

Issue Brief

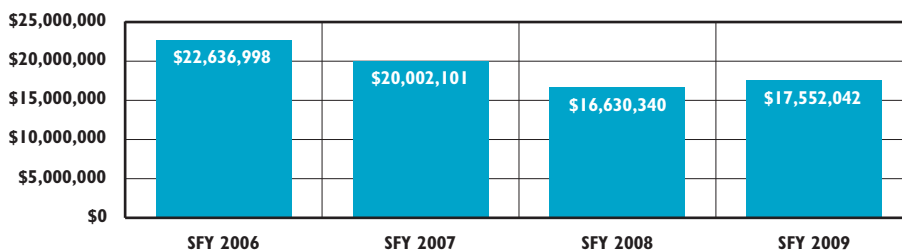
**CHILDREN'S BEHAVIORAL HEALTH:
PSYCHIATRIC HOSPITALIZATIONS
AND THE CONTINUUM OF CARE**

One in five children ages nine to 17 in Rhode Island and in the United States has a diagnosable mental health disorder, and one in ten has a mental health problem that is severe enough to substantially interfere with their functioning at home, in school, or in the community.^{1,2} Despite the high rates of mental health disorders among children, four out of five children do not receive needed treatment and those that do often receive treatment in a setting that does not best meet their needs or the needs of their families.^{3,4}

Mental health systems continue to be fragmented and crisis-driven with disproportionate spending on more intensive services within the continuum of care.^{5,6,7,8,9} National estimates suggest that about half of the resources spent on children's mental health are spent on psychiatric hospitalizations.¹⁰ When there is an inadequate supply of home-based and community-based services, children may be hospitalized unnecessarily, unable to find a bed in a psychiatric hospital when this level of care is needed, "stuck" in psychiatric hospitals when this level of care is no longer needed, or readmitted because the follow-up care that they and their families need is not available.^{11,12}

Many states, including Rhode Island, are working to build a system of care for children's behavioral health that invests in prevention and early intervention, increases access to home- and community-based services and reduces unnecessary hospitalizations and residential treatment placements.^{13,14,15}

**INPATIENT PSYCHIATRIC HOSPITALIZATION COSTS,
CHILDREN UNDER AGE 21 RECEIVING MEDICAL ASSISTANCE
THROUGH MANAGED CARE, SFY2006-SFY2009**



Source: Rhode Island Department of Human Services, Center for Child and Family Health, 2010. These data include inpatient insurance claims for ICD-9-CM codes 290-319, mental disorders including psychosis, anxiety, depressive, mood, and personality disorders and alcohol and drug dependence.

◆ Between 2006 and 2009 in Rhode Island, spending on psychiatric hospitalizations for children with health insurance through RIte Care or Medical Assistance decreased by 22%, from \$22.6M to \$17.6M. The spending per child hospitalized decreased by 32%, from \$34,298 to \$23,465, largely due to reductions in length of stay.¹⁶



CHILDREN'S MENTAL HEALTH SYSTEM REFORM

Calls for reform of the children's mental health system date back to the 1960s. Since that time, several state and national reports have been released describing the problems with the children's mental health system. These reports have uniformly identified the problems as the following:

- ◆ An overall lack of access to mental health services.
- ◆ Children receiving treatment in overly restrictive settings.
- ◆ A dearth of options beyond outpatient, inpatient and residential treatment with few, if any, intermediate, community-based options available.
- ◆ Lack of coordination across the different child serving systems (e.g., education, child welfare, and behavioral health).
- ◆ Families were not invited to participate as partners in their children's care.
- ◆ Cultural and linguistic differences in the needs of children and their families were rarely considered.

For more than a decade, reform efforts have focused on developing systems of care for children's mental health that ensure access to a broad array of effective, evidence-based treatment services and supports for children and their families. The system of care approach emphasizes the need for an appropriate balance between components of the service system, particularly between more and less intensive services, and recommends that services be delivered in home and community settings when appropriate.

According to system of care principles, children's mental health services should be:

- ◆ Comprehensive and include the full range of treatment service options.
- ◆ Individualized to meet each child and family's needs.
- ◆ Family-driven, with families involved in all aspects of the planning and delivery of services.
- ◆ Culturally and linguistically competent, recognizing and addressing cultural and language differences.
- ◆ Focused on early identification and intervention.
- ◆ Provided in the least restrictive environment that is clinically appropriate.
- ◆ Designed so that the rights of children are protected.
- ◆ Integrated, with linkages between child-serving agencies.
- ◆ Coordinated, with case management to ensure that children's changing needs are met.
- ◆ Designed to ensure a smooth transition to the adult service system.

Source: Stroul, B.A. (2002). *Issue Brief – Systems of care: A framework for system reform in children's mental health*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

A FAMILY-DRIVEN APPROACH TO CHILDREN'S BEHAVIORAL HEALTH CARE

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes choosing culturally and linguistically competent supports, services, and providers; setting goals; designing, implementing, and evaluating programs; monitoring outcomes; and partnering in funding decisions.

Source: National Federation of Families for Children's Mental Health. (n.d.). *Family-Driven – Defined*. Retrieved January 12, 2010 from www.ffcmh.org/family-driven



TOWARD A CONTINUUM OF CARE: BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH

- ◆ Communities provide different types of services for children and adolescents with mental health care needs. The full range of treatment programs and services available is referred to as the “continuum of care.” This continuum describes the services available from least intensive to most intensive with psychiatric hospitalizations as the most intensive form of treatment within this continuum.¹⁷
- ◆ Rhode Island has been working to redesign its continuum of care for children’s behavioral health services to reduce unnecessary psychiatric hospitalizations by providing home- and community-based options that meet children and families’ needs in the community and that reduce lengths of stay and readmissions. Diversion and step-down programs allow children that no longer need the level of care offered in psychiatric hospitals to get treatment in less intensive settings. This also frees up psychiatric hospital beds for children and youth who need a hospital level of care.¹⁸

According to the American Academy of Child and Adolescent Psychiatry, the continuum of behavioral health care for children and adolescents includes the following services and programs.

OUTPATIENT TREATMENT: Visits in a community mental health center, mental health provider’s office, or other outpatient setting, including diagnostic evaluation, psychological testing, individual therapy, family therapy, group therapy and medication management.

INTENSIVE CASE MANAGEMENT: Specially trained providers coordinate or provide psychiatric, financial, legal and medical services to help children or youth live successfully at home and in their communities.

HOME-BASED TREATMENT: A treatment program delivered in the child’s home and designed to help the child and family.

FAMILY SUPPORT: Services, such as parent training, parent support groups, etc., that help families care for their child.

DAY TREATMENT: An intensive treatment program that provides both psychiatric treatment and special education, usually five days a week.

PARTIAL HOSPITALIZATION/DAY HOSPITAL: A treatment program that offers all of the services of a psychiatric hospital but which allows children to go home each evening.

EMERGENCY/CRISIS SERVICES: 24-hour a day services for emergencies, including emergency rooms and mobile crisis teams.

RESPIRE CARE: Short-term care for a child that is provided by specially trained individuals who care for a child away from home to provide temporary relief to caregivers.

THERAPEUTIC GROUP HOME OR COMMUNITY RESIDENCE: A group home that provides a small group of children or adolescents with treatment or special education.

CRISIS RESIDENCE: Short-term crisis intervention or treatment with 24-hour supervision provided for up to 15 days.

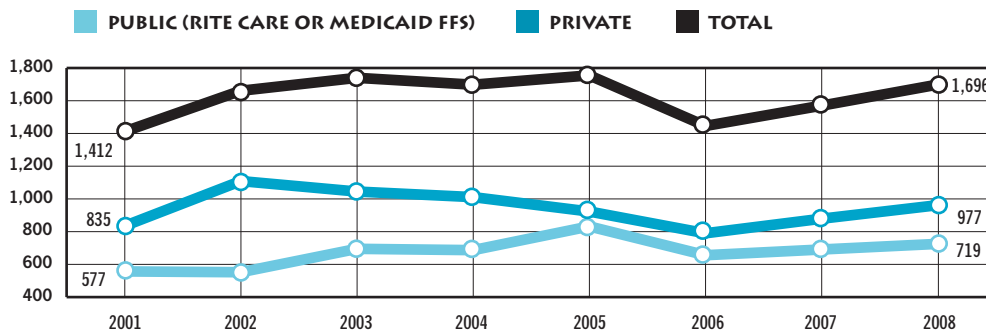
RESIDENTIAL TREATMENT: Intensive psychiatric treatment provided in a campus-like setting on a long-term basis.

PSYCHIATRIC HOSPITALIZATION: Comprehensive psychiatric treatment provided in a hospital setting.

Source: American Academy of Child and Adolescent Psychiatry. (2008). *Facts for Families: The continuum of care for children and adolescents*. Retrieved November 15, 2009, from http://www.aacap.org/cs/root/facts_for_families/the_continuum_of_care_for_children_and_adolescents

PSYCHIATRIC HOSPITALIZATIONS OF CHILDREN AND ADOLESCENTS IN RHODE ISLAND

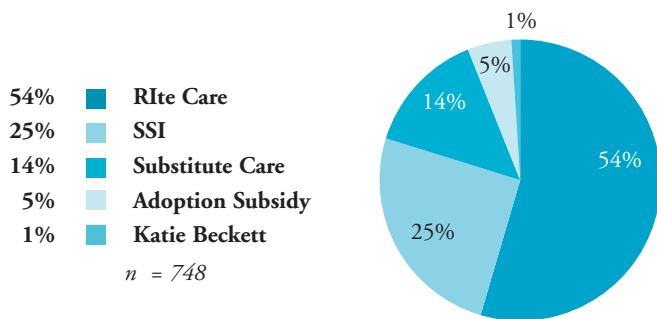
HOSPITALIZATIONS WITH PRIMARY DIAGNOSIS OF MENTAL DISORDER*, CHILDREN UNDER AGE 18, BY INSURANCE TYPE, RHODE ISLAND, 2001-2008



Source: Rhode Island Hospital Discharge Data, RI Department of Health and Medicaid Data Archive, RI Department of Human Services. *These data represent hospitalizations, not number of children; children or adolescents with more than one hospitalization may be counted more than once. Mental disorders include ICD-9-CM codes 290-319, including psychoses, anxiety, depressive, mood, and personality disorders, and alcohol and drug dependence.

- ◆ In 2008, there were 1,696 hospitalizations of children with a primary diagnosis of mental disorder at the following hospitals: Bradley, Butler, Kent, Landmark, Newport, Memorial, Miriam, Rhode Island (including Hasbro Children’s Hospital), Roger Williams, Saint Joseph, South County, and Westerly Hospitals. Some of the hospitalizations reported by community hospitals may represent children temporarily "boarded" on a general medical unit because the recommended service is unavailable.¹⁹
- ◆ Children with private insurance accounted for 58% (977) of the hospitalizations in 2008, while children with public insurance, such as RItE Care or fee-for-service Medicaid accounted for the remaining 42% (719).²⁰
- ◆ Between 2001 and 2005, the number of hospitalizations of children with a primary diagnosis of mental disorder increased by 24 percent from 1,412 to 1,755. During that same time, hospitalizations of children with public insurance also climbed. Between 2005 and 2007, the trend has been less clear with hospitalizations decreasing in 2006 but then increasing in 2007 and 2008.²¹

RHODE ISLAND CHILDREN UNDER AGE 21 HOSPITALIZED WITH A PRIMARY DIAGNOSIS OF MENTAL DISORDER*, BY MEDICAL ASSISTANCE TYPE, SFY 2009



Source: RI Department of Human Services, Center for Child and Family Health, 2010. *Mental disorders include ICD-9-CM codes 290-319, including psychosis, anxiety, depressive, mood, and personality disorders, and alcohol and drug dependence. Percentages may not sum to 100% due to rounding.

- ◆ In State Fiscal Year (SFY) 2009, 748 children receiving Medical Assistance through managed care were hospitalized with a primary diagnosis of mental disorder. Of these children, slightly more than one-half (54%) were in the core RItE Care population (i.e. they qualify for RItE Care based on family income), one-quarter (25%) received SSI, 14% were in foster/substitute care, 5% had an adoption subsidy, and 1% were insured through the Katie Beckett provision for children with complex health care needs who are cared for at home.²²

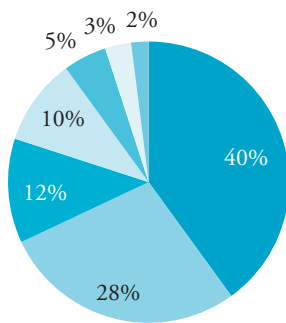
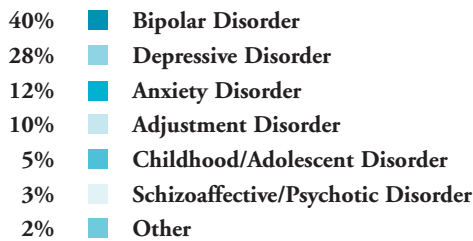
PSYCHIATRIC HOSPITALS SERVING RHODE ISLAND CHILDREN

Rhode Island has two hospitals that specialize in providing psychiatric care to children and youth, the Emma Pendleton Bradley Hospital in East Providence and Butler Hospital in Providence.

BRADLEY HOSPITAL was the nation's first neuropsychiatric hospital for children. Bradley Hospital serves infants, children, adolescents, and young adults. It has three treatment units with a total of 60 licensed beds, including 45 General Psychiatric Services beds for children and adolescents and 15 Developmental Disabilities Program beds for children with mental health needs as well as autism, mental retardation or another development disability. On April 1, 2009, Bradley Hospital opened a new building that includes individual rooms for each child and adolescent. Having individual rooms makes it easier for children to access needed care because the hospital no longer has to match children to roommates of the same sex and age.

BUTLER HOSPITAL is Rhode Island's oldest hospital and the only psychiatric hospital that provides specialty care for all populations, including children, adolescents, adults and seniors. Butler Hospital has two treatment units and a total of 23 beds allocated for children and adolescents, including 15 General Psychiatric Services beds for adolescents and eight Child Intensive Services beds serving children and adolescents with developmental disabilities or with intensive service needs, such as severe aggression or a history of multiple hospitalizations.

PRIMARY DIAGNOSIS OF CHILDREN UNDER AGE 19 RECEIVING INPATIENT PSYCHIATRIC CARE AT RHODE ISLAND PSYCHIATRIC HOSPITALS, 2008



n = 1,535

Source: Lifespan and Butler Hospital, 2008.

- ◆ In 2008, 1,535 children and youth under age 19 were admitted for inpatient psychiatric treatment to either Bradley Hospital or Butler Hospital.^{23,24}
- ◆ More than two out of three of these children and youth had a mood disorder, with 40% having a primary diagnosis of bipolar disorder and 28% having a primary diagnosis of depression.^{25,26}
- ◆ The next most common diagnoses were anxiety disorders (12%), adjustment disorders (10%), childhood/adolescent disorders (5%), and schizoaffective/psychotic disorders (3%).^{27,28}
- ◆ The remaining 2% of children had other diagnoses, such as impulse control problems, substance use disorders, eating disorders, and diagnoses not yet determined.^{29,30}

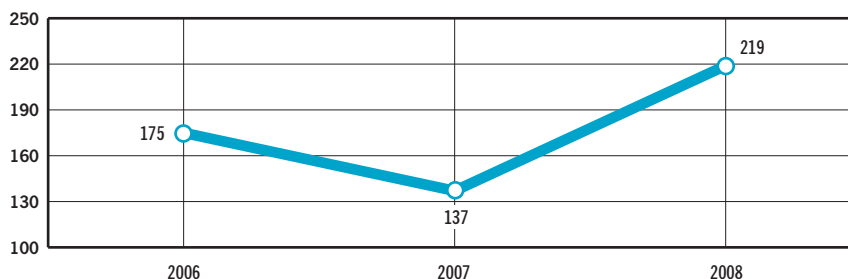
AVERAGE LENGTH OF STAY FOR CHILDREN UNDER AGE 19 AT RHODE ISLAND PSYCHIATRIC HOSPITALS, 2006- 2008

	Bradley Hospital General Psychiatric Services		Bradley Hospital Developmental Disabilities Program*		Butler Hospital General Psychiatric Services		Butler Hospital Child Intensive Services Unit	
	# Treated	Average Length of Stay	# Treated	Average Length of Stay	# Treated	Average Length of Stay	# Treated	Average Length of Stay
2006	700	19 days	55	126 days	559	17.5 days	52	47 days
2007	743	18 days	78	79 days	682	11 days	49	41 days
2008	778	17 days	61	96 days	628	11 days	68	24 days

Source: Lifespan and Butler Hospital, 2006-2008. *About one-half of the children in Bradley Hospital's Developmental Disabilities Program are from out-of-state. RI children in the program generally stay for no more than 30 days and then step-down to less intensive service options (e.g., day treatment, group homes, or home-based programs) available at Bradley Hospital or elsewhere. Children from other states stay much longer because many states do not have other options for children with intensive service needs.

- ◆ In 2008, the average length of stay for children and adolescents on the General Psychiatric Services unit at Bradley Hospital was 17 days, down from 19 days in 2006. The average length of stay for children and adolescents on the General Psychiatric Services unit at Butler Hospital also decreased from 17.5 days in 2006 to 11 days in 2008.^{31,32}
- ◆ In 2008, the average length of stay for children and adolescents on the Development Disabilities Program unit at Bradley Hospital was 96 days, up from 79 days in 2007 but still down from 2006 when it was 126 days. Butler Hospital's Child Intensive Services Unit has seen a steady decrease in the average length of stay from 47 days in 2006 to 24 days in 2008.^{33,34}

CHILDREN "BOARDED" AT HASBRO CHILDREN'S HOSPITAL WHILE AWAITING ANOTHER PLACEMENT, 2006-2008



Source: Lifespan, 2006-2008. Children may be boarded at other general hospitals in Rhode Island, but data on these boarders was not available.

- ◆ In 2008, 219 children between the ages of four and 17 years with a psychiatric diagnosis were “boarded” at Hasbro Children’s Hospital due to the unavailability of an inpatient psychiatric bed or other needed service in the state. The number of children and youth boarded at Hasbro Hospital decreased between 2006 and 2007, but rose again in 2008. In 2008, the average time children and youth were boarded was two days.³⁵
- ◆ In Rhode Island, children and youth are boarded because a more appropriate placement, such as an inpatient psychiatric bed, residential treatment bed, Acute Residential Treatment Service (ARTS) slot, or other placement is either unavailable or not admitting on the day or time of day that the child is seen at the hospital.³⁶
- ◆ Studies suggest that communities can reduce the number of children who are boarded by ensuring that the capacity of psychiatric hospitals and other needed services is adequate to meet the demand and by encouraging programs to admit children at night and on weekends.³⁷

CHILDREN IN THE CHILD WELFARE SYSTEM

- ◆ In the United States, one-half (50%) of children and youth who are in the child welfare system have behavioral health problems.³⁸ The circumstances that brought these children into state care in the first place – prenatal drug and alcohol exposure, witnessing or experiencing physical or sexual abuse, and neglect – put these children at risk for behavioral health problems. Once they enter the child welfare system, they may experience additional trauma, including separation from family members, frequent changes in placement, or recurrences of abuse and neglect that may further increase their risk for behavioral health problems.³⁹
- ◆ Despite high levels of need for mental health services, 85% of children and youth in the child welfare system who are identified as needing mental health services do not receive them. When children in the child welfare system do receive mental health services, they are more likely to be placed in restrictive settings, such as emergency rooms, residential treatment facilities, and other out-of-home placements, than other children. Among children in the child welfare system, children with behavioral health issues are less likely to be placed in permanent homes than children without such problems.⁴⁰

PSYCHIATRIC HOSPITALIZATIONS OF RHODE ISLAND CHILDREN IN FOSTER/SUBSTITUTE CARE PLACEMENTS

Year	Number of Children Hospitalized	Number of Admissions	Average Length of Stay
2005	131	172	26
2006	130	190	22
2007	108	157	16
2008	101	144	23

Source: Neighborhood Health Plan of Rhode Island (NHPRI), 2010. NHPRI is the health insurer that manages the care of children in DCYF Foster/Substitute Care. As of December 31, 2008, there were 2,311 children in DCYF foster/substitute care who were receiving Medical Assistance.

- ◆ Between 2005 and 2008, the number of Rhode Island children in substitute care who experienced a psychiatric hospitalization decreased by 23% and the number of admissions decreased by 16%. During that same period, the average length of stay remained fairly stable, ranging from 16 to 26 days.⁴¹ The total annual spending on psychiatric hospitalizations for children in substitute care decreased by 47% between SFY2006 and SFY2009, from \$6.6M to \$3.5M.⁴²

CHILDREN VOLUNTARILY PLACED IN DCYF CARE

- ◆ Rhode Island General Laws Sec. 42-17-14 provides that the DCYF director may at her discretion admit to the department on a voluntary basis any child who, in her opinion, could benefit from any of the services offered in foster care or in residential facilities available to the department.⁴³
- ◆ In Rhode Island, from July 1, 2008 to June 30, 2009, the Office of the Child Advocate received notice of 21 new petitions to voluntarily place children in the care of the Department of Children, Youth and Families (DCYF), bringing the total number of children in DCYF care on a voluntary basis during this period to 136.⁴⁴
- ◆ Many children are voluntarily placed under DCYF care in order to access needed care for a developmental, behavioral, or mental health problem, particularly when the family cannot afford to pay the costs of such care and it is not covered by private insurance. Of the 136 children voluntarily in DCYF care during the period from July 1, 2008 to June 30, 2009, 20 had developmental disabilities, 28 had behavior disorders, and 36 had mental health disabilities. Some children had multiple problems and others were not identified as having any of these special needs.⁴⁵



CHILDREN'S MENTAL HEALTH SYSTEM REFORM IN RHODE ISLAND

In Rhode Island, the problems with the children's mental health system have mirrored the problems elsewhere. Mental health systems have been fragmented and crisis-driven with disproportionate spending on psychiatric hospitalizations and residential treatment and inadequate investments in prevention and the community-based services that would allow children to receive appropriate levels of care in their own communities.^{46,47,48,49,50}

In 2005, the Rhode Island General Assembly directed the Department of Children, Youth and Families (DCYF) and the Department of Human Services (DHS) to work together to design a continuum of care for children's behavioral health services that encourages alternatives to psychiatric hospitalization and appropriately matches services and programs to the needs of the children and families. The General Assembly directed DCYF and DHS to make three specific changes:⁵¹

1.) Change contracts with RIte Care health plans to clarify that these plans have responsibility for the management of psychiatric hospitalizations and specifically for the development of hospital diversion and post-discharge services.⁵²

In response to this request, the Department of Human Services amended all RIte Care health plan contracts to include a requirement to provide RIte Care children a full continuum of mental health and substance abuse services that address all levels of need. These services must include hospital diversion and post-discharge services, including observation/crisis stabilization/holding beds, Acute Residential Treatment Services (ARTS), partial hospitalization, day/evening treatment, enhanced outpatient services, Child and Adolescent Intensive Treatment Services (CAITS), and community support services. All health plans are also required to use a behavioral health care subcontractor to provide RIte Care behavioral health services, to identify children who are in inpatient care and who will require intensive outpatient services following and to facilitate discharge, and to ensure that the full continuum of children's behavioral health services is available on a timely basis across the state.^{53,54}

2.) Identify and contract with an organization that will take responsibility for coordinating mental health services for Medicaid-eligible children not enrolled in RIte Care, in particular to manage psychiatric hospitalizations and develop hospital diversion and post-discharge services.⁵⁵

This request has not yet been implemented.⁵⁶

3.) Require that Medicaid-eligible children receive crisis intervention services before a psychiatric admission is authorized.⁵⁷

In response to this request, the Department of Children, Youth, and Families established a coordinated statewide crisis intervention system called Kid's Link RI. This system was developed by and is run by community mental health centers and other providers who provide a 24-hour telephone hotline to help families and other caretakers with children in emotional crisis, evaluate children's needs, and provide follow-up care. More information about this system appears on page 9 of this Issue Brief.^{58,59,60}

The General Assembly also directed the Departments of Children, Youth, and Families (DCYF) and Human Services (DHS) to present a report to the Governor and General Assembly that "fully described this continuum of [children's behavioral health] services and outlines a detailed plan for its implementation, including resource requirements, responsibilities, milestones and time frames, as well as a set of indicators and program metrics that will be employed to evaluate its clinical and fiscal effectiveness over time."⁶¹ This report was completed by the Executive Office of Health and Human Services in 2006 and presented to the General Assembly. For further information, see page 10 of the Issue Brief.

KID'S LINK RI: RHODE ISLAND'S EMERGENCY SERVICE INTERVENTION SYSTEM FOR CHILDREN, YOUTH AND FAMILIES

- ◆ In 2006, in response to the state law requiring that all children receiving Medical Assistance receive crisis intervention services before a psychiatric admission is authorized, DCYF developed regulations for organizations providing Mental Health Emergency Service Interventions to children and families who had publicly funded health insurance and who were in crisis.⁶²
- ◆ In 2007, a coordinated statewide crisis intervention system, called Kid's Link RI, was developed. The goal of Kid's Link is to provide high quality, effective emergency service interventions including telephone contact, support, and follow-up.⁶³
- ◆ Rhode Island's community mental health centers (CMHCs) and other mental health providers have partnered together to develop a coordinated statewide Emergency Service Intervention System with Gateway Healthcare as the lead agency. The involvement of all of the CMHCs allows children and their families to access care in their own communities.⁶⁴
- ◆ A 24-hour, 7-day-a-week telephone hotline helps parents and caregivers determine the best place to go for behavioral health treatment for children and youth experiencing mental health problems or crises. Mental health providers provide in-person evaluations and counseling to children who are identified through this hotline or at sites throughout the state within two hours. This evaluation and counseling may take place in an office-based setting, in the home, in group homes, police stations, schools, DCYF offices, hospital emergency rooms, or other community locations. Mental health providers then work with the child's family to develop a follow-up service plan that offers the services and programs that best match the child and family's needs and preferences.⁶⁵
- ◆ In 2008, there were 1,299 phone calls to the Kid's Link RI Hotline, resulting in 442 evaluations by mental health professionals, 415 (94%) of which were conducted within two hours of the initial call. The other calls to the hotline are primarily from families, parents, schools, and providers seeking support, services, or information. In many cases, the callers are linked directly to providers in their own communities to arrange for services on an urgent basis.⁶⁶
- ◆ Kid's Link RI works to reduce unnecessary emergency room visits by encouraging families and providers to call the hotline, triaging calls to determine the acuity of the crisis, and identifying alternative locations for evaluations if there is no immediate safety concern and medical attention is not needed.⁶⁷
- ◆ In 2008, 2,002 children and adolescents with publicly funded health insurance (i.e., RIte Care or fee-for-service Medicaid) were evaluated by emergency service providers. Of those children who were evaluated, 33% (668) were involved with DCYF.⁶⁸
- ◆ After being evaluated, 50% (990) of children and adolescents with publicly funded health insurance were discharged home or returned to their existing placement (e.g., a group home), 28% (569) were admitted to a psychiatric hospital, 11% (227) were boarded in an emergency room or acute care unit pending an available psychiatric bed or other recommended service, 3% (53) were admitted to Acute Residential Treatment Service (ARTS), and the remaining 4% (89) were discharged to some other arrangement, including to another family member or to DCYF. Children are reevaluated while they are boarded and may be discharged to a psychiatric hospital, ARTS program, Partial Hospitalization Program or home with services, depending on their status at that time.⁶⁹
- ◆ Children who were already in treatment at the time of the evaluation were generally referred back to their current provider, a private therapist or psychiatrist, a Community Mental Health Center (CMHC), outpatient program, or other social service or mental health agency. Children who were not already in treatment were referred to a provider.⁷⁰



GAPS IN THE CONTINUUM OF CARE AS IDENTIFIED IN THE 2006 EOHHS REPORT

With the passage of General Law H-5829, the General Assembly directed the Department of Children, Youth & Families (DCYF) and Department of Human Services (DHS) to work together to design a continuum of care for children's behavioral health services. In 2006, the Executive Office of Health and Human Services (EOHHS) prepared a report on the development of this continuum of care. A portion of this report identified gaps in the service system with a particular emphasis on services that, if available, might reduce unnecessary psychiatric hospitalizations. The report identified the following gaps:

◆ GAP 1: COMMUNITY-BASED SERVICES NOT WORKING WITH CHILD AND FAMILY WHILE IN HOSPITAL

Community-based service providers need to work with children while they are hospitalized and be involved, along with the family, in discharge planning meetings to ensure that children and youth leaving the hospital will be able to access the services they need to successfully transition back into their schools and communities. Without such services, children are more likely to require a subsequent hospitalization.

◆ GAP 2: LACK OF CRISIS STABILIZATION BEDS THAT ARE NOT HOSPITAL-BASED

Crisis stabilization beds are secure, adequately staffed, psychiatrically supervised programs that allow time for children to be observed and stabilized when they are in emotional crisis. These beds could be located in Acute Residential Treatment Services (ARTS) facilities, intensive residential treatment programs, or other facilities that offer highly-trained staff, adequate security, and a strong therapeutic and family focus.

◆ GAP 3: STEP-DOWN AND DIVERSION SERVICES IN SHORT SUPPLY

Step-down services allow children that no longer need the level of care offered in psychiatric hospitals to get treatment in less intensive settings. Diversion programs divert children and youth from psychiatric hospitals by providing them with the care they need before their needs become so acute that they require a hospitalization. Increasing the availability of these services would allow children to get the care they need in a less intensive setting and avoid hospitalization or leave the hospital as soon as they are able. ARTS and short-term intensive residential treatment programs are examples of such programs.

◆ GAP 4: LACK OF CAPACITY IN TWO- TO SIX-MONTH RESIDENTIAL TREATMENT PROGRAMS

These programs can serve as a step-down from inpatient care, as a diversion program that keeps children and adolescents out of the hospital, or as a residential placement for children currently receiving care in the community but who need a more intensive, residential setting.

◆ GAP 5: CLINICIANS AVAILABLE NOT ABLE TO MEET OUTPATIENT NEEDS

Having a skilled workforce available to provide outpatient services to children and youth in the community could help address children's behavioral health needs early – before a crisis occurs and they require a more intensive level of treatment. More child psychiatrists, clinicians trained to treat children dually diagnosed as having developmental disabilities and behavioral health disorders, and more clinicians with a range of clinical expertise and approaches to outpatient treatment are needed to better meet children's behavioral health care needs in the community.

◆ OTHER GAPS

The report also highlighted the need for respite services, post-hospital discharge case management, more support for family involvement, increased coordination among service providers, flexible funds communities could use to support non-traditional services or to pay for families' basic needs, more workforce training opportunities, and a requirement that a behavioral health assessment be included in the screening process conducted when children transition from Early Intervention to public school.

Source: Report to the Governor and General Assembly required by Section 42-75-5.2 of the General Laws of Rhode Island on development of a continuum of children's behavioral health programs. (2006). Cranston, RI: Executive Office of Health and Human Services, State of Rhode Island and Providence Plantations.



CHILDREN'S BEHAVIORAL HEALTH SYSTEM REFORMS, 2006-2009

Since 2006, Rhode Island has been working to redesign its continuum of care for children's behavioral health services. Many of these efforts have focused on reducing unnecessary psychiatric hospitalizations, lengths of stay and readmissions by providing more home-based and community-based treatment options to meet children and families' needs in the community.^{71,72} Some of these reforms include:

- ◆ **DHS AMENDED THE RITE CARE HEALTH PLAN CONTRACTS** to include a requirement to use a behavioral health contractor and to provide RItE Care children with a full continuum of mental health and substance abuse services that address all levels of need.
- ◆ **EMERGENCY SERVICE INTERVENTION** is a 24 hour/7 day a week, face-to-face care management and intervention with an individual experiencing a behavioral health crisis. DCYF continues to monitor certified emergency services providers. Approved providers make up the network that service children and families in crisis. A crisis evaluation is a required intervention as part of the inpatient approval process. The new 24/7 response is called Kid's Link RI and has been in full implementation statewide since January 2007.⁷³
- ◆ **CRISIS STABILIZATION** beds are now part of the continuum of care that RItE Care health plans must make available to the children they insure. Due to a collaborative partnership among Neighborhood Health Plan of RI, Beacon Health Strategies, Gateway Healthcare and St. Mary's, crisis stabilization beds are now offered by Acute Residential Treatment Services (ARTS) providers in Rhode Island. Rhode Island Hospital and Gateway Healthcare are also working toward opening a crisis stabilization unit that would be housed at Rhode Island Hospital and staffed by Gateway.^{74,75,76}
- ◆ The **ACUTE RESIDENTIAL TREATMENT SERVICES (ARTS) PROGRAM** provides psychiatric evaluation and treatment in a staff-secure setting and offers specialized services for children and youth with autism spectrum disorder, histories of sexual abuse or other traumas, and other special needs. ARTS was originally designed as a hospital step down for children no longer needing hospital-based care but not yet ready to return home. It is now used both as a step-down option and as a diversion program for children who do not need hospitalization but need more intensive services than are available in their own community. St. Mary's, Gateway Healthcare, and Turning the Corner now offer 32 additional ARTS treatment beds.^{77,78,79}
- ◆ **CHILD AND ADOLESCENT INTENSIVE TREATMENT SERVICES (CAITS) PROGRAM** is a behavioral health program that provides intensive treatment to children and adolescents with serious emotional and behavioral problems who are at risk for being placed in a psychiatric hospital or residential care. CAITS, which is administered by DHS as an in-plan benefit under RItE Care, replaced the former CIS program that had been administered by DCYF. The maximum length of stay in the program was reduced to 16 weeks (per rolling 12-month period) of intensive, home-based and community-based treatment.⁸⁰
- ◆ **FAMILY CARE COMMUNITY PARTNERSHIPS** were developed by the Department of Children, Youth and Families (DCYF) as part of an integrated family and community system of care for families with children and youth who are at risk for abuse and neglect, who have serious emotional disturbance, or who are involved in the juvenile justice system. Four regional provider networks provide coordination and direct services to vulnerable families using both formal service providers and natural, social support resources.^{81,82,83}
- ◆ The **RESPIRE FOR CHILDREN PROGRAM** provides families with temporary relief from their caretaking responsibilities. Under Global Waiver rules, to be eligible for respite care, a child must meet "level of care requirements", which mean that the child must require the level of care typically provided in a hospital, nursing home or Intermediate Care Facility for Persons with Mental Retardation (ICF/MR). Up to 100 hours of respite care is available per year per child. Families apply for respite care through CEDARR Family Centers.⁸⁴ The Rhode Island Department of Human Services recently expanded the Respite for Children Program. As of January 2010, approximately 400 families were enrolled in the program.⁸⁵ New funds available through the federal Lifespan Respite Care Act may allow this program to expand even further.⁸⁶



RECOMMENDATIONS

REDUCE UNNECESSARY PSYCHIATRIC HOSPITALIZATIONS AND BOARDING ON MEDICAL UNITS

- ◆ Involve families in all aspects of their children's care, including decision-making about the care their children receive while hospitalized and planning for post-discharge care.
- ◆ Increase public awareness about Kid's Link RI Emergency Services so families, health care providers, and schools can access information about the full range of behavioral health services available in their communities.
- ◆ Conduct Kid's Link Emergency Services evaluations in locations other than emergency rooms. Children who receive evaluations elsewhere are more likely to be referred to community- and home-based services rather than boarded or admitted to a psychiatric hospital.
- ◆ Offer more intensive home-based and outpatient treatment options that would allow families to maintain their children at home with appropriate therapeutic support.
- ◆ Offer 24 to 48-hour crisis stabilization services in hospital settings or other secure, psychiatrically-supervised programs (e.g., ARTS programs) so children can be stabilized in a safe setting while an appropriate treatment placement is located, rather than being boarded or admitted to a psychiatric hospital for a short stay.
- ◆ Encourage hospitals and community-based providers to develop and/or expand diversion and step-down programs, such as ARTS and partial hospitalization, by referring children in need of this level of service to existing providers and providing adequate levels of reimbursement for these services.
- ◆ Provide staffing coverage needed to allow children with intensive needs to be admitted to appropriate services, including psychiatric hospitals, ARTS programs, and residential treatment facilities, at night and on weekends so children do not need to be boarded while awaiting admission.

REDUCE LENGTH OF STAY AND READMISSIONS

- ◆ Set up a system among DHS, DCYF, the hospitals and the health plans to regularly review data on children enrolled in Medical Assistance who have above average lengths of stay in psychiatric hospitals and residential treatment settings. Determine if there are systemic barriers that delay transition to lower levels of care or result in readmissions.
- ◆ Enhance coordination between DCYF and psychiatric hospitals (e.g., appointment of an identified liaison between DCYF and hospitals, regular meetings, etc.) to encourage more timely discharge of children ready to leave the hospital and move to an appropriate step-down service.
- ◆ Set up systems that enable families and community-based providers to stay involved with children while they are hospitalized. Include families, community-based service providers, and schools in discharge planning to ensure that children and youth leaving the hospital can access the services they need to successfully transition back into their homes, schools, and communities.
- ◆ Ensure that all children who are leaving the hospital are transferred to an appropriate service provider in the community and receive follow-up services appropriate to their level of need within the first 48 hours.
- ◆ Encourage psychiatric hospitals to expand the range of services they offer beyond inpatient care so hospitals have a variety of options to offer families seeking care for their children.



RECOMMENDATIONS

ADDRESS INSURANCE BARRIERS THAT LIMIT ACCESS TO MENTAL HEALTH SERVICES

- ◆ Monitor how the federal *Mental Health Parity and Addiction Equity Act* impacts access to behavioral health care services for children insured under both public and private health insurance. As of January 1, 2010, this federal law mandates that health insurance plans that offer mental health coverage provide the same financial and treatment coverage for mental health services as for other health care services.
- ◆ Ensure that public and private insurance plans cover the full continuum of outpatient, home-based services, wrap-around and treatment services so that children and their families can get the care they need in their communities before they are in emotional crisis and require hospitalization.
- ◆ Require health insurance companies to cover the full-range of mental and behavioral health services that children need (including prevention services, respite, diversion and step-down programs, residential treatment and hospitalization) so that parents do not have to voluntarily place their children in DCYF care in order to access services.
- ◆ Monitor implementation of the Global Waiver to ensure that implementation increases access to a full continuum of behavioral health services for children and families.

EXPAND ACCESS TO COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

- ◆ Make respite services more widely available to families with children that have acute psychiatric needs, so families receive the support they need to keep their children at home.
- ◆ Offer additional behavioral health services in primary care offices, health centers, community-based settings and schools. Co-located services and integrated care models could improve access, early detection of behavioral health problems, care coordination, and communication.
- ◆ Ensure that children in the care of DCYF due to child welfare or juvenile justice issues receive the physical health, mental health, education and social supports that they need to thrive.
- ◆ Develop, train and retain a skilled workforce that addresses the full continuum of health promotion, prevention, early intervention and mental health treatment services for children and their families.

PROMOTING CHILDREN'S MENTAL HEALTH: THE ROLE OF PRIMARY CARE, SCHOOLS, AND EARLY CHILDHOOD PROGRAMS

- ◆ **Pediatricians and primary care providers** play a critical role in promoting optimal social and emotional development, early screening and detection of mental health problems, and treatment of children who are diagnosed with special mental health disorders.⁸⁷
- ◆ **Schools** are often the *de facto* mental health system for children and adolescents. More than four out of five schools across the U.S. provide case management for students with behavioral and social problems. Many schools have mental health professionals on staff and nearly half of all schools contract or make other arrangements with community-based organizations to provide mental health or social services to students.⁸⁸
- ◆ **Early childhood programs** are an important resource to expand the skills of parents, teachers and other caregivers who nurture and support infants and young children. Interaction with parents and other caregivers during the first five years of life lays the foundation for a child's social and emotional development. All families need access to a wide range of services and supports to promote healthy development. Some families need specialized services to mitigate risk factors or address problems young children may experience.⁸⁹

STATE AGENCIES' ROLES IN SUPPORTING RHODE ISLAND'S MENTAL HEALTH SYSTEM FOR CHILDREN

- ◆ The **Department of Children, Youth, & Families (DCYF)** has statutory authority for child welfare, juvenile justice, and children's behavioral health. The Division of Community Services and Behavioral Health is the entity within the Department that is responsible for behavioral health and community services for Rhode Island's children. The Division is responsible for developing public policies and programs to support the needs of seriously emotionally disturbed (SED) children in Rhode Island and planning, monitoring, and evaluating the children's behavioral health service system in the state.
- ◆ The **Department of Human Services (DHS)** is the state's Medicaid agency and is responsible for making decisions about which child and youth behavioral health services will be reimbursable under Medicaid. DCYF and DHS must work together to ensure that the children's behavioral health system meets the needs of Rhode Island's children and families and is also cost-effective.
- ◆ The **Department of Mental Health, Retardation & Hospitals (MHRH)** is the agency authorized to fund, develop and administer a system of services for the state's citizens with disabilities. Within MHRH, the Division of Behavioral Health Services coordinates care for youth in transition from the children's behavioral health system as well as substance abuse prevention, education and treatment programs.
- ◆ The **Executive Office of Health and Human Services (EOHHS)** was created to facilitate cooperation and coordination among the four state departments that administer Rhode Island's health and social service programs -- the Department of Children, Youth and Families (DCYF), the Department of Elderly Affairs (DEA), the Department of Human Services (DHS), and the Department of Mental Health, Retardation and Hospitals (MHRH). Since three of these departments are vital to supporting Rhode Island's mental health system for children, this office can play an important role in ensuring that the coordination necessary for this system to work occurs.
- ◆ The **Department of Education (RIDE)** is responsible for advancing the education of children with disabilities, including children who have emotional or behavior challenges that may require special education. An Individualized Education Program (IEP) must be developed for all students eligible for special education, and services described in this IEP must be provided to students in the least restrictive environment (i.e., to the extent appropriate, integrated into a regular education setting).
- ◆ The **Department of Health (DOH)** has broad-ranging public health responsibilities, including conducting population-based studies, improving the state's early childhood system, reviewing certificates of need required to create or expand mental health facilities, and helping families of children with special healthcare needs navigate the transition to adult services.
- ◆ The **Office of the Child Advocate (OCA)** is the state agency responsible for protecting the legal rights and interests of children in state care. The office ensures that children in out-of-home placement have their physical, mental, medical, educational, emotional and behavioral needs met.
- ◆ The **Office of the Mental Health Advocate (OMHA)** is the state agency responsible for protecting the legal rights of people with mental illness. The office provides legal services to clients of the public mental health system and monitors the policies and procedures of psychiatric hospitals and community mental health centers.



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RESOURCES

Listed here are selected Rhode Island resources for children's behavioral health. For a more complete list, please access the *Rhode Island Parents Guide to Children's Mental Health* at www.childrensmentalhealthguideri.org. For a hard copy of the *Parents Guide*, call 401-432-1036.

Bradley Hospital
(401) 432-1000

Butler Hospital
(401) 455-6200

**Kid's Link RI:
24-Hour Hotline for
Children in Emotional Crisis**
(866) 429-3979

**Mental Health Association
of Rhode Island**
(401) 726-2285

**National Alliance on Mental
Illness of Rhode Island**
(401) 331-3060

**Parent Support Network
of Rhode Island**
(401) 467-6855

**Rhode Island Association for
Infant Mental Health**
(401) 793-8731

**Rhode Island Council of
Community Mental Health
Organizations**
(401) 228-7990

**Rhode Island Disability
Law Center**
(401) 831-3150

**Rhode Island Office of the
Child Advocate**
(401) 462-4300

**Rhode Island Office of the
Mental Health Advocate**
(401) 462-2003

**Rhode Island Parent
Information Network**
(401) 270-0101



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