

Recommendations to Improve Children's Mental Health Crisis Services



**Children's Mental Health Crisis
Services Task Force**

Travis County Kids Living Well

11/28/2018



This report was produced and paid for by Integral Care, the
Local Mental Health Authority for Austin and Travis County, TX.

Table of Contents

Executive Summary	3
Introduction: Building Health & Well-Being for Our Children	6
The Challenges We Face in Austin and Travis County	7
Our Community Collaborates to Improve the Health & Well-being of Our Children.....	11
Our Community Identifies Ways to Create a System that Builds Health & Well-Being	123
Recommendation #1: Improve coordination and communication across systems	13
Recommendation #2: Single Comprehensive Point of Entry.....	15
Recommendation #3: Expand home and community-based intervention services.....	18
#3.1 Expand the scope of mobile crisis response	19
#3.2 Provide intensive community-based crisis intervention	21
#3.3 Expand Wraparound Care.....	23
#3.4 Increase family and youth peer support services.....	25
#3.5 Crisis respite.....	27
Recommendation #4: Expand access to partial hospitalization and intensive outpatient services.....	28
Recommendation #5: Residential crisis stabilization	29
Appendix A: Children's Mental Health Crisis Task Force Meetings	30
Appendix B: Map of Current Mental Health Crisis System.....	33
Appendix C: Map of the Crisis System We Want.....	35
Appendix D: Definitions	37
End notes	39



Executive Summary

Mental health is just as important as physical health. When our children have access to quality mental health care, we support the health and well-being of the youngest members of our community and prevent future mental health crises.

Inspired by the approximately 43,000 children under the age of 18 who have or are at risk of developing a mental health issue, community leaders developed the Travis County Plan for Children's Mental Health (CMHP). [The Plan](#) was first adopted in February 2015. As policymakers, health professionals, non-profit leaders, educators and law enforcement officers put the Plan into action, it became clear that we need to improve crisis services for children in Travis County. Children are considered to be experiencing a mental health crisis when they are at a level of distress, which impacts their ability to function in their environment and/or creates the potential of danger to themselves or others.

The Children's Mental Health Leadership Summit in October 2017 highlighted this need, which resulted in a Children's Mental Health Crisis Services Task Force. The Task Force aims to:

Create a system of care that empowers children and families experiencing a mental health crisis to live safe and healthy lives by offering the least restrictive, most appropriate level of care though a seamless, comprehensive and integrated continuum.

Convened in December 2017 by Co-chairs Sheriff Sally Hernandez and Integral Care Trustee Emmitt Hayes, the Task Force has worked tirelessly to analyze our current system and identify opportunities for improvement.

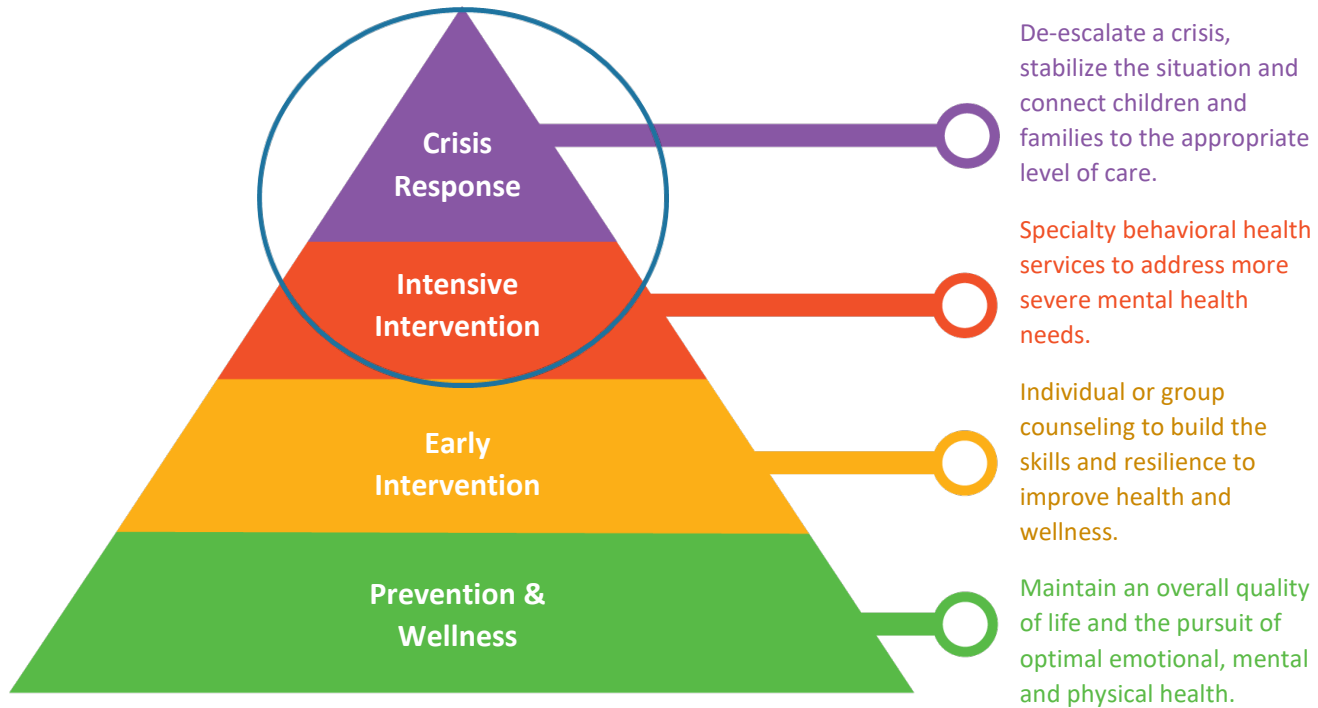
This report summarizes the findings and recommendations of the Task Force and identifies steps our community must take to create a more responsive and effective system that improves the lives of our most important asset – our children.

Challenges identified by the Task Force:

- Stigma prevents parents, children, doctors, teachers and other adults who interact with children from identifying mental health issues at an early stage. That contributes to delays in treatment.
- A lack of clarity for how to respond to a crisis results in children not being connected to the most appropriate level of care.
- Poor coordination across systems results in multiple assessments and delays in receiving care.
- Due to a lack of crisis intervention options, too many children end up in hospital emergency departments or psychiatric hospitals when non-hospital care would be more effective.

Travis County Behavioral Health Continuum of Care

The Continuum of Care pyramid visually represents the levels of mental health care in our community. Since the Children's Mental Health Plan was released in 2015, our community has made great strides in supporting children and families through early intervention, prevention and wellness.



Data suggests that there is still work to do when it comes to de-escalating a crisis, stabilizing the situation and connecting children to the appropriate level of mental health care. Best practice Models and research show that many children with significant emotional and mental health needs have improved health outcomes when care is provided through intensive home and community-based intervention treatment versus more restrictive levels of care, such as psychiatric hospitalization.

Based on the identified need in Travis County, the Task Force focused its efforts on improving intensive intervention and crisis response.

Summary of Task Force Recommendations

The Task Force recommends systemic improvements to help families, providers and agencies work together more effectively. The Task Force also proposed new and expanded services.

- A single point of entry for families with children experiencing a mental health crisis that provides quick access to care. This single phone number will provide screening, triage and connection to the most appropriate level of care as well as a follow-up phone call to ensure the family connected with care.
- Improved coordination and communication between families, providers, schools, foster care and juvenile justice to support more seamless transitions to the community and improve outcomes.
- Expanded home and community-based intervention services, including:
 - Additional mobile crisis response services to be dispatched to homes, schools or anywhere a crisis occurs.
 - Intensive community-based interventions including therapy and skills training to increase stabilization, foster resilience and reduce crises.
 - Expanded wraparound services, which provide a team-based, collaborative process for developing and implementing individualized care plans for children with serious emotional needs and their families.
 - Family and youth peer support services provided by family members or youth who have personally faced the challenges of coping with serious mental health conditions, either as a client or caregiver.
 - In-home and out-of-home crisis respite to provide temporary relief for caregivers, a safe environment for children while they experience a mental health crisis, and therapy, skills training and crisis planning for the family and child.
- Develop partial hospitalization and intensive outpatient services that include connections to a psychiatrist and medication management to help divert children from psychiatric in-patient hospitalization.
- Develop residential crisis stabilization that provides intensive short-term, out-of-home resources for the child and family, helping to avert the need for psychiatric inpatient treatment.



Task Force members discuss needed improvements for our community's system of care for children experiencing a mental health crisis.

► Next Steps

Investing in the Task Force recommendations will provide a seamless, comprehensive and integrated continuum that responds to our children's mental health needs with the least restrictive, most appropriate level of care. It will also provide children and families experiencing a mental health crisis the tools they need to achieve health and well-being. Successful implementation of this plan will require the support and advocacy of community leaders in local and state government, healthcare agencies, child-serving organizations and mental health providers.

We must take action to improve the lives of children living in Travis County. Together, we can ensure that children and families have the opportunity to thrive and meet their full potential.

Introduction: Building Health & Well-Being for Our Children

Families are the cornerstone of a healthy community. Early access to quality mental health care helps children build their health and well-being so they thrive at all stages of life. Like a storm that knocks a house from its foundation, a mental health crisis can knock someone off their feet. Just like we need experts to build a house, families and children need experts and the right tools to, not only survive a mental health crisis, but to rebuild a strong foundation that supports health and recovery.

Our community has the opportunity to ensure children and families have access to experts and the tools they need to prevent a mental health crisis and build healthy, resilient families. The right interventions at the right time can literally mean the difference between life and death as well as minimize years of struggling with undiagnosed mental health issues. Recovery is possible and the earlier a child has access to the right help, the better their chance for long-term recovery.

Our task is to come together to invest in systems and supports that will ensure all children and families can access the help they need when a storm knocks them off their feet. Just as we have committed to and invested in improving the crisis mental health system for adults, we must commit to doing the same for children and families.

This will not happen overnight – it will require a dedicated, long-term effort. Together, we must build better systems and supports that help children in Austin and Travis County not just survive, but thrive and reach their full potential.



The Challenges We Face in Austin and Travis County

Good mental health is a building block for well-being, not only for our children but our community as a whole. When the youngest members of society have good mental health, they are able to thrive and ultimately contribute their unique gifts and talents. We want to ensure they have the tools they need to do so, which includes access to quality mental health care.

Data, demand for mental health services and firsthand reports tell the story of Travis County and the challenges our children face.

- Nationally, 1 in 5 children experiences a mental health issue in a given year.
- Half of all mental illness is evident by the age of 14.
- 2/3 of children do not receive treatment due to stigma and/or lack of information and awareness.
- Suicide is the 2nd leading cause of death among adolescents ages 12 to 17.
- 15% of students surveyed through the Texas Youth Risk Behavior Survey reported that they had made a plan about how they would attempt suicide.
- In Austin, 39 people under the age of 20 died by suicide between 2013 and 2017. Last year there were 6 completed suicides in Austin ISD alone.

Texas Youth Risk Behavior Surveillance Survey				
Texas High School Students	9 th Grade	10 th Grade	11 th Grade	12 th Grade
Felt Sad or Hopeless	34%	38%	33%	32%
Made a Plan to Attempt Suicide	15%	16%	13%	13%
Attempted Suicide	10%	12%	14%	13%

Source: Center for Health Statistics, Texas Department of State Health Services, October 23, 2017

As Austin Travis County grows at a record rate, so does the number of children who need mental health care. Reports from local mental health organizations show an increase in usage of existing crisis services for children, highlighting this need.

Based on an analysis conducted by the Meadows Mental Health Policy Institute (MMHPI), we know that about 1,083 Travis County children were hospitalized in 2015 with the number jumping to 1,425 in 2016. This reflects a 31% increase in psychiatric hospitalizations of children in one year. The chart to the right shows the breakdown by year and hospital.

According to MMHPI, the total financial cost for hospital level care in 2016 for Travis County children was \$6,240,470.

Travis County Child Psychiatric Inpatient Admissions by Year		
Psychiatric Hospital	2015	2016
Austin Oaks	525	430
Austin State Hospital	<17	<14
Seton Shoal Creek	450	460
Texas Neuro Rehab Center	<6	--
Cross Creek Hospital	91	510
Austin Lakes	17	17

Source: Meadows Mental Health Policy Institute

Calls Received by the Crisis Helpline Regarding Children in Crisis in Travis County

	FY17	FY18	% Increase
Total Calls	4248	6226	47%
Unduplicated Children Served	1370	1947	42%
Call Resulted in MCOT Dispatch	401	695	73%
Call Resulted in 911 Dispatch	212	272	28%
<i>Source: Integral Care</i>			

Data from the last two years show a **47% increase in the number of people calling the Integral Care Crisis Helpline seeking help for children in crisis**. This may be due, in part, to the FY18 expansion of the Helpline, allowing them to take more calls and receive all calls within Travis County 24 hours per day.

Data from Integral Care's Mobile Crisis Outreach Team (MCOT) provides additional information about crisis support needed for children in Travis County. Last year, MCOT responded to **655 dispatches for children experiencing a mental health crisis**. MCOT provides crisis support anywhere someone needs help – at home, work or school and is dispatched by Integral Care's 24/7 Crisis Helpline. As the chart at right shows, there was a large increase in the number of unduplicated children served and total number of visits to children. MCOTs focus is to provide crisis assessment,

intervention, and follow-up services until a person is linked to services and/or the crisis is resolved. While MCOT does provide follow-up care for up to 90 days, the team indicates that they must balance the depth of follow-up service with timely response to incoming calls. Limited resources and capacity means that the team is not able to provide both the depth of service and timely response the community would like to have for children.

In addition to MCOT, Integral Care also partners with local law enforcement agencies to operate Expanded MCOT (EMCOT). The primary difference between the two services is that EMCOT is dispatched by 911 and law enforcement and MCOT is dispatched through Integral Care's Crisis Helpline. While EMCOT primarily serves adults, this team of mental health professionals responded to 199 calls regarding children in FY 2018.

Information collected from community stakeholders, providers and families helps create a more complete picture of the need for improved mental health services. Our community faces additional challenges that impact the ability for children and their families to access the right level of care as well as continuity of care once they receive mental health services.

Mobile Crisis Outreach Team Responses to Children in Travis County

	FY17	FY18	% Increase
Total Crisis Dispatches to Children	556	655	18%
Unduplicated Children Served	303	509	68%
Total Number of Visits	1000	1592	59%
<i>Source: Integral Care</i>			

Challenge #1: Lack of Referral Options

Families, schools and some professionals are uncertain where to turn for help and what level of support and intervention to seek on behalf of a child experiencing a mental health crisis. Parents say they do not know who to contact. They are reluctant to call 911 and have armed officers respond unless it is absolutely necessary. School districts report increased numbers of children experiencing crises at school. While they consider student mental health one of their top concerns, districts indicate that they do not have sufficient referral options for children.

Dell Children's Emergency Department		
	FY17 (7/16-6/17)	
Total patients flagged for mental health consult	1430	100%
<i>Discharged home</i>	662	47%
<i>Transfer inpatient</i>	603	43%
<i>Medical admit</i>	85	6%
<i>Unspecified</i>	66	5%
<i>Left against medical advice</i>	14	1%

Source: Dell Children's Medical Center Emergency Department

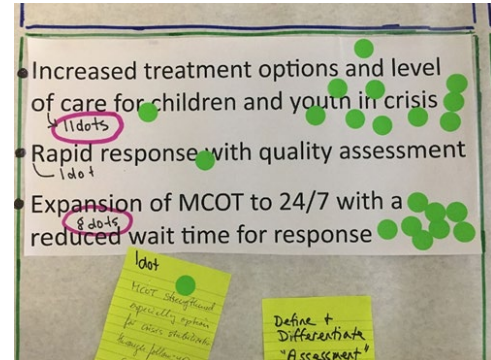
Currently, many children are referred to Dell Children's Medical Center (DCMC), which reported that 47% of children who presented with a mental health crisis in FY 2017 were sent home with service referrals because they did not require hospitalization. This situation has improved with the new services developed at the recently opened Maxwell Unit. In addition to the new 24-bed inpatient hospital, DCMC also offers Intensive Outpatient Services four evenings per week and plans to add partial hospitalization (daytime hospital with therapy and on-line charter school) early next year. DCMC now has increased options for helping children and families and is developing more services. However, many children appear in other emergency rooms across the community, many of which are not well suited for serving children or providing psychiatric care.



Challenge #2: Limited Crisis Intervention Options

Around the country, options for crisis treatment have been updated with new best practices. With competing demands for resources, we have not focused on ensuring the availability of a robust crisis treatment array for children and updating our treatment approaches. Across our rapidly growing community, we lack sufficient types of treatment and the capacity to meet the needs of children in crisis. The choices available to most families are inpatient psychiatric hospitalization or a future appointment with a psychiatrist or counselor, which are not always the best option. The result is overutilization of inpatient hospitalization, an expensive resource to be used only for the most serious cases. According to MMHPI, from 2015 to 2016, there was a 31% increase in children who were admitted to inpatient psychiatric hospitals or residential treatment centers. This resulted in more than \$6 million of payments in 2016.

The Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) report that some children who are admitted to psychiatric inpatient hospitals could have been better served with a fuller array of home and community-based services.ⁱ



Challenge #3: System Fragmentation

To safeguard the privacy of patients, providers, schools and other systems do not share information when a child is experiencing a crisis. Additionally, providers do not use the same tools or processes for assessing and determining the level of appropriate treatment for a child. This can result in a child and family being tossed between systems, children receiving multiple assessments, and duplication of effort – resulting in less than optimal outcomes for our children.

We have identified the problems within our current crisis system. Our opportunity is to repair the system and ensure that our children can thrive and reach their full potential. With the right services and supports, children and families can and do recover from a mental health crisis.



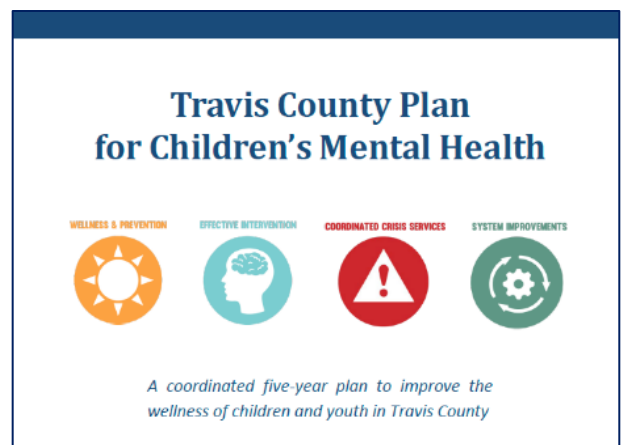
Our Community Collaborates to Improve the Health & Well-being of Children

Austin and Travis County stakeholders have a long history of working together to improve children's mental health services in our community. In 2014, stakeholders developed the Travis County Plan for Children's Mental Health (CMHP) to support the health and well-being of our children.

The Plan was shared at the first Children's Mental Health Leadership Summit in February 2015. Since then, work groups have collaborated to implement the Plan. As partners implemented the CMHP, it became clear that we need to **improve how our community responds to children and their families experiencing a mental health crisis.**

In October 2017, the second Children's Mental Health Leadership Summit sounded the alarm for our community. Panelists from NAMI Austin, Austin ISD, Del Valle ISD, Austin Police Department, Integral Care's Mobile Crisis Outreach Team (MCOT) and Dell Children's Medical Center identified challenges and changes needed to strengthen the children's mental health crisis system. The outcome of the Summit: to **establish the Children's Mental Health Crisis Task Force** and support its work with staff and other resources.

Co-chaired by Sheriff Sally Hernandez and Integral Care Trustee Emmitt Hayes, the Task Force reviewed the current system, identified challenges, learned from other communities, mapped the current and ideal systems and crafted recommendations.



The Travis County Plan for Children's Mental Health was released in February 2015. Since then, Work Groups have been implementing the Plan, under the umbrella of Kids Living Well.



Angela Howard Nguyen, Seton Shoal Creek/Dell Children's Medical Emergency Department, Lt. Brian Jones, Austin Police Department; Marisa Aguilar, Mobile Crisis Outreach Team



Kasie Stagman, Del Valle ISD; Dianna Groves, Austin ISD; Karen Ranus, Executive Director, NAMI Austin

Task Force Vision:

Create a system of care that empowers children and families experiencing a mental health crisis to live safe and healthy lives by offering the least restrictive, appropriate level of care through a seamless, comprehensive and integrated continuum.

For the purposes of its work together, the Task Force adopted the following definition of crisis: ***Children are considered to be experiencing a mental health crisis when they are in a state of distress that they are unable to resolve with the skills and resources available to them, thereby impacting their ability to function in their environment and/or creating the potential of danger to themselves or others.***

This report is the culmination of one year of focused effort to understand the issues, dig into our system and services, envision the ideal system and make recommendations. The recommendations in this report, once implemented, are expected to: streamline services and reduce duplication, create more options for care, improve the experience of families, reduce out-of-home placements and create better health outcomes for children.

Task Force Participation

Any Baby Can
Ascension (Seton)
Austin Child Guidance Center
Austin ISD
Austin Police Department
Austin Public Health
Casey Family Programs
Central Health
Communities In Schools
Community Advancement Network
Eanes ISD
Integral Care
NAMI Austin
LifeWorks
Manor ISD
Meadows Mental Health Policy Institute
Pflugerville ISD
SAFE Alliance
Texas Dept. of Family Protective Services
Texas Dept. of Health and Human Services
Travis County Health and Human Services
Travis County Sheriff's Office
United Way for Greater Austin



Our Community Identifies Ways to Create a System that Builds Health & Well-Being

Recommendation #1: Improve coordination and communication across systems

The first step for improving children's crisis services in Travis County is to improve coordination and communication across systems. Today, our system is fragmented and lacks coordination and clear communication between families, providers and systems. Adopting a common assessment process, developing common language around assessment outcomes, having a shared parental consent form for use throughout the community, and finding ways to share information among providers and across systems will improve coordination and communication.



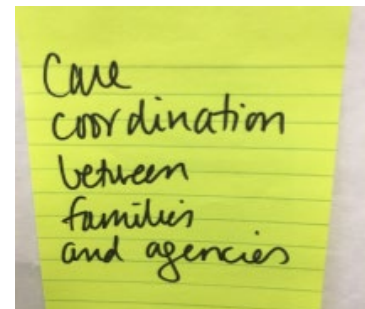
Task Force members divide into small groups to review a map of the current crisis care system and identify challenges in it.

► Issues to be addressed:

Multiple assessments: Parents and providers report frustration that children are often assessed multiple times using the same or different instruments. The outcomes are not easily shared among service providers, even with explicit parental permission, resulting in providers duplicating work and children and families sharing their stories over and over again. This delays access to critical services and creates a burden for everyone involved.

Lack of information sharing: In an effort to ensure compliance with HIPAA and FERPA, the federal laws that safeguard private health and education information, providers and systems often do not share information about children. This contributes to fragmentation and duplication.

Lack of coordination with schools: School representatives note that children in crisis are often absent for a week or longer when a crisis occurs, or return to school after a crisis with no notice or communication with the school. Including schools in discharge planning will support students in their recovery. Providers, on the other hand, note that students and their families often present a school's parental consent form that meets school privacy requirements but not health privacy requirements, limiting the provider's ability to communicate with the school.



► Proposed Improvement:

- Identify a common psychiatric crisis assessment tool that all stakeholders agree to use.
- Develop agreed-upon language around assessment results so that all stakeholders are trained and understand acuity and treatment protocol based on assessment results.
- Develop agreements to support improved communication and shared consents between families, providers, schools, foster care and juvenile justice to allow for more seamless transitions between systems.
- Develop a parental consent/release form that meets Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) requirements, and also addresses the privacy concerns of parents.
- Create a personal mental health medical history form for parents and children to maintain, which they can share with providers as they choose. Explore options for secure electronic digital access.

► Existing resources that may help with this recommendation:

- Georgetown Independent School District and Georgetown Behavioral Health Institute developed a parental consent form that is both FERPA and HIPAA compliant. The form allows parents to specify the information they would like shared. It also specifies the specific individuals in the school who will receive the information and is time limited.
- Integral Care's 24/7 Crisis Helpline currently creates new health records or updates existing records for every person who calls the Helpline. Integral Care is in the process of adopting a new Electronic Health Record system that includes a referral management feature, which allows providers outside of the Integral Care system to indicate once a child is in their care. Integral Care also has a File Transfer Protocol (FTP) site that allows the transfer of records to hospitals, foster care and juvenile justice.
- The Community Care Collaborative (CCC), a partnership between Central Health and The Seton Healthcare Family, operates a case management referral system for the population it serves through an Organized Health Care Arrangement (OHCA). Services provided by the OHCA include a clinical decision support system for treatment purposes and patient navigation services.
- Integrated Care Collaboration (ICC) is an alliance of healthcare providers whose objective is to create a regional health information exchange to enable improved care coordination.

► Possible next steps:

- Gather Additional Information:
 - Meet with Integral Care to understand how they manage health information and how their efforts can inform the Task Force desire for better communication among stakeholders.
 - Meet with CCC to understand how they manage health information and how their efforts can inform the Task Force desire for better communication among stakeholders.
 - Meet with ICC to understand plans for the organization moving forward and how their efforts can inform the Task Force desire for better communication among stakeholders.
- Convene meetings with mental health service providers, private psychiatrists, therapists, schools, Children's Optimal Health and parent representatives to explore creation of a parental consent form that is both FERPA and HIPAA compliant. Draft form for circulation and finalization. Develop agreements among local providers and systems to adopt usage of the form.
- Develop a work group of service providers and parent representatives to adopt a common assessment tool.
- Have the work group develop shared language for use among all providers that facilitates common understanding of assessment results and recommended treatment protocols.

► Anticipated impact:

These improvements will improve coordination and communication that reduces duplication and supports seamless transitions to the appropriate level of care.

Recommendation #2: Single Comprehensive Point of Entry

The Task Force envisions a time when families know where to go for help when a child is in crisis. The Task Force proposes identifying a single point of entry for children and families in crisis with a centralized intake process. In the event of a mental health crisis, community members will call a single phone number for screening, triage and connection to the least restrictive, most appropriate level of services and follow-up to ensure connection.

► Issues to be addressed:

Today, there are many entry points into the crisis system which can create confusion, duplication of effort and less than optimal outcomes for children. Community members and stakeholders are not certain who to call in the event of a mental health crisis. This, combined with a lack of options, results in families being referred to or seeking levels of care that may not be necessary, are expensive and are not aligned with their needs.



After considering the challenges and improvements needed in the children's mental health crisis system, Task Force members prioritize their work.

► Proposed Improvement:

The Task Force proposes a single point of entry (SPOE) - with a single phone number - to act as the "front door" to crisis navigation and services specifically for children. The SPOE should provide the following services:

- Answer calls 24/7 by qualified mental health professionals trained in crisis response.
- Ensure access to interpreters or qualified bilingual staff, in multiple languages, who will follow the caller when transferred to other crisis service providers or other community partner services.
- Provide telephone screening and triage to determine the immediate level of need through a common assessment.
- Provide direct transfer to 9-1-1 for emergency medical or law enforcement response in life-threatening emergencies.
- Connect to the most appropriate, least restrictive crisis services and have the capability to deploy Integral Care's MCOT when necessary.
- Act as a central hub for providers across the community, connecting families to the right level of care. When a community partner, such as MCOT, Psychiatric Emergency Services, a qualified school counselor, a primary health care or mental health care professional in the community, a social worker in a hospital emergency department, or a social worker in a psychiatric hospital completes an assessment of a child, they will contact the SPOE to report the findings and facilitate connections to the most appropriate, least restrictive level of care. Assessment results will go with the child and parent to the provider to whom they are referred.
- Assess insurance status with the caller and the crisis care provider to facilitate faster connections to services.
- Access to real-time information on the availability of crisis intervention services in the community for better referrals.
- Provide follow-up within 24 to 48 hours to ensure services were obtained and assist with further referrals, if necessary.
- Manage centralized data for every crisis call, including how the crisis is resolved and the service provider to whom the child is referred.

► Existing resources that may help with this recommendation:

Integral Care's 24/7 Crisis Helpline (512) 472-HELP is designated by the [Texas Department of Health and Human Services](#) as the single point of entry for mental health crisis services in Travis County, providing most but not all of the features identified as ideal by the Task Force. Integral Care is required by the State to provide crisis services to all people in Travis County, regardless of income, insurance or ability to pay. Crisis calls to the Helpline are answered by qualified mental health professionals who are certified by the American Association of Suicidology, with interpretation services available in multiple languages. The Helpline provides phone screening and direct connections to crisis services, or, if the situation is not a crisis, callers are connected to mental health services at Integral Care and in the community. In addition to taking calls from residents and call transfers from community partners (including NAMI Austin, 2-1-1, and law enforcement), Integral Care is part of the National Suicide Prevention Line (NSPL) network. All calls to the National Suicide Prevention Hotline that originate in Travis County are automatically transferred to Integral Care to be answered within 30 seconds.

United Way for Greater Austin's 2-1-1 Navigation Center provides streamlined access to community resources for people in need through their call center and online community database. 2-1-1 resource referral is free, confidential, multilingual and available 24/7. Calls received after business hours on weekdays or on weekends are answered by Houston 2-1-1. 2-1-1 serves a 10-county region in Central Texas and is part of an integrated network of 25 Centers across Texas. 2-1-1 reports receiving 3,575 mental health related calls in 2017. They do not record how many were for adults or children, or how many were crisis calls.

In addition to providing referrals to community services and resources, 2-1-1 operates the UWATX Navigation Center, in partnership with Central Health, to improve access to health services and to screen for public health benefits eligibility, including Medicaid, CHIP, Medical Assistance Program (MAP), and enrollment in insurance programs through the federal Marketplace. The Navigation Center also offers connections to clinical appointments and mental health services through partnerships with Bluebonnet Trails Community Services and El Buen Samaritano. When 2-1-1 receives mental health crisis calls from Travis County residents, they are transferred to Integral Care's 24/7 Crisis Helpline.

New 3-digit number for mental health: The National Suicide Hotline Improvement Act of 2018, approved by both houses of Congress and signed into law by President Trump in August 2018, directs the Federal Communications Commission to study and assess the feasibility of designating a new three-digit dialing code to be used nationwide for mental health crises. Identifying a three-digit dialing code for mental health, such as 9-1-1 for emergencies and 2-1-1 for referrals to community services and resources, will be much simpler than remembering the phone numbers of the National Suicide Prevention Hotline (1-800-273-TALK) or state-identified crisis hotline numbers, which are different in every community.

► Possible next steps:

- Identify and convene a work group that will focus on moving the SPOE forward for the community.
- Meet with NAMI Austin parent representatives, local counselors and therapists, and crisis service providers to explore how the envisioned SPOE can better meet the needs of children in crisis and their families. Identify specific features and characteristics to be incorporated that have not been identified to date.
- Gather additional information:
 - Meet with United Way for Greater Austin 2-1-1 Navigation Center staff and Bluebonnet Trails Navigation Center staff to understand how mental health crisis calls for children are handled and referred to crisis services. Identify what components of SPOE 2-1-1 offers.
 - Meet with Integral Care's 24/7 Crisis Helpline staff to better understand how calls regarding children are handled and referred to crisis services. Identify what components of SPOE are offered.
- Make a decision about what entity will provide the SPOE crisis services in Travis County and how that will be funded.
- Develop plan to secure funding.
- Develop plan for implementation of SPOE.
- Create a marketing plan to share this information widely with the entire community.

► Anticipated impact:

A single point of entry for children and families in crisis with a centralized intake process will ensure they are quickly connected to the most appropriate level of care to resolve the crisis. This will streamline the process for families and providers with the anticipated impact of reducing wrong doors, connecting families to care more quickly and reducing duplication of effort.



Recommendation #3: Expand home and community-based intervention services

The Center for Medicaid and CHIP Services (CMCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) report that many children who have been treated in psychiatric hospitals or residential treatment centers could remain successfully in their own home or community if they have access to home and community-based services.ⁱⁱ Research finds that these services not only cost less but also receive high marks from children and families in satisfaction surveys.ⁱⁱⁱ

A five-year demonstration project in 9 states, overseen by CMCS, found that children with serious emotional disturbances who were enrolled in Medicaid had better functional outcomes at significant cost savings when they received home and community-based services as an alternative to treatment in psychiatric residential treatment facilities. The services provided included intensive care coordination (wraparound), family and youth peer support services, intensive in-home services, respite care, mobile crisis response and stabilization, and help with funding.

A Joint CMCS and SAMHSA Bulletin further evaluated the CMCS Demonstration program discussed above as well as the SAMHSA Children's Mental Health Initiative. Following are outcomes reported^{iv}:

- The cost of providing in-home community-based services in the CMCS Demonstration was 25% of what it would have cost to serve the children in a residential psychiatric facility, an average savings of \$40,000 per year per child.
- After 12 months of service, 44% of children improved their school attendance and 41% improved their grades, compared to their performance before the program.
- After one year of service, 33% of children significantly improved their behavioral and emotional strengths, which include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, and self-confidence.
- According to caregiver reports, 40% of children served in the SAMHSA program showed a decrease in clinical symptoms from when they entered the program.
- The percentage of children in the SAMHSA program who retained their home placement – either in the family home or a foster home – increased. This meant living situations became more stable.
- Employed caregivers reported missing fewer days of work due to their child's behavioral or emotional problems.
- Within 6 months of service, the number of children reporting thoughts of suicide decreased by 51% and the number reporting a suicide attempt decreased by 64%.
- For children involved in the juvenile justice system, arrests decreased by nearly 50%.

Following are some of the home and community-based services the Task Force proposes for Austin and Travis County. All of these services are among those recommended by CMCS and SAMHSA as best-practice.

#3.1 Expand the scope of mobile crisis response

The Task Force envisions a community in which mobile response is available in less than one hour with expanded capabilities for children in crisis regardless of where they are. The recommendations are to:

- Expand the existing Integral Care Mobile Crisis Outreach Team (MCOT).
- Strengthen community understanding of the purpose, function and capacity of the team.
- Improve information sharing between organizations for improved health outcomes for children.

► The issues to be addressed:

- Continue to ensure timely response and follow-up to crisis calls given increased demand.
- Improve community understanding of MCOT's purpose and capacity.
- Reduce deployment of MCOT for situations other than psychiatric crises.
- Improve information sharing among agencies serving the same child.

► Proposed Changes:

Following are some of the services that the Task Force would like to see:

- Expand the capacity of MCOT teams to ensure the ability to respond within one hour and continue to provide crisis follow-up.
- Ensure the team includes staff certified for dual diagnosis of Intellectual and Developmental Disabilities (IDD) and mental illness.
- Develop written materials that provide information about MCOT crisis response and follow-up services to help children and families understand the services and process.
- Develop written materials that provide information about MCOT crisis response and follow-up services for community, providers, school counselors or nurses.
- Increase cross-training between school counselors and MCOT to support schools to know when mobile response can stabilize a situation and help a student maintain placement in their home, school and community or when hospitalization is necessary.
- Provide cross-training with emergency departments and psychiatric hospitals so that, when hospitalization is not required or when a child is being discharged, MCOT can be deployed to provide intervention and connection to ongoing community services.
- Work with MCOT, hospitals, schools and school-based programs to identify strategies for better information sharing to improve continuity of care for children.

► Challenges:

Increasing awareness of MCOT and the services it provides may increase demand for services. MCOT must find a balance between timely response and depth of services provided, especially with increased demand for services. Funding constraints limit the ability of MCOT to respond to the community's desire for both shorter wait times for crisis response and more in-depth services.

► Existing resources for this recommendation:

Integral Care's Mobile Crisis Outreach Teams (MCOT) currently serves both children and adults 24 hours a day, seven days a week. The goal of MCOT is to stabilize the crisis and connect people to resources in the community

that help support long-term recovery. MCOT responded to 655 crisis calls involving children in FY 2018, which included 509 unduplicated children. The average length of service was about three weeks.

MCOT is dispatched through Integral Care’s 24/7 Crisis Helpline. Whether or not a situation is a “crisis” is left up to the interpretation of the caller. If a family member, the child, or a third party (such as a school counselor) calls the Helpline, reports a child is in crisis, and requests MCOT, they will respond.

Services that can be provided to adults and children by MCOT include:

- Crisis de-escalation
- Psychiatric assessment
- Medication management
- Case management services
- Parent and child psycho-social education
- Development of a care and safety plan with goals set for the one-week in-home follow-up visit
- If medically necessary, a warm hand-off to inpatient psychiatric hospitals, with information about bed availability, insurance and payment information
- Up to 90-days of stabilization support and follow-up in the home, which includes working with the child who had the crisis to develop a safety plan and treatment goals to be reviewed in follow-up visits

Cross Creek Hospital is a local psychiatric hospital that has created its own mobile crisis response service. The mobile response currently has one employee and the service is available from 8 a.m. to 4 p.m. on weekdays. The mobile response person will conduct a field assessment that is identical to the admissions assessment conducted at the hospital. If hospitalization is recommended, the mobile response person will facilitate admission into their hospital or another hospital with availability. If hospitalization is not required, the mobile response person will use Psychology Today or Seton Navigator to connect the child and family to a therapist.

► Possible next steps:

- Develop a staffing model for MCOT expansion that aligns with goals of the Task Force.
- Identify funding to expand MCOT’s clinical staff and add training capacity.
- Bring together school representatives and MCOT representatives to discuss how MCOT could better partner with schools to provide de-escalation services.
- Bring together representatives of emergency departments, psychiatric hospitals and MCOT to discuss how MCOT can better partner with these facilities to provide intervention for children who do not require hospitalization and those who are being discharged.
- Develop audience specific materials that are easy to understand.
- Identify funding for printing of materials.

► Anticipated impact:

Expanding MCOT will improve the ability of the team to respond in as timely a way as possible to crises, helping ensure the safety of the child as well as ensuring they are connected to the right level of care. This will also support schools and other systems as they work to ensure the health of children. Improved communication will help families and other providers have the tools to understand the process for working with MCOT and what services MCOT can provide.

According to a research review by SAMHSA, mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization and are better than hospitalization at linking people in crisis to outpatient services. SAMHSA reports that mobile crisis response can achieve better outcomes at lower cost with higher family satisfaction than emergency departments or inpatient treatment.

3.2 Provide intensive community-based crisis intervention

Intensive community-based therapeutic services are designed to meet the needs of children who are at risk of losing their current home placement due to a mental health crisis. The goal of these services is to provide counseling, skill-building and family education to address the issues that created a crisis for the child, while promoting positive development and healthy family functioning. These crisis stabilization services are proposed to be available for up to 90 days.

► Issues to be addressed:

Intensive community-based therapeutic services are specifically designed to assist, not only the child, but the entire family in recovering from a crisis, maintaining a stable placement, achieving ongoing stability and learning strategies to avoid future crises. These services should also reduce hospitalization and residential treatment utilization.

► Proposed Change:

- Establish pilot project to develop a new crisis stabilization service that assists children and their families in recovering from a psychiatric crisis and achieving stabilization with the skills and supports to maintain recovery and avoid future crises. Model to include:
 - Focus on an area of high frequency of MCOT dispatch and/or repeat use of MCOT or referrals to Dell Children's Medical Center
 - Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Intellectually and Developmental Disability (IDD) services, de-escalation, skills training, and education for children and caregivers for up to 90 days after a crisis
 - Multi-disciplinary team that could include a licensed clinician, certified family partner, a near-aged peer specialist, and clinicians with IDD specialty
 - Children connected to services within 72 hours of a crisis event
 - Families connected to on-going community supports and services

► Resources needed to support this recommendation:

- Funding for the pilot project
- Agency(s) capable of providing intensive intervention following a psychiatric crisis
- Agency willing to sponsor the pilot project and provide the support necessary to launch the project

► Existing resources that can help with this recommendation:

Travis County Health and Human Services, Integral Care and the Meadows Mental Health Policy Institute have been developing a similar model that is focused specifically on foster children. The model will provide team-based, short-term (90 days), intensive in-home support for foster families with children with complex needs. This effort can help inform the proposed pilot initiative.

Austin has many non-profit agencies skilled at providing home and community-based services with a focus on trauma-informed, person-centered care. The Intervention Work Group of the Children’s Mental Health Plan developed a “check-list” for home and community-based services and supports to guide social workers and para-professionals, and improve the quality of home and community-based services. The work group also developed a “Guide to Understanding Home and Community-Based Services and Supports” for area colleges and universities to improve the education of case managers, therapists, and other practitioners who are providing services in the home and community. Our community has non-profit agencies with the skill set and expertise for providing home and community-based therapy. This recommendation calls for tailoring these services for crisis-related response within 72 hours.

► Possible next steps:

- Convene stakeholders to develop the pilot project
 - Consider establishing a collaboration to develop and launch the pilot and/or identify a sponsoring agency
 - Develop a cost model for the pilot project
 - Develop an return on investment (ROI) for the pilot project
- Develop a pilot project proposal for potential funders and a list of possible funders
- Collect data to establish a baseline
- Identify metrics to be tracked
- Establish opportunity for proof of concept study with academic or other partner

► Anticipated impact:

An effective proof of concept pilot project will allow the community to establish the effectiveness of these services in reducing costs and/or improving the outcomes for children and families. This creates the opportunity to pursue a community-wide initiative that could serve more children.

#3.3 Expand Wraparound Care

The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a strengths-based, collaborative process for developing and implementing individualized care plans for children with complex needs and their families. A wraparound facilitator meets with a child and their caregiver weekly. A team that includes additional people who are important in the child's life meet monthly and help develop a plan of care to meet the specific needs and goals of the family.

► Issues to be addressed:

The Task Force envisions a day when there is ready access to wraparound services for children who are experiencing significant challenges and engaged with multiple systems. Many children and families who qualify for wraparound services in Travis County must wait 30 to 60 days to receive services. Increasing access to wraparound care for these children and families can help them move toward recovery, prevent hospitalizations and stabilize home placements. Increasing the availability and access to wraparound services will provide another tool for helping families and children with serious mental health needs stabilize after a mental health crisis and avoid future crises.



Task Force member LeShawn Arbuckle, Director of Counseling Services for LifeWorks Austin, shares what she believes is needed to improve children's crisis services.

► Proposed Change:

The Task Force proposes increasing the capacity for wraparound services in our community so that services can be offered to children and families more quickly, especially following a mental health crisis. Efforts should be made to maximize state and Medicaid reimbursement for wraparound services, to draw down more state and federal funding to the local community. The Task Force also proposes increasing the use of youth and family peer support in the wraparound planning process.

► Existing resources that can help with this recommendation:

There are three programs in Travis County that provide intensive care coordination for children with significant serious emotional disturbance and their families.

- The Children's Partnership uses a collaborative team approach to work with families and children with multiple system involvement. The Children's Partnership employs seven Wellness Recovery Action Plan (WRAP) facilitators and three certified family partners who have access to flexible funding to support the families' wishes. WRAP facilitators are limited to no more than 10 cases each, so the program is able to serve no more than 70 children and families when operating at full capacity.
- Integral Care's YES Waiver program is a state-funded program that serves children with serious emotional disturbance. The program was expanded in FY 2018 from 12 to 16 WRAP facilitators. Based on this level of community demand, the Texas Department of State Health Services would support further expansion of the YES Waiver program. However, the YES Waiver program is not fully self-sustaining. While the State will reimburse for qualified services provided, Integral Care reports that these reimbursements are not sufficient to fund program costs.
- Integral Care's Families with Voices is a wraparound program serving families in the Manor ISD who are at risk of homelessness. All families are referred by Manor ISD.
- Communities in Schools has a Care Coordination program that provides wraparound support to families, connecting them to relevant community partners, certified family partners and other community resources. Six care coordinators are limited to no more than 10 cases each, so the program is able to serve no more than 60 children and families when operating at full capacity.

► Possible next steps:

- Identify and secure funds to expand wraparound services.
- Identify and secure funds to expand the use of certified family partners in wraparound.

► Anticipated impact:

The wraparound process is designed to build on families' strengths and identify and address underlying issues. It is a family-driven process that gives children and families the authority to determine what is best for them. A meta-analysis of seven controlled studies published in peer-reviewed journals found that wraparound services helped maintain home placement, improved mental health outcomes and overall functioning, and resulted in reduced juvenile justice involvement.^v

Research published in the Journal of Mental Health Policy and Economics found that children with serious emotional disturbance (SED) who participate in High Fidelity Wraparound (Wrap) have much lower healthcare spending for up to a year after their Wrap participation, as compared to a control group.^{vi} Researchers found this is due mostly to reduced mental health care costs, especially inpatient hospitalization costs, but also found reductions in general physical healthcare spending.

Communities that have implemented wraparound services to scale have seen large reductions in the cost of providing services to children with SED. According to the Center for Health Care Strategies, Wraparound Milwaukee reduced the use of child inpatient hospitalizations from 5,000 days per year to 200. Maine experienced a 28% reduction in total net Medicaid spending among children in its wraparound service, even as the use of home and community-based services increased. New Jersey estimates that the state has saved more than \$40 million in inpatient psychiatric expenditures over the last three years.^{vii}

#3.4 Increase family and youth peer support services

Individuals with lived experience who are in recovery can bring a critical message of hope that mental health treatment works and recovery is possible. Parent and youth peer support services are provided by family members or youth who have personally faced the challenges of coping with serious mental health conditions, either as a client or caregiver. Family and youth peer support services are used on a limited scale in our community, but the Task Force would like for peer services to be expanded across the continuum of services.

► Issues to be addressed:

The National Consensus Statement on Mental Health Recovery identifies peer support as one of the ten fundamental components of a system of care that promotes recovery. Connecting with peers can be especially relevant given that feelings of isolation and fear may accompany a mental health crisis.^{viii}

► Proposed Change:

The Task Force proposes expanding the use of family and youth peers. This could entail volunteers, support groups, or hiring certified and trained peer support specialists on mobile teams, in emergency departments, in juvenile justice and other settings. Some of the proposals below are also incorporated into earlier proposals covered in this document.

- Incorporate youth and family peer support into the new proposed intensive community-based intervention service.
- Expand use of youth and family peer support in wraparound services.
- Include youth and family peer support in crisis respite services.
- Include family partners in mobile crisis response.



► Existing resources that can help with this recommendation:

[Via Hope](#), located in Austin, trains and certifies family partners and provides the only certification accepted by the Texas Health and Human Services Commission. Public mental health agencies in Texas are required to have family partners on staff and for these partners to be certified within one year of being hired. Currently, most Certified Family Partners work in community mental health centers, although there are a growing number in private and public hospitals, residential treatment centers, juvenile justice centers and other settings.

[NAMI Austin](#) provides peer-led family support groups for family members, caregivers and loved ones of individuals living with mental illness. NAMI Austin also provides #OK2Talk for Teens support groups for middle and high school aged teens experiencing mental health issues.

[LifeWorks](#) is in the process of expanding its use of peers in its programming from 1.5 to 9, including a Certified Peer Specialist. LifeWorks' certified youth peers have life experience with mental illness, substance use disorder, and/or homelessness.

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services has issued guidance to states on how to apply for reimbursement for peer support services under Medicaid.^{ix} Clarifying guidance issued in 2013 specifies that peer-to-peer support is also available to parents or legal guardians of Medicaid-eligible children, when the support is to benefit the Medicaid-eligible child. ^x Texas is beginning to take action in this area and has released a [Draft Texas Medicaid Peer Specialist Services Medical Policy](#) that would allow for Medicaid reimbursement for youth peer support services, though not for family partner services. Family partner services are reimbursable at the federal level, and the hope is that Texas will, eventually, also allow reimbursement for family partner services.

► Possible next steps:

- Work with providers to identify opportunities to expand use of peers
- Develop cost models for expansion
- Identify funding sources to pay for expanded youth and family peer services

► Anticipated impact:

SAMHSA considers peer and family support services to be best practice.^{xi} Research supports the use of peers in mental health recovery showing higher satisfaction among parents and youth and greater improvements in self-esteem, self-rated mental health symptoms and social activity. Fewer inpatient hospitalizations and fewer re-hospitalizations have also been noted in national studies.

A literature review by the Center for Health Care Strategies, Inc. found that family and youth peer support help families connect with and learn from each other and improves caregiver emotional functioning and coping skills.^{xii}

#3.5 Crisis respite

Crisis respite can provide temporary relief for caregivers, a safe environment for children while they are experiencing a mental health crisis, and therapy, skills training and crisis planning for the family and child. The goal is to strengthen the child and family's ability to prevent future crises or to better deal with them if they do occur. Respite services are provided either in the home or approved out-of-home settings. Currently, a few crisis respite options exist in Travis County, serving only children in foster care and the YES Waiver program. We recommend expanding crisis respite options, in order to accommodate any Travis County child in crisis.

► Issues to be addressed:

Reduce the risk of out-of-home placement that can result from stress in families with a child living with a serious mental health issue.

► Proposed Change:

The Task Force proposes both in-home and out-of-home crisis respite options that help children avoid hospitalization or other out-of-home placements. This service could be provided by a mental health professional who stays with a family during a crisis to help them de-escalate the situation, a small group or individual home where children can stay for a few nights and receive therapeutic support, or a more institutional setting. Regardless of the setting, the goal of crisis respite is maintaining stability at home in order to reduce out-of-home placement.

The Interdepartmental Serious Mental Illness Coordinating Committee recommends that respite care be provided to families and caregivers of children with SED, as it currently is for families with children with intellectual or developmental disabilities.^{xiii}

► Existing resources that can help:

These services are currently not available to Travis County children experiencing a mental health crisis and their families.

Bluebonnet Trails Community Services offer children's crisis respite services to children who are diagnosed with a behavioral disorder, including mental health issues and intellectual developmental disorders, and who live in Williamson or Burnet counties. Children are eligible for up to 45 days of respite care per fiscal year.

► Possible next steps:

- Meet with Bluebonnet Trails to learn how their program is designed, accessed and funded.
- Identify community partners that may have an interest in providing a similar service in Travis County.
- Develop a service and funding model
- Identify and pursue funding

► Anticipated impact:

Crisis respite options can help children remain in their community or with their family and avoid more restrictive settings, such as inpatient hospitalization, foster care or juvenile justice. In an analysis of the benefits of respite care for families with children experiencing emotional and behavioral problems, researchers found the most encouraging outcome was the reduction of out-of-home placement.^{xiv}

Recommendation #4: Expand access to partial hospitalization and intensive outpatient services

Partial hospitalization programs (PHP) and intensive outpatient programs (IOP) are programs provided to older children by some psychiatric hospitals. PHPs provide treatment, generally from 8:30 a.m. to 3:30 p.m. Monday through Friday, and include individual and group therapy as well as charter school instruction. IOPs provide individual, family and group therapy several evenings each week. The Task Force proposes expanding the use of these services, not only as a step down from hospitalization, but also as a diversion from hospitalization.

► Issues to be addressed:

Sometimes children need therapeutic treatment that is more intensive than weekly counseling sessions. Sometimes they cannot function in a school setting and they need an alternative to help them transition back to school after a crisis. Cost, transportation, parent work schedules and other issues make it difficult for lower income families to access these services. They need to be better integrated with home and school settings.

► Proposed Change:

- Expand access to PHP and IOP programs.
- Arrange for transportation to these programs, when necessary.
- Ensure that caregivers and family members are included in the treatment.

► Existing resources that can help:

- The Maxwell Unit at Dell Children's Medical Center has an IOP program that provides Dialectical Behavioral Therapy for middle and high school students. There are plans to add PHP programs in early 2019. The new 24-bed children's psychiatric facility also has a separate entrance and waiting room for children and families receiving these outpatient services.
- Georgetown Behavioral Health Institute has new PHP and IOP programming for children. About half of the children participating are stepping down from hospitalization and the other half have not been hospitalized.
- Austin Oaks also provides PHP and IOP services for children.
- Phoenix House has an IOP program that supports dual diagnosis of substance use disorder and mental illness.

► Possible next steps:

Our community has local funds set aside to fund inpatient psychiatric hospitalization for children and adults with no insurance or ability to pay. The Children's Mental Health Plan Steering Committee and supporting work groups can explore whether some of these funds could be used for PHP and IOP services.

► Anticipated impact:

- Smoother transition returning to home, community and school following a crisis
- Diversion from hospitalization

Recommendation #5: Residential crisis stabilization

Residential crisis stabilization provides intensive short-term treatment and stabilization in a setting outside of the home as an alternative to psychiatric inpatient treatment or other placements. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the treatment team and the family to prepare for the child's successful return to the family.

► Issues to be addressed:

Sometimes staying at home is not the best option for the child or the caregiver. Short-term, intensive out-of-home placement can help avoid hospitalization or juvenile justice involvement.

► Proposed Change:

The Task Force proposes creating short-term stay options for children for up to three days. The service will:

- Provide 24-hour crisis admissions
- Address acute mental health needs and conduct a psychiatric assessment
- Include medication management
- Provide individual and family counseling services
- Work with the family from the onset of admission to plan and prepare for the child's return home
- Provide case management services

► Existing resources that may help:

Integral Care's Judge Guy Herman Center for Mental Health Crisis Care provides residential crisis stabilization for adults. It is successful in providing an alternative to inpatient hospitalization and incarceration. Lessons learned from the Herman Center could be useful in developing a similar facility to serve children.

► Possible next steps:

- Explore best-practice examples of this service in other communities, such as the Bellevue Hospital Center Children's Comprehensive Psychiatric Emergency Program.
- Bring together stakeholders involved in the Herman Center with stakeholders in children's crisis services to explore how the Herman Center model could be adapted for children.
- Explore whether there are community stakeholders with the interest and capacity to provide this service.
- Develop a program and cost model.
- Secure support for model along with funding.

► Anticipated impact:

The goal of residential crisis stabilization is to address a family's crisis without losing home placement. SAMHSA reports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. Satisfaction with these services is also strong, and the overall costs for residential crisis services are less than traditional inpatient care.^{xv}

Appendix A: Children’s Mental Health Crisis Task Force meetings

Co-chairs Emmitt Hayes and Sally Hernandez convened the first meeting of the Children’s Mental Health Crisis Services Task Force on December 18, 2017. Following are meeting highlights.

12/18/17:

- Members adopted a Scope of Work.
- Members reviewed data related to children’s mental health.
- Members considered what is working well and what is NOT working well in our current system.

1/19/18:

- Task Force adopted the following definition of crisis for the purposes of its work.
Children are considered to be experiencing a mental health crisis when they are in a state of distress that they are unable to resolve with the skills and resources available to them, thereby impacting their ability to function in their environment and/or creating the potential of danger to themselves or others.
- A panel presentation with leadership from schools, the foster care system and juvenile justice system was followed with individual table discussions focused on each of these systems.
- Each Task Force member listed the top systemic gaps or barriers that need to be addressed in each of the three systems. (Numbers following each statement identify how many times the topic was noted by a Task Force member.)

Schools

- Consistent and clear information about mental health services available in the community (12)
- Common training across County for school staff in trauma informed care and crisis response (10)
- Wraparound services for children and families (9)
- Intermediate care options (8)
- Common assessment tool and consistent protocol (8)
- Crisis stabilization (1)

Foster care

- Emergency short-term crisis respite and therapeutic foster care (20)
- Training for foster families (14)
- Intensive wraparound support for foster families and children (5)
- Intermediate care – PHP and IOP (3)

Juvenile Justice

- Better communication and data sharing across systems – Child Protective Services, Juvenile Justice, schools, community services (25)
- Psychiatric crisis placements for Juvenile Justice children in crisis (7)
- Better integration with community services (14)
- Engagement and support for families (4)
- Culturally competent and accessible services (3)

2/23/18:

- Task Force members amended and revised a map of our current crisis system.
- Members reviewed challenges and needed resources across the continuum of the crisis system and added additional challenges and needed resources.
- Members then prioritized needed resources identified through the process with a dot voting exercise.

3/23/18:

- Meadows Mental Health Policy Institute shared components of an “ideal” children’s mental health system.
- Task Force member Luanne Southern facilitated a phone conversation with Steve Dykstra, Director of the Children’s Mobile Crisis Team for Wraparound Milwaukee, and Wyndee Davis, Assistant Director, New Jersey Children’s System of Care. Both programs are nationally recognized by SAMHSA as best practice models for mobile crisis response systems.
- Task Force members adopted a map of the current children’s crisis services system. (Appendix B)

Needed Resources Prioritization:

- Intensive community-based services to include in-home stabilization services – 11 dots
- Increased treatment options and level of care for children and youth in the community – 11 dots
- Crisis Respite – 11 dots
- Expansion of MCOT to 24/7 with a reduced wait time for response – 8 dots
- Increased slots and reduced wait times to enroll in wraparound services – 8 dots
- Resource Guide for families on how to identify and navigate a mental health crisis – 7 dots
- Increased access to child psychiatrists – 6 dots
- Mental Health Professionals on every school campus – 5 dots
- Community protocol or process to ensure quality integration back into the community post-hospitalization that includes psychiatric care, school planning, safety planning, and mental health services and are available within 48-96 hours of discharge – 5 dots

(Outcome of Task Force work on 2/23/18)

4/20/18:

The recommended **systemic improvements** needed to improve children’s crisis services.

- A seamless, comprehensive, integrated system where children receive the most appropriate, least restrictive level of care
- Common assessment and collaborative discharge planning that includes hospitals, providers, schools and families
- Clear understanding in the community of how the system works

The following were suggested as ways to measure whether the system is improved...

- Decreased number of in-patient psychiatric hospitalizations
- Shorter lengths of stay in in-patient psychiatric hospitalizations
- Shorter response times to a crisis
- Family satisfaction
- Integrated discharge planning

5/11/18:

The Task Force identified recommended **service improvements**.

- Crisis respite to reduce unnecessary hospitalization
- Expanded wraparound services to all eligible children and families
- Expansion of MCOT to include parent coaching, peer support, intensive therapy, and education and skill building for both the child and family
- Clarity on a single point of entry and a central intake system—a phone number to call for screening, triage and a warm hand-off to the most appropriate level of care
- Access to intensive outpatient care

The following were suggested as ways to measure effectiveness of these service improvements.

- Reduction in unnecessary incarceration
- Reduction in in-patient hospitalizations and emergency department visits
- Reduction in re-hospitalization
- Shorter waitlists for wraparound services

9/21/18:

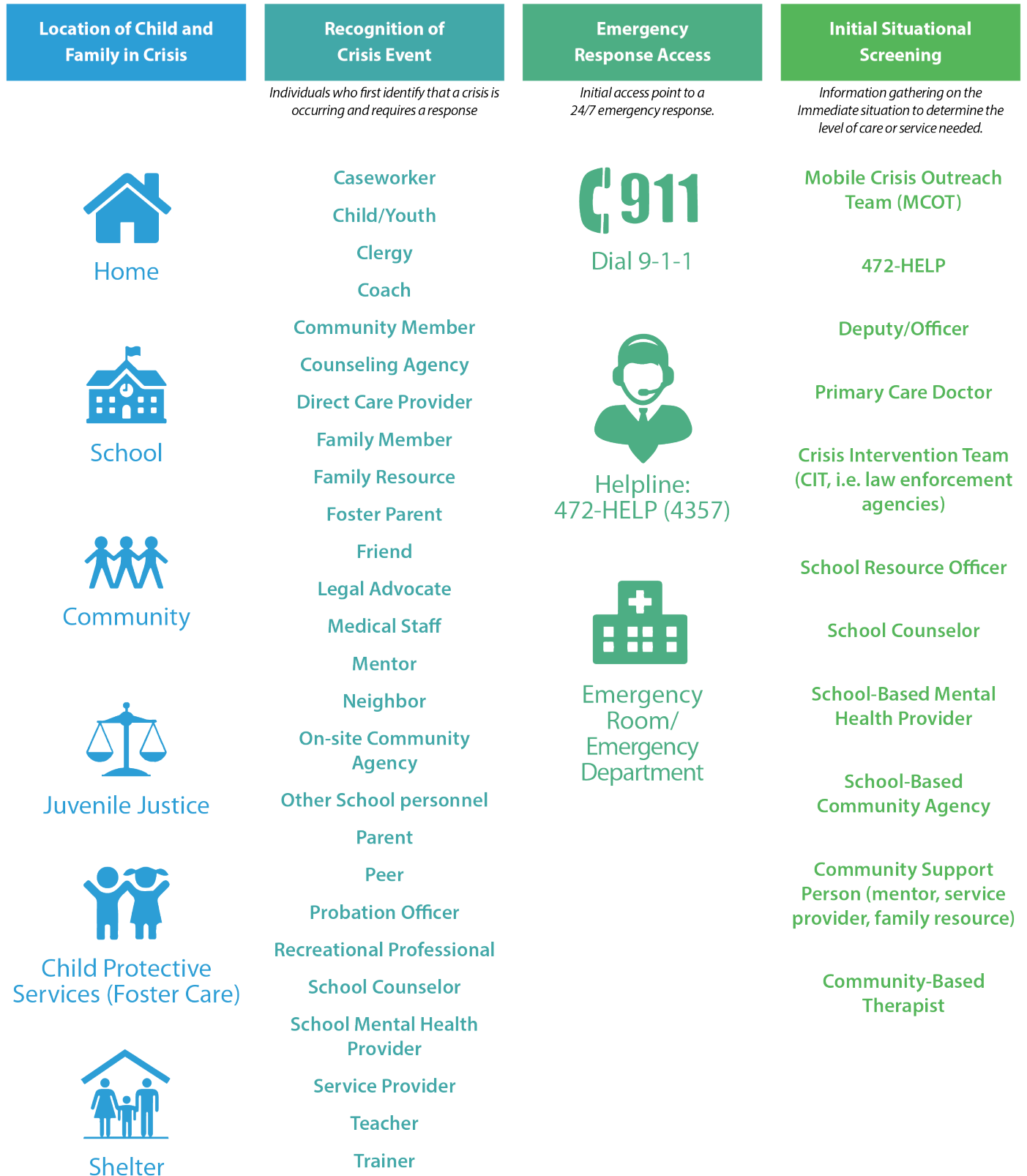
- Reviewed, revised and prioritized draft recommendations.

10/17/18:

- Received results of a parent survey administered by NAMI Austin
- Presentation of a fiscal analysis of Task Force recommendations by the Meadows Mental Health Policy Institute
- Adopted final draft report

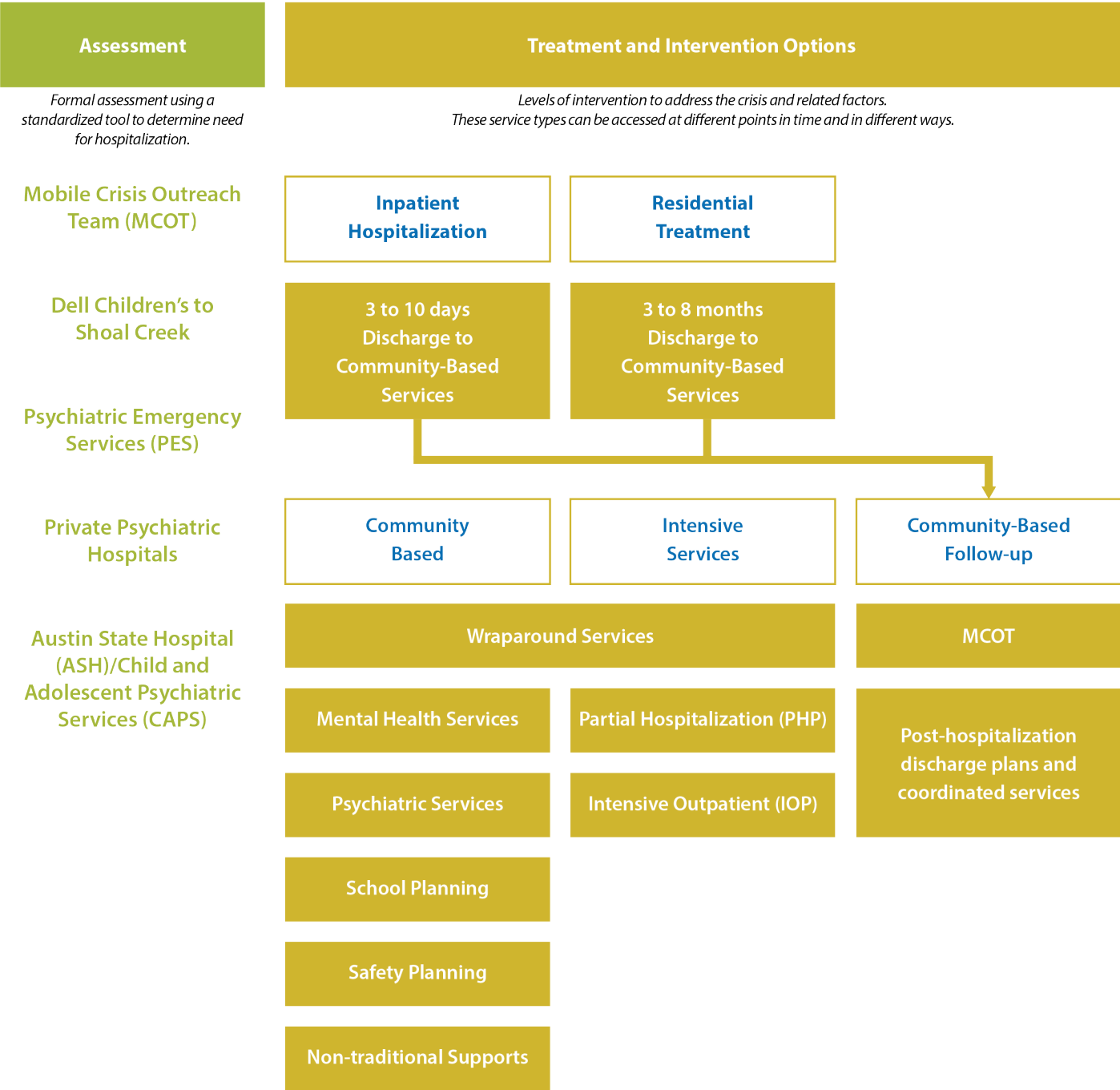
Appendix B: Map of Current Mental Health Crisis System

Visualization of Current Children's Health Crisis



Response in Travis County

Note: Crisis system steps are not sequential.



Appendix C: Map of the Crisis System we want

A crisis can occur anywhere at any time of day or night.

People who may first recognize that a child or youth is experiencing a mental health crisis include:

- The child or youth in crisis
- Family member
- Foster parent
- Friend
- Teacher, school counselor, or other school personnel
- Caseworker
- Mental healthcare provider
- Direct care provider
- Medical staff
- Probation officer
- Clergy
- Coach
- Community member
- Mentor
- Neighbor

Single Point of Entry

One phone number available anytime of day or night for screening, triage and connection to...

1) Crisis De-escalation & Assessment Services

or

2) 9-1-1 Emergency Response.

All crisis calls will be followed-up within 48-72 hours to ensure services were received and to assist with further referrals, if needed.

KEY

Existing service

Proposed expansion of existing service

Proposed new service

LESS INTENSIVE

MORE INTENSIVE

Crisis De-escalation and Assessment

Mobile Crisis Outreach Team:

Mobile team comes to you to de-escalate a crisis and do an assessment. Mental health support and follow-up for up to 90 days. Includes skill-building, medication management, care planning and connection to on-going community services and resources.

Psychiatric Emergency Services:

Walk-in, urgent care clinic open 7 days a week for adults and children having a mental health crisis. Mental health support and follow-up for up to 90 days. Includes assessment, skill-building, medication management, care planning and connection to on-going community services and resources.

Psychiatric Hospital:

For psychiatric assessment and admission to inpatient care, if medically necessary.

Emergency Department:

For medical care, psychiatric assessment and referral to inpatient care, if medically necessary.

911 Emergency Response

(if imminent threat of danger)

Law Enforcement Response:

May seek support of mental health officers or Mobile Crisis Outreach Team. Officers have ability to do involuntary Emergency Detention hospitalizations.

Emergency Medical Services (EMS):

For immediate medical attention and hospital transport in a medical emergency.

Mid-Level Support and Interventions

Peer Crisis Services:

Integrate parents and youth with lived experience into crisis services.

Intensive Outpatient Services (IOP):

IOP provides individual, group and family therapy in the evenings several times a week.

Intensive Community-Based Crisis Stabilization:

Therapeutic interventions provided in the home or community within 72-hours of a crisis for more intensive crisis stabilization for up to 90 days.

Wraparound Intensive Care Coordination:

Individualized care plans with services and supports for children and youth with complex needs and their families provided for up to 2 years.

Crisis Respite:

In-home or out-of-home respite care for several hours or several days.

Higher Levels of Care

Partial Hospitalization (PHP):

Some psychiatric hospitals provide PHP services to children aged 12-17. They receive individual and family therapy, psychiatry and charter school instruction, usually from 8:30 a.m. to 3:30 p.m. Monday-Friday.

Residential Crisis Stabilization:

24/7 emergency stabilization for up to 72 hours. Medical support to address acute mental health needs and a psychiatric assessment. Medication management, individual and family counseling, case management and connections to on-going local services and resources.

In-patient hospitalization:

Psychiatric and therapeutic services provided in an inpatient setting, with 24-hour nursing care, for people with acute mental illness. Medication management, individual and family counseling, case management and connections to on-going local services and resources.

Appendix D: Definitions

Following are the definitions of the home and community-based services outlined in the Joint CMS and SAMHSA Information Bulletin, “Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions”, May 2013.

Intensive Care Coordination: Wraparound Approach

The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports. The wraparound “facilitator” is the intensive care coordinator who organizes, convenes, and coordinates this process. The wraparound approach involves a team for each child that includes the child, family members, involved providers, and key members of the child’s formal and informal support network, including members from the child serving agencies. The child and family team develops, implements, and monitors the service plan.

Intensive In-home Services

Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve child and family functioning and prevent out-of-home placement in inpatient or Psychiatric Residential Treatment Facility (PRTF) settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child and family intensively, gradually transitioning them to other formal and informal services and supports, as indicated.

Mobile Crisis Response and Stabilization Services

Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise.

Peer Services: Parent and Youth Support Services

Parent and youth support services include developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities. The providers of peer support services are family members or youth with “lived experience” who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or a caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth.

Respite Services

Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite services provide safe and supportive environments on a short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings.

Residential Crisis Stabilization

Residential crisis stabilization provides intensive short-term, out of home placement for the child, helping to avert the need for psychiatric inpatient treatment or other out-of-home placements. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.

End notes

-
- ⁱ “Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions,” Joint CMCS and SAMHSA Informational Bulletin, 2013
- ⁱⁱ Ibid.
- ⁱⁱⁱ “Report to the President and Congress, Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration,” As Required by the Deficit Reduction Act of 2005 (P.L. 109-171), Department of Health and Human Services Office of the Secretary, July 2013
- ^{iv} “Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions,” Joint CMCS and SAMHSA Informational Bulletin, 2013
- ^v Suter, J. C., & Bruns, E. J. (2009). Effectiveness of the wraparound process for children with emotional and behavioral disorders: A meta-analysis. *Clinical Child and Family Psychology Review*, 12(4), 336–351.
- ^{vi} Grimes, K., Schulz, M., Cohen, S., Mullin, B., Lehar, S., & Tien, S. (2011). “Pursuing cost-effectiveness in mental health service delivery for youth with complex needs,” *Journal of Mental Health Policy and Economics*, 14, 73–86.
- ^{vii} “Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles,” Center for Health Care Strategies, Inc. 2014. Retrieved from <https://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf>
- ^{viii} “Practice Guidelines: Core Elements for Responding to Mental Health Crises.” HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009
- ^{ix} Ansell, D, Insley, S (2013) “Youth Peer-to-Peer Support: A Review of the Literature,” Youth M.O.V.E. National. Retrieved from <https://gucchdtacenter.georgetown.edu/resources/Webinar%20and%20Audio%20Files/YouthPeertoPeerLiteratureReviewFINAL.pdf>
- ^x Clarifying Guidance on Peer Support Services Policy (2013) State Medicaid Director Letter (SMDL #07-011) retrieved from <https://www.medicaid.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf>
- ^{xi} “The Value of Peer and Family Support,” (2014) del Vecchio, P. <https://blog.samhsa.gov/2014/05/26/the-value-of-peer-and-family-support/#.W5bFCI2WyUm>
- ^{xii} “Family and Youth Peer Support Literature Review, Center for Health Care Strategies, Inc., 2013. Retrieved from http://www.chcs.org/media/FYPS_Literature_Review_FINAL.pdf
- ^{xiii} “The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers,” Interdepartmental Serious Mental Illness Coordinating Committee, 2017.

Recommendations to Improve Children’s Mental Health Crisis Services

2018