



Children's Crisis Residential Services Study

**Report to the Minnesota Department of Human
Services**

June 2017



Dear Counties, tribes, providers, and people of the state of Minnesota:

The 2015 Legislature directed the Minnesota Department of Human Services to gather stakeholder input, conduct research and study the options to develop and fund children's mental health crisis residential services. The National Alliance on Mental Illness Minnesota and AspireMN were awarded a contract to develop recommendations for the Department, which included a wide range of key stakeholder input, especially families who provided valuable information. Children's mental health crisis residential services is a gap in Minnesota's continuum of care, and the recommendations provide a foundation of options to consider in the development of the service for children with mental health concerns and their families.

The Department's Mental Health Division plans to leverage the report's recommendations, models from other states and stakeholder input to address the issue of intensive mental health services statewide. The 2017 legislature directed the Department to study and research options for intensive mental health services for children with complex mental health conditions and their families and report recommendation to the 2018 Legislature. This Children's Crisis Residential Services Study will provide valuable information in examining the continuum of intensive treatment services.

In addition, further study is needed to understand the best application of flexible tools to support prompt and appropriate discharge, including reviews of medical necessity and requirements for authorization of stays exceeding a certain length. While arbitrary limits can have unintended consequences, a child experiencing difficulty in returning to the community requires careful planning and review, including consideration of movement to a planned admission to a higher level of care (PRTF or in-patient hospitalization). Children with longer term and more acute needs are a primary focus of the Intensive Needs Report, scheduled for completion by January 2019. This will include study of how to best use the PRTF level of care for these children.

The Department would like to make this report available to the public to better understand the options and obstacles in developing and funding a children's mental health crisis residential service. The Department is committed to develop a continuum of intensive treatment services and the report provides a significant contribution of information for this effort.

Sincerely,

A handwritten signature in blue ink that reads 'Maisha Giles, MA, LMFT, LICSW, CADC'. The signature is written in a cursive, flowing style.

Maisha Giles, Behavioral Health Director, Minnesota Department of Human Services

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Executive Summary

The 2015 Minnesota Legislature directed the Minnesota Department of Human Services to solicit proposals to convene a stakeholder workgroup to discuss and study options for developing and funding children's mental health crisis residential services that allow for timely access without requiring county authorization or child welfare placement. NAMI (The National Alliance on Mental Illness) Minnesota and AspireMN were awarded a grant to develop recommendations in consultation with stakeholders. This report includes the findings of stakeholder surveys, interviews, and focus groups, as well as learnings from other states' children's crisis residential service models, which informed the recommendations for a Minnesota children's crisis residential model.

Major areas of work included: convening a stakeholder work group, surveying and interviewing families and stakeholders, researching other children's crisis residential service and funding models, and developing recommendations for a Minnesota model. NAMI Minnesota and AspireMN thank the work group participants for their commitment to increasing access to mental health crisis services for Minnesota's youth. Members represented a wide array of stakeholders that are involved in mental health services for children. These stakeholders included hospitals, mental health professionals, counties, health plans, schools, parents, children's mental health collaboratives, youth ACT teams, crisis teams and others who administer or deliver children's mental health services. Work group members met seven times from October 2016 to May 2017.

A dramatic rise in mental health hospital visits signaled the need for expanded options for families with children facing mental health crises. Over the last decade, The Minnesota Hospital Association (MHA) has tracked emergency department visits for this population and found a significant increase: Nearly 20,000 children/youth visits to the emergency room for mental health reasons in 2016, up from under 10,000 such visits in 2007. Minnesota will need to address this issue in multiple ways; increasing hospital and residential treatment capacity are important components, but current models don't provide urgent access or the appropriate level of care for many families. Hospital stays can be both costly and ineffective in providing care to those experiencing a mental health crisis, with hospitalizations costing an average of \$15,540 per stay and studies showing patients often experience an escalation of symptoms in the emergency department and a lack of transition support and coordination with community providers. Likewise, the state's current residential treatment models don't meet the needs of this population, as there are often long wait lists to access care, and the programs are designed as a much lengthier treatment, varying from 100 days to over a year.

Currently, there are few short-term settings for children experiencing a mental health crisis and none that operate without county authorization for placement. Not every person who visits an emergency room needs hospital level of care, but they may not be able to return home. Minnesota has already successfully implemented adult crisis residential services and as the state aims to improve the continuum of children's mental health care, should develop the same level of service for youth. Short-term crisis residential stabilization services assist with deescalating the severity of a person's level of distress and/or need for urgent care associated with a mental health disorder. Crisis

stabilization services are designed to prevent or ameliorate a mental health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services.¹ This level of service provides a range of community-based resources that can meet the needs of an individual with a mental health crisis and provide a safe environment for care and recovery. Core attributes of residential crisis services include providing housing during a crisis with services that are short term and are used to avoid hospitalization.²

Crisis stabilization beds are a critical component to divert youth from higher levels of care, deliver essential screening and treatment, and provide timely intervention. Short-term crisis residential models are uniquely designed to meet these needs. The current literature demonstrates that crisis residential care is effective at reducing symptoms and functioning at lower cost than traditional inpatient care. Importantly, research has found that resources invested in mental health crisis stabilization services provide a significant benefit, with a return of \$2.16 dollars for every dollar invested.

The implementation of adult crisis residential services has revealed a leading obstacle to accessing this critical service and preventing unnecessary hospitalization: the separation of funding sources for room and board and treatment delays authorization and cuts off timely access to care. In light of this dynamic, the work group focused much of the research on funding models for this service in addition to understanding the unique needs of Minnesota families.

Families experiencing a child's mental health crisis should be able to access the appropriate level of care for their needs at the time it is needed. In depth interviews and survey data from families and providers as well as an examination of models operating in other states informed the development of recommendations for a Minnesota model of children's crisis residential services.

This work group's recommendations include:

- Resolve the gap in mental health services for children and adolescents by creating a new level of service for children, adolescents, and young adults ages 5 to 21 with urgent mental health needs requiring rapid admission to temporary stabilization services, or more intensive services to reduce the risk of hospitalization or other longer term residential treatment.
- Improve the consistency and transparency of decision making about how providers refer children to different levels of care to better support parents and facilitate care transitions. Improving and standardizing mental health screening

¹ Substance Abuse and Mental Health Services Administration. (2012) Behavioral Health Service Definitions- A Supplement to SAMHSA Description of a Modern Addictions and Mental Health Service System Brief. Rockville, MD: Substance Abuse and Mental Health Services Administration.

² Stroul, B.A. (1988). Residential crisis services: a review. *Hospital & Community Psychiatry*, 39, 1095–1099.

processes within the children's mental health system would support parents in making informed decisions, enhance the state's ability to evaluate outcomes, and increase access to appropriate levels of care. Consideration should be given to the use of the CANS, specifically the Crisis Assessment Tool. This is an open domain tool for use in mental health service delivery systems for children, adolescents and their families.

- Fund crisis residential services by using all potential funding sources, including federal funding mechanisms such as Medicaid and Mental Health Block Grant funds to the extent possible and commercial health plan coverage.

Introduction

During the 2015 Minnesota legislative session, NAMI (The National Alliance on Mental Illness) Minnesota and AspireMN (formerly the Minnesota Council of Child Caring Agencies) advocated for legislation to have Minnesota's Department of Human Services (DHS) study options for developing and funding children's mental health crisis residential services that allow for timely access without requiring county authorization or child welfare placement.³ NAMI Minnesota and AspireMN were awarded a grant to carry out this research and develop recommendations in consultation with stakeholders.

A mental health crisis is any situation in which the child's symptoms put them at risk of hurting themselves or others and/or when the parent isn't able to resolve the situation with the skills and resources available. Minnesota law defines a mental health crisis as a "behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including but not limited to, inpatient hospitalization."⁴

For too many Minnesota families, when symptoms emerge or return and a child begins to experience a mental health crisis, there is nowhere to go for help. Often the only options are calling law enforcement or going to an emergency room, which aren't the right responses for many experiencing a mental health crisis. There are no urgent care centers that provide mental health services and obtaining an immediate appointment with a mental health professional – especially child psychiatrists – is often impossible. According to input from many families, mobile crisis teams are not readily available in all 87 counties and many of those teams are not yet proficient in addressing the mental health needs of children. Teams typically have practitioners experienced in providing mental health services to adults, but without necessary experience with children's unique mental health needs and involving families. Only two counties in Minnesota have specific child teams, but they don't always respond when families need crisis services. Newly adopted training requirements on children's mental health and how to work with families and support systems will assist the ongoing growth and improvement in these teams' ability to provide effective services. Mobile crisis teams play a critical role in assessing and referring children to the appropriate level of care and their continuing improvement will be essential to meeting Minnesota's mental health needs.

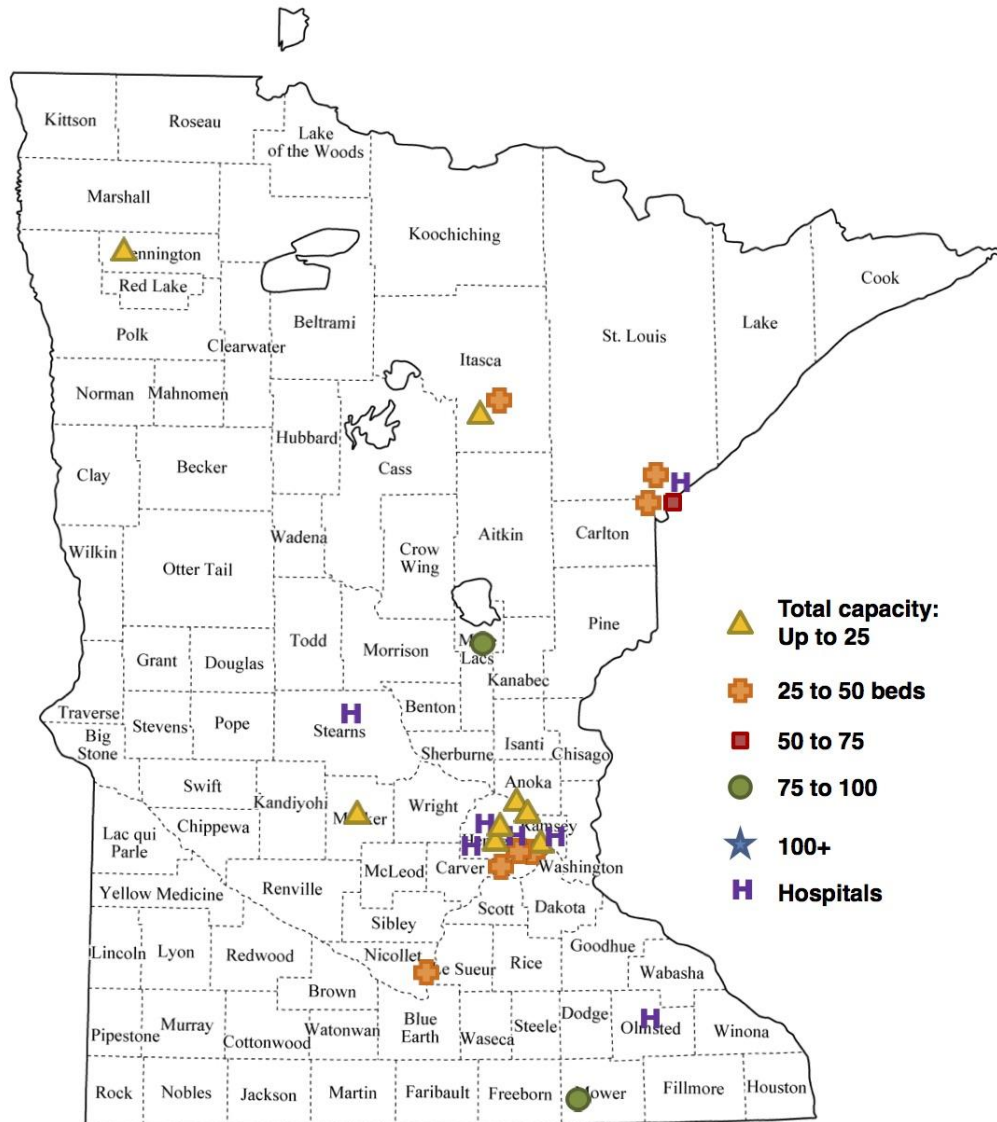
The continuum of residential care is developing in Minnesota, but is not complete. Minnesota has a total of 170 pediatric beds for psychiatric hospitalization, (with 128 in the metro region and 42 in greater Minnesota) and pending legislation will add capacity, but still fall far short of meeting the needs of the growing population of children and youth requiring urgent mental health treatment. In addition to acute care provided in

³ Laws of Minnesota 2015, chapter 71, article 2, section 42.

⁴ Minnesota Statutes 2016, section 256B.0944

hospitals, there are mental health certified residential treatment centers (RTCs), with a total of 636 children’s mental health beds (185 of which are in the metro area and 451 in greater Minnesota). Psychiatric Residential Treatment Facilities (PRTFs) are in development, on schedule to provide 150 beds by July 2018. Minnesota is designing PRTFs to be a step down from hospital level of care and a step up from the current RTCs.

Children’s Mental Health Treatment Facilities



636 children's mental health beds - 185 metro, 451 greater Minnesota
 170 hospital children's beds - 128 metro, 42 greater Minnesota
 806 beds total - 313 metro, 493 greater Minnesota

Lengths of stay in residential settings can vary considerably, but typically range from 100 days to a year or more. A survey of eight other states already operating PRTFs provided information on average length of stay for this setting, with a range of three months to a year or more. Residential treatment programs are also straining to meet the need for this population and families endure long waits to access care at these facilities. Increasing capacity with additional hospital and PRTF beds will be an important step in improving access to needed mental health care for Minnesota's children, however, these additions do not address the needs of those requiring rapid access to shorter-term treatment. Currently, there are few short-term settings for children experiencing a mental health crisis and none that operate without county authorization for placement.

Not every person who visits an emergency room needs hospital level of care but they may not be able to return home. Minnesota's experience in the adult mental health system is that adult crisis residential provides a home-like recovery-oriented setting for adults experiencing a mental health crisis to stabilize when hospital level care is not needed. Adult crisis homes have been very successful in diverting those experiencing a mental health crisis from higher levels of care. Stays are typically 3-10 days, and residential crisis services have a diversion rate of nearly 90%, reducing demand for in-patient hospitalization.⁵ They are funded through two sources: Group Residential Housing (GRH) funds, which pay for the room and board, and Medicaid/MinnesotaCare, which pay for the treatment. Additional funding sources include state crisis grants and county funding.

Research on how to fund and operationalize children's crisis homes must be based on the success for adults as well as learning from that experience how not to fund children's crisis homes. For example, this "dual" funding for adult crisis homes which includes separate funding for room and board and services has proven to be problematic because it is difficult to complete the paperwork for GRH eligibility on a timely basis for such a limited time-period. It can become "county centric" and not available across county lines. In addition, a 2015 DHS report on Rate Setting Methodology for Intensive Adult Mental Health Services found a significant gap between actual monthly provider expenses for room and board costs and GRH rates. Changes made (proposed as part of the Governor's Budget in 2017) in renamed this funding stream as "Housing Supports" and created presumptive eligibility for individuals with Medicaid staying at a crisis residence. This reduces administrative complexity and some of the other concerns raised here. It is, however, still limited to adult eligibility. In fiscal year 2014, the average monthly provider expense was \$1,200, whereas the 2014 GRH rate was \$876. The report clearly stated that "Reliance on the current payment structure, which separates reimbursement for services from facility costs, creates an

⁵ Governor's Task Force Report, "Reforming Mental Health in Minnesota", July 2016. Available online at https://mn.gov/dhs/assets/Overview-Mental-Health-Presentation-ppt_tcm1053-250266.pdf. Accessed on May 12, 2017.

operating hole that has caused some programs to close or to operate at a loss.”⁶ State funding for the room and board portion of the per diem, the use of an 1115 waiver to cover the expanded services or pursuit of the Medicaid Psych under 21 option for programs under 16 beds could be considered to address this issue for a new model serving Minnesota youth.

There are several factors that complicate the situation for children. The first is that the typical federal funding for room and board for eligible children in out of home placements would be Title IV-E, which is now used to fund room and board in foster care (including RTCs). There are multiple problems with this funding source including limited eligibility and the process, typically taking 10 days, for counties to approve the use of Title IV-E and multiple federal requirements for court oversight. In order to access Title IV-E funding, the admission to a crisis residential service would need to be considered an out of home placement through the child welfare system. Title IV-E eligible families are those who meet the eligibility income standards set in 1997 through the former AFDC program. Even if a family were eligible, the county would need to conduct a screening and assessment required under state law and by the time approval could be given, the crisis would be over or the child would have been hospitalized.⁷ The second factor is that children who experience a mental health crisis would need access to insurance coverage for this service. Even if added as a benefit in the state plan, not all children are eligible for Medical Assistance or MinnesotaCare. Unless the service was considered a residential treatment response and thereby was covered by commercial insurance plans, access would be limited for those families and children.

This project looked at a variety of issues related to the target population (diagnoses, age, level of need), payment models used around the country, licensing standards, quality of care, outcomes evaluation, staffing, admission policies, authorization authority, geographic distribution, connection to other services, parity, and more.

⁶ Rate Setting Methodology for Intensive Adult Mental Health Services- Adult Mental Health Division, February 2015. Available online at: https://mn.gov/dhs/assets/2015MH_rates_report_tcm1053-166391.pdf. Accessed May 12, 2017.

⁷ Minnesota Statutes 2016, Chapter 260D.

The work group studied the following issues to develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement:

- Research and interpret best practices for children's mental health crisis residential treatment to inform policy and standards, including researching other state's coverage of crisis residential treatment to inform treatment coverage policy.
- Provide analysis and documentation of best practices from other state models, professional literature, and stakeholder input.
- Develop recommendations to develop a children's crisis residential system that includes, but is not limited to the following;
 - Target population
 - Eligibility Criteria
 - Level of care
 - Length of stay
 - Crisis residential models
 - Geographic distribution
 - Licensing and Certification
 - Payment models
 - Authorization Authority
 - Expected outcomes

To accomplish its assignment, the group conducted two surveys: one of families with children who had experienced a mental health crisis and another of children's mental health providers. In addition, in-depth interviews and focus groups were conducted with families and providers to develop a better understanding of the current gaps in services and how a new program could meet the unique needs of Minnesota families. The group also studied other states' experiences implementing short-term residential programs for children experiencing a mental health crisis to explore successes and challenges with different types of program models. The recommendations incorporate findings from this research as well as build on the work of states and organizations that had researched the need for increased mental health crisis services or implemented short-term crisis residential services for children.

The research included interviews of people from national organizations, a literature search, research of state laws and Medicaid plans, a review of Minnesota mobile crisis and hospital data, and research of funding models. The interviews with national organizations provided a greater understanding of what other states have done in the area of crisis residential models and viable ideas for financing.

The interviews and surveys provided information on who stakeholders believe are in need of this level of care, what this level of care should look like in terms of staffing, what collaborative models could be developed, where they should be located, who should license them and what the licensing standards should include, ideas for funding and treatment components. Multiple methods of providing input were used including

individual interviews, online surveys and an in-depth discussion with the Iron Range Youth Behavioral Health Task Force that has also been studying this issue.

Stakeholder input was gathered through the creation of an advisory committee in collaboration with the Children's Mental Health Division. Meetings were held at NAMI Minnesota providing for free space and the opportunity to have people join by phone. Six meetings were held to review information and findings and to develop recommendations.

Efforts were made to involve professionals and families from culturally diverse communities to ensure that the development of a children's crisis residential model is sensitive and responsive to the needs of all children in Minnesota. In addition to engaging a diverse group of stakeholders to participate in the advisory group, surveys were sent out through a variety of means, both electronic and hard copy, through emails, social media, and by mail to organizations serving families of color and to every corner of the state. In depth interviews and focus groups were conducted with a range of providers and families, reflecting diverse communities and family experiences.

This report contains the findings of the research and surveys and the recommendations from the stakeholder group. The report contains information as to how this service fits into the current continuum or array of services. Concrete recommendations that can create this needed level of care are included.

Background

Minnesota has known of the need to prevent hospitalization for some time. The 2009 report on unmet mental health care needs in the state, identified the need for additional services which are less intensive than psychiatric inpatient care. The need to increase readily available respite care was also identified.⁸ The state has identified a need for children's mental health crisis residential services to improve crisis related services specifically and the state's mental health care continuum more broadly. Children's mental health crisis response services are intensive face-to-face, short-term mental health services initiated during a crisis to stabilize and restore a child or youth to the prior level of functioning. Crisis response services providers must provide immediate intervention to provide relief of distress based on a determination that the child's behavior is a serious deviation from his/her baseline level of functioning. Crisis response services must ensure that all children and families can access crisis services in a timely manner and in the least restrictive setting.

Reducing unnecessary psychiatric hospitalizations and long waits in emergency departments due to a lack of alternatives for children experiencing a mental health crisis are top priorities for Minnesota to improve outcomes for the state's youth. There

⁸ Mental Health Acute Care Needs Report, March 2009, Children and Adult Mental Health Divisions- Chemical and Mental Health Services Administration.

continue to be gaps in providing a comprehensive mental health system, which allows access to the appropriate level of care on a timely basis. Minnesota should be proactive to avoid the problems experienced in other states related to children being routinely “boarded”, i.e., waiting in emergency departments and medical unit beds due to a lack of access to less intensive cost effective care. One relevant case was recently decided in Washington, when the state’s Supreme Court ruled that the state’s Medicaid program did not authorize “psychiatric boarding” or recognize it as appropriate treatment for Medicaid enrollees. As a result, the court’s ruling essentially says that Emergency Department boarding of mental health patients enrolled in Medicaid deprives them of the covered benefits of the Medicaid program and violates their civil rights. The state’s argument that psychiatric boarding is necessary to avoid overcrowding in certified evaluation and treatment facilities was rejected by the court.⁹

Access to and availability of less restrictive services is essential for children and youth who experience serious mental health challenges for support, stabilization and treatment who may otherwise end up in a hospital or more restrictive settings.

Reinforcing the need for increased access to less restrictive treatment settings is the fact that hospitals are burdened by the growing need for mental health services and unable to provide timely care to those requiring urgent access to mental health treatment.

As reported by the Minnesota Hospital Association, from 2007-2014, hospitals in Greater Minnesota experienced a 40% increase in all mental health Emergency Department visits, while those in the Twin Cities metropolitan area saw a 34% increase. For children, ages 0-17, the increase was even greater, with a 56% increase in mental health Emergency Department visits in greater Minnesota and a 40% increase in the metro area.¹⁰ The trend of increased pediatric mental health Emergency Department visits has persisted. Overall, the state went from 9,946 pediatric Emergency Department visits in 2007 to 19,368 visits in 2016.¹¹ This state trend mirrors a national increase in child and adolescent hospitalizations for mental health issues over the past decade.¹² Both medical and financial costs are a concern, with health care costs increasing, the sharp climb of pediatric mental health hospital visits, and the need to ensure effective

⁹ See *In re Detention of DW v. Dept. of Soc. & Health Servs.*, 181 Wash. 2d 201; 332 P 3d 423 (2014).

¹⁰ Mental & Behavioral Health: Options and Opportunities for Minnesota, December 2015, Minnesota Hospital Association.

¹¹ Minnesota Hospital Association data as of April, 2017.

¹² CNN report, “‘Alarming’ rise in children hospitalized with suicidal thoughts or actions”, May 2017. Available online at: <http://www.cnn.com/2017/05/05/health/children-teens-suicide-study/index.html>. Accessed May 5, 2017.

care. A 2013 study found the average emergency room visit costs \$1,233,¹³ while a 2012 study found the average psychiatric patient in medical emergency departments boards for an average of 8 to 34 hours and the average cost was \$2,264. They also found that psychiatric symptoms of these patients often escalate during boarding in the ED, highlighting the need for more effective services.¹⁴ A 2014 study found that mental health hospitalizations are common and costly nationally, with nearly 10% of pediatric hospitalizations being due to a mental health condition and costing an average of \$15,540. The study also found that total charges for all hospitalizations nationally with a primary mental health diagnosis were \$3.5 billion (or 6.5% of total charges for all hospitalizations).¹⁵

While the numbers of those with mental health needs seeking care at hospitals continues to rise, the number of beds available for meeting this need has not kept pace. A 2014 Minnesota Department of Human Services analysis found limited capacity for children's inpatient hospitalization throughout the state, with inadequate availability even in the Twin Cities.¹⁶ Additionally, it has been reported that fewer than half of children who end up in an Emergency Room due to a psychiatric crisis receive any type of mental health treatment, and few are referred for outpatient treatment or follow-up. As Minnesota's 2016 Governor's Task Force on Mental Health reported, "Staff in EDs often lack specialized mental health expertise, leaving them ill-prepared to support

people experiencing a mental health crisis. Some community hospitals do not have a psychiatrist or psychologist on staff at all, and many do not have them available 24/7."¹⁷ In-reach Services are an important tool to address a child's needs related to treatment, education, family support, housing, or anything else that will help reduce the use of emergency rooms or readmissions to the hospital before hospital discharge. Statewide mental health workforce shortages also add to the problems of too little support post-discharge. It is too often the case that at the end of the crisis, the child is without treatment and problems resulting from the crisis are further compounded.¹⁸

¹³ Caldwell N, Srebotnjak T, Wang T, Hsia R (2013) "How Much Will I Get Charged for This?" Patient Charges for Top Ten Diagnoses in the Emergency Department. PLoS ONE 8(2): e55491. doi:10.1371/journal.pone.0055491

¹⁴ Nicks B, Manthey D. Emerg Med Int. 2012.

¹⁵ Bardach, N. S., Coker, T. R., Zima, B. T., Murphy, J. M., Knapp, P., Richardson, L. P., Mangione-Smith, R. (2014). Common and Costly Hospitalizations for Pediatric Mental Health Disorders. *Pediatrics*, 133(4), 602–609. Available online at: <http://doi.org/10.1542/peds.2013-3165>

¹⁶ Minnesota Department of Human Services, "Minnesota's Mental Health System Gaps," 2015.

¹⁷ Governor's Task Force on Mental Health Final Report, November 2016. Available online at: https://mn.gov/dhs/assets/mental-health-task-force-report-2016_tcm1053-263148.pdf

¹⁸ Helping Children in Acute Psychiatric Crisis, Ruth Gerson, M.D. and Fadi Haddadd, M.D, *Psychiatric News*. Available online at:

While increasing hospital capacity to meet the demand for mental health services will be one important piece of the puzzle to improve care access, many children requiring care could be better served in a lower level of care. Literature and clinical experience indicate that inpatient hospitalizations for youth undergoing mental crises only provide a short-term solution to a crisis if coordination with longer term community based services is not included. Removing a child from their home environment for a brief period of time may indeed keep the youth safe and provide the family with a brief respite; however, returning the child directly to the home without addressing the specific clinical and family needs only increases the child's risk for rehospitalization. Treatment services and interventions must include linkage support services that provide sustainable and durable transition support and maintain the wellbeing of the child in the community.¹⁹

Troublingly, one result of the gap in services for youth post-hospitalization, is the use of homeless shelters for youth experiencing mental illness. In a meeting with providers of services for homeless youth and young adults, significant concern was raised over the number of young people who are discharged from inpatient psychiatric treatment to shelters for homeless youth. One provider said that 75% of the young people in their transitional living program had significant mental illness and another described a common practice of ambulances bringing youth to their shelter from hospitals. All emergency shelters serving youth experiencing homelessness in the metro area have reported the experience of children being brought by ambulance directly from the hospital. NAMI Minnesota has also received feedback from metro police departments about how they are often asked to transport children with mental illness to area shelters. This population of Minnesota youth is quite substantial, as a recent Wilder report found that an estimated 6,000 youth are homeless on any given night and 57% have significant mental health issues.²⁰ The group of homeless youth service providers was very interested in and supportive of the development of new crisis residential services which could more appropriately serve these clients and assist with successful reintegration into the community with support services.

Residential Treatment Centers are an alternative to hospitalization and the number of children in these settings has increased over the past two decades. The closing of long-term psychiatric hospitals and in-patient institutions has led to this rise.²¹ However,

<http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2015.12b9>. Accessed March 19, 2017.

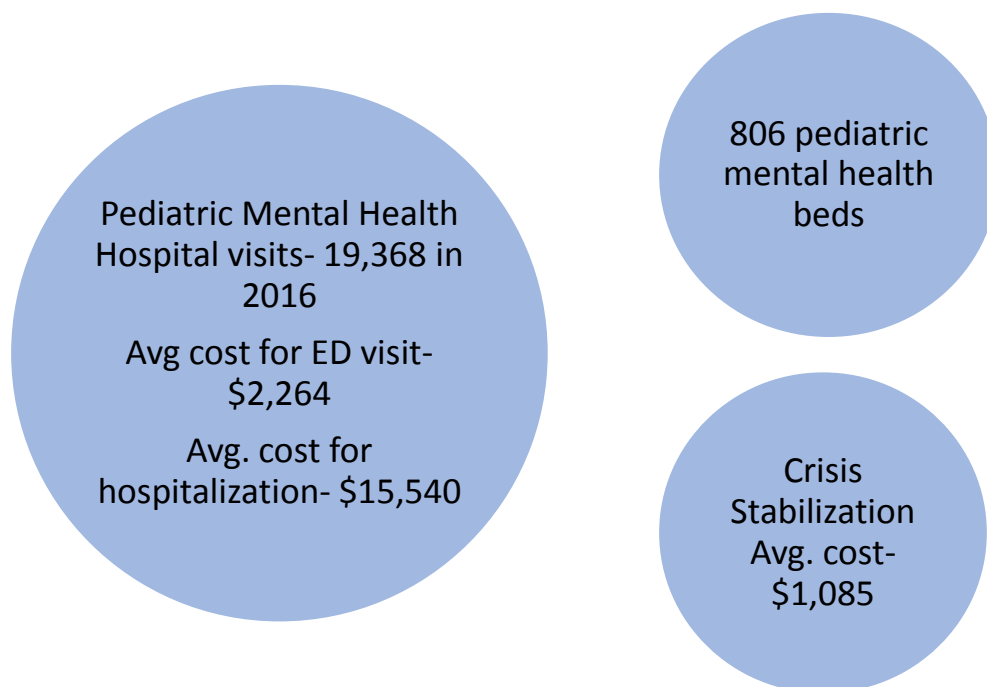
¹⁹ Kids in Crisis: California's failure to provide appropriate services for youth experiencing a mental health crisis, January 2015. Available online at https://cmhacy.org/wp-content/uploads/2016/05/Kids-in-Crisis-White-Paper-_FINAL-rev-4_08_15.pdf. Accessed January 9, 2017.

²⁰ Wilder Research, Minnesota Homeless Study, October 2015. Available online at: <http://mnhomeless.org/minnesota-homeless-study/youth.php>.

²¹ Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies, June 2006, U.S. Department of Health and Human Services.

lengthy waiting lists for residential treatment or any out of home placement has meant many families are not able to access this level of care when it is most needed. In a May 2017 survey of 4 current Minnesota residential treatment providers, organizations reported a total of 337 children and adolescents on their waiting lists.

Need, Capacity, and Costs for Mental Health Care



Minnesota's recent Task Force on Mental Health also identified the need for increased capacity and alternatives for psychiatric hospitalization as well as improvements to the state's crisis response system.²² Crisis services have already been shown to successfully connect individuals with needed mental health care. A 2013 study by Wilder Research examined the impact of a mental health crisis stabilization program on utilization of health care including Emergency Department use, outpatient services, and inpatient psychiatric services. Programs served 315 patients at an average cost of mental health crisis stabilization of \$1,085. The authors found reduced Emergency Department and inpatient use for those who had utilized crisis services. They also

Available online at <https://aspe.hhs.gov/basic-report/public-financing-home-and-community-services-children-and-youth-serious-emotional-disturbances-selected-state-strategies> Accessed May 9, 2017.

²² Governor's Task Force on Mental Health, November 2016, Available online at https://mn.gov/dhs/assets/final-report-executive-summary-11-15-16_tcm1053-263221.pdf. Accessed February 15, 2017.

compared the value of resources invested in mental health crisis stabilization services and found a significant benefit, with a return of \$2.16 dollars for every dollar invested.²³

Within the continuum of crisis response, crisis stabilization beds are a critical component to divert youth from higher levels of care, deliver essential screening and treatment, and provide timely intervention. Short-term crisis residential models are uniquely designed to meet these needs.

The current literature demonstrates that crisis residential care is effective at reducing symptoms and functioning at lower cost than traditional inpatient care. There is evidence that community-based residential crisis care can divert individuals

from unnecessary hospitalizations, ensure the least restrictive treatment option is available to people experiencing mental health crises, and assist in reducing costs for psychiatric hospitalization, while maintaining clinical outcomes.²⁴ Program outcomes show promising results for implementing this level of service for Minnesota youth.^{25, 26} Currently, there are isolated pockets of this level of care in the state. North Homes Stabilization and Evaluation Unit, Woodland Center's Youth Stabilization Services and the University of Minnesota's Masonic Children's Hospital Adolescent Crisis Stabilization Unit currently provide this level of service. However, this level of care is not available to the majority of the state's children and adolescents in the midst of a mental health crisis. North Homes' program is only accessible through the county's child welfare system in which it operates, which prevents direct access for many children who might benefit from this level of service. North Homes program provides 18 beds and serves children 12-17, with options to admit those as young as 11 or as old as 18. Frequently, children are assessed in the Emergency Department by members of the crisis team and can be admitted into the stabilization unit directly from the hospital. Many children admitted to the program are there to adjust to a new medication, but don't require hospital level care for that purpose. The average length of stay in 2016 for youth in the program was 16 days, but is now closer to 30 days, due to fewer community resources available for adequate discharge planning. The length of stay is

²³ Crisis stabilization claims analysis: Technical report Assessing the impact of crisis stabilization on utilization of healthcare services, April 2013, Wilder Research. Available online at <https://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/Crisis%20Stabilization%20Claims%20Analysis%20-%20Technical%20Report.pdf>, accessed January 10, 2017.

²⁴ Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies, 2014, Substance Abuse and Mental Health Services Administration (SAMHSA). Available online at <http://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>, accessed January 10, 2017.

²⁵ Outcome Evaluation Report: Crisis Residential Programs, June 2016, Santa Barbara County Department of Behavioral Wellness

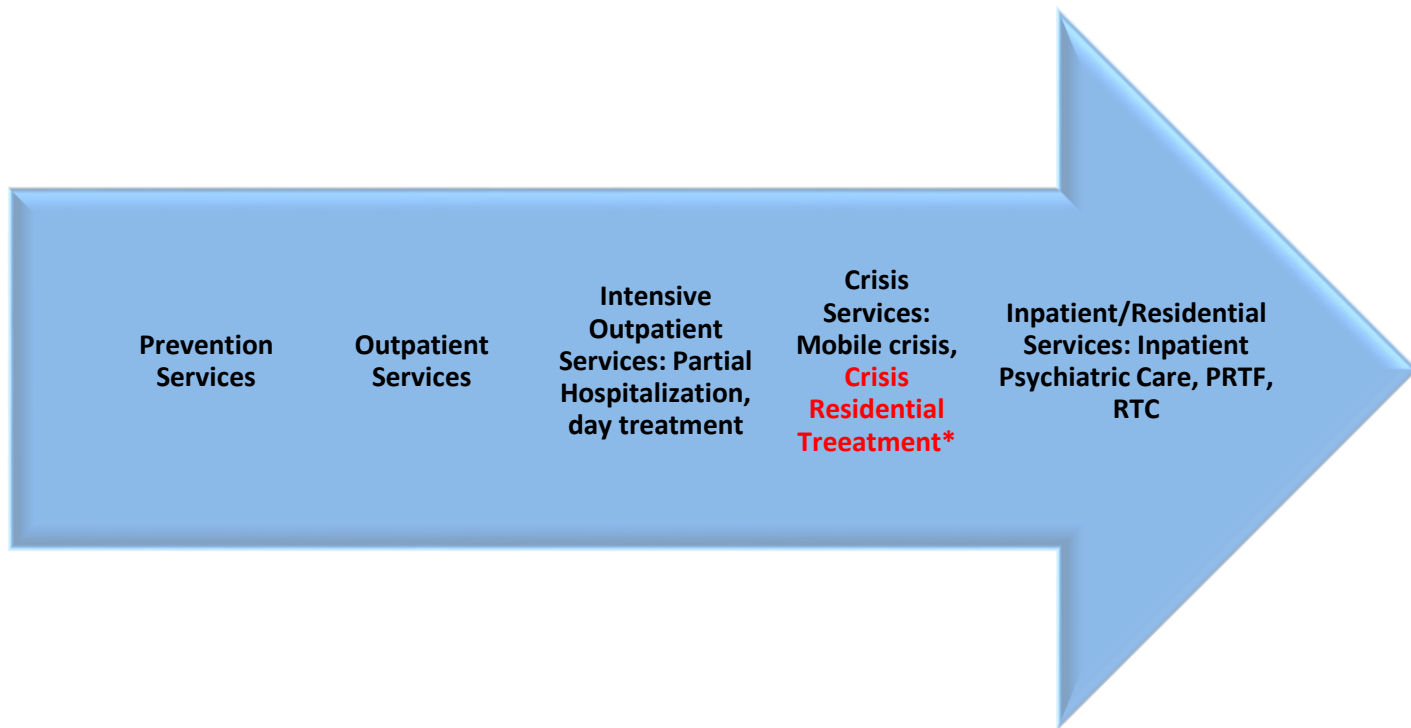
²⁶ Maine Department of Health and Human Services, Integrated Crisis Report, May 2016. Available online at http://www.maine.gov/dhhs/samhs/mentalhealth/consent_decree/May-2016/Section12-Integrated_Crisis_Report_QTR3_FY16%20final.pdf accessed on March 20, 2017.

determined by the individual medical needs of the child. The program provides medication management, assessment, individual and family therapy, a wellness coach, and comprehensive discharge planning. Woodland Center's program provides six beds for children ages 6-17. Children are referred from a variety of settings and the program provides a safe and protective environment, crisis assessment, skills training, discharge planning, and medication administration (however, medications are not assessed or started in this program). The program is staffed by mental health workers, mental health professionals, and nurses. The average stay is three days and most children are able to return home or to their existing placement. Funding for the program is provided by county contracts and purchase of service agreements as well as limited grant funding. The University of Minnesota program is hospital-based and provides 14 beds for five to seven days of crisis stabilization for teens ages 13-18. The program is billed to families' health insurance and is staffed by RNs, Licensed Psychotherapists, Psychiatric Associates and a prescribing Nurse practitioner. County crisis teams refer youth to the program which provides crisis therapy, skills training, family sessions, medication assessment and management, and discharge planning. While these programs provide an essential service in their communities, they are not accessible to the majority of Minnesota youth. The variable funding models also raise questions of accessibility and sustainability. Without a statewide program, too few children will benefit from this essential level of care.

While there are needs for building capacity and improving care throughout the continuum of Minnesota's children's mental health services, the state has a significant gap in caring for children with urgent mental health needs in a short-term residential setting. The Gaps Analysis study conducted by the Department of Human Services gathers information about the capacity of the mental health system and the gaps in the service system. In the metro region for 2015-2016, Psychiatric prescribers (psychiatrists, nurse practitioners, clinical nurse specialists), Crisis Stabilization – residential, Inpatient child/youth psychiatry beds and respite care came up high. Other regions had similar gaps although some also added day treatment, crisis, and services for younger children.²⁷ It's important to note that basic services in the community are needed. For the population with crisis stabilization needs, hospitalization is not always appropriate and they may require more support and resources than are available at home. Residential treatment at a RTC or PRTF does not provide urgent access and usually results in a much longer length of stay than is necessary for families experiencing a crisis. Crisis residential care provides an urgent response, at the appropriate level of care, and at significantly less cost than hospitalization. Children are provided a healing environment, connected to their families and communities, with less disruption and improved connections to other care providers who can assist the transition home and to other community supports.

²⁷ Minnesota Department of Human Services, Gaps Analysis (Currently underway). Available online at: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/gaps-analysis/current-study/>

Children's Mental Health Continuum of Services



**Not currently available*

Findings

To identify who would be in need of this level of care, and understand what this level of care should provide, the group conducted two surveys: one of families with children who had experienced a mental health crisis and another of children's mental health providers. In addition, in-depth interviews and focus groups were conducted with families and providers to develop a better understanding of the current gaps in services and how a new program could meet the unique needs of Minnesota families. The group also studied other states' experiences implementing short-term residential programs for children experiencing a mental health crisis to explore successes and challenges with different types of program models. To determine capacity needs and how a child crisis residential program could be geographically distributed to meet the state's needs, the work group reviewed data from the Minnesota Hospital Association, mobile crisis reports, and other state's utilization data.

Surveys, Interviews, and Focus Group Findings

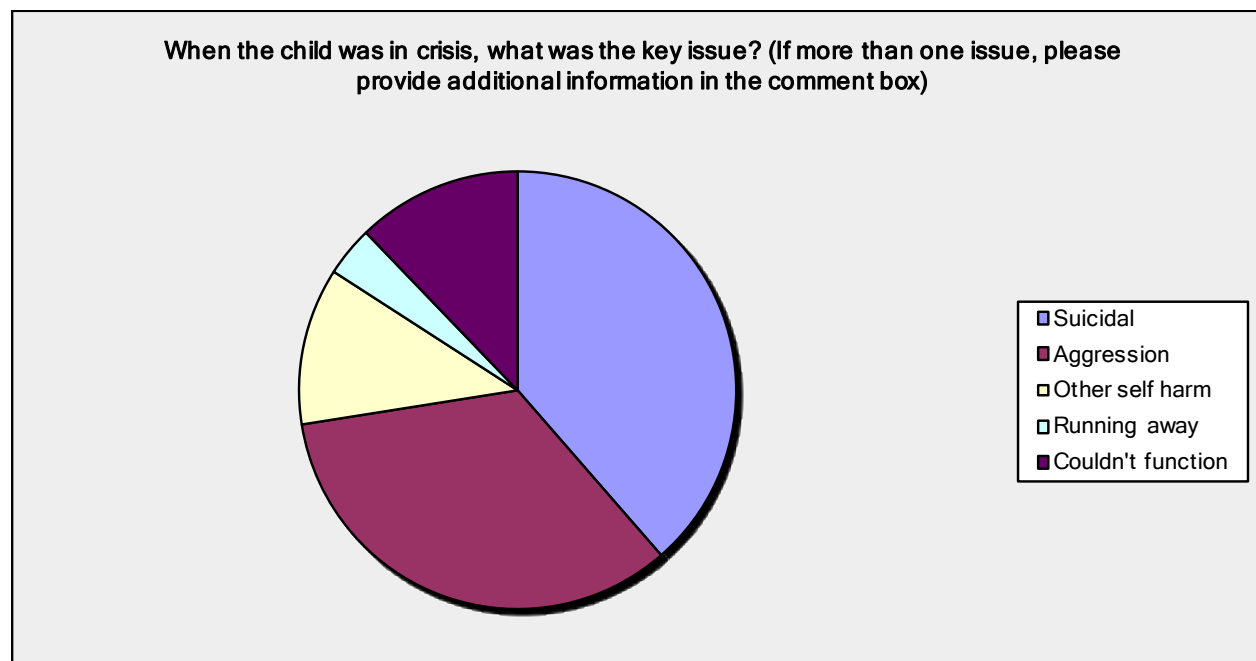
Surveys-

Two surveys were conducted during the course of the project: One for families of children who had experienced a crisis related to a mental health issue and one for

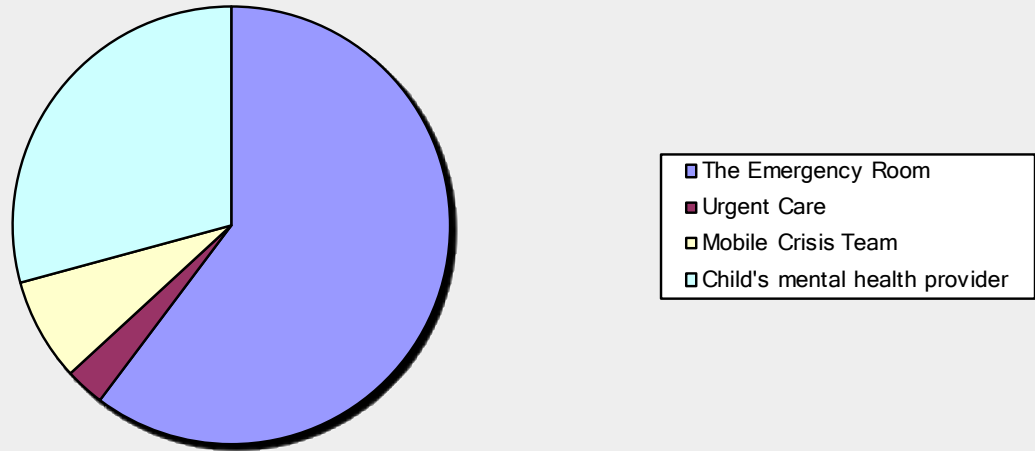
children’s mental health providers. More information regarding the surveys is included in the appendix.

Survey responses were received from 212 families from around the state. To ensure geographic and demographic representation, the work group disseminated the survey to diverse communities throughout Minnesota. Responses were primarily from parents of children ages 11-17, however included an entire age range of 0-24. Demographic data provided by responders described the children who had experienced a metal health crisis: 78% were Caucasian, 10% two or more races, 9% Hispanic, 5% African American, 4% Native American, and 0.5% Asian. 9% of children identified as Lesbian, Gay, Bisexual, Transgender and/or Queer. Responses from 53 of Minnesota’s 87 counties were received, with feedback from the far northwest to the far southwest borders. Most responders identified the key issue during their child’s mental health crisis as involving suicidal or aggressive behaviors. Over 60% of family responders had sought care at an Emergency Room during a child’s mental health crisis as defined by the family. Responders indicated children were not able to access needed services for a variety of reasons: 52% of responders indicated the needed level of care was not available; 54% stated there was too long of a wait for needed treatment; and 28% reported being turned away from needed services when seeking care. When asked what type of program would be most helpful, most families indicated a ‘safe place’ for stabilization, with a preferred length of stay from two days- two weeks as ideal. While families didn’t indicate specific preferences for the type of services or providers, or the size of the treatment setting, families did seem to indicate a preference for a facility type setting as opposed to a group home type setting. They also indicated a strong desire for robust discharge supports and services.

Family Survey Responses About Past Crisis Experiences

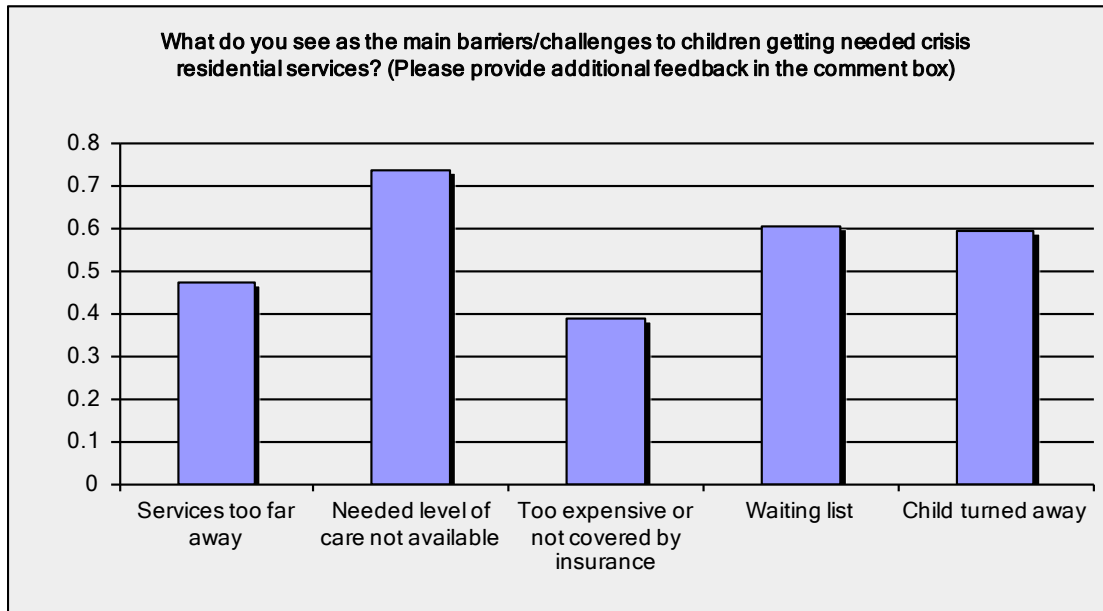


When the child experienced a mental health crisis, where did you seek care? (If more than one, please provide additional information in the comment box)



The provider survey had 88 responses, with a mix of outpatient, inpatient, crisis services, case management, and school based mental health providers. Many provider responses indicated there are no available services for children acting out aggressively. Most providers indicated a 4-10 bed unit with a stay of up to 30 days as the ideal length for a short-term crisis residential program that would provide stabilization, family services, referrals, and skills building. Most provider responses reflected the desire to have as much flexibility as possible to meet the needs of individual children requiring services. Providers also endorsed the importance of connecting with community services and the need for transition planning with other providers, schools, and in home family after-care services.

Provider Survey Responses about Treatment Barriers



Family Interviews-

In- depth interviews with families with children who had experienced a mental health crisis were conducted in February and March, 2017. Ten families were interviewed, with children ages 9-20 years old. Interviews were conducted with biological, adoptive, and step parents. Targeted outreach to diverse families resulted in feedback from 7 families with children from minority communities, in terms of race, ethnicity, and LGBTQ identity. Families from urban, suburban and rural areas were interviewed to ensure geographic representation. More information about the interviews is included in the appendix. Families described crisis experiences related to children with suicidal and aggressive behavioral concerns. All families had sought help through mobile crisis, at a hospital, or through law enforcement.

Two types of experiences/needs emerged from these interviews: 1. Those with an initial or early mental health crisis who were experiencing their first entry into the mental health system/care continuum or 'first timers' and 2. Those with an ongoing high level of need for services and supports, with potential repeated need for crisis residential options

Families identified several areas of need concerning crisis services:

- Help navigating the system;
- Care that ties into the care continuum and the communities families live in;
- A break or a cooling off period for when the caregiver isn't able to resolve the situation with the skills and resources available;
- Safety and stabilization; and
- Connection and follow up with next services, resources, and supports.

Interviewed families stated a preference for a facility type setting over a foster home setting, with a focus on safety and structure. Families provided mostly neutral feedback on what size would be helpful, though stated they would prefer no more than 8-10 kids in a setting. The ideal length identified was 3-5 days for those with fewer needs and 1-3 months for those with more complex or chronic issues. Families identified a need for services that would include family therapy, education, and crisis planning and supports for the child that provided individual and group therapy, skills training, medication management, discharge planning, and intensive follow up care. Most families indicated willingness to travel up to an hour away for these types of services. Families indicated they would be comfortable with some services being provided through telemedicine, specifically to involve the family and to provide follow up.

Family Interview Responses

“Three days and \$8,000 later, she came home with no plan. There was a total disconnect between what happened in the hospital and her return home. The whole experience was traumatizing.”

“We felt so lost in the shuffle. When we were in crisis there was no place to go. There needs to be something besides child welfare, hospital, or jail.”

“We needed a stabilization period focused on safety- not hospital stable, but real stable.”

Family Interview Responses

The ER said to take him home and offered no other assistance, but our child’s mental health problems caused our other child to not be safe.”

“We had to wait to get in to see all these people and in the meantime, our daughter was not getting the care she needed and we ended up back in the ER with another crisis. This could have been avoided if we had better access to care in the first place.”

“When a family is experiencing a first crisis, it’s hard to know what to expect and how the treatment/recovery is going to play out. You look to advice from professionals to help navigate that.”

Provider Focus Group-

A focus group with 28 children's mental health providers was conducted in March 2017. Providers from around the state, representing the full continuum of care for children's mental health, participated in the focus group. More information about the focus group is included in the appendix. Providers recommended a 'home-like' setting that would provide safety and security. Providers discussed the need for crisis respite care for caregivers and the need for ongoing support of a child in the case of an out-of-home placement. For statewide access to short-term crisis care, providers suggested increased use of technology, assistance with transportation, and expanded options for mobile support that can provide support in the child's home or even potentially provide a mobile crisis residence that could meet the family where needed.

Providers identified the need for two tracks of crisis stabilization:

1. With the goal of stabilization within 5 days and
2. Providing 30-90 days of more intensive services, assessment, and transition planning.

Essential services identified by providers were: Therapy, Psycho-education with broader network for child and family, Planning – transition planning with a community-based therapist, Medical support/psychiatric support and medication management, Service coordination, Family therapy, 24 hour nursing availability for crisis response, Plan service delivery around the importance of continuity of relationship with family and community providers, Use telemedicine to connect therapist to family and child during treatment course, Ability to dual bill – specific to deep-level discharge planning that was inclusive of both the crisis service provider and the community provider.

Other State Models

Several states' children's crisis residential models were identified for outreach through reviewing the literature, discussion with national partners, and studying state Medicaid plans. Representatives from the states below were interviewed to learn about their programs' target population, length of stay, program setting, funding, capacity, staffing, services provided, outcomes, and more.

While other state models varied in terms of eligibility, setting, access, staffing, capacity, and outcomes evaluation, common themes emerged across state models:

- Most provided services for up to two weeks, (with options for extensions) and the average length of stay was closer to a week;
- Most programs were primarily funded through Medicaid;
- Most programs were geographically based, so families could access care more easily;
- Programs were mostly co-located with other residential services and;

- Most programs provided stabilization, screening, therapy, family support and education, school linkages, medication management, and coordination with other community based services;
- Most programs have had to increase capacity, accelerate access, and add flexibility in length of stay and ages served.

Variation in target population and access across the models seemed to be driven primarily by where the programs originated. Models that emerged from child welfare programs require case management authorization to access and those that are connected to the crisis continuum have more flexibility. Programs with more limited age ranges have had to expand eligibility or offer waivers to a larger age range to meet the need for crisis residential services. Similarly, while the average length of stay is around a week across all the models, programs have had to build flexibility by offering extensions for children requiring additional stabilization or transition support. Variation in setting between residential treatment centers and foster home beds was driven by available regional resources. A new program in Canada is utilizing space in a hospital to create a crisis stabilization unit for adolescents, to streamline assessment and referral from the emergency department.²⁸

Connecticut- Short Term Family Integrated Treatment (SFIT)

Connecticut created a crisis stabilization system out of their shelter system, which has been operating for just over a year. They offer brief intensive services for up to 15 days for children from 12-17 years old, allowing a waiver down to age 10. The goal of the program is to preserve a child's placement, reduce disruption, and reduce emergency department use. Children access the service through mobile crisis or a managed care entity. For the entire state, there are 82 beds available at 8 sites, which have met the need for the state thus far, not requiring anyone to wait for a bed. The state also has a respite option, providing 2 beds at each site available to families needing urgent access to respite care. The program provides individual and family therapy, skills training, screening and referral. The state provides three-year grants to service providers, rather than per diem payments based on utilization, to guarantee beds. Licensing is provided under the larger service provider's certification through the state. Accessing the service within the state's 1-2 hour goal timeframe has proved to be the most challenging aspect of implementing the program. Program staffing includes nursing, social workers, direct care workers, and psychiatric care. Children can continue at their enrolled school during the program, if transportation is arranged. While early in the program's performance, they have begun to track outcomes. During 2016, 227 children entered the program, with 185 discharged home, 10 were hospitalized, and the others went to a variety of other treatment settings or placements.

²⁸ "Surrey child mental health crisis unit to open later this month", May 2017. Available online at: <http://vancouver.sun.com/news/local-news/surrey-child-mental-health-crisis-unit-to-open-later-this-month>

Georgia- Crisis Stabilization Unit (CSU)

Georgia has implemented a crisis stabilization unit program providing a lower level care than hospitalization or a Psychiatric Residential Treatment Facility (PRTF). The state does not have “group homes” or therapeutic foster care or any other type of residential treatment – just PRTFs. Before they developed these units, they had about 500-600 youth in PRTFs on a daily basis – that number has dropped to about 200 per day. Hospitalizations have decreased as well.

These units are connected to their community mental health/developmental disabilities boards, which are regional. There are six regions and each one has one. They are under 16 beds so Medicaid can be used and they are licensed through the state. Because they are run by and connected with these boards (like a community mental health center) the child can be easily connected to community mental health services when they leave.

The unit is staffed with paraprofessionals, nursing, there is a medical director that is there for consultation, and other MH clinicians. Education is not on-site but the school is contacted and they are asked for the next seven days of work and an on-site tutor helps the children with their homework. There are groups and other wellness activities provided. Family involvement and support is required. Seclusion and restraints are allowed in extreme emergencies.

They bill Medicaid and private insurance and Medicaid pays for room and board (the benefit is structured such that there is not a separation between treatment and housing components). Children are admitted mainly by crisis teams or community MH providers, but sometimes families call directly.

The children are largely having a psychiatric crisis and stay around a week to ten days. They did have problems with child welfare and juvenile justice putting children in there and then leaving them there beyond the ten days because there were no other placement options. They now collaborate more closely with child welfare and juvenile justice to talk through any problems.

Maine- Crisis Stabilization Units (CSU)

Maine also operates their children’s crisis residential program through contracting with community agencies throughout the state. Mobile crisis teams assess children for eligibility in the community (home, school, detention center, or emergency room). They also receive about 25% of their referrals as a ‘step down’ placement after a hospital discharge. They offer services to children ages 0-18, with contracted providers offering services to age ranges based on their competence and resources. For example, Sweetser, one contracted provider, provides services to children ages 7-17 for an average stay of 7-14 days. Children are admitted the same day as referred, with an on-call system available to assess referrals during non-business hours. Mental Health professional and youth and family counselors provide staffing, with access to nursing as needed. The program provides family and group therapy, skills training, and discharge

planning. The state has 27 available beds at 7 sites, usually operating at capacity. The program accepts Medicaid and commercial insurers, but some commercial payers are not accepted, due to lack of coverage. Additionally, waiting for services after discharge in the community has been a challenge, as well as serving the more rural areas of the state. The state tracks utilization as a part of their integrated crisis reporting.

Massachusetts- Community Based Acute Treatment and Stabilization, Assessment, and Rapid Reintegration

Massachusetts provides two options for children experiencing a mental health crisis: Community Based Acute Treatment (CBAT), and Stabilization, Assessment, and Rapid Reintegration (STARR). The first option serves children/youth up to age 20 with serious mental health disorders who require a 24 hour/ 7 day staff- secure treatment setting. Services are provided according to age ranges of 6- 12 and 13 – 20 on separate units. It provides short-term crisis stabilization, therapeutic intervention, and specialized programming, 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. Acute therapeutic services include: assessment; monitoring and treatment; nursing; individual, group, and family therapy; care coordination; family consultation; and discharge planning. The program is staffed by a program director, nursing staff, and a multidisciplinary team.

The STARR program serves children/youth up to age 18 needing urgent temporary placement and/or stabilization services, in order to effect reunification or to provide or arrange for assessments to inform future placement decisions. Services are provided for up to 45 days. Youth are referred from a variety of settings, including home, residential programs, or hospitals. Services provided are safety screening, assessment, family therapy, short-term solution focused mediation, and crisis intervention, individual, and group therapy. Staffing is provided by a program director and mental health professionals. The programs are funded through a Medicaid waiver.

The CBAT and STARR programs differ in the intensity of the onsite services provided and the intervention goals. CBAT programs are designed and staffed to provide intensive services. STARR programs are designed for rapid assessment and stabilization with family reunification as the primary goal. Recommendations and referrals are made as needed for further assessment, testing and services.

Montana- Missoula County Youth Crisis Diversion Project

Montana's Children's Mental Health Bureau provides five two-year grants to deliver children's mental health crisis services across the state, with Missoula County operating one of the models. Missoula's program goal is to divert children from higher levels of care and calls are routed to a crisis facilitator through the county hospital. The facilitator assesses the need for services and can refer to two shelters, with crisis beds available. Children ages 0-18 are eligible and can stay up to 14 days. The crisis facilitator coordinates with other community providers and there have been challenges in finding services for children under 12, or accessing more intensive services within the

community. Because the grant is only two years, there are also concerns about sustainability.

New Jersey- Emergency Diagnostic Reception Unit and Stabilization and Assessment Services

New Jersey's Emergency Diagnostic Reception Units (EDRUs) developed out of their child welfare system, but now operates under the Department of Children and Families and the state Medicaid plan. The program serves children ages 12-17 and can go up to age 18 with a waiver. New Jersey is currently undergoing plans to expand the program to ages 5-12. The program offers assessment, stabilization, and skills building. The goals of the program are to provide children with new coping skills, lessen their risk of hospitalization, and reconnect the child with education. The program is accessed through child welfare or case management approval and thus can only be accessed during business hours, although the goal is access within 24 hours. Currently, there are two sites with fourteen beds available for the entire state. There is a separate program for children with developmental disabilities that provides a longer treatment period, immediate access, and separate facilities for younger and older children. The program operates in two sites: one is a facility connected to a shelter and the other is connected to a group home. The program is 30 days with two- fifteen day extensions, however many children stay longer and the average stay is around 50 days. Staffing is provided by a licensed behavioral clinician and a nurse. Outcomes are evaluated by tracking length of stay, the CANS assessment, and strengths and needs assessments. The program has seen success in stabilizing children and discharging them back to the community.

North Carolina- Facility-Based Crisis Service

North Carolina is in the planning stages of creating Facility-Based Crisis Service for children and adolescents that provides an alternative to hospitalization for an eligible individual who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility with 16 beds or less. Facility-Based Crisis Service is a direct and indirect, intensive short-term, medically supervised service provided in a physically secure setting, that is available 24 hours a day, seven (7) days a week, 365 days a year. Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations. State funds cannot cover Facility-Based Crisis Service delivered to a child or adolescent stepping down from an inpatient level of care including a psychiatric residential treatment facility. Providers have to bill third parties such as Medicaid before billing for state grant funds.

Washington- King County Children's Crisis Outreach Response System (CCORS)

Washington's King County developed a wraparound crisis services model starting 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. While the program is currently open to children up to age 18, the county plans to expand eligibility to young adults, ages 18-24 due to a need in the community for more options for this population. The crisis team is available 24/7 and responds to a family within 2 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. There are 5 beds available in the county, with options for more if needed. The stabilization beds are available from 72 hours to 14 days, with an average length of stay of 3-5 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. The program is paid for through a combination of state and local funding and does not bill utilizers. The program has faced challenges in serving the more rural areas of the county and maintaining staffing and will confront issues concerning funding as the state develops new models for administering mental health services.

Other Models

Age Range	Primarily 12-18, with many states expanding to serve younger children and young adults
Length of Stay	Most programs provide up to two weeks, and all provide extensions for longer stays, if needed. Average stays range from two to fifty days and are most strongly related to referral options post-discharge
Funding	Programs are funded by a range of options, primarily through Medicaid, commercial insurance billing, and state grants
Setting	Most programs co-located with other residential services
Services	Most programs provide stabilization, screening, therapy, family support and education, school linkages, medication management, and coordination with other community based services
Challenges	Most programs have had to increase capacity, accelerate access, and add flexibility in length of stay and ages served. Programs have also had challenges related to funding sustainability, if not covered by state dollars.

Capacity Needs and Geographic Distribution

While crisis residential services are still a relatively new option for adults in Minnesota, the state's mobile crisis teams now track how many individuals are referred to that treatment setting after a crisis team response. A review of the state's mobile crisis data shows that about 7% of adults are referred to a crisis bed under the current system. Mobile crisis data for youth, indicate about 20% of nearly 4,000 annual mobile crisis utilizers are referred to the emergency room, a homeless shelter, a residential facility, emergency foster care, or elsewhere.

The Minnesota Hospital Association (MHA) has tracked emergency department visits for mental health needs and found a significant increase in hospital visits among this

population over the past ten years. MHA data indicates nearly 20,000 children/youth visits to the emergency room for mental health reasons in 2016, up from under 10,000 such visits in 2007.

For a child and adolescent population that might better predict the numbers of Minnesota youth who might require a crisis residential program, Maine has tracked the number of children referred to a crisis bed from their mobile crisis responders. In the last several years, Maine's reported referral rate has been between 14 and 16.5% for those under 18 years of age.²⁹

Funding of Crisis Residential Services

One purpose of the study is to develop funding recommendations that will allow for timely access without requiring county authorization or placement of a child in child welfare. As the review of other states illustrates, states use a variety of funding mechanisms to pay for child, adolescent, and young adult crisis residential services. The goal of the financing plan for children's crisis residential services is to identify and use all potential funding sources in Minnesota for crisis residential services. Another goal is to use federal funding mechanisms to the extent possible (e.g., Medicaid, IV-E Waiver funds for children in the dependency system). The funding sources that we have identified include Medicaid for those children, youth, and young adults who are Medicaid eligible; mental health general revenue funds and/or block grant funds; child welfare and juvenile justice general revenue funds for youth in these systems, commercial insurance plans and self-pay.

The review of other states conducted for this report as well as a recent SAMHSA Report on crisis services, indicate that other states use Medicaid for psychiatric emergency services including crisis residential programs; our recommendation is that Minnesota use Medicaid for funding the total cost of crisis residential services if the child, adolescent or young adult is Medicaid eligible.

Medicaid services to meet mental health needs may be covered under several service categories under section 1905(a) of the Social Security Act: Psychiatric Rehabilitation Option: An option that incorporates rehabilitative, community-based services to persons with psychiatric and co-occurring psychiatric-substance abuse problems. Services that the rehabilitation option cover may include crisis management services, targeted case management, or peer supports. Section 1115 Research and Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Section 1915(i)---Home and Community Based Services State Plan option, permits states to provide a full array of home and community-based services to individuals whether or not they qualify for an institutional level of care, as long as they

²⁹ Maine Department of Health and Human Services, Integrated Crisis Report, May 2016. Available online at http://www.maine.gov/dhhs/samhs/mentalhealth/consent_decree/May-2016/Section12-Integrated_Crisis_Report_QTR3_FY16%20final.pdf accessed on March 20, 2017.

have significant need including mental health and substance use disorders. Regarding Medicaid coverage for the crisis residential services, one option is to add this service under the Psychiatric Rehabilitation Option, however this option would require a state grant to cover room and board. The state could also explore a Section 1915(i) waiver.

Another option would be to utilize the funding mechanism used for other state residential programs. The Social Security Amendments of 1972 amended the Medicaid statute to allow States the option of covering inpatient psychiatric hospital services for individuals under age 21. Originally the statute required that the psych under 21 be provided by psychiatric hospitals. OBRA 1990 provided authority for CMS to specify inpatient settings in addition to the psychiatric hospital setting. In 2001, CMS established PRTFs as a new category of Medicaid facility, and as an additional setting for which the psych under 21 benefit can be provided. Psychiatric services include certification of need for the services, active treatment, components of an individual plan of care, and the team involved in developing the plan of care. Services must be provided before the individual reaches 21, or if the individual was receiving services just prior to turning 21, the services must cease either when the individual no longer requires services or when the individual reaches 22 years of age.

Payment for inpatient psychiatric services to individuals under age 21 includes the need for room and board as well as the provision of a comprehensive package of services.

Other federal funding mechanisms, such as IV-E waiver funds or an HCBS waiver are not advised for this model, as it is not a child welfare placement and there are significant challenges to waiver applications and implementation, which would create uncertainty about their feasibility.

For children, youth, and young adults who are not Medicaid eligible and not covered by a commercial health insurance plan, we recommend the use of a combination of mental health general revenue funds and block grant dollars. The Substance Abuse and Mental Health Services Administration awards formula-based Mental Health Block Grants to states. There is significant flexibility for states to decide how these funds are used. States use block grant funds for treatment, recovery supports, prevention and other services that Medicaid does not cover in a state.

Finally, for children whose families have coverage by commercial insurers, Minnesota's mandated coverage of residential treatment provides assurance that this level of care would be covered by policies governed by Minnesota law. Self-insured plans would be governed by the Affordable Care Act and federal mental health parity law, particularly non-quantitative treatment limits.

Another financing decision is setting the per diem rate. In most states, the per diem for child and adolescent crisis units is the same as for adult crisis units. Since Minnesota has a per diem rate for adult crisis units, this rate should be reviewed and a decision made about its feasibility. In most states providers of crisis services negotiate individual rates with Medicaid managed care plans and other payers; the 2017 rates for treatment

costs for Minnesota's adult crisis services range from \$386 to \$653, not including room and board costs. These rates are based on costs of services and occupancy rates.

Another component of the funding model is the quality assurance mechanisms that should be in place. These mechanisms include criteria for continued eligibility for stays over a certain length of time. In most states, Medicaid managed care plans closely monitor crisis stabilization stays over 3-5 days, require periodic reviews of continued medical necessity for this level of care, and set annual limits of service use. The length of stay should be based on the needs of the child recognizing some with more chronic or acute conditions will require greater flexibility to complete appropriate assessments, adjust to medication changes, and facilitate transition planning.

Discharge planning is another critical performance area for crisis stabilization units. Research has shown that crisis stabilization units can be revolving doors if appropriate discharge planning services are not offered by the crisis unit. HEDIS measures require linkages to after care services within 7 calendar days of discharge from crisis stabilization units and psychiatric inpatient units. Some Medicaid managed care plans are tracking whether children, youth, and young adults and their families receive appropriate services after discharge, such as outpatient treatment services and in-home support services. Some plans also are offering fiscal incentives for providers who achieve positive outcomes, such as reductions in recidivism. Planning for the crisis stabilization services should consider what will be the local accountable care entity that will monitor and track performance indicators such as lengths of stay, linkages with after care services, and recidivism rates. These indicators should also be tracked by race/ethnicity to ensure cultural competence in the delivery of services.

The establishment of crisis residential services in Minnesota will require the use of all potential funding sources, including federal funding mechanisms such as Medicaid and Mental Health Block Grant funds as well as commercial health plan coverage. As shown in the table below, there are several federal options, but only one that meets both criteria of allowing for timely access without requiring county authorization or child welfare placement and covers both treatment and room and board. While expanding Medicaid Inpatient Psychiatric Services, under age 21 would meet these criteria, it would have the added requirement of being provided under a physician's direction. If the Rehab option is pursued without coverage for room and board, there would need to be a state appropriation to cover the housing component.

Advantages and Disadvantages of Four Financing Mechanisms for Supporting Child Crisis Residential Treatment

Funding Mechanism	Advantages	Disadvantages
Expanding Medicaid rehabilitation option	Offers states opportunities to include certain types of intensive home and community-based mental health services into state plan coverage Services available to all Medicaid beneficiaries, not just subgroups	Only covers treatment options, not room and board
Expanding Medicaid Inpatient Psychiatric Services, under age 21	Covers treatment and room and board	Must be provided under a physician's direction
HCBS waiver	Allows states to provide intensive services not covered in state plan Waives parental deeming requirements Waives statewide requirements Promotes increase in number of providers offering intensive home and community based services Gives states experience in pricing intensive services and individual care plans	Application development and waiver implementation can be challenging. Does not support preventive or step-down services. Does little to reduce geographic disparities within state.
IV-E Waiver funds	Currently used to fund room and board in foster care (including RTCs)	Limited eligibility and approval process too long to meet crisis needs

Recommendations

The work group offers the following recommendations for funding and implementing children's mental health crisis residential services that allow for timely access without requiring county authorization or child welfare placement. In general, the work group kept recommendations at a high level, acknowledging the need for services to be client specific and based on the purpose of the crisis response. The work group recognized the need to improve mental health screening processes within the entire children's mental health system to enhance the ability to evaluate outcomes, support care transitions, and increase access to the appropriate level of care. Establishing a new level of care within the state should provide an opportunity to strengthen the entire continuum of care. Pending legislation regarding crisis services should also be taken into consideration as this level of care is established.³⁰

The Department of Human Services should contract with providers, similar to the process for establishing PRTFs. The Department should issue an RFP that takes into consideration: Capacity needs, regional resources, target population, and treatment standards.

Target Population and Eligibility-

Children, adolescents, and young adults ages 5 to 21 with urgent mental health needs that can't be adequately addressed or stabilized in the child's living environment where the child is a danger to themselves or others and requiring emergency admission to temporary stabilization services, or more intensive services to reduce the risk of hospitalization or other out of home residential treatment.

Children, youth, and young adults ages 5 to 21 would be eligible for this level of service and each facility could determine the age group it can best serve based on service model, or licensing standards required to serve particular age groups. Providers for this level of service would need to demonstrate how they would address the unique developmental needs and vulnerability of different ages within their facility. The work group also recognizes the need for more short-term crisis residence options for young adults ages 18-24 that are appropriate to this unique developmental stage.

The Department should consider a separate program for children with acute mental health care needs who do not have the ability to benefit from traditional mental health services due to a developmental or intellectual disability.

Length of stay-

³⁰ MN State Legislature, SF 1291, Reg. Session 2017- 2018 (2017). Available online at: https://www.revisor.mn.gov/bills/text.php?version=latest&session=ls90&number=SF1291&session_year=2017&session_number=0

Provide crisis residential services for children and adolescents. Length of stay would be based on medical necessity. While intended to be a short-term stabilization, the actual length of stay should be governed by the needs of the family rather than an arbitrary limit. Based on the review of other state models, Minnesota's adult crisis homes, and the needs identified by families and stakeholders, having the length of stay determined by the unique needs of the child and family will be essential to provide appropriate and effective mental health crisis treatment. While most children would likely only require several days in crisis residential treatment, some with more chronic or acute conditions will require greater flexibility to complete appropriate assessments, adjust to medication changes, and facilitate transition planning.

Setting-

Providers of this level of service should be certified and contracted through the state. Setting type should be flexible based on the region's available resources and population needs. Multiple options, depending on area- Dedicated beds in RTC facilities OR Foster or group home beds for crisis needs OR Dedicated stand-alone facility for youth mental health residential crisis services, or attached to or adjacent to a hospital. Consideration of area resources, regional need and practical implementation need to be taken into account in establishing these settings. As PRTFs develop, the state could also explore using dedicated beds in PRTF facilities in situations meeting eligibility criteria and federal regulatory requirements. The state should take into account geographic resources, distance to the nearest available inpatient bed, and the results of the IMD study when considering this option. The state should also study the experiences of other states providing emergency access to PRTF facilities as potential models for using this option. Kansas, Kentucky, and North Dakota all provide emergency access for a limited time to their PRTF facilities, under certain conditions, such as certifying the need and making a determination of whether available community resources could meet the individual's needs. Under federal law³¹, planned PRTF admissions require the approval of an independent approval agency, emergency admissions can occur with the assessment and approval process of the PRTF and then may be transferred for further approval by the independent agency. This may require special approval by CMS but may provide the level of supervision and intervention necessary for this service.

Access and Authorization Authority-

With a goal of 24/7 availability/access, assessment/ screening would be made by mobile crisis staff, crisis center staff, ER/hospital staff, or other qualified professional. Crisis Residential Services optimally would have the capacity to admit and discharge 24/7, 365 days per year. Other state's models do not consistently require this capacity

³¹ (According to federal Chapter IV- Centers for Medicare & Medicaid Services, Department of Health and Human Services Part 441_ Services: Subpart D Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs Sec. 441.153 Team certifying need for services. (c) For emergency admissions, the certification must be made by the team responsible for the plan of care (Sec. 441.156) within 14 days after admission.)

and this may be beyond the capacity of Minnesota providers given the workforce shortages many regions are experiencing, however, timely access should be the goal.

Services/ Level of Service-

Services would be client specific and based on the purpose of the crisis response. As with the adult crisis stabilization services, children's crisis stabilization services must be provided by qualified staff and meet standards outlined in statute to include a crisis stabilization treatment plan, assessment, help with referrals, supportive counseling, skills training, and collaboration with other service providers in the community.³²

To meet the unique developmental needs of children and youth, assessment should be a critical component of this model and be comprehensive to include: mental, physical and developmental assessments by a pediatrician; family resources; school performance/learning-related concerns; social functioning; and trauma. Other services provided should include: Crisis stabilization, safety planning, therapeutic intervention, culturally appropriate family support (parenting resources and education) as well as means restriction education, medication management (tele-psychiatry allowed), referral for specialty assessment, crisis planning, connection to community services/ resources, post- discharge follow up, and peer support for parents. An educational component and school linkages should also be included as a part of the array of services to assist with the successful transition back to the child's community.

Discharge/Transition Support-

Providers of this level of service would need to coordinate services with community providers to help with the transition back to the community. Providers should deliver a full array of transition support and services, have a MOU with another organization who can provide transition support, or operate under a Certified Community Behavioral Health Clinic, with the necessary resources available to offer transition assistance. Standards for this level of service's transition support should include: A follow-up appointment with a provider of mental health services within seven calendar days post-discharge; Within 72 hours of transition, a crisis provider should contact the child and their family to review the transition plan and address any new concerns or questions; Facilitating the connection to the child's care providers and/or support network; and Medication reconciliation.

Staffing-

This model should be staffed by a multidisciplinary team, including a mental health professional program director, nursing access, medication management and prescriber access, health care navigator, family peer specialists, and others necessary to provide services.

³² Laws of Minnesota, 2016, Chapter 256B, section 256B.0624.

Staff Ratios-

The license holder should provide enough appropriately trained staff to ensure that a resident will have the treatment needs identified in the resident's individual crisis plan of care met during the resident's stay in the facility.

The license holder should have access to nursing 24 hours a day, 7 days a week.

The license holder should have the capacity to promptly and appropriately respond to emergent needs of the residents and make any necessary staffing adjustments to assure the health and safety of residents. Within 30 minutes, treatment staff should have access in person or by telephone to a licensed mental health professional. The license holder must maintain a schedule of the licensed mental health professionals who will be available and a means to reach them. The schedule should be current and readily available to staff.

School Linkages-

This level of service should be classified as care and treatment, for purposes of education. Arrangements to provide educational services should be made between providers of the service and the school district, based on the needs of the child and the length of service.

Licensing and Certification-

Licensing for this level of service could be modeled or adapted from existing sources, including Minnesota Rules chapter 2960, adult residential crisis (256B.0624), Intensive Residential Treatment Services or IRTS (256B.0622) as well as models from other states. DHS is currently undertaking a significant review of certification and licensing standards, in an attempt to align and clarify service standards across the continuum. This project is currently intended to encompass the standards for IRTS and crisis residential for adults. In conversation with stakeholders, DHS should consider Children's Crisis Residential as part of this process.

Evaluation/ Outcomes Tracking-

Oversight should be provided through a central tracking system. Tracking outcomes and utilization at the state level is especially important to identify trends, successes, challenges, and access throughout the state. This level of service would be evaluated by tracking utilization, length of stay, time to access service, referral source, disposition, family satisfaction, diversion from higher levels of care, readmissions within 30 days, family reunification, and a 30-day follow-up with the family on how they were able to connect to community supports. There are several available tools that could also be used to monitor outcomes and facilitate quality improvement, including The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment and The Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Capacity and Geographic Distribution-

To satisfy need for this level of service, there should be 150 beds across 10-15 sites throughout the state. Facility size- 8 – 10 beds. Ideally a site would be within one hour from any location within the state. *Analyzing crisis teams and hospital data to estimate need.

Funding-

This level of service should be covered under state Medicaid and private health plans.

Use all potential funding sources for crisis residential services, including federal funding mechanisms such as Medicaid and Mental Health Block Grant funds to the extent possible. For users who are Medicaid eligible, add crisis residential services under Minnesota's Rehabilitation Option along with a state appropriation to cover the housing component. Another option is expanding Medicaid Inpatient Psychiatric Services, under age 21, which would cover both treatment and housing components. If these options are not possible, explore the use of a Section 1915(i)---Home and Community Based Services State Plan option. For users who are not covered by Medicaid or commercial health plans, use a combination of Mental Health Block Grant Funds and Mental Health general revenue funds. Under state law, commercial health plans in Minnesota are required to cover residential treatment. Crisis residential services should be reimbursed in accordance with this requirement.

Conclusion

While there are needs for building capacity and improving care throughout the continuum of Minnesota's children's mental health services, the state has a significant gap in caring for children with urgent mental health needs in a short-term residential setting. Hospitalization is not always appropriate for this population, but they may require more support and resources than are available at home. Residential treatment at a RTC does not typically provide urgent access and usually results in a much longer length of stay than is necessary for families experiencing a crisis. Crisis residential care provides an urgent response, at the appropriate level of care, and at significantly less cost than hospitalization. Children are provided a healing environment, connected to their families and communities, with less disruption and improved connections to other care providers who can assist the transition home and to other community supports. Families experiencing a child's mental health crisis should be able to access the appropriate level of care for their needs, at the time it is needed.

Crisis stabilization beds are a critical component to divert youth from higher levels of care, deliver essential screening and treatment, and provide timely intervention. Short-term crisis residential models are uniquely designed to meet these needs. The current literature demonstrates that crisis residential care is effective at reducing symptoms and functioning at lower cost than traditional inpatient care. Importantly, research has found that resources invested in mental health crisis stabilization services provide a significant benefit, with a return of \$2.16 dollars for every dollar invested.

Families experiencing a child's mental health crisis should be able to access the appropriate level of care for their needs, at the time it is needed. In depth interviews and survey data from Minnesota families and providers as well as an examination of models operating in other states revealed important information about how to implement a Minnesota model of children's crisis residential services.

Minnesota should resolve the gap in mental health services for children and adolescents by creating a new level of service for children, adolescents, and young adults with urgent mental health needs requiring rapid admission to temporary stabilization services, or more intensive services to reduce the risk of hospitalization or other longer term residential treatment.

Appendix A: Work Group Members

Representatives from a wide array of organizations were invited to participate in the work group. NAMI Minnesota and ASPIRE MN thank the individuals listed below for their participation. Recommendations in this report reflect the views of individual work group members and not necessarily the organizations that employ them. Meeting minutes from all work group meetings held between October 2016 and May 2017 attached in separate document.

- Ben Ashley-Wurtmann, Minnesota Department of Human Services
- Angie Baratto, Healing Foundations
- Ginnee Engberg, People Inc.
- Willie Garrett, MN Association of Black Psychologists
- Linda Hall, Ramsey County
- Paula Halverson, Minnesota Department of Human Services
- Connie Hayes, Intermediate School District 916
- Margaret Hayes, Wilder
- Angie Hirsch, Minnesota Department of Human Services
- Keith Kozerski, Catholic Charities
- Kristin Loncorich, MHA
- Karen Meyering, Woodland Centers
- Jessi Oliver Tebben, Parent
- Kay Pitkin, Hennepin County
- Mike Poindexter, People Inc.
- Deborah Saxhaug, MACMH
- Cynthia Slowiak, Hennepin County
- Kim Stokes, Virginia School Board, Iron Range Youth Behavioral Health Task Force
- Nelly Torori, Minnesota Department of Human Services
- Karen Wendt, Fairview Behavioral Services
- Brandi Worrath, Healing Foundations

NAMI Minnesota and AspireMN staff involved in the work group and/or the preparation of this report included Sue Abderholden, Mary Regan, Kirsten Anderson, Lynn Sando, Sam Smith, and Hannah Fairman. Mary Armstrong from the University of South Florida contributed to the section on funding models.

Appendix B: Research Questions

	National/ State Organizations	Providers	Families
Current Barriers/ Challenges	<ul style="list-style-type: none"> What are the current barriers/ challenges to providing/accessing needed services? 	<ul style="list-style-type: none"> What are the current barriers/ challenges to providing needed services? 	<ul style="list-style-type: none"> What are the current barriers/ challenges to accessing needed services? What have you needed in the past and didn't have?
Target Population	<ul style="list-style-type: none"> What population does the program serve? (Diagnosis, age, level of need, etc.) What are the admission/eligibility criteria? Is it accessible throughout the whole state? What is the geographic distribution? What barriers have the target population faced in accessing the program? What's the typical length of stay? Is there a maximum number of days? Who admits the child? Do they have to be medically cleared through an ED? How is program set up to serve wide range of ages/needs? 	<ul style="list-style-type: none"> What population should the program serve? (Diagnosis, age, level of need, etc.) What should be the admission/eligibility criteria? How to make accessible throughout the whole state? How to ensure potential barriers are resolved for the target population to access the program? 	<ul style="list-style-type: none"> What population should the program serve? (Diagnosis, age, level of need, etc.) What level of service is needed? What should be the admission/eligibility criteria? How to make accessible throughout the whole state? How to ensure potential barriers are resolved for the target population to access the program?
Best Practices	<ul style="list-style-type: none"> What models are operating in other states? What are the treatment standards? What are the funding models? (Accessible through state or private coverage?) 		

	<ul style="list-style-type: none"> • How are they staffed? (Qualifications?) • Collaborations/ partnerships? • How does it fit into the system of care? • How coordinated with education/schools? • Characteristics of children served? • Admission/eligibility criteria? Access points? • Work outside of child welfare system? • How quickly is treatment accessed/authorized ? • Length of treatment? • What organizations operate programs? (public/private?) • How are they licensed/accredited? • How large are they? • Geographic variation? How accessible in rural areas? • How does the program fit into the health care continuum? • What kind of family supports/services are available? 		
Operations	<ul style="list-style-type: none"> • What do they call the program? (What language used to describe services?) • What organizations operate the program? • What are the treatment standards? Core components of the program? • What are the licensing standards? • How are outcomes measured? Quality evaluated? 	<ul style="list-style-type: none"> • What organizations would operate the program? • What should be the treatment standards? Core components of the program? • What should be the licensing standards? • How would outcomes be 	<ul style="list-style-type: none"> • What organizations could operate the program? • What should be the treatment standards? Core components of the program? • What should be the licensing standards? • How would outcomes be

	<ul style="list-style-type: none"> • How is the program staffed? • How are they connected with other services? How is care coordinated? • How are they coordinating with crisis teams? • How do they coordinate with education? • What challenges have the program faced in operating? • Policy on use of seclusion and restraints? • Transportation provided? 	<p>measured? Quality evaluated?</p> <ul style="list-style-type: none"> • How would the program be staffed? • How would the program connect with other services? How would care be coordinated? 	<p>measured? Quality evaluated?</p> <ul style="list-style-type: none"> • How would the program be staffed? • How would the program connect with other services? How would care be coordinated? • How could the family be involved in treatment/transition planning? What kind of family services/after care services would be helpful?
Funding	<ul style="list-style-type: none"> • How is it funded? • Is it covered under state plans? (If so, how prescriptive?) • Commercial plans? • Other coverage? • Who provides authorization authority? • What challenges present in the funding model? • How much is being spent on this program as compared to costs with emergency room or other costs? 	<ul style="list-style-type: none"> • How should it be funded? • Coverage under state plans? (And how prescriptive should it be?) • Commercial plans? • Other coverage or funding sources? • Who would provide authorization authority? 	<ul style="list-style-type: none"> • How can the program be financially accessible? • What insurance coverage do you have now?

Appendix C: Survey and Interview Questions

[Survey questions provided in separate attachment]

Appendix D: Stakeholders, Organizations, and Families Surveyed and Interviewed

Organizations interviewed- NAMI (National Alliance on Mental Illness-

NAMI National office), National Organization of State Associations for Children (NOSAC), National Council on Behavioral Health, Joint Commission, The Council on

Accreditation, New York State Office of Mental Health, Providers of emergency shelter services for homeless youth, and The Behavioral Health Committee of the MN Council of Health Plans

Other State Programs Interviewed- Connecticut, Georgia, Maine, Massachusetts, Montana, New Jersey, Washington

Provider Survey- The provider survey was conducted from December 2016 through February 2017 through Survey Monkey and distributed to a diverse group of providers through NAMI MN, AspireMN, and work group networks. The provider survey had 88 responses, with a mix of outpatient, inpatient, crisis services, case management, and school based mental health providers.

Providers Surveyed

Inpatient	7.1%
Residential Treatment	13.1%
Group home	3.6%
Foster Care	6.0%
CTSS/Day Treatment	16.7%
OutPatient	34.5%
Juvenile Detention	3.6%
Temporary Shelter	6.0%
Other (please specify)	47.6%
Other responses:	
Crisis services	9
Case Management	10
School based mental health	6

Provider Focus Group- A focus group was conducted in March 2017 with 28 providers representing 8 organizations* with a statewide scope of practice representing the full continuum of care for children's mental health (with the exclusion of hospitalization).

(*9 outpatient providers, 6 residential treatment providers, 8 foster care providers, 5 short term diagnostic evaluation residential providers).

Family Survey- The family survey was conducted from December 2016 through February 2017 through Survey Monkey and distributed to a wide range of families throughout the state through NAMI MN and work group networks. The family survey had 210 responses, with both online and written responses. The majority of respondents were parents of children ranging from age 11-18. Most written comments described suicidal and aggressive behaviors and seeking help from law enforcement or the emergency room. 60% of respondents sought help from an emergency room during a past crisis.

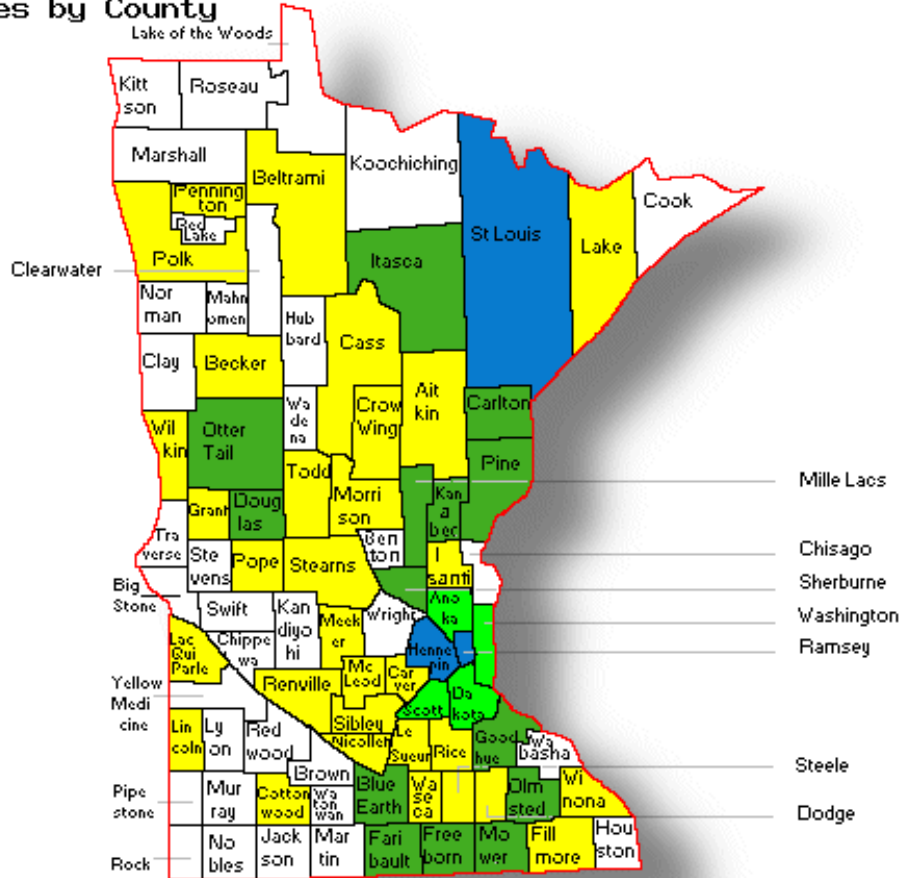
Targeted outreach to minority communities was conducted by disseminating the survey web link to a wide network, as well as providing paper surveys to clinics serving communities of color. Responding families identified as about 10% Hispanic, 10% Two

or more races, 4% African American, 4% Native American, 8.5% LGBTQ. Family responses were also broken down by county and showed responses from every corner of the state. Most families had insurance coverage through an employer or Medical Assistance (or both).

Survey Demographics

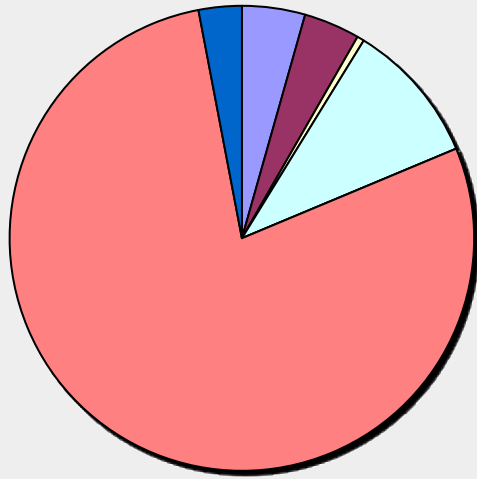
Survey Responses by County

- - 15+ responses
- - 7-14
- - 3-6
- - 1-2



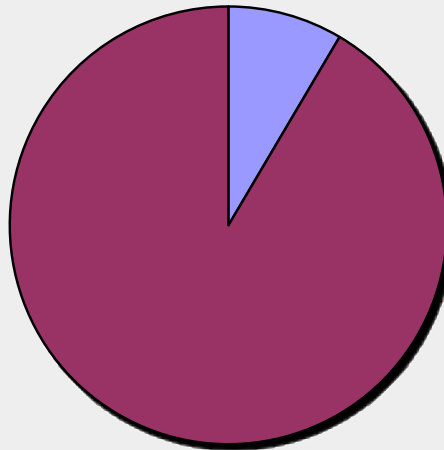
Source: diymaps.net (c)

How does the child living with mental illness identify?



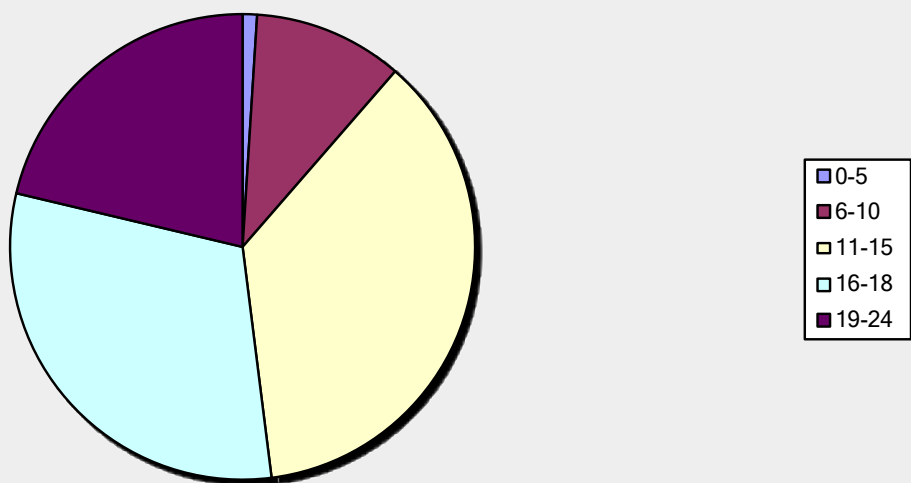
- African American or Black
- Alaska Native or American Indian
- Asian
- Two or more races
- Native Hawaiian or Other Pacific Islander
- Caucasian/ White
- Other (please specify)

Does the child identify as LGBTQ (Lesbian, Gay, Bisexual, Transgender and/or Queer)?



- Yes
- No

What is the age of the child living with a mental illness?



Family Interviews- Family interviews were conducted in February and March, 2017 with families identified through the survey for follow-up or through stakeholder outreach. 10 families were interviewed, with children ages 9-20 years old. Interviews were conducted with biological, adoptive, and step parents. Families described crisis experiences related to children with suicidal and aggressive behavioral concerns. All families had sought help at a hospital or through law enforcement.

Targeted outreach to diverse families resulted in feedback from 7 families with children from minority communities, in terms of race, ethnicity, and LGBTQ identity. Families from urban, suburban and rural areas were interviewed to ensure geographic representation.