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I write to support LD 118 and to second the testimony of Dr. Lyndsey Tweed.
I am a child psychologist who has provided assessment and begun intervention with several children admitted to hospital emergency departments for mental health problems, where they remained while waiting for more appropriate services.
The anecdote I would add is an eight year old hospitalized after an alleged fire-setting incident who spent several days in the emergency department. He was active and socially engaging and somewhat of a challenge for medical staff to manage. I had the flexibility with a number of home-visit Mainecare clients in my practice to provide daily "hospital-visit" outpatient therapy sessions within the ER, but this is probably not widely available and not the best solution. Between family, hospital staff, and myself we attempted to implement a trauma-informed approach, recognizing the roles that trauma may have contributed to the emergency care and minimizing contributing to additional trauma associated with the hospitalization experience.
Mobile crisis assessment/stabilization/referral services could provide data about placement in EDs, but this would not document the in-hospital and discharge data that would be important for system planning and improvement. As multiple child-serving systems (child welfare, mental health, education, primary care, law enforcement, etc.) are often involved with such children, I strongly support involvement by the Childrens' Cabinet, along with offices within the Department of Health and Human Services; as well as community crisis and mental health services providers.
Thank you for your attention to this bill.
Mark Rains, PhD