



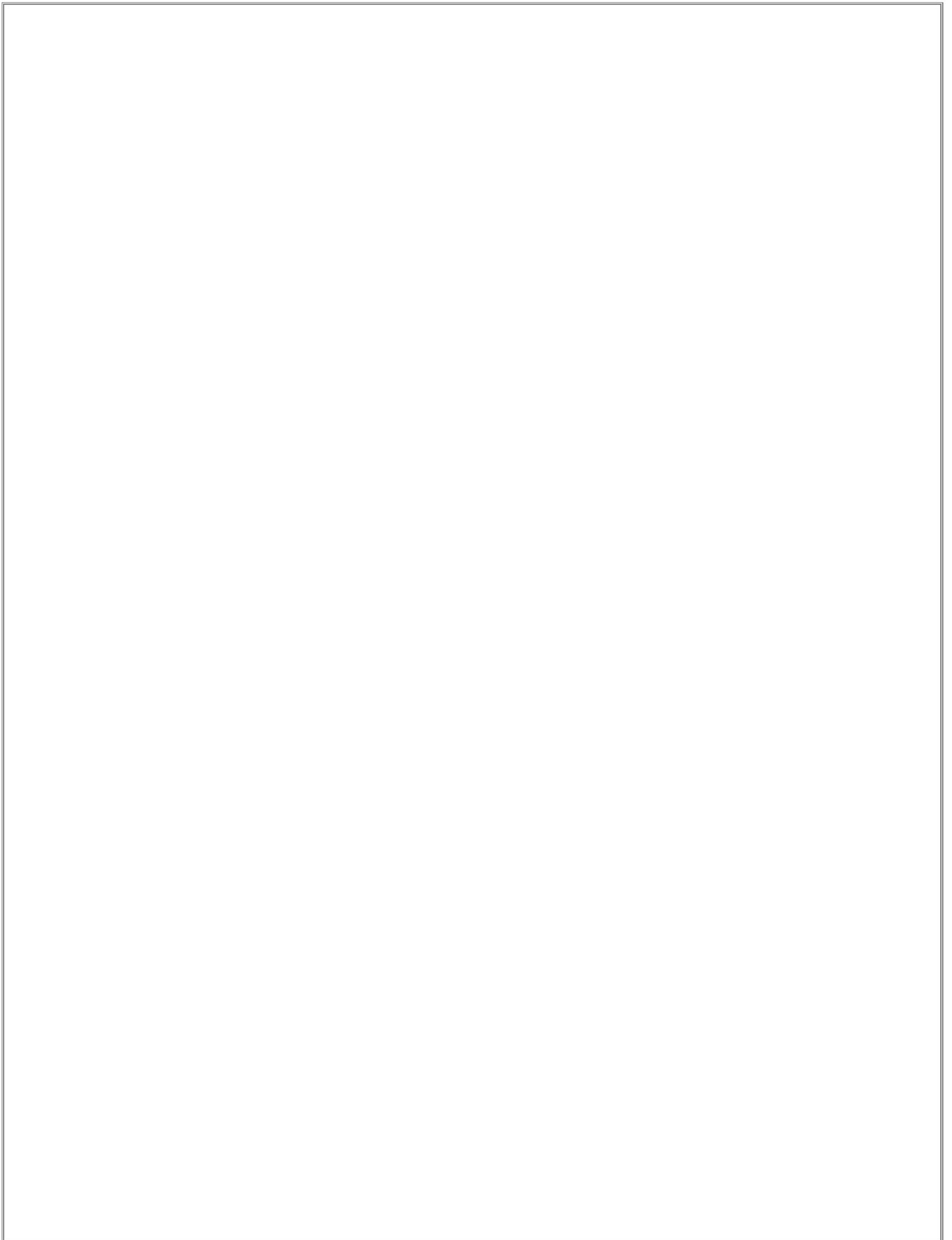
Briefing Memo

3A: Improving Crisis Services for California’s Children and Youth

Panel Presentations

October 22, 2015

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Introduction and Background

Among the duties and authority of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) is to advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness and assist in providing technical assistance to accomplish the purpose of the Mental Health Services Act. In support of this oversight and accountability role and under the leadership of Commissioner John Boyd, the MHSOAC has chosen to examine one area of California’s mental health system, crisis services for children and youth, which deserves renewed focus and attention. The MHSOAC is uniquely positioned to increase understanding of the needs of children and families experiencing a mental health crisis, as well as, highlight and encourage the implementation of effective services components and models to meet these needs.

“Children and youth become increasingly distressed beyond the state in which they were brought into the emergency department. The increased stress further aggravates an already difficult situation, making recovery less likely to occur quickly” —Madelyn Schlaepfer, Stanislaus County Mental Health Director (Carlson, 2015).

Crisis Services Project Overview

By focusing attention and resources on this project, the Commissions hopes to document the current state of crisis services for children and youth throughout California and develop recommendations for improving the delivery of those services and the associated outcomes for children, youth, families and the communities in which they live. Each phase of this project is guided by the knowledge and expertise of an advisory workgroup consisting of subject matter experts from a broad array of private and public sector service providers, advocacy groups, law enforcement, schools and consumers. Advisory group meetings conducted over the past two months have helped to lay a foundations for understanding the complexity of delivering effective crisis services, gaps in existing services and opportunities for improving both service quality and outcomes.

Prior Panel Presentations and Site Visit

As part of this project, a series of site visits and panel presentations have been scheduled to enhance the Commission’s understanding of the need for comprehensive crisis services for children and youth, as well as the challenges and obstacles currently faced by counties, services providers and communities in meeting these needs. On September 23, 2015 staff and several commission members visited the Edgewood Center for Children and Family Services located in San Francisco.

“The Bay Area has put lots of money and leadership into this realm, other counties have not done as well, but no county has the full array of crisis services” —Ken Berrick (MHSOAC Panel Presentation 9/24/15)

In addition to describing the range of crisis services offered through this center (e.g. crisis stabilization, crisis services unit, mobile crisis) Edgewood staff highlighted a number of existing challenges including restrictive regulations related to crisis services (23-hour facilities) and the lack of adequate psychiatric beds for children throughout the state. Accessing an appropriate level of funding or reimbursement for the

level of intensive services children in crisis need also continues to present a significant barrier to meeting the needs.

Advisory Workgroup Activities

The participants in the crisis services advisory workgroup bring a tremendous depth and breadth of expertise and personal experience, which continues to provide a strong foundation for understanding the nature of mental health crisis; its impact on children, youth and family members; existing barriers to providing effective services; and opportunities for improvement. During the first two meetings participants of the advisory workgroup discussed foundational issues including the definition of children’s mental health crisis, potential goals of an effective system of crisis services for this population and key program and services elements. All workgroup meetings are open to public and strive to incorporate a range of perspectives and experiences to support the development of shared knowledge and ensure that group recommendations address the needs and interests of diverse communities throughout California.

Key Elements of Effective Crisis Services for Children and Youth

The work of the Crisis Services Advisory Work group has 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 is the importance of providing services in the most appropriate and least restrictive setting possible and the ability to “ratchet up” and “ratchet down” 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 and information 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.

During Fiscal Year 2013-14, more than 23,000 children were placed on an involuntary 72-hour detention for evaluation and treatment in California (DHCS, 2015)

Children’s Crisis Service Delivery Models

During prior advisory workgroup meetings, panel presentations and site visits; participants highlighted significant efforts to improve crisis services currently underway in a number of locations within California and across the nation. Although this is by no means a comprehensive list, some background information regarding these efforts is provided in the sections below to

“We have wonderful best practice models. We know how to do this”—Melinda Bird (MHSOAC Panel Presentation 9/24/15)

inform the discussion and increase the Commission’s understanding of alternative crisis service delivery models.

EMQ Families First (EMQFF)—Santa Clara County Continuum of Crisis Services

EMQ Families First Continuum of Crisis Services 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: the Child Adolescent Crisis Program (Mobile Crisis), the Crisis Stabilization Unit, and the 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 (EMQ Families First, 2015).

Seneca Family of Agencies—Crisis Response Programs (Alameda and Contra Costa County)

Willow Rock Center is an adolescent crisis stabilization and treatment facility provided through a partnership among Seneca Family of Agencies, Telecare Corporation, and Alameda County Behavioral Health Care Services. Willow Rock Center has three complementary levels of programs: a 23-hour crisis stabilization unit, an inpatient psychiatric program (Telecare), and a short-term outpatient mental health program. 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.

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. The STEP Program provides structured and individualized treatment interventions including assessment, group therapy, family therapy, psycho-education, and medication management. (Seneca, 2015)

Massachusetts Department of Mental Health

The Massachusetts’ Department of Mental Health has implement a comprehensive system of care for seriously emotionally disturbed children, which is guided by a number of core values and principles including collaboration with the child, family and service providers; focus on functional outcomes; accessible and timely services provided in the most appropriate settings possible; and connecting to natural supports. The Massachusetts service delivery model includes several components including intensive care coordination, comprehensive home-based assessment, family training and support, mobile crisis intervention and stabilization, and crisis stabilization. Three of these program components are described in more detail below.

Intensive Care Coordination (ICC) provides youth, with serious emotional disturbance, under the age of 21 services and supports driven by the needs of the youth and developed through a Wraparound planning process consistent with Systems of Care philosophy. The ICC includes the following components: comprehensive assessment to guide the development of a child- and family-centered Individual Care Plan (ICP) and risk management/safety plan, referral and care coordination based on the ICP in collaboration with service providers, and monitoring and follow-up activities to reflect the changing needs of the youth and family.

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. This service is provided 24 hours a day, 7 days a week.

Values and Guiding Principles for Crisis Services
<i>Avoid harm</i>
<i>Intervene in Person Centered Ways</i>
<i>Shared Responsibility</i>
<i>Address Trauma</i>
<i>Establish feelings of personal safety</i>
<i>Strength Based</i>
<i>Recovery, Resilience and Natural Supports</i>
<i>Timely access to supports and services</i>
<i>Services provided in the least restrictive manner possible</i>
<i>Peer support is available</i>
<i>Plans are strength-based</i>
<i>Help individuals regain a sense of control</i>
<i>Rights are respected</i>
(SAMHSA, 2009)

Mobile crisis intervention services include a crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 72 hours 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.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff coordinate 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.

Crisis Stabilization is provided for youth who do not require hospital level of care. Services are designed to prevent or ameliorate a behavioral health crisis and are focused on the rapid return of the youth to their home/community environment. Crisis Stabilization staff continuously evaluate and treat the youth as well as teach, support, and assist the parent or caregiver to better understand and manage behavior that has resulted in current or previous crisis situations. Crisis Stabilization services also link the youth to other appropriate services. Crisis Stabilization services are available to a youth based on medical necessity in short-term (typically 24-48 hours and typically no more than 7 days), therapeutic staff-secure settings that provide 24-hour behavioral health care for youth in crisis. Crisis Stabilization services offer an opportunity for the family to restore safety and stability to the home environment while the youth is in a developmentally appropriate, structured, community-based therapeutic environment. Crisis Stabilization services include solution-focused assessments, crisis counseling, intensive, solution focused family interventions, assisting the youth and parent(s)/caregiver(s) in developing coping and behavior management skills, and working collaboratively with any existing service providers to prepare for the youth's return to their home environment. (This information was compiled from multiple source documents and reports from the [Massachusetts Department of Mental Health](#))

Washington—Wraparound with Intensive Services (WISe)

As part of a children's mental health lawsuit and settlement agreement, the Washington State Department of Social and Health Services implemented Wraparound with Intensive Services (WISe) which provides comprehensive behavioral health services and supports to Medicaid eligible youth, up to 21 years of age, with complex behavioral health needs. WISe is designed to provide individualized, culturally competent services that keep youth with intense mental health needs safe in their own homes and communities.

WISe comprises three program components including Intensive Care Coordination, In Home and Community-Based Direct Services, and Mobile Crisis Intervention and Stabilization Services. The development, implementation and operation of each program component is guided by a number of principles including prioritizing family and youth voice and choice in all phases of the process, relying on a multi-agency collaborative team approach, drawing on sources of natural supports, and delivering services in the most normative and least restrictive settings possible. Services are also designed to be culturally relevant, individualized, strengths based, unconditional and outcome-based. Additional descriptive information regarding each of the three program components that make up WISe is included below.

Intensive Care Coordination includes facilitating assessment, care planning, coordination of services, and monitoring of services and supports to address children's mental health conditions by a single consistent care coordinator.

Intensive Home and Community-Based Services are individualized, strength based interventions designed to correct or ameliorate mental health conditions that interfere with the child's functioning.

Mobile Crisis Intervention and Stabilization Services include crisis planning and prevention services as well as face-to-face interventions that support the child in the community.

Services are provided in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends. Using a Wraparound model, WISE relies on the strengths of an entire team to meet the youth and family's needs. Intensive care coordination between all partners and team members is essential in achieving positive outcomes. Each team is individualized and includes the youth, family members, natural supports, a therapist, a youth partner and/or family partner, and members from other child-serving systems that are involved in a youth's life. Other team members could include family friends, school personnel, a probation officer, a religious leader, a chemical dependency counselor, or a coach/teacher. The team creates one Cross-System Care Plan that identifies strategies and supports, using the youth and family's voice and choice to drive their plan. (Washington DSHS, 2015)

Panel Presentations

In continued support of the Commission's effort to improve crisis services for California's children and youth, a number of individuals have been invited to share their knowledge and expertise with Commissioners and members of the public. Panels including providers, subject matter experts, and policy leaders will provide foundational knowledge and experience supported by a discussion of existing barriers, challenges and potential opportunities for improving crisis services for children and youth throughout the state. Each panel will be followed by a roundtable discussion between presenters and Commissioners to further explore key issues and ideas.

The panel presentations are intended to continue to build on the larger work of the Commission to gain an increased understanding of the challenges faced by individuals, families and communities in accessing crisis services in a way that emphasizes resiliency and recovery, reduces trauma frequently associated with mental health crises, and supports the use of the least restrictive alternatives possible while at the same time supporting the safety of individuals and the communities in which they live. Three separate panels are scheduled for the October 22, 2015 Commission meeting to provide diverse perspectives regarding the current state of crisis services in communities throughout California and begin to explore opportunities for improving outcomes associated with those services.

A brief description of each panel presentation is provided below followed by potential areas of additional discussion and background information for the invited participants.

Panel 1: Setting the Stage. Crisis Services Providers

In preparing for their presentation to the Commission, members of Panel 1 were asked to respond to the following questions:

- What are the existing system challenges and barriers to effectively meeting the needs of children and youth experiencing a mental health crisis?
- In your experience, how does the existing crisis service delivery system impact children, caregivers and communities?
- In what area do you believe the Commission could have the greatest impact on improving the effectiveness of crisis services for children and youth?

Panel 2: Why Solve the Problem? State and Local Government Representatives

In preparing for their presentation to the Commission, members of Panel 2 were asked to respond to the following questions:

- What challenges do children and caregivers currently face when accessing mental health crisis services in your community?
- What opportunities exist for improving those services and the outcomes for children, families and the communities in which they live?
- What can the Commission do to support improved services in this area?

Panel 3: How Can We Solve This? State and Local Leaders in Crisis Services for Children and Youth

In preparing for their presentation to the Commission, members of Panel 3 were asked to respond to the following questions:

- What are the key elements of an effective crisis services system of care for children and youth?
- In your experience, what are the existing gaps in available children's crisis services in communities throughout California?
- In what area do you believe the Commission could have the greatest impact on improving the effectiveness of crisis services for children and youth?

Potential Areas for Discussion

Following each panel, Commissioners will have an opportunity to engage in a roundtable discussion with presenters. Potential areas for discussion include the following:

- What should be the principle goals of an effective and efficient system of crisis services? How do we know when we are successful?
- How can the Commission engage with additional external partners (e.g. law enforcement, schools, social services, private health insurance, faith-based organizations) in understanding the challenges and identifying potential solutions?

- What information, data and additional resources are currently available that will help to guide and inform the Commission in developing and evaluating potential policy recommendations?
- Are there alternative funding mechanisms and resources to support children's crisis services that the Commission should explore?

Panel Members Background

Brief background information is provided for each of the individual panel members is provided below in the order in which they appear on the meeting agenda.

Lyn Morris, LMFT, 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-laude honors. She has been a licensed Marriage and Family Therapist for over 16 years.

Ms. Morris began her career at Didi Hirsch as a Program Director for Adult Outpatient Services. In 2005, she became the Division Director for the Suicide Prevention Center. 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.

She has conducted over 150 clinical lectures on suicide assessment and intervention to approximately 5,000 psychotherapists, social workers, nurses, interns, physicians and psychiatrists. She has also trained various law enforcement agencies and first responders in crisis intervention including: FBI, SWAT Crisis Negotiators, Los Angeles Police and Fire Departments, 911 Dispatchers and the LAPD Mental Evaluation Unit, amongst many others.

Ms. Morris is also a certified trainer in ASIST (Applied Suicide Intervention Skills Training) and safeTALK; both best practices in suicide prevention. In addition, Lyn Morris and Dr. Farberow were invited by Drs. John McIntosh and John R. Jordan to co-author a mini-chapter in their book, GRIEF AFTER SUICIDE: Understanding the Consequences and Caring for the Survivors which was published in 2010. Her passion and dedication to suicide prevention comes from personal experience. Ms. Morris is a survivor of suicide having lost a cousin in 1999 and a close friend in 2004.

David Ketelaar, MD 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. Dr. Ketelaar 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, LCSW 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. Prior to becoming Program Manager earlier this year, Adams worked as a Clinical Supervisor for over a year and as a Crisis Specialist with SAFTY for almost

3 years. Prior to joining the SAFTY team Ms. Adams was the Conference Coordinator at the Glendon Association working closely with suicidologist Dr. Lisa Firestone assisting in presentation development and research on topics including violence and suicide prevention. Ms. Adams has served as a board member for the local unit of the National Association of Social Workers since 2012. 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, Mr. Williams 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. Until his election, Williams served as a national board member of the National Organization for Women (NOW), and taught at Antioch University in Santa Barbara. Prior to his public service, Mr. Williams worked as a junior high school teacher, as well as a legislative aide to California State Assembly Member Hannah Beth Jackson.

Mr. Williams 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, Supervisor Wolf has led on issues of concern to women and children's health, public safety, environmental stewardship and education.

Through her service on the Commission on Children in Foster Care, the Mental Health Commission, the Juvenile Justice Coordinating Council Supervisor Wolf has always been committed to insuring that our most vulnerable populations receive the care they need. A commitment to environmental stewardship and sustainable community planning also informs Supervisor Wolf's leadership.

Supervisor Wolf serves as the Board's representative on a variety of Boards and Commissions, including the Santa Barbara County Retirement Board, CenCal Health, Juvenile Justice Coordinating Council, and the Community Corrections Partnership, the entity overseeing AB 109 Criminal Justice Realignment.

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.

Mr. Bennett 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, MFT, ADMHS Chief Quality and Strategy Officer, is responsible for leadership of the Office of Quality Care and Strategy Management (OQSM) within ADMHS. Ms. Grimmesey began her work with “at risk youth” in the Santa Barbara County community 25 years ago. She has worked with the Santa Barbara County in the Department of Alcohol, Drug and Mental Health Services (ADMHS) for 18 years. Prior to her work with the County, she worked as the Director of Residential Services for Klein Bottle Youth Programs and was responsible for developing several programs within the CSOC of Santa Barbara County (operated by ADMHS), funded through the Federal CSOC grant known locally as MISC. Ms. Grimmesey developed the original program models for the Emergent Concern and SAFTY programs which provide crisis response services for children and families throughout the county, SAFTY being the operational program since 2004. She served as the Division Chief of Children’s Services and later Child and Adult Services, within the ADMHS department, for over 10 years. 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.

Ms. Grimmesey’s professional experience includes work in a variety of public service and non-profit areas such as administrative and direct work with youth, families, and adults, residential programs, grant writing, program community development, training, quality care management, acute hospitalization, and community collaboration. 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 CSPP-LA 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. Dr. Innes-Gomberg is the Co-Chair of the County Behavioral Health Directors’ Association’s (CBHDA) MHSA Committee, including a member of its Governing Board. She is a leader in LA County and across the State on the outcome and evaluation of mental health programs, co-chairing the CBHDA Measurements, Outcomes and Quality Assessments workgroup and is a member of the Mental Health Services Oversight and Accountability Commission’s Financial Oversight Committee.

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.

Dr. Kussin previously served as Academic Chair of the Clinical Psychology Doctoral Program of Phillips Graduate Institute and has served as faculty for graduate and undergraduate programs for 30 years, including public and private colleges. In addition, Dr. Kussin has served as an evaluator and expert witness for forensic immigration cases.

Rusty Selix, JD has been Executive Director and Legislative Advocate for CCCMHA since 1987 and has grown the association considerably during the intervening years. 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.

Mr. Selix has been a legislative advocate in Sacramento since 1978 when he joined the staff of the League of California Cities. He also serves as Executive Director of the Mental Health Association in California and provides legislative advocacy for the (Los Angeles) Association of Retired Teachers. Prior to becoming a lobbyist, Mr. Selix served as Deputy City Attorney for the City of Sacramento where he was the city's principal legal advisor on land use and environmental issues. From 1980 to 1984 he was also a member and chairman of the State Bar's Committee on Environmental Law. Mr. Selix attended Northwestern University where he received a Bachelor's Degree in Economics; he received his law degree from UC Davis.

Scheduled Site Visits

Prior to the October 22 meeting, Commissioners and project staff were invited to participate in a presentation and site visit in Ventura and Santa Barbara Counties to hear and see firsthand from crisis service providers. Site visit locations included the Casa Pacifica Center for Children and Families residential center and mobile crisis team, as well as, Santa Barbara Counties Children's Clinic.

Casa Pacifica operates two mobile crisis response teams (CRTs) designed to serve children and youth exclusively; one operates within Ventura County; the other within Santa Barbara County. Both programs are nationally accredited by the American Association of Suicidology. Staff work collaboratively with law enforcement, County partners from Behavioral Health, Child Welfare Services, Juvenile Justice, local school districts, and a child/youth's existing treatment team.

Goals of the Casa Pacifica Children's Mobile Crisis Teams include:

- Reduce danger and restore safety to youth and families by providing immediate support when there is danger of harm to self or others;
- Keep youth in the community in the least restrictive setting; preferably in their homes;
- Provide time-limited follow-up services to develop coping strategies that promote safety in the environment and linkage to community resources.

The Children's Intensive Response Team (CIRT) is a mobile crisis response service, available to all Ventura County children and youth under the age of 18. CIRT is available 24 hours a day, seven days a week, 365 days per year, under contract with Ventura County Behavioral Health (VCBH)

since March of 2007. 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, assessments for inpatient psychiatric hospitalization, follow up safety planning and safety monitoring, 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. Staff are 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.

The Safe Alternatives for Treating Youth (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, Casa Pacifica SAFTY team provides crisis services 24 hours a day, seven days a week, 365 days a year. Crisis situations are handled by phone and in person. The program design includes an in person response within 60 minutes, when clinically indicated. 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.

Next Steps

The next meeting of the advisory workgroup is tentatively scheduled for November 9, 2015. The workgroup will continue to support the documentation of common themes and key issues, guide future project activities, and inform potential recommendations for review and consideration by the full Commission. Project staff also plan to reach out to national experts to further explore model programs and service approaches and continue to review available literature and published reports on effective service delivery models and funding streams. The project site visits, panel presentations, advisory workgroup meetings and subcommittee activities planned for the next several months will support a final report summarizing the project findings and recommendations which will be presented to the full Commission in early 2016.

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