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FINANCING MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

Contents

Proponents of extended hospitalization for the most seriously disturbed children and adolescents face increasing difficulty in obtaining funds for such expensive care. The author advocates a continuum-of-care system that will provide a spectrum of treatment modalities, and she notes that when costs are averaged for all children treated at various points on the continuum, the cost per child drops dramatically. She challenges mental health care professionals to justify their treatment effectiveness to payers (1) by developing creative treatment programs that will reduce costs and (2) by compiling research data to demonstrate the cost-effectiveness of extended hospitalization for seriously disturbed children and adolescents. (Bulletin of the Menninger Clinic, 54, 127-139)

The timeliness of this conference on the role of psychiatric hospitalization in the treatment of children and adolescents cannot be overestimated. The professional commitment that this meeting has emphasized--according priority to high-quality diagnosis and treatment of children and to the training of mental health care professionals to deliver it--is unusual in these penurious times. The rapid changes now taking place in the health care field will continue to challenge the ingenuity of Menninger; adhering to such high standards of excellence will require an unwavering commitment

There is a growing trend away from admitting children to psychiatric hospitals. In fact, the continuu-of-care concept articulated by the Joint Commission on Mental Health of Children (1969) and reinforced by the President's Commission on Mental Health (1978) has been translated into public policy that emphasizes little or no use of hospitalization. Nevertheless, the continuum-of-care concept, by definition, does include a role for the psychiatric hospital, despite the pressures of public policy, professional conviction, or financial expediency. A critical challenge faces those mental health care professionals who consider hospitalization to be an important part of the continuum. They must provide convincing evidence to those who make policy, both treatment policy and financial policy (Melton, 1987). Such evidence can be provided by addressing five relevant questions: (I) What kinds of children need extended hospitalization? (2) How can they be identified? (3) How is it determined that other approaches will not work with these children; (4) How is it determined that extended treatment is necessary and shorter term treatment will not suffice? (5) What community programs must be in place to sustain the efforts of extended hospitalization and, perhaps, to shorten the length of stay?

Professionals cannot respond to such questions with a belief system alone, although that is a good place to stare. Answers to these questions require hard data gleaned from controlled cone rolled high-quality research, not only follow-up studies based on clinical impressions. Controlled studies require a cooperative effort at several sites to determine which components of hospital-based treatment contribute to a good outcome and whether or not the hospital is the only setting, best setting, or equal setting for such services.

Research validating the use of psychiatric hospitalization for children is virtually nonexistent. Several recent reports (Harper & Geraty, 1989; Institute of Medicine, 1989; Kiesler, 1989; Pfeiffer, 1989; U.S. Congress, Office of Technology Assessment, 1986) note this lack of validation. However, there is little validation for other treatment approaches either. When money is scarce and getting tighter, those who finance services would be foolish to fund the most expensive rather than the least expensive service available if there is no demonstrated difference in their efficacy.

At Menninger, there is a strong belief that extended hospitalization makes a difference for children and adolescents with certain kinds of problems. You may be right, but your confidence alone will have little influence on case reviewers and third-parey payers. Table I depicts a continuum of care and compares the present availability of services with the proposed system. Currently, hospitalization and residential treatment (at one end of the continuum) and various outpatient services (at the other end) are financed mostly through public funds and third parties; services in the middle of the continuum of care are not. most places, these mid-range services do not exist in any reasonably systematic form. Many professionals recognize the value of the mid-range services and are working to secure reimbursement, through public funds, third parties, and other financing mechanisms, for a system that combines mid-range services with those at both ends of the continuum.

Without the mid-range of services, children treated on an outpatient basis who fail to improve are often transferred to the other end of the continuum--that is, the hospital. The overuse or inappropriate use of hospitals in pare relates to the use by these children who would not need to be hospitalized if appropriate services existed.

Current patterns of reimbursement also limit the access to the few existing mid-range treatment approaches. Another group of children who are "inappropriately" hospitalized are those for whom such treatment might be necessary but for whom discharge is delayed for lack of aftercare services. Third-party reimbursers need evidence that for some children, hospitalization could be avoided if the midrange of services were available, and that for others, the length of stay can be shortened when adequate after care is available.

Current challenges

Public policy

During the past two decades, many changes in public policy have contributed to the increased use of the mental health system (Behar, 1988). Major changes in other systems that provide care for children have excluded seriously emotionally disturbed children, or have included them in ways that only illuminate their mental health needs. For instance, Public Law 94-192, passed in 1975, promised to provide education for ad handicapped children. This law has been seen by many people as a promising vehicle for the financing of mental health services for children in the 1990s. This law has brought about significant changes in the education system and in some treatment services for children in terms of attitude, philosophy, and practice, but it has done little in terms of actually financing needed mental health services. In some communities, the tax base is sufficient to allow the school system to pay for intensive treatment. However, in most communities, federal, state, and local funds are insufficient to provide for the range of in-school services required to educate handicapped children.

Another major change in public policy was the passage of the Juvenile Justice and Delinquency Prevention Act in 1974, which provided for the deinstitutionalization of status offenders. Despite the original lofty expectations of increases in community-based services, this act provided for less treatment intervention than anticipated. Further, although many children were subsequently moved out of the most restrictive part of the juvenile justice system into psychiatric hospitals, they were often simply contained in a different environment. Weithorn (1988) and Schwartz (1989) have reported on the skyrocketing use of hospitalization in place of incarceration, recognizing that rather than moving children to community-based services, the result of the deinstitutionalization of status offenders has been a shift in populations from the juvenile justice system to the mental health system.

The third major change in public policy came in the early 1980S through welfare reform under Public Law 96-272, which was designed to decrease foster care and increase family unity by keeping children in their homes. Again, the result has been a substantial shift of children from the foster care and child welfare system into the mental health system. The child welfare system has often had more funding available for mental health services than have either the juvenile justice or the education systems, primarily through the enticements due to children in foster care--that is, Medicaid and Titles IV-B and IV-E of the Social Security Act. Currently, many states are attempting to maximize the use of such funds to fulfill the states' obligations to children who have been removed from their families.

Funding

Expectations of the services to be provided by the mental health system, how ever, have increased without a concomitant increase in public funding. Numerous public statements during the past decade have emphasized the increasing treatment needs of children, the decreasing resources, and the consequent necessity to devise less expensive, less restrictive services. The Joint Commission on Mental Health of Children (1969) and, more recently, Knitzer (1982) both emphasized that the treatment provided these children is far below our level of knowledge and our capabilities because of the scarcity of financial resources.

One funding initiative by the National Institute of Mental Health, the Child and Adolescent Service System Program (CASSP), now focuses on practical planning, improved advocacy, and increased cooperation with parents to develop appropriate treatment programs. The impact of this initiative in both the public and private sectors has seemingly brought health professionals to a consensus regarding the importance of expanding funding to cover the midrange of the continuum of care outlined in system Table 1. As noted earlier, without such services, hospitalization tends to be averused, both by hospitalizing children who could be treated adequately at a less comprehensive level and by delaying discharge because of limited accessibility to adequate aftercare programs.

The Joint Commission report (1969) implied that public funds would be available from either the federal or state governments. In the past, funding of mental health services has been primarily a state responsibility. Most federal funding is channeled through Medicaid and, for military personnel, through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), plus a small amount through CASSP, Public Law 94-142, and Titles IV-B and IV-E of the Social Security Act. A blending of funds from all these sources could stretch the capacity to pay for impraved services for children.

During the past 4 or 5 years, other methods of limiting the expenses of health care, such as managed care programs, have been developed. Unfortunately, health maintenance organizations (HMOs) and preferred provider organizations (PP()s) have, in many cases, not expanded or improved the delivery of mental health services. However, one HMO at Harvard does have a substantial mental health component. Its administrators seek to provide certain services (primarily outpatient emergency services and same-day treatment services) and to purchase the residential services. Like everyone else, they are seeking the best service at the lowest cost. Nevertheless, their program employs highly qualified professionals to deliver services and incorporates some creative features, particularly in the area of quality assurance, that merit further exploration. Like the Harvard HMO, other managed care programs are seeking quality care at the rawest cast. Those two factors are not entirely antithetical, but they are not synonymous either. The challenge remains to discover ways to deliver quality care for less.

Overhospitalization

During the first 6 years of this decade, the use of psychiatric hospitals for children increased more than 400% (Weithorn, 1988). That figure is astounding. In 1986, more than 50,000 children were served in psychiatric hospitals, and that total may be an underestimation because of the possibility that all sources of data were not reviewed. Recent surveys suggest that many of these children are being hospitalized unnecessarily. The documentation comes from two different approaches. One approach was to ask practitioners to indicate how many of the children in their hospitals did not need to be there, either because (1) they would not have been admitted if less restrictive services were available or (2) they were appropriately admitted but could not be discharged for lack of aftercare services. In three studies (one national, two within states) using this approach, the response was that 40-43% of the hospitalized children did not require hospitalization (Behar, 1988). The second approach was to ask people who refer children to psychiatric hospitals how many of their referrals would be sent to less restrictive settings if appropriate-services were available. The response was 50-53%. Such poor use of an expensive resource should be a powerful message for policymakers.

Possible remedies

Over the past 10 years, the problems involved in providing mental health care for children have at least gained visibility as responsibility has shifted among various child-serving systems. A great deal of turmoil has been generated by the concern that the financing of child mental health care is driving the way services are delivered. Now, at the turn of the decade, we can talk about the challenge for the 1990s just as the Joint Commission discussed the challenge for the 1970s. It seems essential that we develop a balanced perspective about the continuum of care. We must determine where and how children can secure appropriate treatment, and we must establish the mechanisms to pay for it. Some models (described in what follows) have been in operation, or soon will be, that offer some hope of bringing about the changes that professionals have sought for services to emotionally disturbed children.

The North Carolina experience

In 1979, a suit was brought against the state of North Carolina for its inability or failure to provide appropriate treatment and education for institutionalized children, the majority of whom were seriously emotionally disturbed; all were assaultive (Willie M. et al., 1983). By most standards, the Willie M. lawsuit was the most significant litigation in this century on behalf of children (Sorer & Warboys, 1989). The suit itself was similar to many others; however, the state's response was remarkable (Behar, 1985). First, North Carolina agreed to settle quickly rather than to drag out the litigation, as has happened elsewhere. The state then agreed to provide a whole continuum of community-based treatment as an alternative to institutional care for these children. Most spectacularly, North Carolina agreed to finance that continuum of care for about 1,200 children, which now costs $30 million a year. This appropriation represents the most substantial funding ever committed by a state for mental health services for a discrete subpopulation of children who are seriously emotionally disturbed. These funds represent an expenditure of approximately $25,000 a year on each child in the program, a modest amount compared to the cost of hospitalization or other types of residential care.

With a full continuum-of-care program statewide, North Carolina can provide the structure, the control, and the 24-hour implementation of treatment plans for more than 99% of the 1,200 children without using hospital care; only .002% of the children in the state program are hospitalized. Although that is a small number, it is not zero. It is apparent, after 10 years of serving this population, that a small number of children need hospitalization. Some of them may need it for only a few weeks or months, but some of them need it for longer periods of time. There is a small but critical need for such intensive services. Appropriately, Menninger is not proposing to build a 2,000-bed hospital but is instead planning to develop hospital services for only a small number of children.

After 10 years of observing the data and the children, many professionals have come to believe that the availability of a continuum of services reduces the need for hospitals and other restrictive facilities (Buder, 1988; Friedman, 1986; Gair, 1988; Kiesler, 1982; Lourie & Isaacs, 1988; Stroul & Friedman, 1986). After all, appropriate treatment in an appropriate setting is the essence of our professional challenge.

We have also learned, in contrast to the original conceptualization of a continuum of care as a linear series of events, that the treatment plans for children with complicated disorders simultaneously use multiple services from various parts of the continuum (Behar, 1988). Developing and implementing a good individualized treatment plan may require the coordination of as many as 10 people or agencies, and the plan must be the driving force of the child's treatment. That really is what transpires in a hospital. Such individualized care is harder to accomplish in the community, but for most children it does cost less. And surely it is better for children to remain in their communities if they can be adequately treated there.

In addition, we have learned that children who use public-sector services need access to several agencies concurrently, as probably do many seriously disturbed children in the private sector. These children need a cohesive response from all segments of their community. The coordination of such programs is extremely complex.

Another lesson from our experience in North Carolina is that as systems of care mature, children are less frequently removed from the home. In North Carolina, as well as in other states, the Edna McConnell Clark Foundation of New York has provided funding for Family Preservation, an in-home crisis stabilization service designed to prevent removal of children from their families. When a family is on the brink of separation--that is, when a child is about to be admitted to a hospital, to a juvenile justice training school, or placed in foster care--an intensive intervention provided in the home can help the family alter their pasterns of interaction. Careful assessment of the impact of these services indicates that more families remain together, with a success rate of 82% after a 6-week intervention. At 6-month follow-up, the success rate drops slightly to 76%.

Finally, we have learned that our professional reliance on the concept of treatability is not substantiated. In the service system designed as a response to a lawsuit, clients could not be rejected or ejected. Projections of who would do well or who would be cooperative in treatment, except perhaps at the extremes, were often inaccurate. The question really became not whether a child is treatable, but rather by what means and through how much effort can treatment be provided, thus focusing on a treatment plan to delineate the kinds of services that should address that child's problems.

The Alaska Youth Initiative

Another innovative treatment system for children is the Alaska Youth Initiative, a program developed as a response to the number of children served out of state. Before this program was implemented in 1987, the high cost of providing services in Alaska often forced the state to send children who needed mental health services to other states. The underlying tenets of the program were that these children might be better served in their own communities and at less cost to the state. Recognizing each child's cultural, family, and personal needs, individualized treatment plans were developed for each of the 100 or so children who were being treated elsewhere. Once the children had returned to their home communities, the treatment plans were implemented through a variety of agencies and individuals, many of whom were not professionally trained. To oversee implementation of the treatment plan, a supervisor visits each community (ideally) once a month to monitor the program--no small undertaking in a land where distances are great, weather is extreme, and villages are often inaccessible except by air.

The children for whom this program was developed were severely disturbed, with diagnoses across the spectrum of mental disorders: psychoses, schizophrenia, behavior disorders, borderline personality disorders, and major depressive disorders. Two-thirds of them were substance abusers, and half of them had been victims of sexual, emotional, or physical abuse. These children were returned to their homes to participate in the new program of "wrap-around" services. Only 18% of the children have required subsequent hospitalization or residential treatment; the rest are progressing satisfactorily in their native villages.

Even in Alaska, where the value of money tends to inflate costs, the Alaska Youth Initiative costs less per child than the earlier method of purchasing residential services out of state. This program, which emphasizes the importance of an individualized case plan as the basis for providing services, is considered across the country as a partial answer to the problems of financing mental health treatment.

Demonstration programs

The $25,000-per-year-per-child price tag for community-based services for the Willie M. Program in North Carolina seems modest to mental health professionals, who can readily compare it to the cost of hospital treatment. However, it is an astronomical figure to public decision makers, who are afraid that it might be the cost for each emotionally disturbed child to be served. Thus, for economic as well as humanitarian reasons, it is important to design demonstration projects that cover the broad spectrum of children with emotional problems so that public decision makers can be presented with a more reasonable price tag for the continuum of care. In fact, the treatment needs of many children are minimal and can be met at very little cost, the cost perhaps of 10 to 15 outpatient visits totaling less than $1,500. When the treatment costs for those children are factored into the model, along with the $25,000 or $50,000 or $100,000 required for the adequate treatment of seriously disturbed children, the average cost per child is considerably less intimidating to the architects of public policy. To this end, two major programs have been undertaken to demonstrate that appropriate treatment within a continuum of care can be delivered at an appropriate cost, that is, at a decreased cost per child compared with costs of serving children in hospitals.

In 1988, the Robert Wood Johnson Foundation established and funded a national demonstration program to be developed in one community in each of eight states. The program has been funded at a total of $20.4 million during a 4-year demonstration period. The Foundation initiative first established a national project office based at Prudential Life Insurance Company and directed by Mary Jane England, a child psychiatrist and a vice president of Prudential. The project goals are to develop programs to serve children outside of hospitals and to bring about a restructuring of the financing mechanisms in the participating states. In addition to having an impact on the use of Medicaid and Titles IV-B and IV-E of the Social Security Act, project planners will scrutinize employee assistance programs and other third-party health care funding now available for children's services to develop models that will maximize the use of such funds for community-based treatment programs.

The second demonstration project involves the U.S. Department of Defense through a contract with the state of North Carolina's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS). This division is operating as an exclusive provider organization making available diagnostic and treatment services to all children with mental health problems at the Fore Bragg Army post, which has approximately 43,000 children residing in its catchment area. The Defense Department, through its health benefit plan for family members, has experienced significant increases in costs for adolescent psychiatric hospitalization. The goal of the demonstration project is to develop a continuum of mental health services that will provide alternatives to unnecessary hospitalization, prevent the need for hospitalization, and provide aftercare for those children who have been appropriately hospitalized.

The project will provide a unique opportunity for a comprehensive evaluation of the effectiveness of this approach. During a 4-year period, data will be collected to determine both the progress of the children and their clinical outcomes. To assess how their improvement compares with that of children in traditional service systems, two control sites will be used where no new services will be provided. The project evaluation will also include a comparison of costs at the demonstration site and the control sites. Other comparison sites are also important. Perhaps Menninger could become another comparison site to collect data so that your costs and outcomes can be compared with those from other sites.

Recommendations

First of all, I would recommend the development of the continuum of care outlined in Table 1. Table 2 offers a comparison of current practices and the proposed system. In the current system, a hypothetical treatment plan for a seriously disturbed child might involve hospitalization for 60 days in a traditional setting, followed by a year of residential treatment, and then outpatient treatment, for an average cost of $244 per day. In the proposed system, the same child would be hospitalized for 15 days, then transferred successively to a group home with a day treatment program, back to the child's home with continued day treatment, then to outpatient treatment, for an average cost of $178 per day. In each case, the length of treatment is 608 days. Table 3 demonstrates that the difference in daily costs for moderately disturbed children is even more dramatic--$216 for the current traditional treatment, compared to $83 in the proposed treatment program.[*]

By reducing the per child treatment cost, the proposed system will make more funds available for those children who really do need expensive hospital services. Otherwise, the current practice of providing only the two extremes of treatment will continue to limit the available financing and the level of affordable treatment. It is crucial not only that the cost of mental health treatment be reduced for many patients, but also that funds be available for those in need of expensive, extended treatment. Because this proposed continuum of services is not a competition between the various levels of service, it can facilitate the delivery of appropriate treatment to the appropriate patients.

Secondly, to reach this goal, greater research and program evaluation efforts are essential. In the absence of any data that indicate superior outcome for specific treatment programs, those who finance health care programs will obviously opt for what seems less expensive. Providers who are convinced that some children require more expensive extended treatment must therefore conduct the research and collect the data to demonstrate its efficacy to other mental health care professionals and to justify its cost to those who pay for treatment.

The continuum-of-care concept embraces a total spectrum of mental health services and assumes that there is a need for all of them. Menninger's extended care program may best serve a relatively small segment of the child patient population, but for those children, that service may be critical. Thus Menninger clinicians and policymakers should view developing a new children's hospital not only as an opportunity to treat children, but also as an opportunity to evaluate the place of extended treatment in the continuum.

[*] These figures are based on the estimated costs of units of service, using a cost-finding method developed in North Carolina.

Table I. Comparison of services

Services	Current system	Proposed system
Hospitalization	X	X
Residential treatment		
Large setting	X	X
Group home		X
Professional parenting, specialized foster care	--	X
Supervised independent living	--	X
Day treatment		
High management--full day	--	X
Moderate management--full day	--	X
Moderate management with public school--half day	--	X
Therapeutic vocational placement	--	X
Therapeutic preschool (ages 0-6)		X
Evening treatment		
After school or work--half day equivalent	--	X
Therapeutic camping		
Weekend, summer, or year round	--	X
Outpatient		
Individual treatment (office or home)	X	X
Family treatment (office or home)	X	X
In-school support services		X
Emergency services (available 24 hrs./day)	X	X
Family preservation		
In-home crisis stabilization	X	X

Table 2. Comparison of services for a child with serious mental health problems

Current system:

Services	Days	Cost
Hospital	60	$ 31,800
Residential treatment	365	113,150
Living at home + outpatient for child and family	183	3,552
Total	608	$148,502

Average cost per day: $244

Proposed system:

Services	Days	Cost
Hospital	15	$ 6,429
Group home + day treatment		

+ outpatient for family + ease management	227	76,327
Living at home + day treatment + outpatient for child and family + ease management	183	18,296
Living at home + outpatient for child and family + ease management	183	4,164
Total	608	$105,216
Support services		3,000
Average cost per day: $178		$108,216

Table 3. Comparison of services for a child with moderate mental health problems Current system:

Services	Days	Cost
Hospital	60	$31,800
Residential treatment	183	56,730
Living at home + outpatient for child and family	183	3,552
Total	426	$92,082
Average cost per day: $216		

Proposed system:

Services	Days	Cost
In-home crisis stabilization	30	$4,950
Living at home + day treatment + outpatient for child and family + ease management	213	23,640
Outpatient for child and family + case management	183	4,776
Total	426	$33,366
Support services	--	2,000
Average cost per day:	$83	$35,366

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