Report

Project Planning Workgroup #3 – Coordinating Crisis Support Teams

June 9, 2014 Conference Call
Steve Coleman, Lead

Small Group Task: Gather information, including the list of deliverables below, with recommendations to be determined by the larger workgroup

Deliverables: List and describe the services needed to implement a *Coordinating Crisis Support Team model.*

Note: This group will also be gathering information about, 1) eligibility criteria and determination, 2) establishment of a database, and 3) training, educating and possible credentialing of staff.

a. Specific list of services (service components) needed
b. Type of provider(s) or team members
c. Time frames for the services and/or service limitations
d. Qualifications of providers (If there is to be a new designation, list criteria)
e. Statute (regulation) changes required in order to implement the service
f. How the service differs from current services being provided
g. Next Steps

A conference call was held on June 9, 2014 to discuss the services assigned and consolidate information gathered to begin addressing the Deliverables. The conference call focused on deliverables a – f.

Present:
Rita Castor, APD; Tom Shea, Carlton Palms; Sharon Boyd, Parents in Action; Mark Swain, & John Riehm, Sunrise ARC; Patty Houghland, Disability Rights, FCC; Nicki Postma, Positive Behavioral Supports; Clint Bower, Mactown; Jennifer Cannon & Christine Sands, Adams Acres, Inc., Norma Wagner, Broward Behavioral Health Coalition; Steve Coleman, APD

Summary of Discussion on Deliverables

Eligibility Criteria	Eligibility criteria for those needing some form of “crisis” intervention should include those who are eligible for APD services and are likely to have or have been identified as having a mental health condition (Axis I diagnosis), or exhibit significant (continuous and ongoing) behavioral challenges before or during a crisis in which they are a danger to self and others. Historically, those exhibiting the greatest risk for this service have required police involvement or have been Baker Acted, and would likely meet the eligibility characteristics for either Behavior Focused or Intensive Behavioral Res Hab, regardless of their current living setting.
Data Collection	In order to build capacity, to prioritize where the greatest need might be met or who and how many people might be eligible for this service a survey approach in the short term could be conducted. A pilot project has already

Regulation Change	been completed (Skovmand-Wilson, 2014)[1] demonstrating the efficacy of this approach. Long term, the needed data elements should be added to the existent ABC database or the axial diagnoses should be incorporated into the electronic client record now under development. As noted in Workgroup #2, Short-term Crisis Residential Services and Behavioral Respite, as well as this component (Crisis Support Teams) of a comprehensive crisis service system will require the addition of a new service under the Medicaid Waiver, and the addition of language in the Waiver Services Coverage and Limitations Handbook to address the Purpose, Critical Definitions, Provider Qualifications, Covered Services, Limitations, Exclusions, Procedure Codes and Reimbursement Rates. This will likely effect the iBudget rule and the iBudget computer application, as well as whether this will be an unbundled service, or be bundled with a broader comprehensive crisis service system. As a general theme, there was considerable discussion about the need for strengthening inter-agency communication, discussion and relationship building. This will need to be done beginning at the local office level between APD and DCF Mental Health, or at least with the Managing Entities in the regions throughout the state. This would need to be done with the intent of including the existing mental health crisis infrastructure rather than attempting to duplicate it in total without having the necessary physical, professional or funding resources. This could also include the development of Interagency Agreements between Agencies, Memos of Agreement with Managing Entities and Memos of Understanding with existent Receiving Facilities and Law Enforcement at the local level. In addition, F.S 394, Florida Mental Health Act could benefit from some editing to strengthen access to mental health services by persons with developmental disabilities. For example, within the definition of mental illness, the following language is included: "For the purposes of this part, the term [Mental Illness] does not include a developmental disability as defined in chapter 393". This can be interpreted to mean that those with developmental disabilities are excluded from services. Rather, it would be clearer if the language read, "those with developmental disabilities, alone" or "except when those with developmental disabilities are exhibiting symptoms of mental illness."
Service Components	

[1] Skovmand-Wilson, Kirsten; Diagnosis and Referral Rates for Psychotherapy of Individuals Diagnosed with Developmental Disabilities and Mental Illness; Dissertation; Florida State University, 2014.

	The following components for the proposed Florida Model for community-based crisis services for persons with developmental disabilities incorporates components from evidence-based models that have been implemented across the nation and recognized as best practices. The beauty of the Florida Model is the comprehensive and collaborative nature of involving all stakeholders who need to have ongoing communication with each other to ensure that all supports and services are aligned with the same mission – to provide a timely optimal response to minimize the possibility of a crisis situation occurring and to help people to remain in their homes. In order to achieve this goal the following service components have been identified as critical elements in establishing a fully integrated service model: 1. **Clinical Competency Development** – There will likely never be sufficient funds or numbers of highly trained clinicians to support individuals with developmental disabilities and intensive behavioral challenges or a serious mental health condition, alone. In order to have a foundation upon which to build a fully integrated system to reduce and potentially prevent crises throughout the state the level of clinical expertise must be increased. To some degree all stakeholders will need training and education in developmental disabilities, dual diagnoses and interventions that are proven effective with these individuals. To effect this change, training is needed for consumers, family members, direct service staff working with these consumers, APD providers and provider agencies as well as agencies outside of APD. As examples, this would most likely include DCF Mental Health, Florida Department of Law Enforcement, and the State University System of Florida. Training for consumers would likely address adaptive skill alternatives, understanding their mental health conditions, engaging in healthy life styles, accessing treatment and other prevention plan skills. Training for family members would include, understanding their mental health conditions, appropriate treatments for their person's condition, how to interact before, during and after a crisis event, what to expect from clinicians like their behavior analyst and psychiatrist, a crisis unit, the START Team (or Florida equivalent), and accessing treatment. Providers, including direct support staff and provider agencies, especially those serving the dually diagnosed, will need to know the mental health conditions of those they serve, how to support appropriate behavior and recognize symptoms of their condition. This may be an area where special "certification" or a supplemental rate is available to identify those with special expertise. Agencies like, Florida Department of Law Enforcement, in the local areas could benefit from the Crisis Intervention Training (CIT) and certification that is already being implemented in some communities in the state. A collaborative agreement could be established with universities offering instruction in behavior analysis and psychiatry to offer training,

supervision, and opportunities for practica or internships to bring new energy and recruitment for a workforce committed to serving consumers with developmental disabilities and the dually diagnosed.

2. **On-Site Consultation** – This component of the system brings expert clinical services to families or agency staff at their location regarding a specific consumer. One or two crisis team members with psychological, behavioral or psychiatric expertise gather information from family members and/or staff and records related to the consumer's condition and draw conclusions, make recommendations and help the family or provider team (and all stakeholders) to develop an intervention plan. Once trained and implemented the crisis team will follow-up to discuss problems, successes and plan changes. A consumer may be followed for only a few visits or up to one year.

3. **Crisis Beds and Follow-Along (≤ 30 days)** – Several states, including Vermont, California, Massachusetts (START), Virginia (START), and New York have established small local or regional homes to serve individuals who are in crisis and need to leave their place of residence temporarily. These homes are staffed and operational 24/7 and serve from 4-6 individuals for up to 30 days. However, depending on demand, these beds may be split functionally into providing different services. For example, there may be two crisis beds, two respite beds for planned or unplanned respite and two step-down beds to receive individuals from a Crisis Stabilization Unit or jail until an appropriate residential placement can be found or the original location receive training or additional in-home services to support the returning individual. For those individuals who had on-site consultation, those plans are continued in the crisis home, with carry over and follow-up back in their place of residence in the community. While a person stays at the crisis residence they are provided with as meaningful a day schedule as possible.

4. **Respite Beds (Planned)** – Respite beds are an integral component of the crisis support services. Family members at times simply become physically and emotionally exhausted from the day-to-day strains of living with someone who is developmentally disabled with a mental illness or extremely challenging behaviors. At times, respite may be accessed on an emergency basis due to caregiver illness or family emergency. On the other hand, some families my wish to plan annual family travel or other special events when they cannot or would benefit from their disabled family member remaining with professionals who are trained and can occupy that individual while they are absent. These bed stays could be for up to 90 days or 90 days per year. While a person stays at the crisis residence they are provided with a meaningful day schedule.

	5. **After Hours Response System (Mobile)** – A critical component that California, Massachusetts (START), Virginia (START), and New York models included was a 24-hour mobile crisis service. After hours (5 p.m. -9:00 a.m. M-F, all weekend crisis clinicians rotate on-call responsibilities and are available to provide assistance to families, the funding agency (APD), psychiatric pre-screening teams and residential providers 24 hours a day, seven days a week. After hours contacts may include phone calls to assist during a time of crisis, clinicians providing mobile evaluation services and assisting a mental health crisis team to determine whether or not a psychiatric inpatient admission is needed, assistance locating an available inpatient bed, or pre-screening the individual for an emergency respite admission. 6. **Proactive Assessment & Support Planning** – Some states have included a variety of mechanisms to ensure that crises are prevented and that people are supported in their current residence. Some regions establish and maintain a list of "at-risk" individuals, or even develop a "risk plan" to assist service coordinators and providers in predicting and intervening at early stages of potential behavioral crises and how to respond. This information is provided to on-call staff via laptop computers. This or the threat of losing one's residence may illicit an immediate assessment of an individual's situation, and ensure that the responsible regional center provide necessary services and supports, and convenes a Support Plan meeting of the individuals support coordinator, service providers, family members and other key persons as soon as possible. At the very least this may lead to the region and the crisis team to identify who the 7. **Building Collaborative Relationships** – Collaboration between service agencies at the state level and with local mental health entities is integral to the development of a fully integrated system of supports and services for individuals who are dually diagnosed or exhibit significant maladaptive behavior. At the local regional level meetings between the Managing Entities and Memos of Understanding (MOUs) need to be established to open communication surrounding those individuals who are most likely to be served by community mental health hospitals and general community hospitals providing psychiatric inpatient services. These agreements allow coordination between hospitals providing the bulk of services to individuals with developmental disabilities in the region, so that the Crisis Treat Team (or START Team) can pick up the case for transitioning and ongoing follow-up. Also, Regional Interagency collaborative meetings help to identify high risk individuals, coordinate the behavioral health needs of persons with developmental disabilities, including the provision of comprehensive diagnostic evaluations, active family involvement and education, early diagnosis and treatment, vocational services, residential services, and family support with short-term crisis care facilities to provide back-up support when needed

Provider(s)/ Team Members	8. **Use of Telemedicine** – This technology has been effectively incorporated into some rural areas to provide psychiatric and psychotropic medication consultations, and may be useful to some limited degree for other supportive services, including training and feedback to caregivers. 9. **Flexibility to Enhance Staffing** – This has been found to be effective when one-to-one staffing can be arranged and implemented quickly to aide in maintaining someone in their home on a short term basis, with a corresponding plan to fade staff. 10. **Peer Mentors** – Many feel that using peer mentors provides support and education to individuals who live day-to-day with individuals with mental health issues or significant behavioral challenges. Mentoring allows those in a similar life experience who have lived through and survived such an experience the chance to teach and support those who are currently trying to cope with their feelings, frustrations, and fatigue. The peer mentor may challenge the mentee with new ideas, and encourage the mentee to move beyond the things that are most challenging to them or that are not under their control. Crisis Support Team Members are likely to include: 1. Respite/Crisis Providers – these would be respite workers with advanced training in mental health, behavior management, emergency procedures training, possibly with certification, e.g., Registered Behavior Technician (BACB), with a higher rate 2. Personal Care Assistants with Certification – PCAs with advanced training in mental health, behavior management, emergency procedures training, possibly with certification, e.g., Registered Behavior Technician (BACB), with a higher rate 3. Trainers – providing basic and advanced information, e.g., about the Crisis Support Team model, introduction to mental health conditions and treatment options, basic interaction skills, what to expect from your behavioral health services provider 4. Behavior Assistants with Certification – BAS providers with advanced training in mental health, behavior management, emergency procedures training, possibly with certification, e.g., Registered Behavior Technician (BACB), with a higher rate 5. Behavior Analysts – could be BCBA's with advanced training in mental health, emergency procedures training and medication management, with a higher rate 6. Nursing/ARNP - 7. Psychiatry -

	8. Pharmacist - 9. Primary Care - 10. Medical Home – this model and its philosophy should be considered for structuring the Crisis Support team. The medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. Within this model all medical and non-medical needs and supports are met. 11. Peer Mentors/Parent Trainers – additional training beyond experience may be helpful, or could qualify individuals as “Mentors”. 12. Crisis/ Respite Placement provider – requirements for this home or facility provider will need to be developed to ensure it is consistent with licensing and any other existent requirement that has been established for existent receiving facilities. Legal will need to be involved in this, including the issues surrounding competency, guardianship as well as voluntary vs. involuntary placement.
Time frames/ Service Limitations	**Crisis Support Team** – depending on the condition of a particular individual, the active involvement of the team may be nominal, enough to simply know that someone is on the “high risk list” regionally, or to gather assessment information and develop a “crisis plan” with a couple of follow-up visits, others may be actively followed for up to a year with up-front discharge criteria being met, still others may come and go through the team service over time. If the “medical home” concept is adopted the individual could be seen by a psychiatrist at the team’s headquarters for medication management only. **Crisis Placement** – placement would be for 30 days on less depending on the nature of the crisis, the consumer’s condition and the necessity to make arrangements for return to the community. **Behavioral Health Respite** – planned and emergency respite would be short term or less **the** 90 days, again, depending on circumstances or the individual and associated caregivers.
Provider Qualifications	If one or a combination of the national models used as the basis for this information is to be adopted, it is strongly recommended that the lead proponent or Director of that model be contacted to arranged for consultation in advance and on an ongoing basis to evaluate current status of our service system and what components and provider requirements will need to be established. Otherwise, providers must be certified by the Agency and comply, at minimum, with the requirements in the Medicaid Waiver and Limitation handbook. Additional requirements will need to be established for new services, and as a starting place the details for qualification established in

Difference from Current Services	the Report on Project Planning Workgroup #2 – Short-term Crisis Residential Services and Behavioral Respite (residential) offer excellent requirements and considerations for providers that this workgroup would certainly endorse. Currently, there is no Crisis Support Team for individuals who are dually diagnosed or exhibit severe and significant levels of challenging behavior, other than use of Law Enforcement and the Crisis Stabilization Unit, when then are transported and accepted into these services. Respite as it currently exists is often provided in a person's home, for short periods of time by people who are generally not trained in mental health, behavior management, or emergency procedures. There is no on-site, in home, intervention that come to intervene or develop a plan of intervention, and does follow-up specific to an individual's mental health condition. Respite may be available out of home in some few cases, but it is typically provided on a planned basis to free a family up to engage in other activities or to rest. There are no or limited options available for emergency respite resulting from behavioral or mental health crisis.
Next Steps	Moving forward, if this collaborative approach to a comprehensive and systemic model of support and service is adopted, the following steps should be considered: 1) Develop a survey procedure to canvas all Field Offices and Support Coordinators to determine: • Who and how many individuals are dually diagnosed • What are the Axis I diagnoses these individuals have • Who and how many individuals are eligible for BF or IB Res Hab, but do not have an Axis I diagnosis • Who and how often have individuals been Baker Acted or encountered Law Enforcement due to behavioral and mental health crises • What types of mental health/crisis services an individual could benefit from 2) Modify ABC to allow the entry of multi-axial diagnoses 3) Obtain the cost of consultation and "baseline assessment" by an expert engaged in implementing one of the evidence based models for crisis services for individuals who are developmentally disabled, e.g., the START model 4) Determine whether a statewide implementation is feasible or where a pilot site would be most successful 5) Establish an implementation workgroup composed of representatives from the disciplines that will be involved in the roll out of the project or pilot to work with the consultant. 6) Determine cost of scaling up a pilot to go statewide to allow at least one Crisis Support Team in each Region so that there is equity in availability of this service according to regional population and level of need.