Appendix D-3: CEDCS Recommendations

CHILDREN'S EMERGENCY DETENTION AND CRISIS STABILIZATION WORKGROUP: RECOMMENDATIONS TABLE

Crisis Prevention	Crisis Intervention/Stabilization
Coordination	
Build and maintain relationships with schools and private insurers. Encourage MOUs with schools and health systems to identify and connect at-risk youth to services. County representatives noted that many crisis cases were unknown to them because they came from private providers/insurers.	**Coordinate internal efforts to free up staff resources.** Encourage county use of NIATx or similar quality improvement process to improve internal process (ex: Jefferson, Rock).
Promote and maintain linkages between tribal crisis and mental health services and county crisis and mental health services.	**Coordinate regional or statewide efforts to maximize use of resources.** Investigate what functions can be effectively regionalized or even handled at the state level. Ex: call centers, centralized psych bed coordination system.
Promote and maintain linkages between crisis services and Coordinated Service Teams and Comprehensive Services programming. Strong collaboration will ensure that crisis plans are available to every member of the youth/families' support team.	Meet with hospital associations/hospital administrators to address the perception that hospitals have adopted new policies which make it increasingly difficult to **admit a youth on a voluntary basis.**
Training	
Introduce information about the Adverse Childhood Experience Study and **trauma-informed care** to anyone who touches the life of a child. Provide **simple sensory de-escalation strategies** and information about **Wellness Recovery Action Plans (WRAP) plans** for providers, youth and families.	**Crisis Intervention Team (CIT) trainings for law enforcement.** This specialized training provides officers with information about mental health issues, reduces risks of injuries to consumers and officers, enhances working relationships with mental health providers, increases family involvement and reduces the need for more costly services.
Provide stakeholders with information about the **CST approach and CCS service array and approaches to suicide prevention**.	**Establish training protocol for crisis staff, school liason officers, school staff, corporation council and other stakeholders.** The training would focus on crisis assessments, de-escalation techniques, developing crisis plans, working with special populations (e.g., developmental disabilities, dementia patients), trauma informed care and cultural competency, working effectively with partners, identifying and addressing vicarious trauma and burnout.
Provide law makers, county supervisors, local leaders and businesses with information related to the **cost savings in investing in early intervention** versus youth crisis services and psychiatric hospitalizations.	**Train stakeholders (e.g., law enforcement, corporation council, schools, hospital staff) understand potential liability concerns so that EDs are not seen as a necessary default option.** In addition to concerns over legal liabilities, crisis workers express safety concerns over meeting youth in the home or community and limit contact to hospitals and police station. Training directed at reducing these concerns may increase successful crisis contact and planning.
Retain workforce by providing **training and support related to vicarious trauma through the development of Wellness Recovery Action Plans (WRAP) and reflective supervision**.	**Train service administrators on billing Medicaid for crisis intervention, stabilization, and related services.**
Access	
Incorporate specialized support into service array. Monitor the development of certification for Parent Peer Specialists and incorporate onto support teams. Occupational Therapists are often able to provide sensory strategies to be used for de-escalation.	**Establish out-of-home stabilization options (23-hours and/or motel model with parents on site) as well as in-home crisis stabilization services.** Explore potential for using Psychiatric Residential Treatment Facilities.
Review MA reimbursement rates and prior authorization practices for mental health screenings, assessments, and treatments with special attention to in-home, family-centered approaches.	**Partner with hospitals** to access voluntary youth psychiatric beds.
Plan respite using GPR or other funding source. Explore greater use of foster care options, group homes, family resource centers and Peer Run Respites, where available and applicable to age group.	**Provide mobile crisis services** to better meet youth and families 'where they are at'.