CHILDREN'S EMERGENCY DETENTION AND CRISIS STABILIZATION CROSS AGENCY WORKGROUP SUMMARY

OVERVIEW: The cross agency work group was formed in response to an increase in the number of youth being sent to Winnebago Mental Health Institute (WMHI). County, state agency, provider, and parent representatives were concerned about this trend and set out to address it.

The initial workgroup was facilitated by the Department of Health Services-Division of Mental Health and Substance Abuse Services (DHS-DMHSAS) from September to October of 2014 ending with the short term goal of developing a residential crisis stabilization services for children that would reflect progress made in the adult system (e.g., crisis stabilization sites established as Community Based Residential Facilities and Adult Family Homes). This group also recommended promoting linkages between crisis services/crisis planning to Coordinated Services Teams and Comprehensive Community Services programming to ensure crisis plans for children and families are accessible among service systems. Longer term goals included the following: (1) Develop a youth crisis assessment and de-escalation training protocol for counties and crisis intervention partners, law enforcement, and school systems; (2) Expand coverage to include the home as a crisis stabilization site for hospital diversion funded by Medicaid; and (3) Investigate RCC's potential to be a resource for crisis services.

In January of 2015, the Office of Children's Mental Health agreed to facilitate the workgroup's continued meetings in order to better understand the problem and establish further recommendations. The information below is based on meeting activities and available information from both formal analyses (e.g., of hospital discharge data) and from stakeholder observations.

DESCRIPTION OF THE PROBLEM: Although the initial focus of the group was on the high census at WMHI, additional information was needed to put the WMHI numbers in context. For instance, an analysis of youth admissions from both state psychiatric facilities, WMHI and Mendota Mental Health Institute (MMHI), indicates that the number of youth admissions has not increased significantly, but the closure of MMHI youth beds shifted the entire youth population to WMHI. When this observation was made to stakeholders, they posited that the closure of MMHI youth beds did not fully capture the problem. Thus, more discussion and analysis resulted in an increased understanding about the trends at WMHI. Additional issues and information included the following:

- **Wisconsin has high rates of youth psychiatric hospitalizations** and these have increased in recent years even as other youth medical hospitalizations have declined.

- **Many of the hospitalizations are involuntary.** Though it is not possible to determine the exact number of Emergency Detentions, counties reported 1,066 youth (18 and under) were Emergency Detained in 2014. The actual number is likely higher due to inconsistent county reporting.

- **Psychiatric hospitalizations are expensive** and are the primary Medicaid expenditure for youth using mental health services.

- **Many hospitalizations can be avoided:** The data indicate that only a fraction of youth admissions at WMHI result in a civil commitment, settlement agreement, or post-probable cause confinement. The majority of youth legal issues are dropped before that point. Additionally, Medicaid data indicates that only half of youth who were known to have been Emergency Detained had any outpatient therapy in the calendar year of their detainment. It was also noted that youth with developmental disabilities are Emergency Detained for behaviors that, with the right training, could likely be addressed in less restrictive settings.

PROBLEM ANALYSIS: Although we may be unable to identify all the factors that contribute to Wisconsin's high rates of youth psychiatric hospitalizations and EDs, the workgroup collectively identified many facets of the problem as described below.

- **Strain on families***:* In Wisconsin, as well as the rest of the nation, we have seen an *erosion of the middle class* and an increase in the number of children living at or near the *poverty* line. Various health and human service sectors have noted this increased strain. The Department of Children and Families reports *increases in the number of children being removed from the home* and coming in *contact with the Child Protective System*. A variety of stakeholders report *increases in adult and youth substance abuse*. Anecdotally, educators report that children are expressing *more problem behaviors*.

- **Strain on mental health services:** Wisconsin has a pronounced *lack of mental health providers*. A report by Mental Health America placed Wisconsin 42nd in the nation in the number of providers, and a report by Kaiser Family Foundation ranked Wisconsin last in terms of the ability to meet mental health needs; this creates challenges in meeting children's needs for mental health screening, assessment, and outpatient treatment. Counties report that their *workforces are over-extended* and that their *staff lacks the support* they need to meet the service demand. Providers report that Wisconsin's *Medicaid (MA) has low reimbursement rates* for mental health services. In addition, *MA reimbursement is not available* for certain categories of preventative treatment (e.g. respite care for families in crisis). More positively, there is some indication that *youth detentions have decreased* in recent years which may, in part, be due to a growing recognition that mental health issues are at the core of many delinquent behaviors. Though a positive shift in youth treatment, this may place additional strain on the mental health system.

- **Strain on crisis services:** In a recent Department of Health Services' (DHS) county crisis services' survey (July 2015), the majority of counties pointed to *under-staffing and high employee turnover* as problems. This erodes the level of stability and expertise in crisis services; it also may lead to other practices that make Emergency Detentions more likely, such as:

  Reliance on law enforcement: In the crisis services' survey referenced above, many counties noted that they rely heavily on law enforcement to respond to crises and make determinations about the appropriate course of action, especially after hours. While law enforcement may have an important role to play in the crisis system, this over-reliance could inadvertently promote the use of primarily law enforcement related options.

  Lack of time to attend to the crisis: Best practice with youth in crisis dictates that enough time be allotted for a crisis worker to assess the situation, de-escalate, and work with the family to stabilize the youth. In the DHS survey, approximately half of the respondents (52%) said that they used face-to-face assessments most of the time. Some counties noted that they were more likely to use mobile crisis services when youth were involved. Some rural counties noted that while they are able to offer mobile services, in practice the travel time is a challenge with limited staff. Successful counties indicated that youth are most successful when the crisis response can be holistic and family-centered, and, when appropriate, lead to ongoing services.

  ***Lack of less restrictive options*:** The majority of counties surveyed expressed concern over the lack of youth hospital diversion or stabilization options. While most counties said that they try to divert individuals from hospitalization whenever possible, they noted that the lack of options makes this particularly difficult. Workgroup members and the counties reported that they are experiencing *increased strain on the foster care system* making it harder to use foster care licensed facilities for short-

term mental health stabilization. *The number of residential care centers has also declined* in recent years. Data from the Wisconsin Hospital Association Annual Surveys shows that the *number of psychiatric beds has declined*. In addition, counties report that many of the beds that have closed were youth beds and that *some hospitals have adopted new policies which* make it increasingly difficult to admit a youth on a voluntary basis. Instead, more *hospitals reportedly require an ED for admission*.

***Stakeholder knowledge and beliefs*:** Many counties expressed the need for more training for their staff in order to more effectively assess and de-escalate crises. In the DHS survey, many counties indicated that they were *only willing to see consumers in a secure environment* (e.g., hospital emergency room or police station), and/or that they require that police accompany crisis workers in non-secure environments. While it is imperative to protect crisis workers' safety, there may be ways to provide crisis services in less restrictive and potentially triggering conditions. Even when a crisis staff person determines / assesses that a situation can be safely handled outside of an Emergency Detention, counties report that sometimes other stakeholders take a *highly cautious approach and default to the side of an Emergency Detention* if there is any perception of risk. This has been mentioned with regard to law enforcement, corporate counsel, and hospital staff.

EXAMPLES OF COUNTY SOLUTIONS: Counties have been creative and proactive in seeking solutions. Below are some examples cited by the work group.

- Some counties are focusing resources *on early identification*, identifying youth at risk of crisis and targeting services to meet their needs.
- *Police CIT training* focused on serving youth.
- At least one county will *meet youth/family at the Emergency Room and follow-up with 15 to 20 hours of face to face services a week*. While another county provides an in-home treatment model that includes longer term treatment (more than 90 days).
- Several northern counties *stabilize youth in a non-hospital setting within 24 hours* but have very limited capacity. Others report using *foster and group homes*. While others are considering a 'flexible use' model to provide an *"hotel model" stabilization* – the parent stays with the child in a stable setting.
- Ten counties contract with a network to help serve and place youth. They offer *planned respite* for families out of general state revenue or county funds to be used as a diversion to hospitalization, as a step down coming out of hospital back into community, and as a planned response to address a need prior to crisis. This network also provides *training and technical assistance* for counties dealing with youth in crisis. They attribute much of their crisis diversion to *face-to-face assessment* which they also use to de-escalate the situation. If they feel a hospitalization is not necessary but services are needed, they can place the child in a ***stabilization site***, which could be a foster home, group home, or treatment foster home, all of which are licensed by DCF and must have specialized DHS 34 training.

NEXT STEPS: The group created three workgroups focused on improving crisis response. These include:

- **Best practices:** This group will collect and disseminate information on the best practices occurring nationally and within Wisconsin, both directly in the crisis system and in work with stakeholders (e.g., hospitals, law enforcement, schools). The information will serve as a standing resource for counties.
- **Training:** The Wisconsin County Human Services Association will lead an effort to help define a standard set of crisis training materials statewide.
- **New options for placement:** This group will design and pilot a regional group home that can be used in lieu of hospitalization for the purposes of crisis stabilization.