include psychologists and recreational therapists on staff. The recent Florida study comparing the special units serving only children with those serving both a child and adult population, found that the general units have 1.8 times more nurses, 3.7 times the psychiatrist time and 3 times the recreation therapist time that special units have. (The study cautions that these figures may be somewhat misleading because part of the staff of hospital-based units is not counted in the crisis unit budgets and, thus, not included in the computations.) Special units, which serve most of the child population, have slightly more psychologist time than the general units.

Therapeutic foster care homes that are used to provide emergency services employ specially trained foster parents or human service providers as foster parents. In the Counseling Service of Addison County, Vermont, program each emergency home has one adult member of the household with a B.A. in a human service field and experience working with adolescents. The South Shore Mental Health Center's Respite House stipulates that one of the members of the live-in couple managing the unit have an M.S.W. or equivalent degree.

Shelters tend to put less emphasis on the importance of degrees for their staff. Shelters do not generally qualify for third-party reimbursement, so they have more flexibility in the types of staff hired. Shelters also stress the importance of developing rapport with youths who are runaways; therefore, in their view the skills and personal qualities of staff outweigh the significance of degrees. Staff of those shelters responding to the survey included social workers and counselors at the master's and bachelor's level, mental health associates and paraprofessionals, both youth and adult. None of the shelters had a consulting psychiatrist on staff. Full-time Huckleberry House staff do meet with a psychiatrist for training and consultation for two hours on a monthly basis.

Several crisis programs of various types reported that more important than the particular degree are the experience, skills and personal qualifications of crisis staff. Staff need extensive experience and well-developed skills in assessment, emergency treatment and family work.

Certain personality characteristics emerged that were similar for all crisis staff despite the diversity of programs. To be successful and effective, staff, it was generally agreed, needed to possess the following qualities:

- The ability to be flexible and adaptable,
- A certain innate talent for crisis work,
- A high degree of energy,
- A high level of commitment,
- An ability to connect quickly with clients,
- A strong sense of confidence and self-esteem,
- An ability to get totally involved and then pull back,

- An ability to set boundaries and limits, and

- An ability to work as part of a team.

The latter point was considered to be extremely important, especially by the clinic and mobile outreach crisis teams. Staffs of the Philadelphia Child Guidance Clinic, the Houston Child Guidance Center, and the South Shore Mental Health Center all stressed how intensively team members work together and with families. In order to nurture, however, staff need to be in an environment that nurtures, and staff need to be able to take care of each other. Houston Child Guidance Center staff stated, "Team members must be prepared to emotionally immerse themselves." But in the staff debriefing at the end of the family sessions, staff members must attend to the needs of the team. The process of dealing with crisis situations together tends to generate a strong bond among team members.

In addition to the effects of the type of setting on the staffing patterns of crisis programs, a number of other variables differentiate programs. The deployment of staff on clinic-based and mobile crisis teams varies. Some programs, such as the Riverview Crisis Unit and Helpline, train and assign staff specifically to the crisis unit; staff are not responsible to any other program element of the system. Other programs, such as the South Shore Mental Health Center, rotate crisis staff, assigning them to other teams in the agency. One argument for a staff dedicated specifically to the crisis team or unit is to increase and build expertise. Additionally, staff do not feel fractured in their responsibilities. The rotation of staff, on the other hand, provides respite and relief from the intensity of crisis work. Further, since funding sources often pay for only portions of positions, staff must be assigned to several different teams.

Another deployment issue concerns whether staff work in teams of two or more or handle cases individually. Mobile teams, such as Trenton's Youth Emergency Services, usually have two members on the team. Houston's Child Guidance Center usually has six members of the crisis team participating in the intensive family sessions. A decision regarding how many members of a team will meet with a child and family may be situational, depending upon the availability of staff and the type of case. This is frequently what occurs at the South Shore Mental Health Center.

Use of students and/or volunteers is another factor which differs among crisis programs. Some programs believe the use of volunteers is inappropriate because of the skill level and experience needed to work with clients in crisis. Other programs find volunteers extend staff and add a valuable dimension to the program by enhancing the activities that are offered and increasing the level of support to clients. In this study, shelters appear to be more likely to use volunteers and students than other programs. Several programs provide clinical training for graduate students who also help expand the staff complement.

The types of roles staff play can depend on the setting. Staff of clinic and outreach crisis teams are engaged in intake, assessment, evaluation, individual and family treatment, contacts with other agencies, and case management. In addition to staff who perform these roles, residential facilities also have "house" staff who assist in the daily milieu. These staff manage the facility schedule and routines, run activities, conduct group discussions and provide staff support at meals and bedtime. They are part of the therapeutic environment and are considered to play an important role in crisis stabilization and treatment. Residential programs may also have staff who provide special educational instruction and/or recreational activities. Educational programming tends to focus on skill building and socializing activities rather than adhering to a specific instructional curriculum. In therapeutic foster care homes,

the crisis home is staffed by a couple in residence. The foster parents and house staff play multiple roles in duplicating a family environment and providing crisis stabilization and treatment.

Because crisis programs function on a 24-hour basis, all staff usually work on shifts. House staff may be assigned to a day, evening or night shift. Clinical staff provide on-call backup and support to each other and to house staff, if the program has a residential component.

Because of the intensity of crisis work, staff communication, support and supervision are vital to an effective program. In all programs studied, there are many opportunities built in for staff to meet. Staff communicate with each other and with supervisors frequently on both a formal and informal basis. Staff being available to one another is an intrinsic part of a crisis program. Clinic and outreach programs reported weekly or biweekly meetings for staff to discuss cases. Supervision is usually provided on a weekly basis. In residential programs, including shelters, clinical staff meet weekly or more frequently. House or shift staff meet regularly at shift changes to check on the status of youth in the facility.

Training is considered to be critical for adequately preparing staff to work in a crisis setting and for supporting staff on an ongoing basis in their work. While all programs stressed the value of training, the ways in which it is provided varied. Several crisis teams indicated that the process for orienting and training new staff involved a new staff member initially participating on the team as an observer, and then taking on a case with another, more experienced member of the team providing support, or in some cases observing through a mirror to provide advice and support after the session. The types and extent of training offered by an agency often depend on the size of the agency. Larger agencies may have someone on staff who is in charge of training. Larger agencies also have the advantage of drawing upon agency staff and their individual expertise to provide training on specific issues. Smaller agencies generally seek resources outside the agency for specialized training. Several agencies reported that even if resources are limited, some funding is made available for staff to attend courses or training sessions. Training is also provided through supervision and in-service sessions held either at regularly scheduled staff meetings or specifically designated times. Peer review of records also provides a training opportunity for staff.

At TRIS/CCIS, the consulting psychiatrist conducts weekly in-service training sessions. Huckleberry House has established an extensive seven week, 60-hour training program for all part-time staff and volunteers. Training sessions focus on the development of crisis intervention and counseling skills. Specific training programs are also provided to all staff around such topics as suicide prevention and detection of physical and sexual abuse.

As would be expected, burnout of staff is a major issue for crisis programs. But most programs emphasized the dedication and high level of commitment of their staff. Programs indicated that by hiring qualified staff suited to do crisis work, they minimize problems of extensive turnover. Several antidotes to burnout were offered: agency training, supervision and support of staff, opportunities for team building and socializing, rotation of staff to provide a diversity of experience, and liberal vacation policies. Cohesive teams, where members can laugh with and soothe each other, compensate for the stressful work. Many staff stated that crisis work provides them with highly challenging and rewarding experiences.

RESOURCES

The financing of community-based crisis programs is a complex area. Several overriding issues affect the resources available to fund services. These include:

- o Limited data -- Specifically there is a lack of data on program costs, cost comparisons using similar measures across different types of crisis programs, and cost effectiveness of community-based crisis services.

- o Lack of third-party reimbursement for community-based services -- Incentives are skewed towards the reimbursement of services provided in inpatient settings and towards more medical models of care.

- o Differing requirements of multiple contractors -- Programs with multiple contractors usually have to develop different cost reporting procedures and may need to establish different unit costs for discrete services.

- o Difficulties convincing public and private sector funders to provide adequate financial support to cover the intensive costs of emergency/crisis treatment -- These costs include 24-hour coverage, intensive treatment sessions with children and families, travel time, and work with other agencies for treatment planning and ongoing support.

Scanty data exist on the costs and financing of crisis programs. In part this is due to the scarcity of information, in general, on crisis programs for children and adolescents. Financial data were available for only a small number of programs in this study, and these programs represented very different types of services and settings, making comparisons difficult. Because of the diversity of crisis programs, there is a corresponding diversity in the array of funding arrangements and support for these services. Often it is the funding source that dictates the nature of the service provided.

Programs are usually financed through a combination of resources that can include contracts with, or other funding support from, public sector human service agencies at the state and/or local level; federal grants; private sector funding; philanthropic donations; third-party reimbursements from Medicaid and private insurers; and, patient fees, generally based on a sliding fee scale. The extent to which each, or any, of these funding sources support a program depends very much on the type of treatment service provided, the staffing arrangements and the setting.

Clinic-based and off-site crisis teams usually receive the majority of their funding through contractual arrangements with state departments of mental health and/or from state social service or child welfare agencies. In some localities the bulk of this public sector funding comes from county agencies. A relatively small percentage -- under 20 percent -- of program revenues are derived from direct fees and third-party payors. A typical breakdown appears to be 5 to 10 percent in direct fees, 5 to 10 percent from Medicaid, and 5 percent from commercial insurance and Blue Cross. Some agencies such as the Houston Child Guidance Center are expanding into the private sector and have contracts with corporations and/or health maintenance organizations to provide services to specific employees. These contracts allow for greater flexibility in the types of services offered and the ways they are provided. Private not-for-profit agencies may also receive United Way or other private foundation dollars. These sources generally appear to account for approximately 10 percent of agency revenue.

There are a number of reasons for the lack of third-party coverage. One reason for limited third-party reimbursement stems from the caps which Blue Cross, commercial insurers and

Medicaid set on visits and rates. These caps usually are based on a typical model for provision of individual and/or family outpatient counseling. This model does not take into consideration the nature of crisis counseling and the intensive services required in emergency situations. In addition, private and public third-party payors do not usually take into account the travel time for delivery of off-site services or the time expended in working with other agencies and setting up support services. For example, South Shore Mental Health Center estimates at least a half an hour of collateral services (such as phone calls and meetings with other providers) for every hour of service given. Most funding sources do not pay for this collateral service time. In most states Medicaid covers only a limited number of outpatient visits. Extensive clinical justification is required for approval of continued service.

The crisis stabilization programs in Florida and New Jersey are primarily funded through state contractual dollars. The contractual process enables a mix of provider arrangements, e.g., a mental health agency may contract with a hospital for beds as does the Northwest Dade Community Mental Health Center in Florida or the Children's Psychiatric Center in New Jersey; or a home-based service program may contract with therapeutic foster care homes for back-up beds, as in Trenton, New Jersey. TRIS/CCIS, which is New Jersey's only crisis unit that is not hospital based, receives almost 90 percent of its funds from the state department of mental health. Except for a small percentage of funds (less than 3 percent) from the state department of education for a nutrition program and from the local county school board for homebound instruction, the remaining program revenue sources come from Medicaid. In New Jersey, Medicaid covers youth who are in the custody of the Department of Youth and Family Services. Data from the Florida crisis units located in both hospital and freestanding facilities show that the crisis units are funded predominantly by the state through Baker Act funds or contracts with the Children, Youth and Families Program Office. Less than 10 percent of payment for services comes from client and third-party payors (Serow, 1988). South Shore Mental Health Center's crisis respite house is paid for entirely by Massachusetts mental health funds.

Shelters are also funded through a number of different sources. The main source of support is generally through state departments of human services. However, shelters can also obtain federal funding support through the Runaway and Homeless Youth Act, and most of the programs in this study derived a portion of their income (16 to 33 percent) from this grant source. Other support comes from city or county governments and the United Way.

Information on program costs is limited. In addition, it is difficult to make comparisons across programs because costs are calculated so differently. There are inconsistencies in how agencies determine the service costs and the units of service per child and family. At the outset, it should be noted that, despite the inconsistencies, costs in general are dramatically less than the average cost of a stay in a private psychiatric hospital, where an increasing number of adolescents are being served. Between 1980 and 1984, according to the National Association of Private Psychiatric Hospitals (1988), admissions of adolescents to private psychiatric hospitals increased an estimated 450 percent, rising from 10,764 to 48,375 youth. In 1987 the mean length of stay for an adolescent was 43.7 days at a rate of $377 a day, a per episode cost of over $16,000 per youth.

Based on 1987 figures, the average cost per hour of the South Shore Mental Health Center's child and adolescent outreach and crisis program is $145. These costs include the direct and indirect costs of 10 full-time equivalent staff who provide the following services: 24-hour prescreening for children and adolescents, short-term crisis intervention and stabilization services for adolescents and their families, intensive ongoing community outreach and adolescent and parent groups. The actual fee schedule for on-site emergency service at the South Shore Mental Health Center is $50.00 per 30-minute visit. Medicaid and Blue Cross pay $31 per visit. The Respite House costs are $230 per day per child, with an average length of

stay of six days. Thus, the average cost for a child staying in the house is approximately $1150. Costs include emergency screening and referral; residential care, including room, board and supervision; on-site treatment; and aftercare. Not included are costs of the emergency crisis team and case management. The mean cost of Houston Child Guidance Clinic's crisis intervention program was reported to be $3,200 per family. The Philadelphia Child Guidance Clinic's home-based crisis program costs about $6,000 to $7,000 per year per child and family; however, it should be noted that this program continues to provide care for six months to a year. This compares with a cost of $13,000 to $15,000 per episode for a stay in the inpatient unit. These figures are presented to illustrate the high costs of inpatient hospitalization compared to other alternatives. The Philadelphia Child Guidance Clinic offers a range of services, so that hospitalization is provided to only those children and youth requiring this level of care.

TRIS' Children's Crisis Intervention Services' per diem cost per child is $262. Average length of stay is 23 days, resulting in an average total cost per child of $6,026. This dollar figure includes all costs for the facility.

In Florida, 1986-1987 figures show that the average cost of a bed day is comparable in both the special and general units, $143 and $129, respectively. (In Florida, because units are funded according to the bed space made available and not according to the specific number of days a client is served, per day and per admission costs need to be computed.) The major difference in expense between the two types of units is a function of length of stay. The average mean length of stay in general units is 5.0 bed days resulting in a cost of $645 for an average length of stay. The average mean length of stay in the special units, where most youth are served, is 21.8 bed days costing $3,117 for an average length of stay. This latter figure is a more accurate reflection of the costs of care, since many of the youth who are served in the general units are referred to inpatient facilities, thus accounting for the shorter length of stay (Serow, 1988).

The recent evaluation of Florida's crisis units concluded that a considerable savings is realized by using multiple visits to crisis units as a means of maintaining youngsters at the same level of care rather than moving them to a more restrictive environment. On the other hand, long-term use of crisis units as "holding tanks" for youth awaiting placement is more expensive than any alternative except hospitalization (Serow, 1988). According to the Florida report:

- Maintaining a minor at home for a year, including two average stays in a special crisis unit, is an annual savings of $7,420.65 over placing him in a therapeutic foster home.

- Maintaining a minor in a therapeutic foster home for a year, including two average stays in a special crisis unit, is an annual savings of $6,026.35 over placing him in a therapeutic group home.

- Maintaining a minor in a therapeutic group home for a year, including two average stays in a special crisis unit, is an annual savings of $11,213.00 over placing him in the next most restrictive level of residential care (Serow, 1988).

In Florida, estimated costs for the various levels of care are shown in the chart on the following page.

The Counseling Service of Addison County, serving a rural county in Vermont, has developed a low cost alternative to providing emergency shelter for youth in crisis. Shelter for up to two weeks is provided in the homes of human service professionals who have experience and have been given special training in working with adolescents in crisis. The actual cost of the therapeutic emergency homes is $40 per day. The average length of stay is one week,

COSTS FOR VARIOUS LEVELS OF CARE

Level of Care	Amount per Year
Therapeutic Foster Home (TFH) $37.41/day	$ 3,654.65
Therapeutic Group Home (TGH) $71.00/day	25,915.00
Other Residential Setting $118.80/day	43,362.00
Minor Maintained At Home	
-- with two "average" (21.8 days) stays in special unit per year	6,234.00
-- with two "average" (5.0 days) stays at general unit per year	1,290.00
Minor Maintained in TFH	
-- with two "average" stays in special unit per year	19,888.65
-- with two "average" stays in general unit per year	14,944.65
Minor Maintained in TGH	
-- with two "average" stays in special unit per year	32,149.00
-- with two "average" stays in general unit per year	27,205.00

* This information was taken from Florida's Evaluation of Mental Health Crisis Units Serving Children and Adolescents by E.G. Serow, 1988.

resulting in a cost of approximately $280 per youth. The program operates with six emergency homes, and, on average, each family has three youth during a year. A counselor works with the youth, family and therapeutic home providers. This cost is not included in the daily rate and adds a part-time professional salary to the cost of the program. The program is considered to be cost effective; program data have shown that "intense therapeutic intervention at the point of crisis with teens and their families can significantly decrease the need for more costly long-term intervention" (Counseling Service of Addison County, 1981; Tannen, 1984). Additional information on the costs of therapeutic foster care programs is provided in Volume III of this series.

Huckleberry House provides an example of the costs of shelter care. Because of the extensive costs of the first day of treatment, which is extremely intensive, Huckleberry House has established a differential rate for its contractors for the first 24 hours of treatment. Unit costs are established for emergency crisis services (the first 24 hours), emergency follow-up, shelter care and aftercare. The actual cost for the first night for shelter care and crisis counseling is $227. Subsequent overnight cost and crisis counseling cost is $118 per night. The cost for shelter without crisis counseling is $45 per night. The average length of stay is approximately four days, resulting in an average cost for shelter care and crisis counseling of approximately $581 per youth. This does not include the aftercare component of Huckleberry House, which is estimated to cost $36 per day for a youth and family.

EVALUATION

In general, the evaluation of service programs and different types of treatment interventions for children and adolescents has been inadequate, but evaluative data for community-based crisis programs for youth are seriously lacking. A review of the published literature failed to produce information on research findings comparing different crisis treatment models and programs and evaluating their effectiveness. Most programs contacted for this study had either no evaluation component or had developed relatively simple procedures for collecting data and tracking clients to document the success of their program. The major reasons hindering the undertaking of research and crisis program evaluation appear to be a lack of resources to support a research and evaluation capability; staff who are service, not research oriented; and, the very nature of crisis programs that are focused on helping clients in extreme distress.

Florida's comprehensive comparison of two types of crisis units, those that serve a mixed population of adults and children and those that are specifically designated to serve children, makes a significant contribution to the literature because of the extensive data generated on crisis units. However, the comparison of these two types of programs is not particularly useful since most experts in the field generally concur that separation of youth and adult services is critical.

Evaluating the success of a treatment program is a complex process that generally cannot be made on any single quantitative or qualitative dimension (Jacobsen, 1985). Most community-based crisis program evaluation efforts measure the success of the program based on the prevention of hospitalization or placement in more restrictive settings, since such diversion is one of the major goals of community-based crisis programs. Other outcome measures and indicators of program effectiveness used by programs include:

- The disposition or types of referrals after discharge, determining the numbers of youth who remain at or return home and those who are placed in out-of-home settings;
- Readmission rates to the program;

- Measures of improvement in the individual child and the family's functioning, using various behavior and mental health status assessment tools.

No programs contacted for this study used any control group to compare the effectiveness of different treatment interventions. A number of programs such as the Akron Youth Emergency System and Huckleberry House indicate that they collect data to measure the accomplishment of program goals and objectives. Programs also collect data to evaluate utilization rates and patterns, appropriateness of referrals, and clients admitted. Most programs that have evaluation components in place collect data at several intervals: intake, discharge, and one month, three months, six months and one year after discharge. The usual procedures for program data collection post treatment consist of follow-up phone calls and/or questionnaires to families and/or youth.

The majority of programs mentioned that their evaluation component included the peer review and quality assurance mechanisms that their agencies have established for internal quality control, as well as reviews conducted by state agencies or the Joint Commission on the Accreditation of Hospitals to ensure compliance. For example, three levels of review are conducted at the South Shore Mental Health Center. Every three months a team comprised of a physician, a psychologist and a social worker from the Child and Adolescent Service reviews clinical records; a similar multidisciplinary team provides a utilization review at the center level; the state department of mental health conducts a yearly review.

For the purposes of this report, it is difficult to compare data from different programs because of the variability in the types and size of programs, the communities and populations served, state policies, and the time periods in which data were collected, as well as numerous other factors. However, from the outcome data that are available from individual programs, it appears that community-based crisis programs have been successful in averting hospitalization and/or maintaining or returning youth to their homes as well as showing successes on other measures.

One of the most thorough studies conducted of a crisis approach is the Houston Child Guidance Center's evaluation of its Systemic Crisis Intervention Program (SCIP). While no control group was used, the study attempted to measure the effectiveness, safety and economic viability of an outpatient model designed to respond to adolescent crisis by mobilizing and restructuring the family's kin system (Gutstein & Rudd, 1987). This evaluation focused on 75 youth treated by SCIP over a year and a half period. The population ranged in age from 7 to 19 years. Suicidal behavior precipitated treatment in 47 of the subjects, with 26 reporting serious suicidal threats and 21 recording actual attempts. Other problems reported included severe depression, violent behavior, serious substance abuse and family conflict. All but one youth was living with at least one biological parent at the time of the crisis.

Measures were taken during the family's initial intake evaluation, and follow-up interviews were conducted at 3 months, 6 months and at a period between 12 and 18 months. A small subsample was followed for 24 months to assess treatment stability. The program was evaluated based on five criteria:

- Can treatment be conducted safely?
- Can the program alleviate the sense of crisis?
- Does the program affect future crises?

- Can treated families avoid institutional solutions to future crises?

- Is the program economically viable?

The findings were as follows: Of the 75 adolescents involved in the study, two made minor suicide attempts during the follow-up period. There were no suicide attempts during treatment. Although the majority of parental ratings described the adolescents' presenting problem as "severe" at the outset of treatment, only a very small minority were rated as such following treatment. Following treatment, there was a significant decrease in a wide range of problem behaviors. Of the adolescents treated and followed, five were hospitalized or in a residential placement during the follow-up. The mean cost of SCIP is $3,200. Fees range from $1,100 to $10,500 with the higher costs resulting from brief hospitalization as an emergency response.

The study also assessed clinical effectiveness based on five criteria: 1) no occurrence of suicidal behavior or actions that would endanger others during follow-up; 2) a clear decrease in parental ratings of the severity of adolescents' behavior; 3) no occurrence of new crisis behavior; 4) no time spent in an institutional setting; and, 5) regular attendance in school or work. Of the 63 cases analyzed, 74 percent met all five criteria for success; 21 percent failed to meet one of the five criteria.

Data from other agencies tend to be more limited. In 1979, prior to the establishment of South Shore Mental Health's Adolescent Crisis Team, there were a total of 18 admissions to the state hospital unit of youth aged 13 to 18 from that agency's catchment area in Massachusetts. During a two-year period between 1981 and 1983, there were only four adolescent admissions, all court referred. This represents a decrease of admissions of 89 percent, while statewide during that same time period there was a 35 percent decline (SSMHC, 1986). In subsequent years, hospital admissions have stabilized whereas admissions to the Respite House have increased almost twofold.

According to evaluation data of the Philadelphia Child Guidance Clinic's home-based crisis program for children and families, in 1984, the first year of the program, 96 clients and their families were served. Fifteen of the clients previously had been at the state hospital; 31 had been hospitalized in the inpatient unit of the Child Guidance Clinic, some several times; and 11 had been hospitalized at other facilities. During the first year none of the youth had to be admitted or re-admitted to the state hospital unit. Only eight youth had to be hospitalized after entering the program; six of these were admitted to the Child Guidance Center's inpatient unit (Sefardi, 1986).

From 1984 to 1986, the Addison County, Vermont, emergency therapeutic foster care program received 81 referrals and placed 19 youths; one youth was placed twice. Eighty percent of the youth placed in the program or receiving crisis counseling services through the Counseling Service of Addison County have remained with their families. The program indicated its success rate for the first year for youth placed in homes was 69 percent. "Success" was based on three factors: a decrease in runaway and suicidal gestures; an increase in families in treatment; and prevention of placement in child welfare custody (Counseling Service of Addison County, 1986).

Of the 200 clients served by TRIS/CCIS in 1987, 61 percent returned to their homes, 12 percent were placed in foster care, and 7 percent were hospitalized either in a private psychiatric facility, a community hospital adolescent psychiatric unit, or the state's child treatment facility. Six percent were discharged to a group home and 6 percent to a residential treatment center. According to staff, without CCIS intervention all of these children would have been admitted to the state hospital system.

The evaluation of Florida's crisis units found that 74 percent of all admissions were discharged to the same types of setting from which they came, rather than to a more restrictive setting. Of all admissions, 56 percent were from, and returned to, their homes. In a review of client records, the overwhelming majority of clients whose discharge status was indicated were found to have improved after treatment (Serow, 1988).

The Florida study made an attempt to determine whether the presence of special crisis units in a district would have the following impacts: a decrease in admission rates to hospitals, general crisis stabilization units, residential facilities and detention programs; a decrease in the size of the waiting list for residential placement; and, a decline in the suicide rate among minors. These rates were examined over time, comparing districts with and without special units. No systemic relationship between any of these factors and the presence of special crisis units was found. Various inadequacies in the data were cited as the primary reason for the inability to establish any relationship. However, the lack of systemic relationships was considered to be not surprising considering that three-quarters of all admissions return to the same level of restrictiveness from which they came and that 56 percent of all admissions were from and to home (Serow, 1988).

Huckleberry House has developed a number of forms and tracking systems for collecting data on youth served. This information is computerized and linked to programmatic goals and objectives. The director believes this kind of documentation and evaluative information has been essential in maintaining funding support for the shelter, particularly in periods of funding instability. Of 698 cases during 1986, 53 percent of youth returned to their family home, 18 percent moved to another home situation, and 7 percent were placed in an institutional setting. Based on follow-up phone calls 60 to 90 days after leaving the shelter, it was found that 83 percent of the youth had not run again.

Preliminary data indicate that community-based crisis programs can be effective in reducing hospitalization and keeping youngsters with their families and in their communities; however, there is clearly a need for more research on evaluating the success of treatment on multiple dimensions and comparing different treatment approaches.

MAJOR ADVANTAGES AND CHALLENGES

Interviews with program staff, policymakers and families indicate the numerous advantages that community-based crisis services offer. While more data are needed to document the gains, the overall experience of existing programs has been positive. Some of the major benefits cited include the following:

o Community-based crisis services provide an effective gatekeeper to hospitalization.

Crisis services serve an effective triage function. Available 24 hours a day, crisis services provide an opportunity for screening and evaluation to assess a child's and family's needs and to determine the most appropriate system response. At this juncture, a decision can be made as to whether hospitalization is necessary or whether another alternative is more appropriate. In most cases, intensive crisis intervention provided in a youth's home or in a clinic setting can stabilize the crisis. However, if placement is necessary, community-based services such as therapeutic foster homes, small community residences or crisis stabilization facilities offer a less costly, more normalized experience than hospitalization.

o Community-based crisis services are a cost effective alternative to hospitalization.

Inpatient psychiatric hospitalization represents the most expensive treatment setting. Increasingly, other alternatives that provide treatment to youth in crisis are being viewed as therapeutically effective, more appropriate for serving children and adolescents, and less costly. In a period of limited resources and rapidly escalating costs, hospitalization needs to be reserved for those who cannot be treated in other settings. With fewer dollars going to hospital care, more children can be served by other less costly alternatives.

- Community-based crisis services enable children to remain in their communities through the use of community supports, preventing a syndrome of repeated hospitalizations whenever there is a crisis.

Community-based crisis programs strive to treat children without removing them from their homes. Efforts are directed at working intensively with families and, if necessary, utilizing services from multiple agencies as well as family and other community supports to enable the child and the family to learn better coping skills to prevent or minimize future crisis situations. If placement is necessary, the setting and the treatment approach are designed to assist the child in functioning in a normal community environment. Since many children and families in crisis have life situations marked by poverty and other stresses that exacerbate crisis, there is a potential for multiple hospitalizations if alternative treatment approaches are not utilized. Community-based crisis services attempt to prevent that syndrome of repeated hospitalizations. Studies have also provided evidence that for an adult population even a single psychiatric hospitalization can greatly increase the probability for future and repeated hospital utilization (Kiesler, 1982; Machotka & Flomenhaft, 1971).

- Intensive work with families and linkage with ongoing services and supports in the community strengthen the youth and family's ability to cope and address problem situations.

An integral aspect of community-based crisis programs involves exploring the types of supportive services and follow-up care that a child or adolescent and the family need and assisting the family in obtaining those services. A youth and family thus become involved with a service system which can provide ongoing support and help. A crisis program that is part of a larger service network is generally more successful in implementing these linkages.

- Screening can help to identify children in crisis and provide needed services.

A number of programs, as part of a crisis service, routinely conduct screening of children entering juvenile correction settings and dependency settings. This process of screening can identify children who may be in crisis, especially since placement out-of-home can precipitate a crisis. Once identified, an appropriate intervention can occur.

- Outreach and a timely response to a crisis can prevent the escalation of a crisis and/or the need for out-of-home placements.

Crisis intervention is based on the theory that the crisis provides an opportunity for change, but timing is a critical ingredient. Community-based crisis services are structured so that interventions are immediate and intensive. There are no waiting lists. Programs providing outreach teams that go to homes, schools, or other settings where youth are can prevent a crisis from escalating and avoid disruptive out-of-home placements. Shelters and crisis programs that are available to youth who do not seek out traditional agencies also play a critical role in assisting troubled youth in beginning to take control of their lives.

Given the generally well accepted advantages of community-based crisis services, it would be logical to assume that such services would be more widespread. However, that is not the

case. There are number of barriers that impede the development of crisis services and create problems for programs. Overcoming these difficulties poses a challenge to the field. Some of these barriers and problems are listed below:

o The complex challenges of financing crisis services.

Third-party payors are biased toward the provision of care in inpatient settings and offer few incentives toward the development of alternatives to hospitalization. The funding of crisis services depends primarily on contractual arrangements with public sector agencies and, to a lesser extent, on reimbursements from third-party payors. Payment rates established by these payors do not take into consideration the actual costs involved in providing this intense service, including travel time for outreach, extended counseling sessions with family members, debriefing time for staff, and extensive contacts with other agencies for follow-up care. Rates are often based on an outpatient model of care.

o Difficulty in recruiting staff.

Community-based crisis programs require staff who are willing to work in nontraditional ways and settings. Mobile crisis teams go to clients' homes, detention centers, juvenile courts, hospitals and schools to counsel youth. Staff also need to be willing to work odd shifts and hours to maintain 24-hour coverage. Working under these circumstances is unorthodox for many professionals trained to work in clinic settings. Alternatives to hospitalization also present different treatment settings for professionals accustomed to inpatient and medical models of care. Many staff feel uncomfortable in these environments and less professional. Professional training schools are not preparing graduates for work in a range of alternative settings. Yet crisis program require staff with strong clinical and diagnostic skills. Programs report that it is difficult to find staff that are suited to work in community-based crisis programs.

o Burnout of staff.

In addition to difficulties in recruitment, another challenge for crisis programs is the retention of staff. Most programs attribute their success to the competence and dedication of their staff. Yet working with youth and families in crisis as well as being available at off-hours is stressful. Programs need to seek ways to prevent burnout and staff turnover through higher salaries, training, extra vacation benefits, the development of close staff relations, praise and other means of building staff morale.

o A need for more adequate case management.

Crisis programs depend on adequate follow-up care, post crisis intervention and stabilization. Although exploring options and planning next steps is an integral part of intervention, many families and youth need case management to assist them in actually linking up with programs and making the transition from the crisis service to the follow-up service plan. Crisis services focus on evaluation, screening and treatment, but they may not be organized or funded to provide case management; thus, the provision of case management becomes the responsibility of the agency accepting the referral. Too often there is a lack of good case management, an essential link for service continuity and coordination.

o A lack of available services and resources for follow-up care.

One of the most critical challenges facing crisis programs is the lack of adequate service alternatives for referral once the crisis is stabilized. Children in crisis stabilization facilities or other types of residential placements, who cannot return home, may have to remain in the

crisis setting longer than necessary because of a lack of placement alternatives. Often, after intensive crisis counseling is provided through clinic-based, home-based or outreach teams, the only alternative is an outpatient service where a youth is seen once a week in a clinic setting. Such an approach is not sufficiently intense nor does it provide an adequate transition for youth and their families.

o Lack of coordination among different service systems.

The lack of coordination among different systems serving children acts as a major obstacle to the development of effective crisis services. Young people in the juvenile justice, child welfare, education and mental health systems are all vulnerable to crisis, yet the provision of crisis services to youth served in any of these systems generally is either totally lacking or is inadequate and fragmented. With a few exceptions systemwide approaches to treating children in crisis do not exist. More common is a patchwork arrangement. For example, a child welfare agency may contract with a mental health agency to provide crisis services to its client population, but once a child is stabilized, there are no placement alternatives. Juvenile justice agencies frequently have no service in place to deal with youth in crisis, and it is expected that the mental health system will provide and cover the costs of care. Children and adolescents caught in the cracks caused by agency disputes or service gaps do not get the services they need.

o Problems with establishing crisis facilities in residential neighborhoods.

Although crisis programs that operate out of homes in residential neighborhoods try to maintain a low profile and cooperate with neighbors to foster support, there is still resistance in many communities to the provision of care in non-hospital institutional settings. There are concerns primarily about threats to safety (youth running away or hurting themselves and others) and depreciating property values. Programs in community-based facilities may be more vulnerable to litigation and can face difficulties in obtaining liability insurance. Despite these perceptions and concerns, most programs operating facilities in residential neighborhoods report that their experience has been positive. There have been few negative incidents, and for the most part neighbors are either supportive or unaware of the program's presence.

o Increase in private psychiatric hospitals.

With the growth of private psychiatric hospitals, more and more youth are being treated in these settings. Between 1980 and 1984 admissions of adolescents to private psychiatric hospitals increased 450 percent, rising from 10,764 to 48,375 (National Association of Private Psychiatric Hospitals, 1985). Private psychiatric hospital chains are seeking Medicaid benefits as a means to fill beds not filled by privately insured patients. This growing and forceful trend thwarts the development of community-based crisis alternatives.

o A lack of crisis services, as well as other services, for the increasing number of youth who are severely troubled, resulting in an overtaxing of existing services.

Crisis programs report that they are having difficulty meeting the growing needs of youth in crisis -- youth who are suicidal, runaway and homeless, youth who are victims of abuse and violence, and those who are substance abusers. At a national, state and local level, public policies and funds need to be directed to help children and youth and to support the development of services for this population.

PROGRAM DEVELOPMENT

There is not the same systematic effort to encourage and promote the development of community-based crisis services that there is for other service components such as home-based services. There are, however, a number of forces that are proving to be favorable to the development of community-based crisis services and, as a result, these services are receiving increased attention. These forces include:

- The concern about youth suicide is mobilizing many communities to evaluate how youth suicide is addressed in their localities and to develop a systemwide response that involves multiple agencies.

- Concern about youth suicide at the federal level is generating support in Congress to appropriate more federal resources for suicide prevention and treatment activities. Several bills in the most recent session of Congress dealt with youth suicide.

- Concern, especially in major cities, about high-risk youth -- youth who are homeless and youth who are intravenous drug users and at risk of AIDS -- is forcing these urban areas to develop more outreach activities to assist these young people.

- The rapid expansion of private psychiatric hospitals, the overwhelming increases in the admissions of adolescents, and the high costs of this type of care are forcing states to explore ways to stem the tide of growth of this industry and to redirect service development. The role of crisis programs, as a gatekeeper and referral source to alternative forms of treatment, is being favorably viewed as an alternative.

- The demonstrated effectiveness of home-based services as a crisis intervention supports the overall development of time-limited, focused and intensive interventions for youth and families.

- An increased demand (in policy statements if not in resource allocations) for the development of community-based services, including crisis services, is being heard from more and more systems serving children and youth such as child welfare, education, maternal and child health and mental health agencies.

Thus, these are indications of increasing interest in developing crisis services for severely emotionally disturbed youth. There is also a growing awareness and recognition of the importance of a continuum of crisis services that includes a range of coordinated services and settings to meet the needs of youth and families.

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III. PROGRAM DESCRIPTIONS

ADOLESCENT CRISIS TEAM AND RESPITE HOUSE
SOUTH SHORE MENTAL HEALTH CENTER (SSMHC)
QUINCY, MASSACHUSETTS

History

The Adolescent Crisis Team is a multidisciplinary team of ten professionals operating out of a community mental health center who provide prescreening, evaluation, short-term intensive individual and family therapy, referral and follow-up for adolescents in crisis and their families, 24 hours a day, seven days a week. A respite care home located in the community accommodates up to two adolescents at a time for a maximum of two weeks. The crisis team serves as the screening unit for all potential state hospital admissions, with the occasional exception of court referred youth.

The Adolescent Crisis Team was initiated by the Massachusetts Department of Mental Health (DMH) because of state and local concerns about the rise in the numbers of adolescents in crisis and the increase in admissions to state hospital units. Historically, Massachusetts was one of the early states to adopt policies of deinstitutionalization for the mentally ill and to promote the development of community-based service alternatives to avoid hospitalization. In 1978 a survey of the state hospital population, conducted by DMH, found that 40 percent of the adolescents admitted to Massachusetts state hospitals could have been diverted if adequate community alternatives were available. Extrapolating from the survey data, it was estimated that in the South Shore region 73 percent of the adolescents admitted would not have required inpatient treatment had appropriate community arrangements been available. State statistics also showed that one half of the adolescents admitted to a state hospital stayed less than ten days, suggesting the need for a period of crisis intervention and short-term evaluation (Handorf, 1987).

In conjunction with pressures from the state, local groups were also expressing similar concerns. In the late 1970s the Council for Children of the South Shore Area designated adolescents in crisis as a priority issue for the region based on the steadily increasing incidence of psychiatric crises among adolescents and the increase in adolescent admissions to the local unit of the state hospital (Handorf, 1987). The Council was particularly concerned about youth being placed in adult units and also wanted to reduce bed utilization.

To respond to these concerns, the South Shore Mental Health Center (SSMHC) and the area office of the state Department of Mental Health negotiated a contract to provide services within the catchment area for adolescents in psychiatric crisis. It was the program's intent that treatment interventions would help maintain the youth in crisis in the community, reserving hospitalization as a last resort. This initiative of the DMH was the first "deinstitutionalization" effort in Massachusetts focused on children and adolescents. The treatment team began operations with a staff of two in 1979. The opening of the Respite House occurred the following year.

Agency and Community Context

The Adolescent Crisis Team and Respite House operate out of a large and complex community mental health center. The South Shore Mental Health Center, Inc. was established with federal funding in 1979 as a comprehensive mental health center. The SSMHC evolved, however, from the child guidance movement and actually began operations in 1922 as the Quincy Child Guidance Association. Today, it has a budget of over $13 million, a staff of 400

employees located in multiple sites, and 35 student trainees. It is the largest freestanding community mental health center in New England.

The South Shore Mental Health Center serves three diverse communities in a region south of Boston. (In April 1987, after the site visit for this study, the SSMHC expanded its service area to encompass the Coastal Area, which includes seven towns and a population of approximately 160,000. In July 1987, SSMHC assumed responsibility for all residential contracts in the Plymouth Area. Budget, staff figures and program statistics reflect these expansions.) The area is predominantly white with few racial minorities. Quincy, where several of the major service sites are located, is the largest and poorest of the communities in the area. Quincy's population of approximately 85,000 is heavily blue collar and ethnic, primarily Italian, Irish and French Canadian. For years the major industry was shipbuilding until the recent closing of the shipyards. Almost 7 percent of the population is below the poverty level. Many families experience multiple problems, including unemployment, a high level of substance abuse, family violence, child abuse and neglect, legal difficulties and school failure. Milton, in contrast, is an affluent community, considered to be a desirable, close-in, older suburb for many of Boston's professionals. While the community's population is not immune to problems, it tends to use the private mental health sector. Randolph is a middle to lower middle class suburban community; like Quincy, its population is highly ethnic, with many families experiencing multiple stresses, such as marital discord and poor parent-child relationships.

The SSMHC operates five major service systems. Each of these is described briefly below:

o The Child and Adolescent Service

The Child and Adolescent Service represents the core of the SSMHC. As noted earlier, SSMHC grew out of a child guidance clinic that was established in the 1920s and over the years developed a national reputation for its excellence as a clinical and training center. This legacy remains a part of the SSMHC, and the success of the Child and Adolescent Service today is based in part on these historical roots. A budget of approximately $3 million supports the following components of the Child and Adolescent Service:

- Outpatient mental health services providing evaluation, short-term and long-term therapy to children, adolescents and their families;
- Outreach services provided to two health center sites in Quincy;
- 24-hour emergency services provided through the Adolescent Crisis Team;
- A Respite House with a capacity for two youth and a maximum stay of two weeks, located in the community and staffed by a resident human services professional;
- Case management;
- Consultation, evaluation and clinical services to schools, including an on-site team at the Randolph High School, providing mental health assessment and treatment to children identified through the Education for All Handicapped Act and their families and serving as a liaison and consultant to teachers and special education personnel; similar on-site services to students and staff at five schools in Quincy; and a Drop-out Prevention Program at three Quincy high schools;
- Special treatment teams including a sexual abuse and a substance abuse team.

o The Community Support Service

This service area focuses on adults who are chronically mentally ill. It includes a range of community-based support services for the population of this catchment area, targeted for Massachusetts deinstitutionalization efforts. Services include 24-hour crisis intervention, a continuing treatment and aftercare program, case management and an elderly outreach program. The budget for this service area totals approximately $3 million.

o The Day Treatment Service

This service includes a day/evening treatment program for clients who require a more extended therapeutic contact than can be provided in traditional psychotherapy but do not need hospitalization. The program includes activities to develop independent living skills, socialization, vocational planning and a therapeutic work experience. A Social Club is also provided for clients not using the day/evening treatment program but who need an extended social support network to maintain a stable level of functioning in the community. The budget for these two service components is $750,000.

o The Behavioral Service

This service area includes a range of programs for clients who are developmentally disabled or have a dual diagnosis. Services include behaviorally oriented residences serving 115 clients daily; a day habilitation program; outpatient services with staff specially trained to work with clients who are developmentally disabled and their families; and, a respite care program for families of developmentally disabled individuals of all ages providing a therapeutic program in private homes. The program budget for this service area is approximately $5 million.

o The Developmental Service

This component, funded at slightly less than $1 million, offers early intervention services to families and children from birth to three at several community sites as well as in homes. Services include evaluation, assessment, treatment and day care.

In addition to these five major service areas, the SSMHC operates a number of other programs including:

- Project Optimus -- an interdisciplinary training program for professionals serving handicapped children from birth to age six.
- Project WIN -- a federally funded project aimed at children (birth to three years) at risk of AIDS.
- The Consulting Center for Business and Industry -- a program providing consultation, education, training and treatment to business, industries, unions and government agencies to assist employees with problems interfering with job performance.
- Bayview Center -- providing outpatient services on a fee-for-service basis.

This complex, multifaceted agency is administered by an active board of directors and an executive director. Reporting to the executive director is an associate director for administration and finance, the medical director, a deputy director for policy and training, the directors of each of the five service areas and the directors of the various special projects.

The SSMHC services are located in multiple sites in the catchment area. The administrative offices are housed separately in a modern office building in Quincy. The main office of the Child and Adolescent Service is located in an office building in the central business district of Quincy, close to public transportation and other service providers, including the local office of the Department of Social Services (DSS). There are, as noted, also a number of outreach sites in the schools, courts and clinics throughout the service area.

In Massachusetts, the state mental health system is regionalized. For each jurisdiction, an area board and local service center administer a service system for children and adults. In the South Shore area the service system for youth includes SSMHC's Child and Adolescent Service, a day treatment program, three district residential programs, beds for 12- to 18-year olds in an acute care unit at Taunton State Hospital, inpatient beds for youth 13 and under at the Gaebler Unit of the Metropolitan State Hospital, and case management services. The regional office monitors all programs that are part of the local service system for children and adolescents, meeting regularly with program directors; in addition, the regional office performs a variety of administrative duties such as contracting, data collection and issuing quarterly reports.

Philosophy and Goals

The primary mission of the Adolescent Crisis Team and the Respite House is to serve children, adolescents and their families in severe behavioral, psychiatric or emotional turmoil. The adolescent crisis program seeks to provide intensive, community coordinated clinical outpatient services to families as a means of maintaining the client in the community. Outreach and clinical intervention strategies are provided by the program with the intent of preventing more restrictive alternatives (institutionalization, residential treatment, incarceration) while assisting families in strengthening family bonds and coping with mental health crises and ongoing problems.

Underlying the mission and services of SSMHC's crisis program is the basic premise that children and adolescents should be served in the community through service networks and support and not be hospitalized except when there is a clear and present danger to themselves and/or to others. According to a paper developed by Timothy Handorf, the director of the crisis team, while hospitalization may be the "safest" approach in the short run for treating a distraught youngster, removing an adolescent from family and community poses a number of problems: it identifies the youngster as the problem or the source of the problem, often absolving parents and family members of the responsibility to work towards a solution; and it robs the youngster of the opportunity to translate insight into constructive action within his own family system and community while being treated clinically.

Given this philosophical premise, several principles further guide the treatment approach of the SSMHC's crisis program:

- To have a holistic view of the child and family situation;
- To support and empower parents;
- To focus on the presenting problem;
- To give the family in crisis a framework to develop new coping strategies;
- To create a supportive network, mobilizing and coordinating different providers and supports around the problem which often requires assisting a care-giving system in crisis.

The goals of the Adolescent Crisis Team are to:

- Prevent child and adolescent hospitalizations by intervening at the time of crisis.
- Reduce child and adolescent admissions and readmissions to state hospital units and private psychiatric hospitals.
- Reduce admissions to residential treatment programs and juvenile detention settings.
- Diagnose and treat adolescents and their families in a setting more appropriate to where client problems originate.
- Help integrate adolescents back into the community following treatment in public and private psychiatric hospitals, residential programs, foster care or respite care.
- Decrease the amount of truancy, adolescent runaway and delinquent behaviors of adolescents served.
- Promote the coordination and consolidation of services to the multiproblem families served by the program.

The Respite House is an alternative to psychiatric hospitalization for adolescents who experience psychiatric crisis of such proportions that they are unable to adequately test reality or control impulses and are thereby at risk of hospitalization. Its goals are similar to those of the Adolescent Crisis Team:

- To prevent child and adolescent hospitalization by utilizing a less restrictive alternative service to meet client needs.
- To reduce the child and adolescent admission and readmission rates to inpatient units.
- To diagnose and treat clients in a setting more appropriate to where client problems originate.
- To replace child and adolescent psychiatric hospitalizations (both public and private) with an alternative which does not facilitate depersonalization and alienation from one's home and community.
- To encourage linkage and coordination of existing community services to insure continuity of care and the provision of comprehensive follow-up.

Services

The Adolescent Crisis Team, which provides 24-hour emergency service, and the Respite House comprise only one unit of SSMHC's Child and Adolescent Service. Crisis intervention as well as other prevention and treatment services are provided through a variety of vehicles and outreach programs, all under the umbrella of the Child and Adolescent Service. The services and treatment approaches of the Child and Adolescent Service are characterized by their flexibility. Diverse interventions are used, and clients are seen in a variety of settings. No one treatment approach is dominant since different clinicians have different treatment styles. The common denominator, however, is that the focus of treatment is on the child as well as the family and larger community systems. Services include individual, marital and family therapy as well as a number of groups. Teams are organized to work with hard-to-reach youth in schools, housing projects, clinics and other settings. As noted previously, one team

works in the Randolph High School; other teams work with five schools in Quincy; child clinicians are assigned to work with two health center sites in neighborhoods with a high incidence of multiple social problems. Special teams also provide services focused on specific problem areas such as sexual abuse and substance abuse. The sexual abuse team, for example, conducts evaluations for the Department of Social Services and the courts. These outreach services are in addition to the outpatient services that are provided in the central unit of the Child and Adolescent Service.

A detailed description of the specific services provided by the Adolescent Crisis Team and the Respite House follows. A description also is provided of the outreach programs in the schools, because these services are an important supplement to the crisis team enabling mental health professionals to intervene early with youth.

1. Adolescent Crisis Team

The Adolescent Crisis Team provides 24-hour emergency service to children, adolescents and their families in severe behavioral, psychiatric or emotional distress. Services are provided at the main office of the Child and Adolescent Service or at the site where the emergency is occurring. Services include assessment, short-term crisis intervention and stabilization, intensive family oriented treatment, case management, group treatment, referral and case coordination.

Intake

During the day, referrals to the crisis team usually come from schools, the Department of Social Services, the courts and the police. After-hours calls are generally made by parents. Rarely does an adolescent in crisis call the agency for help.

A call may go to the main switchboard of the agency or directly to the Adolescent Crisis Team. The director of the team or the staff person on call will take the call. Evaluations generally take place at the mental health center. Depending on the time of day and the nature of the crisis the staff on call may go to the site of the emergency such as the hospital, court, police station or school. Evaluations never take place at a client's home, since a neutral site is considered to be better for stabilizing a crisis. For the initial intake meeting, every effort is made to have the individual making the referral present (e.g., the police officer or DSS worker). Also a legal guardian must be present in the event that hospitalization is required.

In the intake process the worker usually talks to all parties, individually and together, to achieve several objectives -- to gain as much knowledge as possible about the precipitating event as well as background information; to assess the mental status of the youth and the family situation; and to begin to connect and develop a relationship with the youth and the family. The mental status interview is intended to gain a complete picture of the youth, seeking information about what brought the youth to the agency, his feelings (depressed, suicidal, angry), whether physical or sexual abuse is involved, any involvement in substance abuse, the youth's social life, and any changes in eating and sleeping habits. In the interview the worker tries to connect with the client emotionally and to determine the potential for building rapport and establishing a relationship. In addition, an effort is made to assist the client in determining what is needed to help stabilize the family crisis. If key figures in the family, such as a parent or a parent's significant other, are missing in the intake interview, are efforts are made to schedule another interview at a time when everyone can be present.

The intake worker completes a written evaluation of the youth and makes recommendations for further treatment. If crisis intervention is needed, a worker on the team will then be

assigned to take the case. The staff person who conducted the intake may stay involved It also is not unusual for the whole team to be involved in a case. The disposition may involve hospitalization, a referral to the Respite House a referral to another service of the SSMHC's Child and Adolescent Service, or to an outside agency. As discussed previously, the agency is reluctant to hospitalize unless there is no other alternative. The state's criteria for hospitalization are -- harmful to self, harmful to others and unable to provide self-care. In cases where these criteria may apply, there is usually a healthy tension between the agency's consulting psychiatrist and the director of the adolescent team regarding the appropriateness of hospitalization.

Crisis Intervention

If a youth and family is to receive crisis intervention services, the member of the team assigned the case meets again with the youth and family for further evaluation. The timing of the sequence of events for these initial interviews and meetings is condensed, most often occurring in the same day. Treatment is highly structured; treatment begins by formulating a treatment plan and contract with the family, identifying the problem or key problem areas for resolution, specifying goals to stabilize the crisis and prevent future crises, and determining the time frame necessary for accomplishing these goals. The client and/or family signs the treatment plan so that both the therapist and the family are clear about the goals and objectives.

Treatment involves intervention at several levels -- with the youth, the family and the community. According to the director of the Adolescent Crisis Team, "Treatment focuses primarily on building and maintaining a viable family system and on fostering the adolescent's successful functioning in the community." Treatment uses the crisis to bring about changes in family dynamics and patterns. "The advantage to treating the family in crisis," according to the team's director, "is that vulnerability is high, needs are intense and the client-therapist bonding is fast and strong . . . the family is open to therapeutic suggestion and ripe for change" (Handorf, 1987). If at all possible, treatment sessions involve all members of the family unit. Treatment helps family members to define roles and boundaries.

Developing supportive networks for the youth and family is also a critical aspect of the treatment process. Usually when a youth is in crisis, all the youth's systems are in crisis--family members, school personnel, the DSS worker and others involved in that youth's life. The role of the crisis worker is to begin to facilitate different parties to work as a support system for the youth by involving and coordinating a network of professionals, relatives and friends.

Follow-up

In order to avoid a waiting list, treatment is limited to approximately 12 sessions. When the crisis treatment goals are attained and stabilization has occurred, the worker on the crisis team begins to move toward termination. Usually the family is referred for ongoing treatment through the outpatient clinic of the Child and Adolescent Service. The family might also be referred to other treatment components such as case management or a group. Because of the strong bonds that develop between the crisis therapist and the family, special efforts are made to ensure a smooth transition between termination of crisis treatment and referral for ongoing interventions. If possible, both the crisis therapist and the outpatient therapist meet jointly with the family in the final crisis sessions. Referrals also may be made to other agencies or settings for follow-up care and the crisis worker facilitates those arrangements as well.

2. Respite House

SSMHC's Respite House is a home in a comfortable residential neighborhood of Quincy, one block from the ocean. The house can accommodate two youngsters for a maximum period of two weeks. It is used for youth ages 12 to 18 who are at risk of hospitalization and need to be temporarily removed from their environment. The Respite House is a voluntary alternative to hospitalization. Its primary purpose is to deter a hospital stay. The house serves as a diagnostic center, holding environment and treatment milieu. The residence is staffed by a live-in couple, one of whom is required to be a human service professional. The Respite House is licensed by the DMH and the State's Office of Children as a residential home. In Massachusetts residential programs are considered to be educational in nature and, as such, are not subject to zoning restrictions.

Intake

If placement in the Respite House is recommended, an admission conference is held, which generally includes the adolescent, parents, the team clinician, DMH case manager, any significantly involved community workers and the manager of the Respite House. The purpose of the conference is to determine the conditions of the adolescent's stay and to develop a service plan. The adolescent and the legal guardian must sign an individualized contract specifying certain conditions and privileges such as visits with friends and telephone calls, a plan for family visits and the projected length of stay. The specific agreement varies with each individual case. Unless contraindicated, extensive family involvement is required. At a minimum, there are two family meetings per week. If DSS is involved and if indicated, the DSS worker is responsible for developing a long-range residential plan for the youth.

Treatment

The Respite House provides an open, homelike environment. The house is set up for family living with a comfortable living room, dining room and kitchen, and separate bedrooms for each youth -- if two are staying in the home -- and the resident couple. Supervision is provided at all times, but there are no physical restraints, locked doors or quiet rooms. The resident couple does not provide active night time supervision. In difficult cases where 24-hour, one-on-one supervision is required, a specialized aide is brought in to assist the resident couple.

An individualized program is developed for the adolescent in residence tailored to the needs of the adolescent and the schedule and lifestyle of the house manager. One of the treatment modalities consists of participation of the youth in a household which models a constructive family experience where there are demands and routines. For this reason, all family visits occur in the Respite House. At the time of the site visit, the couple managing the house recently had a baby. The baby, the couple and the youth placed in the home all were part of the "family" and its routines. Activities might include attending school, going to work, participating in the area's day treatment program, participating in activities planned by the house manager, as well as participating in normal household activities such as going to the grocery store and preparing meals. If necessary, medications can be dispensed at the Respite House under the recommendations of the prescribing physician. The key to treatment is the relationship that develops between the youth and the house manager.

While at the residence, the youth continues to participate in individual counseling sessions with a clinician on the Adolescent Crisis Team, who also provides intensive therapy and consultation with the family. This involvement continues until the crisis has stabilized. The

house manager works closely with the assigned therapist in order to communicate information and coordinate the specific service plan. The crisis team provides 24-hour, on-call back-up to the house manager.

Discharge

A discharge date is set within two weeks of the admission conference. Typically, the length of stay is less than two weeks, usually six days. A stay may be extended but only after intensive review. A short-term stay is therapeutically desirable because it forces quick mobilization of the supportive network (Handorf, 1987). Usually families and youth utilizing the Respite House follow up with outpatient treatment. The crisis team clinician assigned is responsible for follow-up post discharge, working in close conjunction with the DMH case manager.

3. School Outreach Teams

The outreach teams that are located in local schools extend the SSMHC's capacity and capability to prevent a crisis from occurring or to intervene as quickly as possible if a youth is in crisis.

The Randolph School System supports a team of five mental health professionals plus several student interns who work on-site at the high school. This program is known as the Randolph Cooporative Mental Health Component (the COOP). Team members provide individual, family and group counseling to youth identified as handicapped through the Education for All Handicapped Act. Referrals are made to the Coop staff through the special education department. A team member is assigned to each of the contained special education classrooms to consult with the teacher one hour a week, to provide individual therapy, if needed, and to conduct groups. Staff are mobile and meet with youth and families in their homes or at a work site, if appropriate. Staff are on call at all times in case of emergencies. In an emergency, the Coop team provides crisis intervention and makes referrals to the Adolescent Crisis Team when necessary. Coop team members work extensively with other service systems and agencies to develop a service network for families. The treatment model is intended to be short-term (ten weeks), focusing on concrete goals. Staff see their role as supporting youth, providing a role model, advocating for the youth at schools or in the courts, and empowering families. The key to treatment is relationship building. Over 100 youth are involved in various groups through the Coop, some of which occur during class time and some after school.

At the Quincy Schools, outreach is provided to an elementary, middle and selected high schools. Staff of the Child and Adolescent Service provide consultation in emergencies as well as a range of consultation and in-service training activities for school staff and parents. Mental health staff also are located at the three Quincy high schools through a special grant targeted at drop-out prevention. Working on-site at the school provides mental health staff with access to students and helps reduce the incidence or the exacerbation of crisis.

Networking and Linkages

If one core value could be distilled from the SSMHC's overall treatment philosophy, it would probably be the importance of building community networks to provide outreach to clients and to develop support systems within the community. At the SSMHC, the commitment to outreach, networking and the development of interagency linkages is demonstrated on many levels: in the ways services are delivered, the activities of staff and the treatment goals for individual clients.

Historically, the SSMHC has worked cooperatively with the communities it has served. In the 1960s and 1970s one of the center's most valued services was the consultation and education it provided to schools and other agencies. Through this service the agency was able to reach out to clients to provide treatment as well as assist school personnel and providers in handling difficult situations. This commitment to community outreach and developing effective interagency relationships has continued. The directors of the agency and the Child and Adolescent Service have provided strong leadership in this area. Community leaders and other agency staff affirm the Child and Adolescent Service's reputation for excellent services and its importance as a valuable resource for clients and service providers. In particular, the service director of the Child and Adolescent Service is credited for her active role in being available and accessible to other agencies and community leaders.

The ability of the Adolescent Crisis Team to respond immediately to emergency situations and to go on site, if necessary, coupled with the availability of the Respite House, also have served to foster positive relationships with other agencies. This is a service that aids providers as well as the client in crisis. As previously described, staff of the Child and Adolescent Service provide extensive outreach in the community. This outreach has numerous benefits. Going into the community and working on site fosters better communication and improved relations among staff of different agencies. This facilitates treatment planning for clients because staff from different agencies work cooperatively to help develop supportive interagency networks for clients. Such cooperative ventures also provide a role model for families.

The agency's contract with both the Quincy and the Randolph schools to provide a team to work on site has been highly successful. School personnel in both school systems find the support of mental health professionals extremely helpful. In turn, the Child and Adolescent Service has been able to reach more clients, many of whom would not normally seek services from a traditional mental health center. The outreach to the health centers has served this same purpose.

The agency also has sought to work collaboratively with the Department of Social Services since so many clients are involved with this agency. SSMHC has three contracts with DSS: 1) a collaborative early intervention effort aimed at children who are environmentally at risk; 2) a service contract whereby the Child and Adolescent Service provides outreach counseling and ca management activities for certain adolescents and families designated by DSS; and 3) a special counseling program for victims of sexual abuse. As another initiative to build bridges, Child and Adolescent Service staff meet with DSS staff one morning a week in an ombudsman role to review cases and seek referrals. These collaborative efforts have improved relationships between DSS and mental health staff and have thus improved services to clients. While there are still system conflicts regarding financial responsibility and cost sharing, workers try to work cooperatively around treatment and service planning for youth and families.

In addition to working with other agencies, SSMHC reaches out to community groups. For example, the service director of the Child and Adolescent Service has been meeting on a regular basis with church and community leaders and agency representatives in Germantown, an impoverished area of Quincy. Meetings have focused on ways agencies can better serve residents of this area. The mental health center has been an active participant in this planning process and has a high degree of credibility.

Clients

The Adolescent Crisis Team serves youth who are in severe behavioral, psychiatric and/or emotional turmoil. Typical presenting problems include adolescents who are suicidal or

potentially suicidal, violent or assaultive, runaways or psychotic. The only type of cases the crisis team does not accept are youth who are severely mentally retarded or those who are going directly to court. Otherwise, any youth who is in need of crisis services will be seen by the team.

Sixty percent of the youth are between the ages of 16 and 17; 35 percent, 13 to 15; and 5 percent over the age of 17. All 18- and 19-year olds are screened. If a clinician feels the individual is an emancipated minor, the youth is referred to the adult emergency service. On average, 60 percent of the clients are male. The vast majority of the youth (99 percent) are white, reflecting the demographics of the community, which includes few racial minorities.

The agency is reluctant to use rigid diagnostic labels. It is estimated that over 80 percent of the youth have both conduct and emotional disorders. Approximately one third of this population has substance abuse problems as well. Five percent are psychotic or schizophrenic. Most of the youth display borderline characteristics: weak internal controls, poor insight and impaired ego functioning. Many of the youth come from multiproblem families where there is poor communication and frequently physical and sexual abuse. This client profile is similar for those youth served in the Respite House. The Respite House cannot admit clients who are legally committable.

In the last three years the number of youth served by the crisis team and respite unit has grown. In 1986, the Adolescent Crisis Team conducted evaluations for 202 youths. In 1987, 232 youths were served and in 1988, 338. The Respite House served 29 youths in 1986 for an average length of stay of 5 days. In 1987, 42 youths were served for an average length of stay of 6 days; and in 1988, 56 youths were served for an average stay of 6 days. In a one-month period during 1986 the Adolescent Crisis Team conducted intake and evaluation for 20 new cases for a total of 56 hours. Six intakes were off site and 14 at the SSMHC; 15 occurred during regular hours and 5 after hours.

Staffing

The SSMHC is known for the high calibre of its clinical staff. It has an outstanding reputation as a teaching program and is sought after as an internship placement for students. Because of this reputation, the center is able to attract and maintain excellent staff.

The Child and Adolescent Service includes 60 staff who are highly trained and experienced clinicians. On staff there are 44 master's level social workers, 8 doctoral level psychologists, 4 psychiatrists, 2 master's level psychologists and 2 master's level occupational therapists. At any one time there are 6 student trainees.

The Adolescent Crisis Team consists of 23 staff from the Child and Adolescent Service. Service on the crisis team is not full-time. Staff are assigned to other teams as well, in part because of funding sources, but mostly to balance caseloads to include noncrisis cases and thus prevent staff burnout.

The multidisciplinary Adolescent Crisis Team includes doctoral level psychologists, master's level social workers and one staff with a bachelor's degree. The Respite House is staffed by a couple, one member of whom is required to have a degree in a human service field and who must commit to the position for at least a year. The current house manager has an M.S.W. and has been in the position for over two years.

The Adolescent Crisis Team staff work two shifts, 9:00 a.m. to 1:00 p.m., and 1:00 p.m. to 5:00 p.m. On each shift there is a staff member on call and a back-up person, generally the director of the team or a senior psychologist. Back-up staff are assigned for a week at a

time. Staff are assigned on-call duty for one shift per week. From 5:00 p.m. to 9:00 a.m. two staff provide coverage by beeper. In addition, the director of the team is always available during this time period.

Staffing is generally handled in the following manner: The person on call conducts the intake, with the back-up person providing continuity and support. Once intake occurs, the case usually is assigned to another member of the team who evaluates the case and continues to provide crisis intervention and stabilization. If the youth is placed in the Respite House, the same clinician will participate in the admissions conference, provide individual and family therapy and be on call for the youth, the family and respite staff. However, the crisis team staff serve as the emergency backup when the ongoing clinician is unavailable. If a referral is made to the Child and Adolescent Service for ongoing treatment, the Adolescent Crisis Team therapists will work closely with their colleagues in the Child and Adolescent Service to facilitate the transition.

The primary responsibility of the Respite House manager is to oversee the operation and management of the house and to provide supervision and treatment, in conjunction with the primary therapist, to youth staying in the home. The respite manager participates as a team member and is involved in in-service training, case conferences and general consultation. Relief for the respite manager and spouse is provided by a trained couple who take over every other weekend. The primary couple may stay in the house or leave. The relief staff for the Respite House also are available by beeper. The Respite House staff is provided clinical and medical back-up at all times.

Supervision is an important element of the Child and Adolescent Service because of the agency's role as a clinical training program and its commitment to support staff in providing community-based treatment to very troubled clients and families. All staff have one to three hours of supervision on a weekly basis. On the crisis team four staff provide supervision to the team members. In turn, all members of the team provide supervision to students. A rigorous peer review system also provides a means of oversight and supervision. All records are reviewed every three months, with comments by a psychiatrist, social worker and psychologist.

Meetings are also an intrinsic part of staff activities. All Child and Adolescent Service staff meet weekly for case presentation and consultation. The child therapists meet weekly to receive in-service training on various issues, and these sessions are open to all clinical staff. The crisis team meets twice a week to review cases, keep abreast of day-to-day team functioning issues, and provide support for each other. The service director of the Child and Adolescent Service holds a weekly coordinating meeting with the various program directors to review priorities, initiatives, scheduling and team coordination.

Training is built into the team meetings and supervision. New staff to the crisis team receive on-the-job training when they are first assigned to the team. Initially, staff will work on a shift with the director of the team observing cases. Staff will also work with other team members on cases. When the staff member is assigned a case "solo," team members will observe through a mirror and provide feedback and consultation.

Staff cite a number of special requisites that enable the crisis team members to be effective in their jobs and function in situations that are highly stressful.

- The team is cohesive. This cohesiveness results from a number of factors. Working with crises has a bonding effect on staff. Team members also function as a family for each other. Members know a great deal about each other and their families. They share in social activities. And, most importantly, they nurture each other.

- o Staff have a talent and ability to do their job well. Team members bring a high level of competence and experience to the job. They are highly trained and possess strong clinical skills.

- o Training and supervision are ongoing and considered to be essential to the functioning of the team.

- o Staff have a vision of the possibilities and po ntial for the youth and families in crisis who come to them.

The issue of burnout is dealt with in various ways. Staff rotate on different teams to provide a diversity of experiences and to help reduce the stress level. Staff did mention, however, that this rotation and serving on several teams has a negative side effect as well because it produces a sense of being fractured. Supervision, training, staff relationships and bonding are other means of alleviating burnout. The Child and Adolescent Service also has designated a staff room so that staff have a place to go to vent and relax. This relatively simple measure has been very beneficial.

Other issues that staff of the Child and Adolescent Service struggle with are tensions around good clinical service in the face of budget constraints as well as the enormity of paper work involved in working for a large, comprehensive community mental health center. The service director of the Child and Adolescent Service tries to bridge the gap between these clinical concerns and administrative demands.

Resources

The total operating budget for the SSMHC is $13 million, and, of this amount, the budget for the Child and Adolescent Service is approximately $3 million. The emergency service components of the Child and Adolescent budget include the Adolescent Crisis Team and the Respite House. The annual operating expense for each of these components is as follows: crisis team, $889,000 and respite care, $63,614. Seventy-five percent of the crisis team's expenses are allocated to personnel costs; 12 percent to overhead costs; and, 13 percent to indirect costs such as rent, supplies and telephone. Approximately 43 percent of the Respite House budget is devoted to personnel; 26 percent to rent, supplies and telephone; and 17 to overhead costs. Liability insurance is covered through the agency and is not included in overhead costs. Each of SSMHC's facilities has a different rating.

The average per hour cost per youth and family treated by the Adolescent Crisis Team is $145.53. This includes intake, evaluation, short-term treatment and crisis stabilization. The per diem cost of the Respite House is $230.67.

Revenues for the Respite House are solely through a state DMH contract. Payment is on a cost reimbursement basis, so there is no incentive to fill beds. The Adolescent Crisis Team is funded through multiple sources: 63 percent through state mental health contracts, 17 percent through state DSS contracts, 10 percent from Medicaid, 6 percent through Blue Cross, 3 percent from direct fees based on a sliding fee scale, and the remaining from commercial insurers. Rates for the emergency service, both on site and at the SSMHC, are the same and vary only according to payor. The fees for Blue Cross and Medicaid are $31.12 per 30-minute visit and for direct bill and commercial insurers, $50.00 per 30-minute visit.

Medicaid and Blue Cross rates are established by a statewide rate setting system. Departments of Mental Health and Social Services' rates are individually negotiated based on historical costs with adjustments for inflation. These rates are subject to appropriation of funds to the funding agencies by the state legislature.

The Departments of Mental Health and Social Services as well as Medicaid fund services through a "purchase of service" contract that specifically defines what services are to be provided. Often the services are quantified in the contract and, in addition, the treatment modalities and eligible clients are specified. The DMH and the DSS specify 10,000 contact hours on a yearly basis.

The school outreach programs are funded through contracts negotiated through the local school systems. The Quincy schools contract budget is $137,000. Revenues come from state block grant dollars, billings to Medicaid and other insurers and fees. Medicaid covers 36 percent of the costs, since the service can be billed as an outpatient clinic service. The mental health center also provides free care. A drop-out prevention program, provided through the Quincy schools, is funded through a grant to the schools and a subcontract with SSMHC. The budget for the Randolph Coop program is $158,527. SSMHC receives $86,000 from the Randolph school system; $26,000 from Blue Cross and other commercial insurers and the remainder from Medicaid.

Agency personnel note a number of problem areas with the financing of services:

- State funding agencies are beginning to define the mandated populations to be served using increasingly restrictive criteria. As a result, some clients presenting to the child and adolescent emergency service may not fit into any of the eligible categories. DMH, while not perceiving itself as having primary responsibility for youth (since DSS has primary responsibility), has recently executed an agreement with DSS to retain responsibility for emergency services.

- Blue Cross and commercial insurance rates are capped at a maximum amount that is established on the model of outpatient family counseling. The rates do not take into consideration the nature of crisis counseling and the intensive services required in emergency situations.

- Third-party payors do not pay for outreach; staff are committed to providing off-site interventions to work with hard-to-reach youth but then feel pressure to increase treatment hours to justify the outreach.

- Medicaid benefits are capped at a maximum of 17 service hours, at which point an extensive clinical justification must be submitted for approval of continued service.

- Funding sources, except for DSS and Medicaid, do not incorporate in their rates the concept of collateral service time, i.e., contacts with other agencies for treatment planning and networking. The Child and Adolescent Service estimates that at least a half-hour of collateral services is provided for every hour of treatment given.

- Funding sources are not willing to pay for the long-term therapy that many youth and families require. Clinical staff are concerned that budget issues determine and compromise clinical interventions.

Evaluation

SSMHC has a comprehensive peer and utilization review for quality assurance but no formal evaluation based on outcome measures. At the time of the site visit, the state was exploring options to implement a performance-based system that would use outcome determinants. Possible outcome measures include engagement of the family, number of appointments kept, numbers cancelled, drop-out rate, and school attendance.

Agency data show an 89 percent reduction in adolescent admissions to the state hospital psychiatric unit during the two-year period after the development of the Adolescent Crisis Team. Statistics for the last four years detailing the number of emergency evaluations, hospital admissions, Respite House admissions and respite days are shown below. The increases in 1988 reflect the expansion of SSMHC's service area to include the seven towns in the Coastal catchment area. During this time period hospital admissions have remained relatively stable, whereas admissions to the Respite House have increased. The majority of the Respite House discharges are to the youth's home.

SSMHC Emergency Evaluation, Hospital Admissions,
Respite House Admissions, Respite Days
Fiscal Year 1984-1988

Fiscal Year	Emergency Evaluations	Hospital Admissions	Respite House Admissions	Respite Days
1984	129	13	23	156
1985	201	18	37	202
1986	202	16	29	141
1987	232	16	42	251
1988*	338	39	56	339

* SSMHC expanded its service area to include seven additional towns. The 1988 statistics reflect the growth in the agency's catchment area.

Major Strengths and Problems

The Child and Adolescent Service receives high praise for its work from community leaders, state officials, agency staff and families. The Adolescent Crisis Team is viewed as an integral and critical part of the Child and Adolescent Service. The reasons for this success are attributed to:

- The service director of the Child and Adolescent Service's sense of vision and willingness to take risks to improve service to clients.
- The visibility of the service in the community.
- The willingness of staff to work in the community and accept feedback from other agencies.
- The competence of staff and their excellent clinical expertise and judgment.
- The 24-hour access to and availability of staff.
- Good communication between the SSMHC staff and staff of other agencies.
- The commitment of staff.
- The existence of the Respite House for those crisis situations where placement is necessary.

Most of the problems and challenges that the agency faces are systemwide issues. It is widely agreed that more resources need to be made available for adolescent services and that there is a need for more service components to achieve a viable system of care. These include therapeutic day treatment programs; a facility for youth who are awaiting residential placement to prepare them for placement; a secure residence for six- to nine-month treatment; more group and therapeutic foster homes for adolescents; and, support and skill building programs for parents. With agencies narrowing their missions in terms of the populations to be served, there is concern that there will be an increase in youth and families receiving no services. In particular, the courts need to develop a service system for youth under their jurisdiction.

A continuing dilemma is the inadequate training and the lack of availability of professional staff for an outreach, community-based, crisis intervention model. According to SSMHC staff, the outreach model has few disadvantages, but one problem noted was the conflicts around confidentiality. For example, in the school-based programs, teachers often want more information about youth and families than staff can share and still respect the family's right to confidentiality.

Dissemination and Advocacy

Case advocacy is an integral part of the role of the crisis team. Staff reach out to staffs of numerous other agencies such as DSS, the schools and the courts to build bridges and develop service networks for clients. As a result of the alliances developed with personnel of these agencies through the various outreach activities, interagency contacts and communication, there is a solid foundation for cooperative working relationships.

Staff of the Child and Adolescent Service, as discussed previously, play an active role in the community and are involved on a regular basis in advocating and making presentations to improve services to troubled youth and multiproblem families. Staff frequently lobby on behalf of youths' needs, for new program ideas or additional resources. Staff have been involved in public service programs on radio and television and have contributed to newspaper articles. Staff are also active members of community groups and boards, in some cases serving in their professional capacity and, in other cases, as residents of the communities where they live.

Members of the staff have also made numerous presentations on a local, state and national level regarding the Adolescent Crisis Team and Respite House treatment model. The program is well known and well regarded in the state and has been promoted as a model for other community mental health centers.

Case Example

"M" was referred to the Adolescent Crisis Team by her mother. At the time of referral M was approaching her 17th birthday. Her presenting problems were disorientation, paranoid ideation and suicidality. M lived with both parents in public housing in Quincy. The family had no history of outside agency involvement. The on-call clinician evaluated M with both her parents, despite some initial resistance to involve the father due to his physical disability. The evaluation revealed a number of family stresses including a long history of marital discord, alcohol abuse and the father's pending death of heart disease. The treatment plan included an admission to the Respite House, consultation with the team psychiatrist and a 12-week therapy contract. Respite provided a structured environment away from the family stress, which enabled M to recompensate. The family met with the therapist three times a week, and M was also seen individually. The crisis with M provided an opportunity to make some structural changes in the family as well as to address the family's underlying conflicts.

Through therapy, M became increasingly less anxious and depressed, and the family better prepared to cope with the father's death. M continued in individual treatment and later participated in a group for teenagers of alcoholic families.

Technical Assistance Resources

- Adolescent Crisis Team Presentation at the Regional Meeting of the National Council of Community Mental Health Centers, October, 1986.
- Description of the Adolescent Crisis Team and Respite Home by Timothy R. Handorf, SSMHC, 1987.
- Description of Child and Adolescent Service
- Agency Crisis Procedures
- Statistical Information FY 1984-1986
- Agency Forms

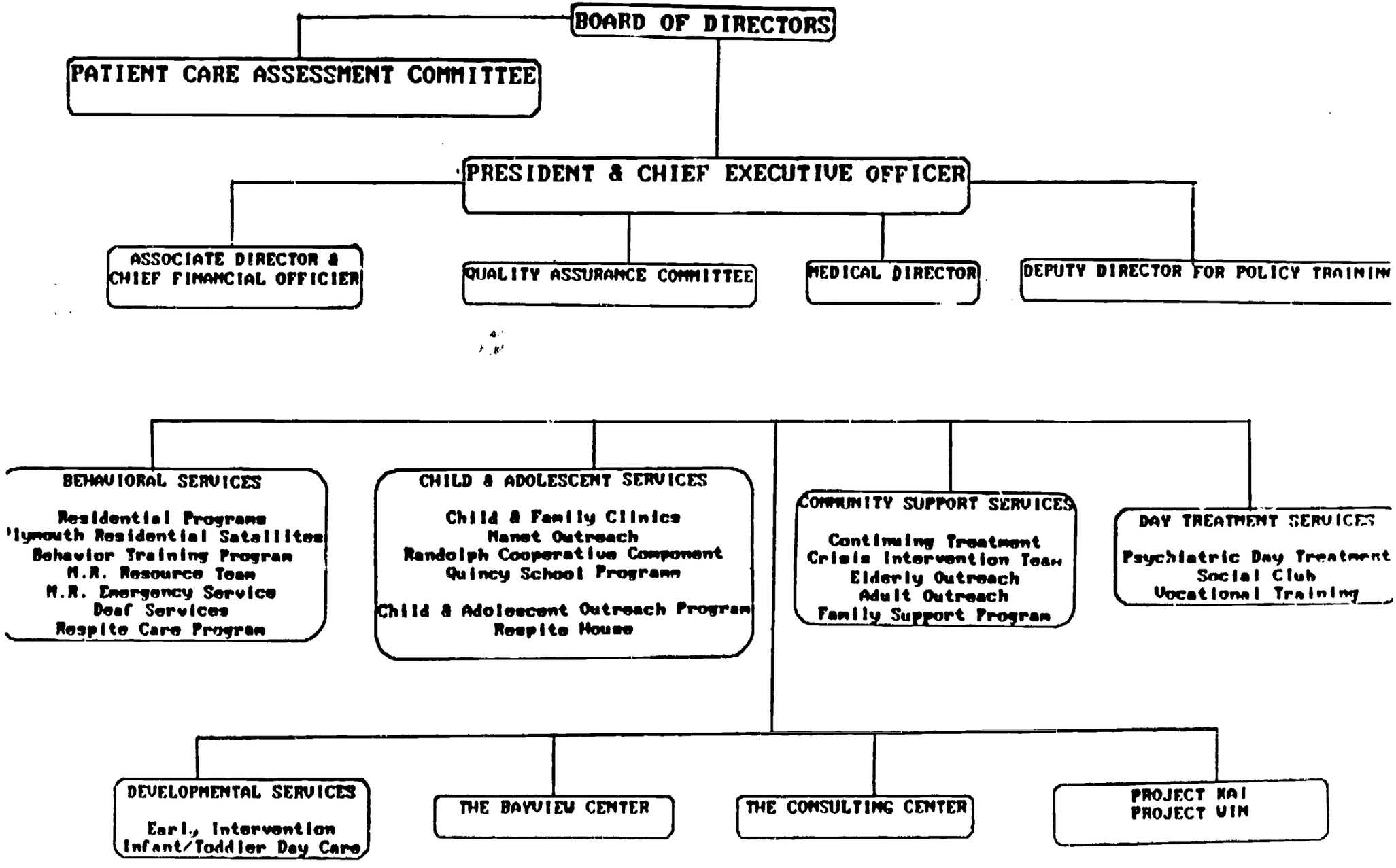
  Monthly Progress Reports
  Emergency Statistical Reports
  Service Delivery Reports
  Emergency Staff Coverage Sheets

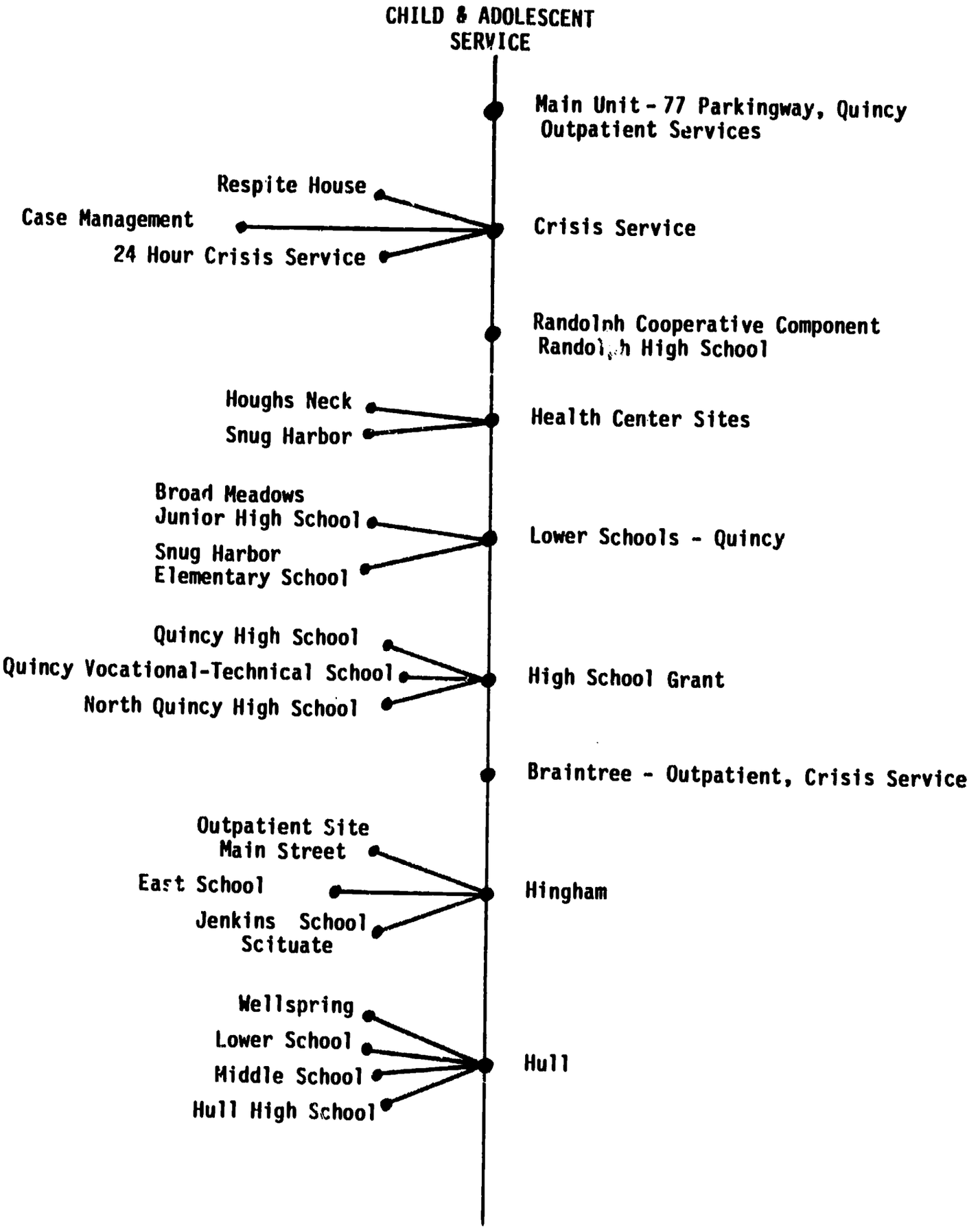
- Respite House Forms

  Parental Agreement
  Rules
  Admission
  Daily Log
  Discharge

- Listing of Current Treatment Groups
- Billable Outpatient Services Fee Schedule
- Agency's Sliding Fee Scale

SOUTH SHORE MENTAL HEALTH CENTER, INC.




CHILD & ADOLESCENT SERVICE
Main Unit - 77 Parkingway, Quincy
Outpatient Services
Respite House
Case Management
24 Hour Crisis Service
Crisis Service
Randolph Cooperative Component
Randolph High School
Houghs Neck
Snug Harbor
Health Center Sites
Broad Meadows
Junior High School
Snug Harbor
Elementary School
Lower Schools - Quincy
Quincy High School
Quincy Vocational-Technical School
North Quincy High School
High School Grant
Braintree - Outpatient, Crisis Service
Outpatient Site
Main Street
East School
Jenkins School
Scituate
Hingham
Wellspring
Lower School
Middle School
Hull High School
Hull

CHIL 'EN'S CRISIS INTERVENTION SERVICE (CCIS)
TRANSITIONAL RESIDENCE INDEPENDENCE SERVICE (TRIS)
SICKLERVILLE, NEW JERSEY

History

The Transitional Residence Independence Service (TRIS) located in Camden County, New Jersey, is a private, nonprofit, psychiatric rehabilitation agency, which offers a range of services and community-based programs for children, adolescents and adults. One of TRIS's service components, within the system of care TRIS has developed for youth, is the Children's Crisis Intervention Service (CCIS), a community-based residential program providing crisis intervention and stabilization services to youth from seven counties in southern New Jersey.

Prior to 1978 New Jersey's Division of Mental Health and Hospitals (DMH&H) maintained children's units at each of the four state psychiatric hospitals as well as a special facility for treating children with psychiatric problems, the Arthur Brisbane Child Treatment Center (ABCTC). The units at each of the psychiatric hospitals served that hospital's respective catchment area. In the late 1970s, these units were serving a daily population of between 300 and 350 children and adolescents.

Concerns about the role of these units, the quality of care provided to children and adolescents, and accreditation of the psychiatric facilities prompted a departmental study of these children's units. As a result of this study, DMH&H recommended an innovative plan calling for the creation of a continuum of services for youth and the development of specialized programs to meet, in a more adequate way, the needs of the children. Specifically, the plan called for the creation of regional community crisis intervention service units to provide the first 28 days of inpatient psychiatric care to stabilize a child's crisis and avoid further hospitalization.

Between 1979 and 1981 this plan was implemented, and regional crisis units were established across the state. Three of the former psychiatric units for children were closed. Staffing was increased at both the Trenton Psychiatric Hospital Adolescent Unit and the Arthur Brisbane Child Treatment Center to provide long-term psychiatric hospitalization for those adolescents and children who either needed continued inpatient care subsequent to treatment in the crisis u or could not be handled in a less restrictive setting. As part of this plan, partial hospitalization and outpatient services were to be developed to support a community-based system of care and provide additional alternatives to inpatient care. This recommendation has yet to be fully implemented.

TRIS has been operating the CCIS for the southern region of New Jersey since 1980, when it was selected by DMH&H as the organization responsible for the programmatic and clinical administration of the CCIS in that region. It is the state's only free-standing crisis facility located in a community residence, with no formal hospital affiliation. In response to a policy initiative in 1986 (state legislation is currently pending) prohibiting the institutionalization of any child between the ages of five and ten in New Jersey, TRIS opened a second children's crisis intervention center, Ginger Grove, the following year, to serve this age group. This program also is located in a community residence.

Until 1980, TRIS's programs were adult oriented. The agency began in 1977 as a small residential program providing predischarge and psychosocial rehabilitation services to six clients with histories of long-term institutionalization. In 1980, with the development of CCIS, TRIS moved into the provision of children's services. In 1981, TRIS conducted a thorough analysis of the area's service system for children to identify service gaps that were

having a negative impact on CCIS children and families. TRIS then designed a basic framework for a continuum of services. In a six-year period, TRIS sought and secured funding for:

- o A regionally based network of specialized foster care services, capable of providing home-based support and counseling services for severely emotionally disturbed children and adolescents;
- o An intensive treatment oriented group home,
- o An adolescent partial care program, and
- o A specialized psychoeducational support program for families.

Since its inception, TRIS has grown from a $65,000 budget with six employees in one site to a budget of $5 million with 180 full-time employees, 35 part-time employees and a cadre of specialized consultants, located in 15 different sites, offering a continuum of services to children, adolescents and adults.

Community and Agency Context

TRIS and CCIS serve seven diverse counties in the southernmost area of New Jersey--Atlantic, Bridgeton, Camden, Cape May, Cumberland, Gloucester and Salem. The region is both rural and urban. The city of Camden, home of Campbell Soup and RCA, has a high unemployment rate and a population that is predominantly black and low income. In stark contrast, Salem County is rural and the population white, but also poor, like most of the area. Cumberland is primarily agricultural, with a large Hispanic population. It has one of the highest unemployment rates in the nation coupled with a high rate of alcoholism and suicide. Cape May is known for its beautiful beaches, Victorian houses and tourists, but there are almost no social services for its residents. Many of the problems experienced by the region's population are generational, rooted in poverty, isolation and a lack of education, health and social services.

TRIS provides multiple clinical and programmatic services to respond to the needs of three client groups: children and adolescents, aged 4 to 17, experiencing psychiatric crisis; young adult chronic psychiatric clients, aged 18 to 30, who have had multiple short-term hospitalizations; and severely chronic, long-term institutionalized clients. Access to all services is through a centralized intake system.

Services to adults include:

- o A residential program with five supervised group homes and four apartments;
- o Affiliated boarding homes providing support services and crisis intervention;
- o Two partial care programs assisting 230 clients to attain a higher level of functioning;
- o A vocational program, also serving youth aging out of the children's care system, aimed at teaching on-the-job behavioral skills and finding job placements;
- o A support group providing education in parenting skills for court ordered, abusive parents.

The children's services provided by TRIS include:

- o CCIS -- a community residence and crisis program, serving up to 12 youth, ages 12 to 17, for a maximum stay of 28 days and providing psychiatric evaluation; individual, group and family counseling for crisis intervention and stabilization; education, recreation and leisure activities; case management, and referral. It is an open unit with no locked doors or traditional "quiet rooms."

- o The Interim Group Home (IGH) -- a group home serving eight adolescent youth from the seven-county area. The program is funded by the Division of Youth and Family Services (DYFS) through the DMH&H. The average length of stay in this community residence is 14 to 16 months.

- o Adolescent Partial Care (TAPS) -- an after school day treatment program for youth in the IGH or directly from the community. The program uses a behavior modification and level system to foster the development of socialization skills. The maximum capacity of the program is 25 youth. The program serves Camden County exclusively.

- o Specialized Foster Care -- specialized services provided by a mental health counselor to children placed in DYFS approved foster homes. For each child, the mental health counselor develops a service plan in conjunction with the foster parent. Services can include assessment, home-based care and crisis intervention, transport to, and liaison with, the child's therapist and support to the foster parent. A monthly support group to foster parents is also provided. This service extends to all seven counties. It serves youth aged 5 to 18, but targets a population of 5 to 10 year olds. Each mental health counselor has a caseload of eight children; at a minimum, the counselor sees a youth once a week for two hours.

- o Ginger Grove -- a group home and crisis center for children aged 5 to 10, providing comprehensive psychiatric evaluation and treatment; nursing coverage and medication monitoring; individual, group, family and play therapy; psychoeducational, recreational and skill building activities; a daily academic education program coordinated with local school districts; and case management.

These services are located in a variety of sites in the seven-county area. Program administration, however, is centralized. Administrative staff are housed in a low-rise office building off a main thoroughfare in Stratford, New Jersey, in Camden County.

Because of its size and diverse programmatic components, TRIS has a relatively complex administrative and organizational structure. Overall agency administration is provided by an executive management team that consists of the executive director, an associate director, and a cabinet of three executive managers with different functional responsibilities, including personnel and organizational development; program design and development as well as utilization review and quality assurance; and finance and agency wide operations. The associate director also provides oversight to all clinical activities. The executive and associate directors and two of the cabinet members have each been with TRIS over eight years. Their experience in sharing successes and surmounting difficulties has produced a close relationship among the members of the executive management team. Reporting to the executive management team are five managers responsible for children's services, adult services, intake and outreach services, educational and training services, and administrative services (i.e., facility management). The coordinators of the individual programs report respectively to either the director of adult or children's services.

Providing policy oversight to TRIS is an 11 member board. The board meets every other month and includes members that provide a breadth of expertise and experience. The current board consists of two parents who have used TRIS services, several clinicians, several local business people, an executive director of a vocational program, and a past president of a university. The board president and executive director meet regularly, usually on a weekly basis. The board grapples with such issues as the agency's financial future, clinical treatment approaches, policies around AIDS, or, as it did recently, an appropriate site for the Ginger Grove facility.

The CCIS program is located in Sicklerville, a semi-rural community experiencing rapid suburban growth. Much of the land has been used for farming, so it is flat and open. Recently subdivisions have been cropping up everywhere. Houses in the neighborhood where CCIS is located are spaced quite far apart with large, expansive yards. The houses are well kept, modest frame buildings, mostly ranches and split levels. The CCIS lot is five acres and the house is indistinguishable from the other homes in the area. Staff report that neighbors are not disturbed by the program and have been very supportive.

The main level of the house includes the living room, dining room and kitchen as well as bedrooms for the youth and a small area for nursing staff. The lower level includes offices for the program coordinator, the therapist, case manager, intake workers and a large open classroom area. The yard is used for recreational activities. The house conveys a homelike feeling; it is comfortable and well maintained.

Philosophy and Goals

A hallmark of TRIS is the underlying principles that guide the development and the implementation of all the services the agency provides. These guiding principles specify that:

1. Services must reflect a basic foundation of hope and belief in every client's ability to achieve his fullest potential.

2. Services must be provided in a manner that supports the integrity and empowerment of the community.

3. The range of services must be organized according to individual, family and community needs. If at all possible, the client must be given instant access to service.

4. Successful treatment intervention is further assured when creativity and flexibility are encouraged as essential elements of the service delivery system.

5. The system must promote a holistic service approach, recognizing that every aspect of the child's emotional, physical and spiritual needs warrants careful consideration.

6. The delivery of a comprehensive range of services, within a system of care, is most effective when provided by an enthusiastic and committed staff. Educational enrichment programs, regularly available technical assistance, and a consistent, structured opportunity to explore effective problem-solving techniques and methods for managing diversity must be included as part of an employee development program.

7. A commitment to excellence in service delivery must be the fundamental ideal and motivating force for every staff member.

In interviews with many different staff, it was clear that there is a strong acceptance of these values at all levels, from the executive director to the shift staff, the human service

advisors. Stated somewhat differently, staff articulate an agency philosophy that is based on hope; a belief that clients want a better life, that the program can make a difference in clients achieving their potential; and that it is important to pay attention to basic human needs and social stresses.

In addition to its commitment to its clients, the TRIS executive director believes the agency has a responsibility to enhance the quality of life for its employees. The agency's internal value system opposes institutional racism and sexism and supports personal growth and development. As such, the agency acts to encourage team building and conflict resolution.

The mission of CCIS is to prevent the inappropriate institutionalization of severely emotionally disturbed children and adolescents by providing short-term crisis stabilization and intervention, using a natural support network and community-based treatment. Specific goals set forth by the agency include:

- To prevent or reduce inappropriate institutional care by providing community-based care or other forms of less intensive care.

- To enable people to achieve or maintain self sufficiency (the ability to care for themselves) so as to prevent or reduce dependency.

- To prevent or remedy neglect, abuse or exploitation of children and adults unable to protect their own interests and, when possible, to preserve, rehabilitate or reunite families.

Services

The services provided by CCIS are short-term and intensive, aimed at crisis stabilization. They include a 12-bed, 28-day, community-based crisis stabilization residence, with 24-hour clinical supervision; comprehensive psychiatric evaluation and treatment; 24-hour nursing coverage and medication monitoring; individual, group and family therapy; psychoeducational, recreational and skill building activities; an academic program coordinated with local school districts; and case management and advocacy to activate community treatment support and insure necessary system linkages.

All clients referred to CCIS for treatment must be initially screened by a DMH&H state-designated local screener. In the southern region, screening for three counties occurs at a hospital-based emergency room. For the four northern counties, the screener is located in a local mental health center. The screeners determine the level of care needed by the client and serve as a gatekeeper to the regional crisis units. The CCIS serves as the gatekeeper to the state inpatient facilities for children and adolescents.

When the children's crisis intervention services were established in New Jersey, it was intended that the units would have no waiting lists and youth would be admitted immediately. However, the insufficient development of other services along the continuum, such as intensive outpatient and day treatment, has produced an overcrowding of the CCIS units statewide. CCIS clients may stay longer than necessary and may be referred to the CCIS because of the lack of other appropriate alternatives. As a result the CCIS units have been experiencing waiting lists for services. To deal with this problem, TRIS established a mobile outreach service in 1986. In the outreach service, a team evaluates the youth and the situation, providing support and case management services to the child and family to maintain the child in the home and community. The experience has been so successful that a proposal has been developed to expand the outreach service. Although the outreach service has minimized the waiting list, a client still may wait a week or two before admission to CCIS. Two beds also

have been added to accommodate any children and adolescents who have a need for immediate access to an inpatient facility.

When the local screener refers a youth and family to the TRIS-CCIS, a triage decision is made as to whether the client can be stabilized in the community through the outreach service, admitted to CCIS, or referred to a hospital or other treatment setting. A joint decision is generally made between the local screener and CCIS staff.

Intake at CCIS usually involves one of the two intake workers and the case manager. An effort is made in the intake process to involve any agency staff, such as the DYFS worker or other therapist involved with the family, along with the child and parents. Parents or a legal guardian must sign consent forms to admit a youth to CCIS.

The intake worker develops an initial individual service plan. The goals of this plan are usually aimed at helping the youth settle into the program and reduce stress. As soon as a youth is admitted, a staff person is assigned to provide one-to-one supervision. The psychiatrist makes the determination when this one-on-one status is no longer necessary.

Soon after admission, a therapist meets with the child to develop an individual service plan that is updated every week. The goals of the treatment plan are based on the presenting problem. Families are involved at intake and in subsequent sessions with the therapist in exploring issues that precipitated the crisis and in developing goals. By the second week, planning for the youth's discharge begins to occur. Weekly treatment meetings are held to review cases. The treatment team participating in the weekly meetings includes the program coordinator, the psychiatrists, the case manager, the therapists, the nurse supervisor, both intake workers, TRIS's associate director and the director of children's services. The goals of treatment are to:

- o Decrease the youth's anxiety and any suicidal ideation;
- o Gather information on the child and the family, from both perspectives;
- o Focus on problem resolution;
- o Help the child and family begin to make changes;
- o Plan and implement next steps.

The treatment approach at CCIS is holistic, involving the environment, the activities, the clinical interventions and the support and nurturance of the staff. All staff are involved in the treatment process. Treatment strategies include:

- o Developing a trusting relationship with the youth;
- o Providing the youth with a forum in which realistic goals are identified and explored;
- o Providing the client with an accepting milieu where newly learned behavior can be practiced;
- o Ensuring the provision of a uniform and consistent clinical approach.

At CCIS the building of relationships is paramount in the treatment process. In the short time available all staff work to build a relationship of trust with the client. To engender this trust, staff try to be believable and predictable. They work to ensure that the youth can

have a successful experience, yet at the same time staff are not immune to the tragedies that many of these youth have experienced. Staff try not to put pressure on the youth but to be available to listen to their problems. An atmosphere of respect pervades the program in the ways staff treat and communicate with each other and the youth.

The therapist works intensively with the child and family around identifying problems, developing goals, exploring different coping means and options and making decisions for follow-up. The therapist, along with the case manager, serve as a liaison to the agencies involved with the family. Usually, the therapist meets with the youth at least twice a week for extended sessions and meets weekly with the family. There is also extensive phone contact with the family. Both the therapist and case manager are available to clients during the day.

Efforts are made to involve families from the point of intake throughout treatment. However, since many of these youth have been involved in abusive family situations, to allow crisis stabilization to occur, the agency has developed some strict policies around contact between the youth and family. For the first week, no visits are allowed and only telephone contact is permitted. This policy is believed to be an important factor in reducing the stress level and allowing stabilization to take place. The first visit by parents is on the grounds of the facility and is monitored by staff. Additionally, phone calls are monitored, and children are allowed to make two a day. During the second week, a youth may make a visit home, and, if all goes well, during the next visit may stay overnight.

CCIS is structured to create an environment and atmosphere that is warm, nurturing and homelike. Treatment policies support that environment. Staff are called by first names. There are no locked doors or quiet rooms. Physical restraints are never used. Medication is not used as a chemical restraint but is prescribed only when necessary and essential to the child's treatment. It is the staff's role to make the environment safe. Holds and hugging are used to deal with any violence and one-on-one relationships to support and calm a youth. If a youth runs, a staff person will follow.

The routines established also help to convey a normalized, homelike environment. Youth eat meals together in the dining room; they sleep in bedrooms with two to four beds to a room. Activities take place at the dining room table, in the living room, the large classroom on the lower level or in the yard. The house staff run groups three times a week on such issues as peer pressure and other topics of concern to adolescents. Sports, arts and crafts and other recreational activities take place during the day and evening. The nurses also conduct two groups a week on health issues. Chores are part of the normal routine of the house to encourage youth to take responsibility in a family.

During the week, youth spend the morning in the education program. Education is not generally geared to an academic curriculum; rather, the goals focus on skill building and resocialization. The intent is to create a positive, not a stressful, situation. The time is devoted to a series of individual and group activities. For example, one activity might be a role playing exercise in which a youth is asked to write up a brief situation that might occur in a family. Other youth are then assigned roles, acting out their parts in a spontaneous way. Then a discussion is led centering on how family members might have acted differently. Sometimes movies are used to illustrate certain situations and lead to a discussion of different options for resolution. An activity guide has been developed for staff use, providing guidance on structuring the time for daily activities and providing a diverse range of skill building and socializing events.

Throughout treatment, linkage is maintained with other agencies as part of the planning for service support after discharge. Most youth (61 percent) return home with a variety of

community support services arranged. These services may include individual outpatient and family counseling, working with a counselor at school or assigning a youth advocate. TRIS has affiliation agreements with the mental health centers in the counties guaranteeing that within seven days a youth and his family will have an appointment. Youth may stay involved with TRIS through TAPS, the partial care program. Other youth are discharged to foster homes (12 percent), other residential centers (20 percent), or to inpatient units (7 percent). With each of these discharges, the CCIS therapist and case manager play an active role in the planning and transition.

CCIS, as noted previously, has a 28-day maximum length of stay mandated by the state. The average length of stay is approximately 23 days, with approximately 10 to 15 percent of the youth staying beyond the 28-day limit due to problems in finding placement after discharge.

Since the focus of CCIS is on short-term crisis treatment with an emphasis on developing community supports, the program has established a no contact policy after the youth is discharged. It is believed that continued contact with CCIS staff will prevent the youth from bonding with support contacts out in the community. The policy is aimed at helping youth stay connected to the community, but it has at times presented difficulties for program staff an youth.

Networking and Linkages

TRIS and CCIS staff are committed to working collaboratively with other agencies and systems so that children who are emotionally disturbed receive the services they need. Because TRIS-CCIS serves a regional area through a state contractual arrangement, CCIS interagency linkages are on a state, regional, county and local community level.

TRIS-CCIS staff work closely with, and try to merge through their efforts, four separate service systems: the Division of Mental Health and Hospitals (DMH&H), the Division of Youth and Family Services (DYFS), the Department of Education (DOE), and the Department of Corrections (DOC). On a state level, the DMH&H and DYFS are both divisions of the New Jersey Department of Human Services but are administered by two different deputy commissioners. Education and Corrections are separate departments. TRIS-CCIS tries to engender positive and cooperative relationships with these four systems through a free flow of communication and constant availability as a way to promote cross-system linkages and a responsive service continuum for youth. Information exchange, referrals and joint planning occur with all these agencies. In addition, TRIS-CCIS has formalized affiliation and service contracts with DMH&H and DYFS.

The following examples illustrate some of the ways in which TRIS and CCIS have worked collaboratively with other agencies.

- The DOC was experiencing problems in referring youth to Trenton Psychiatric Hospital (TPH), the adolescent inpatient facility, from one of the youth detention facilities. TRIS staff served as consultants and were able to negotiate arrangements to address the problem. A mobile team from TPH now goes to the detention facility to assess a youth in crisis. If appropriate, an admission to TPH is facilitated, with the agreement that, following treatment the client will return to the detention facility. A special admission unit called the "Welcome Spot" has also been opened at the hospital. This unit initiates outreach to the regional CCIS units and correctional facilities in an attempt to develop appropriate alternatives to the state psychiatric facility. If a youth is committed, the unit tries to stabilize the child without involvement in the ongoing hospital program.

- o TRIS staff volunteered to meet with staff of the Camden DYFS office to provide support and consultation around difficult cases.

- o Regular visits are made to the county emergency screening service units designated by DMH&H to discuss new procedures for client referrals that will result in a more flexible, responsive referral practice.

- o The outreach component, whereby CCIS staff provide outreach service to children and families when there is a waiting list for CCIS admission, is designed to be responsive to children, families and referring agencies by meeting the needs of families experiencing crises. Staff from all agencies such as schools, mental health providers and child welfare are encouraged to come to CCIS for intake, case meetings and treatment planning.

- o A "bed registry" has been established listing the status of bed availability in the CCIS unit and the interim group home.

- o TRIS and the adolescent unit of a local protective services agency are collaborating on a research project that attempts to demonstrate that the merging of two systems at the point of intake and the early provision of mental health services can prevent removal of a child from the home.

- o TRIS-CCIS staff make continuous efforts to encourage conflict resolution among agencies rather than ignoring feelings of anger and hostility that may exist.

TRIS-CCIS recognizes that the services it provides for youth and families are dependent on the support networks and continued services that its clients receive upon leaving the CCIS. Positive relationships with community agencies are therefore acknowledged to be essential to its success as an agency.

Clients

The main sources of referral for youth to the CCIS are DYFS, the juvenile justice system and the state psychiatric facilities. As noted previously, all youth prior to being admitted to the CCIS must be screened by the state designated screener, usually located in a local community mental health center or hospital. TRIS-CCIS policy is not to reject any youth who has been referred to the program for service. As a result, the CCIS works with some very difficult clients whom some agencies and clinics may have believed could not be helped in a community setting and/or would require long-term institutional placements. By taking this risk, staff believe that the program can make a difference for a diverse population of extremely troubled youth.

It should be noted that youth who are severely mentally retarded, have organic syndromes or a primary drug or alcohol addiction are not usually referred to or admitted into the program. Admission criteria specify that a youth must have a primary psychiatric diagnosis and demonstrate an impaired level of functioning that requires the intervention of a residential treatment program.

At the time of the site visit, CCIS served both a child and adolescent population ranging in age from 4 through 17. Since that time, Ginger Grove, a similar program for 5- to 10-year olds, has opened, so CCIS now predominantly serves only the older youth. Three quarters of the youth served in 1986 were aged 13 to 17. Twenty-three percent were 6 to 12, and 2 percent, 5 or under. About half the youth are male. The male/female ratio is affected by bed availability, since rooms are shared by youth of the same sex. In 1986, 52 percent of the youth served at CCIS were white, 38 percent black and 10 percent Hispanic. The highest

percentage of youth came from Camden County, which is the most heavily populated county in the region.

As noted earlier, the clients treated at CCIS demonstrate a wide range of psychiatric and behavioral disturbances. Typically, a youth referred to CCIS is experiencing an acute psychiatric crisis of such intensity that an inpatient treatment intervention is required. The youth served at CCIS usually have multiple problems and chaotic life experiences. These are children with a history of episodic incidents of extreme violence. The majority have been severely neglected and/or physically and sexually abused. Sixty percent of the girls and one-third of the boys have been sexually abused. Approximately 90 percent of the youth are from families where there is drug or alcohol addiction. The majority of the youth are in the custody of DYFS. Many have had extensive involvement with the juvenile justice system.

Virtually all of the youth suffer from depression, and many are suicidal. Clients include psychotic youth, children and adolescents with a history of committing serious sexual offenses, and youth with a dual diagnosis of mental illness and chemical abuse. According to 1986 statistics, the primary diagnosis for 46 percent of the CCIS clients was conduct disorders; for 20 percent, adjustment disorders; and for 12 percent, schizophrenia or other psychoses. In addition to having a primary psychiatric diagnosis, many CCIS clients are neurologically impaired, learning disabled and/or have chronic medical problems.

Whenever possible, CCIS staff try to work with and involve the family while the youth is at CCIS. A review of the youth served in the program for a four-month period in 1987 showed a range in the family situations of youth and the willingness of families to be supportive. Of 35 youth, 9 had intact two-parent families (7 were considered supportive and active in treatment); 19 were from single parent families (4 were involved, 7 were not involved and 8 were described as too overwhelmed to be involved in treatment); 6 of the youth were in foster families; and one was with adoptive parents who were actively involved in treatment.

Staffing

CCIS employs 30 full-time equivalent (FTE) direct service staff. The staff consists of a coordinator, two therapists, a case manager, two intake workers, three full-time and seven part-time nurses, a part-time educator, the equivalent of 12 full-time human service advisors (HSAs) and two part-time psychiatrists. The TRIS associate director and director of children's services also provide overall supervision and direction to the program.

Staff bring a range of degrees and experience to the program. TRIS executive staff stress that educational background is not as important as values, commitment, competence and the ability to be flexible. The agency also is committed to hiring a staff that is racially and ethnically mixed. At the time of the site visit, 35 percent of the staff were minority. All staff are involved with the youth and play a role in treatment. The agency encourages all staff to be professional in their work. Professionalism means acceptance of the treatment philosophy and ethics of TRIS and adhering to the policies, procedures and routines of the agency.

The intake workers usually have a bachelor's or master's degree in social work or psychology. Other qualifications required include a high energy level, an ability to connect quickly with clients and good writing skills because of the necessary documentation required. The intake workers are the client's first contact with the agency, and they remain involved in treatment and planning throughout the youth's stay at CCIS.

Therapists usually have a master's degree in social work, psychology, or special education. They supervise all cases and are responsible for treatment planning, individual and family counseling and agency liaison work for most of the youth at CCIS.

The therapist is assisted by the case manager. The case manager is the primary therapist for some cases. The major role, however, is to work closely with other community agencies for information gathering, treatment planning and referrals. The case manager also provides follow-up to cases at 30, 60 and 90 day intervals, contacting the DYFS worker, family or residential facility if a youth has been placed after discharge. CCIS's case manager has a bachelor's degree in psychology and previous experience as a case manager.

The nursing staff includes both RN's and LPN's. Their primary responsibility is to provide close supervision and monitoring of the youth. They administer and monitor medications as well as monitoring any medical conditions. They run health groups for youth on different topics of concern and provide information on health issues to both youth and staff. They also provide one-on-one supervision for youth who are severely depressed and/or suicidal and are constantly observing youth to pick up any signals that would be helpful for treatment. The nurses assist the clinical and HSA staff in all aspects of treatment, participating in house activities and treatment meetings.

The human service advisors, or HSA's as they are called, serve as house staff. In hiring the HSA staff, the agency looks for certain special qualities: a sense of self-confidence, an ability to relate to youth, an ability to work as part of a team, and an ability to not become too enmeshed with a client. This latter quality is extremely important. The agency has found that HSA's (as well as other staff) often will over-empathize with a youth's problems and become attached to a youth in trying to help. It is then difficult to let go emotionally when the youth is discharged after three or four weeks. This dynamic of bonding and letting go is a constant struggle for all crisis staff.

HSA's have multiple responsibilities. They conduct daily activities, assist with the normal routine of the house -- bedtime, meals, chores -- talk with the youth and observe the youth at all times. The HSA's are supervised by a captain, who facilitates the implementation the daily activity plan, maintains daily notes on the youth, makes assignments and provides overall supervision to the house activities and staff.

The psychiatric consultants devote a total of 40 hours a week to CCIS. Their role primarily is to provide support and consultation to staff. The consultants are involved in the diagnosis and treatment planning of all cases, and usually they both participate in the weekly treatment planning meetings. They also provide in-service training to staff. On occasion, a psychiatric consultant will conduct individual and/or family therapy sessions, but this generally is not the practice. Having psychiatric consultants as an integral part of the staff has helped build acceptance of the program in the professional community.

The role of the coordinator of CCIS is to provide overall direction, leadership and supervision to the program. The coordinator defines his job in the following terms: "To pull everything together, set a positive tone, maximize staff performance, serve as a sounding board and be available to staff, youth and families." The coordinator makes a point to meet with youth on the day they are admitted to the program. On a daily basis, he reviews each child's charts and medications and checks all critical incident reports. He meets regularly with the clinical staff and participates in all treatment planning meetings. On an informal basis, he relates regularly with all staff and youth, joining in meals, house meetings and various activities.

The CCIS schedule is organized around three shifts: 8:00 a.m. to 4:00 p.m.; 4:00 p.m. to 12:00 p.m.; and 12:00 p.m. to 8:00 a.m. On the 12:00 to 8:00 shift, a nurse and three HSA's are on

duty. On the other shifts, house staff include a nurse and five HSA's. Shift staff meet at each shift change, reviewing both staff and nurses reports as well as any critical incidents. A critical incident can include a youth acting out of the ordinary, having an inappropriate phone conversation, or more extreme behavior such as running. Clinical and administrative staff are available for emergencies by beeper on an on-call basis, 24 hours a day, seven days a week.

Meetings are a vital part of the CCIS staff routine. They enable staff to keep informed about the youth, to assist and support each other, and to develop appropriate treatment interventions. As mentioned, house staff meet at each shift change; treatment planning meetings are held weekly; and all staff meet every other week. In addition, staff are flexible about meeting with each other at any time if a meeting is needed.

Training is handled in different ways for different staff. TRIS's assistant director of children's services and the coordinator for educational services and training oversee training activities for CCIS staff. When hired, HSA staff receive an orientation to the agency, its treatment philosophy and the responsibilities of their job. This information is supplemented by a training manual. Usually for a brief time period, a new HSA will observe or shadow a more experienced staff person until he or she feels oriented and comfortable in the position. Unfortunately, because of the desperate need for staff to fill these jobs, CCIS has found that there usually is not the time for adequate preparatory training of the HSA's. If any staff feel they need training on a particular issue and request to attend a meeting or intensive course, TRIS will try to accommodate staff by covering the cost of the session and granting time off. At CCIS, staff also try to conduct in-service training for each other. The nurses may run sessions for staff and, as noted previously, the consulting psychiatrists conduct in-service training for staff.

Most staff indicate that CCIS is a challenging and rewarding place to work. Staff like their jobs, feel positively about their colleagues and are devoted to their clients. The major issues, which staff raised as problems, are the understaffing of HSA's, the low salaries of HSA's and a need for more support in helping HSA's plan activities for the youth.

The agency recognizes that the low salaries of HSA workers serve as a disincentive. TRIS is committed to providing staff mobility and has instituted a number of mechanisms to provide advancement within the organization. One of TRIS's executive manager's responsibilities is to improve employee hiring, counseling and developmer' A record of all agency openings is maintained and publicized, encouraging staff to a. .ce in their jobs. New recruitment strategies have been tried to fill staff positions using a community employment consortium and networks.

As in most crisis programs, staff burnout is an issue. Strategies that TRIS and CCIS have adopted to alleviate burnout are support for training, empow rment of staff through agency policies and practices, a sense of humor and opportunities for staff to socialize together.

Resources

The total budget of TRIS is approximately $5 million with approximately $1.1 million allocated to CCIS. The average cost per child and family is estimated to be $7,658, obtained by dividing the program costs by the total number of youth served in a year, approximately 150 youth annually. The per diem rate is $262.

The CCIS budget is allocated to the following cost centers:

$176,456	for administrative costs, prorated for each program
$745,339	for personnel
$125,600	for consultants
$ 37,335	for program supplies and food
$ 39,051	for facility costs, including utilities, insurance and repairs
$ 26,450	for miscellaneous costs such as travel, training, telephones

The major source of revenue for CCIS is derived from a contract with DMH&H that in fiscal year 1986 generated $990,056 in funding. The contract specifies that the program will serve a certain number of clients per year. Another source of funding is Medicaid which reimbursed the program $151,767 in 1986. Since most of the youth are in the custody of DYFS, they are eligible for medical assistance. Each youth admitted to CCIS is opened as a DYFS case on a pro forma basis and a Medicaid number assigned. If a DYFS worker determines that its agency should remain involved, the youth becomes eligible for Medicaid. Medicaid reimburses the program $38.50 per day, the state's rate for partial care. Until recently CCIS has received approximately $5,000 from the local board of education for homebound instruction, and $8,500 for a federally subsidized nutrition program. As a result of negotiations between DMH&H and the Office of Education, there will be a substantial increase in education funds to CCIS for a special education component. Families are charged no fees for the services they receive through the program.

Funding support for CCIS has been expanding, and recently TRIS received additional funding support from the state to open a facility for children aged 5 to 10. The major fiscal problem is the lack of adequate funding allocation for facility maintenance and repairs. TRIS owns the house where CCIS is located, having purchased the facility with funding from a previous program operated by TRIS. The state made $168,000 available for renovation when the program was initiated, but additional funding for facility upkeep has been difficult to obtain. Contractors also do not pay for staff training, which is crucial to the successful operation of a program.

Evaluation

TRIS and CCIS do not have a formal evaluation component; however, the agency is exploring methods for evaluating successful outcomes and conducting client satisfaction surveys. Since the mission of CCIS is to prevent the inappropriate institutionalization of children and adolescents, success is measured by the number of clients who can be stabilized in the least restrictive setting and can return to a community-based setting upon discharge. CCIS maintains statistics on the clients served through the outreach service and the facility, and documents the setting where youth are discharged.

In 1987, 61 percent of the youth served were able to return to their homes. Through CCIS treatment, family dynamics were able to change; issues surfaced and were addressed; and ongoing community support services were arranged. In 12 percent of the cases, the youth were placed in foster homes, many of them receiving the intensive specialized counseling provided to youth in foster care through TRIS. Twenty percent were discharged to another residential setting such as a group home or residential treatment center. The remaining 7 percent were hospitalized. CCIS experiences approximately a 10 percent recidivism rate of youth returning to the program for at least one other placement. In 1987, of the 243 referrals to CCIS, 56 (23 percent) were successfully stabilized in the community as a result of outreach intervention and did not require subsequent admission to CCIS.

TRIS has developed a quality assurance program for internal evaluation and quality control. This program requires CCIS to submit weekly program reports for review by the service director, the executive managers and the executive director. The quality assurance and

utilization review committee reviews monthly statistics on the number of intakes, critical incidents, hospitalizations, extensions and incidents of recidivism. Services, staff and facilities also are evaluated regularly.

Major Strengths and Problems

State and community agency representatives and families of youth served at CCIS attest to the program's positive reputation in the communities it serves and to its accomplishments in helping a population of very troubled youth. TRIS and CCIS staff attribute their success to the following factors:

- o TRIS' commitment to a system of care for youth who are seriously emotionally disturbed.
- o The homelike and accepting environment of CCIS.
- o The commitment of the staff to youth and their potential for growth.
- o The willingness of staff to do "whatever it takes" to help a child and family.
- o The staff's support for each other.
- o The agency's commitment to the staff.
- o Agency and program flexibility.
- o A passion for excellence at all levels.
- o The intensity of the situation to produce change.

Despite its successes, a number of problems, both internal and external to the program, were identified. Several major problems experienced by the CCIS units are systemwide. A report issued by the New Jersey Department of Human Services in 1987 concluded that "CCIS units have proven to be an important advancement in New Jersey's mental health system for children. Since 1981, they have been successful in facilitating a 50 percent decrease in the average daily populations at the state psychiatric hospital units compared to 1978 levels." However, the report also found that there have been significant problems in the system:

- o CCIS units are overcrowded and frequently have waiting lists.
- o CCIS units have not been routinely serving children referred from juvenile detention centers or correctional facilities.
- o CCIS units have not been routinely serving children requiring psychiatric care who are in less restrictive facilities in the DYFS network.
- o Inappropriate admissions are made to inpatient hospitals and CCIS units because of a shortage of partial hospitalization and outpatient services.

The lack of a comprehensive continuum of services also results in youth staying beyond the 28-day maximum because of inadequate alternatives at discharge. To alleviate these problems, the state is proposing an expansion of the CCIS units and their responsibilities. The units will become regional psychiatric service agencies responsible for administering a service network, including outreach services and expanded case management.

TRIS's major systems problems include waiting lists for the limited number of CCIS beds, a lack of appropriate alternatives for post crisis stabilization, problems with the screening process and conflicts involving mental health, child welfare and the juvenile justice agencies. To deal with its waiting list, TRIS developed, on a voluntary basis, the outreach service, described in the service section of this report, to stabilize clients not able to be admitted immediately. TRIS has developed proposals to expand the outreach services, as well as to develop a group home that could provide continued intensive treatment and support for 6 to 24 months after discharge from CCIS. TRIS-CCIS has found that at least 20 to 25 percent of its clients require residential care post crisis because they cannot return to families. Too often, staff have found that treatment interventions are undermined by a lack of appropriate and available residential facilities. The foster family system and family group homes are overloaded and backed up, and, as a result, other residential treatment alternatives are needed.

The most pressing internal organizational issues include problems with recruitment and retention of staff, especially given the low salaries of the HSA and therapist positions, and the need for more adequate resources for training and staff development.

Dissemination and Advocacy

The TRIS executive director and senior staff have a strong commitment to developing a system of care for youth and their families, and they have put tremendous energy into developing a model in their region. Their efforts and successes have received attention in New Jersey as well as other states. As a result, they have been called upon on numerous occasions to share the TRIS-CCIS experience with others in the field. Staff have conducted workshops and training sessions for national, state and local policymakers and providers. They also have served as consultants to other states in developing a similar model of care. Most of these activities are conducted using personal annual leave.

In their dissemination efforts, TRIS staff are strong advocates for the clients they serve and for providing a service delivery system that is responsive to this population. At the state, regional, county and community level TRIS staff advocate on behalf of their clients for systems and services that are youth- and family-centered. At CCIS the coordinator, case manager, therapists and intake workers regularly interface with staff of other agencies to ensure appropriate services and follow-up. If necessary, TRIS administrative staff will become involved to assist a youth and family.

Case Examples

"P", a 15-year-old, was admitted to CCIS because she was making suicidal threats. P has extreme outbursts that begin as verbal explosions and progress to violence. Her parents are divorced. She lives with her father and two brothers. Alcoholism is pervasive in the family. Her mother is an alcoholic and her father may be an alcoholic, but he denies this. P told the DYFS worker that her father molested her, but the mother believes these accusations are untrue. Staff at CCIS are working closely with DYFS workers to try to get treatment for the father. P is close to her grandparents, and the plan is that she would return to their home with ongoing individual and family counseling arranged. CCIS staff have worked to help P understand what makes her angry and lose control and to help her recognize and build on her many strengths.

"J", an eight year old girl, was referred to CCIS after the children's protective service agency had substantiated both physical and sexual abuse. At the time of intake J lived with her mother, who is borderline mentally retarded, and a younger sibling. The mother is pregnant. Their father is not involved with the family. Recently the grandmother moved in with the family. When J came to CCIS, she was withdrawn and fearful. It was difficult for staff to

develop a relationship with her. CCIS staff provided her one-on-one attention and individualized activities to help make her feel safe and accepted. Gradually the period of involvement with the school and group activities increased. She became more accessible. CCIS also worked intensively with the mother, grandmother and the mother's sister. It was arranged to have a homemaker help stabilize the home environment. The mother was also engaged in ongoing supportive counseling and a community program for retarded adults. The grandmother remained, at least temporarily, in the home. J was able to return home from CCIS.

Technical Assistance Resources

- Training Manuals

  Human Service Advisor Employee Orientation Manual
  Direct Service Staff
  Social Work
  Nursing

- Agency Forms

  Initial Contact Form
  Residential Placement Agreement
  Face Sheet
  Release of Information
  Histories
  Treatment Consent
  Client Rights
  Information Sharing
  Intake Application (Fiscal)
  Complaint Procedure
  Progress Notes Chart
  Individual Service Plan
  Physician's Orders
  Medication Progress Notes
  Emergency Medical Form
  Nursing Assessment
  Correspondence Checklist
  Discharge Summary
  Client Consent to Follow-Up
  CCIS Activity Sheets
  Assignment Sheets
  Pass Permission
  Incident Form
  One-on-One Schedule

- Service Description

- Learning Program Schedule

- Proposals

  "Cape May Digs" -- A Specialized Residential and Psychosocial Program for Teens

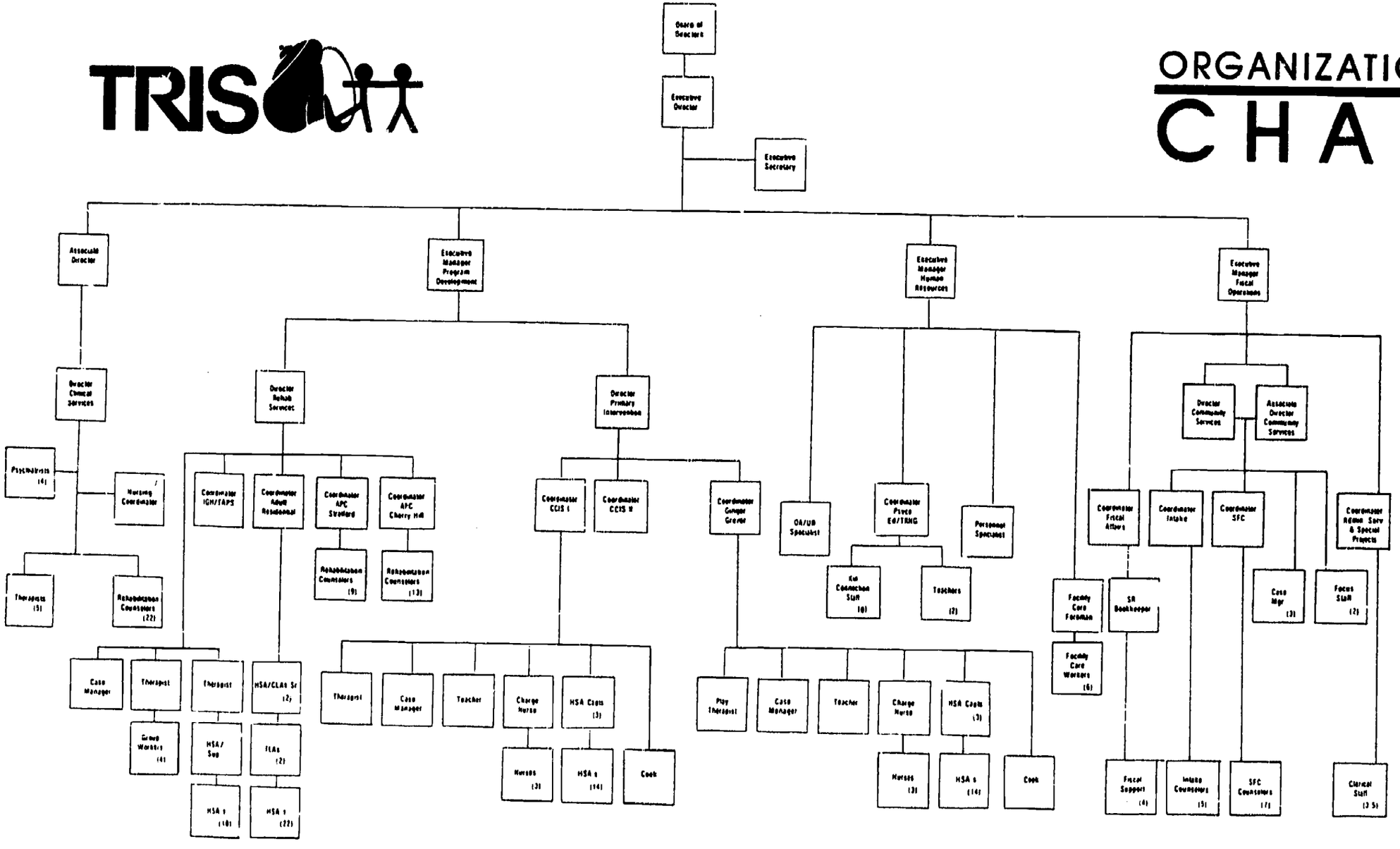
  Children's Community Outreach Team -- Serving the Southern Region

- Children in Crisis, TRIS Responds. A manual on the TRIS-CCIS program, prepared for the Training Institutes on Community-Based Services for Severely Emotionally Disturbed Children, Boulder, Colorado, July, 1988.

- Plan for the Establishment of Regional Psychiatric Programs for Seriously Mentally Ill Children and Adolescents. New Jersey Department of Human Services, 1987.

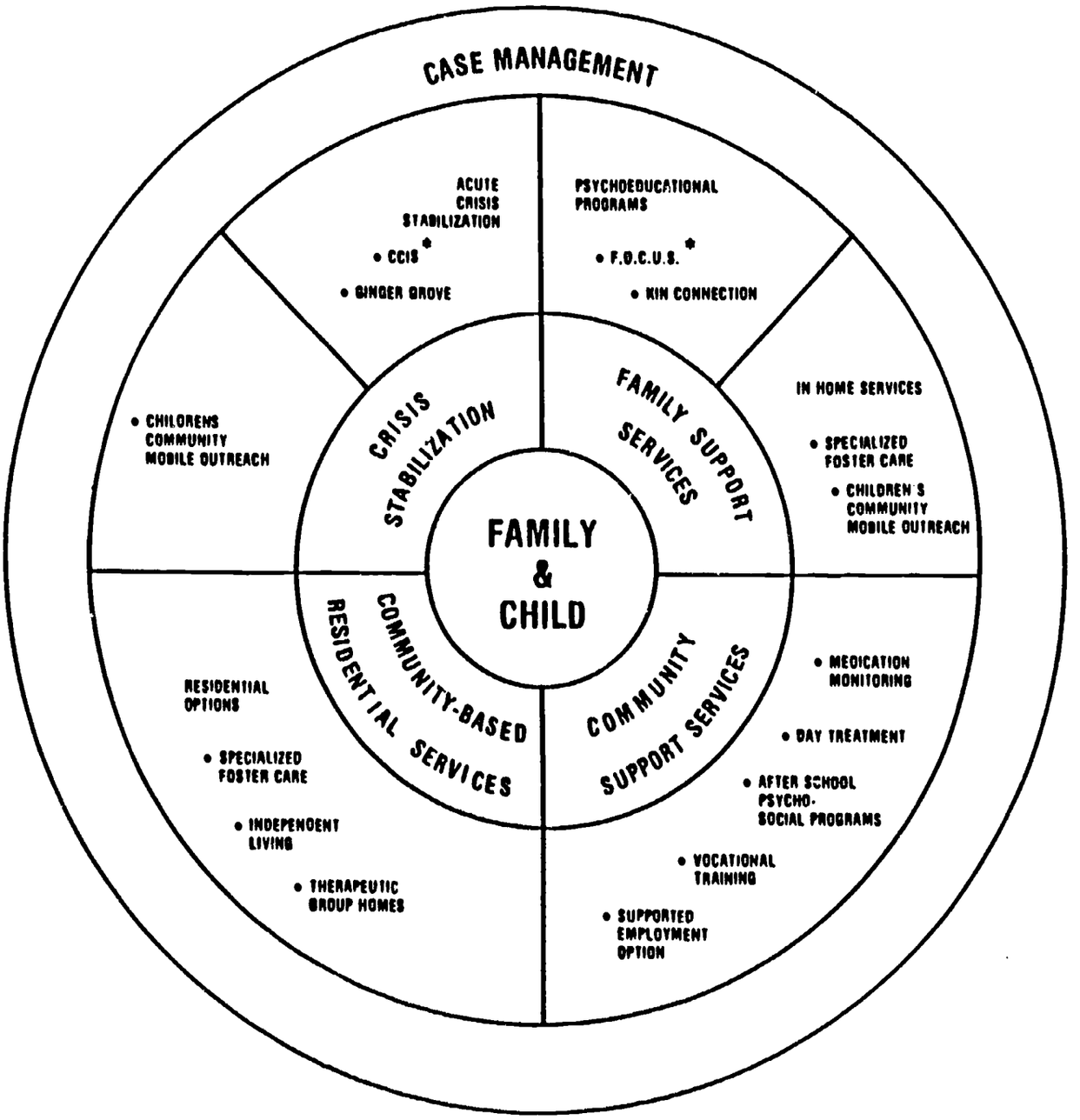
TRIS

ORGANIZATIONAL CHART



February 1988

System of Care



* Children's Crisis Intervention Service
* Family Options for Coping Under Stress

HUCKLEBERRY HOUSE
COLUMBUS, OHIO

History

Huckleberry House is a private, nonprofit organization that provides emergency shelter and crisis counseling as well as longer term counseling for youth and their parents. It is a voluntary program primarily aimed at assisting runaway youth.

Huckleberry House has long standing roots in Columbus, Ohio. It was established in 1970 in response to the increasing number of runaways and so-called "street kids" who sought out the Ohio State University (OSU) area of the community. Initially, the University Council of Churches hired, for one summer, a seminarian with an M.S.W. to work out of an abandoned church and provide outreach and counseling to troubled youth "hanging out" on the OSU campus. In conjunction with this outreach effort, a community needs assessment was conducted which established the need for a more permanent program to assist runaways, street kids and youth on drugs.

Stemming from these initial efforts, Huckleberry House was founded. A corporation was formed and a board selected. Funding support came from a variety of sources. The mental health board provided $10,000 in seed money; a consortium of metropolitan churches contributed $10,000, and local foundations gave $10,000 for a total of $30,000 for start-up costs. The seminarian hired to do the original outreach work was appointed director two years later and still holds that position today. The house where the program currently is located was purchased in 1976 with funds provided through the Runaway Youth Act (1974) and with local foundation grants. The state mental health agency financed the costs of remodeling and equipment. The shelter and crisis program were expanded in 1983 through demonstration project funds from the Department of Health and Human Services, Administration for Children, Youth and Families (ACYF), to provide ongoing counseling, support and family therapy for abused adolescents and their families. Three participating agencies were funded--Huckleberry House, Columbus Children's Hospital and the League Against Child Abuse. This demonstration grant provided the impetus for Huckleberry House's aftercare program. Today, 18 years after its inception, Huckleberry House has grown into a program with a half-million dollar budget, a staff of 30 and almost 100 volunteers.

Community and Agency Context

Huckleberry House is an independent agency supported through a variety of public and private funding sources. It is regulated under Ohio law as a shelter for runaway youth. For youth who are runaways, Huckleberry House serves as a voluntary alternative to a detention home or to youth continuing to wander the streets. Running away is a status offense, and runaways, as juveniles, come under the jurisdiction of the juvenile justice system via their status as "ungovernables" or persons (children, juveniles) in need of supervision. The Juvenile Justice and Delinquency Prevention Act of 1974 and the amendments that constitute the Runaway and Homeless Youth Act (1980) authorized the development of voluntary facilities to care for runaway and homeless youth by providing temporary emergency housing and crisis counseling. In Ohio, these facilities are regulated by the local mental health boards.

Huckleberry House serves youth primarily from the city of Columbus, Ohio, and surrounding Franklin County. As a crisis shelter, however, the agency will serve runaways and homeless youth from any locale. In the 1970s, youth were more likely to travel greater distances and frequently came from areas outside of Columbus.

Huck House, as it is usually referred to, is one of Columbus' historic homes. Built in the late 1800s, it is architecturally distinctive because of the large tower incorporated into its red brick structure. The program makes use of all three levels of the building. Youth coming to the shelter are met in the foyer by the crisis counselor on duty. The main floor consists of a large living area, a dining room where meals are served family style, kitchen, and office space for crisis counseling. Shelter beds are on the second floor and arranged dormitory style with separate quarters for boys and girls. The aftercare program is also located on the second floor. The third floor is devoted to administrative offices and space for group counseling sessions and discussions.

The house is located in a low income, racially mixed neighborhood of Columbus. The neighborhood is near the downtown area and also borders on the campus of OSU. It is a poor neighborhood of deteriorating houses. Staff report that Huckleberry House is well accepted by its neighbors, although there have been some occasional incidents of vandalism.

Columbus is a rapidly growing city of approximately 570,000, with a metropolitan population of 1.2 million. An ailing economy has been refueled by insurance companies, the banking industry and scientific research firms. As a result, downtown Columbus currently is undergoing a revitalization. But, despite the signs of a healthy economy, Columbus has a sizeable working class and poor population living in older, deteriorating neighborhoods. Approximately 12 percent of the city's population lives on incomes below the poverty line. Other demographic factors which have an impact on Huckleberry House are the high rate of mobility -- 55 percent of the county population has moved during the previous five years-- and the divorce rate, second only to that of Los Angeles.

Huckleberry House is administered by an executive director who reports to a 21-member board of trustees. The board is a policy-making body whose role has varied over the years, depending upon the issues faced by the agency. The support of the board has been critical in ensuring the financial stability of Huckleberry House, a problem plaguing most crisis shelters. The board seeks to include members who are human service professionals as well as individuals with legal, fiscal management and fund raising skills and expertise. Members also serve as a sounding board for new ideas proposed by staff and each other. Most importantly, the board provides support for the program in the community. Shelters and the care they provide sometimes can be controversial because they are considered, and promote themselves, as an alternative to traditional agencies. But good relationships with the public, community hospitals and other service providers are vital to their survival and effectiveness. The board members, in concert with the executive director, play a critical role in maintaining positive community relations.

Reporting to the executive director are a coordinator for the crisis shelter and stabilization program, an aftercare coordinator and an administrative coordinator. All staff and volunteers for each of the two service areas are administratively responsible to either the crisis or aftercare coordinator. In the past, when the program was smaller and less complex, some fiscal matters were handled by an outside service bureau. Now all financial management is conducted in-house by the administrative coordinator.

Philosophy and Goals

Huckleberry House's threefold mission is to assist young people in regaining control over their lives; to help youth and adults communicate and understand each other; and to prevent running away and the breakup of family relationships. To be able to fulfill that mission Huck House is structured and organized to be the kind of place that troubled young people will seek out. The program provides a safe place for young people and an opportunity for youth to assess and develop a plan for dealing with the realities of their lives. The emphasis is on

developing a plan that will provide a legal alternative to their status as runaways. Treatment focuses on engagement and relationship building.

The program is based on a number of fundamental beliefs that guide the program's operation. Central to the program is a belief in:

- Self determination of the client -- The young person who comes to Huckleberry House does so voluntarily. The youth determines what his or her goals are, and the staff are direct about whether the program can assist the youth and how.

- Empowerment -- The emphasis of the program and the staff is on enabling the young person to feel and to be in control. Staff help the youth in working through the crisis and by providing support, but the youth must make decisions and implement them.

- Developmental growth -- The program focus and philosophy is based on the model that individuals experience crises because of chronic or situational events, but there is the potential for growth and change. The focus is not on a client being sick and needing to be cured.

Implementing these beliefs, the program tries to minimize any red tape or sense of being institutional or bureaucratic. The environment is homey and informal; staff and volunteers include young people, as well as adults, who are comfortable with youth; staff play an active role in exploring options and supporting decisions, but the authority comes from the young person; and traditional diagnostic determinations are not made or labels used. In the executive director's view, the shelter is a vehicle for crisis intervention, conflict resolution and family reconciliation.

Huckleberry House has established six program goals, each with accompanying specific objectives. These include:

1. To alleviate the immediate problem of runaway and homeless youth during the running episode.

   - Provide an emergency counseling process 24 hours a day.

   - Provide shelter care 24 hours a day.

2. To reunite runaway, homeless and other youth in crisis with their families and encourage the resolution of family problems.

   - Provide to at least 60 percent of cases, who make parental contact during emergency counseling, follow-up counseling to effect reunification.

3. To strengthen family relationships and encourage stable living conditions for youth following termination of shelter care.

   - Provide services so that 60 percent of runaway cases develop a living arrangement that is a legal alternative to running.

   - Provide a systematic post crisis service for 30 to 50 percent of these crisis cases.

4. To help youth decide upon a future course of action.

   o Maintain services which are accessible and identifiable 24 hours a day.

   o Provide services so that youth can successfully engage in the program and can resolve the crisis.

5. To provide community education, information and referral, consultation and prevention about the problems of runaway and other youth in crisis.

   o Provide information to the general public, providers and youth about Huckleberry House.

   o Make staff available for participation in community activities 15 to 20 hours per month.

6. To provide teaching, training and volunteer opportunities in the area of youth services.

   o Provide volunteer opportunities for the community-at-large on an ongoing basis.

   o Provide special training opportunities for students in high school, college and professional programs.

Services

Huckleberry House's service program is essentially divided into three components: 1) the shelter and crisis counseling program; 2) a voluntary ongoing counseling program for adolescents and their families called "Parents and Teens" (PAT) or aftercare; 3) and follow-up. Other services include information and referral services, educational programs for community groups, and training for volunteers, peer counselors and students in human service professional programs.

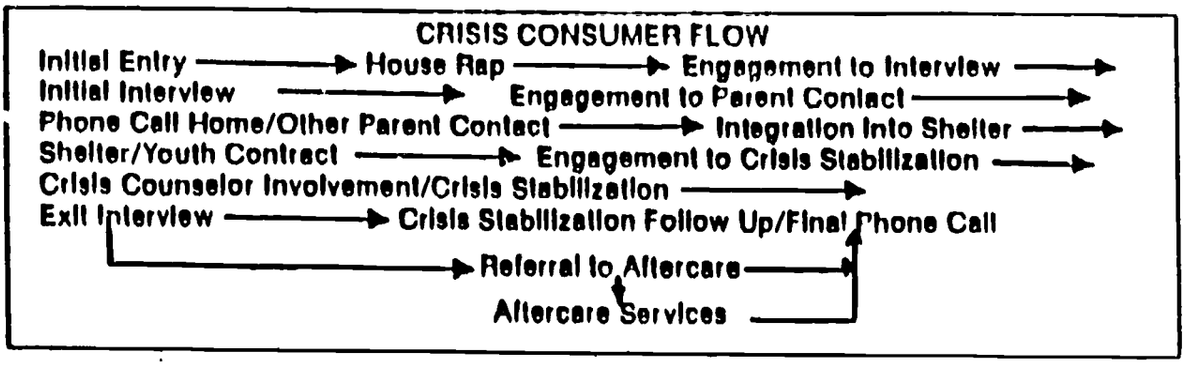
The shelter and crisis counseling program is the core of Huck House. The services include an emergency residential shelter for three to four days and 24-hour a day crisis counseling provided to young people and their families. Counseling services are available to youth staying in the shelter as well as to youth or their parents who call Huck House. Phone coverage is provided 24 hours a day and extensive counseling is provided over the phone.

The overnight capacity for the shelter is 20 beds but any more than 12 youth in the shelter at a time severely strains the capacity of the program. Smallness and the ability to provide individual attention are critical to the program's success because the key to treatment depends on observation, relationship building and engagement.

The aftercare program, PAT, was established in 1983 by a federal grant. Funded as a demonstration project involving three agencies -- Huckleberry House, the Columbus Children's Hospital and the League Against Child Abuse -- the program was designed to explore alternative approaches for engaging abusive families in counseling. Huck House found that providing ongoing counseling to youth and their families after crisis stabilization strengthened the crisis program. Youth and families engaged with Huck House through the crisis could now receive ongoing support. With this assurance of continuity, crisis counselors were less reluctant to explore with the youth and family key issues that could not be resolved during the crisis counseling. Once the demonstration funds ceased, Huckleberry House sought additional funding support to continue the program.

1. Shelter and Crisis Stabilization

As mentioned previously, the shelter serves as a vehicle to enable crisis stabilization to occur. The shelter provides a safe haven where a youth's basic needs can be met. For runaways, food, a place to sleep and attendance to any medical needs are essential before beginning to deal with the issues that precipitated the youth to run. The shelter also allows a youth in crisis and parents some respite from the conflict; this brief "time out" can enable conflict resolution to take place. The routines and procedures of the shelter and the role of staff provide the context for Huckleberry House's crisis intervention and treatment model. The model used is depicted in the chart below.



Intake

Over 57 percent of the referrals to Huck House are walk-ins or referrals from friends or family members. The local child welfare agency refers 29 percent of the youth, usually when there is an abusive family situation. The remainder of the referrals come from other agencies, the police and schools. Intake can occur at any time during a 24-hour period. About 40 percent of youth come to the shelter between 7:00 p.m. and midnight. The other peak time of entry is between 1:00 and 6:00 in the afternoon.

Whether youth are referred by an agency or come to Huck House on their own, which is the situation for the majority of youth, the intake procedures are the same. Huckleberry House has an open door policy. Each youth is greeted at the door and given the House Rap by a staff member (either a crisis counselor or house manager or volunteer). The House Rap provides basic information about Huckleberry House, explaining the ground rules, how the program can help and its limitations. As a shelter for runaways, staff are obligated to assist youth in notifying their parents and in seeking a living arrangement that is a legal alternative to running. If the youth has been involved in criminal activity, the police must be notified. In addition to conveying information, the Rap is designed to obtain information from the youth and to create an accepting atmosphere. It is the staff person's responsibility to engage the youth.

When the youth seems ready, the staff person conducts an initial interview. During this interview, a full assessment and history are taken. Staff are trained to identify and assist youth who are suicidal. As part of the initial interview each youth is asked a series of questions that are indicators of suicide lethality. Based on this assessment, if a youth is highly suicidal, a staff member provides close supervision. Huckleberry House makes a referral for hospitalization if staff determine the youth requires further assessment or inpatient care. Staff are trained to utilize other community resources if needed.

In the initial interview the staff person helps the youth to identify the problems or events precipitating a crisis and to explore possible options. The intent is to develop a plan of action. For 75 to 80 percent of the youth that plan includes making contact with the family. The phone call home is critical to the family's ultimate reconciliation. It is the first step toward re-establishing communication after the runaway or crisis episode. It is also the agency staff's first opportunity to view the family relationships and dynamics and to hear "the other side of the story."

The same person who conducted the House Rap and the initial interview helps the youth to prepare for the telephone call home. After the youth makes the call, the staff person introduces himself and Huckleberry House's program to the parents and explains his role as a communicator and mediator. Staff help the youth and parents discuss issues and problems and begin to help them consider options. The call concludes when the parent and youth have made a decision about how they plan to proceed. The basic options include a decision to return home, to seek other help, to continue running, or to use Huck House services -- the temporary shelter and counseling.

The next step depends upon the decision made. If the young person returns home, staff will arrange for a crisis or aftercare counselor to meet with the family for further counseling and follow-up. If the young person decides to stay, staff help the youth to integrate into the shelter, and a new plan is developed with the youth. This shelter plan includes the youth's activities while in the shelter and any exceptions to house rules as well as planned next steps. Each phase of the intake process is carefully documented on a set of forms developed by the agency.

Crisis Counselor Involvement and Crisis Stabilization

After the intake is concluded, a crisis counselor is assigned. The counselor works with both the youth and the family, if possible. Within 24 hours after the phone call home is made, an initial session is scheduled for the crisis counselor to meet with the youth and family. In most cases, the family comes to the agency, but in some cases a home visit is made. Limited resources and the need to have staff at the shelter make home visits, as a general practice, difficult.

During the three to five days that the youth stays in the shelter, the crisis counselor meets jointly with the youth and family as well as having individual sessions with the youth and the parents. In these sessions, the crisis counseling focuses on the following four areas:

- Assessment of issues, needs and dynamics for both the youth and the family -- This process of identifying long and short-term issues and understanding individual and family dynamics continues throughout the crisis stabilization process.

- Resolution of the precipitating event -- Initial family sessions focus on the precipitating event as a way to begin to identify old patterns of coping and examine possible strategies.

- Decision making about crisis resolution -- In this phase the family begins discussion of the options for resolving the crisis and deciding on the youth's future living situation. Discussion centers on what the youth would need to occur in order to return home and what the parent's needs are. Agreements are based on family members trying new solutions to old problems. If agreements cannot be worked out, alternative living situations are discussed.

- Decision about future needs -- The crisis counselor seeks to help the family recognize that longstanding problems and behavior patterns cannot be resolved in three to four days;

as a result continued services may be necessary to help replace current patterns with more healthy alternatives and avoid future crises.

In addition to providing individual and family counseling, the counselor is a link to other community resources and assists the family and young person in gaining access to other services if needed. The counselor also monitors the implementation of the youth's treatment plan while the young person is in the shelter. During an average three- to five-day stay, the counselor meets frequently with the youth and at least one to two times with the family.

While the youth is in the shelter, he or she continues a normal routine of activities. Meals are provided in the shelter. If the youth is working or in school, participation in these daily activities is expected to continue. Youth also have chores, since these are part of family living. Volunteers, house staff, crisis and peer counselors are available at all times to talk with youth and engage in informal activities. Group meetings for youth in the shelter occur twice a day at 4:30 p.m. and 8:30 p.m. for an hour. There is also a morning meeting for youth not in school. These group sessions focus on house issues and on the development of problem solving and social skills.

Termination

When the youth leaves the shelter, the crisis counselor conducts an exit interview. In situations where the outcome has been unsuccessful (e.g., the youth is leaving, the parents have refused involvement), the staff's focus is on helping the youth consider the possible consequences of the decision to leave, informing him or her of other resources and options and encouraging the youth to return if the plan does not work out. In situations where the outcome is successful, the crisis counselor helps the family to continue to reach closure around the crisis experience. Most families are encouraged to use Huckleberry House's aftercare program or may be referred to another agency for service. An aftercare counselor may join the exit interview to facilitate the transition. At this time, a feedback questionnaire is given to the youth and family.

2. Aftercare

Huckleberry House's aftercare program, "Parents and Teenagers" (PAT), has a staff separate from the crisis program. PAT provides, at no cost to the clients, ongoing individual, family and marital counseling, case management and support groups. About 50 percent of the youth and families in the crisis program are referred to the aftercare program at Huckleberry House. A referral usually is made unless a family is receiving services elsewhere, refuses services, or the youth is from out of state or out of county. If possible, the aftercare counselor participates in the exit interview when the youth leaves the shelter in order to "hook up" with the family. Otherwise, contact is made with the family within 48 hours of exit from the crisis program. The purpose of the immediate engagement is to maintain the trust developed in the crisis program and facilitate the development of an individualized plan that is workable for the family. PAT has no waiting list, and a family is generally seen within a week of the initial phone contact or exit interview.

The initial aftercare session usually takes up to two hours. The counselor, youth and family members identify needs and goals. A contract is signed and an evaluation agreement date set. Usually within four to six weeks all parties meet to evaluate the process to determine whether it is meeting the family's needs. An attempt is made from the outset to set realistic expectations about the counseling process. At the time of the evaluation a determination is made as to whether the family will continue in counseling, and goals are reviewed and revised, if necessary.

If a youth is assessed as suicidal or at risk, a safety plan is developed. The crisis program continues to provide 24-hour back-up if the aftercare counselor is unavailable. If a young person does re-enter the crisis program, the aftercare counselor remains the primary counselor, working closely with the crisis counselor assigned to the youth and family.

In aftercare the counselor generally meets with the family weekly for hour-long sessions. However, flexibility is one of the program's strengths. If necessary, a family and youth can be seen daily. If a family engages, aftercare treatment in most cases will continue for six months.

The treatment approach tends to be reality-based and systems-oriented. Treatment plans focus on the accomplishment of concrete goals. Interventions vary depending upon the style of the counselor and the families. Role playing often is used to provide insight, improve communication and explore options. For clients who have difficulty verbalizing, nonverbal techniques are used such as drawing, relaxation exercises and games. In addition to counseling, case management constitutes an important aspect of treatment. The counselor's role as case manager is multifaceted. The counselor assists the youth and family in obtaining services elsewhere, if needed, and provides ongoing support to insure involvement; the counselor serves as an advocate for the client in hearings or other situations; and the counselor provides follow-up when terminating cases.

Several support groups have been established through aftercare. A teen group has been meeting with two PAT counselors for three years. Skill building groups for adults and youth were in the process of being developed at the time of the site visit. It was planned that these group sessions would run for six weeks with 12 in a group.

3. Follow-Up

The youth and families receiving crisis and aftercare services from Huckleberry House may terminate at a number of junctures. The termination may be the result of a successful resolution of a crisis or may be because the youth or family leaves the program. Before a case is determined inactive, a crisis or aftercare counselor tries to make contact with the youth and family, clarifying the decision to stop services. Sixty to ninety days after a case is transferred to an inactive status, Huckleberry House staff attempt a final follow-up phone call. The purpose is to determine the need for further services and to provide follow-up information for the agency. Often families become reinvolved with Huckleberry House through this call.

Networking and Linkages

Huckleberry House works closely with and interfaces with a number of community agencies and systems for multiple purposes, for funding support, referrals to and from the agency, service integration for its clients and community planning.

As will be discussed more fully in the section on resources, Huckleberry House has service contracts with the county mental health board, the children's protective service agency, and the Department of Youth Services. Huck House works closely with these agencies around client referrals and follow-up care.

Through the crisis counseling and the aftercare program Huckleberry House staff develop working relationships with the staff of numerous community agencies in order to link youth and their families with an array of needed services. Most of the families and youth served by Huck House require services from multiple agencies. The aftercare program, in particular,

places a strong emphasis on case management and assisting families in getting the various supports they need to cope.

Staff have also developed cooperative relationships with programs and agencies that are used as backup to the crisis shelter such as hospital emergency rooms and the inpatient psychiatric facilities serving the community. As noted earlier, Huckleberry House's aftercare program evolved from a joint venture of the Columbus Children's Hospital and the League Against Child Abuse.

In addition to the relationships with health, social service, and juvenile justice agencies Huck House works with local schools on several different levels, including case consultation, consultation and education on particular topics such as youth suicide, and teaching a course on peer counseling at two alternative high schools in the area.

The executive director of Huckleberry House is actively involved in a number of interagency efforts dealing with issues of community concern such as suicide prevention, a crisis service network for youth, and development of more community-based services alternatives for older youth. He is a member of the Ohio Youth Services Network as well as other interagency committees.

Huckleberry House is viewed in the community as a nontraditional agency. That perception is important because youth turned off by more traditional agencies may be encouraged to seek out Huck House services as a more acceptable alternative. At the same time, positive perceptions on behalf of the provider community and the community-at-large are critical for Huckleberry House's survival. Because of this factor, the executive director places a strong emphasis on building community support. This is accomplished in numerous ways. Huck House tries to be an available resource for agencies, for service and for consultation and education; the executive director plays an active role in community-wide planning and interagency activities; a strong link and good working relations are maintained with the police.

Clients

The shelter has an open door policy in accepting youth; thus Huckleberry House attempts to serve all youth who come seeking help. However, as a shelter for runaways it has certain legal commitments, and as a result there are some youth that Huck House can assist in very limited ways. It is Huckleberry House's responsibility to assist youth in securing an alternative to running that constitutes a legal living arrangement. For those young people committed to not working with their families, Huckleberry House can offer limited assistance in exploring other alternatives. If there is a warrant out for the arrest of a youth, staff can play an advocacy and advisory role, supporting the youth in contacting or going to the police. But Huckleberry House cannot hold a person. Huckleberry House does not turn away youth who are on drugs, psychotic or suicidal. Psychiatric and/or medical backup are sought when appropriate. The program is not well suited to assist youth who are retarded or those who are actively psychotic, because in the latter case youth are not able to feel safe given the open structure of the program and facility.

The typical youth who arrives at Huckleberry House has been gone from home less than 24 hours and usually lives within a 15-mile radius of the shelter. In about a quarter of the cases, the youth have not run but are seeking crisis counseling. The majority of the youth (80 percent) are between the ages of 14 and 17. Eighteen percent are 13 or younger. About 60 percent are female. About one-quarter of the youth are minority, predominantly black.

The youth coming to Huckleberry House have multiple problems. The most frequently cited reasons for the crisis, offered by the youth, include general family confusion and abuse or emotional neglect. One-third of all the clients are involved with the children's protective services agency; however, close to two-thirds of the youth receive a high child abuse score in the assessment tool used by Huck House staff. About half score high to medium on suicidal lethality measures. Fifty percent of the youth have either drug or alcohol abuse problems. Huckleberry House does not ascribe a primary diagnosis according to DSM III; rather, staff assess the situation of the youth and family. For 43 percent of the youth, the crisis is attributed to family situations that are chronically dysfunctional. In 23 percent of the cases the problem is more of a situational issue involving the family such as a recent divorce. For 38 percent of the youth, this is the first time they have run. Their most critical needs concern family and personal counseling as well as counseling about other resources available to them.

In 1986 there were 698 crisis cases: 530 youth were seen for the first time; 168 had previously used Huckleberry House services. Three quarters of the youth stayed in the overnight shelter at least one night. The average length of stay was 4.1 nights.

Staffing

Staff at Huckleberry House include 30 paid staff, 20 volunteers and generally 8 to 12 trainees of graduate and undergraduate programs from universities in the area. The executive director provides overall direction to the staff. Staff are assigned either to the shelter and crisis stabilization program, the aftercare program or administration. Each unit has its own coordinator.

The shelter operation and staffing are similar to most residential programs. House staff are assigned to shifts and provide 24-hour coverage. Staff include a full-time house coordinator; eight part-time adult house managers; four youth house managers who are high school students; and three part-time night managers. The local workfare program assists with facility maintenance and cooking staff.

House managers and the house coordinator are responsible for the day-to-day running of the facility. Responsibilities include intake, establishing daily activity schedules, writing daily summaries, planning menus, ordering and maintaining an inventory of food and supplies, and participating in case and clinical reviews and shift meetings. On the night shift, which extends from 10:00 p.m. to 10:00 a.m., there is always an adult house manager and a night assistant house manager on duty, with a crisis counselor on call. Room and board in a carriage house behind the shelter are provided to the night assistant house managers. Adult house managers usually work a 20-hour work week and youth house managers 10 to 13 hours per week. Shifts rotate to include evenings, late night duty and weekends. House managers, for the most part, are juniors and seniors in college, many majoring in the human services. The youth house managers are high school juniors and seniors in a peer counseling program. These adolescents provide positive role models for the shelter youth.

The crisis counseling staff are on the premises from 10:00 a.m. to 10:00 p.m. daily, with on-call back-up support in the late evening, early morning hours. There are three crisis counselors on staff; all have a bachelor's degree or equivalent experience. All are committed, highly skilled and like working with and relate well to youth. These attributes are considered to be more important than clinical degrees. The crisis coordinator started ten years ago as a volunteer and moved through the ranks of the program. The aftercare staff also include the equivalent of three full-time counselors. Because of the longer term therapeutic counseling they provide, this staff has more graduate training and clinical experience. Two of the staff

have master's degrees in social work and two have bachelor's degrees, one with 13 years experience.

Volunteers, screened and supervised by a full-time volunteer coordinator, participate in all aspects of the program. Volunteers work four-hour shifts and must make a six-month commitment. Student trainees work one-on-one with the crisis or aftercare counselors. In order to provide continuity for the clients and the students, when assigned a case, the student stays involved until termination. Experience in intake and assisting the house coordinator are also integral parts of the students' training. Placement students have proven to be a successful source for recruiting staff.

One of the characteristics of the Huckleberry House staff is their diversity as individuals. The addition of the aftercare staff brought a new dimension to the staff complement since the aftercare staff are older, more experienced and have more professional credentials. Despite their differences, all staff adhere to two common values, a belief in the importance of the family and in youth taking responsibility for their decision making.

Huckleberry House is committed to ongoing training and staff development, which are built into the program in a variety of ways. Staff meetings are an intrinsic aspect of the program and occur often. They are used to support staff, provide training and carry out treatment planning. At each of the three shift changes, staff meet and confer on youth in the shelter and on any issues which have arisen. House managers also meet for two hours weekly; this time is used for training on issues identified by staff. Supervision is provided for an hour monthly, but is available any time if needed. Crisis and aftercare counselors each attend weekly case review meetings. On a monthly basis, full-time paid counseling staff have two hours of consultation with a psychiatrist. The executive director meets with the coordinators weekly for one hour. A monthly meeting is scheduled for all full-time staff. Volunteers meet monthly.

All staff of the agency receive an orientation on agency policy and procedures. Other training for full-time paid staff is developed by the crisis or aftercare coordinator and is based on individual needs and experience. The crisis coordinator and volunteer coordinator conduct an extensive training program for all volunteers, part-time staff and placement students who work in the program. This training program was recently augmented to include suicide intervention techniques through a cooperative effort between the North Central Mental Health Services' Suicide Prevention Service and Huckleberry House as a result of funding to Huck House from a federal grant from the Office of Human Development Services. The 60-hour training program extends over a seven-week period and provides, among other skill building experiences, training and techniques for early detection, intervention and treatment to prevent suicides in the adolescent runaway population. Training methods include didactic approaches, small group engagement in role playing and problem solving, and one-to-one job shadowing. Usually 12 to 15 trainees participate at any one time in the training sessions.

As with most crisis services, staff turnover and burnout are issues that must be addressed. Crisis and aftercare counselors generally stay at least two years and some longer, but there is more frequent turnover among the house staff. To alleviate burnout, efforts are made to help staff in managing stress such as using students and volunteers help to support staff and relieve them from being overburdened. The agency has a liberal vacation policy, with three weeks leave for full-time paid staff and four weeks after a three-year tenure. Staff also have access to outside training paid for by the agency. Efforts are made to reward staff by promotions within the agency. Attention is paid to team building. Staff do not work in isolation but are supported by other staff; if needed, other staff make themselves available to assist a colleague in dealing with a young person. There is frequent communication among all staff with numerous vehicles to create and support communication channels; for example, client

information is shared among staff. As noted previously, staff meet regularly together and with their supervisor. The agency also holds retreats at least annually as another means of building staff bonds and dealing with staff concerns.

Resources

Huckleberry House's total operating budget for the fiscal year ending in 1987 was $517,620. Major sources of revenues were derived from agency contracts, federal grants and United Way dollars. Clients are not charged for crisis or aftercare services at Huck House, so client fees are not a source of revenue. Twenty-three percent of the agency's budget ($118,713) came from a contract with the Franklin County Children's Services; 27 percent ($140,579) from a contract with the local mental health board; 20 percent ($101,000) from a three-year grant from the Youth Development Bureau (Runaway and Homeless Youth Act funds); and 24 percent ($125,438) from the United Way. In 1987, monies were also available through local revenue sharing and the Ohio Department of Education's Office of Missing Children. Contributions from parents, church groups and others generated approximately $15,000 in revenue, or about 3 percent of the total operating funds. A small amount of funding (approximately $7,000 each) came from the Ohio Department of Education for food reimbursement and from the Department of Youth Services for purchase of bed nights in the shelter.

For that same time period, total expenses were approximately $532,000. Salaries and fringe benefits accounted for approximately 69 percent of the costs. The remaining costs can be attributed primarily to administrative support and facility costs. To cover the shortfall the agency used carryover dollars and money from its unrestricted fund balance.

The actual costs, including all overhead and administrative expenses, for 1987, based on actual units delivered, are as follows:

Emergency/crisis counseling (the first 24 hours)	$ 23.57/hour
Emergency follow-up counseling (post 24 hours)	22.78/hour
Aftercare	36.40/hour
Shelter care	45.04/night
Consultation and education	129.21/hour
Training (Costs are based on 9,046 hours of volunteer time in 1987)	4.04/hour

For both historical and political reasons, crisis services have been calculated as days or nights of service so that the units will be more comparable to similar services such as non-therapeutic group homes or long-term residential programs. As such the hours of crisis intervention service are "rolled into" shelter costs to derive a unit of service that mental health and children services agencies will pay. Each pay $100 per night per youth. The county children's services agency pays only for youth referred, while mental health pays for all youth up to a maximum amount. United Way and other resources augment these "artificial" units.

Huckleberry House's funding also is complicated because each of the funding agencies specifies those services to be provided and paid for in the contractual arrangement or grant requirements. Mental health covers the costs of shelter care and emergency crisis counseling for clients who are "walk-ins" to Huckleberry House; whereas, the children's service agency covers the costs of shelter care and follow-up crisis counseling for those youth they refer to Huck House. Children's Services can also cover 120 days of care after the crisis. The Youth Development Bureau's grant covers costs of aftercare for those clients who are not referred by the county children's services agency or who remain in treatment after 120 days. Not only do funding agencies have different rates of payment for different units of service, but

Huckleberry House's four major funding sources all have different funding cycles, further complicating the administration and budgeting for a small agency.

Based on 1987 figures a more realistic estimate of the cost of shelter care and all crisis counseling in the first 24 hours (i.e, to engage the youth, most of whom are self referred, effect treatment plans, and make parent contact) is $227.00 per youth for the first night. The average cost for all subsequent nights and all other crisis counseling is $118.29. The average cost for each of the 733 episodes in 1987 was $481.85 per youth. However, because some youth had more than one episode, the actual average cost for 1987 per youth was $558.85. This average is based on the total units of counseling in the first 24 hours, the actual number of first nights and subsequent nights and the total units of counseling after 24 hours.

As is the case for many nonprofit agencies serving youth, funding stability is a major issue. United Way funds have grown over the years, but monies from Franklin County Children's Services, a fairly stable source for about nine years, have recently been cut back. In addition, local revenue sharing dollars are no longer available. The Runaway and Homeless Youth Act has provided a consistent source of funding since 1976, but this resource depends on federal funding. Given the federal deficit, these dollars are never secure. In the past, the community's perception of the program and the level of concern about troubled, vulnerable youth represent other variables that impact on agency funding and can fluctuate over time. However, balancing the next year's revenues and expenses is a necessity for the agency. Huckleberry House's executive director has found that providing extensive documentation of the program's activities and results with clients has proven highly successful in obtaining and sustaining funding support.

The agency has not sought Medicaid reimbursement because in order to qualify, the clinical staff of the crisis counseling program are required to have master's degrees in social work. The program wants flexibility in the staff they hire because the type of person, not the degree, is considered to be most critical to the program's success. Agency salaries also make it difficult to hire graduate trained professionals. The agency is, however, exploring the possibility of Medicaid coverage for the aftercare service.

Evaluation

Huckleberry House collects extensive data on the clients it serves and on staff and agency activities. This information is aggregated and presented in monthly and yearly statistical reports that are impressive for a small agency, especially one devoted to serving youth and families in crisis. Data are used to measure the program's success in accomplishing its goals and objectives in order to document achievements or make programmatic improvements. As noted previously, this information has been a necessary tool for the program's survival, since shelters can be vulnerable to criticism from more traditional agencies and funders.

At intake and during the initial interview for both the crisis counseling and the aftercare programs, detailed information is obtained and recorded for each youth seen in the program. At the exit interview a feedback questionnaire is completed by both parents and youth. A follow-up phone call also is made to all clients 60 to 90 days after termination. When conducting follow-up, at least three attempts are made to reach the youth. Any information obtained about the youth is recorded at this time as well.

The agency has not had the funding or staff capability to engage in in-depth, longitudinal studies with comparison populations or to track individual clients. But it has amassed comprehensive and valuable data on the approximately 700 runaway youth and youth in crisis that it serves each year. Data include profile information on the age, sex and race of youth; the running patterns; individual and family problems; and outcomes.

Huckleberry House tracks the following outcomes during and after the treatment process and uses these outcomes as criteria for determining success:

- o The number of young people seeking out Huckleberry House as a resource.
- o Engagement of youth in the program.
- o A call home
- o Family reunification and return to home, as opposed to a placement situation.
- o Remaining with the family.
- o No contact with juvenile justice.
- o No other episodes of running.

Outcome data show that 53 percent of youth return to the primary family home; 18 percent go to another home situation; 7 percent are placed in an institution; and 6 percent are placed through the children's service agency. In 85 percent of the cases, a legal alternative is achieved. Seven percent of the youth never engage initially in the program, and another 7 percent return to the streets. In 76 percent of these cases, youth engage with a parent or parents in improving communication and working towards solutions of problems. Of the 47 percent of cases referred to the aftercare program, 55 percent of the families actually engage in aftercare. Forty-six percent of the youth had no contact with the juvenile justice system, 19 percent a brief contact only, 10 percent a contact before the crisis, 5 percent an informal contact, 5 percent were ruled dependents, and 7 percent charged or placed. The follow-up phone call provided information on 77 percent of the youth; 83 percent had not run again. About 5 percent of the youth return to Huck House multiple times.

Major Strengths and Problems

Staff of Huckleberry House, youth and families served by the program, and representatives from community agencies cited a number of positive factors, which contribute to the agency's success:

- o Clarity of goals and values that provides an underpinning for staff and their decision making.
- o Strong leadership to guide a diverse staff, provide sound management, and develop good community relationships.
- o A belief in an adolescent's ability to make decisions for him or herself.
- o A commitment from all staff to being truthful, open and direct with youth.
- o Team work and open communication among staff.
- o Effective training and supervision for paid and unpaid staff.
- o Use of volunteers and placement students to generate fresh ideas and prevent burnout.

- Flexibility on the part of the agency's staff and administration and willingness to learn, to change and to improve.

- An excellent reporting system.

A strength expressed by both the staff and youth, in different words, is that Huckleberry House provides a program that is structured and yet at the same time appears to be unstructured. This seeming contradiction is an important element in the program's success. The level of staffing, the intensity of service, the basic supports provided through the shelter, and the efficiency of management all enable the youth to feel a sense of nurturing and safety. At the same time, the informality and low key nature of the staff, the involvement of youth counselors, and the relaxed environment are welcoming to youth skeptical of adults, formal organizations and service agencies.

Several problem areas were noted as well. Huckleberry House sometimes is criticized for not having more professionally trained staff on board and for using peer counselors and volunteers. These are concerns expressed among some members of the provider community who believe that difficult, troubled youth cannot receive adequate treatment in such a setting and that more professionally trained staff are required for crisis intervention with mentally ill youth. According to this view, Huckleberry House works effectively with a certain segment of the population, but is limited in those it can serve.

Staff believe (and agency statistics tend to support this belief) that the agency works effectively with youth with many kinds of problems, generally multiple in nature. The role of the crisis staff is to intervene and stabilize the crisis, but aftercare staff, who have more clinical training, play an essential role in ongoing treatment for the youth and family. When the agency cannot adequately serve a youth, a referral to a more appropriate source of care is made.

Another issue that the agency continually struggles with is sustaining the delicate balance between maintaining a good relationship with the police and maintaining credibility with youth so that the word on the streets is that Huck House is a good program.

Aftercare staff indicate that determining when clients should be terminated is not always clear-cut. Many families, in order to sustain gains in treatment, require ongoing support. The establishment of more support groups is one approach under consideration for dealing with this issue.

Recruiting staff who have the right attributes to work in such a unique program is not an easy task and is an issue the agency perpetually faces. It takes a particular combination of skills, self-esteem, savvy, presence, commitment and caring for youth to be effective. Added to these requirements are the demands of the job, concerns about achieving a sexual and racial balance, and the salary provided by a small, nonprofit, human service agency; thus, finding staff to fill positions is a continual challenge.

Dissemination and Advocacy

One of Huckleberry House's goals is to provide community education and information about the problems of runaway and other youth in crisis. Although staff would like to have the time and resources to do more community outreach and prevention, a number of ongoing activities enable Huckleberry House to reach a broader community to assist youth at risk for crisis.

Through a contractual arrangement Huckleberry House produces a newsletter four times a year that is sent to an extensive mailing list of community providers, youth organizations, parents

and others. The newsletter varies in the topics covered; usually it highlights activities of Huckleberry House, provides examples of youth and families helped through the program, and gives information on such topics as youth suicide, potential warning signals, running away and other stresses facing young people today. In a one-year period, staff made 75 presentations to approximately 1,200 people as another dimension of Huck House's prevention and community outreach activities. Extensive information also is given to providers over the phone.

Through its joint efforts with the North Central Mental Health Services' Suicide Prevention Service and funding from the Office of Human Development Services, Huckleberry House staff have developed a comprehensive training manual. including a curriculum and intervention procedures to prevent suicide among runaway youth. This manual has generated national interest and has been disseminated to many providers and organizations working with youth.

While Huckleberry House is a service organization, not an advocacy organization per se, staff emphasize that a significant part of their role is advocating on behalf of the young people they work with both on an individual and community level. When youth enter Huckleberry House, they gain an advocate in helping to work through issues and take control of their lives. Staff become an ally for the youth in advocating for that youth with other agencies and service providers. Agency staff are also involved in advocacy for youth on a community-wide level through participation in such organizations as the Ohio Youth Services Network.

Case Examples

"F" was a 16 year-old who entered the crisis program with his 14 year-old sister, "L". F and L were referred to Huckleberry House by friends with whom they were staying. Upon entering the program, F and L identified allegations of sexual maltreatment by parents. Huckleberry House staff helped the young people to contact the Child Protective Services and provided support to F and L and their family through the investigation and decision making process. The crisis counselor assisted in getting the young people to address issues related to sexual maltreatment (e.g., sexual confusion and acting out), self-esteem and overprotectiveness. The plan that the family, Huck House crisis counselors and the Child Protective Services developed was for L to live with relatives and for F to live with friends of the family, as the Child Protective Services continued to investigate the sexual maltreatment allegations. Huckleberry House continues in an aftercare management role.

"S" was a 15 year-old who entered the crisis program after leaving home because of intense family conflict with parents over job expectations and family roles. Huckleberry House provided S with support in reaching out to his family and developing a plan to begin to address his identified issues. Through the family reconciliation process S and his parents identified family issues (e.g., parenting techniques, family role expectations, marital conflicts) as well as individual issues (e.g., self-esteem and peer relationships) which began to be dealt with in individual and family sessions. The young person returned home and became active with the aftercare program.

"T" was a 15 year-old who ran from home after school due to the possibility of parents confronting her on drug involvement issues. T entered the crisis program with cuts on her wrist and identified conflict with her stepfather and mother. After deciding to use Huckleberry House, T and the staff made contact with T's mother, at which time both were unwilling to consider the family's reconciliation. However, both were willing to look at other options for housing while using the program. T identified strong feelings of suicidal ideation, which increased as her list of housing options decreased. The crisis counselor provided support to the family and to her as well as helping her to develop plans to deal with suicidal feelings. After exhausting all alternatives to the current living situation, T returned home

and began to deal with her family. She and her family are continuing in therapy with the aftercare program.

Technical Assistance Resources

- o A Manual: Emergency Intervention Procedures to Prevent Suicide Among Runaway Youth (including Training Curriculum)

- o Notebook of Crisis Counseling Procedure Forms

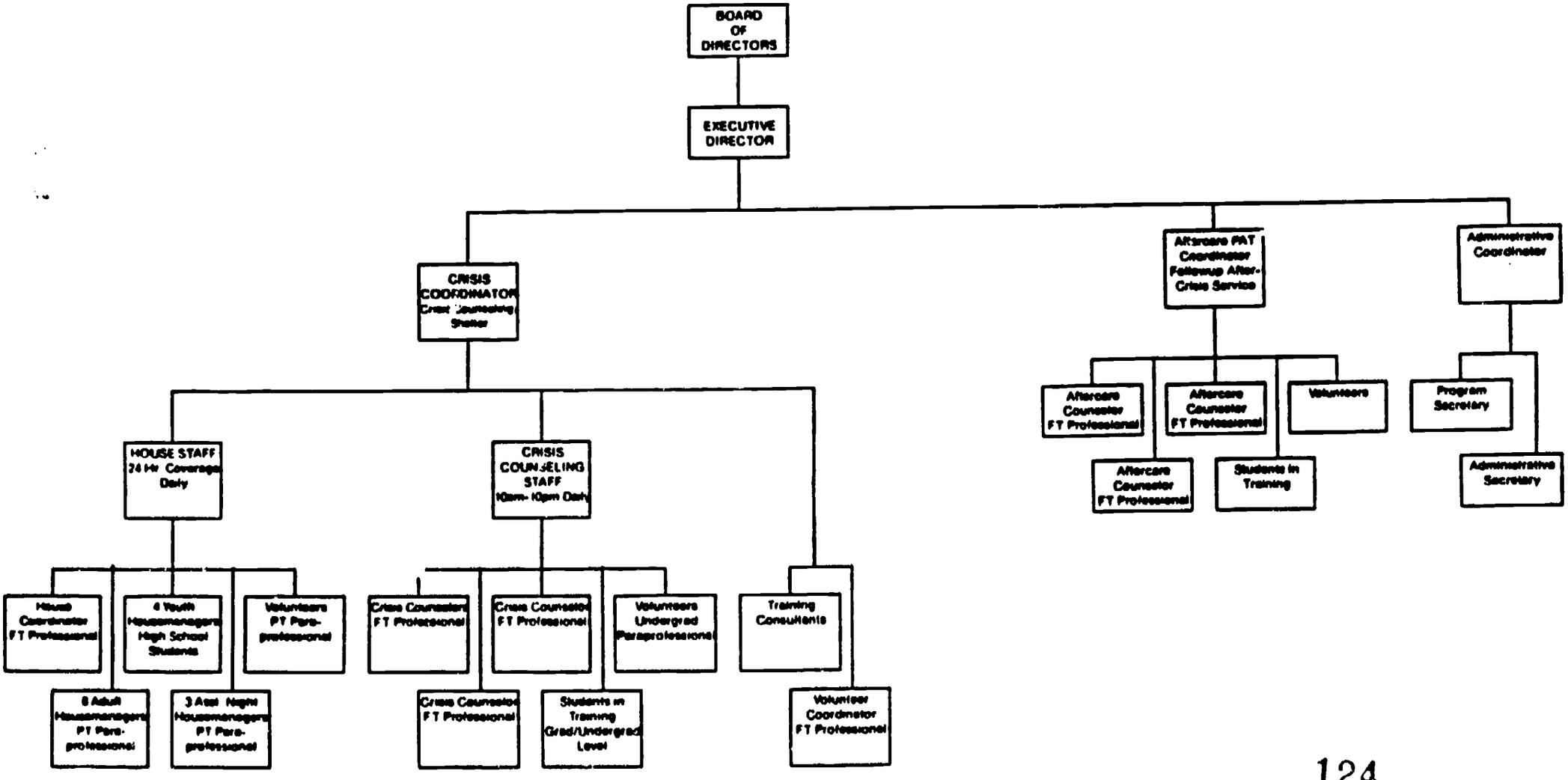
  Face Sheet (Consumer Identification and Socio-Demographic Inform ion)
  Individualized Counseling Assessment Plan and Services
  Current Status of Service Goals
  Daily Plans
  Transfer and Service Area Disposition
  Information Alert
  Case Review for Team Review Documentation
  Termination Review
  Final Follow-up Phone Call
  Brief Contact Only Summary
  Huckleberry House -- "How Are We Doing?" -- Questionnaire
  Crisis Counseling Summary
  Fact Sheet (Exit and Termination)
  Service Planning: Objectives -- Activities -- Rationale
  Engagement Activities
  Initial Interview Plan
  Phone Call Home -- Other Parent Contact Plan
  Integration Into Shelter Activities
  Temporary Shelter Plan
  Initial Interview and Beyond Narrative
  Suicide Lethality Assessment
  House Service Sheet and Shift Report

- o Notebook of "PAT" Aftercare Procedure Forms

  Face Sheet (Consumer Identification and Socio-Demographic Information)
  Face Sheet (Initial Entry, Exit and Termination)
  Parents and Teenagers Counseling Plan Agreement
  PAT Counseling Goals Worksheet
  Individualized PAT Counseling Plan
  Transfer and Service Area Disposition
  Case Review Form -- Team Review Documentation
  Parent and Teenagers Exit Summary
  Termination Review
  Crisis Counseling Summary Sheet
  Youth and Parent Feedback
  PAT: Initial Information, Data, Assessment
  Problem List in a Role Performance Profile
  Client Self-Evaluation Screen
  General Problem Description - Narrative
  Staff Assessment

- o Program Performance Standards, Centers for Runaway and Homeless Youth, Self Assessment Instrument

HUCKLEBERRY HOUSE, INC.
Table of Organization



HUCKLEBERRY HOUSE, INC.

A TABLE OF GOALS, SERVICE PROGRAMS, AND ACTIVITIES

MISSION: DEDICATION TO HELPING YOUTH AND ADULTS TO COMMUNICATE AND UNDERSTAND EACH OTHER
ALTERNATIVES to running away; PREVENTION of running away and breaking family relationships

ALLEVIATE THE IMMEDIATE PROBLEMS OF RUNAWAYS AND OTHER YOUTH (AND THEIR FAMILIES) DURING THE CRISIS EPISODE	STRENGTHEN FAMILY RELATIONSHIPS AND ENCOURAGE STABLE LIVING CONDITIONS AFTER THE CRISIS AND TEMPORARY SEPERATION	CREATE A COMMUNITY AWARENESS AND PUBLIC RELATIONS TO ENABLE THE DEVELOPMENT OF RESOURCES SUFFICIENT TO FUND AGENCY PROGRAMS	PROVIDE SUPPORT ACTIVITIES TO ENHANCE CLIENT AND SERVICE GOALS AND OBJECTIVES

REUNITE RUNAWAY AND OTHER YOUTH IN CRISIS WITH THEIR FAMILIES AND ENCOURAGE THE RESOLUTION OF INTRA-FAMILY PROBLEMS	EDUCATE THE COMMUNITY ABOUT THE PROBLEMS OF RUNAWAY AND OTHER YOUTH IN CRISIS TO PREVENT BREAKING FAMILY RELATIONSHIPS	PROVIDE VOLUNTEER WORK EXPERIENCES AND PROFESSIONAL TRAINING OPPORTUNITIES

Reductions of risks to young people

Help Youth make future decisions

Provide opportunities for youth communication and decision making

24 HOUR COMPREHENSIVE CRISIS STABILIZATION	24 HOUR SHELTER CARE	AFTERCRISIS CARE PARENTS AND TEENS	COMMUNITY RELATIONS & PUBLIC INFORMATION	RESOURCE DEVELOPMENT (ADMINISTRATION)	TRAINING	ADMINISTRATION
EMERGENCY COUNSELING CRISIS FOLLOWUP COUNSELING						
Public Awareness Engagement Emergency Plan Development Emergency Plan Implementation Followup Planning Crisis Stabilization Ind & Gp Counseling Exit Interview Services Followup	Milieu Engagement Shelter Integration 3-5 days food & shelter Protection Plan followup Fire, Safety, Health Standards	Pre-engagement during Crisis Aftercare planning Service Implementation Ind & Gp Counseling Assertive Outreach Engagement/Re-Engagement Link with crisis/shelter Casemanagement Referral	Case finding Presentations Community Planning Community Liaison Public Information Information/Referral Information re: runaway/missing youth	Community relations Newsletter Fund Drive United Way Special Events Grants Government Relations	Volunteer Recruitment & Training Academic Placement General Relief Program Staff Dev Outside T/TA Workshops & Conferences	Office Mgt Grants Mgt Program Mgt Quality Assu Records Mgt Fiscal Cntrl Personnel Audit Evaluation Research

IV. PROFILES OF CRISIS SERVICE PROGRAMS

The first phase of the study of community-based services for children and adolescents who are severely emotionally disturbed involved identifying existing programs. A range of programs providing home-based services, crisis services, and therapeutic foster care were identified during the first phase of the study. A questionnaire was sent to each identified program in order to gather detailed information about the program's characteristics. The information from these questionnaires was summarized in the form of a one-page profile of each program in order to provide specific examples of a variety of programs.

The profiles contain the following information about each program:

- Type of Community - urban, suburban, rural, or mixed.
- Type of Agency - agency type and whether public, private nonprofit or private-for-profit
- Capacity/Staffing - number of children or families served at a given time and number of full-time equivalent (FTE) staff.
- Age Range - range in age of children served.
- Majority Age - age categories of majority of children served.
- Sex - percent of males and females served.
- Race - racial characteristics of children served.
- Diagnosis/Reasons For Not Accepting - percent of children served with various diagnoses and reasons for which children would be considered ineligible or inappropriate for services.
- Duration/Intensity - length of the intervention in weeks, months, or years and number of hours per week spent with the child and family.
- Description - brief description of the program and the services provided.
- Observations - funding sources, other services provided by the agency, interesting aspects of the program, availability of evaluation data, noteworthy evaluation results, linkages with other agencies, whether case management is provided, advocacy activities.

It should be noted that programs were asked to use readily available data to complete the questionnaire so as to minimize response time as well as response burden. Programs without data were asked to provide estimates for purposes of these profiles. Therefore, the data contained in the profiles should be considered estimates. Further, information in some categories (such as diagnoses) may be collected and used differently by each individual program. Thus, certain categories of information are not directly comparable across programs.

These profiles are not intended to represent the universe of crisis service programs. There are, of course, many more programs in existence. These profiles are intended as examples of a variety of programs to assist states and communities in their program design and development efforts.

APPALACHIAN MENTAL HEALTH CENTER, YOUTH CRISIS SHELTER
Elkins, West Virginia
Reg. III
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Rural	Private nonprofit	8 children 10 FTEs	12-17	45% 13-15 45% 16-17 10% 6-12	50% Male 50% Female	99% White	60% Behavioral/Conduct 20% Emotional 5% Schizophrenic/Psychotic Will not accept if: o suicidal gestures o violent behavior o active psychosis o severe retardation	30 days 112 hours/week with child ? hours/week with family

DESCRIPTION

- o 30-day crisis shelter for adolescents
- o Services include individual, family and group counseling, evaluation and referral

OBSERVATIONS

- o 100% funded by West Virginia Department of Human Services
- o Case management
- o Agency also has in-home services, therapeutic foster care, wilderness program (Appalachian Sojourns)

BROWARD COUNTY MENTAL HEALTH DIVISION, CHILDREN AND ADOLESCENTS PROGRAM (CAP)
Hollywood, Florida
Reg. IV
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	15 children 16.5 FTEs	Infant - 17	35% 13-15 35% 16-17	60% Male 40% Female	76% White 21% Black 3% Hispanic	50% Behavioral/Conduct 30% Emotional 10% Schizophrenic/Other Psychotic Disorders 10% Substance Abuse Will not accept if: o individuals are experiencing acute, unstabilized medical problems	2 weeks 80 hours with child 4 hours with family

DESCRIPTION

- o Crisis screening and stabilization services for medically indigent population - in-patient, short-term residential and respite
- o 10-bed unit
- o Spectrum of services includes: formal education, living skills training, recreation, group therapy, one to one, aftercare, interface with other agencies
- o Behavioral model

OBSERVATIONS

- o State and county funding
- o Division is public receiving facility, also provides short-term treatment, acute in-patient and short-term residential
- o Variety of linkages with agencies
- o Education provided by county schools
- o Case management for each youth

CHILD GUIDANCE CLINIC OF JACKSONVILLE, CHILDREN'S EMERGENCY SERVICE TEAM
Jacksonville, Florida
Reg. IV
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	20 new children/ families per month 2.5 FTEs	7-17	70% 13-15 20% 6-12	52% Male 48% Female	61% White 30% Black 1% Asian	100% Behavioral/Conduct Will not accept if: o sexually abused o neglected or physically abused o chemically dependent o adjudicated youth	6 months face to face contact with child and family 1.5-2 hours, not necessarily weekly

DESCRIPTION

- o Family crisis intervention program for walk-in emergencies and families that have filed a status offense against a child
- o Structured family therapy is primary therapeutic approach; treatment is goal oriented; all family members are involved
- o Objective is to prevent placement
- o Services include brief family focused treatment and referral

OBSERVATIONS

- o 100% state funding - HRS Prevention Program
- o Ongoing or auxiliary services are provided by parent agency, Child Guidance Center
- o Agency linkages either limited or not delineated; referrals by HRS
- o Case management; advocacy

CHILDRENS CENTER OF WAYNE COUNTY, CENTRAL SCREENING
Detroit, Michigan
Reg. V
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	60 children/ month 3.3 FTEs	4-17	40% 13-15 30% 6-12 20% 16-17 10% 0-5	55% Female 45% Male	80% Black 15% White 5% Hispanic	50% Emotional 35% Behavioral/Conduct 15% Schizophrenic	4 weeks 3 hours/week with child 3 hours/week with family

DESCRIPTION

- o Screen children referred for inpatient hospitalization
- o No further description provided

OBSERVATIONS

- o Agency also has in-home, foster care, outpatient, day treatment, group home tutorial, teenage parent programs, etc.

HOUSTON CHILD GUIDANCE CENTER, FAMILY CRISIS PROGRAM
Houston, Texas
Reg. VI
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	30-40 children 17.2 FTEs	6-21	40% 13-15 40% 16-17	50% Male 50% Female	70% White 15% Black 15% Hispanic	50% Behavioral/Conduct 20% Emotional 10% Schizophrenic/Other Psychotic Disorders 10% Dual (Conduct and Substance Abuse) Will not accept if: o parents unwilling to participate	4-6 weeks 5-120 hours/ week with family

DESCRIPTION

- o Intensive crisis intervention program working with family network of up to 30 members
- o Program integrated with day treatment program and family crisis in-patient unit (18 beds)
- o Philosophy: brief, intense, systemic intervention teaching families to use natural networks
- o 4-6 therapists see approximately 150 families/year

OBSERVATIONS

- o Diverse public and private funding sources
- o Agency linkages primarily referral sources
- o All cases assigned a case manager

HUCKLEBERRY HOUSE, INC.
Columbus, Ohio
Reg. V
Established: 1970

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	Up to 20 children Approximately 20 FTEs	13-18	53% 13-15 36% 16-17	60% Female 40% Male	75% White 21% Black 2% Hispanic	40% Chronic Dysfunction situation 30% Situational/Developmental Situation 30% Unknown/Not Enough Information Will not accept if: o past history of violent acting out o youth needs closely structured supervision o severely retarded	3-4 days 1 hour/day individual sessions with youth 1-2 family sessions in 3-5 day period

DESCRIPTION

- o 24-hour comprehensive crisis shelter for runaway and other youth in crisis
- o Services include residential shelter, crisis stabilization, counseling - family and group - post crisis counseling, 24-hour intake and information and referral
- o Family system development: communication, problem solving, reconciliation, plan development, empowerment of youth and families

OBSERVATIONS

- o Variety of funding sources: local, state, private
- o Staffing supplemented by volunteer and high school aged youth
- o Case related information exchange with wide range of agencies

NORTHEASTERN FAMILY INSTITUTE
Burlington, Vermont
Reg. I
Established: 1984

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	2 children 13 FTEs	13-17	50% 13-15 50% 16-17	50% Male 50% Female	100% White	100% Emotional	7 days

DESCRIPTION

- o Emergency beds (1 or 2) for adolescents in acute psychiatric crises
- o CMHC crisis team screens and refers clients who receive one-on-one emergency supervision, psychiatric, psychological and case management services

OBSERVATIONS

- o 50% medicaid waiver DMH and 50% social services
- o Have virtually replaced use of VT State Hospital for adolescents

NORTHWEST DADE COMMUNITY MENTAL HEALTH CENTER, INC., CRISIS STABILIZATION UNIT (C.S.U.)
Hialeah, Florida
Reg. IV
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	Evaluate as many as necessary Inpatient capacity 12 outpatient 400 12 FTEs	Infant - 18	35% 16-17 30% 6-12 30% 13-15 5% 0-5	55% Male 45% Female	55% Hispanic 30% White 15% Black	37% Emotional 30% Behavioral/Conduct 21% Schizophrenic/Other Psychotic Disorder 10% Substance Abuse 1% Mental Retardation 1% Developmental Disabilities All youth are evaluated. Child must meet criteria for hospitalization	3 weeks inpatient 6 months outpatient intensity: outpatient - 2 hours with child 1 hour with family

DESCRIPTION

- o Contractual arrangement between state agency, a mental health center and hospital
- o Services include screening, evaluation, and case management services 24 hours a day, 7 days a week; hospital provides in-patient beds for stablilization, CMHC provides short-term psychotherapy

OBSERVATIONS

- o Funding: state (Children, Youth and Family Services), 1/5 United Way and fees
- o Strong case management component
- o Advocacy
- o Linkage with community resources
- o Data base available

RIVERVIEW MEDICAL CENTER/CHILDREN'S PSYCHIATRIC CENTER MENTAL HEALTH SERVICES
Red Bank, New Jersey
Reg. II
Established: 1977

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	-- 6.8 FTEs	6-18	55% 16-17 20% 18-21 18% 13-15 5% 6-12 2% 0-5	52% Male 48% Female	84% White 15% Black 1% Hispanic	46% Other (Not Specified) 32% Affective 8% Substance Use 2% Anxiety 2% Suicide Threat 1% Bizarre Behavior/Thought Disorder Will evaluate any child	Several hours to complete psychiatric evaluation

DESCRIPTION

- Crisis Unit and Helpline provide direct crisis intervention and psychiatric evaluation 24 hours a day by telephone and face to face
- Joint program between Riverview Medical Center and CPC
- Uses specially trained emergency services staff
- Helpline provides assessment and crisis intervention by telephone and makes appropriate referrals for services
- Crisis Unit provides evaluation, assessment and treatment of mental health crises, including crisis intervention, psychiatric evaluation, rapid tranquilization, 24-hour holding, screening for state hospitals, medical evaluation

OBSERVATIONS

- Funded 87% by New Jersey Division of Mental Health and Hospitals, 4% Medicare, 3% Medicaid, 2% Third Party, 2% Fees, 2% Riverview Medical
- Children have direct access to full range of services provided by the Children's Psychiatric Center and are often seen on a priority basis
- Involved in case and class advocacy
- Families involved in evaluation and assessment
- Have JCAH and state reviews and internal program effectiveness evaluation
- CPC has comprehensive network of services including outpatient services, 2 schools for SED children, therapeutic foster homes, group homes, in-home services, partial hospitalization, summer camp, pediatric liaison services (psychologists placed in pediatrician's office), substance abuse services, consultation and education, etc.

SOUTH SHORE MENTAL HEALTH CENTER, ADOLESCENT CRISIS TEAM
Quincy, Massachusetts
Reg. I
Established: 1979

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	100 children 10 FTEs	7-19	60% 16-17 35% 13-15 5% 18-21	60% Male 40% Female	99% White	80% Dual Diagnosis Behavioral/Conduct and Emotional (1/3 have substance abuse problems) 5% Schizophrenic/Psychotic	

DESCRIPTION

- o 24-hour crisis intervention program which attempts to keep child in the home and community
- o Initial contact is 1-5 hours
- o Provides pre-screening, evaluation, short-term intensive family therapy, referral and follow-up
- o Uses respite house, family, friends and shelters when needed to avert hospitalization
- o Provides consultation to schools, courts and other agencies
- o Outreach basis by mobile crisis team

OBSERVATIONS

- o Funded 63% state DMH, 17% state social services, 10% Medicaid 6% Blue Cross, 3% fees, 1% commercial insurers
- o Agency also has respite house and case management programs
- o Program has succeeded in substantially reducing state hospital admissions (89% decrease)
- o Strong linkages to schools, courts and other agencies
- o Acts as screening unit for all state hospital admissions

SOUTH SHORE MENTAL HEALTH CENTER, RESPITE HOUSE
Quincy, Massachusetts
Reg. 1
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	2 children 1.1 FTE	7-19	50% 13-15 50% 16-17	50% Male 50% Female	99% White	70% Dual Diagnosis (Behavioral/Conduct, Emotional, Substance Abuse) 10% Behavioral/Conduct 10% Emotional 10% Schizophrenic/Psychotic	6 days 39 hours/week with child 2-3 hours/week with family

DESCRIPTION

- o Residential home with 2 beds for clients in crisis
- o Used as alternative to hospitalization
- o Maximum stay is 2 weeks
- o Children must attend school, work or day treatment
- o Intensive family treatment is provided
- o Also used as a diagnostic setting to assess a child's placement needs
- o Voluntary program

OBSERVATIONS

- o 100% funded by Massachusetts Department of Mental Health
- o Married, live-in couple. One is Resident Manager and has MSW
- o Agency also has emergency service and case management

TRANSITIONAL RESIDENCE INDEPENDENCE SERVICE (TRIS), CHILDRENS CRISIS INTERVENTION SERVICE (CCIS)
Sicklerville, New Jersey
Reg. II
Established: 1980

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	12 children 27 FTEs	5-17	45% 13-15 30% 16-17 23% 6-12 2% 0-5	50% Male 50% Female	52% White 38% Black 10% Hispanic	48% Emotional 12% Schizophrenic/Psychotic 36% Other (School problems, abuse/neglect, family problems) Will not accept if: o mentally retarded o autistic o alcohol/drug addicted o socially maladjusted without psychiatric disorder o disorder can be treated in a nonresidential setting	23 days 24 hours/day 7 days/week with child 1 hour/week with family

DESCRIPTION

- o Provides comprehensive mental health services to youth who would have been institutionalized
- o Uses no locked rooms, quiet rooms or physical restraints
- o Provides psychiatric evaluation, individual, group and family counseling, education, recreation/leisure activities, case management and referral
- o Has "home-like" atmosphere in open setting
- o Maximum stay 28 days

OBSERVATIONS

- o Funded 89% by New Jersey Division of Mental Health, 1.5% by New Jersey Department of Education, 8.6% Medicaid, .9% Camden County Freeholders
- o Agency also has specialized foster care, interim group home, adolescent partial care for day treatment
- o Employs team concept across all TRIS programs
- o Provides case management and case advocacy
- o Families encouraged to participate in weekly treatment planning meetings, to take children on passes, etc.

VENTURA COUNTY MENTAL HEALTH SERVICES, VENTURA COUNTY CHILDREN'S MENTAL HEALTH DEMONSTRATION PROJECT, SHOMAIR-CRISIS INTERVENTION
Ventura, California
Reg. IX
Established: 1985

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Public	5-7 children/ week 350-400/ year	0-18	57% 6-12 25% 13-15 10% 0-5 8% 16-17	63% Female 37% Male	84% White 16% Black	50% Emotional 30% Behavioral 5% Schizophrenic/Psychotic 5% Substance Use 5% Mental Retardation 5% Developmental Disabilities All children are assessed	1-2 visits 1 to 1-1/2 hours with child

DESCRIPTION

- Provides mental status assessment of all children entering shelter care as a result of an abuse/neglect report
- Provides feedback on child's emotional state and need for services to Child Protective Services Agency
- Can make one additional visit for crisis intervention or refer child for needed services
- No contact with natural parents
- Provides support and consultation to shelter care parents

OBSERVATIONS

- 100% state funded
- Behavioral checklists and demographic data obtained on all children screened
- Part of Ventura County Demonstration project with comprehensive system of children's mental health services
- County has 10.5 FTE case managers ("brokers") to coordinate full continuum of services and interagency network
- Other services provided include enriched foster care, youth center, mental health services to juvenile hall, group homes, day treatment on a school site, outpatient services, case management, prevention, etc.
- County has interagency policy council, interagency case management council, written interagency agreements and is working toward an interagency service system

YMCA CENTER FOR YOUTH ALTERNATIVES, SHELTER HOUSE FOR RUNAWAYS
Louisville, Kentucky
Reg. IV
Established: 1974

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Urban	Private nonprofit	24 youth 12 FTEs	13-17	60% 13-15 40% 16-17	55% Female 45% Male	75% White 25% Black	80% Behavioral/Conduct 12% Emotional 5% Substance Abuse Will not accept if: o suicidal o violent o retarded o psychotic o program cannot handle	2 weeks staff with youth 100% 10 hours/week counseling youth 12 hours/week with family

DESCRIPTION

- o 24-hour, 7-day a week runaway shelter
- o Services include intensive counseling (individual, group and family), life skills, recreation, aftercare in addition to shelter
- o Intensive, short-term focus with emphasis on client advocacy and family reunification

OBSERVATIONS

- o Funding: federal and local grants, private, donations
- o Variety of linkages with agencies
- o Comprehensive outreach provided in 205 sites
- o Each counselor assigned provides case management and advocacy

YOUTH ALTERNATIVES OF SOUTHERN MAINE, GREATER PORTLAND YOUTH SHELTER
Portland, Maine
Reg. I
Established: 1977

COMMUNITY SERVED	TYPE OF AGENCY	CAPACITY/ STAFFING	AGE RANGE	MAJORITY AGE	SEX	RACE	DIAGNOSIS/ REASONS FOR NOT ACCEPTING	DURATION/ INTENSITY
Mixed	Private nonprofit	12 children 10 FTEs	7-17	60% 16-17 25% 13-15 15% 6-12	100% Male	99.9% White	85% Behavioral/Conduct 15% Emotional Will not accept if: o history of arson o actively suicidal o actively homicidal o profoundly violent	12 days 7 hours/week with child in individual counseling 1 hour/week with family

DESCRIPTION

- o Provides emergency shelter 24 hours, 7 days a week to homeless, runaway youth
- o Maximum stay is 21 days
- o Provides counseling, assessment, tutoring, outreach family counseling, placement assistance, coordination of community resources, follow-up and aftercare for a minimum of 3 months
- o Daily program includes counseling, recreational activities, educational activities and group meetings
- o Emergency foster care in trained foster homes is a component of the program, providing placements for an average of 2 weeks

OBSERVATIONS

- o Funded 56% by Maine Department of Human Services, 16% Federal grant, 13% Department of Education, 6% Department of Agriculture, 5% county and 4% Juvenile Justice
- o Provide outreach family counselors to work with client and family to promote reunification
- o Agency also has foster care, emergency foster care program, therapeutic group home, (ROADS) juvenile justice alternative service
- o Emphasizes assessment and long-term planning involving all external significant parties

APPENDIX

LIST OF PROGRAMS RESPONDING TO SURVEY

Appalachian Mental Health Center
Youth Crisis Shelter
Rt 1, Box 4-1
Elkins, West Virginia 26241
(304) 636-2431
CONTACT: Angela Garcia
Director

Broward County Mental Health Division
Children and Adolescents Program
1000 S.W. 84th Street
Hollywood, Florida 33025
(305) 963-3156
CONTACT: John A. Spencer, Ph.D.
Clinical Psychologist

Child Guidance Center of Jacksonville
Children's Emergency Service Team
1283 East 8th Street
Jacksonville, Florida 32206
(904) 353-9121
CONTACT: William Devereux, Ph.D.
Coordinator

Children's Center of Wayne County
Central Screening
3245 East Jefferson
Detroit, Michigan 48207
(313) 259-8780
CONTACT: Angela Tzelepis, Ph.D.
Coordinator

Houston Child Guidance Center
Family Crisis Program
3214 Austin Street
Houstin, Texas 77004
(713) 526-3232
CONTACT: Chris Hershberger
Executive Director

Huckleberry House, Inc.
1421 Hamlet Street
Columbus, Ohio 43201
(614) 294-5553
CONTACT: W. Douglas McCoard, MSW
Executive Director

Northeastern Family Institute
P.O. Box 83
Burlington, Vermont 05401
(802) 658-2441
CONTACT: Lisa Natti
Program Director

Northwest Dade Community Mental
Health Center, Inc.
Crisis Stabilization Unit
106 W. 9th Street
Hialeah, Florida 33010
(305) 884-4400
CONTACT: William Delaney
Director

Riverview Medical Center
CPC Mental Health Services
Helpline & Crisis Unit
1 Riverview Plaza
Red Bank, New Jersey 07701
(201) 530-2438
CONTACT: Miles Wagman, MSW, ACSW
Coord. of Emergency Serv.

South Shore Mental Health Center
Adolescent Crisis Team and
Respite House
77 Parking Way
Quincy, Massachusetts 02169
(617) 770-7700
CONTACT: Pamela Maltz, MSW
Dir., Child & Adolescent Serv.

Transitional Residence Independence
Service (TRIS)
Children's Crisis Intervention
Service (CCIS)
628 Sicklerville Road
Sicklerville, New Jersey 08081
(609) 728-0200

TRIS Main Office
1 Colby Avenue
Stratford, New Jersey 08084
(609) 346-1800
CONTACT: Clement D. Maynard
Executive Director

Ventura County Mental Health
Services
Children's Demonstration Project
Crisis Intervention
300 Hillmont Avenue
Ventura, California 93003
(805) 652-6737
CONTACT: Randall Feltman
Project Manager

YMCA Center for Youth Alternatives
Shelter House for Runaways
1410 S. First Street
Louisville, Kentucky 40208
(502) 635-5233
CONTACT: Elizabeth Triplett
Executive Director

Youth Alternatives of Southern Maine
Greater Portland Youth Shelter
175 Lancaster Street
Portland, Maine 04101
(207) 874-1175 (Adm. Ofc.)
(207) 874-1184 (Shelter)
CONTACT: Michael Tarpinian
Executive Director