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KIDS IN CRISIS: CALIFORNIA'S FAILURE TO PROVIDE APPROPRIATE SERVICES FOR YOUTH EXPERIENCING A MENTAL HEALTH CRISIS

When California children experience a mental health crisis, they and their families face untenable choices. Many are brought to hospital emergency rooms that are not designed to provide ongoing mental health treatment to address their needs. This report documents how in the absence of crisis diversion programs, families have no choice but to bring their children to Emergency Rooms where they are often held for scores of hours, even days, in ER hallways and examining rooms, with no mental health treatment, while staff try desperately to locate an inpatient psychiatric facility that has the capacity to admit a child. If such a facility is identified, children as young as nine years old are frequently transported alone, without their parents, to a far-away hospital in another county. All of this aggravates their mental crisis and can cause lasting trauma.

In November 2014, the family of a young girl – only nine years of age – 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 for more six hours north, by which time the original hold has 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.

Some children and families have learned that the mental health system offers them no help short of emergency hospitalization, and try to manage on their own. This results in untreated mental health issues, which will only worsen over time. When families reject hospitalization for their child, but feel they have no safe alternative, the result is severe lasting mental health issues, which often results in suicide attempts or completions in the pre-teen to teenage years.[1]

California families deserve better alternatives when their children are in a mental health crisis. In some counties, and several other states, families DO have good alternatives due to highly effective and efficient, community-based crisis programs. These alternatives offer early intervention to prevent children from being sent to emergency rooms in the same way that

[1] Over 90 percent of children and adolescents who commit suicide have a mental disorder.

urgent care centers help patients with physical health avoid being taken to emergency rooms. For example, some counties offer mobile crisis teams that come to the family home and stay for as long as it is necessary.

These effective programs operate in a small number of California's 58 counties. For the remainder, serious gaps in mental health care needlessly force children into further traumatizing situations, and thus worsening their current crisis, even though their conditions could be de-escalated with more access to appropriate care.[2]

17 y/o student called mobile crisis team while contemplating suicide on a bridge. The responding clinician kept the student engaged on the phone while enlisting an additional clinician to phone 911 for an immediate response. The first clinician worked to get enough detail on the student's location to help guide the police to his/her location. Trained Crisis Intervention Team officers responded to scene before student was able to follow through her/his plan to jump from the bridge.

Why does California have such a fragmentation of treatment resources that children in some counties receive the prompt care they need to grow into healthy adulthood, while others face days of waiting to access acute inpatient care hundreds of miles away from home, or left untreated may result in failed suicide attempts or worse? Although there are multiple causes, the following three are primary:

- Lack of attention to this issue by the state, health plans and counties. The traditional view of health care is simple outpatient and inpatient without regard to people who are too unstable to participate in an outpatient program but who do not meet the very narrow and extreme conditions that warrant a hospitalization (which means that hospital capacity will be limited to a very low number of available beds). Patients in this gap can be more effectively treated by other forms of crisis care services.
- The lack of clearly articulated state funding, standards and procedures to do what is required by federal law which to ensure that every county (technically considered a local mental health MediCal managed care plan) has the system and resources to provide children with the full range of the appropriate and prompt treatment they require when in crisis.
- The continued practice of funding "silos" or funding only specific programs and failing to account for the true cost of delayed treatment for children in mental health crises.

The prevalence of mental health challenges and the rates of inpatient hospitalization amongst children highlight the gap in California systems: **there is no comprehensive child and adolescent acute crisis service system throughout the state.** This issue has manifested in many ways for children and families, including (1) the denial of timely access to appropriate levels care in the least restrictive environment; and (2) a shortage of alternative care to inpatient hospitalization, which is the most restrictive type of intervention.

[2] 5 of every 1000 youth ages 5 to 19 are hospitalized when they present with symptoms of a mental health issue.

California is in need of a comprehensive system of care that will offer a breadth of crisis care service options, each of which are focused on stabilizing and sustaining young people in the least restrictive settings to ensure the health, safety, and well-being of California's children.

THE PROBLEMATIC CURRENT SYSTEM

When children and families experience a crisis they turn to emergency law enforcement services where the youth are taken to hospital emergency rooms for care. ERs are not the place for a child in crisis. ERs are noisy, chaotic, and not an appropriate environment to manage and care for children undergoing a mental health crisis. They were not designed to do so. Thus, emergency rooms staff do not have the specialized psychiatric training nor the time and infrastructure to appropriately address the needs of individuals experiencing psychiatric crises. At this point, youth and families wait for many hours (some cases documenting up to 90 hours) in emergency rooms while an inpatient bed is sought for them, and in many cases their needs could have been addressed in a more appropriate, less restrictive setting closer to their home community. As a result, once a bed is located in the state after 48+ hours the child is transported to that facility somewhere within the state, and shortly after arrival, the receiving psychiatrist will release the child because the acute symptoms are no longer present. In fact, less than half of youth who end up in an ER due to a psychiatric crisis receive any type of mental health treatment, and few are referred for outpatient treatment or follow-up. [3] It is too often the case that at the end of the crisis, the child is without treatment and further traumatized.

Alternatives to Emergency Rooms and Unnecessary Hospitalization

Alternatives to inpatient hospitalization are essential to both children experiencing a mental health crisis and the family. Instead of ERs or unnecessary hospitalization, what a child needs is a calming and therapeutic place where he or she can receive treatment to work through the crisis. Community Based programs provide just that, in the form of crisis intervention services. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in an appropriate treatment service to address the problem that led to the crisis. These services are performed either at the child's home (as is the case with mobile crisis units), or at a residential home-like setting. This provides the optimum environment for a child to feel relaxed while receiving essential therapeutic help. It can also be provided within a crisis respite program.

Literature and clinical experience indicate that inpatient hospitalizations for youth undergoing mental crisis only provides a short term resolution to a crisis when effective services really need to be available in the community for long term improvement. Removing a child from their home environment for a brief period of time may indeed keep the youth safe and provide the

[3] Helping Children in Acute Psychiatric Crisis, Ruth Gerson, M.D. and Fadi Haddadd, M.D, Psychiatric News, available at http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.12b9.

family with a brief respite; however, returning the child directly to the home without addressing the specific clinical and family needs only increases the client's risk for re-hospitalization. Rather, treatment services and interventions must include linkage support services that provide sustainable and durable transition support and maintain the wellbeing of the child in the community.

The research base on the effectiveness of crisis services is mounting. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can help individuals avoid unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs associated with psychiatric hospitalizations, without negatively impacting clinical outcomes.

Necessity to Increase the Availability of Crisis Services

For children's crisis services, the state has observed a decrease in the availability of inpatient psychiatric hospital beds, all while still lacking a comprehensive community-based solution to meet the mental health needs of children within our communities. While there are several existing crisis service programs in California, the availability of these programs are limited in the type of services that are available and vary significantly from one county to another county. For example, a handful of counties may operate children's mobile crisis teams, but there are no crisis stabilization units or beds within their region. Therefore, inpatient hospitalization is the only option for a youth experiencing a crisis in many areas of the state, and in many instances it is the least effective measure.[4]

The lack of consistent community-based services, which provide treatment in the least restrictive setting, is an Olmstead violation. Olmstead requires that persons with disabilities be treated in the lease restrictive setting, such as within their own community and not through inpatient hospitalization Further, the failure of private insurance companies to fund alternative crisis services, such as mobile crisis units, violates the Parity Act, which requires that private insurers who offer mental health or substance abuse coverage to provide that plan coverage with no greater financial requirements or treatment limitations than is applied to general medical or surgical benefits.

The emergency room should be the last resort for a child in crisis, yet in our current system, this is where children are first being identified. This provides further evidence of the need for program models that provide earlier and more effective identification and intervention.

COSTS OF DEFICIENT MENTAL HEALTH CRISIS SERVICES

A 2012 California Hospital Association report stated that **two thirds of the people brought to the hospital emergency rooms for psychiatric emergencies do not in fact need to be**

[4] Inpatient hospital is sometimes necessary, typically when involving the need for medications alterations, blood testing, etc.

hospitalized. Nationally, more than 6.4 million visits to emergency rooms in 2010, or about 5 percent of total visits, involved patients whose primary diagnosis was a mental health condition or substance abuse. By one federal estimate, spending by general hospitals to care for these patients is expected to nearly double to $38.5 billion in 2014, from $20.3 billion in 2003.[5] The California Hospital Association report also noted that one third of individuals could be effectively served through crisis stabilization, while another third would benefit from crisis residential treatment.

The costs of needless inpatient and emergency treatment are dramatic. The average cost for an emergency room visit is $2,000,[6] and hospitalization in an inpatient pediatric mental health unit alone is more than $3,000.[7] Transporting children to psychiatric facilities miles away in the middle of the night for the one available bed is also catastrophically expensive. The average cost for an emergency ambulance transport in Los Angeles County is $1,000[8]. For families without insurance, these costs can be financially devastating, especially if the transport is to a different county. One mental health provider agency regularly hears from families about insurance co-pays of $2000 to $5000 for hospitalization and transport. A staff member recalls: "One father recently was openly weeping to our clinician regarding a second hospitalization occurring when the family had not even been able to pay off his daughter's first hospitalization."

Nearly half of all Americans will need mental health treatment some time during their lifetimes, with initial symptoms frequently occurring in childhood or adolescence.[9] In California, 8.5 percent of children ages 4 to 11 and 13.2 percent of adolescents ages 12 to 17 were identified as having mental health needs.[10] Research finds that three out of four children with mental health needs in California do not receive treatment. Left untreated, childhood mental health issues may lead to serious negative consequences for a child's academic achievement, social development, and physical health.[11] The worst consequences of untreated mental health issues are suicide attempts and completions. Suicide is the third leading cause of death in youth

[5] ER Costs for Mentally ill Soar and Hospitals Seek Better Way, Julie Creswell, The New York Times, available at http://www.nytimes.com/2013/12/26/health/er-costs-for-mentally-ill-soar-and-hospitals-seek-better-way.html?pagewanted=all&_r=1&

[6] Caldwell N, Srebotnjak T, Wang T, Hsia R (2013) "How Much Will I Get Charged for This?" Patient Charges for Top Ten Diagnoses in the Emergency Department. PLoS ONE 8(2): e55491. doi:10.1371/journal.pone.0055491

[7] California Hospital Association, 2014.

[8] Ambulances: Basic Info About a Service You May Take for Granted, Lisa Zamosky, The Los Angeles Times, Jan.26 2014, available at http://articles.latimes.com/2014/jan/26/business/la-fi-healthcare-watch-20140126

[9] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 62(6) (2005): 593-602.

[10] From *Ask*CHIS query for combined years 2007 and 2009, October 21, 2013. *www.askCHIS.ucla.edu*

[11] Wang PS, Berglund P, Olfson M, Pincus HA, Wells KB, Kessler RC. Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 62(6) (2005): 603-613.

ages 15 to 24, [12] and states spend nearly $1 billion annually on medical costs associated with suicide attempts and completions by youth up to 20 years of age.[13]

Widespread community based crisis treatment could drastically decrease both the prevalence of untreated mental health issues in youth and the treatment costs for families and healthcare providers. The monetary cost of community-based residential care is substantially lower than hospitalization. Due to the lower overhead cost for medical staff and facility expenses, community based care can be operated at a much lower price. In 2008-2009, the cost to operate community crisis residential programs was approximately 25% of the cost of hospital inpatient care ($330 dollars compared to $1,129 for hospital impatient care). [14] Aside from the monetary savings, the unaccounted for savings in human costs is difficult to measure. Community-based residential crisis care allows for a more focused, individualized, and home-like environment which is all-around a more beneficial model for providers, patients, and the community.

Why have decision-makers failed to address these costs and expand cost-effective, community based alternatives that will avert emergency situations and the need for hospitalization? Unfortunately, these cost savings have little impact on a county's decision to increase funding for children's crisis services because they impact the budgets of other agencies and levels of government, such as the California Department of Corrections, county sheriff and probation departments, EMS, fire and ambulance (transport), school districts, private hospitals, etc. In such a situation, state decision-makers must step in and do the right thing: enforce current regulation and develop timely access and network adequacy standards. If action is not taken, federal court intervention is highly likely, which will include litigation costs and the impeding loss of control brought by a lawsuit.

WHAT CALIFORNIA MUST DO TO PROVIDE CHILDREN WITH NECESSARY MENTAL HEALTH CRISIS SERVICES

The good news: We can address the access and availability of appropriate assessment and treatment programs using pre-existing models, best practices and innovative program designs.

PROPOSED SOLUTIONS

Follow precedent models from other states

[12] McIntosh, J.L.. & Drapeau, C.W. (for the American Association of Suicidology). (2012). *U.S.A. suicide: 2010 official final data.* Washington, D.C.: U..S. Department of Education.
[13] NGA Center for Best Practices, *Youth Suicide Prevention: Strengthening State Policies and School-Based Strategies*
[14] Crisis Residential Programs, California Mental Health Planning Council , available at http://www.dhcs.ca.gov/services/MH/Documents/CrisisResidentialProgramsMarch2010.pdf.

Washington state and Massachusetts have undergone litigation involving children's mental health crisis care. Both states are now in the process of implementing the settlement plans, which include a state-wide continuum of crisis care to youth who need intensive mental health services in order to grow up healthy in their own homes, schools, and communities. (See references contained within Appendix C.)

Washington

In November of 2009, a Medicaid lawsuit, *TR vs. Quigley and Teeter*, was filed in Washington State regarding the lack of intensive children's mental health services.[15] The lawsuit was based on federal EPSDT (Early and Periodic Screening, Diagnosis and Treatment) statutes, requiring states to provide any medically necessary services and treatment to youth, even if the services have not been provided in the past. After several years, a settlement was reached in 2013, where Washington State committed to build a mental health system that will bring EPSDT statutes "to life" for all young Medicaid beneficiaries who need intensive mental health services. It is Washington's duty to create a consistent and sustainable delivery service system **for intensive mental health services provided in home and community settings** to Medicaid eligible youth.[16] The specific agreed upon package for statewide implementation is called Wraparound with Intensive Services (WISe), which ensures that services are individualized and that youth are served in the most natural and least restrictive environment. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements. The service array includes assessment, intensive care coordination, intensive services provided in home and community settings, and 24/7 mobile crisis intervention and stabilization services.

Massachusetts

In 2001, a lawsuit was filed challenging Massachusetts's failure to provide medically necessary home-based services to children with serious emotional disturbances (SED), as required under federal EPSDT statutes, and its failure to inform parents and children of their entitlement to these covered services.[17] In 2006 the court found that Massachusetts violated the EPSDT provisions of the federal Medicaid Act by failing to provide home-based services to thousands of children across the state. A state-wide remedial plan was subsequently developed and approved in 2007, which provides intensive home-based services to children with SED. The array of services[18] are designed to help children succeed at home and avoid unnecessary hospitalizations. Among the services to be available includes 24/7 mobile crisis intervention, where in addition to intervention the team will be able provide short-term emergency care in

[15] *See* Wraparound with Intensive Services (WISe) Implementation Plan, August 2014, available at https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/TR.ImplementationPlan.8.1.2014.pdf.
[16] *See* Wraparound with Intensive Services (WISe) Implementation Plan, August 2014.
[17] *See http://www.rosied.org/page-84580.*
[18] Services include intensive care coordination, a comprehensive home-based assessment, family training and support, mobile crisis, crisis stabilization, in-home behavioral service, in-home therapy services, and therapeutic mentoring. *See* http://www.rosied.org/page-84580.

the home to evaluate and treat a child in crisis. Another element of the array of services is a crisis stabilization program which allows for up to seven days of treatment to occur in the home or another community setting.[19] All services are designed to conform to child-centered, family driven principles, which focus on tailoring the services to meet the specific needs of the child and family within the most appropriate setting.

Expand effective program models already in place in a few counties in California

In California, there are a limited number of counties that operate community based programs alternatives for children such as Alameda, Contra Costa, Santa Clara, San Francisco, San Diego, Santa Barbara and Ventura. (See Appendix A.) These counties operate model programs with positive outcomes, which should be expanded throughout the state (though to be clear there is not one county that has addressed the full continuum needed for children, i.e. one may have a mobile crisis team to respond, but no crisis stabilization services.) For the purposes of this paper, we will highlight two counties that have a more fully developed and robust continuum of services to support children experiencing a mental health crisis.

Alameda County

Seneca Family of Agencies offers both mobile response services and crisis stabilization services that work in conjunction with one another to create a seamless experience for children and families during their most difficult times. All youth served through these programs receive transition planning and linkage support to ensure long term success for youth and families.

At the front-end of services, the Mobile Response Team (MRT) is the first line of support for children and adolescents in crisis, offering immediate, community-based interventions in order to divert young people from psychiatric hospitalization and/or disruption of their current living situation. The MRT works to stabilize the child with his/her caregivers (family or group home staff), develop a safety plan, and determine together with the caregiver(s) what support services are needed to avert future crises and promote longer-term stability. Once the immediate crisis is addressed, the MRT staff assist the youth and family or other caregivers in accessing whatever community services and supports may be required to avert future crises. MRT is able to stabilize 80% of youth in their home. For youth that require an inpatient hospitalization, the staff is able to support them with the transition home.

Willow Rock Crisis Stabilization Unit (CSU) provides multi-disciplinary assessments to adolescents experiencing an acute psychiatric crisis by engaging the youth, caregivers, and others to determine the most appropriate and least restrictive means to promote the youth's immediate safety and long-term wellbeing. This year, for youth brought in on an involuntary psychiatric hold, Willow Rock was able to divert 50% away from hospitalization.

[19] *See* http://www.rosied.org/resources/Documents/Crisis%20stabilization.program%20specs.final.09.pdf.

Willow Rock Center consists of two separately operating programs co-located on the same campus, offering crisis stabilization services and psychiatric health facility (PHF). The Willow Rock CSU is the receiving center for all adolescent psychiatric emergencies within the county. All youth that arrive at Willow Rock receive medical screening and clearance and initial evaluation to determine the most appropriate level of care. This includes evaluating whether an involuntary hold should remain in place, recommendation for transfer to the Willow Rock PHF, existing crisis response service, other medical facility, or discharge to family or other caregivers. Furthermore, youth transitioning from the CSU access MRT on the back-end to help provide supportive transition services and prevent their return to the Willow Rock facility.

Santa Clara County

EMQ FamiliesFirst is another innovative and comprehensive mental health treatment program that serves multiple counties in California. EMQ FamiliesFirst believes the most effective form of care for children, youth and their families is based in the community and uses an individualized approach to help each client. EMQ FamiliesFirst's *Continuum of Crisis Care* program includes Mobile Crisis[20], Community Transition Services (CTS)[21], and the Crisis Stabilization Unit[22] for children and youth experiencing 5150 diversion and hospitalization diversion.

All activity in the combined programs are designed to stabilize the immediate crisis, achieve a thorough assessment, develop a realistic and concrete plan, and provide all necessary supports to achieve a successful transition and follow up. The EMQ FamiliesFirst Mobile Crisis program has achieved over a 70% hospital diversion rate in its twenty years of operation.

The integration of mobile crisis and crisis stabilization services in both Alameda County and Santa Clara Counties helps to ensure that youth experiencing psychiatric emergencies receive prompt and the most appropriate treatment given their needs.

Design and implement new program models that can effectively meet the needs of youth

Intensive Residentially-Based Hospital Alternatives Program – Establish a short-term (up to six months), two-bed, 24-hour, residential program utilizing a house-parent model to provide highly individualized crisis residential services for children and adolescents. This model will address the needs of youth who required treatment in a structured, supervised and protective environment, and is envisioned as an enhanced Intensive Treatment Foster Care (ITFC) program.

[20] The Mobile Crisis program offers 24/7 5150 Crisis response and safety planning for families in need.
[21] The Community Transition Services provides diversion from hospitalization, transition support to families, caregivers, and children, proactive/reactive safety planning for families and caregivers, referral and linkage to community service providers, and assessment and referral to appropriate level of service.
[22] The Crisis Stabilization Unit provides assessment, linkage to the CTS program, and 23:59 minutes crisis stabilization for youth and families.

Mobile In-home Intensive Crisis Stabilization Services– As noted above, the design of an in-home crisis stabilization service would include provision of intensive, longer-term intervention and follow-up for clients who present as risks of danger to self and/or others. The focus will be to intervene in the family's natural environment with the goal of diverting psychiatric hospitalization. An "enhancement" to the above model proposes to include the use of a RV for families without a permanent home structure (i.e. homeless) or inadequate space, (i.e. many family members living in a converted garage.) This would provide the needed space and structure to provide services under "in home " model – would provide space for individual/small group sessions, respite for family members, and could provide for basic needs items to support families with immediate basic needs.

PROPOSED FUNDING STRATEGIES

Enhance Previous Legislation

The Investment in Mental Health Wellness Act of 2013 (Senate Bill 82 of 2013) was designed to provide funds to counties to increase capacity of individual assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. Exactly the type of funds needed to address the gaps in the children's crisis care system.

Not surprisingly, the lack of crisis care also affected adults. The overall needs for adult beds was greater since there are 10 times as many psychiatric hospitalizations of adults as children. Accordingly nearly all county applications and nearly all approved funding went to adult crisis care programming, leaving the children's crisis care needs virtually unimproved by this vital and valuable funding.

As of November 2014, 30 counties were recipients of a total $92,438,203[23] allocated by the state and made available through SB 82. After two rounds of funding $60 million remains for crisis residential beds, and while the needs for that level of care for adults may exhaust that funding, some of that money could be specifically set aside to meet the needs of youth.

However, it is clear that the problem, both for children and adults, is bigger than what can be done through SB 82 and a new more comprehensive approach- especially for children is now required.

Augment EPSDT funding for counties similar to other EPSDT mandated service elements that California has not implemented. This can be done through legislature to avoid costly lawsuits and the issuance of a federal court order.

[23] http://www.calhospital.org/sites/main/files/file-attachments/sb_82_grants.pdf

Over the past 20 years California has lost several lawsuits brought on behalf of Medi-Cal children who were not getting their medically necessary mental health care. A provision of federal law known as EPSDT (Early and Periodic Screening Diagnosis and Treatment) requires that all Medicaid optional services, including Specialty Mental Health Services, are mandatory for states for youth under the age of 21. Successful cases have required special support services for youth at risk of out of home placement and for additional support for foster youth. Each case resulted in a court settlement that mandated additional funds to be paid to counties to meet a need that was not already being met. **Legal advocates are ready to file such a case for crisis care in California**.

That can be averted if the California Legislature can establish a funding program for counties to implement this at a reasonable level and demonstrate the commitment to address unmet acute mental health needs of these children.

Ensure that commercial health plans provide appropriate crisis care either by contracting with counties or contracting directly with providers.

In addition, private health plans also can be obligated to provide this care through a legislative declaration, which is implicitly already required. Many recent court decisions have clarified that health plans must provide all medically necessary care for mental illnesses and that the absence of a direct parallel for a service for physical health care does not mean that type of care is exempt from mental health parity laws, which were strengthened by the Affordable Care Act.

The legislature could make findings that every health plan is expected to be able to offer all enrollees with all necessary care in a convenient location in a timely manner. Then it could direct the state health insurance regulatory agencies- Department of Insurance and Department of Managed Healthcare to require each plan to verify that they have this in place either through their own networks or through contracting with counties.

File State Plan Amendment (SPA) in order to establish a daily residential rate that funds crisis residential mental health services as an alternative to hospitalization

Several states use state general funds, state Medicaid match, and Medicaid, including 1115, 1915(b), and 1915(c) waiver funds. (Source: SAMSHA. Effectiveness, Cost Effectiveness, and Funding Strategies. HHS Publication No. (SMA) 14-448, 2014.)

Identify potential untapped state or federal funding sources that could be used to fund crisis response programs for children and youth. Examples: Title IV-E dollars, SAMHSA grants for suicide prevention efforts (i.e. RFA Number: SM-15-003, posted 12/31/14), other federal/state grants.

In California there is no state Medi-Cal (EPSDT) Specialty Mental Health Services fiscal structure for children's residential crisis care. Nor is there a licensing category for children's crisis residential services, preventing the creation of such programs for youth. The implications of this reality are that programs and organizations are unable to access sustainable funding resources in order to support hospital alternatives such as crisis residential programs without an investment of individual county behavioral health departments. While some counties have made this investment, many have not, furthering exacerbating the variability of services available to children and adolescents. Without appropriate funding stream to support hospital alternative crisis care programs, the availability of these types of programs with continue to be scarce.

CONCLUSION

The children's system remains profoundly neglected in terms of available and appropriate levels of alternative intensive mental health crisis services in lieu of inpatient care that is often not needed, and more often than not, does not provide any therapeutic value to the child or his/her family.

California policy makers and legislative leaders need to address the following question (the big, fat elephant in the room): "What is getting these children to the point that they need to be hospitalized?" Why is a 9-year-old child sitting in an emergency room for 72 hours and not receiving any care? Why is a CPS report filed on a mother for taking her daughter home after sitting in the hallway of an ER with her scared child for over 48 hours? Should this really be considered taking a patient home "Against Medical Advice" rather than negligence on the part of the system for failing to provide timely assessment and treatment? The answer is obvious: It is California's lack of a comprehensive continuum of care, a lack of specialized mental health services for children, particularly for those youth with significant mental health issues. With the appropriate investment in services we can divert potentially tragic outcomes and suffering. Data supports model treatment programs in the least restrictive environments as a means of diverting unnecessary hospitalizations such as one county's crisis stabilization program's 50% diversion rate. It is incumbent upon us to help these children; not "board" them in an inappropriate environment, where they wait for days to be seen and then subsequently released without any interventions. California voters, legislators and policy makers should expect and demand a children's mental health system that provides access to timely and appropriate treatment in the least restrictive, community based program alternatives. This is not a complex regulatory matter. Simple solutions are available that will result in better outcomes for these children and their families, resulting in healthier and more productive communities throughout the state of California.

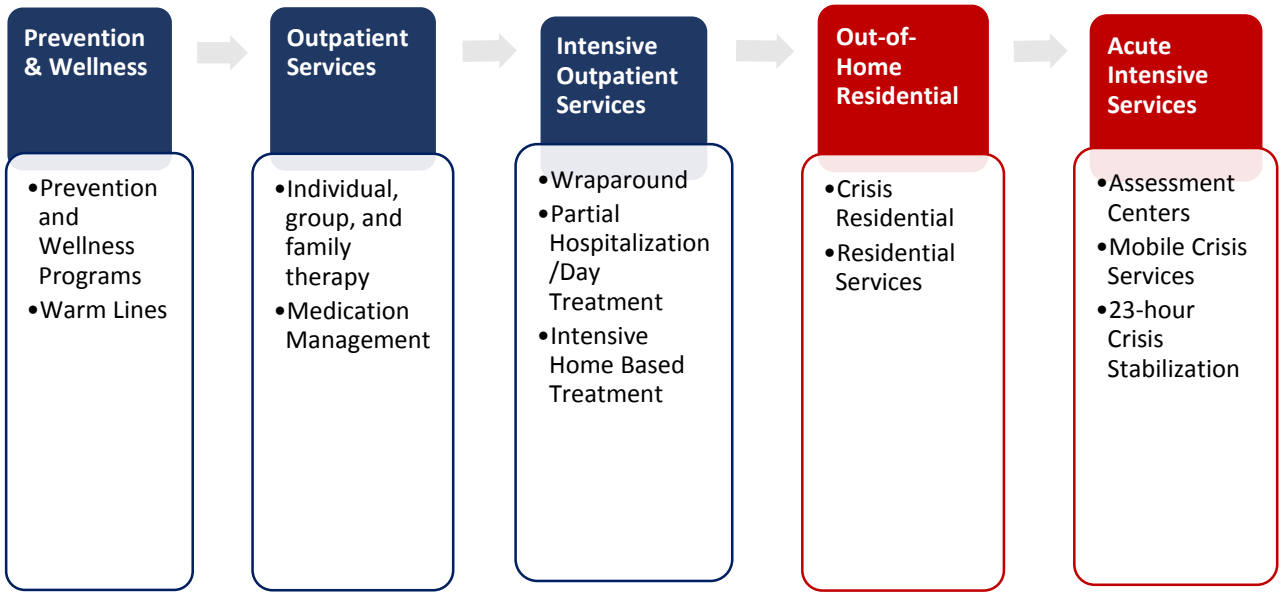
APPENDIX A

EXAMPLES OF COMMUNITY BASED PROGRAM ALTERNATIVES FOR YOUTH EXPERIENCING A MENTAL HEALTH CRISIS

CALIFORNIA	County	Program/Provider	Funding Sources	Summary of Service Activities
Mobile Crisis Services	Alameda	Mobile Response Team/Seneca Family of Agencies	Medi-Cal; County General Fund	Rapid response to assess the individual, and resolve situations that involve children who are experiencing crisis. Brief intervention and linkage.
	Contra Costa	Mobile Response Team/Seneca Family of Agencies	Medi-Cal	
	Ventura	Children's Intensive Response Team/Casa Pacifica Centers for Children & Families	Medi-Cal, MHSA	
	Santa Barbara	Safe Alternative For Treating Youth/Casa Pacifica Centers for Children & Families	Medi-Cal, MHSA	
	Santa Clara	Mobile Crisis Team/EMQ-FF	Medi-Cal, MHSA, County General Fund	
23-hour Crisis Stabilization	Santa Clara	Continuum of Crisis Care Program/EMQ-FF	Medi-Cal, County General Fund	Triage, Clinical Assessment, triage, hour crisis stabilization, Linkage to the Community Transition Services (CTS) program
	Alameda County	Willow Rock Center-Crisis Stabilization Unit/Seneca Family of Agencies	Cost reimbursement payment structure in contract with Alameda County Behavioral Health Care Services; Private Health Plan cost reimbursement (i.e. Kaiser); Medi-Cal	Triage, Medical Clearance, Clinical Assessment, Crisis Stabilization, Mental Health Interventions
Short-term Crisis Residential & Stabilization/ Hospital Diversion	Orange County	Community Service Programs, Inc. Children's Crisis Residential Program	Medi-Cal, MHSA, Healthy Families, UMDAP	Emergency shelter, 24-hour supervision, individual, group and family counseling, prevention education, life skills development activities as well as aftercare services.
	San Francisco	Edgewood Center for Children and Families	Major commercial insurance plans	Assessment, crisis stabilization, intensive interventions, intensive individual, group, family counseling, therapeutic classroom, clinical case management
Community Transition Services	Santa Clara County	Continuum of Crisis Care Program/EMQ-FF	Medi-Cal, MHSA, County General Fund	Hospital diversion, transition support to families, caregivers and children, safety planning, assessment and referral to appropriate level of service

APPENDIX B

Continuum of Crisis Services



DEFINING TYPES OF CRISIS SERVICES

It is important to begin by noting that in all models, data indicates that best practices includes having youth services separate and distinct from adult services.

24/7 crisis hotlines: a direct service delivered via telephone that provides a person who is experiencing distress with immediate support and/or facilitated referrals. This service provides a person with a confidential venue to seek immediate support with the goal of decreasing hopelessness; promotes problem-solving and coping skills; and identifies persons who are in need of facilitated referrals to medical, healthcare, and/or community support services[24] (for youth, this increasingly means including chat lines and text lines, as well as phone lines.)

Warm line: Warm lines are telephone lines that are run by trained mental health consumers (i.e., peers) and staffed by people who are also in recovery. A warm line is "a direct service *delivered via telephone by a [peer] that provides a person in distress with a confidential venue to discuss their current status and/or needs*. These also are increasingly including chat lines and text lines in addition to the phone lines.

In-home Intensive Crisis Stabilization Services: The mobile crisis stabilization service will include provision of intensive, longer-term intervention and follow-up for clients who present as risks of danger to self and/or others. The focus will be to intervene in the family's natural environment with the goal of diverting psychiatric hospitalization. Multidisciplinary, bi-lingual staff with psychiatric hold privileges will provide ongoing assessment and intervention for up to three days. A similar model exists in

[24] SAMHSA, 2012. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.

Massachusetts, with a provider (MBHP) that operates a Mobile Crisis program specific children. They are assessing and working with children in their homes, keeping children with their families, and as a last option, they can take a child from home to hospital when needed.[25]

Peer crisis services: An alternative to psychiatric ED or inpatient hospitalization, *peer crisis services are operated by people who have experience living with a mental illness (i.e., peers).*[26] Peer crisis programs are designed as calming environments with supports for individuals in crisis. They are delivered in community settings with medical support. Services are intended to last less than 24 hours but may extend up to several days, if needed. Peer crisis services are generally shorter term than crisis residential services.

*Short-term crisis residential services & crisis stabilization***:** Crisis stabilization is defined as "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous *24-hour observation and supervision for persons who do not require inpatient services.*"

*Mobile crisis services***:** Mobile crisis teams *provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites* outside of a traditional clinical setting. Objectives of mobiles crisis services include: to provide rapid response, assess the individual, and resolve crisis situations that involve children who are presumed or known to have a behavioral health disorder and linking them to needed services.

*23-hour crisis stabilization/observation beds***:** a direct service that provides individuals in severe distress with up to *23 consecutive hours of supervised care to assist with deescalating the severity of their crisis and/or need for urgent care*. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care. The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation.

[25] https://www.masspartnership.com/index2.aspx

[26] Ostrow, L. & Fisher, D. (2011). *Peer-Run Crisis Respites: A review of the model and opportunities for future developments in research and innovation.* Retrieved from http://www.power2u.org/downloads/Ostrow-Fisher-PRCR-12.20.2011.pdf

APPENDIX C

ADDITIONAL RESOURCES ON THE ISSUE:

California Healthcare Foundation, Center for Health Reporting project, Youth in Trouble: Mental illness admissions spike for California's hospitals.

http://centerforhealthreporting.org/article/hospitalizations-way-california%E2%80%99s-youngest-residents

http://centerforhealthreporting.org/article/families-mentally-ill-children-struggle-access-residential-treatment

California Hospital Association releases report on California's Acute Psychiatric Bed Loss.

http://www.calhospital.org/sites/main/files/file-attachments/psych_bed_data_14.pdf

California Healthline releases report on increase in psychiatric wait times in California Emergency Departments.

http://www.californiahealthline.org/articles/2014/10/27/psychiatric-patients-face-long--waits-in-california-eds

The Washington State Supreme Court ruled that psychiatric boarding of mentally ill patients in hospital emergency rooms is unlawful. http://seattletimes.com/html/localnews/2024266358_psychiatricboarding1xml.html

Open Minds released a briefing citing that Washington ban on ER Boarding may have broader implications. http://www.openminds.com/market-intelligence/executive-briefings/future-er-holds-patients-psychiatric-problems.htm

Orange County Register releases a three part series chronicling: (1) severe shortage of psychiatric hospital beds, making hospital emergency departments into virtual bed boarding houses for patients, (2) lack of psychiatric beds available for children in Orange County, and (3) financial barriers to developing two psychiatric emergency centers in the region.

http://www.ocregister.com/articles/psychiatric-639758-patients-emergency.html

http://www.ocregister.com/articles/says-639846-children-mental.html

http://www.ocregister.com/articles/county-639949-psychiatric-patients.html

Kaiser Family Foundation releases article about urgent care center opening for people with mental illness in Los Angeles.

http://kaiserhealthnews.org/news/urgent-care-centers-opening-for-people-with-mental-Illness/

SAMHSA released a report on the effectiveness, cost-effectiveness, and funding strategies for crisis services. http://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf

Massachusetts Medical Necessity Criteria Emergency Services, Mobile Crisis Intervention. http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-mobile-crisis-intervention.pdf

Washington Post releases article on State Senator Creigh Deeds' son's mental health challenges. http://www.washingtonpost.com/national/a-fathers-scars-for-deeds-every-day-brings-questions/2014/11/01/2217a604-593c-11e4-8264-deed989ae9a2_story.htmlCo

Massachusetts Behavioral Health Partnership

https://www.masspartnership.com/index2.aspx