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This article describes one of the few studies to examine, using a rigorous research design, the comparative effectiveness of three alternative approaches to in-home crisis services for children and their families. Results suggest that such children and adolescents can be treated successfully in their natural environment, and that some gains for both child and family can be maintained six months postdischarge.

Youth ($N = 238$) were between the ages of 5-17 years ($M = 12.3$; $SD = 3.6$), and had presented at one of two emergency rooms in the Bronx, New York, for a psychiatric crisis that would otherwise result in hospitalization. Half of the sample consisted of boys (53%), and most youth were either Hispanic (59%) or African American (34%), while some were Caucasian (6%), or of other ethnicity (2%). Overall, these youth exhibited considerable emotional and behavioral problems. For example, 53% met criteria for a serious emotional disturbance, 71% had at least one functional impairment, and 40% had two or more functional impairments. The most common presenting problems included suicidal ideation (57%), depression (55%), temper tantrums (45%), verbal aggression (41%), anxiety (34%), and destruction of property (32%). At the beginning of the study, all youth were living at home (with a natural, adoptive, or foster caregiver). Most homes (72%) were headed by a single parent with an average age of 38.5 years ($SD = 10$). Caregivers were often not employed (76.5%), and over half had less than a high school education and received some form of public assistance. After both youth and caregiver consented to receive services, youth were randomly assigned to one of three interventions, outlined below. Each intervention lasted between four to six weeks.

(1) The Home-based Crisis Intervention (HBCI) was the standard treatment model for this area of the Bronx, and included a counselor whose treatment goals were to resolve the immediate psychiatric crisis, teach caregivers communication and other relevant skills, improve family relationships, and to link the youth and family to needed services; (2) The Enhanced Home-based Crisis Intervention (HBCI+) provided all of the above HBCI services, and also included a bilingual family advocate who established parent support groups, provided individual parent support and advocacy, in-home and out-of-home respite care, and \$100 in flexible funding; (3) The Crisis Case Management (CCM) model included a counselor trained in crisis intervention who provided concrete services and links to needed services, along with in-home and out-of-home respite care and \$150 in flexible funding. Relative to the first two interventions, this treatment model was less expensive and therefore of interest to area policymakers.

Child and family outcome measurements were collected at enrollment, upon discharge, and again six months later. Primary measurements included the Piers-Harris Self-Concept Scale, the Family Adaptability and Cohesion Scales II, the Parent Self-Efficacy Scale, the authors' Inventory Of Social Supports and Behaviors, and the Child Behavior Checklist.

Upon discharge from the interventions, 83% of all youth were living in the community; of this percentage, 6% had moved into the home of a relative. With regard to specific interventions, 83% of HBCI youth, 86% of HBCI+ youth, and 78% of CCM youth were successfully maintained in their communities at discharge. At some point during the intervention, 5% of CCM youth, 10% of HBCI youth, and 10% of HBCI+ youth were hospitalized, a low rate for all groups. There were no significant differences across each intervention between youth who were living in the community at discharge.

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Youth in all programs made significant gains on some outcome measures. Between admission and discharge, significant gains were made by all groups in *self-concept* and CBCL *internalizing* scores, with CCM youth making significant gains relative to HBCI and HBCI+ youth. Youth in all groups continued to show positive gains in *self-concept* and CBCL *internalizing* scores at six months postdischarge. No significant gains were made by any group between admission and discharge on CBCL *externalizing* and *social competency* scores; however, significant gains for *externalizing behaviors* were revealed at six months postdischarge.

Family outcomes suggest similar results. From admission to discharge, all programs showed significant gains in *family adaptability* and *caregiver self-efficacy*; these gains were still evident six months later. During the intervention, HBCI and HBCI+ caregivers also made significant gains in *family cohesion*. Between admission and discharge, HCBI+ caretakers also reported improvements in *informal supports*. Because HBCI+ was an enhanced intervention that included a parent advocate and support groups, this finding was expected. However, at six months postdischarge, gains in *family cohesion* were not maintained by either HCBI or HCBI+ caretakers, and *informal supports* were not maintained by HCBI+ caretakers. Thus, the authors note that the enhanced model showed “limited success” (p. 100).

The authors report two major limitations to the study. First, a lack of funding inhibited the availability of staff and other resources, and precluded further follow-up studies. Second, this demonstration included youth and their caretakers who live in some of the “poorest, most violent” (p. 101) neighborhoods in the country, and results may not generalize to other communities. Yet, despite the living situation of the subjects in this study, “the majority of the families did experience gains in parental self-efficacy and adaptability” (p. 101). While results show that intensive, in-home interventions can keep these children in their natural environments, longer-term interventions, “booster doses” of key concepts and services, or transitional services after discharge, may further contribute to the long-term success of intensive, community-based crisis interventions.