Don't Give Up on Our Kids! Saving Teens in Crisis

A nation's health rests on its rising generations. Our young adults will be the parents, workforce and creative energy shaping our future. At their healthiest, they will build on the best of the past, honoring tradition; they will also challenge our traditions and move us to a higher plane.

But they must first sail into adulthood on a sea of successful adolescence. And this is the challenge before us. For some, passage from childhood can be fraught with turbulence and danger. *This is what we believe: How a society helps those most at risk navigate this journey, particularly when it is roughest – when a teen's ship can overturn or head in the wrong direction – predicts its future.*

If successful navigation is the measure, the United States' future is more uncertain than ever. One in five adolescents have a behavioral health (BH) condition. Suicide is now the #2 killer of teens nationwide; rates for girls are at a 40-year high. In Allegheny County, a third of hospitalized 12-17 year-olds had a principal diagnosis of a mental health or substance use disorder. More than a one in three County teens reported intentionally hurting themselves in the past year. These numbers don't even begin to capture the number of teens whose often trauma-triggered behavioral health problems have landed them not in the mental health system, but the juvenile justice system. Nationally, between 60 and 70 percent of adjudicated youth are estimated to have a behavioral health condition, a third of which are considered to be severe. Saying that a lot of teens are in crisis, and that the situation is getting worse, is a woeful understatement.

If the numbers in need were rising along with sufficient and effective services and supports, we'd have a different problem. But nationally, fewer than half of teens with serious depression are even getting treatment. In Allegheny County, even 90 days after the county's main mobile mental health crisis provider responded to a call for help, one in five 12-18-year-olds enrolled in Medicaid do not receive <u>any</u> services.

This Call to Action is an outcome of a community-wide adolescent behavioral health initiative. A final report will be available on request.

In short, our teens are killing themselves and others. School shootings are now becoming commonplace. Youth plunge into cycles of despair with no professional available to help. They take life-altering risks as they struggle to find relief from emotional turbulence.

The facts reveal this sad reality – of distraught teens who have no idea where to turn; of families living in terror that their child will hurt themselves or others while they struggle to find appropriate, timely *and* effective care; and of worried, helpless teachers and peers. The impact can profoundly influence a child's entire life trajectory. Half of all students 14 and older with a mental illness ultimately drop out of high school. For some, adolescence will be the beginning of a lifelong journey trying to manage what will be a chronic health problem. Getting help early in learning how to manage the condition can make the difference between despair and living a satisfying life.

Adolescent mental health crises are 'wicked problems'. They are an illness for which there is no single name or cause (unlike autism or cerebral palsy, for example). Their roots extend well beyond biological predisposition and the inherently unsettling nature of adolescence to include: Unsafe neighborhoods with trauma-inducing events. An epidemic of loneliness and isolation that can be exacerbated by social media. Confusing and unwelcoming medical and mental healthcare systems. Schools ill-equipped to identify and respond to an emerging crisis. A juvenile justice system that punishes, rather than treats, youth offenders. An opaque mental health system which is far too challenging for families to navigate. Perhaps worst of all,

at-risk teens are sent back into their homes and communities on a daily basis to seek treatment that may be delayed, hard to locate, or simply unavailable.

Think of Delilah. She can't sleep, she won't eat, and she has stopped participating in anything. She and her mother await evaluation in a psychiatric emergency room for 11 hours before a harried counselor tells her single mom that Delilah needs to be hospitalized. Unfortunately, the counselor also announces that there are no available beds, except in Baltimore and Cleveland.

There's Tony. In rapid succession, he breaks into a gun safe and is expelled for bringing a weapon to school. He swallows a bottle of sleeping pills. He appears to be both homicidal and suicidal. A counselor prescribes a day treatment center. The family doesn't hear from the center for four months and then, only to schedule another assessment.

Zack is so frantic that he chases his school social worker around the chemistry lab with a butcher knife as she tries to calm him down. She's successful, but then they wait three hours in the cramped nurse's office for a crisis team to arrive. This isn't Zack's first crisis. He and his family have struggled to find effective and affordable treatment for his severe anxiety and hallucinations for three years now.

And finally, Ashley. Ashley and her little sister live with her grandparents, one of whom has serious dementia. Their father is in prison and their mother died of an opioid overdose. Her behavior is out-of-bounds and she has threatened to kill her grandparents. She is hospitalized for treatment and begins to make slow progress – until her psychiatrist is informed that she's about to be discharged. Even though she isn't yet stable, and could put her family and others at risk, her government funding has run out.

These gaps in needed services are abetted by a shortage of resources: personnel, facilities, knowledge and understanding. The gaps are also widened by *inappropriate* use of resources that creates bottlenecks: by psychiatrists whose patients include too many teens who could be effectively treated by primary care providers; and, by overcrowded psychiatric emergency rooms that have to triage many teens who would have been better served with outpatient crisis support in their communities. Surrounding all this is an opaque net of partial or missing information that challenges even parents with deep financial resources and a lot of time to figure out what to do to help their kids *after* the crisis passes.

These gaping holes have serious implications for teens, and for all of us. They are the back story behind both horrific newspaper headlines and 'small' stories of terrible family losses. They are the drivers behind the lost future potential of too many young people. Our nation's future depends on the health and resilience of the next generation: our current teens. And they are hurting.

Not Giving Up on Our Kids is our community's collective challenge. There are policy, regulatory and educational solutions, but we'll need to work together to achieve them. We can save kids in crisis!

Here's our Change Agenda, followed by three initiatives that can be launched right away:

1. Locate and Demand Information on Services: Parents, teachers, and teens themselves often don't know what's available when they need help during or on the verge of a crisis. Families also have a right to know whether the services are sufficient, of high quality, racially and culturally sensitive, and family-friendly. They often don't even know when to seek help: what is normal teen behavior and what's a sign of a serious problem.

2. Make Emergency Services Available Immediately to ALL Teens Who Need Them: Even when those in a teen's life correctly identify warning signs of a developing crisis, too often they are not successful at engaging early intervention support to prevent the teen who is spiraling to a disaster.

3. Make Resources Available for All Critical Components of Crisis Care: We need to identify what services are most essential and effective and then to ensure that they are adequately financed and also committed to the highest quality. They must be affordable, compassionate, and accessible. This could include everything from crisis response services to inpatient psychiatric beds to community care and ongoing supports.

4. Think Along a Service Continuum Leading to Resolution and Stabilization. This means strengthening the whole continuum – from crisis response services to inpatient psychiatric beds to community care and ongoing supports; from creative pre-crisis/ safety-net services to informal networks of family caregivers and teens.

While we work together to make these changes, we'll be holding fast to a vision of repair:

Think back to Delilah. Imagine she and her mother arrive at a psychiatric emergency room that is designed to meet the needs of teens and their families. Available resources include peer advocates for both Delilah and her mother, calming artwork, technology proven to reduce anxiety in teens, and most importantly rapid assessment and stabilization in an available inpatient bed. After her stay, there is a warm, immediate hand-off to the appropriate resources in her neighborhood. Delilah and her mom are later contacted by the peer advocates they met at intake to follow-up on how she's doing and to make sure she knows how to quickly access care if another crisis emerges.

Tony accesses quality psychiatric care and treatment and soon he is ready to return to school. The school administration, counselor, and Tony's teachers welcome him back and provide behavioral health support in the school. The day treatment center is no longer needed. Tony's psychiatrist communicates closely with the school-based resources to ensure coordinated care. Tony graduates high school and continues his treatment and therapy in the community.

The critical connection is made by Zack's teacher, trained in mental health first aid, who recognizes early warning signs. He also knows Zack has transitioned in and out of the school district twice this year, a result of traumatic events in his family. He reaches out to Zack and his family, learns about crises at home, and connects Zack's family with the appropriate school-based and community resources to stabilize their situation. Zack goes on to college, majoring in chemistry.

Insurance coverage is changed. Ashley remains in care as long as her psychiatrist recommends. Ashley is prepared to manage her behavioral health diagnosis as a chronic condition. She and her little sister also receive post-trauma counseling. If another crisis develops, the crisis team responds immediately. The local health plan increased reimbursement for mental health services and created the resources for additional county crisis teams.

Getting Started: Three Strategies. Right. Now.

We understand that the adolescent behavioral health crisis defies easy or conventional causes or solutions, and that none of us has the complete picture. But we need to start somewhere, and we need to start urgently. We will form new, or identify existing, action groups of parents and committed professionals to expose the extent of the problem and rally our legislators and administrators to act. We will work with and be guided by families and teens with lived experience to change policies so that we have sufficient resources. We will listen to families, teens and professionals—and review existing data—to suggest what works and what doesn't work, and we will ensure that we constantly monitor both the provision and quality of services. We will test new ideas, while husbanding precious resources. Three strategies will get us started.

Strategy 1→ *Don't Give Up on Our Kids!* Advocate for Policy, Resource, Regulatory and Practice Changes.

The seriousness of this public health problem is not in dispute, nor are its devastating consequences. Nevertheless, solutions are under-resourced and inadequately assessed. We must mobilize a diverse range of stakeholders – legislators, foundations, nonprofit organizations, government bodies, families, and teens themselves – around an urgent call to action. The *Don't Give Up on Our Kids!* strategy will be a statewide effort to engage media, providers, parents, and community stakeholders to rally around an urgent call to advocate for additional resources for teen behavioral health and crisis services in Pennsylvania.

We will form new, or identify existing, action groups of parents and committed professionals to expose the extent of the problem and rally our legislators and administrators to act. We will engage with national and statewide advocacy groups, as well as health funders and community partners. We will work with and be guided by families and teens with lived experience to change policies so that we have sufficient resources. We will listen to families, teens and professionals—and review existing data—to suggest what works and what doesn't work, and we will ensure the constant monitoring of both the provision and quality of services. We will test new ideas, while husbanding precious resources. In short, by aligning with bipartisan legislative candidates and change agents, this state-wide initiative will:

- Activate media, providers, parents, and community stakeholders to rally around an urgent call to action.
- Advocate for additional resources for teen behavioral health and crisis services in Pennsylvania.
- Engage health funders, consumers, and community partners, learning from other effective advocacy campaigns, including the very effective efforts to increase resources for children with autism.
- Seek support from public and private health plans to fund services that evidence indicates should be financed.
- Demand transparent strategies for ensuring the quality of behavioral health services, beginning with an initiative to invite patient and family feedback on their experiences receiving behavioral health care.

Strategy 2 → *Keep Cool in a Crisis* – A Community Awareness Campaign for Knowing When a Teen is Hurting and Where to Turn for Help

A lot more information is needed to help teens, their friends, families and teachers know when and how to get help in a crisis. This community awareness campaign, using multiple settings and reminders, will get the right information to the right people at the right time. Its goals are:

> "I think more training and more understanding is needed for the teachers, the guidance counselors, even for the principal, everyone there. Even if it was the janitor that needed to recognize that a student who is crying in the halls all the time and that they should tell someone and that's something that needs to be reported." ~ *Focus Group Participant, Young Adult*

Better Prediction. Are there signs of a pending crisis before teens are in a place of being a danger to themselves or others? Can we recognize and share these symptoms and warning signs with parents and teachers and teens themselves?

Better Community Education. Friends, teachers, parents and caregivers don't know whether they should call the police, their doctor, or their child's school when they know or suspect that a teen is in crisis. All of this confusion is compounded by the stress of the crisis itself. Messages about where to get help can be targeted for various audiences.

Better Navigation. There is uncertainty about service options, and confusion with the very language and terms used to describe those services. Neighborhoods and communities should have designated navigators to help families in need.

Engaging Schools. Getting information and services to schools – the place where teens spend most of their time – is crucial. Many organizations provide prevention/intervention services in public schools, including information resources, small intervention groups, classroom presentations, both parent and staff workshops, and peer support networks.

Strategy 3 → *Our Kids* – A Crisis Response Demonstration

Delays in getting safe and supportive care are dangerous to both the teen and to others. Too often teens and their families experience wait times for crisis care, only to finally get a diagnosis and recommendation and then encounter an unacceptable shortage of inpatient beds, and – for longer-term support – a shortage of child psychiatrists and community services. We must overcome bottlenecks in the behavioral health crisis continuum. Perhaps less seriously ill teens may be diverted to responsible community organizations—including schools, reducing wait times for a diagnosis and preventing unnecessary hospitalizations.

> "When my child is hospitalized for an asthma attack, they take a million steps to educate parents on how to prevent and treat asthma. There's an asthma class and six videos with quizzes after. They give you handouts and sign you up with a nurse to stop in your home three times to make sure you understand. This isn't how it works with mental health. No one brings you a book or a video on how to recognize or treat the rollercoaster your child is on emotionally. They literally get your child safe and send them home, telling you to follow up with your doctor in a few days."

For those who need ongoing support, we must enhance collaboration and coordination across the continuum, from mobile crisis response teams to post-crisis services. *Our Kids* takes on each of these challenges.

Our Kids embeds mobile crisis dispatch sites in specific geographic areas and at centers where teens already spend a lot of time (e.g., schools, behavioral health or community centers). Its goal would not only be to get care faster to teens in crisis, but to help guide the teen and family from crisis to stabilization. In addition, *Our Kids* will reconfigure the model from crisis services to also include care transitions and treatment. In the current system, after a child or adolescent receives crisis services, many families are left to fend for themselves to find continuing care in a complex and confusing behavioral health system. The *Our Kids* model works to change that.

In addition to the mobile crisis intervention staff, the team will include a full-time social worker to help the family navigate the complexities of behavioral health services and care coordination; a consulting psychiatrist to respond to questions regarding medication and more complex diagnoses; and family peer specialists, with lived experience, to support family caregivers, helping them understand what to expect and how to advocate for their child, and to offer a shoulder to lean on. Finally, because schools are so central in the lives of teens, after the crisis, the *Our Kids* team will activate the county's Student Assistance Program, ensuring that the adolescent's school is aware of what's going on, that staff are prepared to interact appropriately with the teen, and that any appropriate community providers located in the building can be enlisted to support the teen.

Don't Give Up on Our Kids! Get Involved!

Almost every one of us knows a teen or a family affected by behavioral health conditions that began in adolescence. The problem is pervasive. The three community strategies described above are just first steps toward embracing our kids and supporting the families and professionals who are working so hard with such limited resources. Get involved:

- ➔ Decide Which Strategy Can Best Use Your Skills.
- ➔ Contact Deborah Murdoch at the Jewish Healthcare Foundation: murdoch@jhf.org.