Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents

Findings and Recommendations

Department of Children and Families

and

Agency for Health Care Administration

November 15, 2020

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I. Executive Summary

The Office of Substance Abuse and Mental Health (SAMH) within the Florida Department of Children and Families (Department) is the state's statutorily designated mental health authority[1]. SAMH directs statewide prevention, treatment, and recovery services for children, adolescents, and adults with behavioral health conditions; licensure of substance use services; and designation of Baker Act receiving facilities. The Agency for Health Care Administration (Agency) directs the state's health policy and planning. The Agency is responsible for licensure of health care facilities and administration of the Medicaid program.

During the 2020 Session, the Florida Legislature passed House Bill 945 (HB 945). On June 27, 2020 Governor Ron DeSantis signed HB 945 which was enacted as Chapter 2020-107, Laws of Florida. The law requires the Department and the Agency to assess the quality of care provided in designated receiving facilities to children and adolescents who are high utilizers of crisis stabilization services as follows:

- Review current standards of care for such settings applicable to licensure under chapters 394 and 408, Florida Statutes, and designation under section 394.461, Florida Statutes.
- Compare the standards to other states' standards and relevant national standards.
- Make recommendations for improvements to such standards. The assessment and recommendations shall address, at a minimum, efforts by each facility to gather and assess information regarding each child or adolescent, to coordinate with other providers treating the child or adolescent, and to create discharge plans that comprehensively and effectively address the needs of the child or adolescent[2] to avoid or reduce his or her future use of crisis stabilization services.
- The Department and the Agency shall jointly submit a report of their findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2020.

This report provides background information, a review of current licensure of designated receiving facilities, a review of Florida standards of care, research of national and other state standards, a comparison of Florida standards to national and other state standards, and an assessment of crisis stabilization services provided through designated receiving facilities.

Section VII of this report presents the recommendations that arose from the findings of the review, research, and assessment herein. Findings include:

- A need for designated receiving facilities to develop and implement examination, treatment, and discharge planning policies and procedures explicitly for children who are high utilizers of crisis care;
- A need to improve practice specific to:

[1] Section 394.457(1), F.S.

[2] A child or adolescent, collectively referred to as child, children or adolescent in this report, means a person under the age of 18 years. A child or adolescent may not be admitted to a state-owned or state-operated mental health treatment facility. A child or adolescent may be admitted to a residential treatment center, crisis stabilization unit, or a hospital. The treatment center, unit, or hospital must provide the least restrictive available treatment that is appropriate to the individual needs of the child or adolescent and must adhere to the guiding principles, system of care, and service planning provisions contained in 394, part III.

- Communication between designated receiving facilities, the children in their care, and their parents/guardians;
- Care coordination with other providers and the use of high-fidelity Wraparound; and
- Follow up on provided referrals.

II. Background

In Florida, children who have a mental illness and because of that mental illness pose a real and present threat to themselves or others, may be evaluated involuntarily if they meet the criteria set forth in s. 394.463, F.S. The number of involuntary evaluations of children has risen substantially over the last several years. According to the Baker Act Reporting Center at the University of South Florida, from fiscal year 2013-2014 to fiscal year 2018-2019 (most recent data available), statewide involuntary examinations increased 24.8% for children. It is important to note that the increase from fiscal year 2017-2018 to fiscal year 2018-2019 (5%) was much lower than the previous fiscal year increase of 10%.[3] Involuntary examinations for children made up 18% (37,882) of all involuntary examination in fiscal year 2018-2019. These numbers have raised concerns, resulting in the Legislature requiring the Department to examine what may be leading to the consistent increases.

In 2017 and 2019, the Department was legislatively required to publish reports entitled; The *Task Force Report on Involuntary Examination of Minors* and the *Report on Involuntary Examination of Minors*. These reports analyzed trends related to the increasing numbers of involuntary examination of children under the Baker Act. Although these reports provided valuable insight, it is important to note that the data analyzed was based on numbers of involuntary examinations to a designated receiving facility, not the number of admissions. The information in this report focuses on admissions of children to designated receiving facilities, excluding involuntary examinations that may not result in an admission. Some involuntary examinations do not result in an admission because the clinical examination performed prior to admission determined they did not meet the criteria. For a more comprehensive understanding of what is presented in this report, it is recommended that readers become familiar with the aforementioned reports.

Findings from the Task Force and Involuntary Examination of Minors reports resulted in several key recommendations that were passed into law, including Senate Bill 7026, Senate Bill 7012, and House Bill 945 summarized below.

Senate Bill 7026

Senate Bill 7026, also known as the Marjory Stoneman Douglas School Safety Act, passed in 2018 and resulted in the appropriation of $18.3 million for statewide access to Mobile Response Team (MRT) services and $9.8 million to expand access to Community Action Treatment (CAT) team services. MRTs provide crisis intervention services in any setting for individuals 25 years old or younger. CAT teams serve individuals ages 11-21 with a mental health diagnosis or co-occurring mental health and substance use diagnoses, who are at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more

[3] See, https://www.usf.edu/cbcs/baker-act/baker-documents/reports.aspx

hospitalizations; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance or suspensions.

The goal of the MRT program is to conduct an independent assessment to determine if the individual may be safely diverted from involuntary examination. In addition to helping resolve the crisis, MRTs work with individuals and families to identify resources, provide linkages, and develop strategies for effectively managing potential future crises. The MRT monthly report for July of 2020 demonstrated an 84% statewide average (an increase of 4% from the previous year) of potential diversion from involuntary examination (meaning 84% of calls responded to did not result in a receiving facility admission). The use of MRTs to serve individuals through community-based services is associated with better outcomes and can lower costs when an admission to a receiving facility is prevented.

The CAT model is a unique approach to delivering community mental health services and supports by utilizing a team approach to assist children and their families to build upon natural supports in their community. The average length of time a person is expected to receive services is six to nine months. As a part of the discharge planning process, CAT teams assist families identify resources to successfully maintain progress made in treatment. Overall, the CAT model has demonstrated positive outcomes such as improved family functioning, improved school attendance, and keeping children in their homes as evidenced by performance data reported by CAT Team providers. Out of the 1,798 discharges in fiscal year 2019-2020, 1,615 (89.8%) were discharged from the CAT program into less intensive community-based services[4].

The expansion of statewide access to MRT and CAT services have strengthened services and supports available for children and families, but limitations should be mentioned. Although MRTs provide immediate crisis response (within 60 minutes after prioritization) with the goal of diverting individuals from a more intensive level of care, this service is not designed to meet the long-term service needs of children and families. Additionally, because MRTs often function in partnership with external systems such as schools and law enforcement, service coordination and procedural agreements are required to ensure coordination. CAT programs provide longer-term services, but children must meet specific criteria to be enrolled in the program. Many CAT programs have a waitlist, which may limit access to safe and effective alternatives to intensive levels of care.

Senate Bill 7012

Senate Bill 7012 passed in 2020 requiring receiving facilities to include information regarding the availability of a local MRT services, suicide prevention resources, social supports, and local self-help groups with the notice of the release provided to the patient's guardian or representative if the patient is a minor.

House Bill 945

In addition to this report, House Bill 945 requires the Department and the Agency to identify children and adolescents who are the highest utilizers of crisis stabilization services and jointly submit quarterly reports to the Legislature that list the actions taken to meet the behavioral health needs of these children until fiscal year 2022. The Department and the Agency defined high utilizers as children or adolescents under 18 years of age with three (3) or more admissions into a CSU or an inpatient psychiatric hospital within 180 days.

[4] https://www.myflfamilies.com/service-programs/samh/publications/docs/Community%20Action%20Team%20Guidance.pdf

The agencies plan to develop short and long-term goals, finalize the drafted Data Use Agreement, and explore strategies to reduce high utilization cases in the second quarter of this fiscal year. The information gathered from these quarterly reports over the next two years will provide additional options regarding how to better identify and address high utilization of crisis services among children.

House Bill 945 also requires the Department to collaborate with the Managing Entities and MRT providers in consultation with the Louis De La Parte Florida Mental Health Institute to develop a model response protocol for schools to effectively use MRTs. This includes ensuring facilities provide contact information for MRTs to parents and caregivers of children and young adults up to 25 years of age, who receive safety-net behavioral health services.

III. Licensure and Designation

The Agency licenses hospitals under Chapter 395, F.S. and crisis stabilization units (CSUs) under Chapter 394, F.S. In order for any community facility to hold, evaluate, and treat individuals involuntarily under Part I of Chapter 394, F.S., also known as the Baker Act, they must be designated as a receiving facility. The Department designates all Baker Act receiving facilities which can be either a CSU or a hospital.

CSUs are usually residential units of community mental health centers. CSUs specifically designated to treat children are referred to as Children's Crisis Stabilization Units. The purpose of CSUs is to provide short-term crisis stabilization services and redirect individuals to the most appropriate and least restrictive setting available, consistent with their mental health and substance use needs. In these facilities, individuals are generally offered services such as screening and assessment, and if necessary, admission for observation, stabilization, and initiation of treatment.

Hospitals psychiatric units may be free-standing or part of a larger hospital system. For the purposes of this report, both hospitals and CSUs designated by the Department as a Baker Act receiving facility are included to provide a comprehensive overview of crisis stabilization services in Florida.

By virtue of designation by the Department as a receiving facility, CSUs and hospitals are required to follow the minimum standards for designated receiving facilities including development of policies and procedures to establish, enforce, and monitor the facilities compliance with Part I of Chapter 394, F.S. and Chapter 65E-5, F.A.C.

Chapter 408, Part II, F.S. and Chapter 59A-35, F.A.C. provide the Agency's core requirements including the establishment of forms and fees, application and inspection protocols, background screening of personnel, and disciplinary actions for all providers regulated by the Agency, including all designated CSUs and hospitals.

The Agency's Division of Health Quality Assurance certifies, registers, and licenses more than 48,000[5] health care providers. As of August 1, 2020, the Agency licenses 51 CSUs and 306 hospitals. A total of 22 CSUs and 28 hospitals are designated receiving facilities providing

[5] Agency for Health Care Administration. Retrieved from https://ahca.myflorida.com/MCHQ/index.shtml.

services to children. All 22 of the CSUs providing services to children are accredited by either the Commission on Accreditation of Rehabilitation Facilities or The Joint Commission. Accredited CSUs are exempt [6] from periodic on-site inspections. The Agency conducts initial licensure, complaint, and monitoring inspections as needed.

From January 2015 through July 2020, the Agency conducted 293 inspections at CSUs, averaging 52 inspections per year, of which 278 (95%) were complaints. The Agency identified one or more instances of non-compliance with the regulations, also known as deficient practice, during 107 inspections, of which 55 inspections were conducted at CSUs serving children and adolescents. Table 1 shows the most common deficient practices identified at CSUs providing services to children and adolescents and the number of inspections in which the deficient practice was identified during the review period (frequency).

Table 1: Deficient Practices[7]

Most Commonly Identified Deficient Practices - CSUs Serving Children and Adolescents January 2015 through July 2020		
Statute/Code Reference	**Frequency**	**Description**
65E-12.106(14)	6	Facility, furniture, linens and bedding need to be clean and in good repair
65E-12.105(3)	5	Enough qualified staff shall always be on duty and available to provide necessary and adequate safety and care
435.12(2)(b-d)	5	All staff have a current Level 2 background screen, if required and are included in the background screening clearinghouse
65E-12.106(7)	3	Develop and utilize policies and procedures for intake, screening, notification for guardians or representatives, admission, referral, and disposition
394.463(2)(f)	3	Conduct a psychiatric examination of individuals being held involuntarily without delay
65E-12.106(19)(c)1	3	Document the clinical justification for the use of restraint or seclusion
65E-12.106(19)(c)5	3	Develop and utilize detailed policies and procedures for the use of restraint and seclusion
65E-12.106(20)	3	Develop and maintain a standard manual of nursing services which shall address medications, treatments, diets and personal care

Section 394.461, F.S., authorizes the Department to designate and monitor designated receiving facilities, treatment facilities, and receiving systems. The Department may suspend or withdraw such designation for failure to comply with rules. As noted earlier, unless designated, facilities are not permitted to hold or treat involuntary patients.

The statute authorizes the Department to promulgate rules regarding:

[6] Section 394.90(5) F.S.
[7] Inspections at CSUs serving children and adolescents resulted in a total of 87 instances of deficient practice, including 56 instances identified only once or twice during the review period involving policy and documentation issues.

- Application criteria for the designation of receiving facilities including onsite inspection, licensing status evaluation, performance history, and local service needs
- Monitoring the minimum standards receiving facilities must meet and maintain
- Procedures and criteria for designating receiving facilities
- Department procedures for complaints against receiving facilities
- Department procedures for initiating investigations and inspections of receiving facilities that violate statute or rules
- Procedures and criteria for suspension or withdrawal of designation
- Procedures for receiving facilities addressing the needs of specialty populations

This section of statute does not distinguish between designation of adult and children's receiving facilities but authorizes the Department to promulgate rules that address needs of distinct populations. Specific statutory guidance for children's CSUs is found in section 394.875, F.S. Appendix 1 lists CSUs and hospitals designated as receiving facilities that serve children.

IV. Standards of Care

In addition to reviewing current state standards for designated receiving facilities, the Florida Legislature directed the Department and the Agency to compare Florida's standards to other states' standards and relevant national standards. It is important to note that while there has been an increase in utilization of crisis services, research demonstrates that there is also an increase in the numbers of children with serious emotional and behavioral health disorders in Florida and across the United States.

The number of children hospitalized for suicidal thoughts or behavior has more than doubled since 2008, with suicide rising to the second-leading cause of death among individuals aged 10-24 years old, according to the U.S. Centers for Disease Control and Prevention. Crisis service providers are also treating an increasing number of children with a wide range of behavioral health disorders, including those with extreme anxiety, eating disorders, psychosis or mania.[8]

Florida children are experiencing the same troubling prevalence of behavioral health and emotional problems. For example, among children aged 12–17 in Florida, the four-year annual average percentage with a Major Depressive Episode (MDE) increased from 8.1% (2004-2008) to 12.5% (2013-2017). The annual average prevalence rate of 12.5% for MDE in Florida is similar to the national average of 12.1% and most other states in the U.S.[9]

In February 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) published *National Guidelines for Crisis Care – A Best Practice Toolkit* to support program design, development, implementation and continuous quality improvement efforts for crisis care services. The National Guidelines are intended to help mental health authorities and service providers

[8] Busenbark, Megan M., Kids in Crisis: Children's Hospitals Confront Behavioral Health Care Challenges, Children's Hospitals Today (2018).
[9] Substance Abuse and Mental Health Services Administration, Behavioral Health Barometer: Florida, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-CA. (2019).

advance an evidence-based crisis continuum of care.[10] SAMHSA is the federal agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA also awards and oversees the States' Substance Abuse and Mental Health Block grants and discretionary grants, so it is prudent to review and compare Florida's existing standards for crisis receiving and stabilization services with SAMHSA's National Guidelines.

Many states are currently revising, and/or expanding their crisis receiving and stabilization services as part of their efforts to divert psychiatric admissions from hospital emergency departments and to implement and sustain a comprehensive crisis continuum of care. This model of crisis care is identified in the National Guidelines. States undertaking these efforts towards a crisis continuum include Arizona, Georgia, California, Ohio, Massachusetts, Washington, Colorado, and North Carolina.

Arizona

Facility-based crisis intervention services in Arizona are limited to up to 24 hours per episode. After 24 hours, the individual is transferred and/or admitted to a more appropriate setting for further treatment or sent home for follow up services. Law enforcement are guaranteed a drop-off time of no more than ten minutes.

Arizona licenses short-term crisis residential treatment programs as an alternative to hospitalization for individuals in an acute episode or situational crisis. This program provides admission capability 24 hours a day, seven days a week in the least restrictive setting with the goal of reducing the crisis and stabilization of the individual.[11]

Colorado

Colorado offers walk-in crisis services and children's CSUs. There are twelve walk-in centers open 24 hours a day, seven days a week around the state. Walk-in centers and CSUs have the option of referring individuals to respite care services, which provide therapy management, medication management and inpatient mental health treatment for up to 14 days. Child-specific respite services are also available. Children can stay in respite care for two consecutive nights on the weekend and additional hours during the week. Respite services specialize in supporting the family in its efforts to care for the child in an in-home setting.[12]

Georgia

Georgia CSUs are designed as a first-line community-based alternative to hospitalization or psychiatric residential treatment. They offer psychiatric stabilization and detoxification services on a short-term basis. There are four CSUs that serve children anywhere in the state who are in need of short-term acute stabilization services. CSUs serve children ages 5-17 who require psychiatric or behavioral stabilization, and children ages 13-17 with substance related or co-occurring mental health disorders. The CSUs are connected to regional community mental health/developmental

[10] Substance Abuse and Mental Health Services Administration, *The National Guidelines for Crisis Care – A Best Practice Toolkit* (2020).

[11] Arizona Health Care Cost Containment System, *Fee-For-Service Provider Billing Manual Chapter 19 Behavioral Health Services* (7/14/2020)

[12] Colorado Department of Human Services, Office of Behavioral Health, *Expansion of the Colorado Crisis System Report (C.R.S. 27-60-103 (6) (c))* (2018)

disabilities boards. The boards enable children to be easily connected to community mental health services when they are discharged.[13]

For a more comprehensive overview of crisis receiving and stabilization services offered by these states and others, see Appendix 5.

National Standards and Florida State Standards

The Agency and the Department's review of Florida's current rules and regulations demonstrates that the State substantially meets most of the minimum expectations and a few of the best practices described in the National Guidelines, with some noted exceptions. (See Table 2 and Table 3).

Table 2: Comparison of National Minimum Expectations and Florida Standards for Crisis Stabilization Services

National Crisis Stabilization Services Minimum Expectations	Florida Crisis Stabilization Services Standards	
1. Accept all referrals.	Met	Rule 65E-5.2801(1), F.A.C., requires that whenever an involuntary examination is initiated by a circuit court, a law enforcement officer, or a mental health professional an examination by a physician or clinical psychologist must be conducted.
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program.	Substantially Met	Medical clearance is not required. Rule 65E-12.107, F.A.C., requires all persons to be screened by the receiving facility to identify any high risk individuals If they require treatment for an acute physical condition, they must be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria. All individuals admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process to ensure medical needs are addressed.
3. Design their services to address mental health and substance use crisis issues.	Met	Rule 65E-12.107(2), F.A.C. requires that all individuals who are admitted to a CSU receive an emotional and behavioral assessment within the first 72 hours that includes a history of emotional, behavioral, and substance use problems and treatment. Rule 65E-12.107(4), F.A.C. requires the CSU to develop a service implementation plan that has objectives and action steps written for the individual in behavioral terms. The objectives must be related directly to one or more goals in the individual's comprehensive service plan.
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the	Met	Rule 65E-12.107(2), F.A.C., requires that all persons admitted to a CSU receive a nursing assessment that begins at the time of admission and is completed within 24 hours, and all persons receive a physical examination within 24 hours. The physical examination must include a complete medical history and documentation of significant medical problems. In addition, under Rule 65E-12.107(5), F.A.C., all CSUs in Florida must have access to a hospital inpatient unit to assure that individuals being referred are admitted as soon as necessary.

[13] Ga. Comp. R. & Regs. 82-4-1-.08

National Crisis Stabilization Services Minimum Expectations	Florida Crisis Stabilization Services Standards	
individual to more medically staffed services if needed.		
5. Facility staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community.	Met	Rule 65E-5.180(5), F.A.C., requires the on-site provision of emergency psychiatric reception and treatment services be available 24-hours-a-day, seven-days-a-week, without regard to the person's financial situation. Rule 65E-12.105, F.A.C., sets minimum staffing standards and requires every CSU to have at least one psychiatrist as primary medical coverage, at least one registered nurse, and sufficient numbers and types of qualified staff on duty and available at all times to provide necessary and adequate safety and care.
6. Offer walk-in and first responder drop-off options.	Met	Rule 65E-5.180(5), F.A.C., requires the on-site provision of emergency psychiatric reception and treatment services be available 24-hours-a-day, seven-days-a-week Rule 65E-12.107(1), F.A.C., requires that all persons who apply for admission, or for whom involuntary examination is initiated, must be assessed by the CSU. Also, under section 394.462, F.S., each Florida county is mandated to develop and implement a transportation plan that designates a law enforcement agency and/or an emergency medical transportation company to transport individuals to designated receiving facilities.
7. Structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders.	Met	As specified in section 394.4573(2)(b)1, F.S., Florida counties are statutorily obligated to complete and implement a Behavioral Health Receiving System (BHRS) Plan. The BHRS Plan ensures that the receiving system functions as a "no-wrong-door" model for the delivery of acute care services to all individuals who present with mental health or substance use conditions, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system. Section 394.462(1)(k), F.S. requires that receiving facilities must accept individuals brought by law enforcement officers, emergency medical transportation, or private transport companies authorized by the county for involuntary examination.
8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated.	Substantially Met	Rule 65E-5.180(4)(c), F.A.C., requires a clinical safety assessment to be completed at admission. Rule 65E-12.106(19)(d), F.A.C. requires each CSU to develop policies and procedures for implementing suicide precautions that address: assessment, staffing, levels of observation and documentation. The policies and procedures must require constant visual observation of individuals clinically determined to be actively suicidal. Also, rule 65E-12.107(1), F.A.C., requires each receiving facility to provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and to have policies and procedures for identifying individuals at high risk. (Note: Florida does not require a uniform or prescribed suicide risk assessment.)

National Crisis Stabilization Services Minimum Expectations	Florida Crisis Stabilization Services Standards	
9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.	Substantially Met	Rule 65E-12.106(19)(e), F.A.C. requires each CSU to address high risk behaviors such as elopement and assaultive behavior in their policies and procedures. In addition, rule 65E-12.107(1), F.A.C., requires each receiving facility to provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and to have policies and procedures for identifying individuals at high risk. (Note: Florida does not require a uniform or prescribed violence risk assessment.) Rule 65E-5.1602(6), F.A.C., requires the treatment plan to address levels of aggression and self-injurious behavior.

Table 3: National Guidelines for Best Practices in Crisis Receiving and Stabilization Services

SAMHSA Best Practices Guidelines	Services offered in Florida
1. Function as a 24 hour or less crisis receiving and stabilization facility.	This best practice is generally met as a requirement for receiving facilities in Florida. Under section 394.463, F.S., a person for whom an involuntary examination has been initiated must receive their examination within 72 hours and within 12 hours upon arrival at the receiving facility if the individual is a minor. In Florida, receiving and stabilization facilities operate under a standard 72-hour examination period as a result of the Baker Act statute. Very recently, two new “Access Centers” started operations in rural counties in Florida that essentially function as 24-hour or less crisis receiving facilities. Individuals in crisis in one of these counties are transported to an Access Center for screening and assessment.
2. Offer a dedicated first responder drop-off area.	Although there is not a requirement for a dedicated drop- off area, section 394.4573(2)(b)1, F.S., requires Florida counties to complete and implement a Behavioral Health Receiving System (BHRS) Plan. The BHRS Plan ensures that receiving systems function as a “no-wrong-door” model for the delivery of acute care services to all individuals who present with mental health or substance use conditions, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system. This includes the development of a transportation plan that designates a law enforcement agency and/or an emergency medical transportation company to transport individuals to designated receiving facilities. This process ensures first responders are aware of the location they are to take individuals for crisis services. In Florida, nine central receiving facilities receive funding to implement a central receiving facility model. One goal is to reduce law enforcement drop off times; some central receiving facilities have a dedicated first responder drop off area.

SAMHSA Best Practices Guidelines	Services offered in Florida
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support.	Residential treatment centers (RTCs) are intensive support beds in Florida for children who need additional support. RTCs are 24-hour residential programs that provide mental health treatment and services to children who have a serious emotional disturbance or mental illness. In addition, the Short-term Residential Treatment Program (SRT) in Florida is a state-supported sub-acute to acute care residential alternative service that operates 24 hours per day, 7 days per week and is typically of 90 days or less in duration, and which is an integrated part of a designated public receiving facility. The purpose of this program is to provide intensive short-term treatment to individuals who are temporarily in need of a 24-hour-a-day structured therapeutic setting in a less restrictive, but longer-stay alternative to hospitalization. In accordance with 65E-12.108, F.A.C., persons may be admitted to an SRT only following a psychiatric or psychological evaluation and referral from a designated public or private receiving facility.
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources.	In Florida, Managing Entities and Medicaid managed care plans contract for receiving facility beds. While crisis call centers operate in all parts of the State and serve a critical role in directing individuals to resources, they do not serve as hubs for directing and tracking utilization of receiving facility beds.
5. Coordinate connection to ongoing care.	Discharge planning from a receiving facility must include obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medication and case management. Many children are enrolled in a Florida Medicaid managed care plan. The Agency's contract with managed care plans require plans to provide care coordination/case management to enrollees that is appropriate to their needs. Wraparound care management is provided through most CAT teams funded by the Department.

Other Crisis Stabilization Center Models

In addition to the efficacy of Crisis Stabilization Centers, research has shown that models such as 23-hour stabilization and the Living Room Model are effective at treating individuals in crisis in a very cost-effective manner. Other states have implemented these models for crisis care settings as part of their crisis continuum of care.

23-hour CSUs provide 23-hour crisis respite and observation in a community-based setting. The service is delivered in a safe, home-like environment with the goal of providing observation, determining level of service needs, and ameliorating behavioral health crises. Researchers have found that this service is effective in diverting individuals from psychiatric inpatient hospitalization.[14]

Recently, two "Access Centers" that essentially function as 24-hour or less crisis receiving facilities began operating in different rural counties in Florida. Individuals in crisis in one of these counties are transported to the Access Center for screening and assessment. If further examination or treatment is warranted, the individual is transported to a designated receiving facility. However, the approach does not include the home like environment described above. The

[14] Saxon V, Mukherjee D, Thomas D. *J Ment Health Clin Psychol* (2018) 2(3): 17-26 Journal of Mental Health & Clinical Psychology.

Department is currently drafting rules to ensure the safety and security of individuals served in these access centers.

The Living Room Model is a walk-in respite center for individuals in crisis. These centers offer calm, home-like settings. The goal of the Living Room Model is to provide a safe and secure environment where multidisciplinary professionals can observe and treat individuals in crisis.[15] Colorado offers child-specific respite services that specialize in supporting the family in its efforts to care for the child and in developing a multi-generational, in-home treatment plan.[16]
While Florida's financial rule for publicly-funded services and Medicaid managed care plans currently allow provider reimbursement for respite services, access to the service is limited especially for children with more complex needs. Many respite providers are not equipped to serve serious behavioral health issues that are usually associated with high utilizers of crisis stabilization services.

Performance Metrics

According to SAMHSA's National Guidelines, crisis service providers should be systematically monitored and evaluated to ensure continuous quality improvement. Recommended performance metrics for crisis service providers that are successfully utilized in other states include the following:

1. Number served
2. Percentage of referrals accepted
3. Percentage of referrals from law enforcement (hospital and jail diversion)
4. Law enforcement drop-off time
5. Percentage of referrals from all first responders
6. Average length of stay
7. Percentage discharged to the community
8. Percentage of involuntary commitment referrals converted to voluntary
9. Percentage not referred to emergency department for medical care
10. Readmission rate
11. Percentage completing an outpatient follow-up visit after discharge
12. Total cost of care for crisis episode
13. Guest service satisfaction
14. Percentage of individuals reporting improvement in ability to manage future crisis[17]

The National Guidelines note that a single point of entry into care and a "no-wrong-door" approach are critical aspects of crisis care. All Florida counties have developed Behavioral Health Receiving System (BHRS) Plans, in accordance with section 394.4573(2), F.S. The BHRS Plans ensure that the receiving system functions as a "no-wrong-door" model for the delivery of acute care services to all individuals who present with mental health or substance use conditions, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system.

[15] Saxon V, Mukherjee D, Thomas D. *J Ment Health Clin Psychol* (2018) 2(3): 17-26 Journal of Mental Health & Clinical Psychology.
[16] https://cdpsdocs.state.co.us/ccjj/Resources/Leg/Mandates/2018-05-01_BHCrisisSystemReport.pdf
[17] Substance Abuse and Mental Health Services Administration, *The National Guidelines for Crisis Care – A Best Practice Toolkit* (2020)

The BHRS Plans must be updated at least every three years and present Florida counties with the opportunity to continuously move their crisis continuum of care towards the best practices and newer trends noted in the National Guidelines, such as: implementation of the alternate crisis stabilization center models; harnessing technology for enhancements in communication and data sharing across the crisis continuum of care; and, using performance metrics for continuous quality improvement.

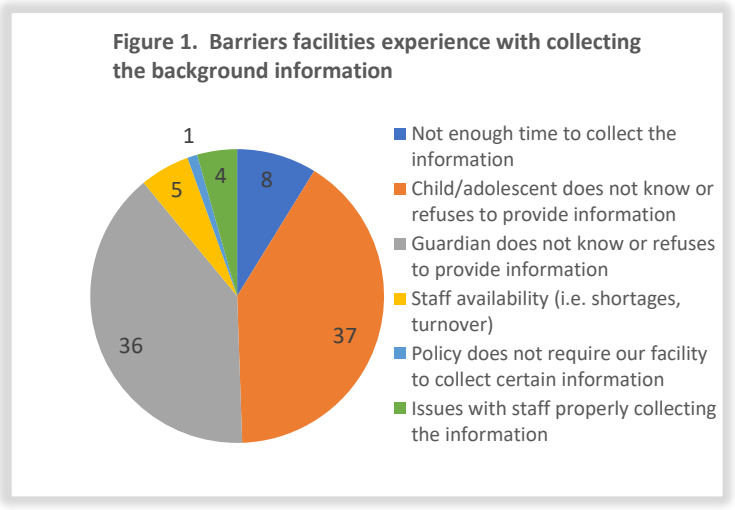
In addition, Rule Chapter 65E-5, F.A.C., titled "Mental Health Act Regulation", is the Florida rule chapter that regulates receiving and treatment facilities. The Department is currently working to update these rules to comply with new statutory changes and evidence-based practices. The Department plans to adopt new rules in this Chapter titled, "Coordination of Care with Other Service Providers" and "Discharge from Receiving and Treatment Facilities" to require providers to implement certain policies and procedures for children intended to reduce readmissions and improve care coordination for these individuals.

V. Assessment

The Department and the Agency developed a survey to assess 44 designated receiving facilities that serve children (Appendix 6). The results reflect a 100% response rate. The survey questions specifically collected information about each facilities' efforts to gather and assess information, coordinate with other providers, and provide comprehensive discharge planning. The survey results are summarized below. A comprehensive list of responses to the survey questions are available in Appendix 7.

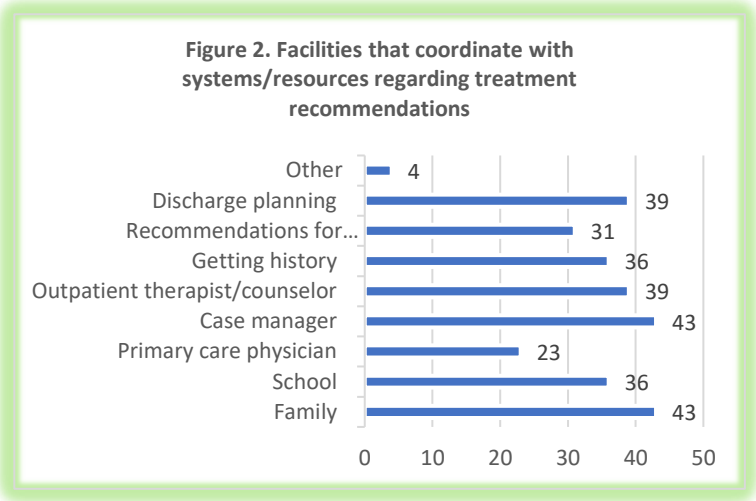
Efforts by each facility to gather and assess information regarding each child

- 44 respondents routinely collect information on each child's strengths, needs, and preferences for treatment
- 43 respondents collect information about suicidal ideation, threatening/ harming self, and threatening/harming others
- 34 respondents collect information about bullying including cyber-bullying
- 30 respondents collect information from Medicaid Health Plans, 21 from Agency for Persons with Disabilities, and 42 from Child Welfare
- 23 respondents have some issues or barriers with collecting information and the majority **(see Figure 1.)** reported that the reason was due to the child or guardian not knowing or refusing to provide the information



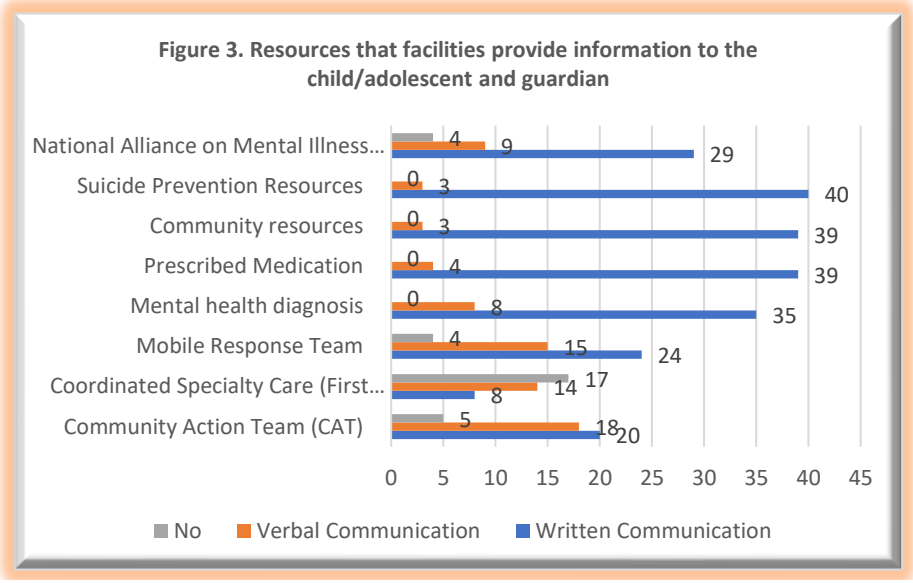
Coordination with other providers treating the child

- 44 respondents assist the child and/or guardian with obtaining aftercare services including treatment provider contact information, date and time of aftercare appointments, and any treatment recommendations
- 43 **(see Figure 2.)** respondents coordinate with family and case managers regarding treatment for children, 39 with outpatient therapist/counselor, 36 with school, and 23 with primary care physician
- 43 respondents reported that their facility routinely documents treatment provider(s) responsible for child's aftercare services
- 36 coordinate to gather historical information
- 31 coordinate for recommendations for treatment



Discharge plans that comprehensively and effectively address the needs of the child to avoid or reduce his or her future use of crisis stabilization services

- 44 respondents meet with the child and guardian regarding the discharge planning process
- 44 respondents provide referrals to any treatment programs indicated
- 44 **(see Figure 3.)** respondents provide some type of information at discharge
- 42 respondents coordinate with the treating psychiatrist, treating therapist, and child welfare system (child protective investigator, foster parent, case manager), 40 coordinate with the targeted case manager, 21 coordinate with the primary care physician regarding referrals



- 30 respondents do not follow up with referrals to find out if the child went to the referral appointment
- 17 respondents have policies or procedures to address high utilizers; 12 are working towards developing them, and 14 do not have policies or procedures
- 14 respondents follow up on referrals given to the child at discharge

VI. Conclusion

The Department and the Agency have provided a comprehensive overview of the current regulations governing crisis stabilization services in Florida. Notably most of the national standards are met or substantially met and many of SAMHSA's best practices in crisis receiving and stabilization services are implemented to at least some degree. There is room for further promotion and implementation of best practices across the state. SAMHSA recently published *The National Guidelines for Crisis Care – A Best Practice Toolkit* to support program design, development, implementation including peer support services and continuous quality improvement efforts for crisis care services.

The Department and the Agency have established a House Bill 945 workgroup that meets weekly to plan and implement activities to identify and improve outcomes for children who are high utilizers of crisis stabilization services. This workgroup can be tasked with completing an in-depth review of the toolkit and determining recommendations to be included in quarterly updates to the legislature. However, it should be noted that the toolkit is a general guide for implementing quality crisis care systems and is not specific to reducing high utilization of crisis services by children. One recommended best practice is MRT Services. Florida has implemented MRTs statewide however challenges remain. The Department can explore the best practice recommendations for MRT services and present them during monthly meetings hosted by the Department with system partners and MRT providers.

The Department and the Agency asked designated receiving facilities serving children to share their suggestions to improve the children's crisis system of care in the survey that was administered. Survey respondents shared that they would like to improve care coordination, receive more support from the Department, more funding, and better support for parents (see Appendix 7 for more details).

VII. Recommendations

Standards

The survey shows that 43 of all facilities collect information about suicidal ideation and threatening/harming self. Florida standards do not specifically require receiving facilities to conduct suicide risk and violence risk screenings and assessments. The Department and the Agency recommend requiring that all individuals presenting for crisis services be screened for risk of suicide and violence using screening and assessment tools that are validated and evidence based.

Intensive Care Coordination

The survey results show that receiving facilities report coordinating with other providers, but coordination with primary care physicians could be improved. However, during the Department's 2019 review of rising numbers of involuntary examinations of children, it was noted that care coordination for by receiving facilities for high utilizers was not adequate to meet the child's needs.[18] There is opportunity to review current practices and procedures in more depth and improve care coordination for high utilizers.

The Department and Agency's House Bill 945 workgroup will be analyzing data to guide efforts and explore strategies to reduce cases of high utilization. These strategies will involve coordinating with Managing Entities and Medicaid managed care plans to connect identified children with intensive care coordination or a high-fidelity Wraparound approach. Wraparound is an individualized, family driven, youth guided team-based care management process of working with children with serious emotional disturbance and their families. During the Wraparound process formal services and natural supports work with the child and their family in their home and community to help them meet their needs and successfully reduce admissions to receiving facilities and psychiatric residential treatment facilities. The Wraparound approach is designed to equip the family with the support they need, decrease their reliance on traditional services, and enable the family to manage future crises. Maintaining fidelity to the Wraparound model is essential and requires coaching and monitoring. There is no dedicated funding source for statewide coaching and monitoring of providers who are implementing Wraparound to ensure it is provided with fidelity to the model. This recommendation may require additional funding.

Discharge planning

According to survey results, facilities are discussing discharge planning with the child and parents or guardians and are providing referrals to outpatient services or treatment programs. Facilities are also coordinating with other facilities for discharge planning. The Department has drafted language to revise Administrative Rule 65E-5, F.A.C. to include the provision of additional resource information at discharge such as the National Suicide Prevention Lifeline, local support groups, and MRT services.

The Department and the Agency recommend adding a follow-up process to the discharge planning process that includes a warm handoff to an intensive care coordinator or mental health targeted case manager for children identified as high utilizers. This process should ensure that the child is engaged with needed community-based treatment and reduces the need for additional crisis admissions. This change will necessitate additional revision to the administrative rule requiring specific discharge policies and procedures for high utilizers.

[18] See, https://www.myflfamilies.com/service-programs/samh/publications/docs/Report%20on%20Involuntary%20Examination%20of%20Minors.pdf, accessed October 21, 2020.

Appendix 1. Designated Receiving Facilities Serving Children

Designated Receiving Facilities	Location
Children, Adolescents, and Adults CSUs	
Apalachee Center	Tallahassee
Centerstone of Florida	Bradenton
Charlotte Behavioral Health Care	Punta Gorda
David Lawrence Mental Health Center	Naples
Life Management Center of Northwest Florida	Panama City
Lifestream Behavioral Center Inc	Leesburg
Mental Health Resource Center* **	Jacksonville
Meridian Behavioral Healthcare**	Lake City, Gainesville
Personal Enrichment Through Mental Health Services	Pinellas Park
Peace River Center* **	Bartow, Lakeland
Children and Adolescents CSUs	
Aspire Health Partners	Orlando
Circles of Care	Melbourne
Citrus Health Network	Hialeah
Mental Health Care	Tampa
New Horizons of the Treasure Coast	Fort Pierce
Park Place Behavioral Health Care	Kissimmee
SalusCare	Fort Myers
The Centers	Ocala
Hospitals	Location
Baptist Hospital**	Pensacola
Central Florida Behavioral Hospital	Orlando
Cleveland Clinic Indian River Hospital	Vero Beach
Coral Shores Behavioral Health	Stuart
Eastside Psychiatric Hospital	Tallahassee
Emerald Coast Behavioral Hospital	Panama City
Fort Lauderdale Behavioral Health Center	Oakland Park
Halifax Psychiatric Center-North	Daytona Beach
Jackson Memorial Hospital	Miami
JFK Medical Center North Campus	West Palm Beach
Lakeland Regional Medical Center	Lakeland
Larkin Community Hospital	South Miami
Larkin Community Hospital Behavioral Health Services	Hollywood
Mease Dunedin Hospital	Dunedin
Memorial Regional Hospital	Hollywood
Morton Plant North Bay Hospital Recovery Center	Lutz

Nicklaus Children's Hospital	Miami
Orlando Health South Seminole Hospital	Longwood
Palm Point Behavioral Health	Titusville
River Point Behavioral Health	Jacksonville
Sarasota Memorial Hospital	Sarasota
St Joseph's Hospital Behavioral Health Center	Tampa
Suncoast Behavioral Health Center	Bradenton
Tallahassee Memorial Hospital	Tallahassee
UF Health Shands Psychiatric Hospital	Gainesville
University Behavioral Center	Orlando
University Hospital and Medical Center	Tamarac

** two designations
***three designations

Appendix 2. Basic Requirements for CSU Licensure

Requirement	Description	Regulatory Reference
Criteria	Affiliated with a public receiving facility.	394.875(5)
	May have up to 30 beds, except in Brevard County, which may have up to 50.	394.875(1)
	May not operate more than 20 beds for children if on the same premises as an adult program.	394.875(7)
	May not operate more beds than authorized as indicated by need and available appropriations.	394.875(6), (9)
Clients	Adults: age 18 years and older.	394.455(4)
	Minors: under the age of 18 years.	394.455(29)
	Adolescent: at least 13 but under 18 years.	394.492(1)
	Child: under the age of 13 years.	394.492(3)
	Young adults: age 18 to 21 years.	394.495(6)(a)
	Facilities shall be locked to provide control over reasonable access and egress.	65E-12.107(7)
Admissions	Voluntary: Adults showing evidence of mental illness and found competent to provide informed consent may be voluntarily admitted for treatment. A child's guardian must provide informed consent and admission may occur only after a hearing to verify the voluntariness of the consent.	394.4625(1)
	Involuntary: A person may be brought to a receiving facility for examination if there is reason to believe they have a mental illness, refused examination or unable to determine if examination is necessary, and are likely to be a harm to themselves or others. Initiation mechanisms: ex parte order, law enforcement, select health care/mental health professionals. No one may be held for more than 12 hours without being admitted or released. Minors: exam must occur within 12 hours.	394.463 65E-12.107
Discharges	Voluntary: A person voluntarily admitted may be discharged upon improvement, per request, or by revoking consent to treatment. If the person does not meet involuntary admission criteria, the discharge must take place within 24 hours from the request.	394.4625(2)
	Involuntary: A person involuntarily admitted for treatment may request to be discharged or transferred to voluntary status. If the person no longer meets involuntary admission criteria, the person must be released immediately. The facility administrator has 2 days after receipt of the discharge request to file a petition for involuntary placement if continued treatment is deemed necessary.	394.4625(4) 394.469
Integrated Services	Adults: A Baker Act receiving facility co-located with an adult addiction receiving facility and licensed as an adult crisis stabilization unit.	394.4612
	Children: A Baker Act receiving facility co-located with a children's substance abuse juvenile addictions receiving facility services and licensed as a children's crisis stabilization unit.	394.499
Building Code and Life-Safety	Local jurisdiction/Fire Marshall	394.879(5)
Food and Sanitation	Local jurisdiction/Department of Health	64E-11

Appendix 3: CSU Staffing Requirements

Staff	Description	Minimum staffing per CSU
Administrator	An individual who is responsible for the overall management and operation of a CSU. Must hold at least a bachelor's degree in the human services field or be a registered nurse	1
Psychiatrist	Licensed under chapter 458 or 459 with at least 3 years of psychiatric experience responsible for the general medical policies, prescription of medications, and medical treatment of persons receiving services. Must make daily rounds and be on call 24/7	At least 1
Physician	Licensed under chapter 458 or 459 who has experience in the diagnosis and treatment of mental illness to provide medical treatment of persons receiving services and to assist with daily rounds and 24/7 call	As needed
Counselor	An individual with a minimum of a master's degree in psychology, social work, psychiatric nursing, counseling education, or mental health counseling to provide intake screening, counseling and treatment services	At least 1
Registered Nurse	Licensed under chapter 464 to assure the appropriate handling and administration of medication, the completion of nursing assessments, and intake screening	At least 1 RN shall be on duty at all times. At least 2 RNs shall be on duty between 7:00 am and 11:00 pm in CSUs with more than 20 clients.
Mental Health Treatment Staff	Individuals who provide support and assistance with daily living and therapeutic activities	At least one shall be on duty at all times. At least 1 per 10 clients shall be on duty between 7:00 am and 11:00 pm.

Appendix 4: Minimum Program Standards

Standard	Description	Detail
Admissions	Screeners ensure clients meet the requirements for voluntary or involuntary admission and notify client's guardians or representatives and case manager that services are being requested	A primary therapist or counselor shall be assigned. An emotional and behavioral assessment shall be completed within 72 hours. A nursing assessment shall be completed within 24 hours. A physical examination shall be completed within 24 hours
Orientation	Staff shall conduct an orientation session with each client and their guardians	Orientation shall cover admissions, discharge standards, rules, procedures, activities and concepts of the program
Quality Assurance Program	Ensure a comprehensive integrated review of all programs, practices, and facility services	Includes administrative activities, treatment services and peer reviews, safety and physical plant maintenance
Critical Incident Reporting	Includes client deaths elopements/missing child, arrest, employee misconduct, sexual abuse/battery, injuries to clients or staff requiring immediate medical attention, suicide attempts	Reporting is required within 1 business day into the Department's designated electronic system.
Continuity of Care	Discharge preparation and referral services	Staff work with clients and their families to prepare the individual to return to a less restrictive setting. Facilities shall have written referral agreements.

Appendix 5: Crisis Receiving and Stabilization Services in Other States

Arizona

In Arizona, facility-based crisis intervention services are limited to up to 24 hours per episode. After 24 hours the individual, depending on their discharge plan, is transferred and/or admitted to a more appropriate setting for further treatment or sent home with arrangements made for follow-up services, if needed (e.g. prescription for follow-up medications, in-home stabilization services). What makes Arizona's centers different is that police officers, who are the first to intervene in nearly all behavioral health crises, are guaranteed a drop-off time of no more than ten minutes.[19]

In addition, Arizona licenses short-term crisis residential treatment programs. These programs are an alternative to hospitalization for persons in an acute episode or situational crisis requiring temporary removal from the home from one to fourteen days. The program provides admission capability twenty-four hours a day, seven days a week in the least restrictive setting possible to reduce the crisis and stabilize the client. Services include direct work with the client's family, linkage with prevocational and vocational programs, assistance in applying for income, medical and other benefits and treatment referral. [20]

California

In California, "Crisis Residential Treatment Service" means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

The services in this program also include provision of direct services to the family, specific linkages with the child's educational system and community educational resources, and development of a support system, including school and treatment referrals. The program is designed for children and adolescents who would otherwise be referred to a psychiatric inpatient unit.

"Crisis Intervention" in California is a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet specific crisis stabilization contact, site, and staffing requirements described in California regulations.

For California, "Crisis Stabilization" means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis Stabilization is provided on site at a licensed 24-hour health care facility or hospital-based outpatient program or a provider site certified to perform crisis stabilization. Medical backup services must be available either on site or by written contract or through an agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies.

[19] Arizona Health Care Cost Containment System, *Fee-For-Service Provider Billing Manual Chapter 19 Behavioral Health Services* (7/14/2020)

[20] Section 36-550.05, Arizona Revised Statutes

Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All children and adolescents receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary's need shall be made, to the extent resources are available.[21]

Colorado

Colorado offers Walk-In Crisis Services and Crisis Stabilization Units (CSU): Walk-in centers are open 24 hours a day, seven days a week, and offer confidential, in-person support, assessment, information and referrals to anyone in need. Individuals who are seeking in-person assistance, or are helping others with a crisis, can always present at one of the existing 12 walk-in centers across the state. Eight of the walk-in locations also include a CSU. These crisis stabilization beds are available for up to five days for individuals who need intensive services. CSUs are designated by the state to accept individuals voluntarily or on a mental health hold and staff are available to vacate a hold or initiate a hold for residential psychiatric treatment. Upon admission, the individual is evaluated by a behavioral health clinician, as well as a psychiatric prescriber within 24 hours. Services during a CSU stay may include continued risk assessment, psychiatric medication management, peer counseling, brief clinical therapy and/or resource coordination.[22]

The walk-in centers and Crisis Stabilization Units have the option of referring clients to respite care services, which provide therapy management, medication management and inpatient mental health treatment for up to 14 days. Children can stay in respite care for two consecutive nights on the weekend, and for several additional hours during the week. Child-specific respite services specialize in supporting the family in its efforts to care for the child and in developing a multi-generational, in-home treatment plan.

By caring for patients as they go back home or elsewhere in their community, respite care services provide family caregivers needed relief, and allow patients to safely transition back into daily life. Volunteers are recruited and trained by Colorado Crisis Services to provide respite care.[23]

Georgia

Georgia CSUs are designed to serve as a first-line community-based alternative to hospitalization, offering psychiatric stabilization and detoxification services on a short-term basis. Georgia implemented this crisis stabilization unit program to provide a lower level care than hospitalization or a Psychiatric Residential Treatment Facility. There are four Child & Adolescent CSUs in Georgia. Each serves youth from all over the state who need short-term acute stabilization of behavioral health challenges.

For Child & Adolescent (C&A) CSUs, individuals aged 5 to 17 requiring psychiatric or behavioral stabilization, and youth ages 13 to 17 with substance related disorders or with co-occurring mental health and substance use needs. All services offered within the CSU are provided under the direction of a physician. Consultation by a psychiatrist is available if the covering physician is not a psychiatrist. It is preferred that the C&A CSU provide services under the direction of a psychiatrist with training or experience in working with children and youth. Children or youth return to their natural environment as quickly as possible; therefore, the total length of stay in a C&A CSU for any one episode of care does not exceed 14 calendar days. At all times there are at least three staff present within the C&A CSU including the charge nurse, who is at least an RN. There are not more than four individuals for every one staff (including the charge nurse).[24]

[21] Cal. Code Regs. Tit. 9, Sections 1810.208-.210
[22] Colorado Department of Human Services, Office of Behavioral Health, *Expansion of the Colorado Crisis System Report (C.R.S. 27-60-103 (6) (c))* (2018)
[23] https://www.coloradohealthinstitute.org/blog/four-years-later-update-colorado-crisis-services
[24] Ga. Comp. R. & Regs. 82-4-1-.08

These units are connected to six regional community mental health/developmental disabilities boards. The units contain less than 16 beds to allow for Medicaid reimbursement and they are licensed through the State of Georgia. These regional boards enable the children to be easily connected to community mental health services when they are discharged.

Massachusetts

Massachusetts offers a program called Community-Based Acute Treatment (CBAT). CBAT is provided to children and adolescents up to the age of 18 (youth ages 19 to 20 may be eligible for admission based on a program's licensing requirements and a child's clinical needs) with serious behavioral health disorders who require a 24-hour-a-day, seven-day-a-week, staff-secure (unlocked) treatment setting. Services are provided according to age ranges of 6 to 12 and 13 to 20 on separate units. The primary function of CBAT is to provide short-term crisis stabilization, therapeutic intervention, and specialized programming in a staff-secure environment with a high degree of supervision and structure, with the goal of supporting the rapid and successful transition of the child/adolescent back to the community.

CBAT services are provided in the context of a comprehensive, multi-disciplinary, and individualized treatment plan that is frequently reviewed and updated based on the child's clinical status and response to treatment. Acute therapeutic services include psychiatric assessment and treatment; pharmacological assessment, monitoring and treatment; nursing; individual, group, and family therapy; care coordination; family consultation; and discharge planning. Children and adolescents may be admitted to CBAT directly from the community or as a transition from inpatient services.[25]

New York

The Comprehensive Psychiatric Emergency Program (CPEP) is a set of hospital-based services that include emergency observation, evaluation, and care and treatment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further evaluation or treatment activities, or discharge to another level of care. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination. Program objectives include providing timely triage, assessments, and interventions; controlling inpatient admissions; providing crisis intervention in the community; and providing linkages to other services. CPEPs are designed to directly provide or ensure the provision of a full range of psychiatric emergency services, seven days a week, for a defined geographic area. The four CPEP service components are:

1. Crisis Intervention Services: The psychiatric emergency room is the setting for CPEP hospital-based crisis intervention services and is available 24 hours per day, seven days a week. Services offered in the emergency room include triage, referral, evaluation and assessment, stabilization, treatment, and discharge planning. These services are provided by a multi-disciplinary team consistent with CPEP regulations. Enhanced staffing is necessary for timely and thorough assessments and more appropriate clinical decision making, especially as high risk or high cost decisions are frequently made. CPEPs help ensure individual and community safety and appropriate inpatient admissions and outpatient referrals.

2. Extended Observation Beds are intended to provide recipients with a safe environment to treat and develop plans for continued treatment as needed in the community or in a hospital or other setting. By regulation, CPEPs may be licensed for up to six extended observation beds. The number of beds per site varies based on geographical need and the CPEP's physical plant. Extended observation beds are usually

[25] Community-Based Acute Treatment (CBAT) for Children and Adolescents Performance Specifications (2014)

located in or adjacent to the psychiatric emergency room, allowing recipients to remain in the emergency room area for up to 72 hours. Extended observation beds enable staff to assess and treat recipients who need short term care and treatment rather than inpatient hospitalization. In addition, the availability of extended observation beds assists in diverting avoidable short-term inpatient admissions.

3. Crisis Outreach Services are designed to provide mental health emergency services in the community. The two objectives of this component of service are to provide initial evaluation, assessment and crisis intervention services for individuals in the community who are unable or unwilling to use hospital-based crisis intervention services in the emergency room, and to provide interim crisis services for emergency room recipients who require follow up. Interim crisis services are mental health services provided in the community for recipients who are discharged from a CPEP emergency room and include immediate face-to-face contacts with mental health professionals to facilitate community tenure while waiting for a first visit with a community-based mental health provider. [26]

4. Crisis Residential Services are designed to offer residential and other necessary support services for up to five days to recipients who recently experienced a psychiatric crisis or were determined to be at risk of an emerging psychiatric crisis. Most CPEPs provide crisis residence services through linkages with State psychiatric centers or other local service providers.[27]

North Carolina

In SFY 2013, the NC General Assembly appropriated funding for Facility Based Crisis (FBC) centers and Behavioral Health Urgent Care (BHUC) centers to serve as alternatives to emergency departments and inpatient hospitalization for persons who experience crises related to mental health, substance use, or intellectual/developmental disabilities diagnoses. More recently, North Carolina expanded the crisis response services to include Child Facility Based Crisis (Child FBC). North Carolina contracts for four Child FBC Service sites that are designated for the treatment of persons who are under voluntary and involuntary commitment. Each Child FBC services site has a 16-bed facility which will provide care and treatment for children and adolescents ages 6 to 17 years old, who need crisis stabilization services and 24-hour supervision due to a mental health crisis, substance use or withdrawal from drugs or alcohol, and will provide access to timely, age-appropriate mental health care during a time of crisis. Each Child FBC site also provides crisis care to young people with intellectual or developmental disabilities.[28]

Ohio

"Crisis stabilization unit" in Ohio means a residential unit providing crisis stabilization for persons needing an intermediate level of care. The standard services of general services and crisis intervention are offered. Treatment interventions are focused on stabilizing the current crisis and mobilizing support and resources so that the person can be treated in a less restrictive setting. The unit provides 24-hour observation, supervision and voluntary treatment services for individuals who do not require the intensive medical treatment of inpatient care. Length of stay on a crisis stabilization unit is anticipated to be no longer than fourteen days duration.

The role and function of crisis stabilization units in Ohio is to provide better intensive residential support with treatment in an appropriate setting less restrictive than that of inpatient care. Crisis stabilization units may appropriately accept individuals placed by probate court order, including individuals under court order

[26] 14 CRR-NY 590.9
[27] New York State Office of Mental Health, *2017 Interim Report to the OMH Statewide Comprehensive Plan*
[28] North Carolina Department of Health and Human Services, *Report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division (January 22, 2020)*

to take their medications. However, crisis stabilization units may not forcibly administer medications (except in emergencies). Individuals whose care and supervision requires these steps should be hospitalized, where higher standards of care apply.

A facility licensed to provide services to children or adolescents must make available, at a minimum, the following activities: (1) Assessments; (2) Counseling and therapy; and, (3) Medical activities. A crisis stabilization unit is required to maintain the ability to adjust staffing levels according to the number and intensity of need of the persons being served at any given point in time.[29]

Washington

Washington's King County developed a wraparound crisis services model called Children's Crisis Outreach Response System (CCORS) in 2005 to provide options other than hospitalization and to reduce long wait times to receive inpatient care for mental health needs. As a part of their crisis system, everything runs through a crisis line: initial screening, and triage, emergent outreach, crisis next day appointments, crisis stabilization beds, stabilization, and intensive stabilization services.

The crisis team is available 24 hours a day, seven days per week and responds to a family within two hours. A mental health specialist and parent partner (or peer specialist) go out to families experiencing a crisis and assess the need for services, with a goal of keeping the child with the family and in the community, if possible. If necessary, children are referred to a crisis stabilization bed, which are contracted foster homes which maintain availability for these types of families. The stabilization beds are available from 72 hours to 14 days, with an average length of stay of three to five days. The crisis team can stay involved for up to eight weeks, working with the family, transitioning the child to other community services, coordinating with the child's school, or providing other needed support. The program tracks outcomes in terms of diversion from hospitalization, child welfare, and law enforcement involvement.

[29] Chapter 5122-29, O.A.C.

Appendix 6. Survey Questions

Part I. Efforts by each facility to gather and assess information regarding each child or adolescent. Questions 1-5 focus on the facility's attempt to collect information for each child/adolescent admitted to the facility.

1.a. Does your facility experience any barriers while collecting demographic data (age, race, gender, social security, health insurance) on children/adolescents?

- o No issues/ barriers
- o Some issues/ barriers

1.b. What are some issues/barriers your facility experiences with collecting demographic data (age, race, gender, social security, health insurance) on children/adolescents? Check all that apply.

- o Not enough time to collect the information
- o Child/adolescent does not know or refuses to provide information
- o Guardian does not know or refuses to provide information
- o Staff availability (i.e. shortages, turnover)
- o Policy does not require our facility to collect certain information
- o Issues with staff properly collecting the information

2.a. Which of the following background information does your facility collect for children/adolescent? Check all that apply.

- o History of psychiatric care/ needs
- o Medical history
- o Substance use history
- o Medication history
- o Trauma history
- o Family history

2.b. Which of the following background information does your facility use for treatment planning? Check all that apply.

- o History of psychiatric care/ needs
- o Medical history
- o Substance use history
- o Medication history
- o Trauma history
- o Family history

2.c. What are some of the barriers your facility experiences with collecting the background information listed in question 2.a and 2.b? Check all that apply.

- ○ Not enough time to collect the information
- ○ Child/adolescent does not know or refuses to provide information
- ○ Guardian does not know or refuses to provide information
- ○ Staff availability (i.e. shortages, turnover)
- ○ Policy does not require our facility to collect certain information
- ○ Issues with staff properly collecting the information

3.a. Which of the following mental health risk factors for children/adolescents are collected by your facility?

	Yes	No
Suicidal ideation	○	○
Threatening/ harming self	○	○
Threatening/ harming others	○	○
Physical health concern	○	○
Co-occurring substance abuse history	○	○

3.b. Which of the following psycho-social risk factors for children/adolescents are collected by your facility?

	Yes	No
Bullying including cyber-bullying	○	○
Academic performance	○	○
Legal history (i.e. arrests or other legal issues)	○	○
Housing status (i.e. stable, transient)	○	○
Food accessibility	○	○
Financial stressors	○	○
Clothing or other personal care items needs (i.e. hygiene items)	○	○
Medical care access	○	○

4.a. Does your facility routinely obtain collateral information from other organizations involved in the child's care?

- Medicaid Managed Care Health Plan
- Agency for Persons with Disabilities
- Child Welfare

4.b. Check the child welfare organizations from which your facility collects information?

- Child Protective Services
- Foster parent
- Child Welfare Case Manager

4.c. Check the managed care plans from which your facility collects information.

- Humana Medical Plan
- Staywell
- Staywell (Serious Mental Illness)
- Sunshine Health Comprehensive Plan
- Sunshine Health- Child Welfare
- Children's Medical Services (CMS) Plan
- Aetna Better Health
- Simply Health Care
- United Health Care
- Miami Children's
- Clear Health Alliance
- Prestige
- Magellan Complete Care
- Lighthouse Health Plan
- Molina Healthcare
- Community Care Plan
- Vivida Health

4.d. For the organizations checked in question 4, was the information used to assist with treatment planning?

- Yes
- No

4.e. Would the information from other organizations listed in question 4 support your facility's treatment planning efforts for children/adolescents?

- Yes
- No

4.f. Check all the barriers that your facility experiences when trying to collect information from other systems listed in question 4.

- Not enough time to collect that information
- The information is not available
- Children/adolescents or guardians do not know the information
- Our facility does not experience barriers

5.a. Does your facility routinely collect information on each child/adolescent's strengths, needs, and preferences for treatment?

- Yes
- No

5.b. Check the barriers that prevent your facility from collecting this information.

- Not enough time to collect this information
- The information is not available
- Children/adolescents or guardians do not know the information

Part II. Coordinate with other providers on treatment. Questions 6-9 focus on the facility's attempt to coordinate with other treatment providers.

6. Does your facility coordinate with any of the following systems/resources regarding treatment recommendations? check all that apply.

- Family
- School
- Primary care physician
- Case manager
- Outpatient therapist/counselor
- Getting history
- Recommendations for treatment on the unit
- Discharge planning
- Other _____

7.a. Does your facility routinely document the treatment provider(s) responsible for child/adolescent's aftercare services?

- Yes
- No

7.b. What are some reasons your facility does not routinely document the treatment provider(s) responsible for the child/adolescent's aftercare services? Check all that apply.

- Not enough time to document this information
- Child/adolescent or guardian does not provide the name of the aftercare services
- Our facility does not require for this information to be documented

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8.a. Does your facility staff assist the child/adolescent and/or guardian with obtaining aftercare services?

- ○ Yes
- ○ No

8.b. Please check all the procedures at your facility that assist with this process.

- ○ Facility staff contacts the provider(s) to make aftercare appointments
- ○ Facility staff provide contact information including name of treatment provider, date and time of appointments, and any treatment recommendations
- ○ Provide contact information for the child/adolescent or guardian to follow-up
- ○ Other _____

III. Discharge plans comprehensively and effectively address the needs to avoid or reduce future use of crisis stabilization services. Questions 10-14 focus on the facility's discharge planning.

9.a. How does your facility encourage the child/adolescent and guardian to participate in the discharge planning process? Check all that apply.

- ○ Discharge planning is part of the treatment planning
- ○ Meet with the child/adolescent and/or guardian
- ○ Ask questions about what provider services the child/adolescent and family would like to go to after discharge
- ○ Provide information about what specific provider the child/adolescent would like to go to after discharge

9.b. Please describe the level that the child/adolescent and guardian typically participate in discharge planning process.

	Low participation	Moderate participation	High participation
Child/adolescent: 12-year-old and under	○	○	○
Child/adolescent: 13-18 years old	○	○	○
Guardian	○	○	○

10. Which of the following treatment providers in the community does your facility coordinate with during discharge planning? Check all that apply.

- ○ Treating psychiatrist in the community
- ○ Treating therapist in the community
- ○ Primary care physician
- ○ Targeted case manager
- ○ Child welfare (child protective investigator, foster parent, case manager)
- ○ Other _____
- ○ None

11. Does your facility provide information to the child/adolescent and guardian regarding the following resources? Check all that apply.

	Written communication	Verbal communication	No
Community Action Team (CAT)	○	○	○
Coordinated Specialty Care (First Episode Psychosis Team)	○	○	○
Mobile Response Team	○	○	○
Mental health diagnosis	○	○	○
Prescribed Medication	○	○	○
Community resources	○	○	○
Suicide Prevention Resources	○	○	○
National Alliance on Mental Illness (NAMI) or other support groups	○	○	○

12. How does your facility deliver referrals to the child/adolescent and/or guardian regarding the following topics. Check all that apply.

	Written communication	Verbal communication
Referrals to any substance abuse treatment programs (if indicated during assessment)	○	○
Referrals to trauma or abuse recovery-focused programs (if indicated during assessment)	○	○
Referrals to other self-help groups (if indicated during assessment)	○	○

13.a. Does your facility follow up on referrals provided at discharge to determine if the child/adolescent received the services?

- ○ Yes
- ○ No

13. b. Who does your facility contact (i.e. via phone calls, emails, texts, secure portal, etc.) to follow up on referrals that were provided at discharge to determine if the child/adolescent received the services?

- ○ Child/Adolescent
- ○ Guardian
- ○ Service provider where the child was referred

13.c. Check any barriers that prevent follow up with referrals provided at discharge.

- Not enough time for staff to follow-up
- Child/adolescent does not consent for referral systems to communicate with our facility
- Guardians do not provide follow-up information to our facility
- Our facility does not have a follow-up policy/procedure

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14. Does your facility have a policy or procedure that addresses unique requirements of services provided to children/adolescents who are high utilizers or who are repeatedly admitted to the facility? The Department defines "high utilizer" as children and adolescents under 18 years of age with three (3) or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days.

- Yes
- No
- Our facility will begin working on policy/procedure for children/adolescents who are high utilizers

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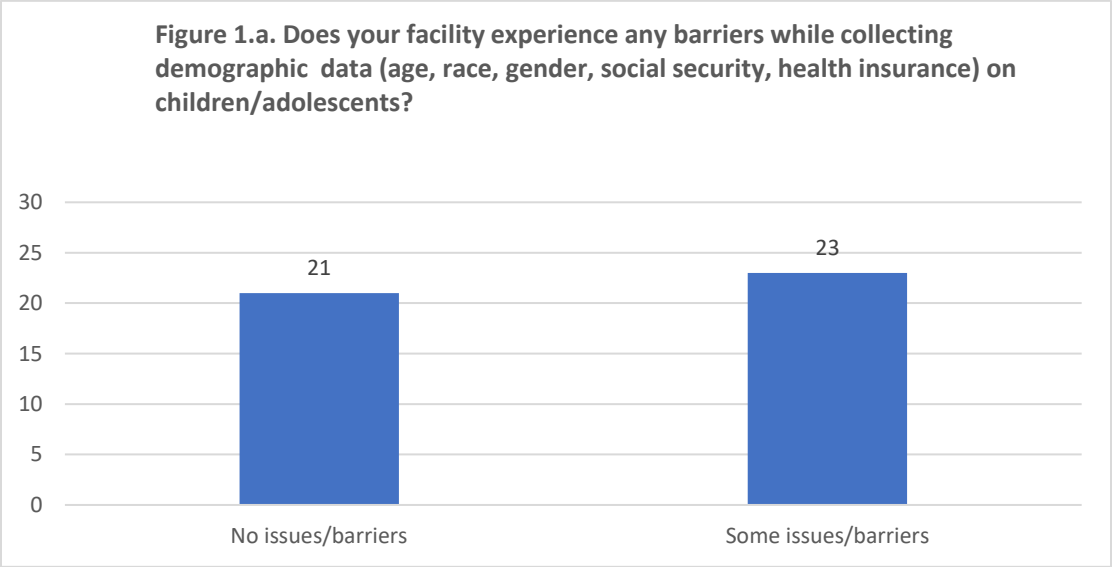
15. What suggestions would you make to improve the children's system of care?

Appendix 7. Survey Responses

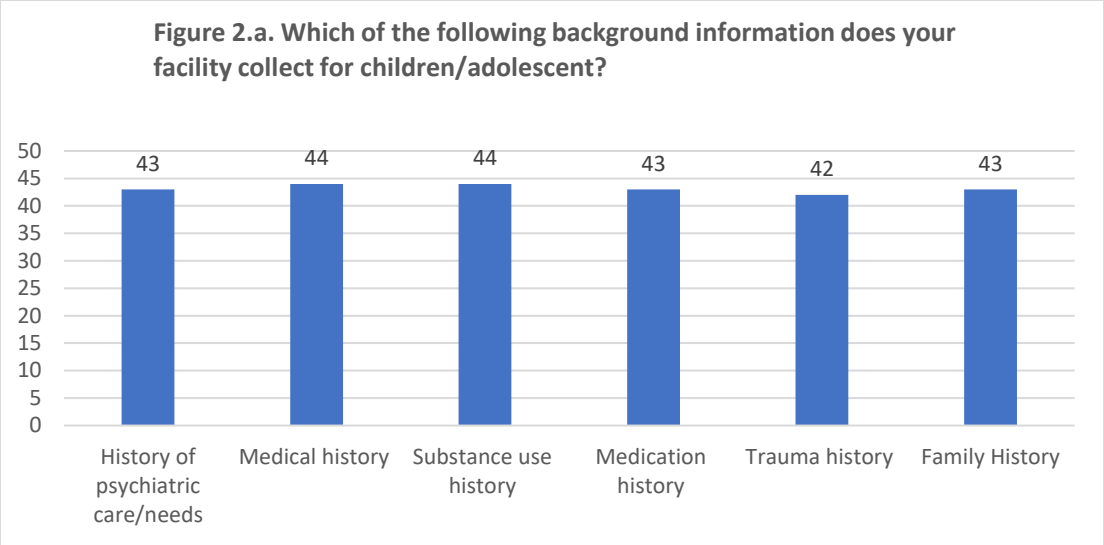
The Department and the Agency distributed a survey to gather information on the policies and procedures for designated receiving facilities regarding children and adolescents who are high utilizers and are admitted for involuntary or voluntary crisis stabilization services. The survey consisted of three (3) parts; part one focused on the way receiving facilities collect information about the children or adolescents, part two on treatment coordination, and part three on discharge planning. The survey was sent via email September 8, 2020 to 44 public and private receiving facilities (hospitals and CSUs) providing crisis services to children, ensuring that facilities completed one survey per designation. Designated facilities were notified prior to the survey and were reminded to complete the survey by regional SAMH offices. The results show that there was a 100% (44) response rate.

Part One: Collecting Information

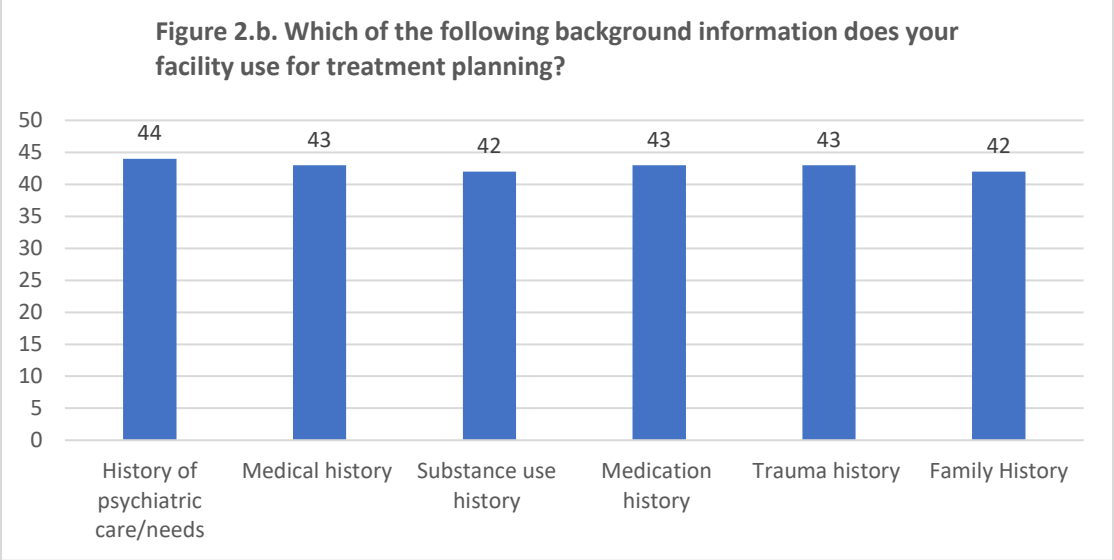
Of the 44 designated facility respondents, 21 reported that they have no issues or barriers while collecting demographics and 23 have some issues or barriers (Figure 1). Of the 23 respondents that have issues and barriers, 3 of facilities reported that they do not enough time to collect the information, 16 reported that the child or adolescent does not know or refuses to provide information, 23 reported that the guardian does not know or refuses to provide information, 1 reported that an issue or barrier is staff availability (i.e. shortages, turnover), 1 reported that their policy does not require the facility to collect certain information, and 4 reported that their issues or barriers are with staff properly collecting the information.



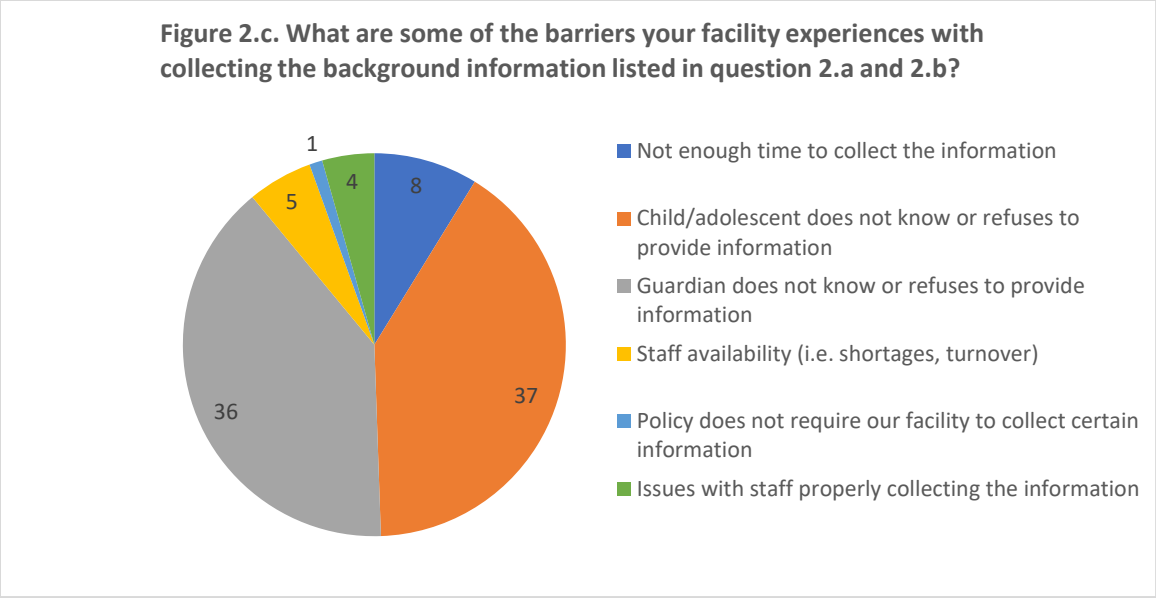
More than 42 of respondents collect background information on the history of the child or adolescent's psychiatric care or needs, medical, substance use, medication, trauma, and family (Figure 2.a.).



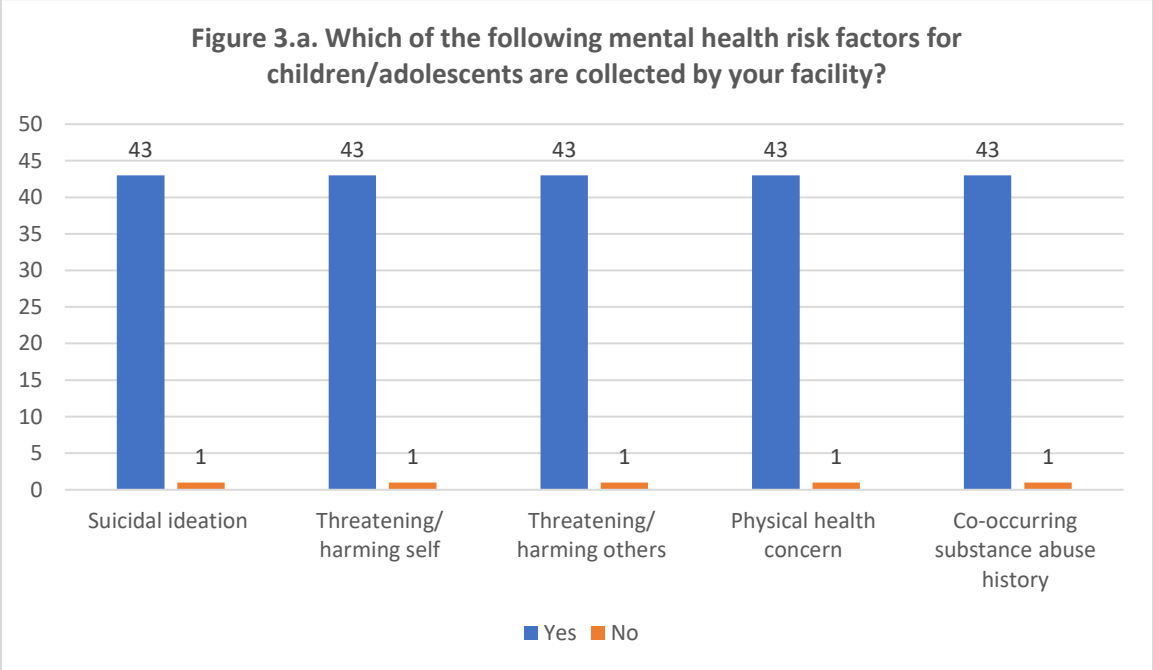
More than 42 respondents use the history of the child or adolescent's psychiatric care or needs, medical, substance use, medication, trauma, and family for treatment planning (Figure 2.b.).



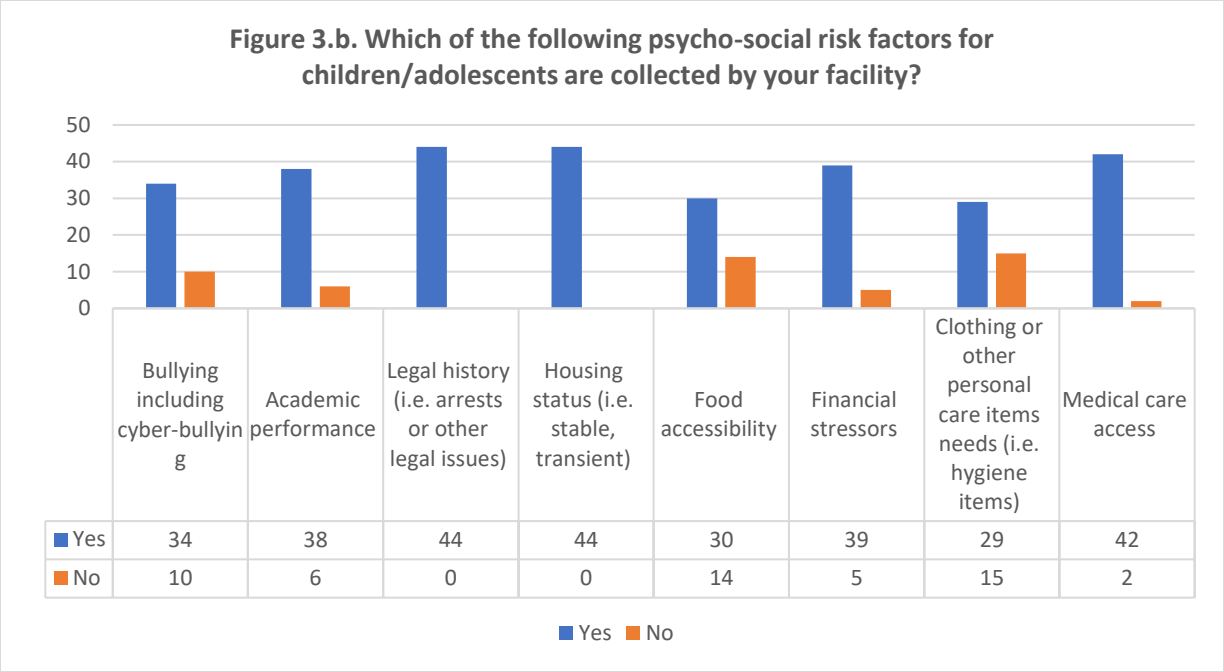
Respondents reported that some of the barriers that facilities experience with collecting the background information and using it for treatment planning are 8 not enough time to collect the information, 37 the child/adolescent does not know or refuses to provide the information, 36 the guardian does not know or refuses to provide the information, 37 staff availability (i.e. shortages, turnover), 1 their policy does not require the facility to collect certain information, 4 issues with staff properly collecting the information (Figure 2.c).



Respondents reported that 43 of facilities collect information about suicidal ideation, threatening/ harming self, threatening/harming others, physical health concerns, and co-occurring substance abuse history, and 2 do not collect any information on the mental health risk factors (Figure 3.a.).

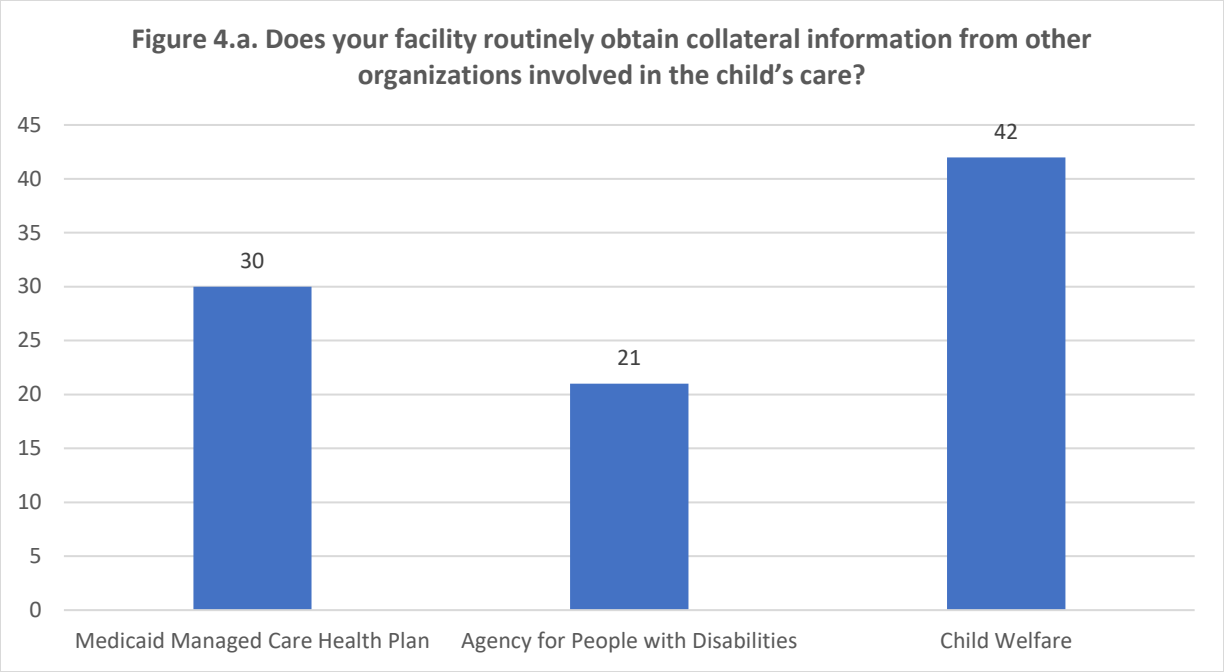


More than 34 of the respondents collect information about bullying including cyber-bullying, academic performance, financial stressors, and medical care access, and 29 collect information about clothing or other personal care items needed (i.e. hygiene items). Information on legal history (i.e. arrest or other legal issues) and housing (i.e. stable, transient) is collected by 44 of the facilities (Figure 3.b.).



	Bullying including cyber-bullying	Academic performance	Legal history (i.e. arrests or other legal issues)	Housing status (i.e. stable, transient)	Food accessibility	Financial stressors	Clothing or other personal care items needs (i.e. hygiene items)	Medical care access
Yes	34	38	44	44	30	39	29	42
No	10	6	0	0	14	5	15	2

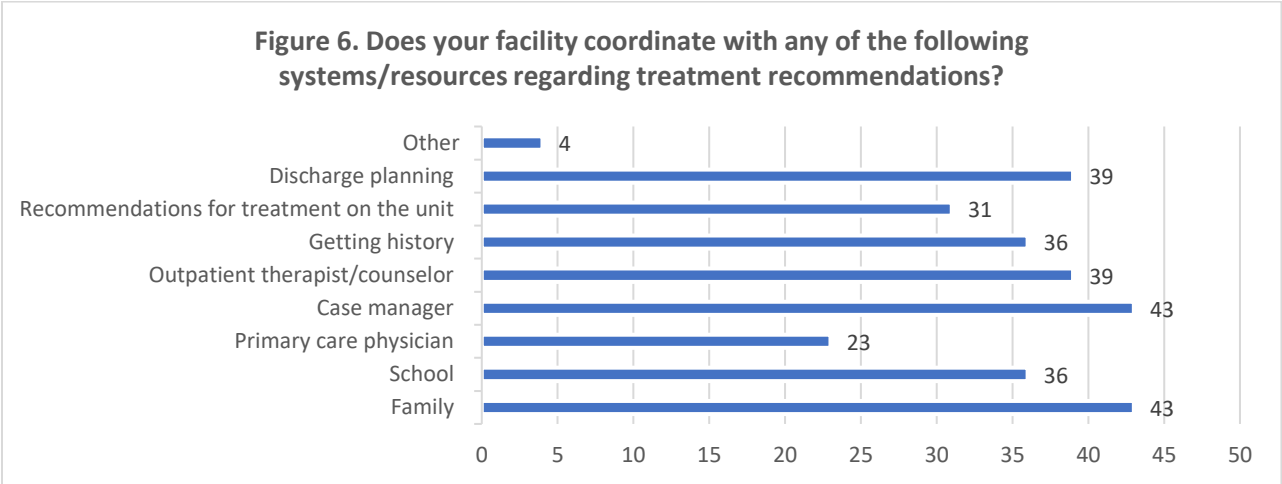
Respondents reported that facilities obtain collateral information from other organizations involved in a child or adolescent's care. The results show that 30 of the respondents collect information pertaining to Medicaid Managed Care Health Plan, 421 collect information from the Agency for Persons with Disabilities, and 42 collect information from Child Welfare (Figure 4). Also, 41 of respondents reported they use the information for treatment planning while 3 do not and 3 reported that collecting the information would support their facility's treatment planning. Of the 42 that collect child welfare information, 39 collect from child protective services, 40 from foster parents, and 41 from the Child Welfare Case Manager. Of the 30 that collect Medicaid Managed Care Plan information more than 16 collect from Humana Medical Plan, Staywell, Staywell (Serious Mental Illness), Sunshine Health Comprehensive Plan, Sunshine Health- Child Welfare, Children's Medical Services (CMS) Plan, Aetna Better Health, Simply Health Care, United Health Care, Prestige, Magellan Complete Care, and Molina Healthcare while less than 39 collect from Miami Children's, Clear Health Alliance, Lighthouse Health Plan, Community Care Plan, and Vivida Health.



The last question for this part asked if facilities routinely collect information on each child or adolescent's strengths, needs, and preferences for treatment. All participants (44) reported that they do.

Part Two: Treatment Coordination

Respondents report coordinating with other systems or resources regarding treatment for children and adolescents. Figure 6 shows that 43 of facilities report that they coordinate with family and case managers, 36 with school, 23 with primary care physician, 36 with getting history, 31 with recommendations for treatment on the unit, 39 with outpatient therapist/counselor and discharge planning, and 4 reported others including NAMI, Child Welfare, and residential treatment.



Respondents were asked if their facility routinely documents the treatment provider(s) responsible for the child or adolescent's aftercare services and 43 reported "yes" while 1 reported "no" with the reason that a child or adolescent and/or guardian does not provide the name of the aftercare services. All respondents 44 also reported that staff assist the child or adolescent and/or guardian with obtaining aftercare services.

More than 39 reported that staff contacts the provider(s) to make aftercare appointments and provides contact information for the child or adolescent and/or guardian to follow-up. All participants 44 reported that staff provide contact information including the name of the treatment provider, date and time of the appointments, and any treatment recommendations, and 5 reported they complete referrals as appropriate, provide suicide hotline and other resources, assist with applying for placement, meet with family members at discharge, and ask family members their follow-up preference.

Part Three: Discharge Planning

The first question in part three of the survey asked participants how their facility encourages the child or adolescent and guardian to participate in the discharge planning process. All respondents 44 reported that they meet with the child or adolescent and/or guardian, 41 ask questions about what provider services the child or adolescent and family would like to go to after discharge and facilities provide information about specific providers the child or adolescent would like to go to after discharge, and 43 responded that they include discharge planning as part of the treatment planning.

Figure 9.a. shows that 37 of respondents reported a high guardian participation during discharge planning process, 6 reported moderate participation, and 1 reported low participation. For children and adolescents ages 13-18, 20 respondents reported high participation in discharge planning and 24 reported moderate participation. Figure 9.a. also shows that 13 reported that children or adolescents ages 12 and under have a high participation, 19 reported moderate participation, and 12 reported low participation.

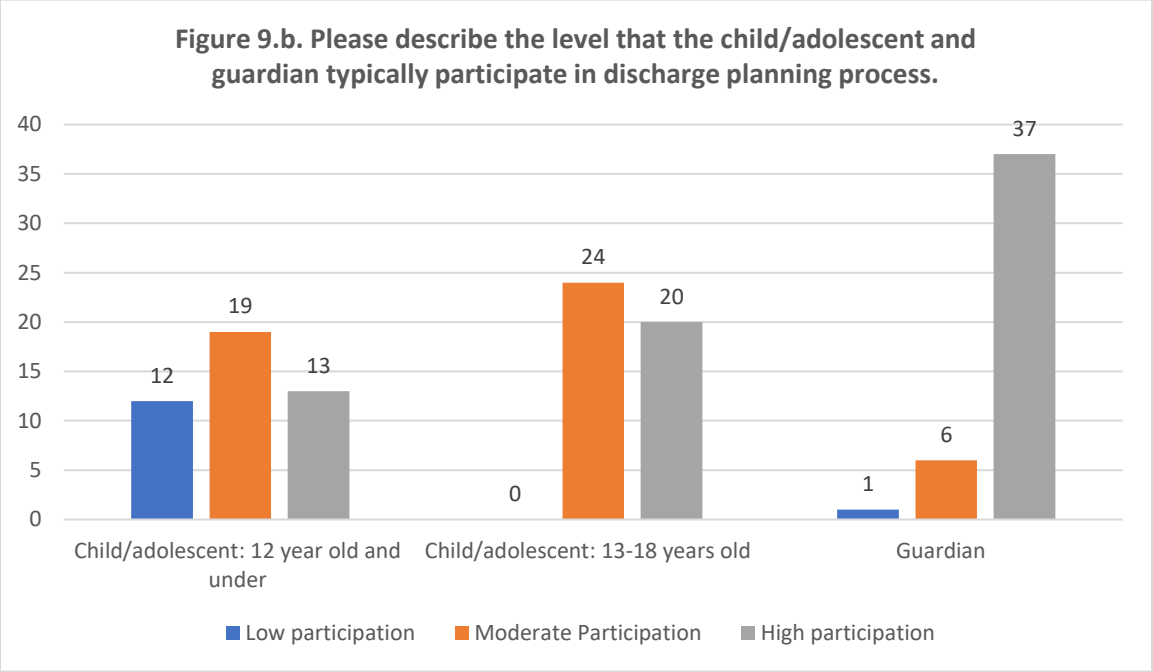
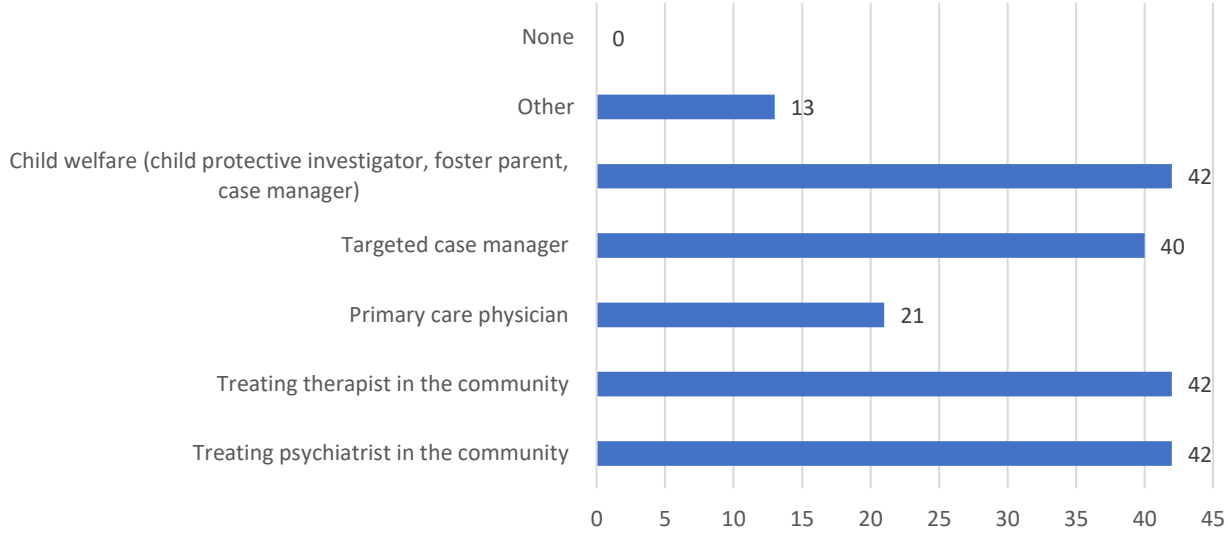


Figure 10 shows that 42 of respondents coordinate with treating psychiatrists in the community, treating therapist in the community, and child welfare (child protective investigation, foster parent, case manager), 21 coordinate with primary care physicians, 40 with targeted case managers, 13 coordinate with others including school system, law enforcement, treatment teams in the community, community partners, everyone the child or adolescents allows, residential treatment providers, programs such as CAT, mobile response teams, and others participating on the treatment team.

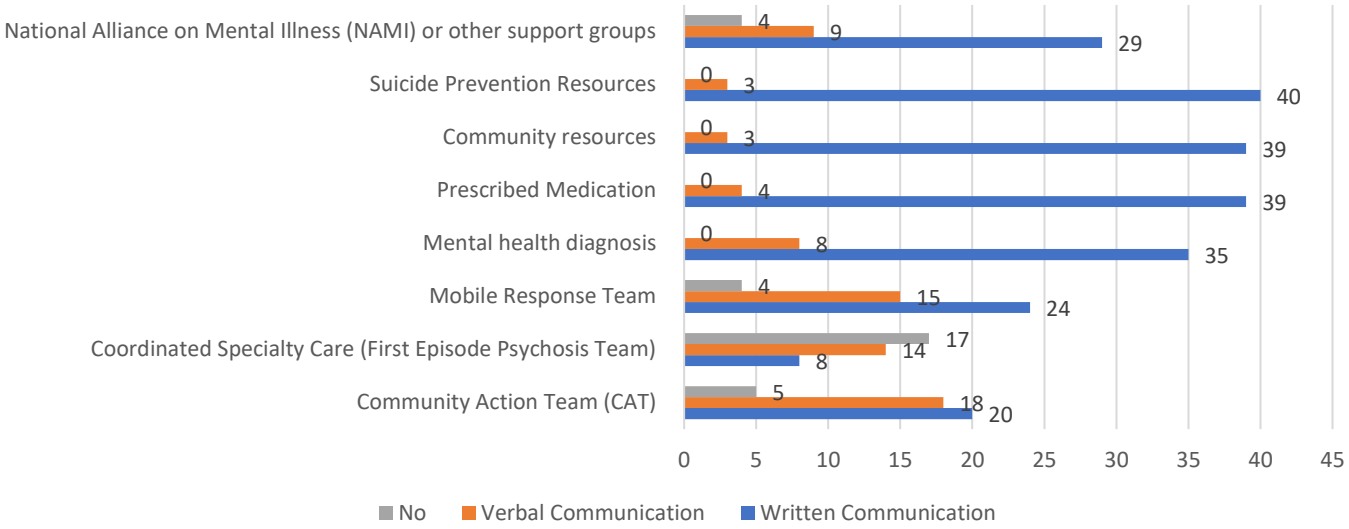
Figure 10. Which of the following treatment providers in the community does your facility coordinate with during discharge planning?



More than 40 of respondents provide written referrals to substance abuse treatment programs (if indicated during assessment), referrals to trauma or abuse recovery-focused programs (if indicated during assessment), and referrals to self-help groups (if indicated during assessment) and less than 4 provide verbal referrals. Also, 14 respondents follow up on referrals provided at discharge to determine if the child or adolescent received services and 30 do not follow up. The reasons for not being able to follow up are: 14 of respondents reported there is not enough time for staff to follow-up, 10 reported that child or adolescent does not consent for referral systems to communicate with the facility, 14 reported that guardians do not provide follow-up information to the facility, and 16 reported that their facility does not have a follow-up policy or procedure. Of those who do follow up, (i.e. via phone calls, emails, texts, secure portal, etc.) 2 reported that they contact the child or adolescent for a follow-up, 13 contact the guardian, and 5 contact the service provider where the child was referred.

More than 35 of respondents reported using written communication to provide information to the child or adolescent and guardian regarding National Alliance on Mental Illness (NAMI) or other support groups, suicide prevention resources, community resources, prescribed medication, Mobile Response Teams, and mental health diagnosis, 20 use written communication to provide information regarding Community Action Treatment (CAT) Teams, and 8 for Coordinated Specialty Care (First Episode Psychosis Team). Less than 18 of the respondents provide the information verbally, and less than 17 of the respondents do not provide any information (Figure 11).

Figure 11. Does your facility provide information to the child/adolescent and guardian regarding the following resources?



Respondents were asked if their facility has a policy or procedure that addresses unique requirements of services provided to children/adolescents who are high utilizers or who are repeatedly admitted to the facility and 17 reported “yes”, 14 “no” and 12 reported that their facility will begin working on policies or procedures for children and adolescents who are high utilizers.

Participants were asked if they have suggestions to improve the children’s system of care. Their responses showed common themes for collaboration, funding, support, process, managed care, parents, and research.

Collaboration

- Identify and close gaps in the system by holding quarterly meetings with inpatient and outpatient providers
- Better collaboration with school systems, primary care physicians, and other inpatient providers
- Intermediate care opportunities
- Improvement on the SIPP process for minors to include timelier link to services
- Increase school and parent involvement in prevention of CSU admissions
- Improved collaboration and follow through
- Better coordination between agencies regarding data
- Centralized contact for case management and a liaison for treatment team, on site if possible
- Mandate schools to notify mobile response team or the Community Mental Health Center when/if there is a child with concerns to assist with pre-crisis
- Provision of services shortly after discharge

Funding

- Increase children's residential services when a referral back into the community is not clinically appropriate; longer inpatient stay
- Increase bed availability at residential treatment centers including short-term residential beds
- Provide alternative programs for autistic and developmentally delayed children rather than inpatient psychiatric

- Limited copays for Partial Hospitalization Programs and reduce co-pays for intermediate care services
- Additional funding to encompass more staff resources for follow-up care after discharge, wrap around, care coordination and therapeutic services
- Offer resources/intensive services to middle class working group that have private insurances and increase resources for children with no insurance.
- Better access to child psychiatry
- More outpatient services, CAT teams, prevention focus
- Funding to increase front line staff salary
- Fund therapeutic teams during afterhours to assist with de-escalation at group homes and foster placements
- Increase base level funding for services
- Expand direct care services

Support

- More support from the Department regarding children in the foster care system
- Provide information/resources that are easily accessible
- More integrated services
- Increase access to the Department for inquiries and support
- Increase involvement and proactiveness from Department staff
- Create an easier and faster process to obtain treatment consent for children in foster care before they are admitted
- Increase timely responses from protective service case managers
- Increase community resources to support hospitals

Process

- Create a smoother process for situations where the parent refuses to pick up a child and the Department must shelter the child.
- Increase inpatient care providers
- Increase access to service professionals to avoid waiting list
- Create an efficient and quicker admission process to RTC/SIPP
- Provide quick intensive services such as residential programming
- Assist families with the application process for residential services
- Contact Mobile Response Teams (MRT) to link a child and family to community resources to avoid Baker Act. Most experienced MRTs have a Baker Act rate of less than 20%

Managed Care

- Review Medicaid carve-outs to ensure they have ample providers in network
- Managed care companies should offer more resources for families not just telephonic
- Allow managed care plans to cover and/or include residential services for children to give access to a wider variety of care to high utilizers
- Allow managed care plans to disclose past treatment authorization and outcomes to current facilities treating children

Parents

- Allow parents to access inpatient services voluntarily
- Allow parental access to all age groups without the consent of the child
- Provide parental training and education
- Recruit more foster parents

Research

- Continuous research of policy and procedures should be implemented for improvements in the mental health system
- Baker Act Statute around the voluntariness of minors