True **Life** Stories

Real world examples as presented at the commission meetings and state documents

CALIFORNIA

HOW IT OFTEN WORKS

Heather (not her real name) was born to a drug addicted mother and placed in foster care shortly after her birth. She is 12 now and has been diagnosed with bi-polar and reactive attachment disorder.

Adopted by her foster parent when she was 18 months old and raised in a loving home, she still has to deal with some very serious disabilities. Heather has been in and out of emergency rooms and in and out of locked psychiatric facilities for the past two years. She has a high level of aggressiveness particularly toward her siblings. On several occasions she has picked up a knife and threatened to stab her foster brother.

She also displays a high level of self-injury and lethality. The system's response has been continually focused on the crisis rather than follow-up care.

There is a wraparound program and Therapeutic Behavioral Services (TBS) in her county and she has been referred to these. A TBS provider was brought in, but they terminated the child's case after about six weeks because they said she was uncooperative. The result is more and more hospitalizations and more and more visits to the ER. Now Child Protective Services is involved and is threatening to remove her siblings because Heather is considered a potential threat to their safety creating another stressor for the mother.

Advocates worked with the mom to call the local crisis line after Heather had again threatened her sibling with a knife. The crisis worker on the line suggested that she give Heather a warm bath and a glass of milk and see if she calms down. Heather had been in the hospital two weeks before. Frustrated and out of options, the mom ended up taking Heather to the emergency room again, and that night she was detained on an involuntary hold and then released about a day-and-a-half later. Within the education system there is a better structure for negotiating services within the IEP process but they cannot find anyone in the county who will shadow her at home.

"Does Heather need to be one of the children that we see clogging up the emergency rooms? The next option is probably to send her out of state to an intensive residential treatment program."

—Melinda Bird, Testimony at 9/24/15 Commission Meeting

HOW IT OFTEN WORKS

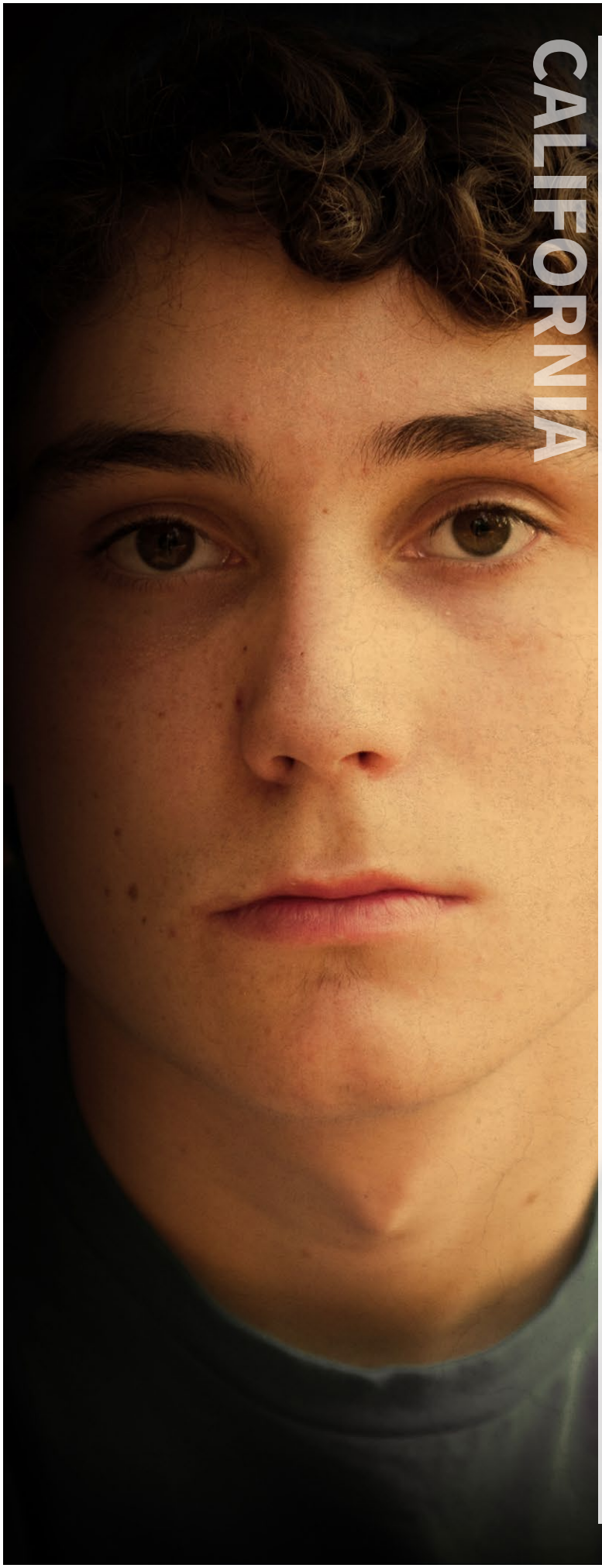
In November 2014, the family of a nine-year-old girl brought her to an emergency room in their southern California community because she was in crisis and a danger to herself. The child was placed on a 72-hour psychiatric hold, but the hospital emergency room could not locate an available inpatient bed for a child.

The family expressed their frustrations and complained to mobile crisis team staff over their child's inability to access timely and appropriate mental health treatment; that their daughter was "stuck" in the ER with no mental health treatment whatsoever. Finally on the third day, the ER found a child bed in a San Francisco hospital, so the girl was placed in an ambulance, alone without her family, and transported more than six hours north, by which time the original hold had expired.

The family could not afford to visit their child during this crisis because she was placed so far away, eliminating their ability to meet with the treatment team and learn how to care for their child after the hospitalization.

– Marika Collins, Testimony at 9/24/2015 Commission Meeting

CALIFORNIA



CALIFORNIA

HOW IT OFTEN WORKS

"As a 16-year-old in an outpatient facility, the staff told my parents to talk to the police and to say that I was dangerous to myself or others. I had incredible stress from school and hadn't slept for a week. My mom took me to Sierra Vista Home, which was at full capacity. My mom got me into an outpatient facility where I was told that I had to take meds. I refused and was told that I was out of compliance and put into Art Therapy. I colored 75 pages of coloring books, then was discharged without support or a discharge plan.

My mom put together a discharge plan for me: sleep, food, peer support, and mentoring. I was able to survive because I had the support of a family, health insurance, and political support. *The system didn't work for me."*

– Matthew Gallagher, Testimony at 9/24/2015 Commission Meeting

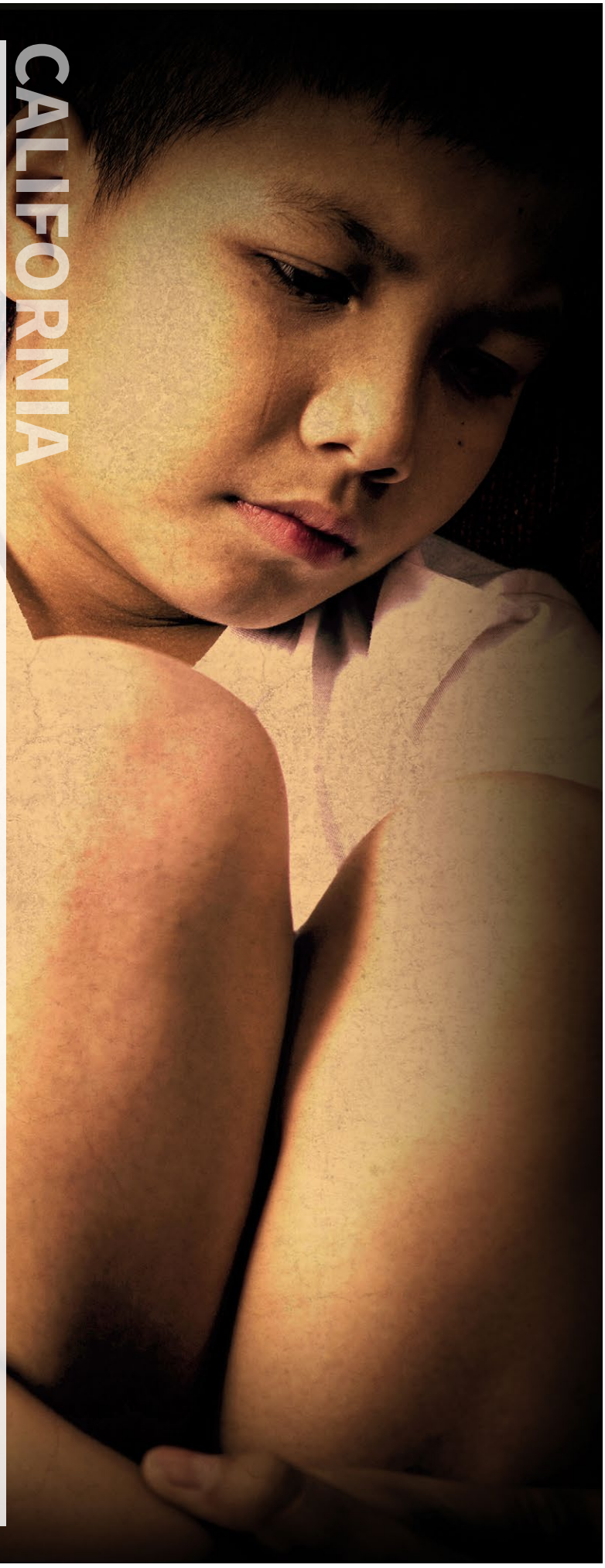
" Children brought in on 5150 holds are languishing while waiting, often 30 to 39 hours, for a bed and the care they deserve. This is occurring daily in emergency departments statewide. I feel horrendous for not being able to provide to them the level of care that is provided to other medical patients. Medical emergencies are whisked away immediately to the necessary medical facility to best treat them, but patients with mental health emergencies are left for hours and days while doctors' call all over the state to search for an available bed for them; many times, there are no beds available."

– David Ketelaar, Emergency Medicine Physician, Testimony at 10/22/2015 Commission Meeting

HOW IT OFTEN WORKS

One parent/caregiver in Ventura County reported that their child had seen four different psychiatrists in 16-month period of treatment. The parent/caregiver characterized the initial wait as a "long time." The child had been hospitalized ten times, and the family was never clear about the diagnosis; with each hospitalization, a new diagnosis was identified. The parent/caregiver believed the child was to be seen by the psychiatrist monthly, but since November, had received only one outpatient psychiatry session. Psychiatric appointments were canceled, without information provided as to the reschedule options. The parent/caregiver was informed that there was no availability when making call backs to reschedule canceled sessions.[30]

CALIFORNIA



WE ~~CAN~~ MUST DO BETTER.

MASSACHUSETTS

HOW IT SHOULD WORK

Daniel was a 12-year-old male who, following discharge from a three-week stay at a community-based acute treatment (CBAT) facility, had begun having side effects from his antidepressant medication. He had made good progress during the placement, but had missed his medication follow-up visit; the family seemed to have difficulty accessing care as they hadn't connected with their In-Home Therapy team.

Daniel had moved recently from the Midwest to Massachusetts with his mother and older brother due to domestic violence in his parents' marriage. He came with a diagnosis of Asperger's that had been identified two years earlier in Ohio. The family had a period of homelessness and lived in several Massachusetts shelters before moving in with family members in a rural community. Daniel's mother had a history of depression and his older brother was also described as being on the autism spectrum, but was more emotionally stable than Daniel.

His mother felt that the school was not meeting Daniel's needs. They had not put Daniel on an Individualized Education Plan (IEP) or a Section 504 Plan and he experienced peer harassment and bullying resulting from his Asperger's traits and eccentricity. He became increasingly depressed and hopeless, and was evaluated by a crisis team and placed in the CBAT facility. He improved significantly, was discharged on the antidepressant medication and set up with In-Home Therapy. There was also an outpatient therapist in place who had been working with both Daniel and his mother for a while under his mother's commercial insurance.

Daniel and his family were an ideal referral to their local community service agency (CSA). Given the long-term problem of managing Daniel's Asperger's characteristics, the current (but improving) acute depression, the mother's history of emotional issues, the multiple situational factors including housing and financial stress, the consequences of family trauma, and the inadequate school placement, a referral to Intensive Care Coordination (ICC) was warranted. **The ICC would be able to help them identify and prioritize their needs, and access both professional services (In Home-Therapy team, an educational advocate and a long-term psychopharmacology prescriber) and environmental supports (such as permanent housing, after-school care and recreation) to reduce their stress and help them settle into their new lives. The PCP worked with MCPAP to taper Daniel off of the antidepressant which resolved the side effects.**

These effective crisis service models have been implemented in jurisdictions throughout the country. Wraparound services, intensive care coordination (ICC), intensive home-based services (IHBS) integrated with mobile crisis capabilities, access to crisis stabilization units, and crisis respite care if resolving the crisis requires separating the child from the caregivers for a brief period of time.

Where It's Working

EXISTING SERVICE MODELS FOR CHILDREN AND YOUTH IN CRISIS

Several states have begun to implement customized Intensive Care Coordination (ICC) programs for children with significant mental health needs. A number of effective models which use wraparound (home- and community-based services), for improved crisis service delivery and outcomes within California and around the nation are discussed in the following sections and serve to inform the project findings and recommendations detailed at the end of this report.

In 2013, The Centers for Medicare and Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) began sponsoring a number of demonstration projects across the nation to support expansion of ICCs and demonstrate potential benefits including cost savings and reduced hospitalizations.

- **Milwaukee** reduced total child population use of psychiatric hospitalization from an average of 5,000 to less than 200 days annually and reduced its average daily residential treatment facility population from 375 to 50 with their Wraparound Milwaukee program.
- **Maine** found a 28% reduction in total net Medicaid spending among youth served in its Wraparound Maine initiative, even as use of home- and community-based services increased. Cost reductions for youth enrolled in Wraparound Maine were driven by a 43% decrease in the use of psychiatric inpatient treatment and 29% drop in residential treatment.
- **New Jersey** estimates that the state has saved over $40 million in inpatient psychiatric expenditures over the last three years through its system of care, which incorporates a wraparound approach for children with serious emotional disorders.[31]

CMS' Alternatives to Psychiatric Residential Treatment Facilities (PRTF) waiver demonstration compared home- and community-based services (implemented using the wraparound approach) to treatment in PRTFs. The PRTF waiver demonstration evaluation report concluded that across all state grantees over the first three waiver years, youth maintained or improved their functional status, while services cost substantially less than institutional alternatives. In most cases, waiver costs were around 20% average per capita total Medicaid costs for services in institutions from which youth were diverted, representing average per capita savings of $20,000 to $40,000. Following are examples of several programs implemented in other states with great success.

State: **MASSACHUSETTS**

MASSACHUSETTS' CHILDREN'S INTENSIVE MENTAL HEALTH SERVICES

The Children's Behavioral Health Initiative (CBHI) is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care to ensure that families and their children with significant behavioral health conditions, including emotional, mental health, and substance use needs obtain the services necessary for success in home, school, and community.

Values (Systems of Care Philosophy)

- Child-centered and family-driven
- Strength-based
- Culturally responsive
- Collaborative and integrated
- Continuously improving

> "Massachusetts was wasting over $22 million a year on unnecessary hospitalization. By redirecting available funding, it could serve more than 1,000 children annually in home-based programs."
> – (Overview of the Case and Summary of the Trial in Rosie D. v. Romney)

As of June 30, 2009, the Massachusetts Behavioral Health Partnership (MBHP) implemented the redesigned Emergency Services Program (ESP) system, under the direction of the Massachusetts Department of Mental Health (DMH) and the MassHealth Office of Behavioral Health (OBH). This redesign included the initiation of Mobile Crisis Intervention (MCI), one of the Children's Behavioral Health Initiative (CBHI) remedy services for MassHealth-enrolled youth up to the age of 21.

The mission of the ESP is to deliver high-quality, culturally competent, clinically and cost-effective, integrated, community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, rehabilitation, and recovery. The ESP provides crisis assessment, intervention, and 24/7 stabilization services 365 days per year to individuals of all ages who are experiencing a behavioral health crisis. A primary goal of ESP is to make emergency behavioral health services accessible in the community – offering viable service alternatives to hospital emergency departments (EDs).

Services Include:

- **Intensive care coordination** involves a single care coordinator, a single treatment team, and a single treatment plan that guide the provision of all mental health and related support services.
- **A comprehensive home-based assessment** includes an in-depth review of past records and treatment, a home visit, multiple interviews with family members, teacher and other collaterals, and leads to a strength-based assessment of the child and his or her needs.
- **Family training and support** helps families participate in the wraparound planning process, access services, and navigate child-serving agencies.
- **Mobile crisis intervention and stabilization** will be available 24/7 to provide short-term emergency care in the home to evaluate and treat a child in crisis, without having to go to an emergency room or medical facility.
- **Crisis stabilization** provides staff and treatment in the home or another community setting for up to seven days.
- **In-home behavioral services** addresses challenging behaviors in the home and community. A behavioral therapist writes and monitors a behavioral management plan with the family, while a behavioral aide works with the family to implement the plan in the home and in the community.
- **In-home therapy services** addresses social or emotional issues. A mental health therapist provides counseling and therapy to the child and family. The therapist may be assisted by an aide who provides support to the child in the home, school or community/recreational settings.
- **Therapeutic Mentoring** helps a child develop independent living, social and communication skills, as well as providing education, training and support services for children and their families.

COMMUNITY-BASED CRISIS INTERVENTIONS

Mobile Crisis Intervention (MCI) is the youth-serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention provides a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any.

MCI services optimally produce more holistic evaluations, solutions and referrals. They are also intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intrusive manner.

This service is provided 24 hours a day, 7 days a week and includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youths who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff coordinates with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also coordinates with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing many youth and families to bypass the stigma of hospital settings, as well as the trauma and disruption of an emergency out-of-home placement. This is accomplished by safety planning in an actual site where long-term safety will matter most, and with the people who are crucial to the plan. The nature and anticipated benefits of a community-based crisis intervention should be discussed with the youth and parent at the earliest stages of the MCI encounter, in order to ease anxiety or safety concerns, support informed consent and decision-making by the youth/caretaker, and clarify the intended purpose of the service.

MASSACHUSETTS CHILDREN'S SERVICE DESIGN AND DELIVERY PROCESS

- **Collaboration with the child and family:** Respect for and active collaboration with the child and his or her parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process and in the planning, delivery and evaluation of home-based services. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and the services they believe are required to meet these goals.
- **Functional outcomes:** In-home support services are designed and implemented to aid children to achieve success in school, to remain with their families, to avoid delinquency, and to become stable and productive adults. Implementation of the individual treatment plan stabilizes the child's condition and minimizes safety risks.
- **Collaboration with others:** A comprehensive assessment is developed and an individual care plan is collaboratively implemented. The care planning team plans and delivers needed services.
- **Best practices:** Home-based services are provided by competent individuals who are adequately trained and supervised. Children have access to a comprehensive array of home-based and other behavioral health services, to ensure that they receive medically necessary treatment. Home-based services are continuously evaluated and modified if ineffective in achieving desired outcomes.
- **Most appropriate setting:** Children are provided home-based and other behavioral health services in their home and community to the extent possible, and in the most integrated setting appropriate to the child's needs. The treatment team uses the care plan to minimize multiple placements.
- **Timeliness:** Children identified as needing home-based services are assessed and served promptly.
- **Respect** for the child and family's unique cultural heritage
- **Connection to natural supports:** The care plan identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

HOW IT'S FUNDED

MassHealth now provides health insurance for a large percentage of the Commonwealth's children. Even if a family earns too much money to be income-eligible for MassHealth, a child in that family with a disability may be eligible for MassHealth benefits, including a child with a mental/behavioral health diagnosis. This type of MassHealth coverage, called CommonHealth, is available, regardless of family income, with a sliding fee scale for premiums. Children and youths younger than 21 who are enrolled in either MassHealth Standard or MassHealth CommonHealth may access medically-necessary MassHealth behavioral health services.

State: **WASHINGTON**

WASHINGTON STATE'S WRAPAROUND WITH INTENSIVE SERVICES (WISe)

The State of Washington has implemented a children's mental health system redesign as a result of three significant initiatives:

- SSHB 1088 that required greater emphasis on early identification, intervention, prevention, and access to a range of coordinated, integrated, and flexible services, with a reliance on evidence-based programs and promising practices.
- A federal class action lawsuit, T.R. vs. Dreyfus and Porter that alleged children and youth with serious emotional disturbances in Washington had insufficient access to intensive home- and community-based services through Medicaid.
- ESSHB 2536, enacted in 2012, directed the state to identify and implement prevention and intervention services for children and juveniles in child welfare, juvenile justice, and mental health systems.

HOW SELECT COUNTIES IN WASHINGTON DIVERTED UP TO 90% OF CHILDREN IN CRISIS FROM INPATIENT HOSPITALIZATIONS

Washington State's Wraparound with Intensive Services (WISe) program is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible individuals, up to 21 years of age, with complex behavioral health needs and their families. The implementation of WISe is expected to be rolled out statewide by June 30, 2018.

WISe is a range of Medicaid-funded service components for youth who are experiencing mental health symptoms that disrupt or interfere with their functioning in family, school, or with peers. WISe modules provide services that are:

- Individualized
- Coordinated
- Culturally relevant
- Intensive
- Comprehensive
- Home- and community-based

WISe team members work at times and locations that ensure meaningful participation of family members, youth, and natural supports, including evenings and weekends. WISe also provides access to crisis response 24/7, by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan.

> "Those counties that have implemented the comprehensive community-based model of children's crisis services have reported diversion rates from inpatient hospitalization as high as 90%."

Once authorized by the RSN for WISe, youth and families participating will have access to a wide array of services and supports to address their specifically identified needs. Although the intensive care coordination and services available under WISe are funded by Medicaid, the program's model is intended to draw in other resources through teaming with both formal (e.g., service providers and representatives of schools and child-serving agencies) and informal (e.g., family, friends, and community members) supports and programs that are offered in a variety of settings (home, community, school, etc.).

HOW WISe WORKS

Regional Service Networks (RSNs) have been established to work within their local communities to ensure diverse representation, and establish appropriate communication channels and assist families with system navigation, eligibility questions, and referrals. RSNs also inform and provide oversight for high-level policy-making, program planning, decision-making, and for the implementation of the T.R. Settlement Agreement.

The service array includes intensive care coordination, intensive treatment and support services, and crisis outreach services, provided in home and community settings, based on the individual's needs and the developed plan. Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment.

WISe agencies provide each youth and their family with a Child and Family Team (CFT), and access to these services:

- Intake evaluation
- Intensive care coordination
- Intensive services
- 24/7 crisis intervention and stabilization services

Program implementation focuses on utilizing the Washington State Children's Mental Health Principles and is designed to:

- Reduce the impact of mental health symptoms on youth and families, increase resiliency, and promote recovery
- Keep youth safe, at home, and making progress in school
- Help youth to avoid delinquency
- Monitor and adapt or transition
- Promote youth development by maximizing their potential to grow into healthy and independent adults

WISe provider agencies are required to collaborate and include other child-serving system partners. The agency works with the youth and family and system partners to develop a single Cross System Care Plan (CSCP) for the youth and family. The CSCP will encompass the individual service plan requirements as well as a variety of other activities. Medicaid services must be prescribed clearly, according to Medicaid documentation standards, regardless of whether the individual service plan is incorporated into the CSCP or a separate document.

Child-serving systems, such as agencies that fall under the auspice of the Department of Social and Health Services (DSHS), Health Care Authority (HCA), school personnel, county and community providers, and service providers will be informed to assist in the identification and referral of youth who might benefit from WISe.

While consideration for referral begins with youth who are Medicaid eligible, under age 21, and who have complex behavioral health needs, other indicators to consider for a WISe referral may include, but are not limited to youth:

- With involvement in multiple child-serving systems (e.g., child welfare, mental health, juvenile justice, develop mental disabilities, special education, substance use disorder treatment).
- For whom restrictive services have been requested, such as psychiatric hospitalizations, residential placement, or foster care placement, due to mental/behavioral health challenges.
- At risk of school failure and/or who have experienced significant and repeated disciplinary issues at school due to mental/behavioral health challenges.
- Who have been significantly impacted by childhood or adolescent trauma.
- Prescribed multiple or high dosages of psychotropic medications for mental/behavioral health challenges.
- With a history of detentions, arrests, or other referrals to law enforcement due to behaviors that result from mental/behavioral health challenges.
- Exhibiting risk factors such as suicidal ideation, danger to self or others, and/or behaviors due to mental/behavioral health challenges.
- Whose family requests support in meeting the youth's mental/behavioral health challenges.

Family Partners and Youth Partners with lived experience must be meaningfully involved in the provision of WISe. The Family Partner and/or Youth Partner must be an equal team member with the Care Coordinator and Mental Health Clinician. The Youth Partner and/or Family Partner meet with the youth and/or family on a regular basis to provide support in addressing the needs of the youth and family, as defined in the Cross System Care Plan (CSCP).

> "The absence in California, of sufficient and cost effective crisis services that are home- and community-based, family centered, culturally competent, and focused on building resiliency in individuals and communities, represents a substantial gap in the continuum of care for children and youth with mental health needs."

State: **WISCONSIN**

WRAPAROUND MILWAUKEE MOBILE URGENT TREATMENT TEAM

Staffed by a team consisting of psychologists, social workers, nurses, case managers and a consulting physician, the Mobile Urgent Treatment Team provides crisis intervention services on a 24-hour basis to families enrolled in the Wraparound Milwaukee Program. In addition, this team provides services to any family in Milwaukee County with a child who is having a mental health crisis when the behavior of the child threatens his or her removal from home, school, etc.

The Mobile Urgent Treatment team goes to where the crisis is occurring, assesses the situation, and determines if the child's behavior or mental health condition can be met with interventions in the home or whether temporary placement in a crisis group home or other emergency setting is required. The team also assesses whether the child's behavior constitutes a danger to that child or others requiring possible psychiatric inpatient hospitalization.

In addition to crisis intervention services, the team can provide short-term case management and can link the child and family to other community services. The team oversees the operation of an eight-bed crisis/respite group home, which can serve as an alternative to inpatient hospitalization or resource for the child to transition from the inpatient facility.[32]

> "Wraparound Milwaukee was able to reduce total child population use of psychiatric hospitalization from an average of 5,000 to less than 200 days annually and reduced its average daily residential treatment facility population from 375 to 50."

State: **CONNECTICUT**

THE STATE OF CONNECTICUT CONTINUES TO EXPAND ITS NETWORK OF EMERGENCY MOBILE PSYCHIATRIC SERVICES (EMPS).

EMPS is a crisis intervention program with a statewide network of about 150 mobile mental health professionals who assist children up to age 18 with behavioral or mental health emergencies. When a call is placed to 2-1-1 from any Connecticut town, clinicians respond within 45 minutes, by telephone or at a face-to-face crisis assessment and intervention at home, at school or in the community. They can remain involved for up to 45 days, creating care plans, coordinating services and following up.

Connecticut is also exploring a number of initiatives to build out a more robust crisis services continuum of care. These efforts include:

- Encouraging psychiatric residential treatment facilities to open more beds by increasing the amount Medicaid pays for this care from $366 per day to $465.
- Freeing up additional beds for use in crisis stabilization or respite care.
- Dispatching emergency mobile psychiatric services to emergency rooms to help link children and families with long-term, appropriate treatment and respond to crisis.
- Expanding emergency mobile psychiatric services to respond to the home and creating community-based behavioral assessment centers that could serve as alternatives to emergency rooms.[33]

“When a call is placed to 2-1-1 from any Connecticut town, clinicians respond within 45 minutes, by telephone or at a face-to-face crisis assessment and intervention at home, at school or in the community.”

State: **CALIFORNIA**

CALIFORNIA MODEL CRISIS SERVICE PROGRAMS

Several communities in California have implemented effective components of a crisis services continuum of care. Several of these service components are highlighted below:

The Safe Alternatives for Treating Youth (SAFTY), Santa Barbara

The SAFTY team is a children's mobile crisis response service available to all Santa Barbara county children and youth age 20 and under who are experiencing a psychiatric emergency.

Through a contract beginning in 2005 with Alcohol, Drug and Mental Health Services (ADMHS) of Santa Barbara County and in collaboration with Crisis And Recovery Emergency Services (CARES) adult mobile crisis team, the Casa Pacifica SAFTY team provides crisis interventions 24/7/365.

Crisis situations are handled by phone and in-person. The program design includes an in person response within 60 minutes, when clinically indicated. However, limited resources coupled with the travel distance from one end of the county to the other, often results in a less than optimal response time. This is an ongoing struggle for the program. SAFTY crisis response services are provided irrespective of insurance or ability to pay.

SAFTY's goal is to prevent psychiatric hospitalization, detention in juvenile detention facilities, or placement in out-of-county facilities and to provide linkage to appropriate mental health services. SAFTY program is designed to help preserve families and strengthen communities. SAFTY services are for any youth age 20 or under in Santa Barbara County that is engaging in behaviors that put him/her at risk of hospitalization or out-of-home placement.

SAFTY services may be provided over the phone through the crisis hotline which was designed to provide immediate telephone support, assessment, and, when warranted, an in-person response. SAFTY also provides emergency mental health assessments, including 5150/5585 assessment and authorization. These services are often hampered due to limited resources to meet an increasing demand as evidenced by increase in call volume. Supportive efforts are also provided, when resources permit, through targeted case management, collateral, evaluation and plan development to provide linkage to community services.

For MediCal recipients, SAFTY has the ability to provide proactive in-home cognitive-behavioral therapy to address the at-risk behaviors. SAFTY proactive therapy services utilizes a time-limited in-home treatment that targets crisis reduction, which includes one assessment with treatment plan and 8-16 therapy sessions.

EMQ Families First Continuum of Crisis Services, Santa Clara

EMQFF in Santa Clara County is structured to provide a variety of services to children and families experiencing a mental health crisis. The continuum is comprised of three component programs:

1. The Child Adolescent Crisis Program (Mobile Crisis)
2. The Crisis Stabilization Unit
3. Community Transition Services

The goal of these programs is to support children/adolescents in the least restrictive and most normative environment appropriate to their needs. All of the crisis services attempt to divert from hospitalization as situations warrant. Interventions maximize the natural supports that exist in the family and community. When more restrictive treatment is needed, transition to a more secure setting is facilitated with appropriate attention to child safety and needs.

The EMQFF Crisis Continuum Program provides community-based and onsite, rapid-response crisis assessment and intervention to children and families who are depressed, suicidal, a potential danger to themselves, others or are in some other form of acute psychological crisis.

Children and families are viewed as living within many interrelated systems, including extended families, schools and communities, as well as professional external resources. Opportunities to involve and draw support from these systems are incorporated throughout the services provided by each component of the program.

Seneca Family of Agencies – Statewide

Since its inception in 1985, Seneca has provided care and support to thousands of children struggling with learning disabilities and life circumstances that interfered with their capacity to succeed. Seneca currently partners with families, school districts, and counties throughout California to provide the critical supports and services that children and families need to succeed in their homes, communities, and schools.

Willow Rock Center

Seneca's Crisis Stabilization Unit (CSU) is the front-end of the continuum of care providing each youth with multi-disciplinary risk assessment to determine the appropriate level of care. The CSU provides mental health interventions necessary to divert from hospitalization adolescents who may be safely discharged to the community. Youth who require inpatient psychiatric services are transferred to the inpatient facility when needed.

The Crisis Stabilization Unit staff and inpatient staff provide a safe and nurturing environment as they assist youth in regaining the stability necessary to safely return home or to a community-based placement. Youth being discharged from the CSU or Telecare inpatient psychiatric program may receive short-term outpatient mental health services until they are linked to community-based mental health services.

Mobile Response Teams (MRTs) support families in serious distress with immediate crisis intervention and mental health services. The teams travel to wherever the youth and family may be in the community, in order to provide effective intervention at the height of the crisis. MRT services can occur in family homes, schools, hospitals, or other community and residential settings. Therapeutic interventions by the teams are primarily centered on assessing the immediate safety needs of the family, stabilizing the youth in crisis, and providing assistance and support to the caregivers. Follow-up linkage services are provided in order to ensure youth and family connections with longer-term mental health services, if needed.

The skills, Transitions, Exploration and Progress (STEP) Program is a partnership between Kaiser Permanente and Seneca Family of Agencies to provide Partial Hospitalization program services to Kaiser insured youth, ages 12 to 17. The goal of the STEP program is to provide the intensive, short-term and stabilization services needed to enable their clients to step down to lower levels of outpatient mental health treatment. STEP provides structured and individualized treatment interventions including assessment, group therapy, family therapy, psycho-education, and medication management. (Seneca 2015)

Edgewood Center for Children and Families – Bay Area

Edgewood Center for Children and Families serves thousands of children and families throughout San Francisco and San Mateo counties who have experienced traumatic stress leading to mental illness and debilitating behavioral issues. Edgewood provides a full continuum of behavioral health services focused on mental health, family relationships, and life skills. Interventions include community-based treatment, day and after school programs, residential treatment, and crisis stabilization.

Casa Pacifica Centers for Children and Families – Ventura

Case Pacifica provides the Children's Intensive Response Team (CIRT), a mobile crisis response service, available to all Ventura County children and youth under the age of 18. Since March 2007, CIRT has been available 24/7/365. Under contract with Ventura County Behavioral Health (VCBH), CIRT delivers quick and accessible service to families by providing specialized crisis intervention and in-home support and linkage to county mental health services or other appropriate assistance. By working in collaboration with the child's existing service providers, CIRT seeks to keep kids and families safe in their homes and communities and avoid psychiatric hospitalization and use of other public resources, such as law enforcement.

Services may be provided over the phone as the initial emergency call is taken (e.g., de-escalation and linkage) or in person (e.g., emergency mental health assessments for inpatient psychiatric hospitalization, follow up safety planning and safety monitoring, and/or collaborative introduction meetings). CIRT services can last up to 14 days and all open cases receive linkage and referrals based on a family's need.

CIRT is available to respond to a crisis in person usually within 60 minutes. Emergency services are provided irrespective of insurance availability or ability to pay. Post-crisis, follow up services for up to 14 days are available to individuals with Medi-Cal and the uninsured. If necessary, CIRT has the authority to facilitate an involuntary psychiatric hospitalization for a child or youth for up to 72 hours.

California Legislative and Policy Efforts

As documented below, California is beginning to recognize the **critical** need to provide additional services, and restructure current services to help children and youth **struggling with mental health crises.**

Assembly Bill 1018 introduced by California Assembly Members Cooper and Dodd would require the State Department of Health Care Services and the Department of Education to convene a joint task force to examine the delivery of mental health services to children eligible for EPSDT services and for services pursuant to the federal Individuals with Disabilities Education Act, and to consider specified subjects. The bill would require the task force to hold at least two public meetings by October 1, 2016, and to submit a report to the Legislature covering key findings and recommendations for further action, if any.

Senate Bill 11 authored by Senator Beall and signed by the governor on October 3, 2015 requires additional training to better prepare law enforcement officers to recognize, de-escalate, and appropriately respond to persons with mental illness, intellectual disability, or substance use disorders. The bill requires that this training be at least 15 hours, address issues relating to stigma, be culturally relevant and appropriate, include training scenarios and facilitated learning activities, and be included in the current hour requirement of the regular basic course. This additional training must be implemented by August 1, 2016.

Assembly Bill 741 introduced by California Assembly Member Williams in 2015 and co-sponsored by the California Alliance of Child and Family Services to modify the existing definition of "social rehabilitation facility" to include services for children and adolescents, in addition to adults. The overarching goal of existing programs is to keep youth experiencing a mental health crisis in calm, familiar environments where their mental health needs can be met.

Assembly Bill 1299 introduced by California Assembly Member Ridley-Thomas in 2015 would declare the intent of the Legislature to ensure that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements.

Assembly Bill 1644 introduced by California Assembly Member Bonta in 2016 would require the State Public Health Officer, in consultation with the Superintendent of Public Schools and the Director of Health Care Services, to establish a four-year pilot program, the School-Based Early Mental Health Intervention and Prevention Services Support Program, to provide outreach, free regional training, and technical assistance for local educational agencies in providing mental health services at school sites.

Senate Bill 260 introduced by California State Senator Monning in 2015 would repeal the exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) for county organized health systems providing services under the Medi-Cal program.

Assembly Bill 2743 introduced by California State Assembly Member Eggman in 2016 would, beginning July 1, 2017, require the State Department of Public Health to establish and administer an Internet website-based registry, known as the acute psychiatric bed registry, to collect, aggregate, and display information regarding the availability of acute psychiatric beds in health facilities to facilitate the identification and designation of health facilities for the temporary detention and treatment of individuals who meet specified criteria for temporary detention. The bill would require a health facility to, on or before July 1, 2017, designate an employee to submit to the registry notification that an acute psychiatric bed has become available at the health facility and to serve as the contact person to respond to requests for information related to data reported to the registry, as provided.

Senate Bill 1273 introduced by California State Senator Moorlach would clarify that the counties may use Mental Health Services Fund moneys to provide crisis stabilization services, including temporary commitment.

Senate Bill 1291 introduced by California State Senator Beall would require each mental health plan, annually on or before July 1 of each year, to submit a foster care mental health service plan to the department detailing the service array, from prevention to crisis services, available to Medi-Cal eligible children and youth under the jurisdiction of the juvenile court and their families.

> “Procuring mental health access for our youth is a smart investment for our State. California should lead the dissemination of effective, integrated and comprehensive mental health services for our Nation's children.”
>
> – ***Dr. Victor Carrio,*** *MHSOAC Chair, Professor at the Stanford University School of Medicine, and the Director of Stanford's Early Life Stress Research Program.*

Crisis Services Legislation Enacted in Other States

Throughout the United States there has been major progress in shifting the way crises are handled for children and youth. Through a number of bills and initiatives, these states have taken the first step in providing a reasonable continuum of care for children and youth in crisis. For example:

HB 1693 **Virginia** permitted a magistrate to authorize alternative transportation for an individual subject to an emergency custody order or temporary detention order.

SF 1458 **Minnesota** budgeted $8 million to create a statewide crisis line, establish a statewide pool of experts, expand mobile crisis services, develop state standards, and fund crisis beds. The provision also requires private health plans to cover mental health crisis services under the emergency services category. The legislation also funds "protected transport" providing for Medicaid reimbursement of transportation to civil commitment in an unmarked car, rather than a law enforcement vehicle or ambulance.

HB 2118**, Virginia** strengthened the state's inpatient psychiatric bed tracking system. It requires all public and private inpatient and crisis stabilization facilities to report on bed availability at least once daily.

HB 367 **Maryland** requires the state crisis response system to evaluate service outcomes on an annual basis. Reported data must include: behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations, hospital diversions, arrests, detentions, and diversion of arrests and detentions of individuals with behavioral health diagnoses.

HB 79 **Florida** directs the Department of Children and Families to develop, implement, and maintain a data system whereby behavioral health managing entities collect utilization data from psychiatric public receiving facilities (crisis stabilization units where emergency mental health care is provided).

SB 175 **Utah** established a statewide school crisis line for youth.

HB 1721 **Washington** amends duties of regional emergency medical services and trauma care councils to identify procedures to allow for the appropriate transport of patients to mental health facilities or chemical dependency programs, as informed by the alternative facility guidelines. Specifically, the bill allows an ambulance service to transport patients to non-medical facilities and instructs the authority to develop a reimbursement methodology for ambulance services when transporting a person to a mental health facility or chemical dependency program.

How to Fund Crisis Services for Children and Youth

The need for mental health services, particularly when it comes to children and families in crisis, will likely always exceed the system's capacity. However, California is in the fortunate position of having access to billions of dollars of federal, state, and local resources available to address behavioral health challenges and support individuals and their families' ability to live full lives in the community. California already invests substantial financial resources toward crisis services for children and youth. Unfortunately, the bulk of those funds are spent on inpatient hospitalization and these costs are expected to continue to rise in the coming years.

The challenge for federal, state and local policy makers and service providers is to ensure that funding is provided in areas that target the greatest need. Based on national estimates, a single hospitalization for a child for a mental health related condition typically costs more than $15,000.[34] Extended stays in emergency rooms while waiting to locate an age appropriate psychiatric bed combined with eventual transportation by ambulance, at times hundreds of miles away from their home county can increase this cost by thousands of dollars. Communities that have invested heavily in multi-disciplinary treatment teams and intensive home-based services combined with a robust mobile crisis response capacity, have experienced substantial reductions in hospitalization rates and associated cost offsets of up to 75%.

Within the publicly-funded behavioral health system, covered services include:

- Intensive in-home services
- Wraparound facilitation or treatment planning
- Intensive care management
- Mobile crisis response and stabilization
- Therapeutic foster care
- Substance use treatment
- Respite care
- Family peer support
- Family training
- Therapeutic mentoring
- Behavioral assistance
- And transportation

COMMUNITY MENTAL HEALTH SERVICES AND SUPPORTS

State and Federal Funding Available for FY 2015/16: $6.2 Billion

Funding Provided by MHSA: $1.3 Billion

County mental health programs are required to offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Funding must be sufficient to ensure that counties can provide each child served all of the necessary services identified in their individual treatment plans including services where appropriate and necessary to prevent an out of home placement.[35]

Each county is required to have in place, all of the following:

- A comprehensive, interagency system of care that serves the target population.
- A method to screen and identify children in the target population. County mental health staff shall consult with the representatives from special education, social services, and juvenile justice agencies, the mental health advisory board, family advocacy groups, and others as necessary to help identify all of the persons in the target populations, including persons from ethnic minority cultures which may require outreach for identification.
- A defined mental health case management system designed to facilitate the outcome goals for children in the target population.
- A defined range of mental health services and program standards that involve interagency collaboration and ensure appropriate service delivery in the least restrictive environment with community-based alternatives to out-of-home placement.
- A defined mechanism to ensure that services are culturally competent, child-centered, and family-focused, with parent participation in planning and delivery of services.
- A method to show measurable improvement in individual and family functional status for children enrolled in the system of care.
- A method to measure and report cost avoidance and client outcomes for the target population which includes, but is not limited to, state hospital utilization, group home utilization, nonpublic school residential placement, school attendance and performance, and recidivism in the juvenile justice system.
- A plan to ensure that system of care services are planned to complement and coordinate with services provided under the federal early and periodic screening, diagnosis, and treatment services, including foster children.
- A defined partnership between the children's system of care program and family members of children who have been or are currently being served in the county mental health system. This partnership shall include family member involvement in ongoing discussions and decisions regarding policy development, program administration, service development, and service delivery.

Total state funding for community-based mental health services for fiscal year 2015/16 is projected to be more than $6 billion. MHSA funds are projected to make up approximately $1.3 billion of this amount and the majority of these funds are designated to support both the child and adult system of care through the community services and supports (CSS). County mental health plans have broad discretion in how these funds are distributed between children and adult systems of care as well as across program priorities within each system. Individual county allocation of MHSA and realigned state funding is established through a local planning process and eventual approval by the County Board of Supervisors.

MENTAL HEALTH SERVICES ACT, PREVENTION, AND EARLY INTERVENTION

Funding Available FY 2015/16: $300 million (approximate)

Twenty percent of the funds from MHSA distributed to county mental health plans are designated to support Prevention and Early Intervention (PEI) programs as a key strategy to "prevent mental illness from becoming severe and disabling" and improve "timely access for underserved populations." PEI programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness including: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

This commitment of MHSA funds was intended to move the mental health system towards a "help first" instead of a "fail first" strategy. PEI identifies individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources. PEI funds are intended to create partnerships with schools, justice systems, primary care, and a wide range of social services and community groups and locates services in convenient places where people go for other routine activities. The MHSA specifies that all funded PEI programs must include:

- Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illness.
- Access and linkage to medically necessary care, as early in the onset of these conditions as practicable.
- Reduction in stigma and discrimination associated with either being diagnosed with a mental illness or seeking mental health services and reduction in discrimination against people with mental illness.

MENTAL HEALTH SERVICES ACT, INNOVATION

Funding Available FY 2015/16: $60 million (approximate)

California Welfare and Institutions Code (WIC) Section 5830 provides for the use of MHSA funds for Innovative Programs and requires 5% of the Community Services and Supports and Prevention and Early Intervention MHSA funding be devoted to Innovative Programs. Innovation projects approved by the MHSOAC and funded through the MHSA account are designed to be novel, creative and/or ingenious mental health practices/ approaches that contribute to learning and developed within communities through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served individuals. An Innovation project is defined as one that contributes to learning rather than a primary focus on providing a service. By providing the opportunity to 'try out' new approaches that can inform current and future mental health practices/approaches in communities, an Innovation contributes to learning in one or more of the following three ways:

- Introduces new mental health practices/approaches including prevention and early intervention that have never been done before; or
- Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community; or
- Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.

Innovation projects are similar to pilot or demonstration projects and are subject to county-defined time limitations within which to assess and evaluate their efficacy. Through this approach, the MHSA's Innovation component provides California the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices.

MHSA-FUNDED INNOVATION PROJECTS

More than $60 million in innovation funds are potentially available to county mental health plans each year. Table (C) below provides a brief summary of prior innovation awards for county-level programs specifically focused on crisis services for children and/or youth:

TABLE C: MHSA-Funded Innovation Projects

COUNTY	PROGRAM DESCRIPTION	FUNDING AWARDED	PROJECT PERIOD	POPULATION SERVED
BUTTE	The Working Innovations Network (WIN) provides services for adults, youth and their families experiencing a mental health crisis that has resulted in psychiatric hospitalization. WIN guides individuals and families in how to connect with outpatient care and community resources, facilitating a resumption of daily life activities while preventing re-hospitalization.	$2,215,743	July 2010–April 2013	Adults, Youth & Their Families
MADERA	This project employed an integrated team of transition age youth (TAY) and adult/family support specialists to engage clients (and families) at initiation of mental health crisis services at the hospital's emergency department.	$347,803	July 2010–June 2013	TAY
ORANGE	The aim of Collective Solutions is to educate families about mental illness, reduce future crisis situations, and assist families in learning, as soon as possible, about the support services and resources that are available to families who have a loved one with a mental illness. In addition, Collective Solutions assists the whole family to develop a plan of action that will serve as a tool in managing crisis situations or supporting their loved one, including safety planning, communication building, de-escalation techniques, and boundary setting.	$586,121	April 2012–March 2016	Children & Families
SAN BERNARDINO	The hostel project is a short-term, 14-bed, crisis residential program for the TAY population who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but a lower level of care than psychiatric hospitalization.	$7,880,817	April 2011–March 2017	TAY

Local Mental Health Funding

In addition to local general funds, the bulk of local mental health services funding comes from state and federal sources. For fiscal year 15/16, county mental health plans are projected to receive nearly $1.9 billion in federal financial participation (FFP) dollars and $2.6 billion in state realignment funding. Additionally, counties are projected to receive more than $1.3 billion in MHSA funding for fiscal year 15/16.[37] County mental health plans generally have broad authority in how these funds are used to meet the individual and system level needs of diverse populations struggling with serious mental illness within their jurisdictions.

LOCAL EDUCATIONAL AGENCIES (SCHOOLS)

Funding Available FY 2015/16: **$420,000,000**

Funding Provided by: **Prop. 63 and Prop. 98**

Federal law requires local educational agencies (LEAs), which in California consist of school districts and some county offices of education and charter schools, to evaluate children in all areas of suspected disability to determine their eligibility for special education and related services. For eligible students, LEAs must develop an individualized education program (IEP). It must describe, among other things, the effects of the student's disability on educational performance, the educational goals for the student, and the special education and related services the student will receive to assist in his or her educational progress.

As the state's educational agency, the State Board of Education, through the California Department of Education oversees the special education program and is responsible for ensuring that LEAs comply with Federal law. As part of its responsibilities, the Department of Education distributes federal and state funds to special education local plan areas (SELPAs), which are made up of individual LEAs or consortia of LEAs and are created by state law to provide special education and related services.

In 2011, Assembly Bill 114 shifted the responsibility to provide mental health services to students with disabilities from county mental health agencies to LEAs. The transfer of responsibility for student mental health services to LEAs included distribution of more than $420 million dollars from both Proposition 63 and Proposition 98 funding sources.[37]

INVESTMENT IN MENTAL HEALTH WELLNESS ACT-2013 (CALIFORNIA SENATE BILL 82)

Funding Available FY 2015/16: **$82,000,000**

Funding Provided by: **CHFFA and MHSOAC Grant Funds**

In recognition of the challenges faced by many communities to effectively serve individuals in crisis, the State Legislature recently passed the Investment in Mental Health Wellness Act of 2013.[4] The Act established a competitive grant program to disburse funds to California counties or to their nonprofit or public agency designees for the purpose of developing mental health crisis support programs. Specifically, funds are intended to "increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams." Unfortunately, only a handfull of counties applied for and received funds to support increased services specifically for children and youth in crisis.

Grants administered by the California Health Facilities Financing Authority (CHFFA) are intended to support capital improvement, expansion and limited start-up costs. Grants currently administered by the MHSOAC are intended to expand the number of mental health personnel available to provide crisis support services that include triage, targeted case management and linkage to services for individuals with mental illness who require a crisis intervention. Examples of grant funded programs specifically intended to meet the needs of children and/or adolescents in crisis are outlined in the appendix.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES AGENCY

Funding Available FY 2015/16: **$57 Million**

Funding Provided by: **SAMHSA Mental Health Block Grants**

The federal Substance Abuse and Mental Health Services Agency (SAMHSA) provides approximately $57 million per year to California state and counties though the Mental Health Block Grants. SAMHSA in collaboration with the National Institute of Mental Health are currently working with states to allocate 5% of the Mental Health Block Grant (MHBG) to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.

At the end of 2015, SAMHSA also awarded California nearly $1 million in planning grants to support the implementation of Certified Community Behavioral Health Clinics (CCBHC) which have the potential to play an important role in the community-based continuum of services for both children and adults.

Private Managed Health Care Plans: Cover Or Be Liable

Medi-Cal, private insurance, child welfare, MHSA, mental health general revenue, public education, and federal/state grant funding are all potential revenue sources for strengthening the continuum of crisis services for children and youth in California. Unfortunately, as noted by several counties, community-based providers and consumers throughout this project, each of these funding streams come with specific, and at times, conflicting eligibility criteria which create substantial obstacles to creating a seamless system of care driven by the needs of the child and family.

> “Federal law requires each state to offer certain mandatory services as part of the Medicaid program. Even though crisis residential treatment services are considered considered covered specialty mental health services, California currently lacks a crisis residential licensing category for individuals under age 18.”

FEDERAL LAW

Medi-Cal/EPSDT

Federal law requires each state to offer certain mandatory services as part of the Medicaid program. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) rules require California to screen all Medicaid eligible youth under age 21 for health conditions including mental health disorders and provide medically necessary diagnosis and treatment services to address those needs. For children and families enrolled in Medi-Cal (California's version of Medicaid) the following crisis and inpatient health services are included in the state plan as eligible specialty mental health services:

- Crisis intervention
- Psychiatric health facility services
- Crisis stabilization
- And psychiatric inpatient hospital services

Crisis residential treatment services are also considered covered specialty mental health services, however California currently lacks a crisis residential licensing category for individuals under age 18.

Private managed health care plans also play a critical role in funding appropriate community-based crisis services. Approximately 1/3 of children requiring crisis mental health services are covered by private insurance plans. Much like publicly funded mental health services, private health care plans are also required by law to provide medically necessary care for behavioral health needs including intensive mental health outpatient services.

In 1999, the U.S. Supreme Court concluded in Olmstead v. L.C. that unnecessary institutional segregation constitutes discrimination per se, which cannot be justified by a lack of funding The Mental Health Parity and Addiction Equity Act of 2008 states that if a plan or issuer treats home health care as an outpatient benefit, than any covered intensive outpatient mental health services and partial hospitalization must also be considered outpatient benefits.[38]

In California, the Department of Managed Health Care (DMHC) plays central roles in ensuring patients receive the medical care and services to which they are entitled. The DMHC Division of Complaint Management and Clinical Review ensures that consumers receive an independent medical review when dissatisfied with a healthcare service plan's decision concerning:

- Services denied due to a plan's finding that the requested care is investigational or experimental;
- Denied, delayed or modified healthcare services following a plan's finding that the service is not medically necessary; or
- Denials of enrollee reimbursement claims for out-of-plan medical services obtained for urgent or emergency care. Clinical personnel are available to provide the necessary knowledge and guidance to ensure that the best interests of the consumer are served.

Comprehensive data is not currently available on the number of children and families with private payer health insurance served by the publicly-funded mental health crisis system. However, anecdotal data collected during site visits and through the advisory workgroup estimated that up to one-third of those helped via publicly funded mobile crisis services have private insurance. Additionally, providers of mobile crisis services are rarely reimbursed for these services. Examples of health plan decisions not to reimburse for mental health crisis related children's services that were subsequently overturned by the Independent Medical Review (IMR) are included in the tables on the following pages.

EXAMPLE 1:

Reference ID	Type	Determination
MN 16-22086	Medical Necessity	Overturned Decision of Health Plan

Age Range/Gender	Diagnosis Category/Subcategory	Treatment Category/Subcategory
11–20 / Male	Mental / Other	Mental Health Treatment / Residential Treatment Center – Admission

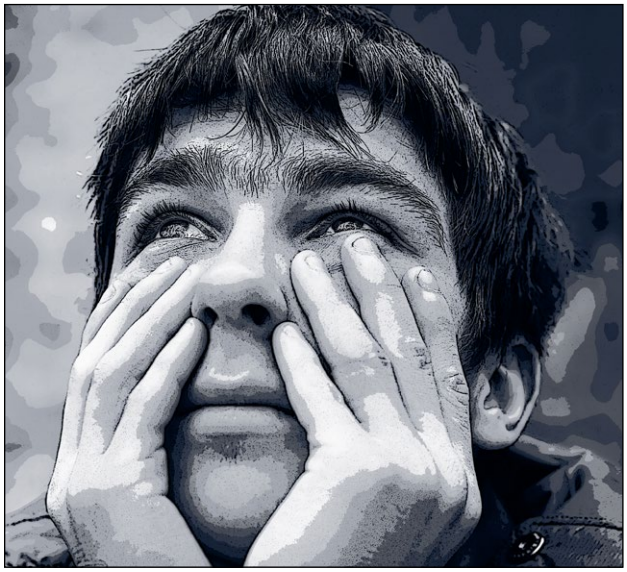
Nature of Statutory Criteria/Case Summary: The parent of an enrollee has requested residential treatment center services for treatment of the enrollee's behavioral health condition.

FINDINGS

The physician reviewers found that the residential treatment center services provided were and are medically necessary for treatment of the patient's medical condition. The patient appears to be very fragile. The patient's main stressor is dealing with peers in the school setting. The patient has had very little experience outside the residential treatment center level of care to gauge his reactions to the normal stressors of his home environment. As confirmed, by details provided by the patient's parent, he is not yet ready for discharge to a lower level of care. The patient is not equipped to handle these stressors and would likely decompensate when expected to do so. Discharge at this time would likely require re-admittance to an acute care facility, thus undoing the gains the patient has made so far. This patient needs to continue in the residential treatment program in order to solidify his gains and slowly transition back home without fear of regression and relapse. Given the above, the services at issue were and are medically necessary for treatment of the patient's medical condition.

FINAL RESULT

The reviewers determined that the services at issue were and are medically necessary for treatment of the patient's medical condition. Therefore, the Health Plan's denial should be overturned. Credentials/Qualifications: The physician reviewer is board certified in psychiatry with sub-specialty certification in child and adolescent psychiatry and is actively practicing. The reviewer is an expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating those with the same or a similar medical condition.



EXAMPLE 2:

Reference ID	Type	Determination
MN16-21881	Medical Necessity	Overturned Decision of Health Plan

Age Range/Gender	Diagnosis Category/Subcategory	Treatment Category/Subcategory
0–10 / Male	Mental / Anxiety	Mental Health Treatment / Other

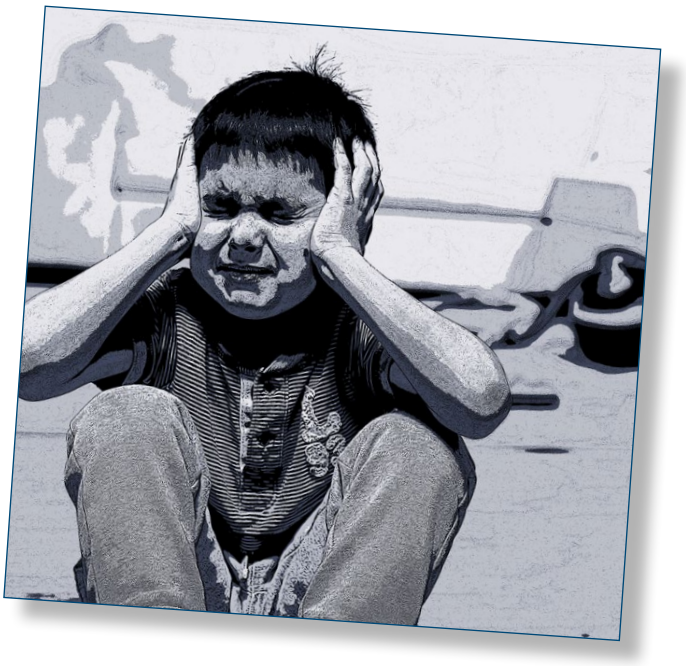
Nature of Statutory Criteria/Case Summary: The parent of an enrollee has requested psychiatric intensive outpatient program services for treatment of the enrollee's behavioral health condition.

FINDINGS

The physician reviewer found that according to the documentation submitted for review, the patient continues to exhibit agitation and head banging behaviors. In addition, the patient's medications are being actively adjusted. The patient has been responding positively overall to interventions, however these will likely need to be skills that are taught to the family to carry forward as the patient transitions to a lower level of care. The study by Vismara and colleagues provided a 12-week, 1 hour per week, individualized parent-child education program to toddlers newly diagnosed with autism. "Parents learned to implement naturalistic therapeutic techniques from the Early Start Denver Model, which fuses developmental- and relationship-based approaches with Applied Behavior Analysis into their ongoing family routines and parent-child play activities. Results demonstrated that parents acquired the strategies by the fifth to sixth hour and children demonstrated sustained change and growth in social communication behaviors." Thus, there is support demonstrating that parents of autistic children who have been taught behavioral intervention skills results in lasting behavioral improvements in autistic children. Thus, continued psychiatric intensive outpatient program services are indicated. The time allows for the patient to transition to a lower level of care as he spends more time with family on a daily basis and the utilization of ABA skills at home with the patient.

FINAL RESULT

The reviewers determined that a portion of the services at issue were and are medically necessary for treatment of the patient's medical condition. Therefore, the Health Plan's denial should be partially overturned. Credentials/ Qualifications: The physician reviewer is board certified in psychiatry with sub-specialty certification in child and adolescent psychiatry and is actively practicing. The reviewer is an expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating those with the same or a similar medical condition.



EXAMPLE 3:

Reference ID	Type	Determination
MN15-21183	Medical Necessity	Overturned Decision of Health Plan

Age Range/Gender	Diagnosis Category/Subcategory	Treatment Category/Subcategory
11–20 / Female	Mental / Eating Disorder	Mental Health Treatment / Other

Nature of Statutory Criteria/Case Summary: An enrollee has requested partial hospitalization program level of care services and intensive outpatient services for treatment of her behavioral health conditions.

FINDINGS

The physician reviewer found that modern psychiatric practice aims to place patients in the least restrictive treatment setting. In general and if feasible, community intervention settings offer optimization of treatment gains. However, transient placement in more restrictive settings is often clinically appropriate. In this case, the patient was extraordinarily ill upon presentation. In the absence of an intensive course of treatment, a poor outcome was expected. Additionally, from the community standard perspective, it is common to utilize partial hospital and intensive outpatient programs in step-wise fashion upon discharge from acute hospitalizations, and treatment stays under these circumstances most often exceed 72-hours. Based on the physician and therapy notes, this patient was engaged in active treatment but had not consolidated the therapeutic treatment gains necessary to succeed in a less restrictive setting. The disputed services were at least in part for purposes of diagnostic assessment and shaping of future clinical interventions. The patient did not possess the clinical stability or harmonized support network to succeed in the outpatient setting. The services in dispute were reasonably expected to improve her condition and prevent a more serious episode of illness. Thus, partial hospitalization program level of care services and intensive outpatient services from were medically indicated for the treatment of this patient.

FINAL RESULT

The reviewer determined that the services at issue were medically necessary for treatment of the patient's medical condition. Therefore, the Health Plan's denial should be overturned. Credentials/Qualifications: The reviewer is board certified in psychiatry and is actively practicing. The reviewer is an expert in the treatment of the enrollee's medical condition and knowledgeable about the proposed treatment through recent or current actual clinical experience treating those with the same or a similar medical condition.

EXAMPLE 4:

Reference ID	Type	Determination
MN15-19599	Medical Necessity	Overturned Decision of Health Plan

Age Range/Gender	Diagnosis Category/Subcategory	Treatment Category/Subcategory
11–20 / Female	Mental / Eating Disorder	Mental Health Treatment / Other

FINDINGS

The parent of a female enrollee requested eating disorder intensive outpatient programming (IOP) treatment for medical treatment of the enrollee's behavioral health condition.

FINAL RESULT

The physician reviewer found that the services at issue were medically necessary for treatment of the patient's medical condition. According to the American Psychiatric Association (APA) practice guidelines for patients with eating disorders, IOP is recommended when some degree of external structure beyond self-control is required to prevent the patient from compulsive exercising. According to the medical records submitted for review, this patient has problems controlling her self-exercise. Summary, the recommendations by her treatment team who have direct knowledge of this patient and her needs are reasonable, appropriate and medically necessary. Thus, based upon the documentation provided, the medical necessity of IOP treatment has been established.

For more information see Appendix G.

Project Findings and Recommendations

A central 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 children, youth, teens 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 increase or decrease the intensity of interventions, across a range of home, community and residential services in response to the needs of children and their unique context.

Crisis service providers must have:

- Expertise and experience working with youth and family members during a crisis
- The capacity to respond rapidly to a variety of community settings 24/7
- The ability to remain with the child and family until the crisis is resolved or a determination is made that a higher level of intervention is required

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.

Although 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, 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 and results in unnecessary delays in mandated and sometimes lifesaving services for youth in crisis.

The project findings and recommended actions outlined below 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.

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.

> "The energy and passion by those at the table who formulated these recommendations, including children, adolescents and their families, will go a long way in ensuring that these recommendations are fully implemented."
> *– **John Boyd**, MHSOAC Commissioner, Sub Committee Chair, Children's Crisis Services Project*

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.

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. Identifying funds to support expanding the existing SB-82 Triage Personnel Grants to include programs and services tailored for children and adolescents experiencing, or at risk of experiencing a mental health crisis.

   vi. Accessing available MHSA 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 populate, 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.

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 access 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.

> "An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences."

Appendix

Appendix A: Children's Crisis Services Project Panel Members Bios

September 24, 2015 Commission Meeting

Marika Collins is the Special Projects & Public Policy Officer for Casa Pacifica Centers for Children and Families, where she works to identify opportunities to enhance current programs or expand the array of services to the children and families they serve in Ventura and Santa Barbara Counties. She has a Masters in Social Work degree with a concentration in Community Organizing, Policy, Planning and Administration from Boston College.

Matthew Gallagher is the policy chair for California Youth Empowerment Network (CAYEN).

Beth Peterson is a family member with lived experience.

Susanna is a family member with lived experience.

Lorraine Hanks is a family member with lived experience.

Shanay Anderson is a family member with lived experience.

Joshua works at the San Francisco LGBT Center and is a transition age youth with lived experience with crisis services.

Patrick Gardner founded Young Minds Advocacy Project in 2012 in order to improve legal advocacy efforts and system outcomes for young people seeking access to quality mental health care. A public interest lawyer for nearly 30 years, Patrick specializes in children's mental health law and policy, and their impacts on youths involved with child welfare, juvenile justice, special education, and mental health systems. A University of Virginia Law graduate, he serves as co-counsel in statewide class actions strengthening children's rights to mental health care, and works with legislative bodies and administrative agencies to improve access to individualized, high quality treatment.

Melinda Bird is statewide Litigation Counsel for Disability Rights California. She specializes in children's mental health issues and jail and prison issues involving disability rights. She was lead counsel in the case of Emily Q. v. Bontá, which resulted in the creation of Medi-Cal Therapeutic Behavioral Services (TBS) for children and youth. She was also a member of the team of attorneys that brought the Katie A. case to establish Medi-Cal coverage of In-Home Behavior Services and wraparound services.

Carroll Schroeder has over 30 years in the field of child and family services.He holds a Master's degree in child development from UC Davis and a Bachelor's degree in sociology from Catawba College. After obtaining his Master's degree, he helped establish and grow Families First, where he worked for 18 years and held a variety of program and administrative positions ranging from youth care worker through social worker, program director, director of training, research and program development, and associate executive director.

Brenda Grealish was appointed Assistant Deputy Director for Mental Health and Substance Use Disorder Services in November 2014. She began her state career with the Office of Statewide Health Planning and Development followed by the Department of Mental Health and the Department of Corrections and Rehabilitation including Deputy Director.
Alison Lustbader has worked for the last 27 years with some of the highest-risk youth and families in San Francisco County. She is currently the program manager for San Francisco County Children, Youth and Families Intensive Services, which includes oversight of the MHSA Crisis Triage Grant. Alison has worked as part of the Child Crises Team, doing 5585 assessments since 1988.

Margaret Ledesma is the Children's Crisis Services and Katie A. Program Manager for the Santa Clara County Mental Health Department.

Ken Berrick is the founder and Chief Executive Officer of Seneca Family of Agencies, a nonprofit agency that provides school-based, community-based and residentially-based services for children with serious emotional issues and their families. Mr. Berrick is a Governor's Appointee on the California Child Welfare Council, a two-time former President of the California Alliance of Child and Family Services and serves on the Board of the California Council for Community Mental Health Agencies. He is a Past President of the Alameda County Board of Education and Past President of the California County Boards of Education. He is co-author of the book, Unconditional Care: Relationship-Based, Behavioral Intervention with Vulnerable Children and Families, and his advocacy work on behalf of children, youth and families includes serving on numerous policy planning groups at both the county and state levels.

Alicia Hooton is the Executive Director for crisis services at Seneca Family of Agencies. She has extensive experience directing and providing clinical services in residential, community based and crisis treatment services throughout the Bay Area. As an agency leader in crisis services she has experience in program development and implementation in community crisis support services, mobile crisis response, crisis stabilization and partial hospitalization. She received her Bachelor's Degree in Sociology at Whitworth University, and holds a Master's Degree in Social Work from the University of Southern California.October 22, 2015 Commission Meeting.

Lyn Morris is Senior Vice President of Clinical Operations at Didi Hirsch Mental Health Services, joined the agency in 2000. She earned her Master's degree in Clinical Psychology from Pepperdine University graduating with Summa cum-laud honors. She has been a licensed Marriage and Family Therapist for over 16 years. She began her career at Didi Hirsch as a Program Director for Adult Outpatient Services. She established the California Suicide Prevention Network (CSPN) in collaboration with ten statewide crisis centers to help build local capacity in suicide prevention and encourage widespread adoption of best practice programs, interventions, curricula and protocols. She is also a trained member of the Suicide Response Team (SRT), which provides support and comfort to family or friends at the scene of a suicide.

Dr. David Ketelaar is the Medical Director of Emergency Services at the Marian Regional Medical Center in Santa Maria, California and runs the MCC Emergency Physician Medical Group, Inc. He graduated from the University of California, Los Angeles David Geffen School of Medicine in 1992 and completed his residency in emergency medicine at Los Angeles County Harbor-UCLA Medical Center.

Sarah Adams is the Program Manager for Casa Pacifica's Safe Alternatives for Treating Youth Mobile crisis program, providing programmatic and clinical oversight and supervision for the crisis response team. She graduated with her B.A. in Sociology and Chicano Studies from University of California at Santa Barbara before earning her Masters in Social Work from the University of Southern California School of Social Work.

Assembly Member Das Williams was elected to the Assembly in November 2010 and represents over half of the County of Santa Barbara, as well as nearly a quarter of the County of Ventura. Growing up in Santa Barbara and Ventura Counties, he has has been an active participant in numerous community endeavors throughout his life. He served for years as a community organizer for CAUSE, a Ventura based non-profit, and headed the group's efforts to stop a proposed big-box retail development in Ventura. He holds a Master's degree in Environmental Science & Management, with a focus on water pollution, planning processes, and land-use law at UC Santa Barbara's Bren School of Environmental Science.

Supervisor Janet Wolf was elected to the Board of Supervisors in 2006 and was re-elected in 2010 and again in 2014. Prior to her election to the Board of Supervisors she served three terms on the Goleta School Board. She also worked in the field of vocational rehabilitation for over 20 years and had offices in both Santa Barbara and Santa Maria. Since her election to the Board of Supervisors, she has led on issues of concern to women and children's health, public safety, environmental stewardship and education.

Supervisor Steve Bennett serves on the Ventura County Board of Supervisors, representing the citizens of District 1. He graduated in 1972 from Brown University with an Honors degree in economics. Before being elected to the Board of Supervisors in 2000, Mr. Bennett was a teacher and high school administrator for 20 years at Nordhoff High school in Ojai. He served on the Ventura City Council from 1993 to 1997. He co-authored the Save Open Space and Agricultural Resources (SOAR) that has made Ventura County a national leader in land-use planning. SOAR slows urban sprawl by requiring a vote of the citizens before greenbelt areas outside of the cities can be rezoned for development.

Suzanne Grimmesey as Chief Quality and Strategy Officer for Santa Barbara County Alcohol, Drug and Mental Health Services, is responsible for leadership of the Office of Quality Care and Strategy Management. She began her work with "at risk youth" in the Santa Barbara County community 25 years ago. She currently provides oversight of both the Office of Strategy Management (OSM) and Quality Care Management (QCM). The overall division provides decision-support services to the Executive Team as well as oversight of the Mental Health Plan. She earned her BA in Psychology from the University of San Diego, holds a Master's degree in clinical psychology from Pepperdine University, and is licensed as a marriage and family therapist.Dr. Debbie Innes-Gomberg received her PhD from the California School of Professional Psychology in 1992 and began work for the Los Angeles County Department of Mental Health the same year as a clinical psychologist. Over the 22 years she has worked for the Department she has assumed leadership roles in Jail Mental Health Services, Adult Systems of Care, served as a District Chief for the Long Beach/South Bay areas of Los Angeles County, most recently, as the District Chief of the MHSA Implementation and Outcomes Division. In this role, she oversees community planning, implementation, reporting and evaluation of MHSA programs. She is currently the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board.

Dr. Jody Kussin, clinical psychologist and author, is the Director of Community Based Services for Casa Pacifica, a children's residential and community based mental health program. She coordinates the Wraparound, Therapeutic Behavioral Services (TBS), Intensive Family Services (IFS), Children's Intensive Response Team (24/7 suicide prevention and intervention program ~ CIRT), Foster Family Agency (FFA), Intensive Treatment Foster Care (ITFC), Intensive Family Services (IFS) and Kindle Family Connections (Family Finding) for Ventura County. She acts as clinical supervisor for clinicians, as well as serving as supervisor and/or mentor to staff, including youth advocates and parent partners.

Rusty Selix, JD has been Executive Director and Legislative Advocate for CCCMHA since 1987. In this capacity, he partnered with Senate President Pro tem Darrell Steinberg to co-author California's Mental Health Services Act, a tax on personal incomes over $1 million to expand community mental health care. In addition he has been instrumental in moving forward a variety of critical mental health-related initiatives, including ensuring the implementation of the federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to serve children with severe emotional disturbances. He also serves as Executive Director of the Mental Health Association in California. He attended Northwestern University where he received a Bachelor's Degree in Economics; he received his law degree from University of California, Davis. Appendix B: Advisory Workgroup Participant.

Appendix B: Advisory Workgroup Participants

Workgroup participants played a vital advisory role in all aspects of this project, however the findings and recommendations are those of the MHSOAC and do not necessarily reflect the views and opinions of all those who served in an advisory capacity listed below

NAME/TITLE ORGANIZATION	AREA OF EXPERTISE	REGION
Adrienne Shilton Director Intergovernmental Affairs County Behavioral Health Directors Association	County Behavioral Health Agencies	Statewide
Alicia Hooton Director, Crisis Services Seneca Family of Agencies	Children's & Family Services	Bay Area
Bill Brown Commissioner/Sheriff MHSOAC/Santa Barbara County Sherif	Law Enforcement	Southern
Bob Ochs Chief Sonoma County Probation Dept.	Community Corrections	Superior
Brenda Grealish Asst. Deputy Director CA Department of Health Care Services Mental Health Services Division	State Agency	Statewide
Craig Wolfe Clinical Director EMQ Families First	Children's & Family Services	Bay Area
Dina Kokkos-Gonzalez Division Chief CA Department of Health Care Services	State Agency	Statewide
Donna Cassettair San Joaquin County Behavioral Health	County Behavioral Health	Central
Elizabeth Spring Attorney IV CA Department of Managed Health Care	Health Care Insurance	Statewide
Frances McNeil Senior Legal Counsel Blue Shield of CA	Health Care Insurance	Statewide

NAME/TITLE ORGANIZATION	AREA OF EXPERTISE	REGION
Hector Ramirez Commissioner LA Mental Health Commission	Consumer Advocate	Los Angeles
Jane Adcock Executive Director CA Mental Health Planning Council	Mental Health Services	Statewide
James Preis Executive Director Mental Health Advocacy Services, Inc.	Legal/Advocacy	Statewide
Jill Anderson Behavioral Health Director Edgewood Center for Children & Families	Behavioral Health Provider	Bay Area
John Boyd Commissioner/CAO MHSOAC/Sutter Center for Psychiatry	Healthcare Provider	Central
John Sayler SELPA Director Sacramento County office Education	Schools/ Special Education	Central
Karen Bayler Deputy Director CA Department of Health Care Services	State Agency	Statewide
Karen Pank Executive Director Chief Probation Officers of CA	Community Corrections Law Enforcement	Statewide
Ken Berrick President/CEO Seneca Family of Agencies	Children's & Family Services	Bay Area
Kiran Savage-Sangwan Director of Legislation and Advocacy National Alliance on Mental Illness, California	Consumer Advocate	Statewide
Laura Champion Exec. Dir. Of Crisis Services EMQ Families First	Children's and Family Services	Bay Area
Lynn Thull Senior MH Policy & Practice Improvement Advocate California Alliance of Child and Family Services	Consumers/Caregivers	Central
Marika Collins Special Projects & Public Policy Officer Casa Pacifica Centers for Children & Families	Behavioral Health Provider	Southern
Melinda Bird Litigation Counsel Disability Rights California	Children's Psychiatric Facilities	Statewide
Michaele Beebe Director, Research & Public Policy United Advocates for Children and Families	Children's & Family Services	Statewide

NAME/TITLE ORGANIZATION	AREA OF EXPERTISE	REGION
Michael Kennedy Director Sonoma County Behavioral Health	Behavioral Health Provider-County	Bay Area
Nancy Rubin CEO Edgewood Center for Children & Families	Children's and Family Services	Bay Area
Patricia Wentzel Member MHSOAC Services Committee	Consumer Advocate	Central
Patrick Gardner President Young Minds Advocacy Project	Children's Advocacy	Statewide
Richard Van Horn Commissioner MHSOAC/Mental Health America-Los Angeles	Mental Health Provider	Los Angeles
Rochelle Trochtenberg Lead Youth Organizer Humboldt Co TAY Collaboration	TAY/Peers	Superior
Sandra Gallardo Assistant Secretary CA Health and Human Services Agency	Health Policy	Statewide
Sheree Kruckenberg Vice President, Behavioral Health California Hospital Association	Hospitals	Statewide
Stacie Hiramoto Director Racial and Ethnic Mental Health Disparities Coalition	Advocate	Statewide
Steve Hornberger Director, Social Policy Institute School of Social Work, SDSU	Behavioral Healthcare Policy	National
Steven Elson CEO Casa Pacifica Centers for Children & Families	Children's & Family Services	Southern
Steve Leoni Consumer Advocate	Consumer Advocate	Statewide
Susan Manzi Executive Director Youth in Mind	Peers	Statewide
Terry Rooney Director Colusa County Behavioral Health	County Behavioral Health Provider	Superior

Appendix C: Recent Developments Regarding Children's Crisis Services in California

In January 2015, a consortium of mental health advocacy organizations including the California Council of Community Mental Health Agencies, California Mental Health Advocates for Children and Youth, United Advocates for Children and Families, California Alliance of Child and Family Services, and the National Council for Behavioral Health issued a white paper titled, "Kids in Crisis: California's Failure to Provide Appropriate Services for Youth Experiencing a Mental Health Crisis." This paper served to spotlight the challenges faced by children, youth, and their families when attempting to access appropriate crisis services who often must rely on law enforcement intervention followed by hours or even days spent in noisy and chaotic emergency rooms that are frequently ill-equipped to adequately meet the needs of child. The report also highlighted a number of successful crisis intervention models currently operating in a few California counties, as well as other states, that could be replicated or expanded.

- In 2015, under the leadership of Commissioner John Boyd, Sutter Health initiated a project to examine crisis services for both children and adults throughout Sacramento County. The project goal was to expand crisis stabilization services in Sacramento County to meet the needs of individuals with behavioral health crises in a timely and effective manner while creating a sustainable care model that improves outcomes and reduces costs. Savings from such a program were intended to support existing and innovative outpatient and non-acute levels of service that complement behavioral health services continuum of care.

- Also in 2015, a consortium of mental health advocacy groups sent a letter to the California Department of Health Care Services regarding denial of access for Medi-Cal mental health crisis services for children and youth. In addition to highlighting a number of challenges and limitations of existing crisis services for children, the letter asked the department to review its existing policies and take action to ensure that children and youth in every county have community-based crisis intervention services available as an effective alternative to psychiatric hospitalization. Specifically, the group called for the Department to issue a Mental Health Information Notice to all behavioral health directors and Mental Health Plans instructing them that the full array of medically necessary crisis services for youth under age 21 must be available in sufficient amount, duration, and scope to meet the needs of beneficiaries.

- In October 2015, DHCS initiated a survey of all Medi-Cal Mental Health Plans (MHPs) regarding the availability of crisis services in California counties. As of February 2016, the Department stated that it is in the process of reviewing the survey results and that they would likely not be available prior to completion of the present report. In November 2014, DHCS confirmed that Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) must be provided to all beneficiaries under age 21 who are eligible for full scope Medi-Cal services and who meet medical necessity criteria for those services. DHCS indicated that they will clarify to county Mental Health Plans that these services must be provided to all eligible youth, and is not limited to those in foster care or at risk of out-of-home placement.

Appendix D: Essential Values for Appropriate and Effective Crisis Services[39]

Avoid Harm: An appropriate response to mental health crisis considers the risks and benefits of interventions and whenever possible, employs alternative approaches. In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions.

Intervening in Person-Centered Ways: Appropriate interventions seek to understand the individual, his or her unique circumstances, and how that individual's personal preferences and goals can be incorporated in the crisis response. Shared Responsibility: An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in — rather than a passive recipient of —services.

Addressing Trauma: It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. Establishing Feelings of Personal Safety: Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.

Based on Strengths: An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.

The Whole Person: An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may — or may not — be immediately paramount.

The Person as Credible Source: An appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information — factual or emotional — that is important to understanding the person's strengths and needs.

Recovery, Resilience and Natural Supports: An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience, and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.

Prevention: an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements.

KEY PRINCIPLES TO ENSURING THAT CRISIS SERVICES EMBODY THESE ESSENTIAL VALUES[40] GLOSSARY

Access to Supports and Services is Timely: Ready access to assistance is important not only because it holds the promise of reducing the intensity and duration of the individual's distress, but also because as a crisis escalates, options for interventions may narrow. Timely access presupposes 24/7 availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site.

Services are Provided in the Least Restrictive Manner Possible: Least-restrictive emergency interventions not only avoid the use of coercion, but also preserve the individual's connectedness with his or her world. Individuals should not be unnecessarily isolated from their routine networks of formal and natural supports and should be encouraged to make contact with outside professionals, family and friends who can provide assistance through the crisis event and beyond.

Peer Support is Available: Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand.

Adequate Time is Spent with the Individual in Crisis: In settings such as hospital emergency departments, there may be intense pressure to move patients through quickly. People who provide assistance must have an adequate understanding of the crisis situation, not only objectively, but also as it is being experienced by the individual who is in crisis.

Plans are Strengths-Based: A strengths-based plan helps to affirm the individual's role as an active partner in the resolution of the crisis by marshalling his or her capabilities. A strengths-based approach also furthers the goals of building resilience and a capability for self-managing future crises.

Emergency Interventions Consider the Context of the Individual's Overall Plan of Services: Appropriate crisis services consider whether the crisis is, wholly or partly, attributable to gaps or other problems in the individual's current plan of care and provides crisis measures in ways that are consistent with services the individual receives (or should receive) in the community. Crisis Services are Provided by Individuals with Appropriate Training and Demonstrable Competence to Evaluate and Effectively Intervene with the Problems Being Presented: Crisis intervention may be considered a high-end service, that is high-risk and demanding a high level of skill. Within the course of a psychiatric emergency, various types of crisis interventions may occur — some by healthcare professionals, some by peers, and some by personnel (such as police) who are outside of healthcare. Throughout, the individual experiencing a mental health crisis should be assured that all interveners have an appropriate level of training and competence.

Individuals in a Self-Defined Crisis are not Turned Away: People who seek crisis services but do not meet the service criteria of an organization should receive meaningful guidance and assistance in accessing alternative resources. This is particularly applicable in organizations or programs that carry out a screening or gatekeeping function.

Interveners have a Comprehensive Understanding of the Crisis: Meaningful crisis response requires a thorough understanding of the issues at play. An appropriate understanding of the emergency situation not only includes an appreciation for what is happening at the moment, but also why it is happening and how an individual fares when he or she is not in crisis. Mobile outreach services, which have the capacity to evaluate and intervene within the individual's natural environment, have inherent advantages over facility-based crisis intervention, especially when an individual who has personal experience with mental illness and mental health crises is a part of the intervention team. Such mobile outreach capacity is even more meaningful when it is not restricted to a special crisis team, but rather when staff and peers familiar with the individual have the ability to literally meet the individual where he or she is.

Helping the Individual to Regain a Sense of Control is a Priority: Regaining a sense of control over thoughts, feelings, and events that seem to be spinning out of control may be paramount for an individual in a mental health crisis. Staff interventions that occur without opportunities for the individual to understand what is happening and to make choices among options (including the choice to defer to staff) may reinforce feelings that control is being further wrested away.

Services are Congruent with the Culture, Gender, Race, Age, Sexual Orientation, Health Literacy and Communication Needs of the Individual Being Served: Given the importance of understanding how an individual is experiencing a crisis and engaging that individual in the resolution process, being able to effectively connect with the individual, is crucial. A host of variables reflecting the person's identity and means of communicating can impede meaningful engagement at a time when there may be some urgency.

Rights are Respected: An individual who is in crisis is also in a state of heightened vulnerability. It is imperative that those responding to the crisis be versed in the individual's rights, among them: the right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one's advance directive considered, the right to speak with an ombudsman and the right to make informed decisions about medication.

Services are Trauma-Informed: Children and youth with serious mental or emotional problems often have histories of victimization, abuse and neglect, or significant traumatic experiences. It is essential that crisis responses evaluate an individual's trauma history and the person's status with respect to recovery from those experiences. Similarly, it is critical to understand how the individual's response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on that history. It also requires establishing a safe atmosphere for the individual to discuss potential traumatic events and to explore their possible relationship to the current crisis.

Recurring Crises Signal Problems in Assessment or Care: Many organizations providing crisis services — including emergency departments, psychiatric hospitals, and police — are familiar with certain individuals who experience recurrent crises. While staff sometimes assume that these scenarios reflect a patient's lack of understanding or willful failure to comply with treatment, recurrent crises are more appropriately regarded as a failure in the partnership to achieve the desired outcomes of care. And rather than reverting to expedient clinical evaluations and treatment planning that will likely repeat the failed outcomes of the past, recurrent crises should signal a need for a fresh and careful reappraisal of approaches, including engagement with the individual and his or her support network.

Meaningful Measures are taken to Reduce the Likelihood of Future Emergencies: Considering the deleterious impact of recurrent crises on the individual, interventions must focus on lowering the risk of future episodes. Crisis intervention must be more than another installment in an ongoing traumatic cycle. Performance-improvement activities that are confined to activities within the walls of a single facility or a specific program are sharply limited if they do not also identify external gaps in services and supports that caused an individual to come into crisis. Although addressing certain unmet needs may be beyond the purview of one facility or program, capturing and transmitting information about unmet needs to entities that have responsibility and authority (e.g., state mental health programs, housing authorities, foster care, and school systems) is an essential component of crisis services.

Appendix E: Crisis Service Continuum of Care for Children and Youth

Definition of Mental Health Crisis for Children and Youth

In framing a project on crisis services for children and youth, it is first important to develop a shared understanding of relevant terms and definitions. For instance, establishing a definition of what the term "mental health crisis" means for children, youth, family members, caregivers, and service providers can help guide the discussion and decision-making throughout this project. Additionally, documenting definitions of common service modalities and approaches can serve as an important reference in establishing a shared understanding of the range of existing services and identifying potential

gaps or areas of need. Although the terms “mental health crisis” and “psychiatric emergency” are often used in the same context, one can argue that there are in fact significant differences in the appropriateness of each term. A psychiatric emergency may be based on a wide spectrum of biological, psychological, and social problems. Although the cause varies, the common thread among all such emergencies is the requirement of an intervention to avoid permanent harm and prevent unnecessary morbidity and clinical deterioration.

The California Code of Regulations, Title 9 defines an "Emergency Psychiatric Condition" as a condition in which a person, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter, or clothing. This situation indicates an immediate need for psychiatric inpatient hospitalization or psychiatric health facility assessment. However, this limited definition does not adequately describe the full trajectory of a mental health crisis. Crisis services delivered only at the point that physical safety becomes the primary concern substantially limit the range and potential effectiveness of interventions as the crisis escalates. Crisis is something that goes beyond an individual’s capacity to cope with their situation. Context is particularly important for kids and youth that are involved in multiple systems (schools, foster care, probation, etc.).

Addressing the circumstances, environmental factors, and individual experience requires a broader definition that considers the child’s experience of emotional or psychological distress within the context of their lives and addresses their social and mental health needs within a broader continuum of services..

Albert Roberts described mental health crisis generally as "an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment. The subjective reaction to a stressful life experience that compromises the individual's stability and ability to cope or function. The main cause of a crisis is an intensely stressful, traumatic, or hazardous event, but two other conditions are also necessary: 1) the individual's perception of the event as the cause of considerable upset and/or disruption; and 2) the individual's inability to resolve the disruption by previously used coping methods."

An alternative definition offered by James and Gilliland describes crisis as “a perception or experience of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanism.”[41] Additionally, the Mental Health Crisis Response Institute provides the following definition “a person has a mental health crisis when they are in a state of mind in which they are unable to cope with and adjust to the recurrent stresses of everyday living in a functional, safe way.”

An important distinction could also be made between the terms “emergency” and “crisis” which in turn may allow for more appropriate referrals and settings for intervention. A recent literature review[42] conducted by the Collaborative Antwerp Psychiatric Research Institute found that overall, authors seem to agree on two aspects of an emergency: 1) it involves a danger of harm to the patient or to others, as primarily determined by the patient’s context, or it involves a context in which there exists a threat to the child’s life or development; and 2) immediate intervention is required. Further exploring the distinction between a crisis and an emergency, the State of Kansas Department of Social and Rehabilitative Services uses the following definitions:

- A ***crisis*** occurs when the demands of a serious acute and potentially dangerous situation overwhelm an individual’s capacity to effectively resolve the situation.
- An ***emergency*** is defined as an often unforeseen crisis situation that requires an immediate response or intervention to prevent harm or potential harm.

Crises and emergencies are typically viewed as time-limited, although contributing or resulting problems may last beyond the time of crisis.[43] Clear verbalization of, or actions which could result in a danger to self or others, require emergency interventions. However, mental health crises in general tend to follow a trajectory that includes intense feelings of personal stress, changes in functioning, and/or catastrophic life events. What is often referred to as a crisis event may in fact be the conclusion of this trajectory. Often the potential emotions, triggers, and experiences which brought the child within their specific context to this point may not be readily apparent at the point at which emergency intervention is provided.

Definition of Crisis Services

Crisis intervention or crisis services are generally described as a short term intervention focused on resolving the most immediate and pressing problems through a process of evaluation and assessment; intervention and stabilization; and follow-up planning. Title 9 of the California Code of Regulations defines "crisis intervention" as a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy (CA CCR Title 9 Section 1810.209). Effective crisis service systems often contain a number of key qualities. Crisis services need to be appealing, engaging, accessible, mobile, and have the ability to respond rapidly. Services should also have the capacity to respond at all levels as the crisis unfolds and resolves, promoting a successful transition through the entire process including follow-up services.[44] By definition, crisis is episodic and must be addressed within a continuum of care. The availability of a comprehensive continuum of services with the ability to match the intensity of services to the needs of the child and their environment is critical. When the focus is placed too narrowly on the immediate need for crisis services without a recognition of the individual and environmental factors that contributed to the crisis and the necessary steps taken to address or ameliorate these factors in the future, we are bound to be disappointed in the outcomes.

Appendix F: Key Program Components and Elements of a Successful System

Goals of Effective Crisis Services

The goals of an effective system of crisis services for children and youth should be to:

- **Address the immediate needs** in the least restrictive setting possible.
- **Build on a continuum of existing services** and bring services into the context where kids feel the safest and can build on natural supports to prevent future crisis episodes.
- **Give children, caregivers, educators, and all service providers the knowledge** and abilities to recognize an emergency crisis and have a plan in place to respond at the earliest possible stage of the crisis.
- **Allow children and youth to receive intensive mental health treatment** in their own homes, schools, and communities before their behaviors and emotional distress escalates to a point where personal safety becomes the primary concern.

An effective system of crisis care needs to provide services across a broad geographic region and at multiple access points including homes, schools, hospitals, juvenile justice, and other social service providers. The first response must include a mobile capability to connect with kids in their communities. The system must be focused on recovery, resiliency, and building support within the family and community both before and after a mental crisis occurs. The system must be able to meet the needs of kids already receiving services and those receiving crisis services for the first time. The needs and challenges faced by both groups are often different and require different responses.

Model service delivery systems implemented in other states have focused on building out a continuum of care that starts with actions that the individual and their caregivers can take, followed by mobile crisis services, crisis stabilization outside of the home, and finally transportation to a psychiatric facility or emergency department if the child requires a higher level of care. Central to both systems is the ability to intervene at the lowest possible level and then ramp up the intensity and duration of the services based on the needs of the individual and their context. The programs also provide a similar ability to transition back to the home environment following the crisis and modify the individual intervention strategies for the future based on these experiences.

The work of the Crisis Services Advisory Work Group guided and informed the identification of a number of key service characteristics and program elements of effective crisis service delivery models for children, youth, and families. Underpinning many of the workgroup discussions regarding effective crisis services was the importance of providing services in the most appropriate and least restrictive setting possible and the ability to increase and decrease the intensity and type of interventions based on the needs of the child, family and their context. This system characteristic is addressed in some communities through the implementation of a broad array of services including respite centers, mobile 24/7 crisis support, 23 hour crisis services units, crisis residential, and partial hospitalization. On the front-end of crisis services, the workgroup highlighted the importance of creating a system of broad access to help including 24/7 warm lines, screening tools, training for educators, law enforcement, pediatricians, parents, and youth. For those children who are already known to the system, several workgroup participants emphasized the importance of developing a safety plan that incorporates youth and family voice and identifies both external resources and natural supports that can be activated before a mental health crisis escalates to the point of a call to law enforcement or trip to the emergency room.

Appendix G: Current Initiatives To Improve Children's Crisis Services In California

In November 2015, the DHCS agreed to end the prohibition on providing intensive community-based mental healthcare to as many as 15,000 low-income youth in need throughout the state. DHCS confirmed that these services, also known as Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), must be "provided to all beneficiaries under age 21 who are eligible for full scope Medi-Cal services and who meet medical necessity criteria for those services." Furthermore, the Department said it will clarify to county Mental Health Plans (MHPs) that membership in the 'Katie A. Subclass', whose members include foster youth or youth at-risk of out of home placement with open children welfare cases, is not a prerequisite for receiving these services. The Department issued this Information Notice to all county Mental Health Plans on February 5, 2016:

KATIE A. SETTLEMENT

Katie A. v. Bonta refers to a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of coming into care. A settlement agreement was reached in the case in December 2011, and child welfare and mental health leaders from state and local levels are working together to establish a sustainable framework for the provision of an array of services that occur in community settings and in a coordinated manner. As part of this agreement, the California Department of Social Services (CDSS) and the California Department of Health Care Services (DHCS) agreed to take specific actions that will strengthen California's child welfare and mental health systems with objectives that include:

- Facilitating the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and transition into a coherent and all-inclusive approach, which is referred to as the Core Practice Model (CPM).
- Addressing the need of some class members with more intensive needs (referred to as "subclass members") to receive medically necessary mental health services in their own home or family setting in order to facilitate reunification and meet their needs for safety, permanence, and well-being. These more intensive services are referred to as Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC).
- Clarifying and providing guidance on state and federal laws as needed to implement the settlement agreement so that counties and providers can understand and consistently apply them.

EMILY Q. SETTLEMENT

In 1998, a federal class action lawsuit, Emily Q. v. Bonta was filed with the Federal District Court on behalf of children with intensive mental health needs and who were eligible for Medi-Cal mental health benefits, but were denied specific Therapeutic Behavioral Services (TBS). TBS is a short-term, intensive one-to-one behavioral mental health intervention that can help children, youth, parents, caregivers, and school personnel learn new ways of reducing and managing challenging behaviors. TBS can avert the need for a higher level of care (or more restrictive placement) or help a child make a successful transition to a lower level of care.

In 1999, the district court issued a preliminary injunction requiring that a certified state-wide class of current and future beneficiaries of the Medicaid program below the age of 21 in California who: are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs; are being considered for placement in these facilities; or have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months. In 2001, the district court issued a permanent injunction favoring the

plaintiffs and in 2004, the court approved a plan to increase the usage of TBS including increased monitoring and a special master was appointed. Pursuant to the Court agreement, the Department of Healthcare Services continues to perform specific activities related to the Emily Q. lawsuit.

Measuring Outcomes and Improving Quality

The Code of Federal Regulations (CFR) at 42 CFR §438.3642 requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states' Medicaid MCPs. The EQRO's performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

In 2015, The California Department of Health Care Services also implemented a Performance Outcomes System (POS) in accordance with legislative mandates to improve outcomes and inform decision-making for children and youth receiving Medi-Cal Specialty Mental Health Services (SMHS). The Performance Outcomes System implementation included a process for bringing together information from multiple sources in order to better understand the results of Medi-Cal SMHS provided to children and youth under twenty-one years of age. The intent of the system is to gather information relevant to particular mental health outcomes from current and enhanced county reporting and state databases to provide useful summary reports for ongoing quality improvement processes and decision-making.

The first reports published by DHCS focused on demographic characteristics of children and youth under 21 who were receiving specialty mental health services based on approved claims for Medi-Cal eligible beneficiaries. Additional statewide reports include service utilization in terms of dollars and time increments. The report also includes data on time to step down services following and inpatient discharge. The reports currently do not specify the location where services are provided (e.g. home, clinic, school, etc.) however a number of additional quality measures and potential new data sources are under review.In 2015, the Centers for Medicare & Medicaid (CMS) approved California's Medi-Cal Specialty Mental Health Services waiver with special terms and conditions focused on the need for improved tracking and measurement of timeliness of care. Waivers are programs under Medi-Cal that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under Medicaid rules. Specific language in the special terms and conditions including following requirements:

> The state needs to establish a baseline of each and all counties that includes the number of days and an average range of time it takes to access services in their county. If county mental health plans are not able to provide this information so that the state can establish a baseline, this will be accomplished through the use of a statewide performance improvement project (PIP) for all county mental health plans. In addition, a PIP to measure timeliness of care will be required for those counties who are not meeting specified criteria. The criteria will be developed collaboratively between the state and CMS. This has significant potential for improving patient care, population health, and reducing per capita Medicaid expenditures.

GRANT-FUNDED PROGRAMS SPECIFICALLY INTENDED TO MEET THE NEEDS OF CHILDREN AND/OR ADOLESCENTS IN CRISIS

TABLE F: MHSA Mental Health Wellness Triage Personnel Grants Focused on Children and/or Youth

COUNTY	PROGRAM DESCRIPTION	FUNDING AWARDED	STAFF	CHILDREN SERVED	TAY SERVED*
ALAMEDA	Alameda County Behavioral Health Services was awarded funds to fill gaps in crisis support services for TAY including outreach, crisis intervention, and targeted intensive case management.	$2.7 million over 4 years	11	–	192
LOS ANGELES	Los Angeles County Department of Mental Health was awarded funds for Youth Crisis Stabilization Teams to provide services during evening, weekend and holiday hours.	$5.8 million over 4 years	18	270	235
SAN FRANCISCO	San Francisco Community Behavioral Health Services was awarded funds to support the following activities: • Create and staff a new Youth Psychiatric Crisis Stabilization Center • Staff four new Crisis Triage Response Teams	$7.1 million over 4 years	40	217	218

**Reported number of children and TAY served as of 9/30/2015*

TABLE E: CHFFA Mental Health Wellness Grants Serving Children and/or Youth

COUNTY	PROGRAM AREA	PROGRAM DESCRIPTION*	FUNDING AWARDED**	STAFF	BEDS	VEH.
FRESNO	Crisis Stabilization	Children and adults experiencing a mental health crisis, including those with co-ocurring substance abuse crises. Services will extend to youth from the county's juvenile justice campus, and there will be 5150 designation capability.	$794,795		16	
LOS ANGELES	Crisis Stabilization	Crisis stabilization programs will serve adolescents and adults.	$4,210,526			
LOS ANGELES	Crisis Stabilization	Mobile Crisis programs will provide field based crisis intervention services to children, adolescents, and adults throughout the county.	$1,682,174		15	4
MARIN	Mobile Crisis	Underserved populations, which consists of youth, Latinos, and Asian Pacific Islanders of west and central Marin.	$439,168	4		
MENDOCINO	Mobile Crisis	Adults and children experiencing a mental health crisis, especially from isolated rural communities.	$40,713	.5		
MONTEREY	Mobile Crisis	Children, adults and families experiencing a psychiatric crisis who are at risk of hospital, emergency room, or law enforcement intervention.	$193,615			5
SAN BERNARDINO	Crisis Stabilization	Crisis stabilization unit will serve individuals experiencing psychiatric emergency conditions and allocated 16 beds for adults ages 18 and older and 4 beds for adolescents ages 13 to 17.	$2,700,000 (includes funds for 36 total beds) 795		4	
SAN JOAQUIN	Crisis Stabilization	Crisis stabilization program will provide services to children and youth in need of stabilization.	$1,836,734		8	
SAN JOAQUIN	Mobile Crisis	Mobile crisis support program will provide services to foster children and youth, mentally ill justice offenders, and adults experiencing a mental health crisis.	$696,573		6	3
SAN LUIS OBISPO	Mobile Crisis	High-risk individuals (adults and youth), individuals who frequently use crisis services, the homeless population, students, and post-release criminal justice clients.	$67,377			2

Counties awarded funding to serve "all eligible consumers" without specifying services for children or adolescents are not included in the list above.

****Funding amounts awarded for some counties and programs include services for multiple age groups as identified in the program descriptions and are not limited to children and adolescents unless specifically stated.***

Glossary

Crisis services typically include an array of services that are designed to reach individuals in their communities and provide alternatives to hospitalization.33 Components of effective crisis service systems include:

Warm Lines: Provides callers with opportunity to speak directly with trained mental health consumers who provide support for individuals in situations that are non-emergency, but have the potential for escalation.

Crisis Lines: Provide callers with immediate support from trained mental health providers via telephone. Staffers facilitate linkage and referral of caller to relevant services and supports. May also serve as a dispatch center for mobile crisis teams. Text & Chat Services: People texting for help receive the same services as those calling in, including risk assessment, emotional validation and collaborative problem-solving.

Mobile Crisis Intervention: Provides consumers with rapid response services in their homes, schools, communities, etc. Service providers provide immediate assessments and seek to resolve crisis situations on-site.

Psychiatric Emergency Response Team (PERT): Integrated law enforcement and mental health worker teams for the purpose of responding to situations involving potential mental health crises.

Crisis or Safety Plans: A safety plan is a personalized, practical plan that can help identify key people willing to help, calming techniques, list of medications and preferred treatment services.

Psychiatric Advanced Directive Statements: Provide individuals the opportunity to designate their psychiatric/mental health treatment preferences should they lose the ability to make said decisions in the midst of a crisis situation.

Wellness Recovery Action Plan (WRAP): An evidence-based practice consisting of a personalized wellness and crisis plan development program. WRAP emphasizes a strengths-based approach to recovery. Participants are encouraged to manage their own wellness and recovery in a manner that is comfortable to them and within their means. The key recovery concepts of WRAP are hope, education, personal responsibility, support, and self-advocacy.

Respite Care: A form of short-term crisis residential care for up to 14 days provided in a home-like setting for clients who can largely take care of themselves but need a temporary place of safety so that they can resolve an acute emotional crisis, perhaps by temporarily removing themselves from a precipitating situation in their customary home. In some cases, a crisis stabilization unit or crisis residential unit may set aside one or more beds for such respite care.

Intensive Care Coordination (ICC): A service that facilitates care planning and coordination services for youth with serious emotional disturbance (SED). ICC provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the youth, are developed through a wraparound planning process consistent with Systems of Care philosophy that results in an individualized and flexible plan of care for the youth and family.

Therapeutic Behavioral Services (TBS): TBS is an intensive, individualized, one-to-one behavioral mental health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention; it is always used in conjunction with a primary specialty mental health service. TBS is available for children/youth who are being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children/youth and their parents/caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child's and family's needs.

Therapeutic Foster Care (TFC): Therapeutic or treatment foster care (TFC) is a clinical intervention, which includes placement in specifically trained foster parent homes, for youth in foster youth with severe mental, emotional, or behavioral health needs. This includes medically fragile or developmentally delayed youth whose physical and emotional health needs require more intensive clinical and medical intervention than can be accommodated in traditional foster care.

Peer Crisis Services: Provides individuals with short-term, community-based services that are administered by trained consumers of mental health services (peers to the individual seeking treatment).

Intensive Home Based Services (IHBS): IHBS are intensive, individualized, and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons, and to help the child/youth develop skills and achieve the goals and objectives of the plan.

Crisis Services Unit (CSU)/23-Hour Crisis Beds: Provides individuals in severe distress with up to 23 consecutive hours of supervised care, including prompt assessments, stabilization, and determination of care.

Behavioral Health Urgent Care Centers (UCC): Behavioral health urgent care centers provide timely behavioral health evaluations, short-term counseling, psychopharmacological services, and referrals for longer-term care when necessary. Emergency Screening Unit (ESU): Provides emergency psychiatric evaluations, crisis intervention, crisis stabilization, brief outpatient counseling, case management, and emergency medication management. ESUs generally operate 24/7 per week. Psychiatric Emergency Services (PES): Serve to screen/evaluate and treat all acute psychiatric patients for a region, eliminating need for urgent psychiatric consults in a general emergency department.

Short-Term Crisis Stabilization: Provides a range of community-based resources, including housing and a safe environment for recovery, to individuals experiencing acute psychiatric crises. Services are short-term.

Crisis Residential Services (CRS): Provide an alternative to acute psychiatric hospital services for clients who otherwise would need hospitalization. The services include case management and referrals to other social services, follow a psychosocial rehabilitation model, and may integrate aspects of emergency psychiatric care as needed. Generally these units are intended for adults, but some communities also have special crisis residential units designated for older adolescents and transitional-aged youth.

Psychiatric Health Facility (PHF): Licensed facility that provides 24-hour inpatient care for people with mental health disorders. Care shall include, but not be limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings.

Acute Psychiatric In-Patient Treatment: Provides 24-hour inpatient care for persons with mental health disorders including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary.

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