



DRAFT

**IMPROVING SERVICES
FOR CALIFORNIA
CHILDREN & YOUTH
IN CRISIS**



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Mental Health Oversight and Accountability Commission

The Mental Health Services Act (MHSA), enacted by voters in 2004, established the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission). The Commission oversees the MHSA and the community mental health systems of care. One of the priorities for the MHSOAC is to oversee and account for the MHSA in ways that support increased local flexibility and result in reliable outcome information documenting the impact of the MHSA on the public community mental health system in California. The Commission is committed to accounting for the impact of the MHSA on the public mental health system in ways that are measurable and relevant to local and state policymakers and California communities. The MHSOAC statutory responsibilities include:

- Advising the governor and legislature regarding actions the state may take to improve care and services for people with mental illness
- Ensuring MHSA funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers
- Oversight, review, training, and technical assistance, accountability and evaluation of local and statewide projects and programs supported by MHSA funds
- Ensuring adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures
- Partnering with the state to establish a more effective means of ensuring that county performance complies with the MHSA
- Participating in the joint state-county decision-making process for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system
- Ensuring that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members are significant factors in all of its decisions and recommendations
- Assist in providing technical assistance, in collaboration with DHCS and consultation with CMHDA, to accomplish the purposes of the adult and older adult system of care and children system of care

The Commission recognizes the invaluable contribution and support of a diverse group of stakeholders, consumers, family members, youth, and subject matter experts from all over the state who participated in this project. This report would not be possible without their extensive knowledge, experience, commitment and passion for helping California children, youth and families, particularly in times of need.



STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



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(Placeholder page for introductory letter.)

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Improving Services for California Children and Youth in Crisis – Executive Summary

PROBLEM STATEMENT

There's a problem with California's mental health care system for children.

For many children and families in California, accessing crisis services may be their first introduction to the state's community mental health system. Addressing the needs of children in crisis is typically more complex and challenging than for adults due to:

- The requirements to coordinate care across multiple child-serving agencies with, at times, competing or contradictory goals
- Multiple funding streams and regulations with restrictive eligibility criteria
- Overly burdensome reporting requirements

These factors present real challenges to effectively meet the needs of the whole child while building on his or her natural supports. Getting crisis care right is critical to overall health and to the individual's and family's resiliency and ongoing engagement with mental health services.

While considerable progress has been made in this arena over the past decade, there remains a high level of unmet treatment and service needs within the children's mental health system of care generally, and crisis services in particular.

There are Tragic Consequences of These Unmet Needs:

1. Law enforcement and emergency rooms are ill-equipped to handle mental crises for children

Far too often, families and caregivers of children, some as young as five years old, must turn to law enforcement and emergency departments that are ill-equipped to address mental health crises for children. The experience of waiting for hours or days in a noisy, chaotic, and frightening emergency department during what is already an extremely stressful and vulnerable time for children and their families can dramatically increase the mental and emotional trauma inherent in a crisis.

2. Lack of adequate home and community-based crisis services

Long waiting periods in emergency rooms often followed by extended ambulance rides to acute psychiatric facilities that are at times several hundred miles away from the child's home, underscores the fact that the **"fail first"** approach to mental health care remains a reality in many communities throughout California. It also provides a strong indicator of the serious work that remains for both privately- and publicly-funded mental health providers in meeting the needs of children and youth in crisis.

3. Many of these children do not need an in-patient care facility

Once a family reaches out to law enforcement, they lose control of the situation. Frequently, the child does not need emergency room or mental care facility services; typically they need other services that are bypassed once law enforcement is called. The enormous costs associated with involving law enforcement, ambulance rides, and in-patient treatment facilities often fall upon the shoulders of the family in need.

"Fail first" refers to an approach of rationing mental health services to those with the highest needs who are often identified following a major incident such as hospitalization, school dropout, or incarceration. The "fail first" approach focuses on providing services following a crisis event rather than emphasizing prevention and early intervention.





Statistics show that the **state is ill-prepared** to care for the increasing number of pediatric mental health crises occurring each year:

Nearly
40,000
California children, ages 5–19, were hospitalized for mental health issues in 2014.¹

Since 2008,
mental health
needs have accounted for the largest share of hospital admissions of children ages 0–17 in California.²

In Fiscal Year 2013–14,
children in California, ages 0–17 experienced more than
23,000
involuntary 72-hour detentions for evaluation and treatment.³

WE MUST CLOSE THE GAP

The absence of sufficient and cost-effective crises services represents a substantial gap in the continuum of care for children and youth with mental health needs. It is important these services be home and community-based, family-centered, culturally-competent and focused on building resiliency.

Providing medically-necessary care to children in crisis in the least restrictive setting possible, as required by federal statute, presents a challenge to local communities. A failure or negligence to adhere to the federal statutes exposes the state and counties to costly and burdensome litigation, which has already occurred in other jurisdictions throughout the nation.

California has the opportunity to learn from evidence-based models of comprehensive continuums of crisis service implemented in other jurisdictions. With continued attention and focused effort, California will be able to address the remaining challenges and barriers, avoid burdensome judicial intervention, and become a leader in ensuring that the mental health crisis needs of all children and their families are met regardless of who they are, or where they live.

Project Description

THE CRISIS SERVICE PROJECT

To understand the state of children’s mental health crisis services, the Mental Health Services Oversight & Accountability Commission (MHSOAC) initiated The Crisis Service Project in 2015. The goals of the project were as follows:

- **Identify issues** – Talk to parents, children, and service providers.
- **Document challenges** – Listen to the challenges presented during a crisis.
- **Research effective service delivery models** – Look at other states, and see how they both improved their system and prevented legal ramifications.
- **Recommend and advance specific policy, funding, and regulatory changes** to improve service quality and outcomes.

To ensure consistency with the direction and intent of the MHSOAC, a subcommittee of the Commission, chaired by Commissioner John Boyd, guided all phases of the project. An advisory workgroup was charged with defining crisis services; exploring the role of these services within a continuum of care that is prevention-focused and resiliency-oriented; identifying challenges, barriers, opportunities, and best practices. Based on the information gathered, the workgroup developed recommendations to improve access, service coordination, and outcomes.

APPROACH

Over the course of several months, Commission members heard from youth, parents, consumers, policy makers, and advocates, to gain a broad understanding of the real world experiences of children and youth in crisis throughout California. Commission members also visited a number of service providers and learned from both the successes and ongoing challenges faced by individuals and organizations working in this area.

Informed by the knowledge, experience and expertise of the advisory workgroup, the MHSOAC staff conducted an extensivereview of published literature, training initiatives, and related material on children’s crisis service models. The project also reviewed national guidelines and specific state models of successful system responses to children’s mental health crises services. This review provided a foundation for the development of specific, action-oriented, policy and practice recommendations.

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Families in California have very few places to turn when their children are in crises. It is time to combine our efforts in order to secure the funding and focus needed to significantly increase the availability of high quality care that meets the needs of our kids.

– *Darrell Steinberg, Founder, Steinberg Institute*

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Challenges

Throughout this project, a

number of challenges to providing effective crisis services to children and families were identified

by subject matter experts,

including:



The **Fragmented** nature of existing crisis service delivery systems



Funding Streams



Insufficient treatment capacity



Lack of full continuum of services with the ability to respond to the child and family's needs as a crisis unfolds and/or is resolved

MULTIPLE PROGRAMS

As it stands today, the existing mental health system of care for children is made up of multiple public and private programs including:



DIFFERENT OBJECTIVES

Each entity has its own mission, organizational culture, institutional procedures, eligibility rules, and funding streams.

The **lack of available data** at the state and local level regarding existing services and the **challenge of sharing data across systems** were also identified as key challenges to delivering effective services and supporting quality improvement efforts.

Opportunities

MODEL PROGRAMS AND SERVICES

A number of states have successfully implemented comprehensive models of community-based crisis services for children and youth. The positive outcomes include reduced reliance on psychiatric hospitalization and substantial cost savings.

Each of these models share many common characteristics. They offer Integrated, home- and community-based behavioral health crisis assessment, intervention, and stabilization services. These services have proven to be high-quality, culturally competent and cost-effective while promoting resiliency, rehabilitation, and recovery. Each of these programs also has the ability to respond to wherever the child is in the community and actively engage with the child's natural supports. Included in this report are ongoing federal initiatives to improve children's crisis services as well as descriptions of selected model programs in the states of Washington and Massachusetts and the city of Milwaukee.

COST SAVINGS POTENTIAL

Throughout this project, a number of factors were identified by stakeholders and subject matter experts that support the likelihood of realizing substantial improvement in children's crisis services throughout California.

There is currently a network of highly-informed and engaged stakeholders and subject matter experts committed to improving children's crisis services in California. Robust funding streams already exist for community-based crisis services with additional growth potential in the coming years. Funding from a number of sources including MHSA and Medi-Cal Early Periodic Screening, Diagnosis and Treatment (EPSDT) is expected to grow substantially over the near term.

The rapidly changing landscape of both the privately- and publicly-funded healthcare delivery system may also support the implementation of new and creative solutions, particularly in the area of crisis services where there is potential cost savings associated with more effective models of care.

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The State of California, its children, adolescents and families deserve care when they need it and where they need it. Bringing together key stakeholders from throughout the state who are focused on recognizing and meeting the needs of California's children is essential to the mission and fabric of California.

– John Boyd, MHSOAC Commissioner, Sub Committee Chair, Children's Crisis Services Project

”

CURRENT SYSTEM IN CALIFORNIA

The average cost of hospitalization for
primary mental health diagnosis **\$15,540⁴**
.....

Ambulance Rides –
\$500–\$2,000 per trip
.....

Emergency Room Boarding **\$2,264/day**
.....

Law Enforcement Response
\$150 per hour
.....

Acute Psychiatric Hospitalization
\$15,000 per episode

ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

The alternatives to Psychiatric Residential
Treatment Facility (PRTF) Demonstration
program funded by the federal Medicare
& Medicaid Services to determine the
effectiveness of **community-based
services for youth** who are in, or at
risk of entering a psychiatric residential
treatment facility found that state Medicaid
agencies **reduced the overall cost of
care by up to 75%, an average
savings of \$40,000 per child
per year.⁵**



Findings and Recommendations

One theme that consistently emerged throughout this project was the importance of implementing a comprehensive continuum of crisis services that focuses specifically on meeting the needs of youth and families at each potential phase of a mental health crisis. To effectively support children and their families/caregivers while also reducing the likelihood of trauma, crisis services must have the ability to vary the intensity of interventions for both residential and community services in direct response to the unique needs and of each child.

A continuum of services provided to individuals experiencing a psychiatric emergency. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in an appropriate treatment service to address the problem that led to the crisis. Core crisis services include: mobile crisis services, intensive home-based services, 23 hour crisis stabilization/observation beds, short term crisis residential services and crisis stabilization, 24/7 crisis hotlines, warm lines, safety planning, and peer crisis services.⁶

- **Establish crisis service providers** – Crisis service providers must have expertise and experience working with youth and family members during a crisis and the capacity to respond rapidly to a variety of community settings, 24 hours per day and seven days per week. In addition, they must be able to remain with the child and family until the crisis is resolved, or a determination is made that a higher level of care is required.
- **Provide a range of intervention services** – While not all mental health crises can be addressed in a community setting, it is critical to have a range of available interventions, with emergency department and/or acute psychiatric hospitalization, representing the last alternative after all other efforts and resources along the continuum have been exhausted or determined inappropriate for resolving the crisis.
- **Save money, time, families and lives** – Several communities throughout California have made significant progress in developing specific program components and services designed to respond to children experiencing a mental health crisis. However, this project identified no county that has successfully built out the full continuum of services required to fully meet the needs of children and families in crisis. This lack of a fully-developed continuum of crisis services places an exceptional burden on emergency rooms and the limited number of acute psychiatric beds available across the state, which results in unnecessary delays in mandated and sometimes lifesaving services for youth in crisis.

The project findings and recommended actions are outlined on the following pages and are intended to support the continued buildout of a viable, comprehensive continuum of crisis services and ensure access for all children and youth regardless of who they are or where they live.



FINDING 1:

Too many California children and youth are not receiving the crisis services they need.

California's delivery system for children in crisis is inadequate. As a result, too many children and their caregivers are often forced to turn to law enforcement, emergency rooms and acute psychiatric facilities at times of crises. This reliance on law enforcement and emergency rooms for crisis services is expensive and often leads to a mismatch between the services children need and what they receive.

California is home to more than 9 million children. One in five of these children, or 1.8 million, have or have had a psychiatric disorder — more than the number of children with cancer, diabetes, and AIDS combined. Children and youth struggling with serious emotional disorders are more likely to experience school failure, substance abuse and criminal justice involvement, all of which come at tremendous cost to them, their families and the communities in which they live. In 2014 alone, more than 40,000 children were hospitalized for mental health related conditions.

Many of these hospitalizations could be avoided through early intervention, intensive home-based services, mobile crisis response, and short-term crisis stabilization services. For children who do experience a mental health crisis, providing a comprehensive array of home and community-based services can reduce the potential trauma for the child and family and build resiliency to avoid future crises.

One of the challenges faced by the state and counties is the lack of agreement on what constitutes minimum standards for medically necessary care for a mental health crisis. In a number of jurisdictions throughout the nation, questions regarding timeliness, location, composition and duration of medically necessary care for those experiencing, or at risk of experiencing, a mental health crisis have been resolved through judicial intervention brought forth on behalf of children and families with unmet needs. Several of these states have made substantial progress in providing comprehensive children's crisis services while at the same time substantially reducing their reliance on costly emergency room visits and hospitalizations.

While progress has been made in California, many communities throughout the state continue to fall short in providing a comprehensive continuum of crisis services for children and youth. California can, and must, do better. First, California must establish minimum standards of crisis care and then work with jurisdictions across the state to close gaps in the existing system.

RECOMMENDATION 1:

California should establish clear and compelling standards for crisis services that ensure that all children facing a mental health crisis receive the services they need in an age-appropriate, culturally competent, and timely manner. Standards should be established regardless of funding source and should include:

- a. Reasonable timeframes for access to care.
- b. Age-appropriate, culturally competent services for children, youth, and transition-age youth.
- c. Clarification of criteria for medically necessary care, particularly in relation to home- and community-based services.
- d. A continuum of integrated services that includes mobile, home- and other community-based services.
- e. Safety planning for children at risk of experiencing a mental health crisis.
- f. Step down plans for services following a crisis.
- g. Consumer and family education and support that reflects goals of recovery, resiliency and wellness.

FINDING 2:

Fragmented mental health crisis services undermines care coordination and outcomes for children and families.

Rural counties in particular face unique challenges in providing a continuum of comprehensive community-based crisis services to children and youth.

The challenges faced by children, families, schools, law enforcement, and service providers are not to be understated. Ensuring that every community has in place the right mix of services, facilities and resources to meet the needs of children and youth in crisis wherever and whenever those needs arise can be a daunting task for local child serving organizations. Providing intensive home and community-based services 24/7 is staff and resource intensive. Building and maintaining collaborative teams involving multiple child servicing agencies and aligning those services with the needs of the child and their caregivers can also be a time and resource intensive effort. However, providing collaborative, culturally appropriate, client-focused services, whenever and wherever they are needed, is at the core of delivering effective crisis services. Addressing the challenge of fragmented and siloed services is critical to getting in front of crisis situations and addressing them in the least restrictive and most effective means possible.

California must also provide additional clarity regarding what constitutes medically necessary care and how, when and where mental health crisis services should be provided in order to reduce the likelihood of more restrictive and costly forms of intervention. What constitutes medical necessity in regard to mental health crisis services has already been addressed in other states through judicial intervention. These states can serve as a model to inform future policy decisions in California.

Each county, in partnership with key stakeholders, is ultimately responsible for designing, implementing, and maintaining a continuum of crisis services. The state also has a responsibility to establish minimum standards of care, support, and innovation to facilitate knowledge exchange across jurisdictions.

“

Even when we do provide services, we often ignore what we're asking of youth and families. One family had multiple young children involved in multiple systems. The result: a total of 35 treatment goals, 45 meetings, and 26 helpers. Unsurprisingly, the family couldn't keep up and was deemed 'noncompliant'. We set these families up to fail, even as we throw resources at them.

– *Patrick Gardner, Commission Meeting 9/24/2015*

”

RECOMMENDATION 2:

The Department of Health Care Services and Department of Managed Health Care, as California's lead mental health agencies, must work with counties, providers, health plans and others to address the following challenges:

a. Explore funding options to expand California's investment in crisis care, prevention, early intervention, and related services. Funding options should include:

- i. Strategies for cost avoidance and savings that can result in redirection of existing funds and the use of growth funds toward crisis care.
- ii. Securing private-sector insurance coverage for some or all crisis-related services.
- iii. Clarifying when and where Medi-Cal coverage is available to cover the costs of care.
- iv. Partnering with other local agencies, including child welfare, juvenile justice, local education agencies and others to leverage available resources where feasible.
- v. Designating additional MHSAs administrative funds to support expanded SB-82 Triage Personnel Grants focused on crisis services for children and adolescents.
- vi. Accessing available MHSAs Innovation funds to implement new interventions and evaluate their effectiveness in meeting the needs of children at various stages of a mental health crisis.

b. Identify best practices for prevention and early intervention, and disseminate those best practices through a training and technical assistance strategy. Best practices should include:

- i. Regional approaches to providing a continuum of crisis services, particularly for rural, sparsely populated, and isolated communities.
- ii. Tailored approaches to meeting the needs of California's diverse populations including bilingual and bicultural approaches that are culturally congruent to the child, youth, family, or community being served.
- iii. Expanded use of mobile, intensive home-based services, crisis stabilization, and short-term residential programs.
- iv. Development of a dynamic service registry that allows counties and providers to more effectively use existing services.
- v. The development and deployment of individualized treatment teams that are multi-disciplinary, involve children and their families/caregivers, and incorporate the perspectives of mental health, education, and other relevant service providers.

FINDING 3:

California lacks a statewide system of accountability and quality improvement to ensure all children and youth have access to crisis services when and where they need them. That system should be designed to document both excellence and gaps in care, and to allow the public and policy makers to understand how effective programs and policies are.

Any effort to improve services, and more importantly the impact of those services on children and their families, must be supported by a robust monitoring and quality improvement system. In response to a legislative mandate, California has made significant progress over the past two years in developing and implementing tools using existing data to support increased transparency and accountability within the children's mental health system. However, substantial work remains

in the area of data collection, analysis and dissemination designed to support continued improvement in crisis services. Documenting the array of existing children’s crisis services in each county, identifying gaps and unmet needs, realigning resources to close those gaps and monitoring outcomes are critical to the state and counties’ ability to sustain progress, address changing needs, and measure results.

RECOMMENDATION 3:

The Governor and Legislature should establish an outcome and accountability reporting system, under the authority of the Department of Health Care Services, with guidance and monitoring from the Oversight and Accountability Commission, for crisis services in California.

- a. That system should be integrated into the Department’s Performance Outcome System and related data and reporting systems. Establish additional crisis specific indicators using the stakeholder advisory process developed for implementing the existing Performance Outcome System.
- b. The Department should provide to policymakers and the public an annual report on crisis services that includes key indicators for each county and the state as a whole, such as:
 - i. The number and demographic characteristics (including disaggregated data on race and ethnicity; and when appropriate, data on sexual orientation and gender identity) of children, youth and transition-age youth who access crisis services,
 - ii. Inventory of existing crisis services,
 - iii. Delays in access to care,
 - iv. Proximity of crisis services relative to a child’s home, school and family,
 - v. Measures of step down and transition planning,
 - vi. Measures of the duration of crisis services utilization, transitional care and repeated use of crisis services, and
 - vii. Efforts to improve these indicators.
- c. The Commission should establish standards for the annual updates and three-year plans required under the MHSA that can be integrated into county Medi-Cal and related plans, and develop a strategy for monitoring those plans that empowers the public, local officials and others to monitor the quality of county plans and assess progress in improving community mental health services, including crisis services.

“

The current data coming from the counties to the DHCS shows what is happening, but does not show how it is happening or whether it is appropriate.

– Brenda Grealish, Commission Meeting, 9/24/2015

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The Role of the Mental Health Services Oversight and Accountability Commission

Introduction

The Mental Health Services Oversight and Accountability Commission (Commission), created through the MHSA, is charged with advising the governor or the legislature regarding actions the state may take to improve care and services for people with mental illness; and participate in the joint state/county decision-making process for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system to accomplish the purpose and intents of the Act. In fulfilling this role, the Commission must ensure that the perspective and participation of diverse community members reflective of California populations and others struggling with severe mental illness and their family members is a significant factor in all of its decisions and recommendations.⁷

WHY FOCUS ON SERVICES FOR CHILDREN AND YOUTH IN CRISIS?

The current system is failing our children. The MHSA includes specific language regarding children with severe mental illness. It states that funding shall be at sufficient levels to ensure that counties can provide each child in need with all of the necessary services set forth in the applicable treatment plan, including services where appropriate and necessary, to prevent an out-of-home placement (WIC Section 5878.3).⁸ Additionally, all counties are authorized to provide children with service alternatives to group home care through the development of expanded family-based service programs. These programs shall include individualized or “wraparound” services, where services are wrapped around a child living with his or her birth parent, relative, non-relative, extended family member, adoptive parent, licensed or certified foster parent, or guardian. The wraparound services developed shall build on the strengths of each eligible child and family and be tailored to address their unique and changing needs (WIC Section 18250).⁹

“

We have no mobile response teams. In our county, you have to call the police or 911. They handcuffed her and took her away. It was horrific.

– California Health Report, January 12, 2016

”

Underlying the MHSA was a recognition that after decades of shrinking budgets, mental health services for both children and adults in many communities throughout California had been reduced to a “fail first” model of care by which limited services and resources were rationed for those with the absolute highest needs, often neglecting prevention and early intervention efforts. It was recognized that increased funding and focus in these “upstream” service areas has the potential of preventing, or at a minimum reducing, many of the serious consequences of untreated or under treated mental illness including school dropout, out-of-home placement, homelessness, arrest, hospitalization, and suicide.

Getting crisis care ‘right’ is critical to health outcomes overall and to the individual’s and families’ recovery and continued or future engagement with mental health services. For many children and families accessing crisis services may be their first introduction to mental health resources. Although not ideal, children and families also tend to be more open to external supports or interventions during a time of crisis. Addressing the needs of children in crisis is often more complex and challenging than it is for adults due to:

- The requirements to coordinate care across multiple child serving agencies with, at times, competing or contradictory goals
- Multiple funding streams and regulations with restrictive eligibility criteria
- Overly burdensome reporting requirements

All of these factors present real challenges to effectively meeting the needs of the whole child while building on their natural supports.

CALIFORNIA IS ILL-PREPARED TO CARE FOR THE INCREASING NUMBER OF PEDIATRIC MENTAL HEALTH CRISES OCCURRING EACH YEAR:

In 2013, nearly 13% of children¹⁰ showing up in emergency rooms (more than 30,000) were there for mental health reasons. While considerable progress has been made over the past decade, there remains a high level of unmet needs despite substantial investment of federal, state, and county resources in children’s community-based mental health services. One of the tragic consequences of these unmet needs is that far too often families and caregivers of children, at times as young as 5 years of age, are forced to turn to law enforcement and emergency rooms when faced with a mental health crisis where they frequently must endure hours and even days waiting for treatment or intervention. The experience of waiting for hours in a noisy, chaotic and frightening emergency department during what is already an extremely stressful and vulnerable time for children and their families can dramatically increase the mental and emotional trauma already inherent in a crisis situation.

The fact that for many children, their first introduction to mental health services involves a call to 911, transportation by law enforcement or ambulance to an emergency room followed by acute psychiatric hospitalization at times hundreds of miles from their home seems to demonstrate that the “fail first” model remains a reality today for many families throughout the state. Children and families waiting hours or days in emergency departments for behavioral health care or intervention is a relatively clear indicator of the serious work that remains for both private and publicly funded mental health services.

By revising our system now, California can avoid legal ramifications. This is a critical time for California to address gaps in the existing crisis services continuum of care for children and their families. Over the past few years, several state and local jurisdictions have been directed, through the courts, to expand or modify their existing crisis services for children and youth. Both Washington¹¹ and Massachusetts¹² were directed by legal settlement agreements to restructure their children’s mental health system by incorporating intensive home-based services, including crisis intervention, following court findings that the previous service delivery system violated the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of the federal Medicaid Act. Both states were found to be in violation of EPSDT’s mandate to screen eligible children, diagnose conditions found through a screen, and furnish appropriate treatment to correct or ameliorate physical and mental illnesses. Federal law requires that these services must be provided promptly and for as long as needed.

The lack of sufficient, cost-effective, compassionate recovery-based crisis services in many communities throughout California represents a substantial gap in the existing continuum of care for children and youth with serious emotional disturbance or serious mental illness and, if not addressed, is likely to expose the State to similar legal interventions in the future.

California, through the leadership of the MHSOAC and its state and local partners, has the ability to learn from the existing evidence-based models to support the continued buildout of a comprehensive continuum of crisis services that addresses the needs of all children regardless of who they are or where they live.

The Crisis Services Project

PURPOSE

The Crisis Services Project was initiated to document the current state of crisis services for children and youth throughout California, and develop recommendations for improving the delivery of crisis services for children, youth, family members, and the communities in which they live. Specific project goals included the following:

- Increase understanding of the nature of mental health crises among children and youth.
- Develop a shared understanding of the current crisis service delivery system and its role within the continuum of care in diverse locations and communities throughout the state.
- Document challenges and constraints of the existing service delivery system and potential benefits of improved access and coordination (e.g. cost avoidance, prevention, improved individual outcomes, improved communities).
- Increase understanding of the motivators that impact the accessibility, quality and effectiveness of crisis services for California's children and youth (e.g. state or local policies and/or procedures, funding/costs, licensing, staffing levels, etc.).
- Develop new strategies and/or identify existing models to improve access to effective crisis services for children and youth.

APPROACH

Advisory Workgroup

To ensure consistency with the direction and intent of the MHSOAC, a subcommittee of the Commission, chaired by Commissioner John Boyd, guided all phases of the project. The Subcommittee also played a central role in formulating action-oriented policy recommendations and communicating these to the full Commission and stakeholder communities.

Additionally, an advisory workgroup was charged with defining crisis services:

- Exploring the role of these services within a continuum of care that is prevention focused and recovery oriented;
- Identifying challenges, barriers, opportunities and best practices;
- Developing recommendations to improve access, service coordination and outcomes.

The advisory group met several times over a six-month period and included subject matter experts from throughout the state (See Appendix: B: List of Advisory Workgroup Participants).

All workgroup meetings were open to the public and strived to incorporate a range of perspectives and experiences to support the development of shared knowledge and ensure that group recommendations address the needs and interests of diverse communities throughout California.

Commission-Sponsored Site Visits and Expert Panel Presentations

Commissioners and staff participated in a number of site visits. Their goal was to:

- Learn about crisis services, their availability, and accessibility.
- Gain an increased understanding of how they function within the larger mental health service delivery system.
- Identify potential challenges or barriers to accessible and effective service delivery systems.

Panel presentations before the full Commission in September and October of 2015 included individuals with lived experience, subject matter experts, policy leaders, and members of the public who provided background and first person experiences supported by a discussion of existing barriers, challenges and opportunities for improvement.

The site visits and public presentations provided the framework for this report and informed the project findings and recommendations. The firsthand experiences and personal stories of consumers, family members, providers, advocates, and emergency responders provided context and helped tell the story of existing children’s crisis services in communities throughout California. Excerpts of their testimonies are included throughout the report and helped to inform the development of findings and action oriented recommendations to address identified challenges and leverage existing opportunities for improved services (See Appendix: A for presenter bios).

Literature Review

Guided by the broad knowledge and expertise of the advisory workgroup participants, the MHSOAC staff conducted an extensive review of published research, training initiatives, and grey literature related to children’s crisis service models. In addition to California specific research and program information, the project was informed by an extensive review of national guidelines and specific state models of successful system responses to children’s mental health crisis services. The review of the existing literature supported the identification of effective service components, challenges, opportunities, findings and recommendations contained throughout the report.

“

In California and elsewhere, children's mental health crisis services represent a substantial, often overlooked component of the mental health treatment system. Mental health crisis services are especially consequential for the lives of ethnic minority and other vulnerable children.

– *Lonnie R. Snowden, PhD, UC Berkeley, Professor of the Graduate School, Health Policy and Management*

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Background

SCOPE OF THE PROBLEM

The rate of children hospitalized for mental health conditions continues to rise across the state. According to the most recent data collected by the Office of Statewide Health Planning and Development (kidsdata.org),¹³ nearly 40,000 California children ages 5–19 were hospitalized for mental health issues in 2014.

Since 2008, mental diseases and disorders accounted for the largest share of hospital admissions of children ages 0–17 in California (see figure A below).¹⁴ According to data collected by the California Department of Healthcare Services, during the 2013–2014 fiscal year, more than 23,000 involuntary 72-hour detentions for evaluation and treatment were placed for children (age 0–17) in California.

Figure A

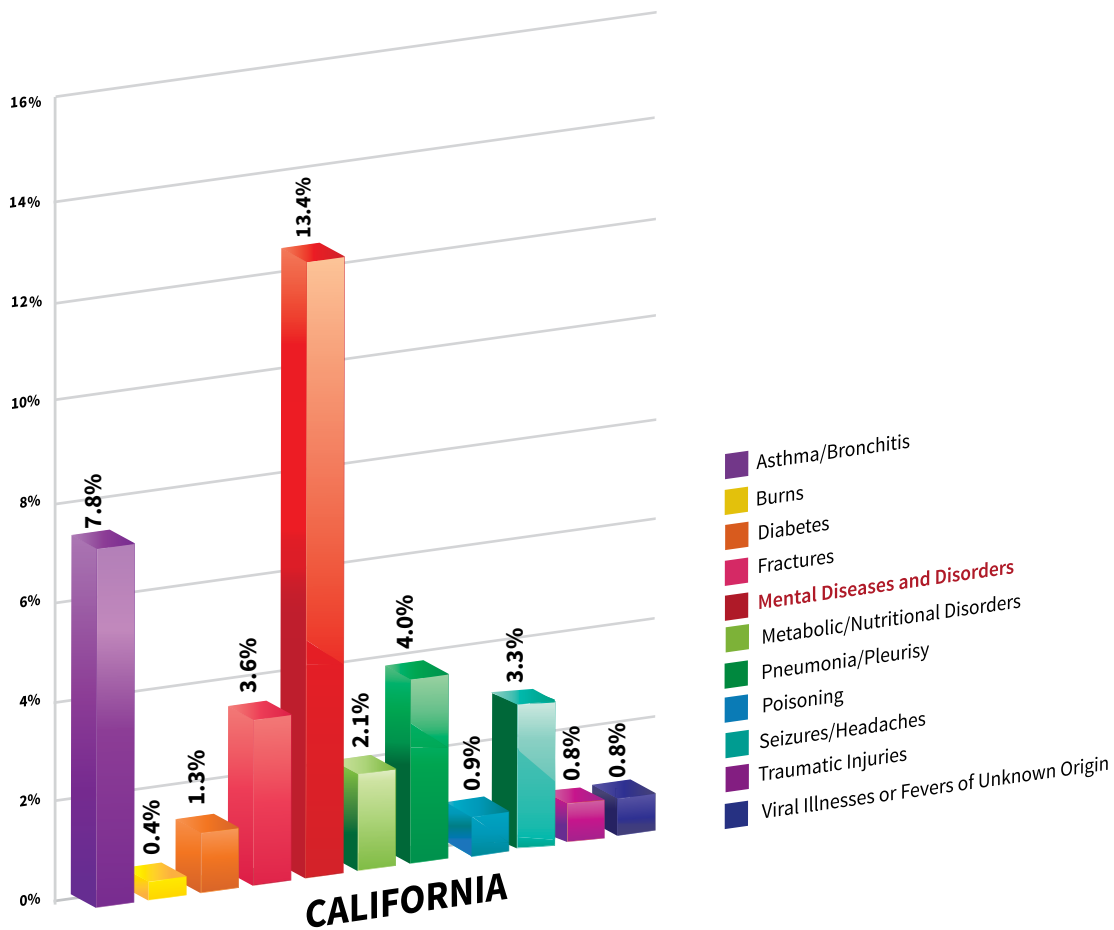


Figure A: Hospital Discharges, by Primary Diagnosis: (2014)

Age Group: 0–17

Definition: Ten most common primary diagnoses for hospital stays among children ages 0–17, excluding childbirth, as a percentage of total hospital discharges. Data Source: As cited on kidsdata.org, Special tabulation by the State of California, Office of Statewide Health Planning and Development (Sept. 2015).

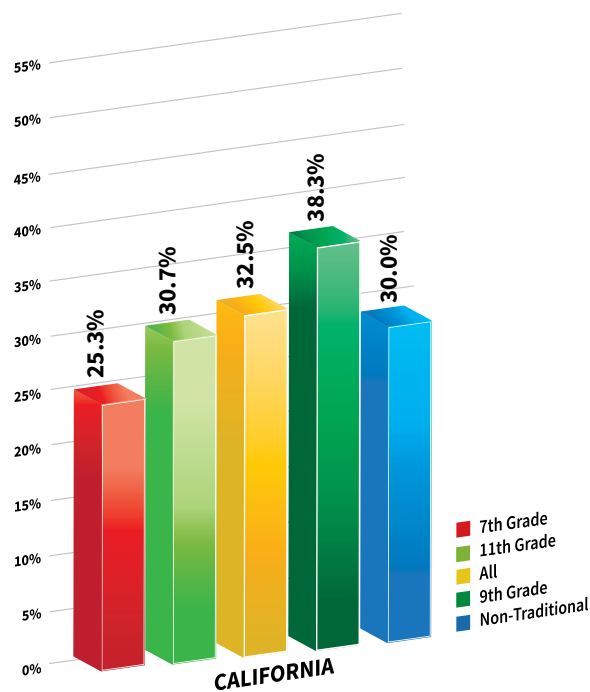
Depression-Related Feelings

By Grade Level: 2011–2013

Based on statewide data from 2013, roughly 1 in 10 individuals accessing hospital-based emergency services are actually admitted to an inpatient psychiatric facility. This is an indication that for many, a mental health crisis could be addressed through less intensive interventions thereby diverting large numbers from overburdened emergency rooms. It is likely that tens of thousands of other children experiencing mental health crises are served by mobile crisis units, stabilization, or other non-hospital settings. However, current data is limited on a statewide level to support an accurate assessment of the number of children each year who are diverted from hospital emergency rooms through less restrictive intervention.

Self-reported data collected through the California Healthy Kids Survey and California Student Survey suggest that the prevalence of less acute, but still distressing, mental health issues are even greater. Specifically, 30% of California students in 7th, 9th, and 11th grades reported feeling sad or hopeless almost every day for two weeks or more during the past year, according to 2011-2013 data.¹⁵

Figure B



(Grade Level: All; Student Response: Yes)

Definition: Percentage of public school students in grades 7, 9, 11, and non-traditional students reporting whether in the past 12 months they had felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities.

Data Source: [As cited on kidsdata.org](http://kidsdata.org), California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd).

Based on mental health service records collected in the statewide Client Services Information (CSI) system, nearly 1 in 3 children between the ages of 15 and 17 who received mental health emergency services in a given year had no record of also receiving non-emergency or planned mental health emergency services either before or after the crisis event. In other words, for nearly one-third of children served in the publicly funded mental health system, emergency services were the only form of mental health services provided. Another study of adolescents served in both the privately- and publicly-funded healthcare system in multiple states found that in the three months following a diagnosis of major depression, more than one-third of adolescents received no treatment and two-thirds did not have a follow-up symptom assessment.¹⁶

Common mental health conditions among children accessing emergency departments include:

- Violence-related behaviors
- Aggressive behaviors
- Emotional disturbance
- Suicide attempts/ideation
- Child abuse and neglect
- Mood and anxiety disorders

UNMET NEEDS

Studies show that a large percentage of children with diagnosable mental health disorders **do not access treatment:**



Among children and youth with severe mental health needs who show up at emergency rooms, **more than 20% exhibit dangerous behaviors and 40% have a history of prior psychiatric hospitalizations.**¹⁷



For those under 18 years of age with a mental health-related condition, adolescents make up the majority of emergency room visits, however there is a concerning trend of younger children seeking emergency psychiatric services in these settings. Foster care placement continues to be strongly associated with emergency room visits for suicide attempts and repeat visits for psychiatric conditions. Children living in rural communities also have higher rates of emergency room visits for mental health-related conditions, possibly due in part to the lack of alternative community-based crisis services.



While hospitalization rates have increased for all children, **Latino children and youth experienced the largest increase with rates rising by 86% between 2007 and 2014,** according to the Office of Statewide Health Planning and Development. That's compared with a 21% increase among whites and 35% among African Americans.¹⁸



Across the nation, **one child or youth between the ages of 14 and 24 dies by suicide every two hours¹⁹ and more than 150,000 are hospitalized for self-injury.**



60% of youth with depression and 80% of youth with a diagnosable anxiety disorder do not access treatment.

right now there is a child thinking about suicide.



Nearly 1 in every 5 students in grades 9 and 11 across California public schools reported **suicidal ideation** within the past year, according to the 2011–13 results of a statewide survey.²⁰



Nearly **90%** of young people that **die by suicide have a psychiatric illness.**²¹



A 2011 Youth Risk and Behavior Survey found that in the previous 12 months among high school students;

15.8% seriously considered suicide;

12.8% made a plan for suicide;

7.8% attempted suicide one or more times;

2.4% made a suicide attempt that had to be treated by a doctor or nurse.²²



In 2013, **suicide was the third leading cause of death for children** and young adults between the ages of 10 and 24.²³



Suicidal Youth

While suicide rates among California's children and adolescents have fallen substantially from the early peaks in the 1990s and remain lower than national averages, rates have consistently trended up over the past several years increasing approximately 10% between 2007 and 2013 suicide rates increase dramatically as teens move from early adolescence to middle adolescence and to young adulthood. **Suicide consistently ranks as the third most common adolescent mortality.**²⁴

Some populations within California are also known to be at substantially higher risk of suicide. For example, one study found that LGBT high school students and students unsure of their sexual orientation were anywhere from 2 to 3 times more likely to have attempted suicide in the last year than their straight peers.²⁵ The risk of suicide also varies among certain racial, ethnic, and cultural groups. American Indian/Alaska Native youth consistently have the highest rate of death by suicide across the nation.

LIMITED ACUTE PSYCHIATRIC BEDS AVAILABLE FOR CHILDREN AND YOUTH

Without a robust home and community-based crisis response system, there are simply not enough beds available to meet the needs of children in crisis.

as of:

July 1, 2014 there were **9,157,390** California residents under the age of 18.

right now:

there are currently **only 655 acute psychiatric beds available** throughout the state for children and adolescents.

and:

for children under 12 who require psychiatric hospitalization, there are currently **less than 100 beds available statewide.**

In the United States, **44 of the state's 58 counties have no child or adolescent beds.** This means that children assessed to be a danger to themselves or others and requiring acute psychiatric hospitalization in 3 out of 4 California counties must be transported typically by ambulance and frequently involve the use of physical restraints to one of the 14 counties with age appropriate beds.



“

When my daughter was 14 years old she came home from school one day and said ‘Dad, I want to kill myself.’

I called a mental health {hotline}, and they told me to take her to the hospital. The doctors put her on a 5150 hold. After five days, they transferred her to Sacramento, but we live in Santa Barbara. She called me every day and would say ‘Dad, can you come visit me?’ A week later, the Sacramento facility called me and told me to come get her because she was ready to be released.

– Public Comment, October 22, 2015 Commission Meeting

”



**6
Hours**



Current Crisis Services Continuum of Care

RELIANCE ON LAW ENFORCEMENT AND EMERGENCY DEPARTMENTS DURING MENTAL HEALTH CRISIS

Crisis Calls To 911

When the focus is on the crisis event which leads to a call to 911 and transportation to a hospital emergency room, it is often too late. Children typically do not go to an emergency room because it provides mental health treatment but in many instances families don't have anywhere else to go, and the hospitals can't turn anyone away.

“

Kids sitting in a hospital emergency department waiting for a bed is not uncommon; the longest was 11 days.

– *Dr. Jody Kussin, Director of Community Based Services for Casa Pacifica*

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There are a number of reasons that calls to 911, reliance on law enforcement personnel, and emergency departments have become the default response to a mental health crisis:

- Hospital emergency rooms are open 24/7 and provide quick access to medical personnel, medication resources, and beds.
- Law enforcement is also available 24/7 and has the ability to transport people to the emergency department.
- Funding streams – whether private or public – support the use of these existing transportation and emergency room services.

“

When law enforcement is your mental health support line, we’re making a systematic error.

– Ken Berrick, Seneca Family of Agencies

”

There is a common belief that emergency departments and inpatient treatments are the best risk management and harm-reduction strategies. However, this default option has shown to be increasingly ill equipped to resolve the crisis at the lowest possible level, minimize cost, reduce potential trauma and effectively serve the needs of children and caregivers within a larger continuum of service. Although comprehensive statewide data is not available on the percentage of 911 calls involving mental health crises, overall, it is estimated that 7% to 23% of the individuals law enforcement personnel interact with on a daily basis have some form of mental illness. Police officers aren’t doctors or therapists, but they are often thrust into being first-responders for those in crisis with mental illness. The National Alliance of Mental Illness ([NAMI](#)) online information for consumers who may be faced with a mental health crisis underscores the somewhat limited options for law enforcement in response to a 911 call: transport the person who voluntarily wants to go to the hospital, take the person involuntarily to the hospital for a mental health evaluation, or conduct a welfare check.

Shifting away from the default response to crisis intervention is complex and requires ongoing collaboration among organizations and providers who at times have worked at cross purposes. A comprehensive crisis system of care is very different from what currently exists in many counties where under-assigned roles and responsibilities, narrow focus, and complex funding mechanisms are frequently more concentrated on resolving the immediate crisis than building resiliency and addressing the individual or environmental factors which contributed to the crisis in the first place, and are likely to contribute to future crises if left unresolved.

EMERGENCY DEPARTMENT “BED BOARDING”

The mismatch between children’s needs and the system’s response continues to be seen most vividly in emergency rooms across the state. Often referred to as “psychiatric boarding” or “bed boarding” is not limited to California and has become a growing problem in communities throughout the nation. From 2001 to 2010, there was a 26% increase nationally in the number of children and youth treated in emergency departments for psychiatric problems.²⁶ Once a child or adolescent is brought to the emergency room, this is often the only available option since the medical staff can’t turn away mentally ill patients, even though in many cases they are not trained sufficiently to deal with them. Essentially, all they can do is stabilize the child and keep them in bed, often in seclusion or strapped down for hours or days at a time.

Concerns associated with the over-reliance of emergency departments on addressing children’s mental health crisis include:

- **Cost shifting** due to the lack of community-based mental health services.
- **Lack of capacity and competency in emergency departments** to appropriately screen, treat, and refer children and youth with mental health-related problems.
- **Compromising quality** which leads to poor health and mental health outcomes.²⁷

Many emergency departments are poorly-equipped to address the mental health needs of children, youth, and their families/caregivers. At the same time, the demand for mental health services in the ER is on the rise. Mental health-related ER visits among all populations increased 75% between 1992 and 2003. In a 2010 national survey conducted by the Schumacher Group, 70% of emergency department administrators reported that they hold mentally ill patients for 24 hours or longer, and 10% said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER by increasing waiting times for all patients which leads to overcrowding.²⁸

“

In 2014, the Washington State Supreme Court ruled that boarding psychiatric patients temporarily in hospital emergency rooms and acute care centers because there isn’t space at certified psychiatric treatment facilities is unlawful. The court ruled unanimously that patients held temporarily in settings that don’t provide individualized psychiatric treatment violates the state’s Involuntary Treatment Act.²⁹ (Citation: Seattle Times August 7, 2014)

”



**MOST ADMINISTRATORS SAY
DELAYS COMPROMISE PATIENT
CARE IN THE ER BY INCREASING
WAITING TIMES FOR ALL
PATIENTS WHICH LEADS TO
OVERCROWDING.**

Mental health-related ER visits
among all populations increased **75%**
between 1992 and 2003.



In a 2010 national survey conducted by
the Schumacher Group, **70% of
emergency department
administrators reported that
they hold mentally ill patients
for 24 hours or longer;**



**And, 10% said they had boarded
some patients for a week or
more.**

References for the above information is cited on
page 27, footnote 28.



How Services for Children and Youth in Crisis **Often Works**

Families and caregivers with no place else to turn during a psychiatric emergency call 911, starting a chain of events, which far too often they and the child have little control over:

- Law enforcement responds with or without ambulance services.
- The child is taken to a local hospital emergency room where they are likely to wait hours in a chaotic and frightening place, at times in physical restraints, for assessment and some form of intervention.
- If based on that assessment acute psychiatric in-patient placement is determined to be the only available means to ensure the child’s safety or the safety of others, they will likely wait hours or even days until a bed is located somewhere in 1 of only 14 counties within the state that provide child or adolescent acute psychiatric beds.
- Once a bed is identified, the child is often transported without a parent, by ambulance, at times up to eight hours away and may be restrained during the transport. Following in-patient placement of anywhere from 3 to 14 days, the child will often be released with medication but no significant community support in place. It will be the family’s or caregiver’s responsibility to determine a means to transport the child back home, at times from counties half away across the state. This is by definition the “fail first” and all too often the “fail frequently” model of crisis services that still exists in many communities throughout California.

HOW IT OFTEN WORKS





How Services for Children and Youth in Crisis **Should Work**

In an ideal world, all children suffering from severe emotional disturbance or serious mental illness would receive the support and care they needed. Ideally, they would not get to the point where the level of emotional and psychological distress overwhelms the capacity of their individual coping skills and natural supports.

During a crisis, children, caregivers, schools, and welfare agencies should have access to crisis intervention services that have the capacity to respond to the child's location, marshal local resources, and natural supports while remaining with the child and family until the crisis is ameliorated or a determination made that a higher level of intervention is required.

If crisis workers, the child, or caregivers make that determination, they must have access to a range of alternative interventions including crisis stabilization units, crisis residential facilities, crisis respite homes, and ultimately acute psychiatric facilities.

Emergency departments still play a vital role in this continuum for children with critical medical needs which must be addressed prior to providing mental health interventions. However, expanded home- and community-based crisis services for individuals not requiring medical interventions can substantially reduce the demand for psychiatric emergency interventions within emergency departments.

HOW IT SHOULD WORK

FOCUS ON CHILDREN AND YOUTH WITH HISTORY OF, OR AT RISK OF, PSYCHIATRIC HOSPITALIZATION



Comprehensive assessment
of child/family strengths and needs

Intensive care coordination team
(members chosen by the child/family) to bring together the main adults in the child's life so that everyone is working together (therapist, social workers, juvenile justice, teachers, friends, relatives, etc.)

In-home behavioral services for the whole family

Safety planning to identify triggers, natural supports and the child's family's preferences during times of crisis

Therapeutic Mentors to support the child and family in challenging situations

Family support and training to help parents and caregivers help their children reach treatment goals

24/7 telephone/text support services

Mobile crisis intervention 24/7
when help is needed right away