CRISIS SERVICCES FOR CHILDREN AND YOUTH

Summary of Survey of Family-Run Organizations and Crisis Services for Children and Youth

fredla

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Crisis Services for Children and Youth: A Survey of Family-Run Organizations

All families caring for children or youth with mental, emotional or behavioral needs can describe one or more crisis where they had to call 911 or take their child to the emergency department at the hospital. It's almost a given that crisis will happen. That said, the availability of crisis services for children and youth is lacking.

The Family-Run Executive Director Leadership Association, FREDLA, conducted a 10-question survey of family-run organizations in June 2015 to get a snapshot of what crisis services are available and in what way family-run organizations may be involved in their crisis system for children and youth.

A total of 18 organizations responded to the survey representing 16 states. The following is a list of the organizations that responded to the survey:

Family Based Services New Jersey
The Younger Years & Beyond, Georgia
Keys for Networking, Inc., Kansas
Texas Federation of Families for Children's Mental Health
Family Support Organization of Passaic County, New Jersey
MIKID, Arizona
National Family Dialogue, Minnesota
Kentucky Partnership for Families and Children
Total Family Care Coalition, District of Columbia
Maryland Coalition of Families for Children's Mental Health
Parent Support Network of Rhode Island
Oregon Health Authority
Nevada PEP
Alaska Youth and Family Network
Federation of Families of Central Florida Inc.
Family Based Services Association, New Jersey
Wisconsin Family Ties
Allegheny Family Network, Pennsylvania

The purpose of the survey was to informally solicit input from family-run organizations and was not conducted using rigorous research standards and methodology. FREDLA believes that the consistency of responses is valuable and provides worthwhile input into discussions about crisis delivery systems for children and youth across the country.

Crisis Services for Children and Youth: A Survey of Family-Run Organizations

Executive Summary

The Family-Run Executive Director Leadership Association FREDLA conducted a 10-question survey for family-run organizations to provide input into discussions about crisis delivery systems. A total of 18 organizations responded to the survey representing 16 states. The following summarizes findings from the survey.

- Across the country there are few crisis services for children and youth
- Most crisis services are for adults only or for all age groups
- Crisis services are a patchwork of services and most are found in urban areas with few crisis or behavioral health services available in rural areas.
- Among a list of crisis services, law enforcement was reported to be the most available service followed by hospital emergency departments.
- Training for law enforcement is critical but few family organizations were aware of any law enforcement training on crisis intervention for youth
- Twelve of the 18 organizations responded that they were not part of their formal state or local crisis response system. All reported that they serve families in crisis.
- When asked whether family-run organizations *could* play a role in crisis services for children and youth, the majority of organizations stated they felt they could make a significant contribution to their crisis response system for children and youth by supporting their families.

Recommendation

Based on the responses from family-run organizations serving families caring for a child or youth with mental, emotional, or behavioral health needs FREDLA recommends that a pilot program be developed that would provide fund family-run organizations to develop model crisis parent peer support services, similar to the adult model programs which have proven to be effective and reduce the need for more costly inpatient hospitalization and out-of-home services.

Acknowledgements

FREDLA Is grateful to the family leaders who completed the survey in the midst of their many responsibilities. This survey was conducted without the use of any federal or state funds and does not reflect the views, opinions or polices of HHS, SAMHSA or CMHS."

Summary of Responses and Recommendations

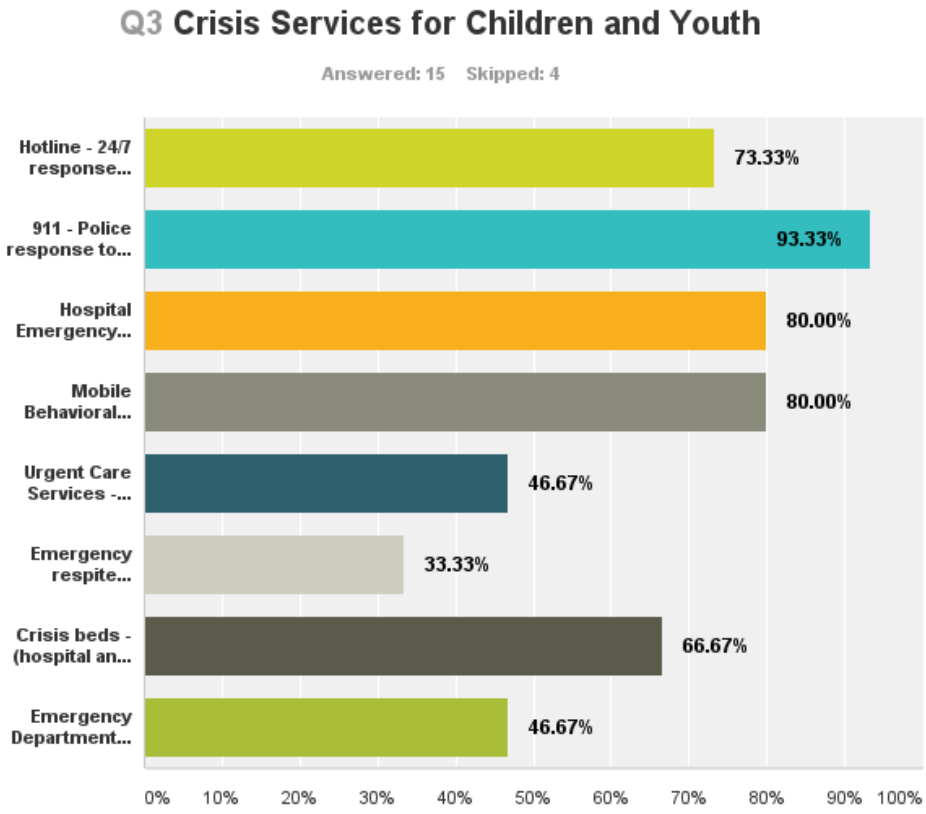
Few crisis services for children and youth
There are few crisis services specifically designed to meet the needs of children and youth with mental, emotional or behavioral needs. The majority of crisis services identified were available for adults only or for both adults and children. Baltimore City Child and Adolescent Response System (B-CARS), operated by Catholic Charities is one of the few crisis programs specifically designed for children and youth.

> ***The Baltimore City Child and Adolescent Response System*** *(B-CARS) provides comprehensive community-based services for children in mental health crisis. B-CARS provides brief and intensive community-based services for children in psychiatric crisis to divert or shorten in-patient hospitalization and to link clients to community providers that will serve them for ongoing care. - See more at: http://www.catholiccharities-md.org/mental-health/crisis-response*

Urban and rural crisis services
Crisis services are a patchwork of services and they are clustered in urban areas and accessing crisis services for children in rural areas is challenging. The lack of crisis services often results in overuse of hospitalization which is viewed by some in rural communities as a "pipeline" to longer-term PTRF placement or treatment foster care.

> *More than 60% of rural Americans live in mental health professional shortage areas and more than 65% of rural Americans get their mental health care from their primary care provider. The mental health crisis responder for most rural Americans is a law enforcement officer. (Western Interstate Commission for Higher Education Mental health Program).*

Law enforcement is most available crisis service
Family organizations reported police or law enforcement as the most available crisis service followed by hospital emergency departments. Mobile behavioral health and trauma crisis teams were available but only in urban areas and not statewide.



Training for law enforcement
With law enforcement noted as the most available crisis service, the need to train law enforcement about responding appropriately to children and youth in crisis who may become agitated or aggressive is critical. Few organizations knew about or were involved in training law enforcement.

Crisis Intervention Team (CIT) for Youth

CIT for Youth aims to improve interactions between youth and law enforcement officers by training law enforcement officers and encouraging a community partnership that effectively connects youth with mental health needs to effective services and supports in their community.

http://www2.nami.org/template.cfm?section=CIT_for_Youth

The Role of Family-Run Organizations in Crisis Services for Children, Youth and Families
Twelve family-run organizations reported they are not part of their state or community's crisis response system. However, all of the organizations indicated they work with families in crisis, mostly through the wraparound process assisting families to develop a crisis plan and helping families navigate through the system. Warm lines and support groups were also noted as services for families in crisis.

At times family organizations reported they were the place families were referred after the crisis. Hospitals referred families to family organizations when their child was being discharged.

When asked whether family-run organizations *could* play a role in crisis services for children and youth, the majority of organizations stated they felt they could make a significant contribution to their crisis response system for children and youth by supporting their families.

> *"Absolutely, one of the services we could provide is 24/7 crisis support to help parents identify level of crisis and walk them through services and agencies. We could and should do the same while the youth are out of home and after they come home. We are simply not funded to do these things."*
>
> *"We could provide peer support services to families as the crisis is happening we would. Families are often confused by this process and need support. This is a potential program that could be successful is funded well."*
>
> *"We would very much like to increase our role in crisis services in our state. Support for increasing family-run services is spotty and appears to be driven by funding and the perception that our services aren't real "behavioral health services." The second perception is largely driven by the fact that we are unable to bill Medicaid and have no clear path to sustainability or increasing our capacity beyond grant funding opportunities."*
>
> *"I think that when children come into the crisis center that an AFN Family Support Partner could be an excellent support to the parent of the child. We could talk to the parents directly and offer our service with that warm hand off that many times parents need."*

A webinar sponsored by NASMHPD on June 10, 2015 described several model adult programs using peers in crisis support. The programs reported a decrease in hospitalization and cost savings as a result. The array of peer services provided included:

- Hospital Diversion
- Warm Line
- In-Home Peer Companionship
- Social Structure (Nights Out)
- Emergency Department Advocacy
- Partial Hospitalization Advocate
- Open Access Navigators
- Recovery Center Services

Many family-run organizations already provide or could provide these services but do not receive funding to provide them as part of their state or community's crisis service system for children.

Recommendation
Based on the responses from family-run organizations serving families caring for a child or youth with mental, emotional, or behavioral health needs, FREDLA strongly recommends that a pilot program be developed that would provide financial support to family-run organizations to develop model crisis parent peer support services, similar to the adult model programs which have proven to be effective and reduce the need for more costly inpatient hospitalization and out-of-home services.

Family-Run Executive Director Leadership Association (FREDLA) is an organization that brings together leadership from more than 35 family-run organizations across the country. FREDLA has accomplished a great deal since it started two years ago and has quickly evolved from an idea into a national voice for family-run organizations with a mission to: *Empower and strengthen executive leaders of family-run organizations focused on the wellbeing of children and youth with mental health, emotional or behavioral challenges and their families.* FREDLA's mission extends to all involved in family organizations – executive directors, board members and mid-level managers, as well as peer support providers. FREDLA grew out of the family movement and has a vested interest in ensuring that the family movement is strong and every family member's voice is heard throughout the system. FREDLA Is governed by a 19 member board of directors comprised of executive directors of local and state family organizations.

FREDLA is a partner in the Technical Assistance Network (TA Network) at the University of Maryland School of Social Work to provide training and consultation to family-run organizations attached to Children's Mental Health Initiative (CMHI) Systems of Care funded communities and states. With funding through the TA Network contract, FREDLA hired an Executive Director located in Maryland and part-time Project Coordinator located in Michigan.

FREDLA has accomplished a great deal since it began in 2013 and has quickly evolved from an idea into a national voice for family-run organizations. Since hiring staff in February 2014 FREDLA has:

- Provided 59 technical assistance contacts to 15 states, many with multiple systems of care sites across the country.
- Designed and implemented a Family Leadership Camp
- Developed the National Data Collection Project
- Developed Standards of Excellence for Family-Run Organizations
- Developed a Diverse Family Leaders Scholarship Program
- Hosted an annual membership meeting in Washington D.C.
- Facilitated calls with SAMHSA Regional Administrators and the family organizations in each of those regions.

FREDLA welcomes the support and involvement of family leaders, as well as partners in the behavioral health field.

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Appendix A. Definition of Crisis Services Used in the Survey

Definition of Crisis Services:

Hotline - 24/7 response staffed by trained behavioral health workers to provide support, screening including triage, information and referral and determination of intensity of services.

911 - Police response to crisis

Hospital Emergency Department - 24/7 evaluation for inpatient care, can be voluntary or involuntary for observation and evaluation of safety to self and others

Mobile Behavioral Health and Trauma Crisis Team - 24/7 behavioral health team available to respond in the community to crises, trauma and disasters. Mobile crisis provides intervention at the time of crisis where the child or youth is located**.**

Urgent Care Services - (non-hospital-based) - immediate appointments with extended hours. Rapid access to licensed behavioral health clinicians. Services include: Psychiatric, psychosocial and medication evaluations, linkage to community resources, follow-up visits and linkage to long term service such as care coordination.

Emergency respite (non-hospital-based) - unplanned respite services provided on an emergency basis. Designed to provide temporary break for caregivers of youth with serious behavioral health needs. Offered in safe environment to include a licensed residential or group home from a few hours up to 2 weeks.

Crisis beds - (hospital and non-hospital-based) 24/7 available beds to stabilize an acute crisis and prevent hospitalization. Hospital-based 23 hour observation beds or non-hospital overnight beds. Psychiatric psychosocial assessment provided by a mental health professional, 24 hour access to psychiatrist, service coordination and support.

Emergency Department Diversion Program (hospital-based) - behavioral health staff available to Emergency Departments to assess youth, deescalate crisis and evaluate service need to divert from inpatient hospitalization

Appendix B. Responses to Survey Questions 3-10

Q3 Does your state offer separate crisis response services for children than for adults? If so, please describe below.

"Only a few centers/regions offer mobile crisis teams and they are so limited in personnel and time that not really available."

"For children and youth: Crisis beds and emergency department diversion are only offered in Baltimore City. Urgent care services and emergency respite are very limited."

"The ER diversion is for adults only."

"The mobile teams we have now are part of the BH Clinics, but I do believe that will change when CRN comes on board."

"Hotline is not JUST for children; unsure about trained staff....."

"Youth Support Partners that will work with youth to support them from a peer perspective which is used to prevent inpatient by helping the family and youth identify the need to get help preventing hospitalization."

"The only two services available across the state are checked above. Counties may provide the other services listed above, but there is no uniform set of services across all counties."

Q4 Often crisis services are not available across a state but exist in certain areas of the state, such as urban areas. Please describe how crisis services are distributed across your state.

"Crisis services are limited to hospital emergency departments and 911 across the state. In more rural communities even those options are non-existent. Families that would benefit from short-term, brief intervention services must often struggle on their own or make the decision to put their child in longer-term out of home care. Anchorage has an acute care facility (stays up to 30 days, but many much longer), but more experienced parents and providers shy away from its use because it is often seen as a pipeline to longer-term PRTC and Treatment foster-care. Even urban areas of Alaska lack meaningful home and community-based support for families, especially children with especially challenging (expensive and resource intensive) behaviors."

"The most availability of crisis services exists in urban areas. I am responding from a rural area and some of the services you asked about above MAY exist, but not as much in rural Arizona."

"Baltimore City is rich in crisis services for children and youth. Other high population jurisdictions have mobile crisis teams (but not specifically for youth, and not 24/7). Western Maryland has no mobile crisis services. The Eastern Shore of Maryland has one provider that covers numerous counties and therefore is slow to respond."

"Mobile Crisis for children and families is available in the two urban areas of Nevada, and in rural areas near the urban centers."

"In PA each county is different. In some of our rural areas the services are handled by the local hospital and are not very adequate. In the more urban areas there are many services for crisis. I believe that 911 is used in the more rural areas as well."

"On a county-by-county basis. More rural counties have less access to such services."

Q5 Families are often instructed to call 911 for police to respond when their child is in crisis. Are the police in your state or community trained to respond to crisis situations for children or youth? Please describe any training police receive in this area, such as trauma training.

"Some police are trained in crisis for mental health through various organizations."

"Yes, but its erratic."

"No there is no training to work with children."

"911 directs police and Mobile Crisis to the event. I'm not aware of specific trauma training directly for police."

"I don't know."

"Kentucky's adult behavioral health and NAMI have trained police in responding, but no training has occurred specifically focused on children/teens with behavioral health challenges."

"Yes, the D.C. Metropolitan Police Department officers are trained to respond to mental health crisis involving children and youth. The Metropolitan Police Department, in partnership with the Department of Mental Health, set up the Crisis Intervention Officer Initiative to train officers to recognize the signs of mental illness, determine the most appropriate response, and to use techniques that build on their skills and training. Over 500 officers have been trained. A Crisis Intervention Officer is trained in handling incidents involving mental health consumers and is equipped to de-escalate a situation and resolve an encounter in the safest possible manner and in the best interest of those involved."

"The only training that police receive is Critical Incident Training, and it is spotty across the state. CIT is geared toward adults experiencing a mental health crisis. The Maryland General Assembly just passed legislation to fund an expansion of CIT in all jurisdictions."

"CIT training happens in both urban areas of Nevada for a portion of officers, it is not required. A small portion of the training is on children. The State cut funding for the program during the budget crisis, and the program has not been restored in full."

"No. Metropolitan Portland has had CIT training."

"Many of our police officers are trained Crisis Intervention Team members, mostly in urban areas."

"In Allegheny County police are trained to address mental health calls in a more understanding way. If an aggressive approach is not necessary the officer will do more talking to de-escalate the situation. It helps with a more education and understanding approach. In many parts of the state I do not believe this is available."

"Yes, they are trained, but the training is spotty and not all police departments attend."

"There is a strong push in some communities for CIT training, but training of law enforcement is uneven and there have been several notable incidents."

"NO"

Q6 Is your family organization involved in crisis services for children and youth in your state? If so, please describe the role and services your organization has in the crisis response system.

"We help parents locate such resources and provide support groups."

"Yes, we work together in county committees. The hospital will give parents our information and make a warm line connection for families not in the system of care. We are currently trying to work out a system of connecting with parents while they are waiting in ER."

"Keys offers a warm line to guide families to services and to support them through crisis at the same time calling and seeing state agency people to help."

"We provide Peer support partners to for families enrolled in CMO services. we are involve only indirectly at first, but once/if a family begins to receive intensive service our Peer Support Partners become involved. Also you are given a referral to you our youth support."

"No, we get them to crisis services, but, other than a quick assessment for DTS/DTO, we do not provide services."

"Not really....we participate on a state-level team for KY's System of Care which includes crisis services, but it has not been a specific focus."

"Yes, we provide support to the youth and the parent/caregiver in the home."

"Not formally. Our Family Navigators and Family Support Partners (in Wraparound) may be called by a family in crisis."

"Nevada PEP participates in CIT class when invited. Nevada PEP is a partner in the children's MCRT program, providing aftercare family support."

"No"

"AYFN currently only provides 24/7 for crisis support for families that are a part of its active caseload due to capacity/funding constraints and the intense needs of the families we serve. We provide these services to prevent movement of children to higher levels of care, and in support of families who are hesitant to use other available services. AYFN will refer to our crisis management (hospital er or 911)

when issues of safety are clearly present or capacity issues prevent us from providing adequate support."

"We are not directly involved but are connected to the operations and the Executive Director of the facility. We at times receive referrals from them."

"No, we are called in after."

"We provide crisis prevention and stabilization services as part of our standard package of parent peer specialist services. We advocate for better responses to crises (law enforcement) and greater availability of appropriate services."

"Our team is a referral source for mobile crisis response in some areas."

Q7 If your family organization is not involved in crisis services for children and youth in your state, do you feel your organization could have a role in the crisis response system for children? Please indicate how.

"Yes we can help parents learn more about resources."

"Absolutely, one of the services we could provide is 24/7 crisis support to help parents identify level of crisis and walk them through services and agencies. We could and should do the same while the youth are out of home and after they come home. We are simply not funded to do these things."

"We could provide peer support services to families as the crisis is happening we would. Families are often confused by this process and need support. This is a potential program that could be successful is funded well."

"We are looking into getting Behavioral Health Respite Homes licensed and could be an option for emergency respite situations."

"Yes, by assisting CSUs and police in being more responsive to youth with behavioral health challenges and their families. Training peer support services to assist in crisis; KY has a grant on First Episode Psychosis which is looking at peer support for these first crisis episodes."

"Yes we are involved."

"I'm uncertain how we could play a role".

"Nevada PEP would like to promote the restoration of the CIT program, and provide an improved children and family focus."

"Yes, with a Family Support Professional on each or available to each response team."

"We would very much like to increase our role in crisis services in our state. Support for increasing family-run services is spotty and appears to be driven by funding and the perception that our services aren't real "behavioral health services." The second perception is largely driven by the fact that we are unable to bill Medicaid and have no clear path to sustainability or increasing our capacity beyond grant funding opportunities."

"I think that when children come into the crisis center that an AFN Family Support Partner could be an excellent support to the parent of the child. We could talk to the parents directly and offer our service with that warm hand off that many times parents need."

"No, we are not first responders, we are contacted after the youth/family is stabilized."

"Yes"

"Yes, we could have a role, if a parent support person were available to call/visit after crisis it could help parents."

Q8 Are parent to parent support services available as part of the crisis response system in your state or community? If so, please describe.

Twelve family organizations replied that they are not part of the crisis response system in their state or community. One organization provided a comment:

"Our organization maybe one other organization provides parent to parent support services as part of a crisis response system. In our role, we usually respond to a youth crisis before the police or crisis intervention. This is because the family calls us. If we are able to de-escalate the behavior without the child being removed, the police officer or crisis intervention team will let us complete the process with the child. If the child is unable to de-escalate the police officer is usually asked to transport to a hospital for 24 hours stabilization."

Q9 Does your organization work with families to develop a crisis plan? Please describe.

Our organization does not.

Yes, with the Care Management Org, at the family's initial meeting.

Yes we use the model from wraparound training ala Vandenberg. We participate with families develop the crisis plans with schools and mental health centers. This is not easy and agencies do not want to do it.

Yes, this is part of our wraparound process.

Yes. We attend the CFTs and have discussions with families about the need for a detailed, effective crisis plan: specific triggers, "safe" people, etc.

We work to build infrastructure. We help train children's case managers and peer support specialists which includes developing a crisis plan with youth and families.

Yes, our parent to parent support workers are trained to assist youth in developing a crisis plan. The purpose of the plan is explained to the youth. The youth is asked who to include and a call tree is established for use at the onset of feeling of anxiety or manic. The youth is asked to have many copies of the crisis plan displayed in the home and on their person.

Our Family Support Partners (in Wraparound) help a family to develop a Plan of Care, which includes a crisis plan.

As a part of the Wraparound process and in CFT's crisis plans are developed, PEP Family Specialists provide support at these meetings.

Yes, safety and respite plan
We work with families to develop crisis/safety plans that include emphasis on the use of existing natural/provider supports with an eye on preventing movement to long-term out of home care.

Yes, we do. In High Fidelity Wraparound families develop a crisis plan and the Family Support Partner (FSP) participates in the process with the family. The families that we support that are not High Fidelity Wraparound if they are in need of a crisis plan the FSP will support them in completing one as well.

Yes, Care Management , with Family and FSO work on a crisis plan at the first family meeting.

Yes.

Yes.

Q10 How would you improve the crisis response system in your state?

"Have more training for police, parents, families, and the whole community on mental health and crisis services for children."

"ER waiting times are sometimes too long. Beds are not always available in the community, long trips for parents make it difficult , if not impossible to be part of treatment plans."

"Train people to do crisis planning, take calling untrained police force off the table--this is criminalizing the mental illness disability. Forge agreements between the agencies that they will do something, offer attendant care when people need it instead of when convenient for the agency, actually have respite care available. We propose that families who have children who need this service are also trained to provide it. The training would help them with their own children and would also increase availability of services locally. We would ask the centers and state to enforce the hiring of parent to parent peer support locally that is a real service."

"Adding family support. and bringing public awareness to the service. Bringing police awareness of the service."

"An emergency department "diversion" program and more access to Urgent Care (BH)."

Peer support!

"Include parent to parent partners with police and crisis teams when responding to a crisis. There is usually a consistent number of youth that have mental health crisis. It is also common that a parent to parent partner may have knowledge of the youth especially when working in multiple systems."

"Based on focus groups that we held with families across the state in 2013, families told us that they wanted: 24/7 Mental Health Urgent Care Centers, with staff trained to work with children. 24/7

Mobile Crisis Teams that arrive in a timely manner, with staff trained to work with children Care Management Entity services that include a care coordinator available 24/7 to assist in a crisis."

"Develop programs for Planned and Emergency Respite which are not available in our system."

"Community based parent support professionals available to crisis team for mobile response and warm line support and pre services engagement."

"Adding the services outlined at the top of this page would be a wonderful start. Adding family and youth voice to all areas of behavioral/mental health services planning and delivery and building systems that are actually responsive and respectful of their input."

"It is very difficult in the rural areas of PA but would certainly be nice to have those community hospitals adequately equipped to respond to mental health crisis in children and adults. In urban areas there are many providers of MH services but the coordination of services is usually the big issue. Family support should be in the forefront of this movement especially for children so that families understand their parental rights as well as getting the resources and support they need at a time of crisis."

"We're not going to change the governmental service delivery structure (county rule), so we are proposing a realtime database of crisis bed availability across the whole state so counties that do not have such services can access them through another county (instead of kids ending up in inappropriate placements such as secure detention). Different and better training should be mandatory for law enforcement officers in the state."

"More widely available across the state."