Implementation of the Crisis Now Model in Palm Beach County

Commissioned by the Health Care District of Palm Beach County

Health Care District
PALM BEACH COUNTY

initium
HEALTH

Executive Summary

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Executive Summary

Crisis care is an integral part of the behavioral health infrastructure, but in most of the United States, an immediate, appropriate response to these types of emergencies does not exist. Instead, people are subject to arrest, or find themselves spending days in hospital emergency rooms, without receiving treatment, waiting for a hospital inpatient psychiatric bed to become available.

A series of systemic shortcomings have inflicted deep wounds on our national identity and exposed alarming gaps in care provision. These deficiencies have persisted for decades, exacerbated by the deinstitutionalization movement and remaining largely unaddressed for the past 50 years.

Communities rely upon hospital emergency rooms, inpatient care, and jails for crisis response, with enormous costs for individuals, families and public systems. The National Guidelines for Behavioral Health Crisis Care, released by the Federal Substance Use and Mental Health Services Administration (SAMHSA), describe the crucial importance of a fully optimized regional crisis call center, mobile crisis teams, and crisis care facilities in meeting community needs. Palm Beach County's crisis care model faces multiple challenges that make it difficult to adhere to national guidelines, creating a heightened reliance on 911, law enforcement, and hospital emergency rooms for crisis care.

Unfortunately, these systems are not designed to respond to behavioral health crises, often leading to delays in care, frequent use of the most expensive resources, and undue burden on both individuals and public resources.

Additional challenges include:

- Lack of awareness of available resources such as the 988 Suicide and Crisis Lifeline
- Limited capacity of mobile crisis teams and crisis receiving and stabilization facilities
- Pervasive workforce shortages, making it difficult to provide optimal care
- Absence of a centralized entry point to services and limited data sharing among providers, creating additional complexities

Lastly, the current crisis care system relies significantly on involuntary mental health examinations as a mechanism for accessing facility-based care. Although an involuntary examination is a civil procedure, law enforcement is frequently involved, and the person in crisis is handcuffed and transported in a police car to a hospital or other receiving facility. This perpetuates the prevailing perception that there is a direct association between behavioral health crises and criminality. As a result of this process and perception, many community members are reluctant to engage with crisis services.

Despite these challenges, there is a notable commitment across Palm Beach County to provide publicly-funded behavioral health services, in addition to a willingness among providers to collaborate.

Recent state, regional and county initiatives provide further support for improving crisis care, creating a favorable environment for change. For example, in October 2023, the state Commission on Mental Health and Substance Use Disorder Subcommittee System of Care Subcommittee presented Suicide Prevention Recommendations for bringing crisis care in Florida into alignment with the National Guidelines.

Based on our assessment, the feasibility of transforming the crisis care continuum in Palm Beach County into a modern system aligned with National Guidelines is dependent on four primary factors:

1. Raising awareness of crisis services and developing trust across diverse Palm Beach County communities
2. Developing effective partnerships to work collaboratively with existing systems and providers
3. Establishing the infrastructure needed to coordinate care across the continuum, including an accountable governance structure, robust technology, and real-time data sharing
4. Securing the resources required to develop new services and facilities

This report details the current state of crisis care in Palm Beach County, evaluates the current state in light of the National Guidelines for Behavioral Health Crisis Care (National Guidelines) and provides recommendations to address these factors and increase the availability of high quality crisis care throughout the county.

Recommendations

Someone to Call: Regional Crisis Call Center

1. Build upon current infrastructure to develop a regional crisis call center aligned with the National Guidelines.
2. Expand call center workforce to meet staffing needs and include clinical supervision.
3. Invest in technology that allows the regional crisis call center to improve service delivery and accessibility, and enhance the interactions between callers, staff, mobile response teams (MRTs), and providers.
4. Develop partnerships with 911 Public Safety Answering Points (PSAPs) to divert behavioral health crisis calls from 911 to 988.
5. Conduct a public marketing campaign to raise awareness of the 988 Suicide and Crisis Lifeline and its purpose.
6. Advocate for increased funding for the 988 Suicide and Crisis Lifeline in Florida.

Someone to Respond: Mobile Crisis Teams

1. Increase the number of mobile response teams (MRTs) in Palm Beach County in alignment with national standards.
2. Align MRT composition, training, and operations with the National Guidelines.
3. Collaborate with law enforcement, EMS, and existing field-based programs to enhance the effectiveness of mobile crisis teams for timely and coordinated responses, and to reduce unnecessary law enforcement involvement.

Somewhere to Go: Crisis Receiving and Stabilization Facilities

1. Increase the number of crisis receiving chairs and short-term crisis beds by developing a crisis receiving and stabilization facility to provide services for children, youth, and adults, including 23-hour observation, addiction receiving services, and short-term crisis stabilization.
2. Gain further insight into the functionality of the recent addition of crisis receiving chairs into the continuum of crisis care in Palm Beach County.
3. Enhance access to facility-based crisis care in Palm Beach County through collaboration.

[1]*Mobile Response Teams is the term used by the Florida Department of Children and Families to describe Mobile Crisis Teams as defined in the National Guidelines. For purposes of this report, these terms are used interchangeably.*

This report provides additional recommendations related to a crisis receiving and stabilization facility including design, regulatory, operational, and financial recommendations, along with workforce strategies. Guidance for crisis care for children and youth, outpatient care, rehabilitative services, essential principles, and accountability are also provided.

Successful implementation will require the coordination and cooperation of all parties involved in the delivery of behavioral health care in Palm Beach County. As an existing medical provider and a taxpayer-funded entity, the Health Care District is well positioned to leverage its resources to facilitate the implementation of the Crisis Now Model in Palm Beach County.

The Health Care District can serve as a convener to support accountability and data transparency and ensure sustainability.

By implementing the recommendations outlined in this report, Palm Beach County has the potential to create an optimal crisis care system, ensuring that individuals in crisis receive timely, effective, and compassionate care. This presents an ideal moment for the Health Care District to pursue transformative change by fostering collaboration, forming genuine partnerships, and securing a steadfast commitment from various stakeholders to establish an exemplary system of care.

Introduction

The Health Care District of Palm Beach County aims to establish an optimal system of care for individuals facing behavioral health crises in Palm Beach County. The term 'behavioral health crisis' refers to a mental health or substance use related situation requiring urgent intervention. The healthcare services needed are commonly referred to as 'crisis care.' Similar to physical health crises, having an emergency response that is available 24 hours a day/7 days a week (24/7) is crucial to ensuring optimal outcomes for individuals facing behavioral health crises.

The Health Care District of Palm Beach County is a political subdivision of the State of Florida established in 1988 as an independent taxing district by special law approved by Palm Beach County voters. The District's goal is to ensure access to a comprehensive health care system and the delivery of quality services for the residents of Palm Beach County. The Health Care District plays a pivotal role in providing health care services for individuals who are uninsured or underinsured. This unique position has provided the District with a firsthand view of the consequences arising from the absence of a fully-resourced, robust behavioral health crisis response system in Palm Beach County.

In view of the evident need, the Health Care District enlisted the expertise of Initium Health, a Denver-based consulting firm and public benefit corporation, to provide a feasibility study assessing the current state of crisis care, and strategies through which the Health Care District can develop optimal crisis services, including a crisis receiving and stabilization facility. This effort is well-aligned with the current direction of the Florida Commission on Mental Health and Substance Abuse, the purpose of which is to advise the legislature on behavioral health-related issues. During the August 2023 meeting, the System of Care Subcommittee recommended analyzing the current capacity of crisis response services and, "producing recommendations around the need for expansion of key services that address challenges, and reduce the need or use of deeper end/more costly services" (Commissioner Harris, 2023, slide 11).

Congress and various federal agencies have also recognized the need for a more robust continuum of crisis services and have developed incentives to promote crisis services. This includes the Consolidated Appropriations Act of 2023 which expands the continuum of crisis services and requires the Centers for Medicare and Medicaid Services (CMS), SAMHSA, and other federal partners to undertake major activities to identify, define, and underwrite these services (Consolidated Appropriations Act, 2022).

This report provides a comprehensive description of the current state of crisis services in Palm Beach County, along with recommendations for aligning these services with the National Guidelines. Additionally, this report provides recommendations for establishing a top-tier crisis receiving and stabilization facility in Palm Beach County.

Methodology

Initium Health was commissioned by the Health Care District of Palm Beach County to conduct a feasibility study for the development of a comprehensive crisis care strategy and crisis receiving facility. This methodology section outlines the structured approach that Initium Health followed during the course of this study.

STUDY OBJECTIVES

1. Conduct an assessment of current behavioral health crisis care infrastructure and ability to meet the current and future demand for services.

Initium Health initiated the feasibility study by conducting a comprehensive service gap analysis. This analysis aimed to identify the essential components required to create a complete continuum of care capable of delivering high-quality and accessible behavioral health services to the residents of Palm Beach County.

Collaborating closely with the Health Care District, we engaged in an in-depth stakeholder engagement process. This involved identifying and reaching out to key service providers, community organizations, and other stakeholders to gain insight into the local behavioral health landscape. Through structured interviews, we assessed the current system's capacity to meet the behavioral health service needs of the community.

Interviews were conducted virtually and in-person. These stakeholders included:

- Palm Beach County - administration and leaders of various county departments
- Hospitals and other healthcare providers
- Behavioral health service providers
- Law enforcement and first responders
- The managing entity, Southeast Florida Behavioral Health Network (SEFBHN), responsible for coordinating behavioral health services in the region
- The School District of Palm Beach County
- The local business community
- People with lived experiences in the behavioral health system
- Advocacy organizations with expertise in mental health and crisis care
- Foundations providing support and funding for mental health initiatives

We leveraged various data sources to develop a comprehensive scan of the behavioral health needs in Palm Beach County. These sources include county, state, and national resources, such as the National Survey on Drug Use and Health, County Health Rankings, the United States (U.S.) Census, and the American Community Survey, as well as community health needs assessments and reports issued by hospitals, Palm Beach County, state commissions, and the managing entity for behavioral health.

We evaluated the current state of behavioral health services in Palm Beach County and developed recommendations using the following resources, among others:

- National Guidelines for Behavioral Health Crisis Care, SAMHSA
- National Guidelines for Child and Youth Behavioral Health Crisis Care, SAMHSA
- Roadmap to the Ideal Crisis System, Group for the Advancement of Psychiatry (GAP) and National Council for Mental Wellbeing
- Crisis Resource Need Calculator, McKinsey Health Institute and Recovery Innovations, Inc. (RI International)
- Crisis Now Scoring Tool, National Association of State Mental Health Program Directors

2. Project the range of services needed to bridge the identified service gaps, considering both immediate and long-term requirements.

Based on data from the service gap analysis and the Crisis Now model, we developed projections of the crisis service capacity needed to meet the needs of Palm Beach County residents. Our analysis resulted in several key outcomes, including an estimate of the number of crisis episodes occurring annually in Palm Beach County, a breakdown of crisis episodes by projected service need, and a demographic description of individuals experiencing crisis episodes.

A needs projection analysis was conducted to calculate projected needs, considering volume, demand, and the required number of beds.

Building on insights from stakeholders in the existing system, we described the client journey to gain a deeper understanding of how individuals in various settings interact with the current crisis response systems. This approach aimed to highlight potential differences in client experience and system effectiveness with the introduction of a crisis receiving and stabilization facility.

Drawing from a review of communities similar to Palm Beach County, we researched and assessed various models of crisis care facilities. We considered nationally-recognized facilities, non-traditional partnerships, and strategies that promote program sustainability. This comparative analysis identified best practices that could be applied in Palm Beach County, with a focus on creating an environment that fosters health and minimizes an institutional feel.

Subsequently, our operational capacity analysis focused on identifying and describing the types of services, methods of service delivery, and staffing recommendations associated with the proposed facility. To refine our recommendations, we conducted a scenario analysis with the Health Care District, examining the scope and potential impact of several types of services on addressing crisis care needs.

This phase was crucial in determining the scale and scope of the proposed facility and the integration of a central crisis receiving facility with existing behavioral health services in Palm Beach County.

3. Advance the proposed facility model in the areas of facility design, ownership, financial projections, funding opportunities, regulatory requirements, and potential workforce development partnerships.

Following the assessment phases, we advanced the facility model by providing detailed layout and design recommendations. These specifications took into account various factors, including law enforcement access, rapid triage capability, service mix, continuity of care, desired outcomes, regulatory recommendations, and characteristics observed in model facilities previously identified. We also provided cost estimates for facility construction in line with the proposed approach.

Initium Health assessed and presented an overview of potential ownership and governance models for the crisis receiving facility. This included an analysis of best practices in private-public partnerships and strategic, operational, and financial recommendations tailored to Palm Beach County's specific requirements. We identified and evaluated funding and financing options, such as federal, state, and local funds, private donor and foundation support, healthcare and payer sources, capital advances, and tax credit programs.

The feasibility assessment was bolstered by a dynamic pro forma and scenario analysis (provided in a separate spreadsheet) that took into account various funding scenarios, changes in demand for services, and other contingencies that could impact the financial viability and sustainability of a crisis receiving and stabilization facility.

We conducted thorough research and review of relevant regulations and policies pertaining to crisis facilities in Florida. This proactive approach ensured that we were fully informed of the regulatory landscape, guaranteeing that the proposed behavioral health crisis care strategy and crisis receiving facility aligned with all necessary legal and policy frameworks.

Finally, recognizing the critical role of a well-prepared workforce in the success of the proposed facility, we took a strategic approach to identify potential partners for collaboration in workforce development and highlighted behavioral health workforce strategies from other areas of the country.

Crisis Now: Transforming Crisis Services

A recent movement toward a better response to behavioral health crises is marked by a 2016 study of the approach to crisis care in the U.S.

This study, cited in the National Guidelines and conducted by the Crisis Services Task Force of the National Action Alliance for Suicide Prevention, found that crisis services were the preferred and most efficient care for people in distress, not hospital-based care.

Pioneering communities embraced this notion and started to build crisis services operating outside of hospital systems, adding to the evidence that a new, appropriately designed system was not only possible, but less costly than the status quo.

In 2020, the National Guidelines for Behavioral Health Crisis Care – A Best Practices Toolkit was released by SAMHSA. These guidelines outline the requirements for an effective system of crisis care, geared to address behavioral health emergencies. A concurrent effort, Crisis Now, led by the National Association of State Mental Health Program Directors, provides communities a roadmap to a safe, effective continuum of crisis care services matching people's clinical needs. According to the National Guidelines, there are four essential components to an effective system of crisis care:

Regional Crisis Call Centers offer 24/7 access to trained professionals for individuals in crisis. These services are staffed by clinically trained personnel and excel at coordinating crisis care in real-time. They evaluate each situation effectively, connecting callers to suitable support based on assessments and preferences. These services prioritize the least invasive approach, with involuntary emergency intervention as a last resort.

Mobile Crisis Teams offer 24/7 in-person intervention by a group of professionals and peers (individuals with lived experience of behavioral health conditions who are in recovery and trained to assist others). These teams are strategically dispatched to address the specific needs of individuals in crisis. Mobile crisis teams deliver a range of vital services, including rapid response to crisis situations, in-depth crisis assessment, resolution of immediate issues, assistance in connecting individuals to outpatient mental health services, crisis planning, and continuous follow up support. Their primary goal centers on reducing the necessity for psychiatric hospitalizations, aiming to provide more appropriate care while simultaneously minimizing unnecessary involvement of law enforcement, visits to hospital emergency departments (EDs), and inpatient hospitalizations.

Crisis Receiving Facilities are 24/7 access facilities that ensure individuals in need can receive immediate care, with a focus on stabilizing those in crisis. These facilities mirror the open-access model of hospital EDs, providing prompt mental health and substance use care. Importantly, they provide a safe environment that does not exacerbate individuals' symptoms. By accepting all walk-ins and referrals from various sources, such as ambulance, fire, and police, without rejection, the facility ensures that help is readily available to anyone in crisis, regardless of age or clinical condition.

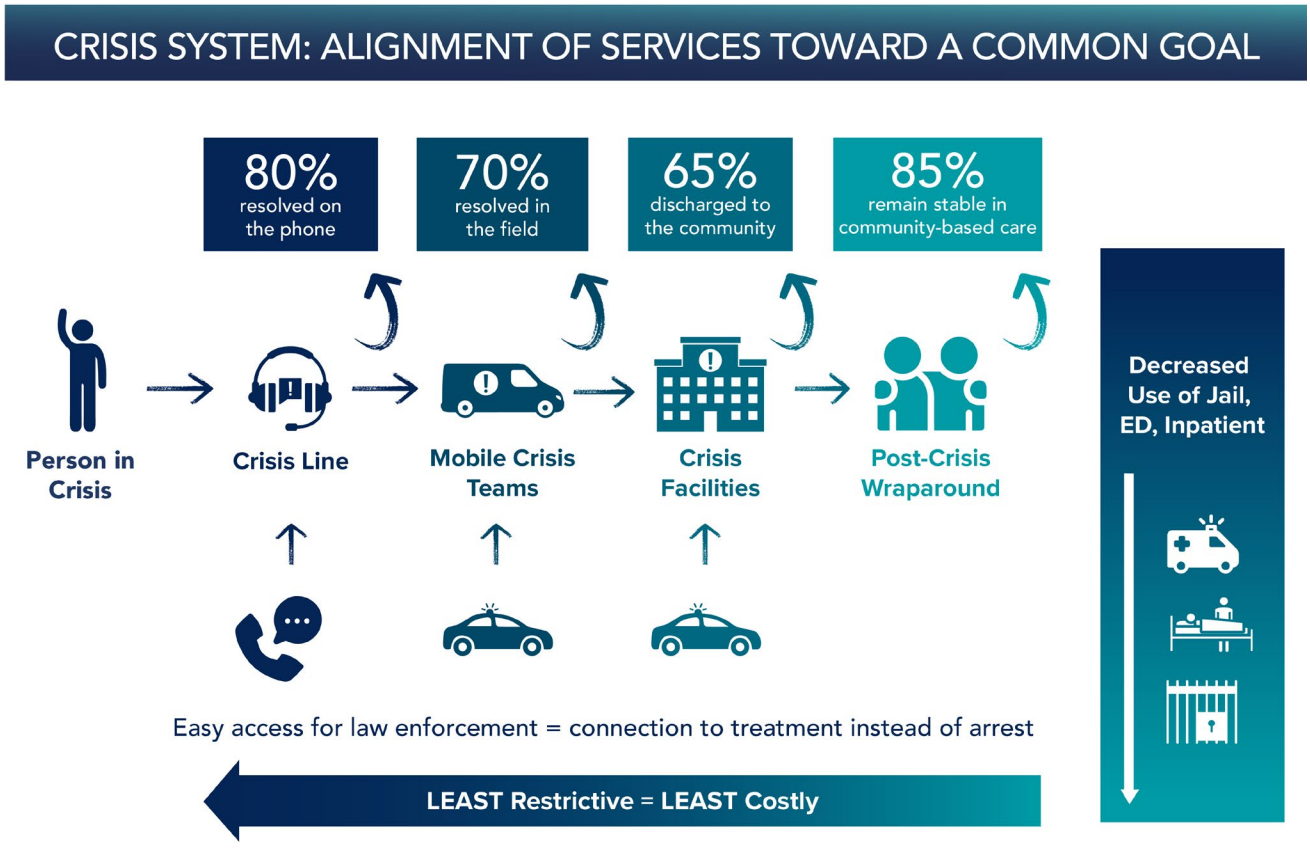
Essential Principles for Modern Crisis Care Systems must be incorporated throughout the entire crisis system, including addressing recovery needs, a significant role in the care team for peer support specialists, trauma-informed care, zero suicide/suicide safer care, safety/security for staff and people in crisis, and crisis response partnerships with law enforcement, dispatch, and emergency medical services (EMS).

Crisis System Effect on the Need for Inpatient Psychiatric Care

A person-centered crisis system delivers services in the most effective, least restrictive settings, minimizing the use of locked facilities, restraint, force, or seclusion. With a fully established crisis continuum in place, the majority of individuals are able to be stabilized through telephonic support from regional crisis call centers, followed by a smaller percentage who receive in-person support in the community from MRTs.

Finally, a percentage of these individuals receive care within specialized crisis facilities such as crisis receiving and stabilization centers. This approach emphasizes steering people in crisis away from jails, EDs, or hospitals for crisis stabilization. Estimates regarding the percentage of cases resolved in each of these settings are derived from a compilation of data from several states (Figure 1).

Figure 1. Illustration of an Effective Continuum.



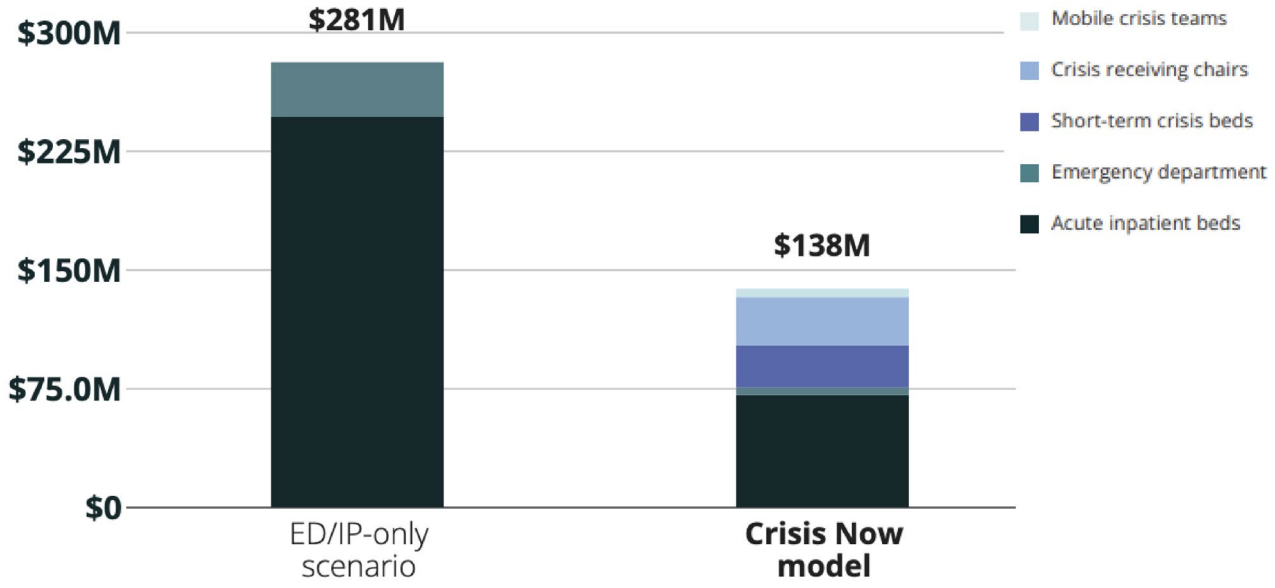
Source: Adapted from Balfour, et al. 2020.

The Crisis Now model provides a Crisis Resource Need Calculator, which offers an estimate of the cost reduction associated with transforming the existing crisis care system in each county in the U.S. The cost projections provided below are based on an analysis of a national database of healthcare claims data. They do not necessarily represent the cost of implementing the Crisis Now model in Palm Beach County, but rather provide a valuable directional estimate of the cost savings associated with the use of a crisis care system in place of hospital ED and inpatient psychiatric care.

Further, we recognize that while the Crisis Now model has specific elements that are required for success, there are a variety of ways to implement and operationalize these components, so local contextualization is crucial.

The ED and inpatient psychiatric services (ED/IP-only) only scenario in Figure 2 is a starting point for communities to estimate their cost reduction potential. From this starting point, which is the traditional approach to crisis care, this system undergoes a remarkable evolution when transitioning to an optimized crisis care continuum.

Figure 2. Costs of ED and Inpatient-Only Scenario versus Crisis Now model for Palm Beach County.



Site	ED/IP	Crisis Now
Mobile Crisis Teams	$0	$5.5M
Crisis Receiving Chairs	$0	$30.4M
Short-term Crisis Beds	$0	$26.6M
Emergency Department	$34.2M	$4.8M
Acute Inpatient Beds	$247M	$71.0M
TOTAL	**$281M**	**$138M**

ED = Emergency Department; IP = Inpatient Psychiatric Care. Source: Source for Crisis Now data: Crisis Resource Need Calculator. https://calculator.crisisnow.com/Accessed on 11/8/2023.

This calculator makes it clear that by investing in a regional crisis call center, mobile crisis teams, crisis receiving chairs and short-term beds, the cost to a community is dramatically decreased compared to reliance on hospital EDs and inpatient care alone. (Note: The ED/inpatient psychiatric services only scenario could be further refined by accounting for the costs of the existing mobile crisis teams, crisis receiving chairs, and short-term crisis beds in Palm Beach County. This would require cost and claims data to be made available by the providers of these services, and was not undertaken as part of this study.)

We collected data on the current volume of crisis services and compared the current state to the recommended level of services in the Crisis Now model. By doing so, we identified the gap that needs to be closed in order to provide an optimal crisis system (Table 1). As shown below, the implementation of a fully equipped crisis system is anticipated to reduce the demand for hospital psychiatric inpatient beds to less than the number in place today. This occurs as more crisis care is delivered in alternative settings, and crises are resolved earlier. The following sections describe the current state and gaps in further detail.

Table 1. Current and Recommended Crisis Service Levels.

Site	Current State: Palm Beach County	Crisis Now Model Projections	Gap
Mobile Crisis Teams	13	20	7
Crisis Receiving Chairs	20	82	62
Short-term Crisis Beds	49	69	20
Acute Inpatient Beds	279	186	N/A

Context

Demographics and Prevalence of Behavioral Health Conditions

With more than 1.5 million residents, Palm Beach County is one the largest counties in the United States east of the Mississippi river (Palm Beach County, n.d.). It is the second largest county in Florida by geographical area and the third largest by population. Situated along the southeast coast of Florida, Palm Beach County spans nearly 2,000 square miles and is larger than the state of Delaware. Interstate 95 traverses the county top to bottom, and many resources are situated alongside this major highway. The eastern part of the county features a 47-mile coastline and several urban hubs while the central and western areas are primarily suburban and rural.

Palm Beach County has a diverse population of residents, with 74% of the population identifying as White, 20% as Black, 3% as Asian, and 2% as two or more races, and 24% identifying as Hispanic ethnicity (US Census, 2020). An estimated one-third of people over 5 years old speak a language other than English at home. Palm Beach County is home to retirees, families, and individuals, including college students studying at Florida Atlantic University, Palm Beach State College, and a variety of private institutions. Approximately 25% or residents are 65 years of age or older, which is lower than Martin County to the north (33%) and higher than neighboring Broward County to the south (18%) (US Census, 2020).

Palm Beach County is among the wealthiest counties in Florida. At the same time, many residents face economic distress both within the cities and more rural areas of the county. Approximately 12% of county residents live in poverty, and 18% of people under age 65 lack health insurance. The absence of health insurance can cause people to delay seeking care due to financial concerns, which leads to poorer health outcomes and an increase in overall healthcare spend.

While Palm Beach County is ranked among the healthiest counties in Florida overall for length and quality of life, many residents are affected by behavioral health concerns (County Health Rankings, 2023). Behavioral health, which includes both mental health and substance use challenges, is an important component of an individual's overall well-being. The following statistics provide insight into various behavioral health concerns in Palm Beach County:

- Among adults, 15% reported frequent mental distress in 2020. While this is similar to state and national rates, it represents a significant number of approximately 185,000 adults across the county (County Health Rankings, 2020).
- The suicide rate in Palm Beach County remains a crucial concern. At 13 deaths per 100,000 people (2022), it is on par with the state of Florida and the United States, both of which had 14 deaths by suicide per 100,000 people during the same period (Florida Health Charts, 2022).
- Palm Beach County had a higher rate of drug overdose deaths (45 per 100,000 people) in 2021, compared to the state of Florida (38), and this continues to be a significant public health concern (Florida Health Charts, 2021).
- In Florida, the percentage of adults with mental illness that have not been treated in the past year was 58%, compared to a national rate of 55% (Mental Health America, 2023).
- According to the 2022 Florida Youth Substance Abuse Survey, 42% of students in Palm Beach County report feeling depressed or sad on most days. This is statistically similar to the state rate at 47% (Florida Health Charts, 2022).
- In the same survey, 16% of Palm Beach County youth ages 10-17 report using alcohol or any illicit drug within the past 30 days, similar to the state rate of 19% (Florida Department of Children and Families, 2022).

Behavioral Health Care Continuum

As with other health conditions, outcomes for mental health and substance use conditions are affected by a variety of factors including the ability to access needed health care services. Behavioral health care services span a continuum which includes prevention and early intervention, crisis services, and treatment and recovery support services (Figure 3). Each of these components is necessary to provide a full continuum of care to address the needs of a community and support individuals before, during and after a crisis situation.

The focus of this study is crisis services, including crisis call centers, mobile crisis services, and crisis residential services.

However, we recognize the interrelatedness of crisis services and other services along the continuum, and the importance of a full core continuum of behavioral health care. For example, having outpatient services readily available is important for crisis teams to be able to resolve these situations and prevent future crises from occurring. Additionally, crisis services need to be coordinated with treatment services such as inpatient psychiatric care to provide a seamless transition for individuals needing a higher level of care.

Figure 3. Key Components of a Behavioral Health Continuum of Care.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). Peer Support Services in Crisis Care. Advisory. SAMHSA Publication No. PEP22-06-04-001.

Crisis Care and the Baker and Marchman Acts

This report addresses behavioral health crises, encompassing both mental health and substance use, while recognizing the interrelatedness of the two. In Florida, a "Baker Act" refers to a legal mechanism that allows for the involuntary examination and temporary detention of individuals who may be experiencing a mental health crisis and are deemed to be a danger to themselves
or others.

The Marchman Act provides for voluntary admissions and involuntary assessment, stabilization, and treatment of adults and youth who are severely impaired due to substance use (Florida Department of Children and Families, 2003). We provide an overview of each of these below related to their role in crisis care and impact on residents.

Baker Act

The Baker Act is named after Maxine Baker, a Florida state representative who sponsored the legislation formally known as the Florida Mental Health Act (Florida Department of Children and Families, n.d.).

There are several important components of the Baker Act:

1. **Involuntary Examination:** The Baker Act enables qualified professionals, such as mental health professionals, law enforcement officers, or judges, to initiate an involuntary examination (also known as a "Baker Act assessment") of an individual they believe may have a mental illness and poses a risk of harm to themselves or others.
2. **Criteria for Involuntary Examination:** To initiate a Baker Act assessment, there must be evidence that the individual is displaying behavior that suggests they may be a danger to themselves or others due to a mental illness. This could include behaviors like expressing suicidal thoughts or engaging in self-harming actions.
3. **Temporary Detention:** If, after the assessment, it is determined that the individual meets the criteria for involuntary examination, they can be temporarily detained in a mental health facility for up to 72 hours for further evaluation and treatment.
4. **Treatment and Evaluation:** During the period of temporary detention, the individual will receive a thorough mental health evaluation to determine the appropriate course of treatment. This may include hospitalization or outpatient care.
5. **Legal Safeguards:** The Baker Act includes legal safeguards to protect the rights of individuals who are subject to involuntary examination and detention. These individuals have the right to legal representation, and the process is subject to review by a judge.

In FY 2021-2022 in Florida, 170,048 involuntary Baker Act exams were conducted, affecting 115,239 people (Florida Department of Children and Families, 2022). Of these, the majority were adults ages 18-64 (79%) followed by children under 18 years of age (21%). Just 1% were adults 65 years of age and older.

The following data highlights two significant concerns. First, they indicate that law enforcement officers and ED physicians, rather than mental health professionals, are the most common initiators of involuntary examinations for individuals in a mental health crisis. Consequently, for the thousands of people who experienced a Baker Act in 2021-2022, this experience often involved being handcuffed and transported in a police vehicle to a hospital emergency room.

Stakeholders indicated that fear of an encounter with law enforcement, coupled with the fear of having a personal record of a Baker Act, keeps many people from seeking assistance.

Second, only a small percentage (11%) of Baker Acts involved stabilization at a crisis facility, with the majority of people treated in an inpatient hospital setting – the most expensive and restrictive level of care. When inpatient psychiatric hospitals are the primary setting for crisis care, communities bear a greater healthcare cost for needs that could have been met in a less expensive setting. Similarly, many individuals experience care that is more intensive and intrusive and not well-aligned with their needs.

Baker Act Initiators

There are three main types of initiators for involuntary examinations: health professionals, law enforcement, and ex-parte order. Ex-parte orders represent petitions that have been filed, typically by a person's family, seeking a judge's order for an involuntary examination or "Baker Act."

The National Association on Mental Illness (NAMI) Palm Beach County stated ex-parte orders are often sought by family members who wish to avoid a law enforcement or emergency physician decision on whether their loved one should be hospitalized. NAMI representatives explained this as a reaction by families to not having their loved one "Baker Acted" when it was needed. With an ex-parte order, the family can have their loved one transported and admitted to a psychiatric hospital based on the judicial ruling alone. However, ex-parte orders make up a small percentage of the entirety of Baker Acts. In the past five fiscal years, there has been an increasing trend of law enforcement initiating a Baker Act (Table 2).

Table 2. Involuntary Examinations by Initiator Type (2017-2022).

	% of Total by Initiator Type			
Fiscal Year	**Total**	**Health Professional**	**Law Enforcement**	**Ex- Parte Order**
2017-2018	9,392	52.0%	46.0%	2.0%
2018-2019	10,420	53.5%	44.3%	2.2%
2019-2020	9,687	50.6%	47.7%	1.7%
2020-2021	8,639	48.7%	49.4%	1.9%
2021-2022	6,269	49.3%	48.8%	1.9%

Sources:

Christy, A., Jenkins, K., Rhode, S., Bogovic, S., Deaton, L., and Dion, C. (2023). Baker Act Reporting Center Fiscal Year 2021-2022 Report. Tampa, FL: University of South Florida, Department of Mental Health Law and Policy, Baker Act Reporting Center.

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Christy, A., Ringhoff, D., Rhode, S., Jenkins, K., Lersch, K. (2019). Baker Act Reporting Center Fiscal Year 2017/2018 Report. Tampa, FL: University of South Florida, Department of Mental Health Law and Policy, Baker Act Reporting Center.

As shown in Table 3, for those Baker Acts that are initiated by a health professional, most are initiated by physicians who are not specialized in this area (i.e., ED physicians), rather than mental health professionals. This data reflects the current high levels of law enforcement and ED involvement in mental health crisis situations.

Table 3. Involuntary Examinations by Health Professional Type.

	Fiscal Year				
Health Professional Type	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**	**2021-2022**
Physician (who are not Psychiatrists)	74.25%	74.25%	77.05%	77.58%	77.58%
Psychiatrist	6.9%	6.9%	7.9%	7.2%	7.2%
Mental Health Counselor	4.2%	4.2%	3.6%	4.4%	4.4%
Clinical Social Worker	3.7%	3.7%	3.2%	2.8%	2.8%
Psychiatric Nurse	2.7%	2.7%	2.4%	2.6%	2.6%
Clinical Psychologist	2.4%	2.4%	2.1%	2.0%	2.0%
Physician Assistant	0.5%	0.5%	<1%	1.1%	1.1%
Marriage and Family Therapists and multiple health professional types entered	0.6%	0.6%	<1%	<1%	<1%
Psychiatric Nurse	4.7%	4.7%	2.4%	2.0%	2.0%

Sources:

Christy, A., Jenkins, K., Rhode, S., Bogovic, S., Deaton, L., and Dion, C. (2023). Baker Act Reporting Center Fiscal Year 2021-2022 Report. Tampa, FL: University of South Florida, Department of Mental Health Law and Policy, Baker Act Reporting Center.

Christy, A., Jenkins, K., Rhode, S., Barnes, A., Bogovic, S., Deaton, L., and Dion, C. (2022). Baker Act Reporting Center Fiscal Year 2020-2021 Report. Tampa, FL: University of South Florida, Department of Mental Health Law and Policy, Baker Act Reporting Center.

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Christy, A., Ringhoff, D., Rhode, S., Jenkins, K., Lersch, K. (2019). Baker Act Reporting Center Fiscal Year 2017/2018 Report. Tampa, FL: University of South Florida, Department of Mental Health Law and Policy, Baker Act Reporting Center.

Baker Act Receiving Facilities

Baker Act receiving facilities are Crisis Stabilization Units and hospitals that are designated by the Department of Children and Families to provide emergency mental health treatment. There are four Baker Act Receiving Facilities in Palm Beach County that serve the general population, along with the West Palm Beach Veterans Administration (VA) Center that serves the veteran population. In FY 2021-2022, most of the people who experienced an involuntary examination did so at JFK Medical Center North Campus, followed by Delray Medical Center Fair Oaks Pavillion (Table 4). Nearly one-third were seen at facilities outside of the county.

Table 4. Involuntary Examinations by Health Professional Type.

Facility	Type	Percent of Baker Acts
JFK Medical Center North Campus	Inpatient Psychiatric Hospital	31%
Delray Medical Center / Fair Oaks Pavilion	Inpatient Psychiatric Hospital	22%
South County Mental Health Center	Crisis Stabilization Unit	11%
NeuroBehavioral Hospitals of the Palm Beaches North Campus	Inpatient Psychiatric Hospital	6%
Facilities located outside of Palm Beach County		30%

Source: Christy, A., Jenkins, K., Rhode, S., Bogovic, S., Deaton, L., and Dion, C. (2023). Baker Act Reporting Center Fiscal Year 2021-2022 Report. Tampa, FL: University of South Florida, Department of Mental Health Law and Policy, Baker Act Reporting Center.

Marchman Act

Chapter 397 of the Florida Statutes, known as The Marchman Act, allows for an involuntary or voluntary assessment to stabilize and treat a person using drugs or alcohol. This allows for treatment of people who are unable or unwilling to seek treatment for themselves.

Procedures

There are various methods in which stabilization and treatment can occur. Court-related procedures include a substance use assessment, and if treatment is deemed necessary, the provision of court ordered treatment.

Outside of the court system, procedures include protective custody by law enforcement. If an assessment is initiated through protective custody by law enforcement, the officer is permitted to to take the person to their home, a hospital, or a detoxification facility with the person's consent. If the person does not give consent, the officer must bring a person to a hospital or detoxification facility unless the officer diverts the case to the criminal justice system (Department of Children and Families, 2022).

Assessments can also occur through emergency admission under the authorization of a physician's certification.

All licensed hospitals must accept a person brought to its emergency department and conduct a medical screening. If an "emergency medical condition" is found, the hospital emergency department must follow the Emergency Medical Treatment and Labor Act before a transfer to another facility can occur.

A spouse, guardian, relative, private practitioner, director of a licensed service provider, or any three adults with personal knowledge of the person's substance use can file a petition for involuntary assessment and/or treatment. For a minor, the petition can be filed by a parent, guardian, custodian, or licensed service provider.

The criteria for an involuntary petition for assessment includes:

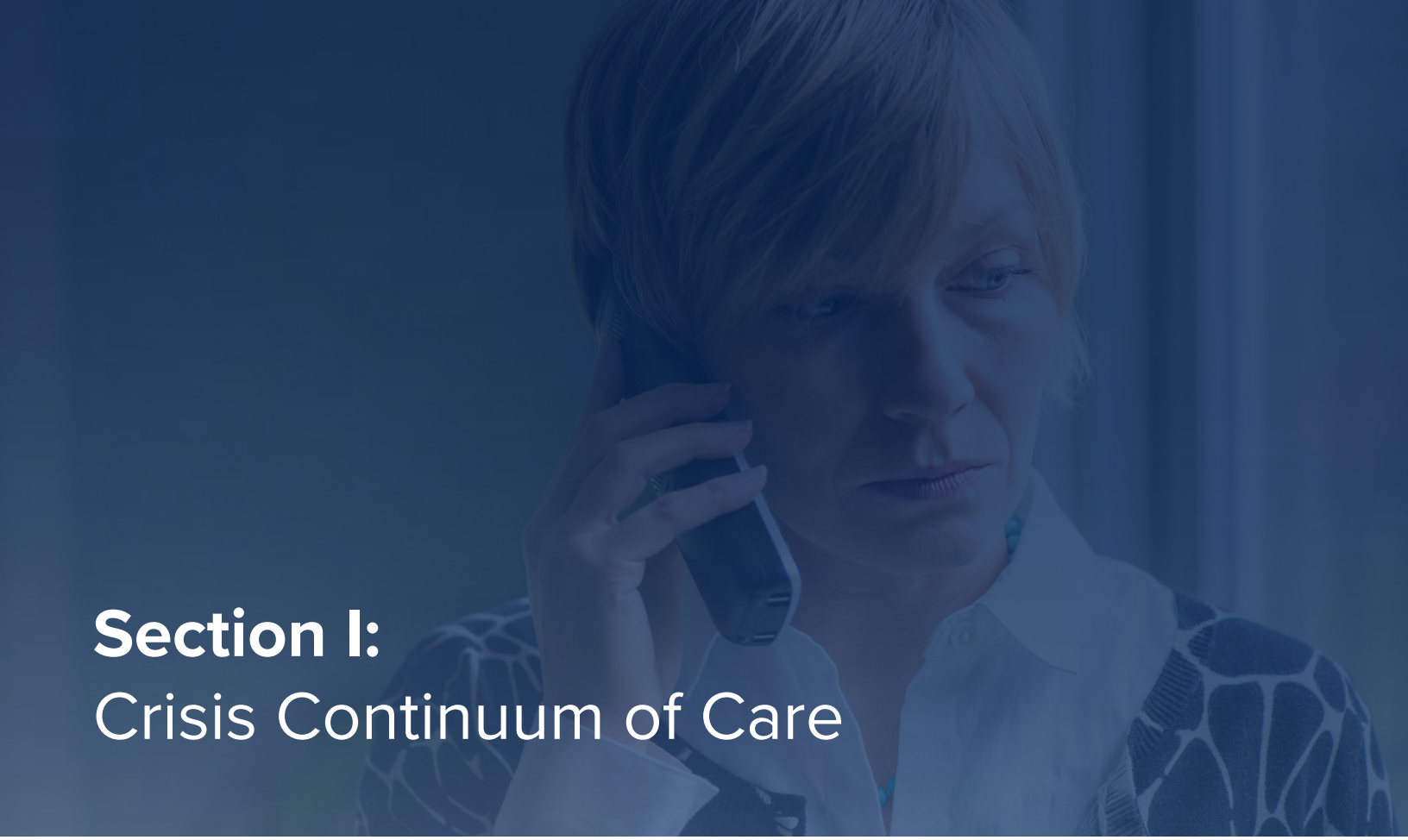
1. The person has lost power of self control with respect to substance use due to the impairment.
2. The person is incapable of appreciating the need for care and unable to make a rational decision to receive substance use services.
3. The person has engaged in, attempted, or expressed intentions to cause harm to themselves or others due to substance use. If the person is not treated for substance use, the person is likely to harm themselves or others due to substance use.

If a person is determined to be in need of treatment, the court has the authority to issue a treatment order for up to 60 days. A treatment order can also be extended up to 90 more days if the extension is filed within 10 days of the original expiration date of the initial order.

The Marchman Act orders an assessment specifically for substance abuse and it cannot be used to intervene or substitute for mental health treatment. Additionally, it does not ensure the availability of a treatment bed, as the court lacks the authority to locate a bed and directly send the respondent from a hearing to a treatment facility. The Marchman Act is a civil procedure that does not involve locked facilities, meaning that if a person decides to leave a treatment center, the center has no authority to stop them. However, the person will have to appear back in court for a contempt hearing. Lastly, the Marchman Act does not pay for a person's assessment and treatment.

The number of annual Marchman Act filings is much lower than Baker Act involuntary examinations. For example, in 2019, there were 766 Marchman Act filings for the 15th Judicial Court, and over 9,000 Baker Acts (Palm Beach County, 2020). Of the 766, 392 people had petitions for assessment filed (O'Brien, 2021). Of those petitions, 261 faced petitions to be committed to involuntary treatment after their assessment.

Notably, this population represents only those who were impacted by Marchman Act filings and not the entirety of people experiencing a substance-use crisis in Palm Beach County. For these and other community members, access to a well-resourced behavioral health crisis system able to accept people experiencing both substance-related and mental health-related crises is imperative.



Section I:
Crisis Continuum of Care

Based on our assessment, the feasibility of transforming the crisis care continuum in Palm Beach County is dependent on four primary factors:

1. Raising awareness of crisis services and developing trust across diverse Palm Beach County communities
2. Developing effective partnerships to work collaboratively with existing systems and providers
3. Establishing the infrastructure needed to coordinate care across the continuum, including an accountable governance structure, robust technology, and real-time data sharing
4. Securing the resources required to develop new services and facilities

This section outlines the present condition of the three operational components of crisis care in Palm Beach County. It assesses the current state in alignment with the National Guidelines and presents recommendations for the Health Care District to address these key factors and increase the availability of high quality crisis care throughout the county. Each section follows the format of National Guidelines, Background, Findings, Assessment, and Recommendations.

Someone to Call

National Guidelines

The National Guidelines describe requirements for a regional crisis call center to provide a service that offers 24/7 access to trained professionals for individuals in crisis, with telephonic, text, and chat options. The call center should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of people at risk of suicide. Staff should be capable of assigning the appropriate resources to each call, including dispatch of MRTs. The call center should be able to monitor real time crisis bed availability. It should function as "air traffic control" for people in crisis, which means call center staff should always know where a person in crisis is in the continuum of care spanning from mobile response to facility-based crisis care. This involves ensuring hand-offs are complete and follow-up procedures are thorough.

In July 2022, the 988 Suicide and Crisis Lifeline replaced the NSPL phone number to better generate access to care through a three-digit, easy-to-remember number.

988 is staffed through local contracts with call centers throughout the country, as well as a national call center that serves as a secondary resource, taking calls when the local call center is unavailable. The goal for 988 is to serve as the entry point for crisis care, providing both direct support through telephonic intervention and connection to other components of the crisis care continuum.

Background

In 2022, 211 Palm Beach and Treasure Coast assumed responsibility for the 988 Lifeline. This organization serves five counties: Indian River County, Martin County, Okeechobee County, Palm Beach County, and St. Lucie County. In 2022, 39% of all requests for assistance came from Palm Beach County, totaling 48,923 calls and 621 texts and emails. Mental health and substance use ranked as the second most frequently identified concerns in all calls, representing 27% of all needs. 211 Palm Beach and Treasure Coast reports receiving 801 suicide-related calls in 2022.

In Florida, the Department of Children and Families (DCF) Statewide Office for Suicide Prevention has been assigned the role of overseeing the state's suicide prevention initiatives (Averhart, 2022). Support for the first two years of implementing 988 from the Department of Children and Families (DCF) is sourced from two federal funding channels. This includes a capacity-building grant, amounting to $5.2 million over a two-year period, and additional funding from the American Rescue Plan's Community Mental Health Block Grant, totaling $16.8 million over two years. The Department is actively working on identifying sources of long-term and sustainable funding for these efforts.

Findings

The regional crisis call center in Palm Beach County does not currently fulfill the key functions outlined in the National Guidelines.

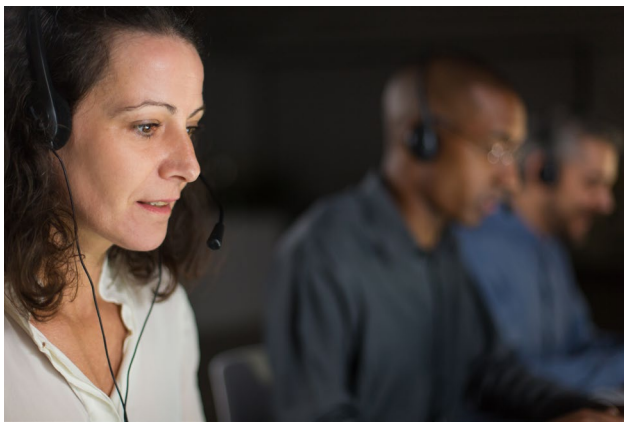
The 988 call center at 211 Palm Beach and Treasure Coast does not coordinate real-time crisis care in conjunction with MRTs and crisis receiving facilities.

Call center staff connect callers to MRTs through a warm transfer, but do not dispatch MRTs. Additionally, the call center does not coordinate walk-in services with crisis stabilization units. Given these limitations, the call center is unable to coordinate care or provide the air traffic control oversight to ensure that individuals in crisis are effectively connected to the right level of care. According to National Guidelines, effective coordination of crisis services requires shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels; including requirements for service approval and transport, shared protocols for medical clearance algorithms, and data on speed of accessibility (average minutes until disposition). An effective program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage (National Guidelines for Behavioral Health Crisis Care, 2020).

The call center does not employ technologies that align with the National Guidelines.

This includes GPS-enabled technology for real-time tracking of MRTs and regional bed registry technology. With GPS-enabled technology, regional call centers are able to dispatch the closest MRT to an individual in need, reducing response time. A regional bed registry would provide transparency for the call center to be able to communicate with MRTs and with individuals about what capacity is available at facilities close to them. The call center is not able to schedule outpatient appointments directly for callers, but expressed willingness to do so with the proper system and necessary participation of service providers.

Currently, the responsibility of scheduling is with the person in crisis, or family members. Additionally, the call center faces limitations in accessing up-to-date information about outpatient service availability. Several stakeholders reported challenges with 211 Palm Beach and Treasure Coast referring to outpatient programs and services that no longer existed or where eligibility requirements had changed due to grants ending or changes in funder requirements.



211 Palm Beach and Treasure Coast reported a lack of standardized reporting metrics aligned with the National Guidelines.

The organization reports a variety of metrics to multiple funders depending on the requirements of the funder, without uniform metrics. This is administratively burdensome and can impede quality improvement efforts. Regional crisis call centers should report standardized metrics reflecting the performance of the entire crisis system that can be used to promote transparency and accountability. The National Guidelines provide key performance indicators for regional crisis call centers:

- Call volume
- Average speed of answer
- Average delay
- Average length of call
- Call abandonment rate
- Percentage of calls resolved by phone
- Number of mobile teams dispatched
- Number of individuals connected to a crisis or hospital bed
- Number of first responder-initiated calls connected to care

Lack of a dependable funding source is a challenge to 988 staffing and promotion.

211 Palm Beach and Treasure Coast reports receiving insufficient operational funds through the state, and no support for 988 promotion.

Several stakeholders brought up the issue of lack of funding for advertising and marketing 211/988 as a major challenge.

Awareness of 988 is foundational to proper use of the resource in the event of a crisis. Without awareness, individuals will default to the traditional systems, i.e. calling 911.

Stakeholders and residents are not aware of 988 and are unclear about its purpose.

In Palm Beach County, the 988 Lifeline is operated by 211 Palm Beach and Treasure Coast, a nonprofit organization which also operates the NSPL and has done so for decades. Given the long history of 211 providing NSPL services, there is confusion among residents about the purpose and role of 988 as a distinct service. Service providers reported that community members call them in a crisis, rather than calling 988/211.

Stakeholders also reported that many residents do not turn to 988 for mental health crisis support because they are not aware of it or they think that the call will result in a law enforcement response. Stakeholders also highlighted unfamiliarity as a barrier to calling 988, especially for communities of color. One nonprofit leader said, "Our community doesn't always understand what a crisis is, why they would call, why they wouldn't call. Things can escalate because people don't know who to call, and that they could avoid hospital visits and de-escalate in place."

Assessment

The National Guidelines outline minimum expectations and best practice guidelines for a regional crisis call center. Based on information we received from 211 Palm Beach and Treasure Coast, we found that this service does not meet all of the minimum expectations for a regional call center (Table 5).

Table 5. Minimum Expectations for a Regional Crisis Call Center.

Minimum Expectations	Status
Operate every moment of every day (24/7/365)	Yes
Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations	Yes
Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call	Yes
Coordinate connections to crisis mobile team services in the region	Yes
Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received	No
Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.	No
Explanation: 211 Palm Beach and Treasure Coast reports that its staff includes trained counselors who meet expectations for suicide prevention counseling, but it does not employ clinical staff to provide oversight. As discussed above, the call center does not coordinate facility-based care. The center contacts mobile crisis services with the caller but does not dispatch mobile response teams.	

The National Guidelines define best practices for a regional crisis call center. Currently, the 211 Palm Beach and Treasure Coast call center does not meet best practice guidelines (Table 6).

Table 6. Best Practices for a Regional Crisis Call Center.

Best Practices (must meet minimum expectations AND):	Status
Incorporate Caller ID functioning	No
Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need	No
Utilize real-time regional bed registry technology to support efficient connection to needed resources	No
Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode	No
Explanation: 211 Palm Beach and Treasure Coast expressed concerns related to the use of Caller ID, stating that anonymity is important to its callers, especially related to behavioral health. To our knowledge, the MRTs in the region (employed by South County Mental Health) do not use GPS-enabled technology, and the regional crisis call center does not have this capability either. Similarly, a real-time regional bed registry does not exist, and currently there are no capabilities for outpatient scheduling beyond callers contacting providers directly.	

Crisis Now Scoring Tool

The Crisis Now Scoring Tool provides scoring sheets to evaluate the current state of the crisis continuum in relation to the implementation of National Guidelines along a continuum ranging from minimal to full implementation. According to the Crisis Now Scoring Tool, regional crisis call center services in Palm Beach County score between Level 1 and Level 2 requirements for crisis call centers, which are described as Basic and Minimal (Table 7).

Table 7. Crisis Now Scoring Tool: Regional Crisis Call Centers.

	Level 1 (Minimal)		Level 2 (Basic)		Level 3 (Progressing)		Level 4 (Close)		Level 5 (Full)
✓	Call Center Exists	✓	Meets Level 1 Criteria		Meets Level 2 Criteria		Meets Level 3 Criteria		Meets Level 4 Criteria
✓	24/7 Call Center in Place to Receive BH Crisis Calls	✓	Locally operated 24/7 Call Center in Place to Receive Calls		Hub for Effective Deployment of Mobile Teams		Formal Data Sharing in Place Between Crisis Providers		Integrated Data that Offers Real-Time Air Traffic Control (Valve Mgmt) Functioning
✓	Answer Calls Within 30 Seconds	✓	Answer Calls Within 25 Seconds		Answer Calls Within 20 Seconds		Answer Calls Within 15 Seconds		GPS-Enabled Mobile Team Dispatch by Crisis Line
✓	Cold Referral to Community Resources or Better Connection to Care	✓	Warm Hand-off to BH Crisis Providers		Directly Connects to Facility-Based Crisis Providers		Coordinates Access to Available Crisis Beds		Shared Bed Inventory and Connection to Available Crisis and Acute Beds
✓	Meets NSPL Standards and Participates in National Network	✓	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services		URAC Call Center or Similar Accreditation		Single Point of Crisis Contact for the Region		24/7 Outpatient Scheduling with Same Day Appointment Availability
		✓	Call Abandonment Rate Under 20%		Call Abandonment Rate Under 15%		Call Abandonment Rate Under 10%		Call Abandonment Rate Under 5%
		✓	Shared MOUs / Protocols with Crisis Providers		Some Call Center Access to Person-Specific Health Data		Some Access to Person Specific Data for All Crisis Providers		Real-Time Performance Outcomes Dashboards Throughout Crisis System
		✓	Priority Focus on Safety / Security		Some Peer Staffing within Call Center		Shares Documentation of Crisis with Providers		Shared Status Disposition of Intensive Referrals
							Peer Option Made Available to All Callers Based on Need		Trauma-Informed Recovery Model Applied
							Systematic Suicide Screening and Safety Planning		Suicide Care Best Practices That Include Follow-up Support
									Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = 1 (Minimum)	Justification of Rating: Regional crisis call center reports an average speed to answer of 22 seconds. It does not provide a warm hand-off to crisis providers although it does connect callers directly to mobile crisis teams. Call abandonment rate was reported as 3.5%. The call center does not have shared MOUs with crisis providers at this time.								

The unchecked items above represent criteria that would need to be fulfilled for the regional crisis call center to meet Levels 2-5 above. As the crisis system evolves in Palm Beach County, this scoring tool can serve as a guide and evaluation tool to monitor continued progress.

Recommendations

1. **Build upon current infrastructure to develop a regional crisis call center aligned with the National Guidelines.**

A partnership should be explored with the existing 988 operator to develop a fully-equipped crisis call center. Benefits to partnership include 211 Palm Beach and Treasure Coast's long history of serving Palm Beach County residents and relationships with service providers. Also, the call center is accredited by the American Association of Suicidology, the world's largest membership-based suicide prevention organization, and by Nonprofits First, which assesses for sound business and program practices.

If the current operation is unable to operate under the standards of the National Guidelines, an additional option includes separating the 988 Lifeline services from 211 and providing those under a different operation. Development of a regional crisis call center fully aligned with National Guidelines will require a significant investment and changes to current operations, including workforce development, technological infrastructure, and close partnerships with other aspects of the crisis care continuum to coordinate care in real time.

2. **Expand call center workforce to meet staffing needs and include clinical supervision.**

Minimum expectations require call centers to be staffed with clinicians overseeing clinical triage and other trained team members when responding to calls. This ensures that counseling services adhere to the highest professional standards. This approach also fosters ongoing professional development and provides an opportunity for clinical review and ongoing quality improvement.

With anticipated increasing call volume to 988 as awareness grows, there is a need for an increase in funding to expand call center staff to meet the needs of Palm Beach County. Vibrant Emotional Health, the administrator of the 988 dialing code at a national level, provided three growth scenarios in its initial modeling of 988 call center volume projections. In the Vibrant model, growth in call volume is determined by the baseline volume received by the National Suicide Prevention Lifeline (Vibrant Emotional Health, 2020). It also considers the volume expected to be redirected toward 988 from other local or regional crisis lines, as well as 911. Additionally, new user volume is factored in, representing the potential population that has not previously contacted the Lifeline, crisis services, or 911, but may use 988 in the future.

We used both the Low and Moderate scenarios to model projected growth of crisis call volume in Palm Beach County (Table 8). Both of these scenarios forecast a substantial increase in call volume, from 13,377 to over 86,000 (Low) and over 162,000 (Moderate) (Table 9).

Table 8. Scenario Modeling of Crisis Call Center Volume Projections.

	Low	Moderate
Growth rate of baseline Lifeline volume	1%	7%
Diversion rate of relevant crisis center volume to 988	70%	80%
Diversion rate of relevant 911 volume	10%	20%
Percent of potential serviceable population (ages 12 and older) contributing to new volume	5%	10%

Table 9. Growth Projections for Crisis Call Center Volume in Palm Beach County.

Scenario	Y1	Y2	Y3	Y4	Y5
Low					
1% growth rate (similar to population growth rate)	13,377	13,511	13,646	13,782	13,920
Up to 10% diversion rate of relevant 911 volume		2,000	3,000	6,000	8,000
Up to 5% of potential serviceable population using 988		15,000	30,000	45,000	64,400
Total Annual Contacts		30,511	46,646	64,782	86,320
Moderate					
7% growth rate	13,377	14,313	15,315	16,387	17,535
Up to 20% diversion rate of relevant 911 volume		4,000	8,000	12,000	16,000
Up to 10% of potential serviceable population using 988		30,000	60,000	90,000	128,800
Total Annual Contacts		48,313	83,315	118,387	162,334

Background and assumptions:

Baseline: In 2022, 27% of itemized needs at 211 Palm Beach and Treasure Coast were related to mental health and substance use disorder. While a single caller may have multiple needs, we used this rate to generate an approximate number of calls related to mental health and substance use disorder (baseline lifeline volume). Using this rate, we estimated that of the total 49,544 Palm Beach County contacts, 13,377 were related to mental health and substance use disorder in 2022 and used this as a baseline for both scenarios.

Diversion rate of relevant crisis center volume: There are no other local or regional crisis lines to divert from in Palm Beach County, so we use a diversion rate of 100% of current crisis center volume in both scenarios. (211 Palm Beach and Treasure Coast reports that 1% of its crisis calls are handled by the National Suicide Prevention Lifeline call center, which is a backup resource to the local call center and we do not expect this call volume to be diverted).

Diversion of relevant 911 volume: Palm Beach County has 15 public safety answering points (PSAPs) that receive over 1,000,000 calls annually. Vibrant assumes 8% of all calls to 911 relate to emotionally disturbed persons.

Potential serviceable population: Vibrant defines the serviceable population as the population age 12 years and older. Using U.S. Census data for Palm Beach County, we were limited to population estimates age 15 years and older.

3. Invest in technology that allows the regional crisis call center to improve service delivery and accessibility, and enhance the interactions between callers, staff, MRTs, and providers.

We recommend implementing real-time regional bed registry technology in partnership with crisis facilities and inpatient psychiatric hospitals in Palm Beach County. In addition, the regional crisis call center should be able to dispatch MRTs using GPS-enabled technology, providing call center staff with real-time geographical information about the teams to facilitate the most efficient response. This approach is expected to improve response times and the overall effectiveness of MRTs. These technological solutions must be accompanied by established procedures and agreements outlined in documents such as memoranda of understanding (MOUs) with MRT operators including South County Mental Health, as well as with crisis receiving and stabilization facilities and inpatient psychiatric hospitals. Additionally, outpatient providers should be included in direct appointment scheduling, as this is a key element supporting crisis resolution.

4. Develop partnerships with 911 Public Safety Answering Points (PSAPs) to divert behavioral health crisis calls from 911 to 988.

Several local governments have developed programs that allow PSAP call staff to identify when a behavioral health response is appropriate. This requires new training for both PSAP and 988 Lifeline staff, shared protocols, technological capabilities, and continuous quality improvement and oversight.

Examples of successful collaboration include:

- The STAR (Support Team Assisted Response) program in Denver, CO. This program embedded a clinician into the PSAP to divert calls from law enforcement and created a systematic guide to support dispatch staff in efficiently triaging calls. STAR has been in operation for almost three years, and recent studies have found it supported a 34% reduction in arrests for "low level" offenses such as trespassing, intoxication, and resisting arrest (Dee et al., 2022).
- Chicago recently launched its Crisis Assistance Response and Engagement (CARE) pilot program, which deploys one of three response teams based on the needs of the caller (City of Chicago, n.d.). The three possible team deployment options are: 1) a multidisciplinary team which consists of a paramedic, a clinician, and a CIT officer; 2) an alternative response consisting of paramedic and a clinician; or 3) an opioid response, consisting of a paramedic and a peer recovery specialist.

There are 15 PSAPs in Palm Beach County managing over 1,000,000 calls per year (Palm Beach County, n.d.). The Palm Beach County Sheriff's Office alone received 439,381 calls in 2021 and 412,642 calls in 2022 (Palm Beach County Sheriff's Office, 2023). As discussed above, Vibrant Emotional Health estimates approximately 8 percent of 911 calls are related to behavioral health situations, and other estimates range up to 25 percent (National Emergency Number Association, n.d.; Abramson, 2021). The diversion of 911 calls will likely result in a significant volume increase for 988 in Palm Beach County.

5. Conduct a public marketing campaign to raise awareness of the 988 Lifeline and its purpose.

Nationwide, local governments are investing in campaigns to raise awareness of 988. A public marketing campaign should be aimed at promoting hope, connectedness, and help-seeking behavior. It should clarify the role and purpose of 988 and 211 so community members are equipped to use the call center appropriately. In implementation of a campaign, the Health Care District should consider the following steps.

- Assess Local Needs: Based on public health data and building on the community input in this study, prioritize at-risk target audiences within the community. Consider demographic factors such as age, gender, race, ethnicity, and geographic locations.
- Tailor Messaging to Local Context: While adhering to national guidelines, customize messaging to address the unique needs and concerns of the local population. Emphasize fostering hope, resilience, recovery, and connectedness while specifically addressing stigma associated with seeking help within the Palm Beach County context.

- Multichannel Approach: Embrace a multichannel approach to reach a diverse audience. Utilize television, radio, digital platforms, billboards, restroom posters, transportation ads, and any other relevant communication channels. Ensure that each channel is carefully tailored to resonate with its intended audience, taking into account local media habits and preferences.
- Local Campaign Branding: Consider creating distinctive and memorable local branding for the campaign. A unique campaign name and visual identity can help build recognition and engagement within the community.
- Engage Local Ambassadors: Identify local influencers or public figures who can champion the cause and amplify the campaign's message through their social media platforms and public appearances. This can significantly enhance the campaign's reach and impact.
- Community Partnerships: Collaborate with local behavioral health organizations, schools, healthcare providers, and community centers to ensure a coordinated effort in promoting 988. These partnerships can help in disseminating information and providing resources to those in need.
- Regular Monitoring and Evaluation: Establish mechanisms for monitoring the effectiveness of the campaign. Collect data on awareness levels, and as possible, call volume to 988. Use this data to make necessary adjustments to the campaign strategy.

6. Advocate for increased funding for the 988 Lifeline in Florida.

One of Florida's Mental Health Advocacy Coalition legislative priorities for 2022-2023 includes supporting 988 Lifeline. The Biden-Harris administration has made an investment of nearly $1 billion to support the 988 Lifeline, including the transition to 988 in July 2022. The American Rescue Plan, Bipartisan Safer Communities Act, and the Federal FY 2023 Consolidated Appropriations Act has also given funding to support 988 Lifeline. However, as of June 2023, there has not been any state-enacted legislation to implement and fund 988 in Florida (National Academy for State Health Policy, 2023).

Advocacy for increased funding will address a critical gap in Florida's crisis response system. According to The National Association of State Mental Health Program Directors (NASMHPD), low salaries at crisis call centers, as well as the inability for staff to obtain licensing hours, places crisis contact centers in the position of being the "great exporter" of talent. Adequate sustainable funding is needed to allow crisis contact centers to be competitive in the job marketplace.

Someone to Respond

National Guidelines

Mobile crisis teams provide community-based intervention services to individuals experiencing a crisis, and offer support wherever the person is. Their goals are to help individuals experiencing a crisis event experience relief quickly, and resolve the situation. Teams consist of two-person units and are designed to help divert individuals from hospital EDs, the criminal justice system, and inpatient hospitalization.

These community based services use face-to-face interventions from professional and peer team members, delivering real-time assistance to individuals in crisis, and aiming for the best possible outcomes. These teams usually consist of Master's or Bachelor's-level clinicians, and peer support specialists, with back up on-call psychiatrists, and other clinicians, as needed.

988 is staffed through local contracts with call centers throughout the country, as well as a national call center that serves as a secondary resource, taking calls when the local call center is unavailable.
The goal for 988 is to serve as the entry point for crisis care, providing both direct support through telephonic intervention and connection to other components of the crisis care continuum.

Background

After the tragic incident at Marjorie Stoneman Douglas High School in 2018, there was an urgent need and attention on addressing behavioral health challenges by enhancing and expanding mobile crisis responses. The Marjorie Stoneman Douglas High School Public Safety Act of 2018 (Ch. 2018-3, Laws of Florida) was established to create a comprehensive network of MRTs throughout the state. Due to this, 29 MRTs were established across the state of Florida. To support these services, the annual budget for MRTs in Florida has increased from $18.3 million in 2018 to $36.3 million in 2022.

DCF contracts with Southeast Florida Behavioral Health Network (SEFBHN) to oversee MRTs in Palm Beach County. SEFBHN works with South County Mental Health Inc. to offer MRT services for all of Palm Beach County. The MRTs are organized into three groups, with each group dedicated to responding in a separate geographic region of the county: the north, south, and Glades areas.

Findings

The mobile response teams (MRTs) in Palm Beach County do not currently fulfill the key functions outlined in the National Guidelines.

There is an insufficient number of MRTs and very low mobile response volume in Palm Beach County. There are 27 mobile response team staff, according to SEFBHN, which equates to approximately 13.5 two-person teams. However, this number may not reflect the number of active teams functioning in community-based response due to mitigating factors such as staffing challenges, or teams being dedicated to a specific response site, e.g. schools. Staffing challenges are a persistent issue for mobile response teams in Palm Beach County and nationwide. Also, there are only approximately 479 deployments per quarter, reflecting a lower than expected volume of deployments. This issue is complex; given the very low volume of mobile response deployments, it is likely that people in crisis are not connecting to crisis services at the rate that they should be to achieve the intended outcomes of the Crisis Now model. Most of the stakeholders who participated in this study reported minimal utilization of MRTs, and that community members primarily experience interactions with law enforcement officers in the event of a behavioral health crisis. This may be because of low call volume to 988 (or to the MRTs directly), with many residents directly calling 911 in the event of a crisis.

The Crisis Resource Need Calculator projects 20 teams of two working 40 hours/week are needed to cover the county. The current model, with 13.5 teams, should be expanded alongside efforts to increase MRT deployment. Strategies employed by states and counties to increase uptake of crisis services include 911 call diversion to 988, media campaigns to promote and educate on 988, and close connectivity between 988 crisis call centers to enable direct deployment of MRTs.

Conflicting reports on response times were received, with both a perception of long response times for MRTs and several stakeholders referring to response times of one hour or less. The Group for the Advancement of Psychiatry recommends mobile crisis has the capacity to respond to calls within one hour more than 90% of the time, and preferably sooner (Roadmap to the Ideal Crisis System, 2021).

Due to current workforce challenges, MRTs have a high rate of law enforcement involvement. Currently, MRTs do not include licensed clinicians and are unable to initiate Baker Acts. This means that in the event a Baker Act may be needed, MRT must call for a law enforcement response. As shown above (see "Context" section), law enforcement maintains a significant role in mental health crisis response and Baker Acts, accounting for 49% of all Baker Acts conducted. Responsive mobile crisis (conducted without law enforcement as much as possible) makes access to help easier and decreases the likelihood of unnecessary ER visits and arrests (Roadmap to the Ideal Crisis System, 2021).

Misalignment and mistrust between MRTs and law enforcement leads to suboptimal decision making regarding Baker Acts. Several stakeholders reported disagreements between MRTs and law enforcement on whether a Baker Act was

needed in a crisis response situation. Due to the law enforcement officer's position as the professional authorized to conduct Baker Acts, the assessment of the law enforcement officer takes precedence over that of the clinician.

Stakeholders described this as a major challenge to community members' experiences with MRTs. Relatedly, they cited the presence of law enforcement officers - particularly those in uniform - as exacerbating crisis situations, especially for communities of color.

Perception of the current MRTs keeps community members from asking for help. Stakeholders discussed a perception by the community that calling MRTs will result in law enforcement involvement, which keeps people from calling. Concerns include the nature of the interaction with law enforcement, the potential for transportation with handcuffs in a police car, and the concern about having such a call on their record. Stakeholders described perception of South County Mental Health as another barrier, noting that stigma attached to receiving care from this organization keeps people from seeking care.

Inconsistent information was received regarding the composition of MRTs. Some stakeholders reported instances where only one team member responded to calls, while others indicated that the teams are typically composed of both a peer and a clinician. South County Mental Health confirmed that its MRTs do not include licensed mental health professionals, however, they do include behavioral health professionals and peers.

Complementary Mobile Teams Provide Similar Services. There are several programs providing field-based services in Palm Beach County. The scope of these services is complementary to mobile response teams, and these programs may serve the same patient populations.

Mobile Integrated Healthcare (MIH) is a program led by Palm Beach County Fire Rescue (PBCFR). The MIH program offers a multidisciplinary approach to post-EMS intervention, aiming to address the diverse needs of patients beyond immediate medical care. The program's team consists of paramedics, nurses, social workers, and other healthcare professionals, forming a collaborative and patient-centered model.

The MIH program provides a range of services, including assessment, disease management planning, care coordination, resource provision, emotional support, and advocacy. The professionals involved, such as medical social workers and community paramedics, work together to support patients and families in navigating their unique challenges. The program identifies patients through data analysis and through referrals from PBCFR crews during 911 calls, ensuring a targeted approach to those who would benefit most.

MIH offers several specialized programs, each tailored to specific needs. The High-Frequency Utilizer Program focuses on reducing reliance on EMS by connecting patients with community-based services. The Chronic Disease Management Program works with patients with chronic illnesses to manage their health and avoid frequent 911 calls. The Addiction Program also provides telehealth support for individuals who have experienced

addiction-related emergencies, offering emotional support and connections to addiction intervention resources. The MIH, including these programs, differ from mobile response teams since they are not called upon to intervene during a behavioral health crisis and their goals are different from MRTs. However, the individuals they work with may experience a behavioral health crisis and these teams should coordinate with mobile response teams when needed. They also educate individuals and families about the MRTs and their role, and when and how to seek help.

The Targeted Violence Unit is an approximate 30-person division of Palm Beach County Sheriff's Office (PBSO). The Targeted Violence Unit operates with a co-responder model that pairs plain-clothed sworn detectives and licensed clinical therapists to respond to concerns raised by law enforcement. Through this collaboration, the teams tackle community threats, domestic violence incidents, and even online threats. The Targeted Violence Unit also encompasses completion of risk protection orders, linkage to community resources through clinical staff, and active participation in the Palm Beach County Threat Management Team.

The Targeted Violence Unit employs two distinct intervention pathways: 1) Law enforcement responds to immediate threats, and 2) Licensed clinicians collaborate with families and individuals to address underlying issues and provide access to community resources for sustained support. The Targeted Violence unit is funded through the Department of Homeland Security, the Department of Justice, and SEFBHN.

The Targeted Violence Unit interventions protocols are strict and require a specific level of community threat. The Unit formulates long-term plans to divert individuals from the pathway to violence. The unit has tremendous support from the community, resulting in a 40% growth leading to future plans of expansion in the next year.

The Targeted Violence Unit serves a different role than mobile response teams. The Targeted Violence Unit is focused on addressing and mitigating potential threats, whereas mobile crisis teams are focused on responding to mental health crises. The licensed clinicians on the Targeted Violence Unit can work with an individual for 30 days or up to 12 months, whereas the mobile response team focuses on-the-spot crisis intervention.

The Community Resource Team (CRT) is a proposed initiative of the PBSO. The primary objective of the CRT is to create and pilot a comprehensive, trauma-informed Co-Responder Community Resource Team. This strategy aims to improve public safety and enhance public health responses to individuals with a mental illness and those with co-occurring mental health and substance use disorders who come in contact with law enforcement.

The proposed structure of the CRT involves properly trained detectives working Monday to Friday, partnering with clinicians, advocates, and peer specialists. The goal is to have these teams available 24/7, providing immediate support and assistance to individuals in crisis without the need for law enforcement intervention. The CRT is designed to be a community-focused initiative that emphasizes collaboration between law enforcement and behavioral health professionals to ensure more effective and compassionate responses to individuals experiencing mental health crises (Bureau of Justice Assistance, 2023).

The CRT and mobile response teams both share common goals in addressing mental health crises, however, they differ in structure, focus, and approach. First, mobile response teams do not employ detectives, whereas the CRT has trained detectives responding with other professionals. Secondly, mobile response teams are available 24/7, even on weekends, whereas the CRT will operate Monday to Friday. Third, the CRT aims to work with individuals who come in contact with law enforcement whereas mobile response teams primarily focus on immediate crisis intervention, de-escalation, connecting individuals to appropriate resources, and reducing law enforcement involvement.

The Alpert Jewish Family Service (JFS) provides efforts to strengthen the capabilities of law enforcement and first responders to respond to behavioral health crisis calls.

JFS introduced the implementation of Mental Health First Aid (MHFA) to Palm Beach County Sheriff's Office. JFS currently has six trainers for MHFA. JFS also provides specialized modules tailored for first responders. This initiative not only expands the knowledge base of PBSO officers and first responders but also ensures a more empathetic and informed approach when handling situations involving mental health challenges, thereby promoting a safer and more supportive community.

Assessment

The National Guidelines outline minimum expectations and best practice guidelines for mobile crisis teams. Based on information received from South County Mental Health Center Inc., it was determined that this operation does not meet the minimum expectations for mobile crisis teams as defined by National Guidelines (Table 10).

Table 10. Minimum Expectations for Mobile Crisis Teams.

Minimum Expectations	Status
Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation.	No
Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times.	Yes
Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.	Yes
Explanation: South County Mental Health reports that it does not have licensed and/or credentialed clinicians on its mobile teams. The teams do respond to where the person is, and connect individuals through warm hand-offs and coordinating transportation (i.e. with law enforcement) when needed.	

The National Guidelines set Best Practices for mobile crisis teams. Currently, the South County Mental Health Inc. MRTs do not meet best practice guidelines (Table 11).

Table 11. Best Practices for Mobile Crisis Teams.

Best Practices (must meet minimum expectations AND):	Status
Incorporate peers within the mobile crisis team.	Yes
Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion.	Yes
Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement.	No
Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.	No
Explanation: South County Mental Health reported that peers are incorporated within their teams. To our knowledge, the MRTs respond without law enforcement unless needed. However, under the current approach, law enforcement is always needed in the event of a Baker Act. As stated in Someone to Call Assessment, the MRTs do not use GPS technology. The MRTs have the capability to schedule appointments for individuals and their families by contacting providers with them while they are in the field, though they are not able to schedule appointments directly themselves or coordinate warm handoffs.	

According to the Crisis Now Scoring Tool, mobile crisis team services in Palm Beach County score an assessed Level 2 for mobile crisis teams, which are described as Basic (Table 12).

Table 12. Crisis Now Scoring Tool: Mobile Crisis Teams.

	Level 1 (Minimal)		Level 2 (Basic)		Level 3 (Progressing)		Level 4 (Close)		Level 5 (Full)
✓	Mobile Teams are in Place for Part of the Region	✓	Meets Level 1 Criteria		Meets Level 2 Criteria		Meets Level 3 Criteria		Meets Level 4 Criteria
✓	Mobile Teams are Operating at Least 8 hours Per Day in at least part of the region	✓	Mobile Teams are Available Throughout the Region at Least 8 hours Per Day	✓	Mobile Teams are Available Throughout the Region at Least 16 hours Per Day		Formal Data Sharing in Place Between Mobile Teams and All Crisis Providers		Real-Time Performance Outcomes Dashboards Throughout Crisis System
✓	Mobile Teams Respond to Calls Within 2 Hours Where in Operation	✓	Mobile Teams Respond to Calls Within 2 Hours Throughout the Region		Mobile Teams Respond to Calls Within 1.5 Hours Throughout the Region		Mobile Teams Respond to Calls Within 1 Hour Throughout the Region		GPS-Enabled Mobile Team Dispatch by Crisis Line
✓	Mobile Teams Complete Community-Based Assessments	✓	Mobile Team Assessments include All Essential Crisis Now Defined Elements		Directly Connect to Facility-Based Crisis Providers as Needed		Support Diversion Through Services to Resolve Crisis with Rate Over 60%		Support Diversion Through Services to Resolve Crisis with Rate Over 75%
✓	Mobile Teams Connect to Additional Crisis Services as Needed	✓	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services		Some Mobile Team Access to Person Specific Health Data		Mobile Teams Receive Electronic Access to Some Health Information		All Mobile Teams Include Peers
		✓	Shared MOUs / Protocols with Call Center Hub		Shared MOUs / Protocols with Call Center and Crisis Facility-Based Providers		Shares Documentation of Crisis with Providers		Shared Status Disposition of Intensive Referrals
		✓	Priority Focus on Safety / Security		Trauma-Informed Recovery Model Applied		Some Peer Staffing within Mobile Teams		Meets Person Wherever They Are - Home/Park/ Street / Shelter etc.

	Level 1 (Minimal)		Level 2 (Basic)		Level 3 (Progressing)		Level 4 (Close)		Level 5 (Full)
							Systematic Suicide Screening and Safety Planning		Real-Time Access to Electronic Health Records
									Suicide Care Best Practices That Include Follow-up Support
									Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = Level 2 (Basic)	Justification of Rating: To our knowledge, MRTs respond within two hours, and operate 24/7. We were unable to obtain information on MRT assessments, training provided to staff, or prioritization of safety and security.								

The unchecked items above represent criteria that would need to be fulfilled for the MRTs to meet Levels 2-5 above. As the crisis system evolves in Palm Beach County, this scoring tool can serve as a guide and evaluation tool to monitor continued progress.

Recommendations

1. Increase the number of MRTs in Palm Beach County aligned with national standards.

It is imperative to address the critical gap in crisis response by increasing the number of MRTs in Palm Beach County. Presently, the county faces a shortage of MRTs. The existing sixteen teams are tasked with covering the entirety of the county, which is inadequate to meet the escalating demands for timely crisis interventions. The Crisis Now model projects a requirement for 20 teams to comprehensively address the county's demands. Furthermore, the current lack of alignment between law enforcement and MRTs highlights the pressing need to expand the number of teams. By strengthening the presence of MRTs, Palm Beach County can more effectively address the diverse and increasing demands of crisis response, ultimately improving community safety and minimizing the involvement of law enforcement resources.

2. Align MRT composition, training, and operations with National Guidelines.

Efforts to align MRT with the National Guidelines will require a multifaceted approach. This will include technological infrastructure, a larger workforce, and

close collaboration with other components of the crisis care continuum such as the regional crisis call center, crisis facilities, and outpatient services.

There is a need to understand the training provided to staff and prioritization of safety and security, and to ensure it aligns with the National Guidelines.

There is also a need to include a licensed and/or credentialed clinician to assess the needs of individuals within the region of operation. To address warm hand-offs, it will be important to ensure a real-time bed registry, as well as the ability to schedule outpatient appointments be integrated into the teams' functionality. One alternative model to consider is the use of telehealth to supplement mobile response teams. By providing a licensed clinician through telehealth, mobile response team capacity can be increased amidst staffing shortages. Henderson Behavioral Health in Broward County, Florida, is currently developing this response model.

3. **Collaborate with law enforcement, EMS, and existing field-based programs to enhance the effectiveness of mobile crisis teams for timely and coordinated responses, and to reduce unnecessary law enforcement involvement.**

Collaborating with law enforcement is strongly recommended to enhance the effectiveness of mobile crisis teams for timely and coordinated responses, while simultaneously reducing unnecessary law enforcement involvement. Law enforcement plays a pivotal role in the Baker Act process, often having varying perspectives on whether an individual should be subject to Baker Act procedures.

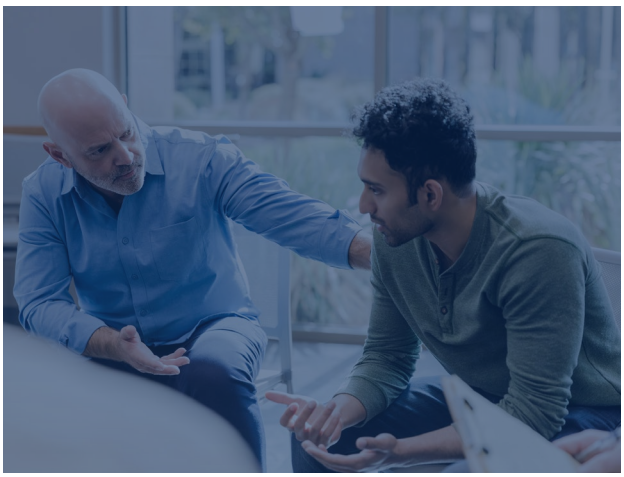
By fostering a close working relationship between law enforcement and MRTs, the aim is to reduce unnecessary law enforcement involvement in situations where individuals may be better served by alternative crisis interventions, and to appropriately use the Baker Act. Importantly, individuals should be able to access crisis facilities without the use of the Baker Act.

The Behavioral Services Division at PBSO runs the Crisis Intervention Training (CIT) program for the entire county, training law enforcement, corrections, and communication personnel through 20-30 classes each year.

This division should be involved in the early stages of planning for a law enforcement partnership. This partnership can lead to more informed decision-making and a streamlined approach to crisis response, ensuring that individuals receive the most appropriate care and safety needs are addressed.

The Health Care District would benefit from coordinating with Palm Beach County Fire Rescue, EMS, and its mobile programs. Developing a shared understanding of the roles, goals, and transfer opportunities for each team will be crucial to coordinating mobile response teams with other efforts. In addition, it will be important for these teams to understand the role of the proposed central receiving facility (described in the following section) and how to assist clients in accessing it.

Somewhere to Go



National Guidelines

The first tier of facility-based care in an optimal crisis care system, as outlined by the National Guidelines, is a crisis receiving facility. Crisis receiving facilities accept all walk-ins and individuals brought in by first responders. Crisis facilities provide 24/7 intensive, short-term stabilization in a warm and welcoming environment. These facilities are specifically designed to provide a short path from client arrival to stabilization and treatment. They provide assessment, therapy, medication services, and referrals. Crisis receiving facilities, as outlined by the National Guidelines, provide individual stays of up to 23 hours and 59 minutes, so are often referred to as 23-hour observation units. The primary goal of a 23-hour stay is the avoidance of unnecessary hospitalization for persons whose crisis may resolve with time and observation.

In order to maximize capacity, crisis receiving facilities typically operate with recliner chairs, rather than beds, where clients can rest comfortably, although some centers incorporate a few beds.

Effective crisis receiving facilities connect patients to ongoing care, with the best performing systems scheduling follow up appointments directly for individuals before the conclusion of their stay. For those patients who need continued stabilization after 23 hours, many facilities offer short-term crisis beds. Lengths of stay, facility type, and levels of care provided vary widely and may depend on state regulations. In Florida, crisis stabilization units provide short-term crisis beds with an average length of stay of 3-14 days.

Background

Both existing crisis stabilization units (CSUs) are located in the southern region of the county, particularly serving the population south of Southern Boulevard. They receive around 400 requests for emergency and nonemergency services every month, and provide behavioral health care for more than 5,000 clients each year. The Jerome Golden Center had previously provided behavioral health services, including crisis stabilization, in the northern region of the county, but closed abruptly in 2019, leaving a significant gap in care for a large number of community members.

Findings

In Palm Beach County, there is a lack of crisis receiving facilities that fulfill minimum expectations outlined in the National Guidelines.

There are not enough crisis receiving chairs or short-terms crisis beds in Palm Beach County to meet the needs of the community.

Historically, Palm Beach County has not had any facilities providing crisis receiving chairs. During this study, NeuroBehavioral Hospitals announced plans to open 20 receiving chairs at its north campus within the next year. The Crisis Now model projects a need for 82 receiving chairs in the county, so this represents an initial step toward addressing this gap.

There are currently 49 short-term crisis beds at two locations operated by South County Mental Health. Crisis Now projects 69 short-term crisis beds are needed in Palm Beach County. South County Mental Health reported severe challenges related to capacity, stating that it is often operating at full capacity or beyond. In a notable incident, the census at its 35-bed facility had surged to 54 patients, surpassing the designated capacity. The organization reported this was due to the requirement to accept law enforcement drop offs regardless of the census. Relatedly, stakeholders reported prolonged admission wait times upon arrival at the crisis stabilization units. Stakeholders also reported instances of refusal and/or turnaway of admissions (not law enforcement admissions).

The insufficient capacity of crisis care facilities is evident in hospital EDs across the county. Reports from various hospitals highlight instances where patients have waited for days in their EDs, seeking admission to an inpatient facility or crisis stabilization unit.

First and foremost, this delay in care is detrimental to patients, as is the brightly lit, chaotic, loud environment of the ED. Secondly, it hampers patient flow and operations in hospital EDs, impacting staff and other ED patients.

In Florida, managing entities contract with hospitals with inpatient psychiatric units to provide care to their target populations. These inpatient psychiatric hospital beds can be referred to as crisis beds. However, the National Guidelines emphasize the importance of shifting care out of the highest cost, most restrictive settings (i.e. hospitals and jails) and into lower cost, specialized crisis care facilities. Therefore, inpatient psychiatric hospital beds are excluded from the count of short-term crisis beds in Palm Beach County.

The Baker Act is excessively employed to gain entry to facility-based crisis care. According to a hospital, two of the four Baker Act receiving facilities in the county require a Baker Act in order to be admitted. Consequently, an individual in crisis voluntarily seeking assistance at an emergency department may be denied admission without a Baker Act. These practices deter people from seeking help voluntarily due to reluctance to have a Baker Act on their record and/or be handcuffed and transported in a police car to one of these facilities.

Stakeholders expressed concerns about the environment of current crisis stabilization facilities. Several stakeholders indicated that the existing CSUs are dated in their design, and the facilities themselves are restrictive and not welcoming. They indicated that these environmental elements exacerbate crisis situations, lead to insufficient engagement in treatment, and deter people from seeking help.

Assessment

The National Guidelines outline minimum expectations and best practice guidelines for crisis receiving facilities. Based on information we received, we found that current operations do not meet all of the minimum expectations for a crisis receiving facility (Table 13). We did not receive the necessary information to complete our evaluation of the current facilities' ability to meet minimum expectations and best practices.

Table 13. Minimum Expectations for a Crisis Receiving Facility.

Minimum Expectations	Status
Accept all referrals.	No
Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program.	Yes
Design their services to address mental health and substance use crisis issues.	Yes
Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed.	No
Be staffed at all times with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community.	Unknown
Offer walk-in and first responder drop-off options.	Yes
Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders.	Unknown
Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated.	Unknown
Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.	Unknown
Explanation: The existing CSUs must accept all clients seeking admission under the Baker Act. This has led to situations where the facilities commonly exceed maximum capacity. We heard conflicting reports from stakeholders who indicated individuals had trouble being admitted to these facilities. The CSUs do not require medical clearance prior to admission, but have challenges with addressing physical health needs that exceed their capacity. The facilities address mental health and substance use crisis issues, and there are walk-in and first responder drop-off options offered. Due to limited data received, we were unable to obtain information on other minimum expectations.	

The National Guidelines outline best practices for crisis receiving facilities. Currently, existing CSUs do not meet best practice guidelines (Table 14).

Table 14. Best Practices for a Crisis Receiving Facility.

Best Practices	Status
Function as a 24 hour or less crisis receiving and stabilization facility.	No
Offer a dedicated first responder drop-off area.	Unknown
Incorporate some form of intensive support beds into a partner program to support flow for individuals who need additional support.	Yes
Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources.	No
Coordinate connection to ongoing care.	Unknown
Explanation: The CSUs do not function as a 24 hour or less crisis receiving and stabilization facility. The CSUs partner with Delray Medical Center for admissions to their inpatient units. There is an absence of a real-time bed registry system operated by the crisis call center. Other best practices were not able to be determined due to the limited information available.	

According to the Crisis Now Scoring Tool, crisis receiving facility services in Palm Beach County score between Level 1 and Level 2 requirements for crisis receiving facilities, which are described as Basic and Minimal (Table 15).

Table 15. Crisis Now Scoring Tool: Crisis Receiving Facility.

	Level 1 (Minimal)		Level 2 (Basic)		Level 3 (Progressing)		Level 4 (Close)		Level 5 (Full)
✓	Sub-Acute Stabilization is in Place for Part of the Region	✓	Meets Level 1 Criteria		Meets Level 2 Criteria		Meets Level 3 Criteria		Meets Level 4 Criteria
	Have 24/7 Access to Psychiatrists or Master's Level Clinicians	✓	Some Form of Facility-Based Crisis is Available Throughout the Region	✓	Crisis Beds / Chairs Available at a Ratio of at Least 3 per 100,000 Census		Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers		Real-Time Performance Outcomes Dashboards Throughout Crisis System

	Level 1 (Minimal)		Level 2 (Basic)		Level 3 (Progressing)		Level 4 (Close)		Level 5 (Full)
✓	In Counties with Sub-Acute Stabilization, at Least 1 Bed / Chair per 100,000 Census	✓	Crisis Beds / Chairs Available at a Ratio of at Least 2 per 100,000 Census		Offers Crisis Stabilization / Observation Chairs as well as Sub-Acute / Residential		Crisis Beds / Chairs Available at a Ratio of at Least 4 per 100,000 Census		Crisis Beds / Chairs Available at a Ratio of at Least 5 per 100,000 Census
		✓	Shared MOUs / Protocols with Other Crisis Providers		Multiple Providers Offering Facility-Based Crisis Services		Support Diversion From Acute Inpatient at Rate Over 60%		Support Diversion From Acute Inpatient at Rate Over 70%
			Staff Trained in Zero Suicide / Suicide Safer Care and BH Services		Some Crisis Facility Access to Person Specific Health Data		Incorporates Crisis Respite Services into the Facility-Based Crisis Continuum		No Refusal to First Responder Drop offs as Primary Service Location
			Priority Focus on Safety / Security		Trauma-Informed Recovery Model Applied		Operates in a Home-Like Environment		Bed Inventory and Referral Centralized Through Crisis Line
				✓	Direct Law Enforcement Drop-Offs Accepted		Systematic Suicide Screening and Safety Planning		Suicide Care Best Practices That Include Follow-up Support
					Least Restrictive Intervention and No Force First Model		Some Peer Staffing within the Crisis Facility		Utilize Peers as Integral Staff Members
							Sub-Acute Stabilization Receive Electronic Access to Some Health Information		Shared Status Disposition of Intensive Referrals
							Shares Documentation of Crisis with Providers		Law Enforcement Drop-Off Time Less Than 10 Minutes
									Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = Level 1 (Partial)		Justification of Rating: Sub-acute stabilization is in place for part of the region, at approximately 2.3 beds per 100,000. We were unable to determine the availability of 24/7 access to Psychiatrists or Master's Level Clinicians.							

Recommendations

1. **Increase the number of crisis receiving chairs and short-term crisis beds by developing a crisis receiving and stabilization facility to provide services for children, youth, and adults, including 23-hour observation, addiction receiving services, and short-term crisis stabilization.**

Based on the gaps in the number of crisis receiving chairs and short-term beds outlined in the Crisis Now model, we recommend the Health Care District establish a crisis receiving and stabilization facility that will function as a central receiving facility in Palm Beach County for both voluntary and involuntary admissions, and provide short-term crisis stabilization services on site. In Florida, a receiving facility is a public or private facility that is authorized by the Department of Children and Families to provide emergency screening, evaluation, and short-term stabilization for mental health or substance abuse disorders under Section 394.445(13), F.S. This facility should serve children, youth, and adult populations. It should also provide receiving and stabilization for individuals admitted under both the Baker Act and the Marchman Act.

Investing in facility-based crisis care will alleviate the burden on hospital inpatient psychiatric beds and ensure more care is provided in less restrictive, lower cost settings.

This holistic approach should encompass face-to-face interventions, a comprehensive array of services, diverse teams, trauma-informed practices, prompt stabilization, and a deeply compassionate response to individuals facing behavioral health crises. The following Crisis Receiving and Stabilization section provides further details on recommendations for this facility.

2. **Gain further insight into the functionality of the recent addition of crisis receiving chairs into the continuum of crisis care in Palm Beach County.**

The Health Care District should work closely with NeuroBehavioral Hospitals to understand how the new receiving chairs are operationalized within the crisis continuum of care. This includes what percent of admissions are voluntary vs. involuntary, patient volume, average length of stay, percent transferred to a higher level of care or longer-term stabilization, and access to post-discharge care. This information will inform the Health Care District regarding implementation of additional crisis receiving chairs in the county. Law enforcement, client, and family feedback should also be collected and used to evaluate how the entities involved can further align their services to be consistent with National Guidelines.

3. Enhance access to facility-based crisis care in Palm Beach County through collaboration.

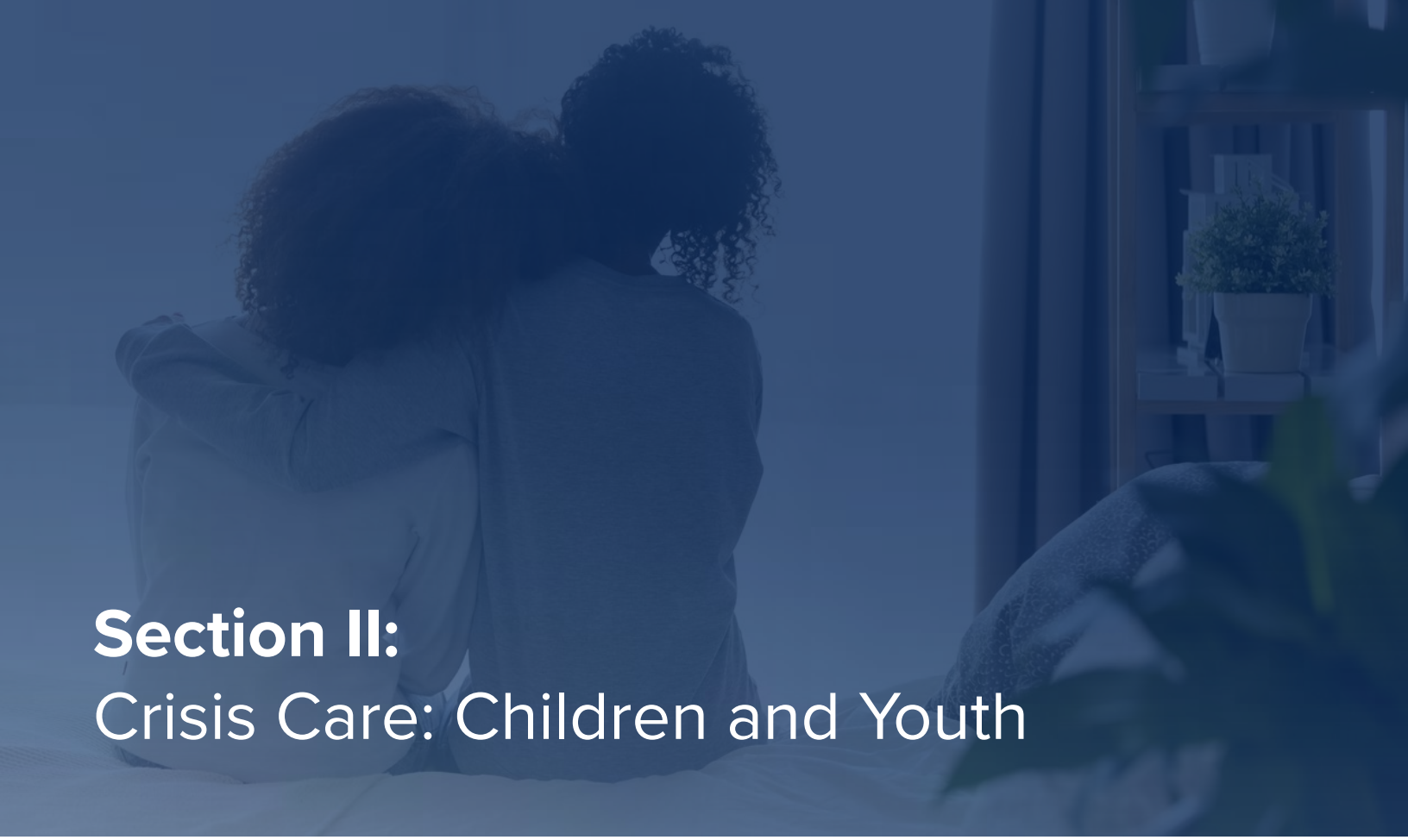
The Health Care District should explore opportunities to partner with existing providers of facility-based crisis services as it develops the recommended crisis receiving and stabilization facility. Existing resources contribute significantly to the crisis continuum of care in the county, and alignment will allow for a more comprehensive approach to crisis care and a stronger commitment to the well-being of the community.

This partnership should include clinical collaboration for client transfers, data-sharing to support care coordination, and a review of opportunities to develop standardized protocols aligned with National Guidelines.

Some existing providers and/or partners include The Drug Abuse Foundation (DAF), Tenet Health - Delray Medical Center, HCA Healthcare - JFK North, and NeuroBehavioral Hospitals.

For example, DAF provides crisis services related to substance use at its Emergency Receiving Center (ERC) which is part of its detoxification services.

The ERC conducts emergency clinical assessments, medical assessments, triage, and admission for detox services. DAF provides 22 short-term (3-5 day) detox beds. In addition, there are several organizations offering residential care for mental health and substance use challenges, including Mandela Healing Center. These programs are an important part of the care continuum and can often serve as the next destination for individuals after crisis care.



Section II:
Crisis Care: Children and Youth

The National Guidelines for Child and Youth Behavioral Health Crisis Care emphasizes that it is vital for crisis services to keep young individuals within their home settings and minimize the necessity for out-of-home placements whenever possible. This approach places a strong emphasis on providing developmentally appropriate services and support, recognizing that youths have unique needs distinct from those of adults.

In striving for holistic care, these crisis services should provide family and youth peer support, as well as individuals with lived experience. In order to address the diverse needs of all families, it is essential to provide services that are not only culturally and linguistically sensitive but also rooted in principles of equity.

The National Guidelines for Child and Youth Behavioral Health Crisis Care also advises that youth crisis services should be centered on de-escalation and stabilization within the home and community. If it is safe, every effort should be made to help youth and children stay in their current living environment. In Palm Beach County, stakeholders report that mental health is the top priority for parents and youth-specific organizations such as Palm Beach County Youth Services.

This section below highlights issues pertaining to regional crisis call centers, MRTs, and facility-based crisis services for youth. Each section follows the format of National Guidelines, Background, Findings, Assessment, and Recommendations.

Someone to Call: Children and Youth

National Guidelines

The National Guidelines for Child and Youth Behavioral Health Crisis Care share similarities with the National Guidelines for Behavioral Health Crisis Care. However, this section will highlight and examine the differences between the two sets of guidelines. For example, the guidelines pertaining to children and youth emphasize that the regional crisis call center should provide brief, developmentally suitable screening and intervention services accessible through phone calls, text messages, and online chat. Additionally, it should have a dedicated team of behavioral health professionals, including licensed experts, as well as family and youth peers, all equipped with specialized training to effectively address the unique requirements of young individuals.

Background

211 Palm Beach and Treasure Coast offers services for children and youth outside of crisis care. This includes free developmental screenings and Help Me Grow care coordinators who provide follow up support to families based on results. The call center also has a special needs helpline to offer care coordination for families in PBC for children with special needs. The staffing and training necessary for these specialized preventative services may serve as foundation for establishing additional specialization in crisis care for children and youth.

211 Palm Beach and Treasure Coast provides a valuable resource for teenagers through its teen help guide. This guide offers information to assist young individuals in coping with life stressors unique to their age group, providing resources to help them lead healthier lives. Notably, 211 offers a dedicated teen hotline that actively listens to teenagers' feelings and aids them in making positive decisions. The teen help guide serves as a comprehensive resource for adolescents, guiding them through information and services available in Palm Beach County. These resources, which include crucial support for mental health crisis services and suicide prevention, refer to services in Palm Beach County.

Findings

There is an absence of a multidisciplinary team focused on crisis services for children and youth at the regional crisis call center.

According to the information we received, 211 Palm Beach and Treasure Coast provides tailored services for children and youth through several programs, but this does not include crisis services.

Crisis call centers should be staffed by clinical and paraprofessional staff that have specialized training to meet the needs of youth, including licensed behavioral health professionals and family and youth peers (National Guidelines for Child and Youth Behavioral Health Crisis Care, 2023).

According to the information we received, 211 Palm Beach and Treasure Coast provides tailored services for children and youth through several programs, but this does not include crisis services.

Crisis call centers should be staffed by clinical and paraprofessional staff that have specialized training to meet the needs of youth, including licensed behavioral health professionals and family and youth peers (National Guidelines for Child and Youth Behavioral Health Crisis Care, 2023).

The School District of Palm Beach County promotes 988 through several means, including printing the number on the back of student ID cards.

The School District of Palm Beach County also has a suicide prevention guide with printable posters for youth warning signs, and other youth-specific discussions for the 988 suicide and crisis lifeline (The School District of Palm Beach County, n.d.).

We did not find promotion of 988 to be common in other organizations or environments, highlighting the significance of these efforts by The School District.

Assessment

The National Guidelines for Child and Youth Behavioral Health Crisis Care outline youth essential operations for a regional crisis call center. Since several of the guidelines have been previously assessed under the general guidelines for all ages, we have excluded them and only included new guidelines. Based on information we received from 211 Palm Beach and Treasure Coast, we found that this service does not meet all of the youth essential operations for a regional call center (Table 16). We requested and did not receive the necessary information to complete our evaluation of the complete set of youth essential operations for a regional crisis call center.

Table 16. Youth Essential Operations for a Regional Crisis Call Center.

Essential Operations for Youth	Status
Have protocols and resources in place to quickly access translation services, and TTY (teletypewriter) for those who are deaf or hard of hearing. Have sufficient capacity and oral fluency in languages that match the community need.	Unknown
Be staffed to answer every contact from youth and families, as well as from agencies and organizations that serve these populations (e.g., schools). If resources are not available to support this, coordinate overflow coverage with another youth- and family-trained crisis center.	Yes
Gather data on call volume, response time, user satisfaction, and outcomes to inform a continuous quality improvement process, which should include regular review of call data to identify and address disparities, identify service gaps, and determine training needs.	Unknown
Explanation: 211 Palm Beach and Treasure Coast coordinates overflow coverage with another the National Suicide Prevention Lifeline. Based on limited information received, we were unable to determine if 211 Palm Beach and Treasure Coast has consistent data reporting to identify service gaps and training needs, quick and accessible translation services, teletypewriter, or oral fluency in languages that match the community need.	

The National Guidelines for Child and Youth Behavioral Health Crisis Care set technology, staffing, training and services for youth for a regional crisis call center. Currently, the 211 Palm Beach and Treasure Coast call center does not meet these guidelines (Table 17). We requested and did not receive the necessary information to complete our evaluation of the complete set of youth essential operations for a regional crisis call center.

Table 17. Technology, Staffing, Training, and Services for Youth.

Technology, Staffing, Training, and Services for Youth	Status
Build technological capacity to incorporate texting, chat, and video.	Unknown
Utilize real-time regional bed registry technologies that integrate information about which facilities have openings for youth (Recognize, however, that most users will not need inpatient services.)	No
Staff crisis call centers with an interdisciplinary team of child and adolescent behavioral health clinicians, family and youth peers, and other trained team members (As much as possible, hire staff whose racial, ethnic, linguistic, and sexual orientation or gender identities are representative of the communities served)	No
Ensure all responders receive relevant training on developmentally appropriate supports and services available in the region or community	Unknown
With the family's permission, schedule home- and community-based follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode, in collaboration with the MRT.	No
Explanation: We were unable to determine if video is built into the regional crisis call center's technological capacity. There is an absence of a real-time regional bed registry, including information on facility openings for youth. Staffing at the crisis call center does not include family and youth peers. Additionally, it remains unclear whether responders receive training on providing developmentally appropriate support and services. Currently, there are no capabilities for outpatient scheduling beyond callers contacting service providers directly themselves.	

Recommendations

1. **Ensure the development of a regional crisis call center aligns with the National Guidelines for Youth and Children.**

It is essential that crisis call centers offer services tailored for youth and children. This includes implementation of video communication to callers, establishing real-time bed registries for pediatric services, securing funding to expand staff to include child and adolescent behavioral health clinicians, family and youth peers, and other trained team members.

It also involves providing developmentally appropriate services, and connecting callers to outpatient services. The National Guidelines also recommend that staff are hired who represent the communities served.

2. **Collaborate with related service providers and systems youth and families encounter, including juvenile justice systems, pediatric providers, homeless shelters, and transitional housing programs.**

This collaboration should include informing these providers and systems regarding the crisis services available, including 988. It should also include cross-education and training, data-sharing agreements, sharing of screening tools, and development of protocols about when and how to contact crisis services (Wasserman, 2021).

Someone to Respond: Children and Youth

National Guidelines

The National Guidelines for Child and Youth Behavioral Health Crisis Care emphasize that MRTs should support families at the location of the crisis within the community. While young individuals can request mobile crisis services themselves, it is common for parents and youth-oriented systems like schools to initiate these requests. MRTs should be trained to work with families and within the school environment.

MRTs should include professional and paraprofessional staff. This can include mental health counselors, crisis intervention specialists, social workers, nurses, trained youth or family peer support providers, and psychologists.

Background

According to the Department of Children and Families, MRTs are designed to offer around-the-clock emergency behavioral health services to individuals across Florida.

These teams should be well-equipped to assist anyone experiencing a severe emotional or behavioral crisis, whether it occurs at home, in school, or any other location. The primary objectives of MRTs include minimizing trauma and mitigating the need for psychiatric hospitalization and involvement with the criminal justice system.

MRTs achieve these goals by employing de-escalation techniques, providing suitable crisis interventions, and facilitating connections to local community resources.

The School District of Palm Beach County developed an updated Policy 5.20 entitled, "Student Mental Health Crisis Response" in 2021. The purpose of Policy 5.20 is to implement behavioral and mental health procedures that encompass prevention, intervention, and postvention strategies. This policy also governs data collection related to The School District's compliance of the "Florida Mental Health Act" (The School District of Palm Beach County, 2021). The School District provides training for school-based employees on behavioral health, and school police officers attend Baker Act and mental health crisis intervention training.

In cases of intervention, school staff aim to use proactive behavioral and calming strategies for de-escalation. If unsuccessful, they seek support from mobile response or CAPE (Crisis Assessment, Prevention, Education and Support) teams. In cases of continued difficulty, a licensed mental health professional, or a school police officer and a supervisor, evaluate the need for transportation for an involuntary examination. They must also attempt to contact the student's parents or guardians. Parents and guardians may assist with de-escalation and transportation for involuntary admissions.

All involuntary examinations are referred to school teams for additional support and services in the postvention phase. To monitor the use of involuntary examinations, district behavioral health staff, ESE (Exceptional Student Education) staff, and school safety staff conduct quarterly reviews of the data. If disparities are found, such as students with disabilities being disproportionately referred for involuntary examinations, recommendations for corrective action are made.

Currently, there is no uniform system in Florida for children to receive timely access to community-based behavioral health services and care coordination in the event of high level risk that cannot be mitigated through school based counseling and support (Commission on Mental Health and Substance Abuse, 2023). The Commission on Mental Health and Substance Use Legislative Report stated that the Marjory Stoneman Douglas High School Public Safety Commission recommended a uniform system to ensure access to care for public school students through a single organization.

Ideally, this would include a coordinated community behavioral health approach that merges school and community-based mental health. The organization responsible would identify behavioral health needs for students, provide on-site service, track outcomes, ensure community education on wraparound services, maintain relationships with The School District and community providers, and collaborate with funders (Commission on Mental Health and Substance Abuse, 2023).

Findings

The School District of Palm Beach County has strengthened its behavioral health services in recent years.

The CAPE teams serve as The School District's mobile response teams. The CAPE teams are composed of mental health professionals, a school psychologist, and behavioral health specialists. The CAPE team's services include providing mental health assessments and de-escalation to prevent hospitalizations, and providing support when a Baker Act is needed. The teams also support student plans, case management, re-entry meetings, impartial objective observations, consultations, professional development and training, and participation in other school-based meetings as required. In addition, The School District of Palm Beach County maintains a behavioral health unit within the school police force, which includes licensed clinicians and police officers. The School District has also invested in training its personnel in youth mental health first aid, with 91% of staff having received training.

Mobile response teams provide additional back up support to school-based crisis response.

If The School District of Palm Beach County does not have a CAPE team present or if the CAPE team is in need of additional support, MRTs are called upon to assist. The School District of Palm Beach County is responsible for initiating any requests for assistance.

This partnership is limited however, by the availability of licensed clinicians on the MRTs, since The School District indicated that it requires licensed professionals to respond.

The MRTs also provide ongoing support to the schools. The managing entity, MRTs, and The School District have regular collaboration meetings to discuss high-risk youth, and youth served by MRT and CAPE teams.

There is a stigma among youth regarding receiving services from mobile response teams.

Youth-specific providers report that youth are afraid that utilizing these services will potentially stigmatize them and harm their future, such as being put on their record and impacting their future college and/or career path.

Assessment

The National Guidelines for Child and Youth Behavioral Health Crisis Care outline youth essential operations and youth staffing, training, onsite, and post-crisis needs for MRTs. Since several of the guidelines have been previously assessed, we have excluded them and only included additional guidelines related to children and youth. Based on limited information we received about MRTs, we have not been able to determine whether Youth Essential Operations have been met (Table 18).

Table 18. Youth Essential Operations for a MRT.

Essential Operations for Youth	Status
Respond to crises on location in home- and community-based settings, including schools and postsecondary institutions, recreational centers, homeless shelters, and other community centers	Unknown
Be available to respond quickly to crises. Arriving onsite within one hour of dispatch is the general standard most mobile crisis teams follow. For mobile response systems covering a large geographic area, there may need to be multiple provider teams at different locations.	Yes
Explanation: The MRTs respond to home and school-based settings. However, due to limited information received, we were not able to determine if the MRTs respond to crises at community-based settings, including postsecondary institutions, recreational centers, homeless shelters, and other community centers. SEFBHN reports an average response time under 60 minutes.	

Currently, the MRTs do not meet youth staffing, training, onsite, and post-crisis needs guidelines (Table 19). We did not receive the necessary information to complete our evaluation of the complete set of standards.

Table 19. Staffing, Training, Onsite and Post-Crisis Needs for Youth.

Staffing, Training, Onsite, and Post-Crisis Needs for Youth	Status
Incorporate youth and family peers within the response team.	Unknown
If needed for the young person's safety and stability, provide a warm hand-off to a crisis receiving and stabilization facility.	No
Have access to a licensed and/or credentialed clinician in a supervisory role who has expertise and experience using evidence-based assessment tools with youth populations. The clinician may be onsite, or they may consult over the phone or through video.	Yes
Provide staff training about how to describe mobile response services to youth, their caregivers, and other callers.	Unknown
Provide a warm hand-off for appointments with appropriate local providers for ongoing care after a crisis episode, if needed, with consent from the family.	Unknown
Know the crisis and medical facilities in the region, and also the broader array of child and adolescent supports and services (including resources and supports that are designed for specific communities).	Unknown
Explanation: Based on limited information received, we were unable to determine if the MRTs incorporate youth and family peers. South County Mental Health reports 24/7 access to an on-call psychiatrist. To our knowledge, the MRTs do not provide a warm hand-off to a crisis receiving and stabilization facility, as there is only one Baker Act receiving facility for youth which is a hospital inpatient unit at JFK North Hospital. Additionally, we are unable to determine whether staff are provided training on how to describe mobile response services to youth, if warm hand-off appointments are given with consent from the family, and whether the MRTs know the child and adolescent services in the region.	

Recommendations

1. **With the expansion of MRTs in Palm Beach County, ensure services align with The National Guidelines for Child and Youth Behavioral Health Crisis Care.**

The previous recommendation (see Someone to Respond) is to scale up the number of MRTs in Palm Beach County, transitioning from 16 teams to 20 teams, per the Crisis Now model. It is important to align this expansion with the National Guidelines for Child and Youth Behavioral Health Crisis Care. Services should accommodate the specific operational, staffing, training, on-site, and post-crisis requirements for youth.

2. **Partner with The School District to enhance crisis response in schools and integration between school and community-based behavioral health care.**

The School District provides a range of behavioral and mental health services. The Health Care District should work closely with The School District to understand the full spectrum of services provided by The School District and how these services are operationalized within the crisis continuum of care.

A key focus of this collaboration should be The School District's CAPE team, who play a critical role in the crisis response system for students. To the extent possible, school-based crisis response should be integrated into and supported by the overall continuum of crisis care in Palm Beach County. This partnership can give further insights into merging school and community-based mental health for students, and how to align them with the National Guidelines for Child and Youth Behavioral Health Crisis Care.

Somewhere safe to go: Children and Youth

National Guidelines

According to the National Guidelines for Child and Youth Behavioral Health Crisis Care, every effort to de-escalate and stabilize within the community and home should be made. However, if the safest and best management of a youth-related crisis involves inpatient care or out-of-home stabilization, the goal is to provide immediate support to the young person and transition them back to home and appropriate services in the community, when it is safe to do so.

Crisis stabilization facilities can offer a safe environment and short term care that diverts youth from hospitalization. This facility should operate a home-like residential setting and provide developmentally appropriate services.

Background

HCA Florida JFK North Hospital is the only Baker Act receiving facility in Palm Beach County that provides services for children and youth.

JFK North has recently increased its capacity in an attempt to meet the needs of children and youth.

In February 2021, JFK Medical Center's North Campus expanded the Behavioral Health Pavilion from a 88 psychiatric inpatient bed unit to a 124 psychiatric inpatient bed unit with the addition of 12 adolescent beds and 24 adult beds (South Florida Hospital News, 2021). JFK North's youth services program treats children and youth between the ages of three and 17.

Findings

There is a lack of crisis facilities for children and youth in Palm Beach County.

Currently, HCA Florida JFK North Hospital is the only Baker Act crisis receiving facility for children and youth. The Drug Abuse Foundation serves adults and adolescents through its emergency receiving center as part of its detox unit. South County Mental Health Center does not provide crisis receiving and stabilization for children and youth.

To our knowledge, there are no short-term residential crisis stabilization facilities for youth and children in Palm Beach County, as recommended by the National Guidelines for Child and Youth Behavioral Health Crisis Care. As discussed above, DAF provides detoxification services for adolescents, but since these services are focused on substance use, they do not fit the parameters of short-term crisis beds as defined by the National Guidelines. Longer term residential programs are available, such as the Walter D. Kelly Treatment Center in West Palm Beach and the Norman C. Hayslip Treatment Center in Fort Pierce, which are operated by DATA.

These centers provide residential treatment for youth with addiction and behavioral health problems, with an average length of stay of three to six months. While not short-term in nature, these programs are an important component of the behavioral health continuum.

JFK North is actively involved in partnerships to support youth crisis care.

Stakeholders spoke highly of the services for children and youth at JFK North. The School District of Palm Beach County reported that JFK North employs a multidisciplinary approach with students including an educational program at the hospital, with a teacher who works with students to provide them with educational support during their inpatient stay.

JFK North employs a liaison who works directly with schools to coordinate reintegration into the school system.

PBC Youth Services also reported a cooperative relationship with JFK North noting remarkable responsiveness and highly qualified personnel.

Assessment

The National Guidelines for Child and Youth Behavioral Health Crisis Care outline essential operations and requirements for staffing, training, facility setting, and services for youth for crisis receiving facilities. Given that many of these are duplicative of the general guidelines, we have omitted the already assessed guidelines, and only included new information. Based on the absence of a youth and child crisis receiving facility that is distinct and separate from an inpatient hospital setting, we found that Palm Beach County does not meet any of the youth essential operations for a crisis receiving facility (Table 20).

Table 20. Youth Essential Operations for a Crisis Receiving Facility

Essential Operations for Youth	Status
Offer developmentally appropriate services to address mental health and substance use crisis issues impacting youth	No
Offer walk-in and first responder drop-off options that accept youth	No
Collect data on crisis resolution, user satisfaction, and other outcomes, and review these data to develop quality improvement plans.	No
Include beds within the real-time regional bed registry system, identifying how many beds are available for youth	No
Explanation: Due to the lack of a crisis receiving facility that works with children and youth, all essential operations for youth have not been met.	

The Youth and Child National Guidelines outline guidelines for staffing, training, facility setting, and services for youth in a crisis receiving facility. Currently, Palm Beach County does not meet any of these guidelines (Table 21).

Table 21. Staffing, Training, Facility Setting, and Services for Youth in a Crisis Receiving Facility.

Staffing, Training, Facility Setting, and Services for Youth	Status
Be staffed at all times with a multidisciplinary team with expertise in meeting the needs of youth.	No
Have staff who can assess physical health needs and deliver care for most minor physical health challenges. Have an identified pathway to transfer the young person to more medically staffed services, if needed.	No
Ensure that staff have appropriate youth and family expertise and experience.	No
Provide training to all staff on effective crisis management strategies that minimize the use of seclusion and restraint.	No
If the facility serves both youth and adults, have separate receiving and support areas. If the facility serves both younger children and adolescents, it is also ideal to have separate areas for them.	No
Provide spaces that are trauma-informed in their design and that promote dignity as well as safety	No
Provide spaces that are calming and welcoming and that offer developmentally suitable supports for youth and families	No
Provide confidential spaces for families to gather, with the young person and without, where they may receive clinical services and support	No
Screen for risk of self-harm, suicide, and risk for violence using tools that are designed or appropriate for youth.	No
If short-term individual and family therapies are provided, integrate community-defined evidence programs and cultural adaptations of evidence-based interventions, in addition to traditional evidence-based interventions	No
Provide warm hand-offs to home- and community-based, youth-serving care	No
Explanation: Due to the lack of a crisis receiving facility for children and youth, these staffing, training, facility setting, and service requirements for youth have not been met.	

Recommendations

1. **Ensure that the development of a central receiving and stabilization facility includes tailored services for children and youth.**

The recommended crisis receiving and stabilization facility should serve children and youth as well as adults. With the current lack of a crisis receiving facility for youth in Palm Beach County, it will be vital for The Health Care District to include this demographic in its expansion of the continuum of crisis care.

Investing in facility-based crisis care will alleviate the burden on acute inpatient psychiatric beds and ensure more care is provided in less restrictive, lower cost settings. According to the National Guidelines for Behavioral Health Crisis Care for Children and Youth, this holistic approach should encompass:

- Multidisciplinary teams with expertise on children and youth
- Staff with appropriate youth and family expertise and experience
- Effective crisis management strategies
- Separate areas for youth, adolescents, and adults
- Trauma-informed design
- Developmentally suitable support
- Confidential spaces to gather
- Short-term individual and family therapy
- Community-defined evidence programs, and
- Warm hand-offs to youth serving care.

2. **Collaborate with JFK North on care for children and youth.**

JFK North's inpatient psychiatric care for children and youth will continue to play a significant role in the crisis response system in Palm Beach County. While lower acuity clients will be seen in the recommended central receiving and stabilization facility, many clients will continue to be seen at JFK North.

Similar to the recommended collaboration with South County Mental Health for adults, this collaboration should include clinical parameters for client transfers, data-sharing to support care coordination, and a review of opportunities to develop standardized protocols aligned with National Guidelines.

Section III:
Central Receiving and Stabilization Facility Recommendations

As the Health Care District aims to develop a robust continuum of crisis services aligned with National Guidelines, a new crisis receiving and stabilization facility is recommended to fill the gap in the number of chairs and short-term crisis beds needed in Palm Beach County. The recommended facility has been conceptualized to function as a safe and secure location for all community members experiencing a behavioral health crisis. As envisioned, it will provide crisis services for children, youth, and adults experiencing crises related to mental health, substance use, and co-occurring conditions.

The National Guidelines for Child and Youth Behavioral Health Crisis Care also advises that youth crisis services should be centered on de-escalation and stabilization within the home and community. If it is safe, every effort should be made to help youth and children stay in their current living environment.

In Palm Beach County, stakeholders report that mental health is the top priority for parents and youth-specific organizations such as Palm Beach County Youth Services.

As a central receiving facility for the county, the facility will provide comprehensive assessments and a coordinated entry point to behavioral health services. In line with the National Guidelines, it will provide a 23-hour observation area, where most clients will have their conditions stabilized. It will also provide short-term crisis stabilization and addiction receiving units, which are residential settings for those who need stabilization for longer than 23 hours.

This section provides recommendations for the site location and design of the facility, workforce and staffing, regulatory requirements, and operational and financial projections.

Operational Recommendations

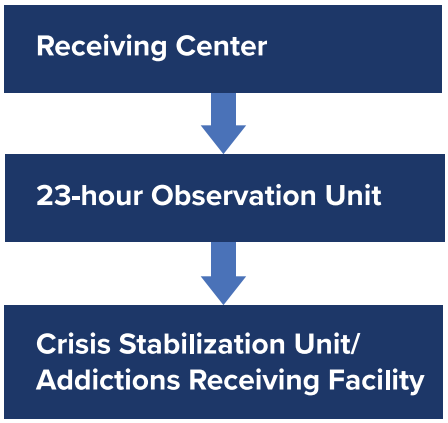
In this section, we present a strategic framework for the effective implementation and operation of the crisis receiving and stabilization facility in Palm Beach County. This section delves into the operational recommendations that encompass a description of services, staffing plans, client demographics, and safety and security protocols.

By aligning with best practices and regulatory guidelines, our aim is to establish a robust operational foundation for the crisis receiving and stabilization facility, optimizing care delivery and promoting positive outcomes for both clients and staff.

Description of Services

Clients will first be served by the receiving center, which will provide emergency screening and evaluation. If indicated, clients will be admitted to a 23-hour observation unit for stabilization. Clients whose crisis was not resolved during an observation stay will be admitted to the crisis stabilization unit / addictions receiving facility (CSU/ARF) (Figure 4). Clients may also be admitted directly to the CSU/ARF based on the results of their assessments.

Figure 4. Crisis Receiving and Stabilization Facility Client Journey.



As discussed in the Crisis Now section, the Crisis Resource Need Calculator provides estimated service levels needed for Palm Beach County based on full implementation of crisis care according to the National Guidelines. Based on this, we developed an interactive financial and operational model for analysis of various scenarios related to chair and bed capacity of the proposed crisis receiving and stabilization facility. This model allows for implementation of the entire projected need for Palm Beach County (82 chairs; 69 short-term crisis beds), the current gap (62 chairs; 20 short-term beds), and a variety of other scenarios. This model was provided in a separate spreadsheet.

The Crisis Resource Need Calculator does not differentiate the projected need for pediatric care from adult care. In light of this, we correlated data from leading crisis care providers, recent statewide implementations, and similarly-sized facilities to arrive at a recommended range of crisis receiving chairs and short-term crisis beds for children/youth (see Appendix E for further detail). The base model used in our financial and operational projections is outlined below and reflects the number of chairs and beds needed to fill the gap described by the Crisis Resource Need Calculator. (We used 22 CSU/ARF beds instead of 20 due to the significant impact on operational efficiency).

Base Model:
Total Chairs = 62
Total Children/Youth Chairs = 16
Total Adult Chairs = 46

Total CSU/ARF beds = 22
Total Children/Youth beds = 10
Total Adult beds = 12

Notably, services for children (e.g., 5-11) and youth (e.g., 12-17) can be combined from a staffing perspective and are discussed together for purposes of operational and financial projections. However, in practice this population is often divided by age with care provided in separate physical locations.

Staffing Plan

Crisis Now provides a staffing calculator for staffing crisis receiving facilities. Staffing is provided with a mix of medical providers, nursing staff, clinical behavioral health professionals, and paraprofessionals including peers, milieu (therapeutic environment) specialists, and behavioral health technicians. Roles of each are outlined below (Table 22).

Table 22. Staff Roles for Crisis Receiving Facilities.

Job Title	Role
Provider	Psych evaluation, re-evaluation, admission orders, petition reviews, emergencies, forms
Clinician	Diagnosis, initial assessment, Columbia Suicide Severity Rating Scale, walk-in assessments, treatment plans
RN	Physical Nursing Assessment, shift assessments, medication reconciliation
LPN	Medication room management, medication pass
Milieu Specialist	Advanced deescalation and engagement supporting program safety
Peer & BHT	Engagement, group facilitation and support

BHT: Behavioral Health Technician, RN: Registered Nurse, LPN: Licensed Practical Nurse.
Source: Crisis Now Staffing Calculator

The Crisis Now Staffing Calculator provides ratios for direct care staff based on leading practices and the projected acuity of the client population. Acuity rating is based on the projected percentage of clients arriving under an involuntary commitment or via law enforcement drop-off, the number of admissions per 24 hours, and other related variables. In the absence of data describing the current client population at CSUs in Palm Beach County, we used the highest acuity rating to provide financially conservative staffing projections.

We projected staffing requirements for the crisis receiving and stabilization facility, inclusive of the CSU/ARF. We adapted the Crisis Now staffing model to align with the minimum staffing requirements for CSUs and ARFs outlined in the Florida Administrative Code (65E-12.105). Staffing for the base model (62 chairs, 22 beds) is provided in Table 23. Direct care is primarily provided through nurse practitioners, RNs, licensed clinicians, and peers.

Table 23. Projected Staffing, Base Model.

Job Title	FTEs
Medical Director	1.0
Chief Medical Officer	0.1
Nurse Practitioner	8.4
Milieu Specialist	28.0
Peer & BHT	33.6
RN	15.4
Nursing Manager	1.0
LCSW	28.0
Program Director	1.0
Office Manager	1.0
Director of Pharmacy	1.0
Plant Operations Manager	1.0
Grand Total	119

FTE: Full Time Equivalent, BHT: Behavioral Health Technician, LCSW: Licensed Clinical Social Worker, RN: Registered Nurse

Client Population and Services

The Department of Children and Families provided a breakdown of the clients served in FY21 by program area (Table 24) (Commission on Mental Health and Substance Abuse, 2023). This data provides a starting point for estimating the needs of the client population for a crisis receiving and stabilization program. As this is statewide data, the actual distribution of clients between adults and children and the service types may vary given the unique requirements and services available in Palm Beach County.

Table 24. DCF Client Population Distribution, FY21.

Client Demographic and Service	Number of Clients	Percent
Adult Mental Health	152,565	64%
Adult Substance Use	43,470	18%
Child Mental Health	34,595	15%
Child Substance Use	6,976	3%

Source: Florida Department of Children and Families

Safety & Security

Ensuring safety and security for both staff and clients is an important planning component for behavioral health centers, since these facilities provide care for individuals who may exhibit aggressive and self-destructive behaviors. Leading crisis facilities employ parameters for crisis services that provide for the safety and security of clients and staff while maintaining a person-centered, warm and welcoming environment. RI International, a leading provider of crisis care and co-author of the National Guidelines, highlights keys to safety and security in crisis delivery settings:

- Evidence-based and trauma-informed crisis training for all staff
- Role-specific staff training and appropriate staffing ratios to number of clients being served
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures
- Strong relationships with law enforcement and first responders

In its "Roadmap to the Ideal Crisis System," the Group for the Advancement of Psychiatry (GAP) recommends that crisis facilities have a safety and security plan that includes input from a wide range of stakeholders. Crisis providers should approach agitated and violent behavior using de-escalation techniques by trained staff instead of security personnel. Staff should use pre-planned and practiced responses to various situations they may encounter so they are prepared when the need may arise. Ongoing training is essential to continually decrease risk, while improving outcomes.

Restraints & Seclusion

Restraint and seclusion are widely considered safety measures of last resort by national regulatory agencies. Florida law aligns with this perspective, maintaining that facilities may not use seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff. Additionally, it requires facilities to ensure that all staff are made aware of these restrictions on the use of seclusion and restraint. Facilities are required to make and maintain records which demonstrate that this information has been conveyed to individual staff members (394.459(4), F.S.).

The GAP notes that the availability of restraint and seclusion within a crisis facility allows that setting to accept clients who would otherwise find themselves in a more restrictive setting, e.g. an emergency department, or jail, without appropriate care. At the same time, the availability of these methods does not require that they are used frequently; rather, an ideal crisis system embraces the operating philosophy of "no force first."

Through a person-centered approach and intentional peer-led engagement, leading crisis receiving and stabilization facilities are able to avert the need for restraint and seclusion on a regular basis. The GAP recommends that crisis facilities have training and processes in place to prevent the use of seclusion/restraint whenever possible, apply seclusion/restraint in the safest and briefest manner possible and employ a quality improvement process for continuous review and improvement of seclusion/restraint processes (e.g., frequency of use, application of best practices, appropriate documentation).

Design Recommendations

Designing a crisis receiving and stabilization facility requires a thorough logistical analysis and a deep understanding of the unique, necessary components required for these types of facilities to meet best practice guidelines. Whether the crisis facility site is to be a brand-new structure or be converted from an existing structure, the built environment of the facility should offer safety for clients and staff, optimal movement of clients within the facility, and a therapeutic environment.
A study by HKS Architects showed that there were 8 primary realms where architecture and design could help behavioral health outcomes: supporting patient dignity, reducing stress/external agitation, mitigating violence/aggression, supporting staff safety, supporting feelings of security, supporting patient/staff communication, supporting patient safety, and supporting patient control and autonomy (Shultz, 2020).

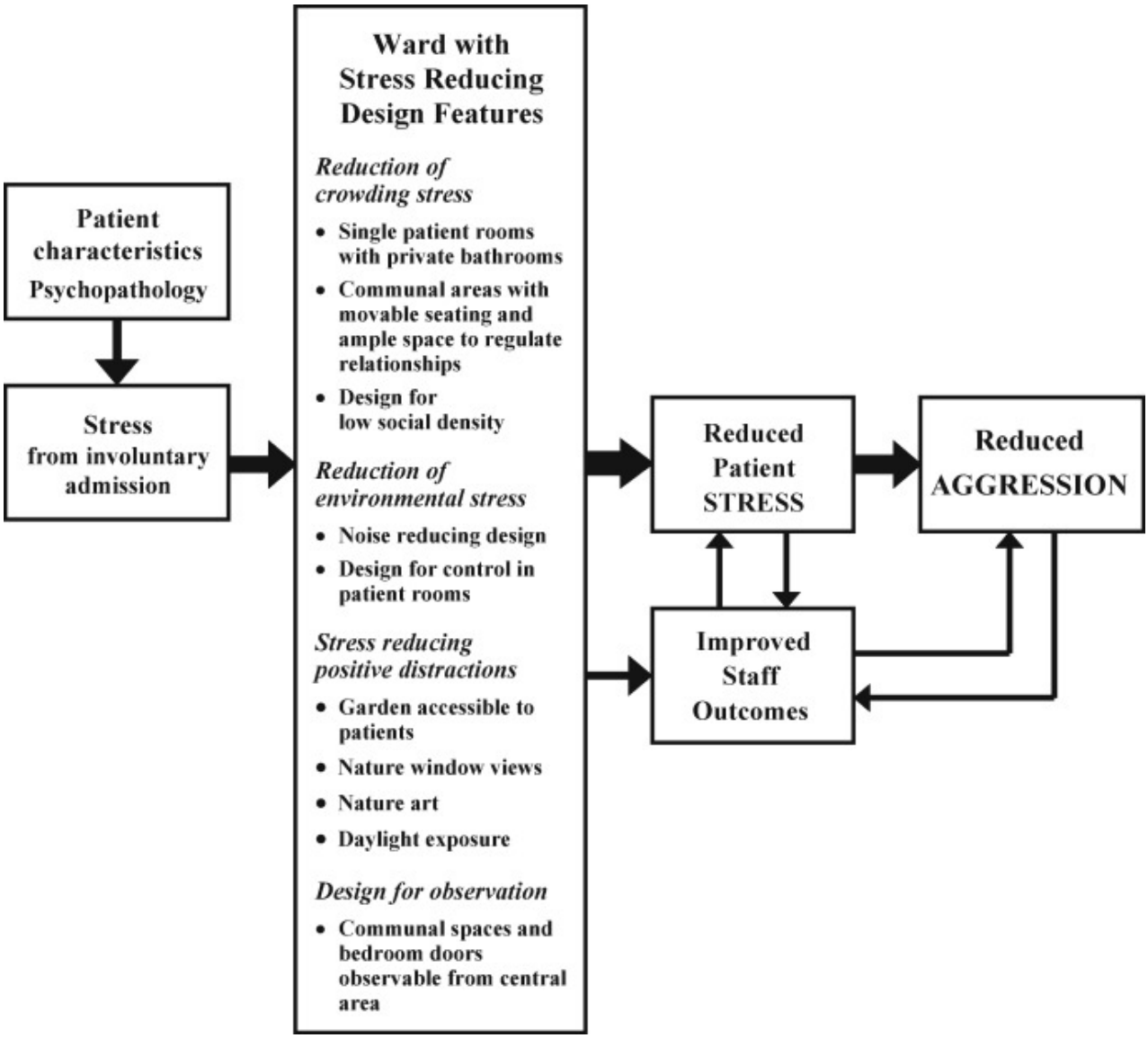
Principles of Architecture of Recovery

An effective approach to designing crisis facilities requires a deep understanding of the populations served by the facility. Knowing that many clients in crisis have a history of trauma, they can become dysregulated if they are placed in an institutional-feeling environment where they feel unsafe.

Design and safety should work together, and the design should convey that clients are not regarded fundamentally as potential threats, unless acting in a threatening manner (Roadmap to the Ideal Crisis System, 2021).

The GAP advises that the crisis care system have facilities that are therapeutic and respect the privacy and dignity of the individual while providing a safe environment (Roadmap to the Ideal Crisis System, 2021). Crowding, loud noise, poor indoor air quality, and inadequate light can contribute to anxiety and agitation. The design should be reviewed prior to construction by an advisory committee of stakeholders that includes crisis staff, consumers, families, and law enforcement.
A conceptual model developed by Roger Ulrich at the Center for Healthcare Architecture, Chalmers University of Technology in Sweden proposed that aggression in psychiatric facilities may be reduced by designing the physical environment with ten evidence-grounded stress-reducing figures (Figure 5). This model was tested in a newer hospital in Sweden and shown to have a significant impact on patient and staff safety compared to an older facility.

Figure 5. Ward with Stress Reducing Design Features.



Source: Psychiatric ward design can reduce aggressive behavior. Journal of Environmental Psychology, 57, 53-66.

Many of these principles are in practice at the facilities highlighted in the case studies below. The first facility is a central receiving facility in Broward County, Florida, that displays a selection of the key elements and design principles described above.

Henderson Behavioral Health Central Receiving Facility & Crisis Stabilization Unit

Henderson Behavioral Health Center, serving Broward County, Florida, provides various care options, particularly for those experiencing a behavioral health crisis. Available services include crisis walk-ins, a centralized receiving center, mobile crisis teams, pharmacy, and crisis stabilization units. Henderson's CSU provides short-term, intensive, residential treatment and stabilization.

Henderson Behavioral Health Central Receiving Facility

The facility houses 48 beds in four stand alone units, and sits adjacent to outpatient services. Each unit includes:

- 6 patient rooms
- Visitor/activity areas
- Living/dining rooms
- Quiet social spaces

Main Entrance

Living Wall

Nursing Station

Reception Area / Meeting Room

Key elements at this facility that help to create a warm and welcoming environment include a reception area with natural lighting and an indoor living wall. Other features include an open nursing station, with no plexiglass, and a soothing natural color palette with bright, mood-lifting accent colors. In this example, there are opportunities to improve certain elements, like better integration of nursing stations and client areas to create more connectedness between staff and clients, and an update to the fluorescent lighting which retains an institutional feel.

Connections Health Solutions

Connections Health Solutions, a nationally-recognized provider of crisis care based in Arizona, also provides excellent examples of how to incorporate many of these design principles. This Crisis Response Center includes a walk-in behavioral health urgent care, a 23-hour emergency psychiatric unit, a crisis stabilization unit, and an outpatient treatment and support program. Mobile crisis teams are also headquartered in this facility.

Crisis Response Center external facility views

The CRC facility has a modern design and nicely landscaped entryway. Tall glass windows and doors along the front of the facility allow for ample natural light to shine through.

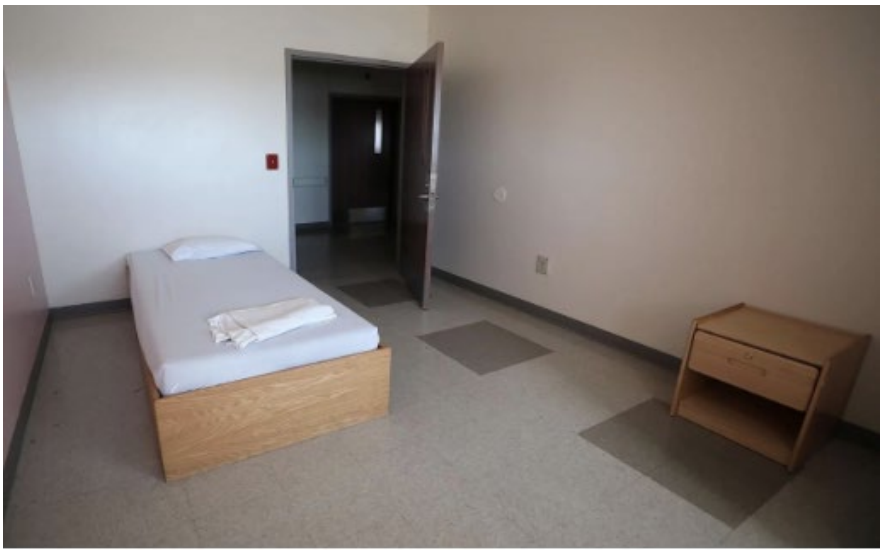
Main Entrance

Law Enforcement Entrance

The main entrance is bright and open, featuring large glass windows and doors. A separate law enforcement entrance is located on another side of the building and provides a secure area and seamless process for officers to coordinate drop-offs.

Crisis Response Observation Area

In the 23-hour observation area, the CRC facility design emphasizes the importance of having all chairs visible from central staff workstations. This layout provides nurses, techs, and others with a 180-degree view of the unit without the need of a plexi-glass. Half-walls provide a measure of privacy for clients during their observation stay, while still allowing for open sight lines and interaction between clients and with staff.



Crisis Response Center Private Residential Room

Clients are given private or semi-private rooms. Notably, these rooms lack the ideal crisis design elements promoting a home-like, non-institutional feel. This is an area of opportunity where an updated design concept could provide a more welcoming residential experience.

North Coastal Crisis Stabilization Unit

The North Coastal Crisis Stabilization Unit in Oceanside, CA provides another example of the best practice design principles in action.

North Coastal Day Room with Living Wall

Nursing Station

This facility, which opened in April 2022, showcases a bright and open environment featuring natural light, bright colors, and an integrated ocean theme. The nursing station extends into the client area and features design elements such as a central counter cut out, lessening the barrier between staff and clients and reducing the sense of "us versus them."

Client Receiving and 23-hour Observation Area

Large, heavy-bottomed planters situated behind the client recliners bring nature directly into the crisis observation area. The reception area is welcoming and comforting, without plexiglass or fully enclosed spaces.

North Coastal Living Wall

The courtyard area provides a living wall, natural light, and a gathering place for quiet conversations. Highlighting natural and modern elements in this facility allows for clients to feel a sense of calm and connectedness when they are receiving care.

Larimer County Behavioral Health Services at Longview

Larimer County Behavioral Health Services is an example of a multifaceted facility that incorporated best practice design principles into its campus in Fort Collins, Colorado. This facility opened in December 2023.

Main entrance, Longview Campus

Courtyard area

SummitStone Health Partners, the operator and service provider, will provide a phased approach to the opening of the facility. Upon opening, they will offer the following services:

- Behavioral health urgent care, available 24/7
- Care coordination
- Substance use treatment with medications
- Withdrawal management
- Crisis stabilization unit (CSU)
- Onsite pharmacy and lab

Future phases of care will be based on community needs. These include:

- Short-term intensive residential treatment (IRT) - for clients focused on recovery
- Opioid treatment program (OTP)
- Behavioral Health Institute/Center of Excellence for training and professional development
- Expansion of existing services

Situated on the corner of two major roadways, the 55,000-square-foot facility sits on a 40-acre campus that allows ample room for expansion. Below is a depiction of the campus and ancillary services.

Site Master Plan

BUILDINGS

1 Behavioral Health Center
- Public Main Entrance
- Staff Entrance
- Ambulatory Drop-Off
- Service Drop-Off

2 Future Supportive Housing

3 Future Supportive Retail

4 Future Adolescent Center

5 Future Conference Center

SITE ELEMENTS

Ⓐ Behavioral Health Center Drop-Off

Ⓑ Behavioral Health Center Visitor Parkin

Ⓒ Behavioral Health Center Staff Parking

Ⓓ Secure Drop-Off & Sally Port

Ⓔ Service & Loading Area

Ⓕ Outdoor Spaces for Varying Activities

Ⓖ Walking Trails and Quiet Areas

Ⓗ Existing Water Station

Ⓘ Future Supportive Housing Parking

Ⓙ Future Supportive Retail Parking

Ⓚ Future Adolescent Center Parking

Ⓛ Future Conference Center Parking

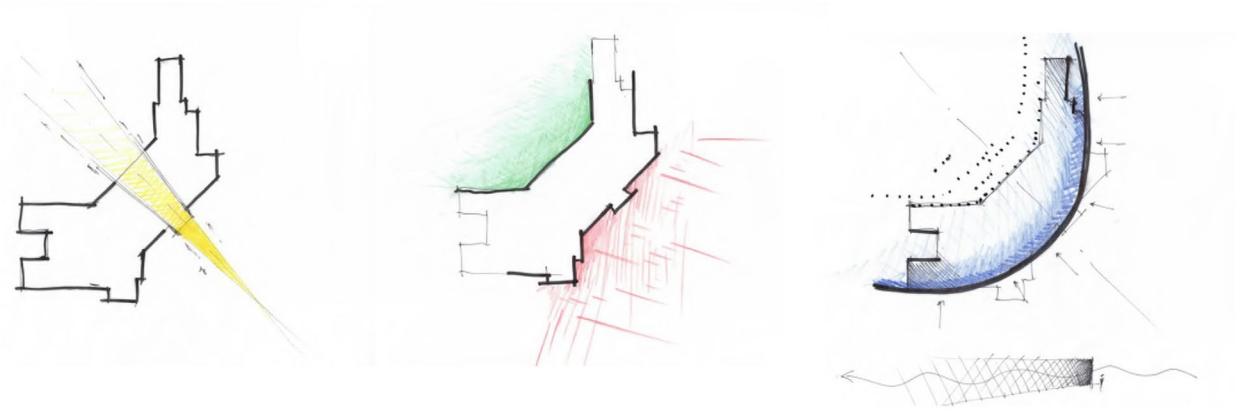
Ⓜ Future Equestrian Center

Ⓝ Future Expansion Parking

Ⓞ Site Drainage Detention Area

Ⓟ Future Cell Tower

The shape and structure of the Larimer County facility itself is designed to foster a therapeutic environment and promote recovery. This layout was thoughtfully and carefully designed to allow ample natural light and views of the mountains and outdoor landscapes.



- Focus on view to Mountains
- Focused entry
- Front door toward SE/Intersection
- Expansion, journey through

- Transition from sickness to wellness
- Toward calming
- Create outdoor respite

- Building protects patients, staff etc.
- Transition toward light and lite
- Opaque to Transparent

It is important to note how recovery is represented by walking through the building and working with natural light to promote recovery from sickness to wellness. The sight line moves toward recovery and more calming landscape and design elements. The transition from opaque to transparent views allows for the personal security/ safety of clients as they move along their recovery journey from more intensive to less intensive care environments.

Semi-Private Room at Larimer County Behavioral Health Services at Longview

This facility works to bring the outdoors inside with a timeless/classic design, with large windows with natural light and beautiful views of the natural landscape. Further detail, including floor plans for this facility, are included in Appendix C.

Additional safety-related design principles

The GAP provides the following guidance in developing a non-institutional and welcoming physical space that also prioritizes safety and security (Roadmap to the Ideal Crisis System, 2021):

- Layout allows easy visual observation of clients by staff, without compromising client dignity and respect
- Furniture is comfortable, heavy (i.e., hard to throw) and easy to clean
- Elopement risks are minimized via the use of secure entry/exit
- Quiet rooms that are separate from the common areas are available where clients can de-escalate
- Interview areas that permit privacy while permitting safe exit if agitation occurs
- Ligature and other safety risks are minimized

In any behavioral health facility, ligature (i.e. hanging) and other safety risks need to be minimized for client safety, especially in bathrooms. Bathrooms require specialized hardware and fixtures, such as sloped-top doors that swing out into the client room (to prevent barricading in the bathroom), plus toilets and shower heads that lack anchor points for ligatures. Chairs and tables with legs are also sometimes avoided due to ligature risk, as are window blinds with long cords, and some soft bedding such as sheets and curtains. Similarly, objects that can be broken and used as weapons (against themselves or others) should be avoided. Examples of anti-ligature design can be seen in this illustration via the American Hospital Association below:

ANTI-LIGATURE / LIGATURE RESISTANCE

1. Ligature-resistant door hardware. 2. A ligature-resistant paper towel dispenser. 3. Recessed toilet paper dispensers allowing toilet paper to be easily removed. 4. A grab bar with a safety fin. 5. A retractable toilet paper holder. 6. A short nurse-call cord. 7. A ligature-resistant toilet with push-button controls. 8. Ligature-resistant shower controls.

IMAGES BY ANNE M. COX, AIA, ACHA, EDAC

Florida regulations regarding design of Crisis Stabilization Units (CSUs) are provided in Section 457.1.4, F.S. (Note: these regulations also pertain to short-term residential treatment (SRT) programs which provide crisis stabilization for up to 90 days.) The regulations emphasize the importance of a supportive environment through design:

"The CSU or SRT shall be designed to create a pleasant functional therapeutic environment throughout, by the use of sunlight, colors, designs, textures, and furnishings. The design shall achieve a secure unit which looks more residential than institutional in its construction and furnishings, while incorporating substantial safety considerations throughout."

Additionally, there are specific requirements related to safety and security:

"The CSU or SRT shall be designed to provide a locked perimeter around a living unit and fenced exercise area within which individuals can reside 24 hours a day in an environment designed to minimize potential for injury.

The CSU or SRT structure shall be a single-story ground level facility. These facilities shall have separate off-unit reception and administration areas which may also be locked. Service corridors and pathways to other non unit activities shall not be through the locked CSU or SRT unit."

Notably, regulations pertaining to a multiservice facility like the one proposed in this report allow for multistory buildings (S394.879(5), F.S.): "However, a crisis stabilization unit, a short-term residential treatment facility, or an integrated adult mental health crisis stabilization and addictions receiving facility that is co-located with a centralized receiving facility may be in a multistory building and may be authorized on floors other than the ground floor."

Further detail on regulatory requirements for facility design are provided in Appendix C.

Site Recommendations

Proximate to High Population Density and Various Modes of Transportation

According to the GAP, a behavioral health crisis facility should be sited in a population-dense area of an urban environment to provide proximity to the greatest number of community members. In an urban area, the commute duration to each hub should not exceed half an hour from any point within the urban catchment zone (Roadmap to the Ideal Crisis System, 2021). The commute duration should be considered by both car and public transportation.

Given the size of Palm Beach County and the gap in services, it is likely that more than one receiving and stabilization facility is needed. Stakeholders described a general division of the county into north and south service areas, so it may be beneficial to consider two crisis receiving and stabilization facilities, one in each region. However, the challenges of operationalizing two facilities simultaneously may require one facility to be established prior to the other.

Accessible by Law Enforcement

The behavioral health center should provide a separate entrance for law enforcement drop-off that is designed to be easily accessible. This entrance should be located on a separate side of the facility from the main entrance. There should be ample space for a gated area that closes behind law enforcement vehicles to prevent clients from leaving on their own during the drop-off.

Connections Health Solutions, a nationally-recognized provider of crisis care highlighted previously in this report, involved law enforcement in the design of its Crisis Response Center in Tucson, AZ. The facility features a designated drop off for law enforcement with a gated sally port. Officers have their own entrance to the facility and access a small reception area where an admissions team meets them. The reception area includes a restroom and a small office space to support any necessary paperwork the officers need to complete. This area is separate from the rest of the facility and clinical areas, so officers are not required to remove their firearms to enter the building, which further streamlines the process.

Proximity to Hospitals

One of the primary goals of facility-based crisis services is to help individuals avoid the need for inpatient hospital admissions. The GAP notes that the more crisis services are hospital-based, the lower the percentage of people successfully diverted from hospital admission. In light of the GAP's guidance, we recommend the behavioral health center be located near enough to hospitals to receive admissions from their EDs, but ideally not be co-located with a hospital.

Zoning

Property selected for a crisis receiving and stabilization facility will need to adhere to local zoning ordinances. Crisis facilities with overnight care are often zoned as a

hospital. For example, Palm Beach County Unified Land Development Code defines a hospital as an establishment that maintains and operates organized facilities for medical or surgical diagnosis, overnight and outpatient care, and treatment of human illness (Palm Beach County, 2023).

Similarly, West Palm Beach zoning and land development regulations define a hospital as an institution licensed by the state department of health which have facilities for one or more overnight patients, which provide services for in-patient medical or surgical care of sick or injured humans, and which may include related facilities such as laboratories, out-patient departments, training facilities, state offices, utilities, and support facilities (EncondePlus, n.d.) (Chapter 94, Article XIX, Section 94-611).

Regulatory Considerations

There are many regulations and Florida laws surrounding CSUs and their operation including The Community Substance Abuse and Mental Health Services Act (Part IV of Chapter 394, Title XXIX of the Florida Statues). This section provides an overview of regulations related to definitions and facility requirements for a crisis receiving and stabilization facility co-located with an addiction receiving facility.

Table 25. Definitions and Governing Regulations for Facility Size

Topic	Definition	Regulatory Section/Source
Designated Receiving Facility	A facility approved by the department which may be a public or private hospital, crisis stabilization unit, or addictions receiving facility; which provides, at a minimum, emergency screening, evaluation, and short-term stabilization for mental health or substance abuse disorders; and which may have an agreement with a corresponding facility for transportation and services	s.394.455(13), F.S.
Crisis Stabilization Unit	A program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state	s.394.67(5), F.S.

Purpose of Crisis Stabilization Unit	To stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds	s.394.875(1)(a), F.S.
CSU Bed Capacity	"A Crisis Stabilization Unit (CSU) license is capped at 30 beds, except in Brevard County, which can have up to 50. An entity that owns a CSU cannot operate more than the bed limit per license. They may apply for more than one license provided there is sufficient funding through the Managing Entity. Each license must maintain compliance with the regulations so entities with more than one license must meet the staffing requirements, administrative oversight, and other requirements at each. No concurrent use of space, staff, etc."	Agency for Health Care Administration
Addictions Receiving Facility	A secure, acute care facility that, at a minimum, provides emergency screening, evaluation, detoxification, and stabilization services; is operated 24 hours per day, 7 days per week; and is designated by the department to serve individuals found to have substance abuse impairment, who meet the placement criteria for this component.	s. 397.675, F.S. s.394.455(2), F.S. s.397.311(26)(a)1., F.S.

Crisis Stabilization Unit and Addictions Receiving Facility (CSU/ ARF): Adults	A facility licensed by the Agency for Health Care Administration, in consultation with the department, to integrate services provided in an adult mental health crisis stabilization unit with services provided in an adult addictions receiving facility. Such a facility shall be licensed by the agency as an adult crisis stabilization unit under Part IV and must meet all licensure requirements for crisis stabilization units providing integrated services.	s.394.4612(1), F.S.
Crisis Stabilization Unit and Addictions Receiving Facility (CSU/ ARF): Children	A facility licensed as a Children's CSU under Chapter 394, F.S., and Chapter 65E-12, F.A.C., by the Agency for Health Care Administration, and is designated as a Children's CSU and an ARF by the department to provide integrated CSU/ARF services within the same facility to minors under the age of 18 years of age who present with a serious and acute mental illness or substance abuse impairment.	65E12.110(1)(2)
Co-location of adult and child crisis receiving and stabilization:	A maximum of 20 licensed beds co-located on the same premises as an adult crisis stabilization unit. To enable this co-location, specific conditions must be met, such as having separate facilities, distinct staffing, and treatment exclusively for minors within the children's unit. The Department, in collaboration with the agency, is responsible for establishing rules that govern the construction of these facilities, staffing requirements, licensing, and the operation of these units for minors. Importance: Bed cap limits child and adolescent capacity and could potentially prevent utilizing existing premises to co-locate adults and children. This note is also important as architects are engaged.	s. 394.875, F.S.

Licensure

CSUs must be designated as a Baker Act Receiving Facility by the Department of Children and Families (the Department) prior to being licensed by the Agency for Health Care Administration (Florida Agency for Health Care Administration, n.d.). Information and applications for designation as a Baker Act Receiving Facility can be found on DCF's Substance Abuse & Mental Health web page.

According to the Agency for Healthcare Administration, CSUs must meet license requirements through the submission of a completed application, required documentation, and completion of a satisfactory survey (Florida Agency for Health Care Administration, n.d.). This includes new facilities and reactivation of an expired license. At least 60 days prior to the effective date, an applicant must submit a licensure application, fees and supporting documents. When all required information is received and acceptable, a licensure survey will be scheduled. A license will be issued when documentation of a successful licensure survey is complete and filed. Note: A valid license is required before services can be provided. Further information on licensing procedures is provided online at the Agency for Healthcare Administration website and in Appendix A.

Funding Opportunities

Funding for behavioral health in Florida originates from federal, state, and local entities and is dispersed via several different agencies. The lack of a single agency responsible for the administration and oversight of behavioral health funds is a challenge to tracking funds, allocating resources, and coordinating services. The Health Care District will need to coordinate with several state agencies in the provision of crisis services. For example, the Health Care District will need to work with the Agency for Health Care Administration (for Medicaid and Managed Medicaid), the Department of Children and Families Office of Substance Abuse and Mental Health, and the regional managing entity, SEFBHN, to contract for services for individuals covered by Medicaid or another public source.

Given the current state, a variety of funding sources should be pursued, both for operational and capital funds. The following opportunities are available to the Health Care District for consideration.

Department of Children and Families funding for central receiving facilities (Florida Department of Children and Families, 2023). State legislature investment in behavioral health resulted in $31M additional investment from the existing $19.8M for central receiving facilities in 2023-2024. The funding mechanism has not been made known so it is unclear whether DCF will administer these funds directly or if they will go through the managing entities. In 2016-2017, DCF awarded funds for start-up or ongoing operational funds to local agencies implementing central receiving systems in their communities. Note: this funding opportunity did not provide for capital outlay projects.

State appropriations for operational and capital outlay requests. For example, in FY 2022-2023, LifeStream Central Receiving Facility in Citrus County received $1.5M to support operations of a 20-bed Baker Act receiving facility.

Payer Contracting. Per the National Guidelines, crisis services should be available to all, regardless of funding source. Commercial health plans vary in their coverage of crisis services, but contracting with these plans may provide an additional revenue source for the crisis receiving and stabilization facility.

Certified Community Behavioral Health Clinic model. The CCBHC model was created through the Protecting Access to Medicare Act of 2014 as a Medicaid Demonstration program. The Act established a federal definition and minimum criteria for CCBHCs. These criteria, operationalized by SAMHSA, must be met for states to participate in the Medicaid CCBHC Demonstration.

The Centers for Medicare and Medicaid Services (CMS) recognizes CCBHCs as a new provider type in Medicaid. As a recognized service, states can receive Medicaid federal financial participation (FFP) for CCBHC services through a (a) Medicaid Demonstration, (b) Medicaid State Plan Amendment, or (c) Medicaid Waiver. States have greater flexibility if they choose to seek federal authority through a State Plan Amendment or Waiver.

The Agency for Health Care Administration was tasked by the FY 2022-2023 state legislature to plan and implement the CCBHC model in Florida collaboratively with the Florida Department of Children and Families and community behavioral health representatives. The plan must include a process for certification, recommendations for Florida specific outcome measures and recommendations for a methodology for value-based payment. The Agency for Health Care Administration must complete the plan to implement by September 1, 2023, and submit a request for federal approval for Medicaid coverage of the certified community behavioral health clinic based on the plan no later than January 31, 2024 (Florida Legislature, 2023).

As outlined in a brief by Sachs Policy Group (2023), CCBHC must provide all nine core services:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization;
- Screening, assessment, and diagnosis, including risk assessment;
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
- Outpatient mental health and substance abuse services;
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk (e.g., BMI, blood pressure, tobacco use, HIV/viral hepatitis);
- Targeted case management;
- Psychiatric rehabilitation services;
- Peer support, counselor services, and family supports; and
- Intensive, community-based mental health care for members of the armed forces and veterans.
- CCBHC designated organizations must also:
- Conduct at least one community needs assessment during the project period;
- Implement infrastructure development activities needed to continue meeting the certification criteria and improve the quality and effectiveness of CCBHC services;
- Involve consumers and family members in designing, providing, monitoring, and evaluating program services; and
- Develop and implement a sustainability plan to support delivery of services once federal grant funding ends.

CCBHC Benefits to the Health Care District

Access to a value-based payment model. Clinics that qualify as a CCBHC receive enhanced value-based Medicaid payments that allow flexibility in how they provide services. Payments may also be linked to quality goals and patient outcomes.

Enhanced payments for crisis services. CCBHCs provide services directly or in formal relationships with Designated Collaborating Organizations (DCO). Therefore, the Health Care District would not need to provide the whole range of services. It could focus on crisis services, for example, and develop formal relationships with other organizations to provide the remaining services.

SAMHSA requirements for Crisis Behavioral Health Services align well with the Health Care District's vision for a crisis continuum of care. These are outlined in the March 2023 update of criteria for CCBHCs:

Emergency crisis intervention services: The CCBHC coordinates with telephonic, text, and chat crisis intervention call centers that adhere to 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC) systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

24-hour mobile crisis teams: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area. These services extend to crisis situations experienced at home, work, or any other location. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours.

Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan.

Notably, 51% of 67 clinics participating in the demonstration project added crisis behavioral health services and 46% added mobile crisis services in the first year - either directly or through a DCO relationship (Siegwarth, et al., 2020).

Crisis receiving/stabilization services: The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services aim to identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care, which may include care provided by the CCBHC. Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted.

The CCBHC should aim to maximize the hours of operation, ideally providing services to individuals at any level of acuity. However, the facility is not required to manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be accessible 24/7, whether individuals present independently, with concerned individuals like family members, or with human service workers and/or law enforcement, in accordance with state and local laws.

In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.

Formal method for coordinating psychiatric rehabilitation services addressing People, Place and Purpose. CCBHCs must provide, or coordinate with DCOs to provide psychiatric rehabilitation services:

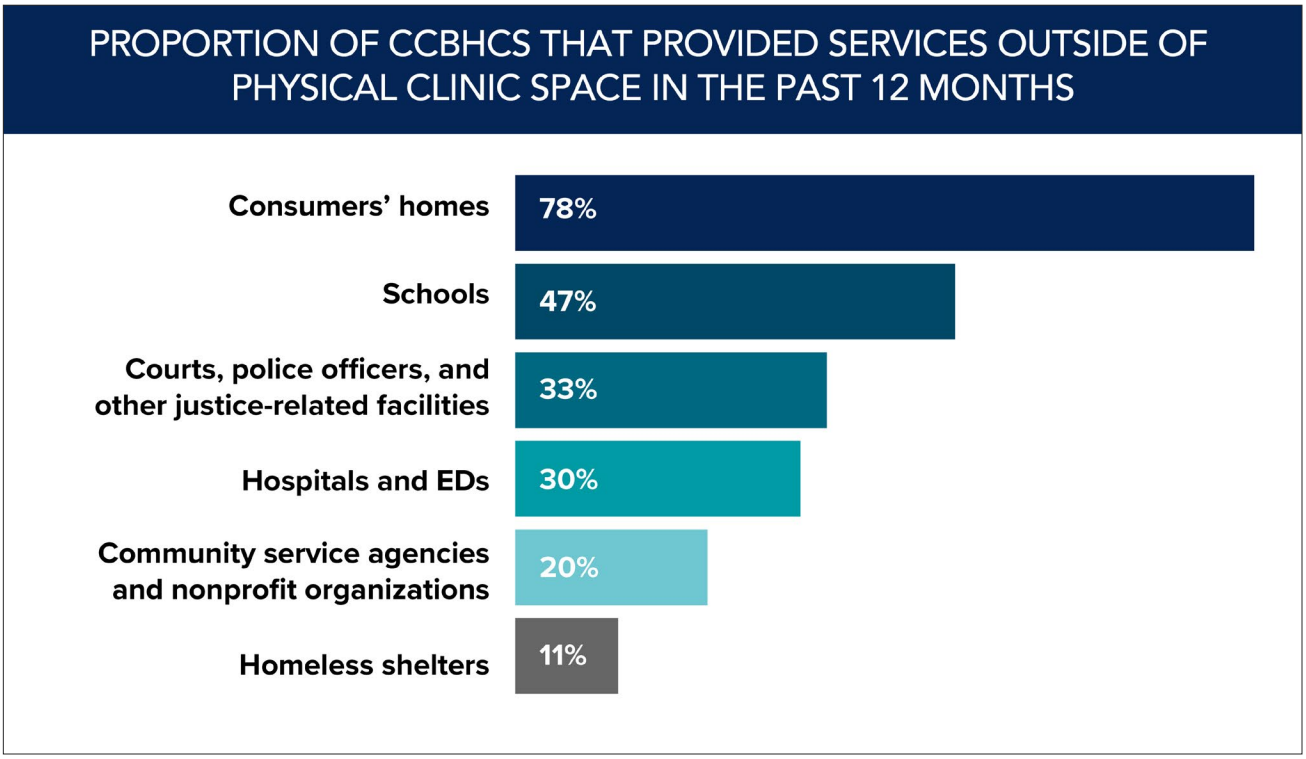
- Includes evidence-based rehabilitation services for both mental health and substance use disorders
- Must include supported employment, social inclusion, supports to find and maintain housing
- This should include coordinated intake process, coordinated treatment planning, information sharing, and direct communication between the CCBHC and DCO to prevent the person receiving services or their family from having to relay information between the CCBHC and DCO.

Formal partnerships between the Health Care District and psychiatric rehabilitation service providers through the CCBHC model would enhance coordination of care through communication and data sharing and promote transparency and accountability.

Note: Regardless of DCO relationships, the CCBHC maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria.

Flexibility in where services are delivered. An evaluation of 67 CCBHCs participating in the first demonstration project in eight states from 2016-2019 found that 64/67 (95%) of clinics provided services in consumer's homes, among other locations (Figure 6) (Siegwarth, et al., 2020).

Figure 6. Proportion of CCBHCs that Provided Services Outside of Physical Clinic Space



Source: CCBHC Annual Progrress Report Demonstration Year 2 data collected by Mathematica and the RAND Corporation, March 2019

Notes: The denominator is the number of CCBHCs that reported offering services outside of the CCBHC physical buildings in the past 12 months as of March 2019 (n=64).

Chart from Implementation Findings From the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration (September 2020). Mathematica Policy Research. Prepared for the Office of Behavioral Health, Disability, and Aging Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Contract #HHSP2332016000171

According to the ACHA Implementation Plan, a leadership group composed of DCF, AHCA, and behavioral health providers will determine Florida-specific CCBHC certification criteria by the end of 2023 (Table 25). The AHCA will initiate the certification process by September 30, 2024. The full timeline is available at *CCBHC.Implementation.Plan_FINAL.pdf (myflorida.com).

Table 26. Florida-Specific CCBHC Certification Implementation Timeline.

Objectives	Actions Steps	Responsible Parties	Anticipated Completion Date
Implementation Report	Deliver CCBHC Implementation Report to the Florida Legislature	AHCA	September 1, 2023
CCBHC Leadership	Identify Collaborating Partners	AHCA	September 15, 2023
	Set planning meeting schedule and logistics	AHCA, DCF	September 30, 2023
Needs Assessment	Complete a needs assessment analysis by region to inform CCBHC service array	DCF, Community Providers	October 31, 2023
Services	Finalize service array to be required of CCBHCs	AHA, DCF, Community Providers	November 30, 2023
Data Capacity	Determine Florida specific	Agency, DCF, Community Partners	December 31, 2023
	Develop data system for CCBHC reporting requirements	Agency, DCF, Community Partners	June 30, 2024
Certification	Determine Florida specific CCBHC certification criteria	Agency, DCF, Community Providers	December 31, 2023
	Develop a Certification Process	DCF	April 30, 2024
	Initiate Certification Process	DCF	September 30, 2024

Financial Projections

We have developed an interactive dashboard for the proposed behavioral health center, providing a comprehensive scenario analysis that encompasses payer mix, utilization rates, financial projections, and more. The financial model's design is informed by key assumptions on staffing, payer mix, rates, capacity, and patient volume projections.

- Staffing assumptions are based on the anticipated demands of a highly acute population, with specific staffing projections delineated for direct care, medical administration, and non-clinical administration. Staffing counts vary based on the numbers of chairs and beds selected. Staffing ratios for direct care staff adhere to Florida regulations for CSUs. Salaries and wages reflect recent local job postings.
- Payer mix considerations draw from the experience of Henderson Behavioral Health in nearby Broward County. This reflects a lower percentage of Medicaid-covered individuals than the Health Care District's clinic population. Payer mix percentages can be adjusted by selected values from the drop-down menus in each cell.
- Reimbursement rates are estimates. For the 23-hour Observation Unit (Crisis Receiving Center), the major payer is the managing entity. In Broward County, Henderson Behavioral Health's Crisis Receiving Center is funded solely by the managing entity and the facility does not bill Medicaid for these services. Given the Health Care District's practice to identify a third-party source of payment whenever possible, we included estimated Medicaid rates for this unit. These are modeled as a discount off of the managing entity rate. The managing entity rate is essentially a cost-based reimbursement rate. Changes made to these rates on the interactive dashboard are automatically updated throughout the P&L for each unit and the facility as a whole.
- Patient volume projections are linked to dynamic variables including the numbers of beds and chairs, and forecasted utilization. The model reflects a phased approach, with adjustable ramp-up periods outlined over the initial years of operation.

The base model used in our financial and operational projections reflects the number of chairs and beds needed to fill the gap described by the Crisis Resource Need Calculator for Palm Beach County. (We used 22 CSU/ARF beds instead of 20 due to the significant impact on operational efficiency). The numbers of chairs and beds parameters can be altered within the interactive model we provided. For the purposes of this report, we use the base model to project capital investments and operating expenses. Capital and operating costs will vary depending on the numbers of chairs and beds developed.

Base Model:

Total Chairs = 62

Total Children/Youth Chairs = 16

Total Adult Chairs = 46

Total CSU/ARF beds = 22

Total Children/Youth beds = 10

Total Adult beds = 12

Capital Expenses

The estimated size of a facility providing these services is 39,590 square feet. This estimate is based on the required square footage for patient care areas per Florida regulations, with a 5% increase in square footage above the minimum requirements. The square footage adjustment is one of the interactive elements of this model. Capital costs are projected to be $17.7M to 22.0M under low / mid / high scenarios. Total staff count is 119, including 105 direct patient care full-time equivalents.

Facility Metrics				
Total Square Footage	39,590		Total Capital Cost (Scenario 1)	$17,669,710.00
Square Footage Adjustment	5%		Construction Cost	$15,836,100.00
Cell M5 provides a sq. ft. adjustment calculator to assess costs relative to increase facility size			FF&E	$781,305.00
			Total Capital Cost (Scenario 2)	$18,540,695.50
			Construction Cost	$16,627,905.00
Total Staff Count	119		FF&E	$781,305.00
Direct Patient Care FTEs	105		Total Capital Cost (Scenario 3)	$22,024,637.50
Medical Administration	11		Construction Cost	$19,795,125.00
Non-clinical Administration	3		FF&E	$781,305.00
Cell M8 - M11 provides a based staffing breakout per number operating CSU beds and Observation Chairs. Staffing costs are adjusted per bed/chair utilization.			Ancillary Buildout	
			Pharmacy	$150,000.00
			Lab	$100,000.00

Operating Expenses

Under the conditions selected, the model projects an operating loss in the first three years of operations, with the facility breaking even in Year 4. Debt financing is not built into the operating budget. This projection assumes a ramp up of utilization from 60% to 95% occupancy from Year 1 to Year 5, and a payer mix of 20% Medicaid, 80% unfunded (Managing Entity or County-funded). At 95% utilization in Year 5, the model projects patient service reimbursement of approximately $13.8M, along with operating expenses of approximately $13.8M.

Category				
Crisis 23 hr Observation Unit				
	Adults		Child & Adolescents	
Chairs	46		16	
Total Chairs	62			
Payer Mix	Managed Medicaid	20%	Managing Entity / County	80%
Payer Rates		$ 255.62		$340.83
Crisis Stabilization Unit (colocated Addiction Receiving Facility)				
	Adults		Child & Adolescents	
Beds	12		10	
Total Beds	22			
Payer Mix	Managed Medicaid	20%	Managing Entity / County	80%
Payer Rates		$ 600.00		$442.17

Estimated Patient Encounters				
Obs Unit - Visits				
Year 1	Year 2	Year 3	Year 4	Year 5
16863	22484	25295	26700	26700
CSU - Admissions				
Year 1	Year 2	Year 3	Year 4	Year 5
1927	2570	2891	3051	3051
Utilization %				
60%	80%	90%	95%	95%

P&L					
	Year 1	Year 2	Year 3	Year 4	Year 5
Patient Service Revenues	7,742,467	10,632,988	12,320,975	13,395,896	13,797,773
Salaries & Wages	6,115,345	7,653,173	8,507,850	9,104,214	9,377,341
Benefits & Other Staffing Costs	1,528,836	1,913,293	2,126,963	2,276,054	2,344,335
Variable Expenses	1,348,973	1,688,200	1,876,732	2,008,283	2,068,531
Net Revenue	(1,250,687)	(621,679)	(190,570)	7,346	7,566

Workforce Strategies

As the Health Care District seeks to build a robust crisis care continuum, comprehensive workforce strategies will be required. According to Mental Health America, Florida ranked 43rd of 50 states in mental health workforce availability in 2023. Stakeholders highlighted workforce challenges including shortages impacting service delivery, increased staffing costs due to inflation, high rates of turnover, and difficulties recruiting staff. This section outlines findings and recommendations to address this issue, including existing initiatives and opportunities for future workforce development efforts.

Findings

There are several existing initiatives in Palm Beach County to grow the behavioral health workforce:

DCF Grant - Recruit and Maintain Behavioral Health Professionals: In March 2023, the DCF allocated $21 million to support the recruitment and retention of behavioral health professionals. This grant program was made available to three managing entities, including SEFBHN, to develop sustainable strategies and plans for addressing workforce challenges within the behavioral health labor force. Funding is intended to enhance recruitment and retention efforts, offer professional development opportunities, and promote workforce initiatives in the following areas: social work, psychology, marriage and family therapy, mental health counseling, psychiatry, and certified peer specialists.

Palm Health Foundation Scholarship: The Palm Health Foundation offers behavioral health scholarships to support individuals pursuing bachelor's and master's degrees in various fields related to mental health and counseling. Last year, it awarded 11 students amounts between $1,250 to $4,000 each, for a total of $30,000 in scholarships.

An additional award of $407,000 was granted in 2023 to Palm Health Foundation by the SEFBHN to expand scholarship opportunities in Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties. This initiative requires recipients to work in SEFBHN's geographic area for a minimum of 5 years after graduation, contributing to regional workforce development.

BeWell PBC - Behavioral Health Technician Curriculum Program / Medical Academy: BeWell PBC provides paid internships and field placements for high school students participating in the Behavioral Health Technician program. Scholarships are offered to students who graduate from the academy, encouraging the pursuit of careers in behavioral health. SEFBHN provided funding for this program.

Palm Beach County School District - Choice Program: The School District of Palm Beach County has recently introduced a course within its Choice Program to educate high school students about mental health and behavioral health careers. This initiative equips students with prerequisites before they enter college or university programs in these fields.

Recommendations

Partner with Existing Initiatives: Current initiatives provide a strong foundation for initial workforce development efforts. The Health Care District should seek to engage with these programs, offering its expertise and providing opportunities to serve as a field placement location for students.

Pursue Funding Opportunities: Seek additional funding opportunities to support workforce development initiatives and expand existing programs aimed at recruiting and retaining behavioral health professionals. The Health Resources and Services Administration provides grants to health care entities through the Bureau of Health Workforce. Other federal agencies that issue funding in this area include SAMHSA and the Centers for Disease Control and Prevention (CDC).

Strengthen Partnerships with Educational Institutions: Collaborate closely with high schools, community colleges, colleges, and universities to promote, incentivize, and reward careers in behavioral health. With these partners, explore opportunities to offer certificate programs, such as:

- Licensed Practical Nurse (LPN) to Behavioral Health Technician transition programs
- RN to Psychiatric-Mental Health Nursing certification
- Post-Masters Certificate of Advanced Study programs for Nurse Practitioners, and
- Mental Health Certificate programs for Physician Assistants (Hennessey, 2022).

Utilize Workforce Strategies Specific to Crisis Care: For example, the National Association of State Mental Health Program Directors (NASMHPD) released the 988 Suicide and Crisis Lifeline Centers' Workforce Challenges and Barriers: Analysis and Recommendations in April 2023, which provides relevant recommendations to develop the workforce needed, such as:

- Incorporate hybrid and remote working options. One successful example of this is in Massachusetts, where an investment of $10M in state funds supported increasing wages and providing hybrid work options, and the state doubled the number of call center staff in the year following the implementation of 988 (Cahan, 2023). Guidelines for remote work implementation are provided in the NASMHPD report.
- Utilize Vibrant Emotional Health's 988 Lifeline modular training, which can be easily incorporated into contact centers' existing training curriculums. This has the benefit of allowing for easy comparisons of differences between or among various types of support lines.
- Incentives such as overnight and weekend shift bonuses, scholarship programs, sign-on bonuses, paid leave, and improved health insurance benefits should be considered by all contact centers as a cost-effective recruiting tool.

Outreach and Recruitment for Diversity: Implement outreach and recruitment strategies to build a culturally, ethnically, and linguistically diverse workforce, ensuring cultural competence and language proficiency among behavioral health professionals. Stakeholders emphasized the need for cultural responsiveness and the importance of having diversity among behavioral health professionals. Key languages highlighted by stakeholders included Spanish and Creole.

Offer Competitive Compensation and Benefits: Ensure competitive compensation packages and benefits to attract and retain top talent in behavioral health. Stakeholders highlighted the challenge of training interns only to have them leave for higher pay in the private sector, underscoring the importance of appropriate compensation in publicly-funded positions.

Provide Advancement Opportunities: Establish clear career ladders and promote career advancement in behavioral health to attract and retain professionals in the field. Provide financial support to existing behavioral health professionals to complete training and continuing education curriculum, ensuring they stay current in their respective fields. Offer specialized training in evidence based methods to develop sought after skills in behavioral health practice.

Promote Loan Repayment Programs: Encourage and promote loan repayment programs, such as those offered by the National Health Service Corps (NHSC), to alleviate the financial burden on behavioral health professionals. NHSC Substance Use Disorder (SUD) Workforce loan repayment program is a subset of the NHSC program that provides up to $75,000 in student loan repayment benefits in exchange for an individual providing three years of full time service at an NHSC-approved SUD treatment facility in a mental health or primary medical care health professional shortage area.

In summary, the implementation of these strategies will help the Health Care District of Palm Beach County in its mission to enhance and strengthen the behavioral health workforce in the region, ultimately improving access to mental health care for the community.

Section IV: Outpatient Care and Rehabilitative Services

Outpatient Care Access

The ability to access outpatient behavioral health services in a timely manner is a crucial component for both crisis care and what happens next - how individuals who experience a crisis recover and regain their health. Within the realm of crisis response, the ability to schedule an outpatient appointment within the next 24 hours can make a significant impact on the crisis responder's ability to resolve a crisis. For example, if a community member calls the 988 Lifeline at 11pm, the telephonic support delivered by a counselor over the phone coupled with an outpatient appointment scheduled in real time for the following day can effectively resolve the crisis before further intervention is needed.

Similarly, MRTs should be able to link individuals - with the assistance of the regional crisis call center to appropriate outpatient services in a timely manner.

Timely access to outpatient care is also key during the time period immediately following a stay at a crisis facility. Discharge planning should be started immediately upon admission to crisis care, and individuals should be able to follow up with outpatient care in a timely manner, both for continued access to medications and other for services. According to the National Alliance for Suicide Prevention's Best Practices in Care Transitions for Individuals with Suicide Risk, crisis facilities should secure an outpatient behavioral health appointment at a date and time that the patient can attend, ideally within 24-72 hours and no later than seven days after discharge.

Findings

Stakeholders described a shortage of behavioral health professionals and long wait lists for services in Palm Beach County. One advocacy organization gave an example of two veterans who were experiencing suicidal thoughts and faced an 18 to 24 month wait list for counseling. "Providers have to decide who gets the limited resources, and it's so limited, you probably couldn't imagine," the stakeholder said.

The longest waits are for those with the least resources, particularly for community members who do not have health insurance or have limited health insurance. According to stakeholders, primary care providers at locations like FQHCs and the county health department are treating mild to moderate behavioral health conditions, but they refer out patients with more serious conditions. One FQHC said they wanted to provide more integrated mental health care, but a psychiatrist would be unaffordable for them. The closure of the Jerome Golden Center, which provided services for individuals with limited or no health insurance coverage, was cited many times by stakeholders as a driving force for the capacity issues seen across a variety of behavioral health services.

Several stakeholders discussed breakdowns in care during care transitions, such as from the ED, inpatient unit or CSU to outpatient care. This was attributed in part to the providers at these locations not offering adequate services to assist in those transitions. It was also attributed to the lack of availability of outpatient appointments. Stakeholders also described a need for more coordination, communication, and data sharing between providers. They discussed major barriers such as lack of transparency about appointment availability, lack of prioritization of clients according to acuity, and lack of accountability by providers to accommodate referrals in a timely manner.

Palm Beach County released its Substance Use and Mental Disorders Plan Update in 2022. This plan highlights the challenges of fragmented and disjointed behavioral health care in Palm Beach County, the resulting ineffective transitions of clients from one setting to another, and the lack of accountability for service providers. The plan recommends establishing a system of care that will ensure uniform assessment of substance use and/or mental health severity, maintain and utilize a comprehensive continuum of treatment services integrated with other social and recovery support services, and provide the structure, process, and outcome measures necessary to meet care coordination goals (Palm Beach County Behavioral Health, Substance Use, and Co-Occurring Disorder Steering Committee, 2022).

Many stakeholders discussed the lack of access to outpatient services for children and youth. Child psychiatrists, who are in high demand both statewide and nationally, were identified as a very difficult provider to access. Additionally, several stakeholders described a wait list of 500+ children waiting for counseling services.

One stakeholder described a "service gap between the haves and the have-nots," referring to the wait lists faced by "families without good insurance, or no insurance, who are migrants, or undocumented." They indicated that challenges can affect children and their families in many ways, including missed opportunities to prevent crises.

Most stakeholders spoke positively about the increased availability of behavioral health support in schools, in light of a recent increase in the number of school-based professionals. Recent action by the Palm Beach County School District to hire more behavioral health professionals and staff a school-based MRT were noted by several stakeholders as positive improvements in access to care for children, youth and families. Additionally, The School District has 136 trainers on staff to equip educators with essential skills for recognizing and responding to mental health challenges in young individuals. On the other hand, some stakeholders expressed concern about limitations in the scope of practice and expertise of school-based professionals.

Recommendations

1. **Explore opportunities to expand outpatient behavioral health services.**

Outpatient care access will continue to have a significant impact on the crisis continuum of care. Even as crisis services are expanded to meet National Guidelines, outpatient services must be available for prevention, follow up, and ongoing care in order to support the long term health and well-being of community members. Outpatient providers throughout the county should be accessible through the crisis call center for direct appointment scheduling. The CCBHC model is a promising opportunity for the Health Care District to expand its services and is discussed further under the Funding Opportunities section.

RI International identified key outpatient services that should complement the establishment of a crisis care continuum (RI International, 2020):

- Assertive Community Treatment (ACT): ACT is an evidence-based practice that improves outcomes for people with SMI who are most at-risk of psychiatric crisis, hospitalization, and involvement in the criminal justice system. ACT is a multidisciplinary team approach with assertive outreach in the community.
- Forensic Assertive Community Treatment (FACT): FACT is an emerging model, adapted from ACT, for preventing arrest and incarceration of adults with SMI who have a history with the criminal justice system. (Note: this is a distinct program from FACT teams in Florida, which are Florida Assertive Community Treatment teams.)
- Intensive Outpatient Programs (IOP): An IOP is a freestanding or hospital-based program that maintains hours of service for at least 3 hours per day, 3 days per week. It may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care, or a partial hospital program. An IOP can be the modality used to treat mental health conditions or substance use disorders, or co-occurring mental health conditions and substance use disorders.

- Medication Assisted Treatment: MAT is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of SUDs. These medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome opioid use disorders (OUD). Options for MAT services include telehealth and hybrid care models where some services are delivered in-person and other services are through telehealth (Teck et al., 2023). In a study conducted by the RAND Corporation, patients rated their satisfaction for telemedicine for OUD a 4-5 on a scale of 1 to 5 (5 being the highest satisfaction) (Sousa et al., 2023).

2. Establish infrastructure to coordinate care across providers and funding streams.

One ongoing challenge to the delivery of outpatient care and behavioral health services overall is the bifurcation of funding between the Department of Children and Families and Medicaid. The Health Care District represents a third funding stream, further adding to the risk of breakdowns in care, inefficiencies, and poor quality care. While it may not be in scope for the Health Care District to completely change this infrastructure, it should develop care coordination services, protocols and data sharing agreements that place the client at the center of their care. This care coordination should include the recommendations of the Palm Beach County Substance Use and Mental Disorders Plan to provide unified assessments, provide the structure, process, and outcome measures necessary to meet care coordination goals and to streamline continuity, communication, and tracking of clients across providers and service settings (Palm Beach County, 2022).

The state Commission on Mental Health and Substance Abuse, in its interim legislative report dated January 2023, emphasizes the need for this infrastructure at a state level. The Health Care District should monitor the implementation of these recommendations, which include:

- Establishing a master client index that will collect demographic and diagnosis information: If implemented, such an index can identify those who would benefit the most from enhanced care coordination to reduce the likelihood of utilizing higher levels of services (e.g., crisis stabilization units, inpatient hospitals).
- Initiating uniform quality metrics for all publicly funded behavioral health and substance abuse care in Florida: Currently, programs such as Medicaid and the Department use similar but varying metrics that can prevent accurate measures of performance. A uniform set will provide a more accurate account on the effectiveness of services delivered statewide.
- Creating a coordinated community behavioral health approach for public school students utilizing a single organization.

In conclusion, by establishing robust protocols, fostering data sharing agreements, and advocating for comprehensive infrastructure improvements, the Health Care District can play a pivotal role in addressing the challenges posed by the fragmented funding landscape.

Rehabilitative Services: People, Place & Purpose

"The problem is medical – mental illnesses are brain disorders – but the solutions must be much broader – including people (social support), place (housing), and purpose (a mission)."

- Healing, by Thomas Insell, former director of the National Institute for Mental Health

As emphasized by Thomas Insell, the 3Ps - people (social support), place (housing) and purpose (a mission) - are essential to overall health, not only for people who experience behavioral health challenges but for everyone. The experience of having a mental illness or substance use disorder can make it difficult to secure these three elements. Behavioral health conditions can strain relationships, disrupt employment, resulting in reduced income, and eventually, lead to poverty and homelessness. Consequently, individuals receiving treatment for these conditions may struggle to fully regain their health because these aspects of life - people, place, and purpose - are elusive. Thus, it is imperative that a system of care for behavioral health addresses these fundamental facets.

In many cases, the services, resources, and workforce needed to help people obtain the 3Ps exist outside of the health care sector. There are links, such as connections to social services, case management, and community health workers who help people navigate the often complex administrative requirements.

The effectiveness of these connections, the quality of services offered, and an individual's ability to successfully access what they require in these domains significantly influence their overall health and their interactions with healthcare systems. Addressing the 3Ps requires cross-sector collaboration between healthcare providers and human services professionals, and a variety of natural supports including family, friends, and community-based organizations. As the Health Care District develops a crisis continuum of care, partnerships and close coordination with the entities supporting the 3Ps will be essential.

Findings

Palm Beach County is home to many nonprofit organizations, foundations, County departments, and human service agencies providing a wide range of services related to the 3Ps. These range from neighborhood-level, highly trusted organizations engaging with communities living in distressed areas to large-scale operations managing large budgets of taxpayer dollars, and many in between. Stakeholders described various programs and organizations. The goal of this section is not to comprehensively describe the breadth of services offered, but rather to identify distinct strengths that the Health Care District can build upon to address the 3Ps.

Many locally-led organizations with trusted relationships in highly impacted communities are addressing behavioral health. Several stakeholders discussed the need for the Health Care District to partner with local, trusted organizations in order for their communities to engage in any behavioral health services offered by the Health Care District.

Concurrently, we heard about several effective programs at these organizations that are reaching people with behavioral health challenges, including those at risk due to trauma.

Program Spotlight #1: Circles Palm Beach County, from Pathways to Prosperity

Purpose: In partnership with Circles USA, this unique program strives to help individuals and families break the cycle of poverty and achieve upward mobility through education, mentorship, and personal determination for success. Circles® initiatives are available in multiple cities across Palm Beach County.

Impact: The program spans 12-18 months, beginning with a foundational 12-week period during which individuals engage in classes and experiences that have a profound impact. It focuses on building social capital through meaningful connections while educating participants about financial literacy and healthy relationships. Moreover, behavioral specialists facilitate powerful discussions to address the emotional trauma resulting from financial challenges, such as being unable to meet basic needs or coping with rent increases. These challenges, intensified by the COVID-19 pandemic, have underscored the importance of addressing the psychological aspects of poverty.

Program Spotlight #2: Bridges

Purpose: BRIDGES, established by the Children's Services Council of Palm Beach County, serves as a community hub designed to meet the daily and long-term needs of local families. Its ultimate goal is to ensure that children are born healthy, grow up in a safe environment, and are prepared for academic success.

Impact: With ten neighborhood BRIDGES locations across Palm Beach County, this program provides a wealth of free services to families, including parenting tips, workshops, guidance on fostering children's growth and learning, assistance in finding community resources, and access to lending libraries and business centers. Notably, 90% of BRIDGES clients are of Haitian descent, and the program has been instrumental in supporting families from various backgrounds, including those who have undergone traumatic experiences to reach the U.S. In response to the mental wellness needs arising from these challenges, BRIDGES has partnered with Trinity Counseling Center to offer mental health workshops along with casual conversations and outdoor meetings in parks focused on addressing mental wellness concerns.

Prominent organizations are supplementing and filling gaps in access to clinical services, providing peer support, and making care more accessible. Organizations mentioned by stakeholders include well-established entities like NAMI and Mental Health America, among others. These organizations are investing in building robust peer support services to assist individuals experiencing gaps in care. For instance, in situations where individuals are discharged and faced with extended waitlists and need to follow up with psychiatric or therapeutic services, these organizations are working to provide immediate access to peer support services.

Additionally, efforts have been made to explore establishing additional Clubhouses in Palm Beach County. According to Clubhouse International, "Clubhouses offer people living with mental illness opportunities for friendship, employment, housing, education and access to medical and psychiatric services in a single caring and safe environment – this social and economic inclusion reverse the alarming trends of higher suicide, hospitalization and incarceration rates associated with mental illness." Prior to COVID-19, several peer organizations joined with these leading agencies to connect with Clubhouse providers in Miami-Dade with the goal of bringing more Clubhouses to Palm Beach County. This alignment of interest and enthusiasm for the Clubhouse model provides a promising opportunity for collaboration.

The Palm Beach County Community Services Department plays a central role in managing and overseeing homeless services and housing programs. This department operates three shelters, including a family shelter, highlighting their commitment to addressing homelessness. Furthermore, the department provides extensive funding to approximately 125 different entities supporting a variety of human services programs. Through a centralized call center, Community Services connects individuals with the services they need. A real-time referral system streamlines the referral process to relevant resources, enhancing the efficiency of service delivery. Collaborative efforts with 211 and the integration of the county's referral and data system with courthouse data also contribute to the overall strength of the system.

Stakeholders discussed the importance of establishing coordinated care to improve the effectiveness and efficiency of service delivery. Overcoming challenges in accessing services for clients is critical to preventing delays in client engagement and treatment. The current system does not have a method of prioritizing human services clients, which creates challenges especially those who may struggle to navigate available resources. Additionally, there is a need for more comprehensive support services, such as care coordination, housing specialists, and support for transitioning into different housing arrangements. Stakeholders discussed challenges related to data sharing, transparency in resource availability, and communication between agencies, the County, and SEFBHN.

Recommendations

- Develop a robust catalog of existing services and engage with providers to understand their requirements for admission, retention, and discharge. Identify opportunities to improve coordination and ensure individuals are connected with the right level of services.
- Provide central care coordination services to all individuals receiving crisis care, including ongoing case management to address the 3Ps.
- Explore collaboration with existing systems to ensure crisis response staff across the continuum have access to a coordinated system for referrals, tracking, and follow up.
- Partner with organizations that are deeply connected to their communities to identify opportunities to build trust with communities, highlight the crisis services available, and fund programs that are responsive and effective in addressing the 3Ps.

Addressing Homelessness

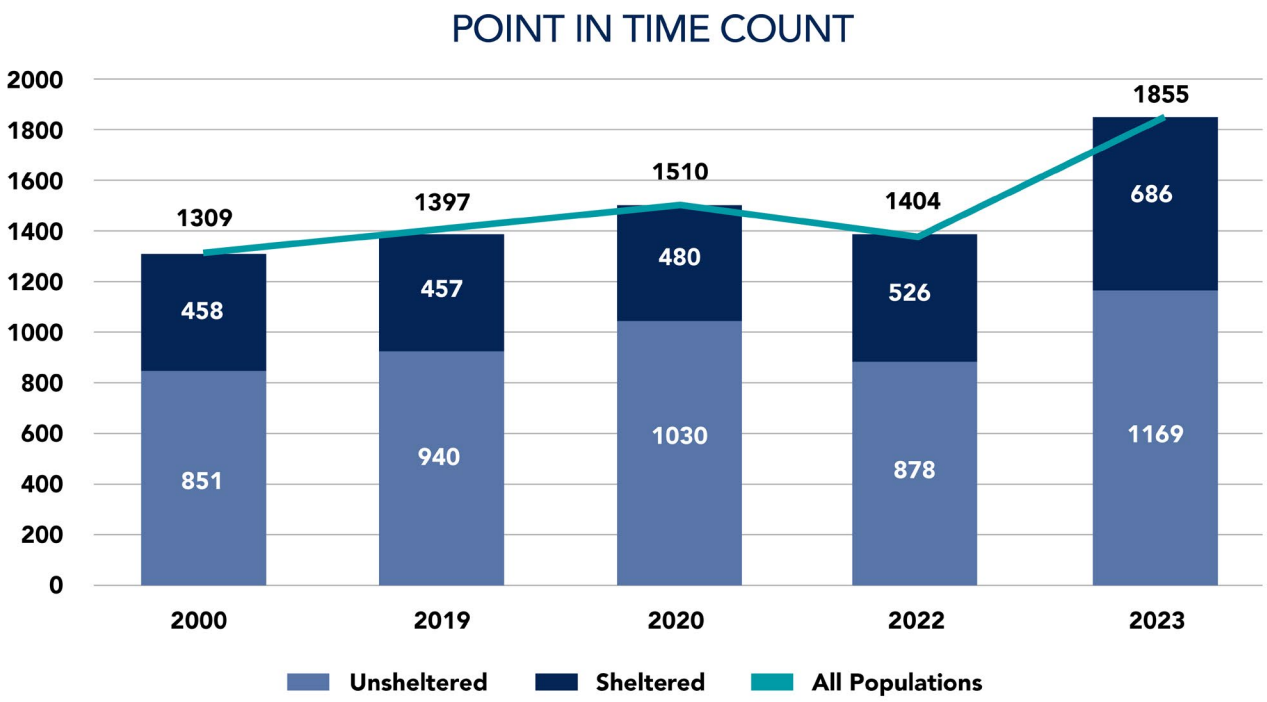
SAMHSA's Best Practices in Recovery Housing emphasize that having a stable and safe place to live is one of the major dimensions of supporting a life in recovery. The Homeless and Housing Resource Center and SAMHSA recommend stronger collaboration between behavioral health services and homelessness services. Their April 2023 document, "Coordinating Systems of Care to Provide a Comprehensive Behavioral Health Crisis Response to People Experiencing Homelessness," advocates for providers to help their clients develop crisis plans that identify a person's preferences in the event of a behavioral health emergency. These plans should be started at intake and updated as needs change. One type of plan they advise is a Wellness Recovery Action Plan (WRAP) to increase a person's awareness of formal and natural supports. They also advise that "warm handoffs" and regular communication between homelessness and behavioral health agencies can often prevent an individual from escalating into crisis.

Findings

A recent increase in the number of people experiencing homelessness in Palm Beach County is a top concern among certain stakeholders. The number of people experiencing homelessness in Palm Beach County increased 32% from 1,404 in 2022 to 1,855 in 2023, according to the homeless point-in-time count (Figure 7) (The Homeless and Housing Alliance of Palm Beach County, 2023). The proportion of people experiencing unsheltered homelessness remained steady at 63%, but the overall number increased by 291 people. An increase in unsheltered homelessness has brought additional visibility and attention to the issue.

Stakeholders from the business community in West Palm Beach described "a noticeable spike, and a precipitous increase in the number of incidents related to mental health," including violent events. Stakeholders voiced other concerns including people being discharged from jails, hospitals, or behavioral health facilities with no home and ending up staying on the street.

Figure 7. Homelessness Point in Time Count, Palm Beach County.



Source: Homeless and Housing Alliance of Palm Beach County

Many people experiencing homelessness have behavioral health conditions which are exacerbated by the stresses of experiencing homelessness. The physical and emotional stresses of street homelessness have been shown to compound mental health and substance use issues, with substance use challenges known to be both a cause and an effect of homelessness. Depression and suicidality are markedly higher among people experiencing homelessness. Studies have shown higher rates of traumatic events and adverse childhood events (ACEs) like sexual assault and physical violence, including head trauma, among populations of people experiencing homelessness (Padgett, 2020).

There are challenges with accessing resources for people experiencing homelessness. Palm Beach County Community Services reports difficulty accessing services including beds for people experiencing homelessness. Additionally, as many as 75% of people who are served by the County's shelters have experienced a mental health crisis. However, services for this population are not integrated or coordinated with shelter services.

Recommendations

Explore the potential of developing street medicine teams providing behavioral health services to stave off behavioral health emergencies upstream. Palm Beach County Community Services' homeless outreach teams should provide useful information to gain additional insight into specific details such as how and where services should be delivered. By taking medical and behavioral health care outside the four walls of a clinic or shelter, street medicine teams can make dramatic upstream changes in the health outcomes of unsheltered people experiencing homelessness. Street medicine teams have been found to be effective in delivering needed primary care, urgent medical care, and behavioral health care to unsheltered people experiencing homelessness. Street medicine teams have also been found to be helpful in ongoing care of patients after hospital discharge.

A recent report from the California Health Care Foundation, The California Street Medicine Landscape Survey and Report, provides insight into the twenty-five street medicine programs operating in California. More than two-thirds of street medicine programs diagnose and treat mental health conditions and substance use disorder, with 60% providing medication-assisted therapy. The majority provide primary care services (Feldman et al., 2023).

Integrate homelessness service providers to the continuum of care for behavioral health. Creation of a real-time bed registry and outpatient appointment scheduling will bring new capacity for care coordination to Palm Beach County. Case managers working with people experiencing homelessness should have access to this system. Clear pathways for referral, shared assessments and definitions, along with documentation, can greatly improve the ability for case managers to assist individuals with getting the care they need.

Collaborate with Palm Beach County Community Services and the Homeless and Housing Alliance of Palm Beach County to address the needs of people receiving behavioral health crisis services who lack housing. An optimal crisis system must be capable of addressing the unique complexities of each person's situation, especially those facing homelessness. This collaboration would involve screening for homelessness, integrating housing into discharge planning, sharing essential data, receiving real-time alerts, and jointly identifying resources. By working together, both organizations can effectively manage transitions of care and housing placements, providing comprehensive

support for individuals dealing with both physical and behavioral health conditions. Florida Statutes provide guidance for facilities including crisis stabilization units and detoxification centers to ensure that persons leaving their care are not discharged into homelessness (S420.626, F.S.). These include:

(a) Development and implementation of a screening process or other mechanism for identifying persons to be discharged from the facility or institution who are at considerable risk for homelessness or face some imminent threat to health and safety upon discharge.

(b) Development and implementation of a discharge plan addressing how identified persons will secure housing and other needed care and support upon discharge.

(c) Communication with the entities to whom identified persons may potentially be discharged to determine their capability to serve such persons and their acceptance of such persons into their programs, and selection of the entity determined to be best equipped to provide or facilitate the provision of suitable care and support.

(d) Coordination of effort and sharing of information with entities that are expected to bear the responsibility for providing care or support to identified persons upon discharge.

(e) Provision of sufficient medication, medical equipment and supplies, clothing, transportation, and other basic resources necessary to ensure that the health and well-being of identified persons are not jeopardized upon their discharge.

In summary, a collaborative initiative with Palm Beach County Community Services and the Homeless and Housing Alliance of Palm Beach County, guided by Florida Statutes, would promote integration of housing into the discharge planning process and establish a comprehensive framework addressing the complex needs of individuals facing homelessness in conjunction with behavioral health crises.

Section V:
Essential Principles, Coordination and Accountability

National Guidelines: Essential Principles for Modern Crisis Care Systems

The National Guidelines include a set of core principles that are crucial to ensuring a high quality modern crisis system. In addition to adherence to the guidelines provided for each of the three operational elements - Someone to Call, Someone to Respond, Somewhere to Go - these overarching principles must be internalized and exemplified by crisis providers across the system. The essential principles are provided below along with a short synopsis of each. The National Guidelines provide a robust discussion for each principle along with implementation guidance.

Addressing Recovery Needs: In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different from the traditional model. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery and ability to respond effectively to future crises.

Significant Role for Peers: Including peers—especially people who have experienced suicidality and suicide attempts and have learned from these experiences—can be a safe and effective program mechanism for assessing and reducing suicide risk for persons in crisis. Emphasizing engagement as a fundamental pillar of care that includes peers is a vital part of a crisis program's service delivery system.

Trauma-Informed Care: Trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis; especially those with trauma histories. Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves.

Zero Suicide/Suicide Safer Care: Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2) commitment to dramatic reductions in suicide among people under care.

Safety/Security for Staff and People in Crisis: Safety for both individuals served and staff is a foundational element for all crisis service settings. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised.

Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services (EMS). In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the de facto mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. Effective mental health crisis care enables the care team to collaborate with law enforcement in a manner that enhances both public safety and mental health outcomes.

Considerations

Implementation of the essential principles of crisis care across the crisis system requires that the Health Care District assumes a multifaceted role as a provider, convener, partner, and influencer. It is imperative for the Health Care District to lead by example, institutionalizing these principles within its own policies, procedures, training programs, and staffing recommendations. Additionally, to effectively anchor these principles within the collaborative framework, the Health Care District should formalize its commitment by embedding these principles into Memoranda of Understanding (MOUs) and collaborative agreements with crisis system providers. This formal integration will establish a clear foundation for the shared objectives and responsibilities outlined in the collaboration.

Demonstrating the alignment of the crisis care principles with broader state-level goals and priorities will further support the collaborative effort. Moreover, securing buy-in from DCF and the managing entity at the leadership level will further integrate these principles into existing systems of care.

Addressing the primary care needs of individuals in crisis presents a promising avenue for the Health Care District to enhance collaboration and engagement with providers of behavioral health care. As a primary health care services provider for uninsured or underinsured individuals in Palm Beach County, the Health Care District is well-positioned to strengthen behavioral healthcare by addressing primary care needs that arise in behavioral health crises. Leadership from prominent behavioral health care organizations expressed a critical need for more timely access to primary care services for their clients. Many individuals seeking services exhibit a spectrum of needs with both behavioral and physical health aspects.

They emphasized the need to "tap into the public health system quickly" for individuals who have pressing medical conditions. One example provided was that of an individual in need of substance use treatment who also had uncontrolled hypertension. Delays in treating hypertension meant delays in substance use treatment as well. This need has become more acute recently, with an increase in clients who have medical problems as well as behavioral health concerns.
By addressing primary care needs, the Health Care District can play a pivotal role in meeting the evolving and intertwined challenges of behavioral and physical health in crisis scenarios.

Strengthening partnerships with community providers and nonprofits is crucial to developing the trust needed to serve Palm Beach County residents. In a recovery-oriented approach, an optimal system of crisis care seeks to resolve individuals' crises by engaging them in the least restrictive setting. This includes telephonic and mobile team interventions. Engaging people in the least restrictive settings will only be possible if they are aware of available services, and if they are acceptable and accessible to them.

Several stakeholders advised that the Health Care District invest in deepening its relationship with key community organizations and conducting outreach to diverse populations of Palm Beach County residents. One stakeholder suggested, "If the district is looking at creating a crisis unit I would say hold off. They need to work on nonprofits and other community based organizations to break down the stigma." Another stated, "Deep in neighborhoods, they are not talking about 211, they are using home remedies. How do you speak to the neighborhoods?"
In light of these insights, building robust partnerships with community organizations emerges as a strategic approach to ensure that crisis services are not only available but also culturally sensitive and readily embraced by the diverse residents of Palm Beach County.

Coordination and Accountability

For a crisis continuum of care to be successful, there is a need for crisis services to be integrated and coordinated with existing systems including community mental health, hospital providers, and first responders. The National Guidelines provide a continuum to evaluate crisis systems and collaboration (Figure 8). Coordination is essential to ensuring the crisis system meets the needs and preferences of individuals regardless of which entity they encounter during a crisis, so they are assessed and routed to the appropriate resource to meet their needs. Additionally, data sharing across entities supports a more informed, effective approach to care, similar to the benefits realized across healthcare settings in other health areas. For crisis care to be fully aligned with the National Guidelines, Level 5 connectivity or "air traffic control" must be achieved.

Figure 8. Evaluation of Crisis System Coordination and Collaboration.

Crisis System Community Coordination & Collaboration Continuum				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Minimal	**Basic**	**Basic**	**Close**	**Close**
Agency Relationships	Shared MOU Protocols	Formal	Data Sharing (Not 24/7 or Real-Time)	"ATC Connectivity"

Recommendations

Develop a formal meeting structure, data sharing agreements, data collection and analysis, and quality improvement processes. In the "Roadmap to the Ideal Crisis System,"the GAP emphasizes the importance of accountability and transparency. A formal meeting structure, data sharing agreements, data collection and analysis, and quality improvement are essential elements of coordination of the crisis system. Quality improvement should be supported by a dashboard of performance metrics that include Key Performance Indicators (KPIs) to foster transparency and data-driven decision making (Table 26).

These measures should be reported automatically from an electronic system. The dashboard should be used for ongoing quality improvement efforts and provide valuable insight into the services provided, effectiveness, efficiency, and the improvement once the recommendations are implemented. This dashboard will also empower decisions to be made to refine and enhance service-delivery. For example, this level of accountability would include measuring the number of mobile response team deployments, and comparing those versus the expected numbers, to evaluate the effectiveness of those resources.

Table 27. Key Performance Indicators.

Someone to Call - Crisis Call Center Services
Call volume
Average speed of answer
Average delay
Average length of call
Call abandonment rate
Percentage of calls resolved by phone
Number of mobile teams dispatched
Number of individuals connected to a crisis or hospital bed
Number of first responder-initiated calls connected to care
Someone to Respond - Mobile Crisis Services
Number served per 8-hour shift
Average response time
Percentage of calls responded to within 1-2 hours
Longest response time
Percentage of mobile crisis responses resolved in the community

Somewhere to Go - Crisis Receiving and Stabilization Services
Number served (could be a measure of individuals served per chair daily)
Percentage of referrals accepted
Percentage of referrals from law enforcement (hospital and jail diversion)
Law enforcement drop-off time
Percentage of referrals from all first responders
Average length of stay
Percentage discharged to the community
Percentage of involuntary commitment referrals converted to voluntary
Percentage not referred to emergency department for medical care
Readmission rate
Percentage completing an outpatient follow-up visit after discharge
Total cost of care for crisis episode
Guest service satisfaction
Percentage of individuals reporting improvement in ability to manage future crisis

Henderson Behavioral Health provides a local example with learnings that may benefit the Health Care District. This organization, which is also featured in the Design Considerations section, was highlighted by a stakeholder as an exemplary model for crisis care. This stakeholder formerly worked in Broward County and was very familiar with Henderson Behavioral Health. The crisis receiving facility has been in operation for decades, according to the stakeholder, and Henderson Behavioral Health has a proven track record of success, not only for adults but also for youth.

Henderson Behavioral Health provides comprehensive crisis services to the entire county and serves as the primary crisis line and receiving facility. Their extensive network of 17 locations enables them to seamlessly connect individuals with various services, fostering a holistic approach to mental health care.

They are committed to collaboration, evidenced by not limiting referrals solely to their internal services but actively engaging with partner organizations. They not only participate in partner monthly meetings and reporting but also host these meetings. Open and robust communication and collaboration has been pivotal in their remarkable success as the county's receiving facility for over 30 years.

Notably, Henderson Behavioral Health also operates the Florida Assertive Community Treatment (FACT) teams in Palm Beach County, and is an active recipient of a SAMHSA CCBHC grant. Henderson Behavioral Health's experience may offer valuable insights to the Health Care District, and they should be contacted regarding their willingness to engage in discussions to share their knowledge and experience.

Conclusion

In conclusion, this report underscores the challenges facing behavioral health crisis care in Palm Beach County and the significant opportunity for transformative change. Despite existing hurdles such as capacity constraints, workforce shortages, and systemic complexities, the dedication of providers and their openness to collaboration create a favorable environment for positive shifts. Ongoing initiatives at the state, regional, and county levels further fortify the groundwork for change.

Our assessment identifies four critical factors pivotal for reshaping the crisis care continuum:

- Raising awareness of crisis services and developing trust
- The development of effective partnerships
- Establishing a robust infrastructure for coordinated care, and
- Securing necessary resources.

The proposed recommendations, spanning the "Someone to Call," "Someone to Respond," and "Somewhere to Go" components, provide a roadmap for the Health Care District to foster meaningful change in crisis care.

Through collaborative efforts and an unwavering commitment to essential principles, the Health Care District has the opportunity to lead by example, setting a benchmark for excellence in crisis care. The outlined enhancements, coupled with a comprehensive approach, support the development of a model crisis care system that prioritizes the well-being of its residents during moments of vulnerability.

Appendix

Appendix A: Definitions

Acute Inpatient Beds: see Hospital Inpatient Psychiatric Bed.

Addiction Receiving Facility:

"A secure, acute-care, residential facility operated 24 hours-per-day, 7 days-per-week, designated by the department to serve persons found to be substance abuse impaired as described in Section 397.675, F.S. (involuntary commitment), and who meet the placement criteria for this component. Detoxification may be provided" (U.S. Department of Health and Human Services, 2021).

Co-Response / Co-Responder Teams:

"These programs typically involve a specially trained team, including at least one police officer and one mental health professional, that jointly respond to calls for service in which a behavioral health crisis is likely involved" (UC Center for Police Research and Policy, 2020).

Crisis Call Center:

"Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) - quality coordination of crisis care in real-time" (National Guidelines for Behavioral Health Crisis Care, 2020).

Crisis Receiving Chairs:

Recliner chairs used in the provision of stabilization services for up to the first 24 hours of a client stay at a receiving facility or crisis stabilization unit. This time period is also referred to as an observation stay.

Crisis Receiving and Stabilization Services:

"Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment." (National Guidelines for Behavioral Health Crisis Care, 2020).

Crisis Stabilization Unit (Florida-specific):

"The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds" (Section 394.875(1)(a), F.S).

"[Crisis Stabilization Unit] stays average 3 to 14 days, resulting in return to the patient's own home, placement in a long-term mental health facility, or other living arrangements" (Agency for Health Care

Administration, n.d.).

Hospital Inpatient Psychiatric Bed:

"A bed designated for the exclusive use of patients receiving hospital inpatient psychiatric services as defined by this rule" (Section (j), 59C-1.040, FAC).

Hospital Inpatient Psychiatric Services:

"Services provided under the direction of a psychiatrist or clinical psychologist to persons whose sole diagnosis, or in the event of more than one diagnosis, the principal diagnosis is a psychiatric disorder defined in subsection (2) of this rule" (Section (k), 59C-1.040, FAC).

Mobile Crisis Teams:

"Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion" (National Guidelines for Behavioral Health Crisis Care, 2020).

For purposes of estimating the number of teams needed, the Crisis Resource Need Calculator assumes each team consists of two staff members working a 40-hour work week (https://calculator.crisisnow.com/).

Mobile Response Teams: (Florida-specific language for mobile crisis teams)

"Mobile Response Teams (MRTs) are meant to provide 24/7 emergency behavioral health care to anyone in the state of Florida. These teams are prepared to meet anyone having a severe emotional or behavioral health crisis in their home, school, or wherever they are. The goals of MRTs are to reduce trauma, prevent unnecessary psychiatric hospitalizations and criminal justice involvement through de-escalation, appropriate crisis intervention, and connecting people to resources in their communities" (Florida Department of Children and Families, n.d.).

Receiving Facility (in Florida):

"A public or private facility or hospital designated by the department to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider. The term does not include a county jail" (Section 394.445(40), F.S).

Short-term Crisis Beds:

"Beds within small, home-like short-term residential facilities…to support individuals who do not require inpatient care after their crisis episode" (National Guidelines for Behavioral Health Crisis Care, 2020).

Appendix B: Licensing Procedures

65E-12.104 Licensing Procedure.

(1) Every entity operating as a CSU or SRT is required to obtain a license from the agency unless specifically excluded from licensure under the provisions of Section 394.875, F.S. All applicants for licensure must comply with the requirements of Chapter 394, Parts I and IV, F.S., Chapter 408, Part II, F.S., and Chapter 59A-35, F.A.C.

(2) Accredited Programs. CSUs and SRTs which are accredited by The Joint Commission (TJC), Council on Accreditation (COA) or Commission on Accreditation of Rehabilitation Facilities (CARF) shall provide proof of accreditation as required by Section 394.741, F.S. Application for licensure by accredited programs does not preclude monitoring by the department, the agency and fire marshal, and compliance with the provisions of rule Chapter 65E-12, F.A.C.

(3) Liability Insurance Coverage.

(a) Applicants shall provide proof of professional liability insurance coverage from an authorized insurer in an amount not less than $300,000 per occurrence with a minimum annual aggregate of not less than $1,000,000.

(b) Applicants shall provide proof of general liability insurance coverage from an authorized insurer in an amount not less than $300,000 per occurrence with a minimum annual aggregate of not less than $1,000,000.

(4) A license issued by the agency shall be posted in a conspicuous place on the premises and shall state the type of service to be performed by the licensee and the maximum bed capacity of the CSU or SRT.

(5) Certification of Authorized Beds. The agency shall issue a license certifying the number of authorized beds and available appropriation for each facility as determined by the department based upon existing need, geographic considerations, and available resources. The department formula, ten CSU beds per 100,000 general population, may be used as a guideline.

(6) Program Closure. If a licensee voluntarily closes a facility licensed under this rule, the licensee shall notify the agency, the department, and the managing entity under contract with the department, in writing, at least 30 days prior to such closure. The CSU or SRT that is closing, with the assistance of the managing entity under contract with the department, shall attempt to relocate each individual receiving services, with the individual's lawful consent, to another CSU or SRT along with their clinical records and files. The licensee shall notify the agency, the department, and the managing entity under contract with the department, where the clinical records and files of previously discharged individuals are and where they will be stored for the legally required period.

Rulemaking Authority 394.876, 394.879(1) FS. Law Implemented 394.741, 394.875, 394.876 FS. History–New 2-27-86, Amended 7-14-92, Formerly 10E-12.104, Amended 9-1-98, 4-8-18.

Appendix C: Regulations for Facility Design

Below is a summary of Florida's Division of Mental Health chapter, "65E-12.109 Minimum Construction Standards for New CSU and SRT Facilities Initially Licensed After July 14, 1993":

- Each person receiving services in a CSU or SRT must be provided a minimum of 175 square feet of usable client space.
- Single occupant bedrooms shall be a minimum of 80 square feet.
- Multiple occupant bedrooms shall be a maximum of four occupants, with each bed having a minimum size of 60 square feet per bed and a minimum separation of 30 inches between beds.
- Seclusion rooms shall be a minimum of 70 square feet.

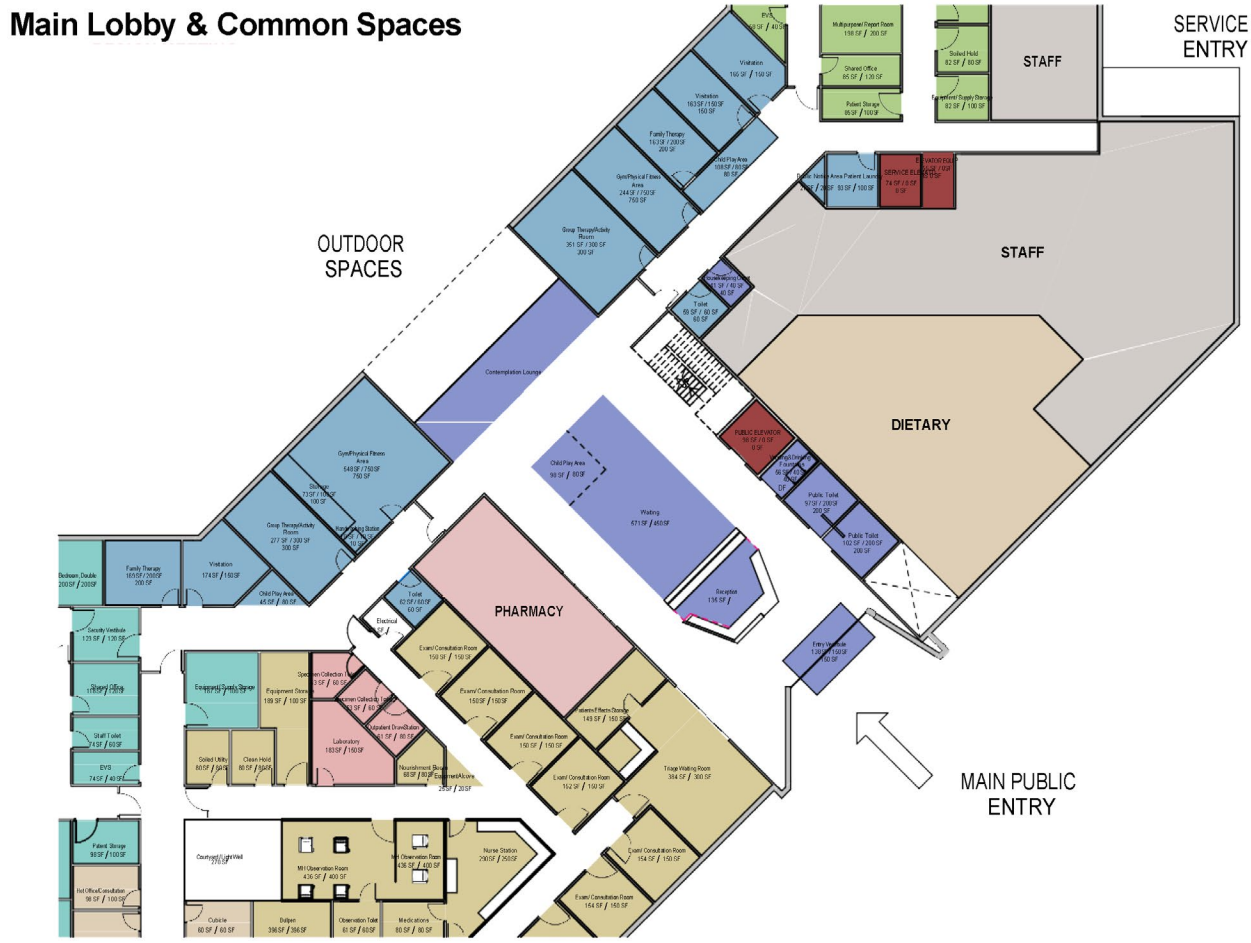
These square footage requirements ensure that the living and service areas within these facilities meet specific space standards for the comfort and well-being of individuals receiving services.

Additionally, below is a checklist of environmental and life safety requirements for newly constructed CSUs and SRTs:

- Compliance with building codes, fire codes, accessibility standards, and federal Americans with Disabilities Act (ADA).
- Modernization or renovation must meet new construction requirements and not reduce life safety features.
- Proper sewage disposal in accordance with relevant state chapters.
- Compliance with sanitary facility requirements.
- Compliance with plumbing standards.
- Adequate and safe water supply from an approved source.
- Health and sanitation inspections and Certificate of Occupancy are required before occupancy.
- Automatic sprinkler and smoke detection system protection throughout the facility.
- Surge protection in compliance with the National Electric Code.
- Design for a locked perimeter and fenced exercise area.
- Use of durable materials and design to minimize maintenance.
- Design for a therapeutic and secure environment.
- Separation of close observation and general observation areas.
- Ventilation requirements with central, ducted supply and return forced air systems.
- Special considerations for doors, including locksets and door closures.
- Corridor width requirements and minimum ceiling height.
- Requirements for hot and cold running water and accessible water temperature.
- Minimum door size, glass limitations, and television security.

- Emergency locking and generator systems for electronic locks.
- Door vision panels and windows with privacy.
- Tamper-resistant screws for electrical switches and outlets.
- Ground-fault protection for electrical switches and outlets in wet areas.
- Perforated metal grills for air ducts.
- Hose bibs with vacuum breaker devices.
- Adequate drinking fountains.
- Nine-foot ceilings in bedrooms, activity areas, and bathrooms.
- Perimeter lock control for access and egress.
- Restroom for waiting rooms accommodating persons with physical disabilities.
- Grade-level entrance accessible to persons with physical disabilities.
- Lobby with drinking fountain and interview space.
- Emergency screening area for law enforcement admissions.
- Seclusion room requirements for safety and monitoring.
- Janitor's closet with safety features.
- Requirements for bathroom design and fixtures.
- Designated examination room.
- Ceiling design to prevent access to overhead areas.
- Security features for beds and heavy furniture.
- Kitchen and nourishment preparation area standards.
- Dining area design for easy cleaning.
- Laundry facilities for soiled and clean laundry.
- Fenced recreational area with safety features.
- Multi-purpose room for group activities.
- Durable, flame-resistant, cleanable furnishings.
- Off-unit storage areas for operating supplies and personal belongings.

Appendix D: Larimer County Behavioral Health Facility Layout



Behavioral Health Triage Hub

Level 1 Floor Plan

Appendix E: Youth Crisis Stabilization Unit Review

Considerations for the number of youth crisis receiving chairs and short-term crisis beds were derived from a review of several sources, including:

- Connections Health Solutions, a national leader in crisis care, offers 34 adult chairs and 10 youth chairs at its Crisis Recovery Center, and short-term crisis beds only for adults, with no youth beds.
- The state of Wisconsin implemented youth crisis stabilization facilities across the state with a maximum of 8 beds and reports an average length of stay of a few days.
- Central Virginia has a population of 1.4M (nearly the size of Palm Beach County) and provides an 8-bed CSU that has about 200 admissions per year.
- Merced County, CA with a population of 281,000 people established a youth CSU with 4 beds operating under 23-hr observation.

Appendix F: Case Studies

Georgia's Crisis Call Center: a Hub for Crisis Care

In 2009, the United States Department of Justice (DOJ) initiated legal action against the state of Georgia, alleging violations of the Americans with Disabilities Act and the Supreme Court's 1999 Olmstead v. L. C. decision. This legal action was rooted in the unjust confinement of individuals with mental illness or developmental disabilities in state hospitals, which failed to adequately prepare them for successful reintegration into the community.

The 2010 settlement agreement between the DOJ and Georgia outlined a comprehensive plan aimed at revamping the state's crisis care and expanding its mental health resources. The initial five stages of the timeline were as follows:

- 2012: Implementation of six mobile crisis teams.
- 2013: Establishment of twenty-two Assertive Community Treatment (ACT) teams.
- 2014: Deployment of eight Community Support Teams (CST).
- 2014: Creation of three additional Crisis Stabilization Programs.
- 2015: Introduction of fourteen Intensive Case Management teams.

The CSTs were designed to deliver in-home services, ensuring that the necessary community resources were available to support individuals within their communities.

Crisis Stabilization Programs were instituted to provide psychiatric stabilization and detoxification services in community-based settings. Intensive Case Management teams were tasked with coordinating treatment and support services while facilitating access to community resources. These centers offered walk-in psychiatric and counseling services, staffed 24/7 by clinical professionals. A pivotal deliverable for the state was the creation of a toll-free statewide crisis line.

Georgia successfully established the first statewide crisis line capable of real-time tracking of available crisis beds and utilizing GPS data to dispatch mobile crisis teams. Georgia introduced a centralized bed board system that allowed individuals across the state to view the real-time availability of crisis and detox beds. This system, developed in partnership with Behavioral Health Link on proprietary software, formed the foundation for the 988 statewide 24-hour call system, accessible through calls, texts, and chat interventions. The call center facilitated urgent and emergent appointments and utilized GPS data from mobile crisis teams to dispatch assistance to individuals in crisis.

By integrating mobile crisis teams, crisis stabilization units, contract beds, and peer respite centers into the existing framework, the Georgia Crisis Access Line (GCAL) evolved into a comprehensive system that could aid any individual facing a crisis. GCAL serves as a model system for Palm Beach County to follow as it develops 988 into a true crisis care hub.

New Hampshire's Statewide 988 Promotion Campaign

In September 2023, the New Hampshire Department of Health and Human Services launched their "Strong as Granite" campaign to educate residents about behavioral health services available to them.

The campaign's name, Strong as Granite, evokes the spirit of self-sufficiency that New Hampshire residents have long embraced. Messages focus on strength, resiliency, and hope, and direct audiences to state and national resources available 24/7. Working with the Office of Governor Christopher T. Sununu and NH Department of Health and Human Services (DHHS) the campaign launched during National Suicide Prevention week. "New Hampshire has worked to rebuild our mental health system from the ground up, with an emphasis on providing Granite Staters support when and where they need them," said Governor Chris Sununu. "The Strong as Granite campaign provides yet another set of tools to quickly access resources in a time of need."

When people call the rapid response number, operators can deploy mobile crisis teams through the state's 10 mental health centers. This is part of what's called the "Crisis Now" model, which has three pillars: someone to call, someone to respond, and somewhere to go. In the future, the state is planning to pilot crisis stabilization centers, Jenny O'Higgins, a senior policy analyst in the department's behavioral health division said.

Strong as Granite uses ads in a targeted fashion, depending on public health data trends in various regions. For example, a billboard in Manchester, New Hampshire targets women between 30 and 40 with a message to call 211, given that rates of overdose among women in that age group are among some of the highest in the state. In addition to participating in campaign imagery, New Hampshire residents shared their own experiences with both mental health and substance use challenges. Shared storytelling is empowering with people who have experienced significant challenges in their lives. By sharing their stories, they also help others find inspiration, hope, and connection.

"The campaign is meant to be broad and upstream, so people can call early and often and do not need to wait until a time of crisis."- Jenny O'Higgins, Senior Policy Analyst, DHHS

Crisis Assistance Helping Out On the Streets (CAHOOTS)

In 1989, CAHOOTS (Crisis Assistance Helping Out On The Streets) was launched as an innovative community-based public safety system through a partnership between the White Bird Clinic and the City of Eugene, Oregon (White Bird Clinic, 2020). It was introduced as a mental health response system aimed at addressing crises involving mental illness, homelessness, and addiction, and now operates in both Eugene and Springfield, OR.

CAHOOTS is a mobile intervention program that plays a crucial role in assisting Eugene Police Department personnel by assuming responsibility for a variety of behavioral health-related calls, including crisis response. CAHOOTS team members also conduct proactive outreach, frequently initiating contact and arranging transportation for individuals struggling with issues like intoxication, mental health challenges, or disorientation. They also facilitate non-emergency medical transportation when needed.

Calls directed to CAHOOTS are channeled through Eugene's 911 system or the non-emergency police contact number, and in Springfield through the non-emergency number. Dispatch personnel undergo specialized training to identify situations characterized by non-violence but involving behavioral health aspects, ensuring that these calls are promptly redirected to CAHOOTS. In 2019, out of nearly 24,000 calls, the CAHOOTS teams requested police backup just 150 times.

The program deploys two-person teams, composed of a medic (typically a nurse, paramedic, or EMT) and a crisis worker extensively trained and experienced in the realm of mental health. The teams provide immediate stabilization of urgent medical requirements or psychological crises. They also provide comprehensive assessment, information dissemination, referrals, and advocacy, and, when deemed necessary, facilitate transportation to the subsequent phase of treatment. Their approach relies heavily on trauma-informed de-escalation techniques and harm reduction strategies.

It is important to note that CAHOOTS staff do not assume the role of law enforcement officers and are not armed; instead, they utilize their specialized training and expertise as the primary tools to ensure the non-violent resolution of crisis situations. Additionally, they proficiently address non-emergent medical issues, effectively averting the need for costly ambulance transportation and emergency room treatment.

The financial savings achieved through the CAHOOTS program are substantial. While the program operates with an annual budget of approximately $2.1 million, the combined annual budgets for the police departments in Eugene and Springfield amount to $90 million. In 2017, CAHOOTS teams addressed 17% of the entire call volume of the Eugene Police Department (Smith, 2020). This initiative translates to estimated annual savings of $8.5 million in public safety expenditures for the city of Eugene.

CAHOOTS' success showcases the effectiveness of a mobile crisis intervention program, and how partnership with law enforcement can strengthen the mobile teams. This program is a testament to how mobile crisis intervention enhances the community's well being and minimizes unnecessary emergency response costs.

Be Well Orange County's Transformative Approach: Uniting Communities or Mental Health

For years, Orange County was grappling with an ineffective mental health crisis system plagued by critical shortcomings, particularly concerning access to suitable care, especially for youth and adolescents. The fragmented healthcare landscape resulted in service gaps and a disconnection in the continuum of care. Individuals in crisis could not navigate the system or access timely help, often leading to adverse outcomes.

In 2017, Be Well Orange County (Be Well OC) was established with a bold mission: to transform Orange County into the happiest and healthiest community in the United States by redefining its mental healthcare system. Be Well OC, a nonprofit organization, brought together a diverse coalition of public, private, academic, and faith-based entities to facilitate communication and bridge existing gaps. Their aim was to eradicate barriers and establish a seamless continuum of care for all individuals experiencing mental health crises.

In 2022, Be Well OC opened a 93-bed campus offering round-the-clock crisis receiving and stabilization services for adolescents and adults in two 23-hour units. They provide crisis residential services for adults requiring more intensive treatment or facing voluntary/involuntary hospitalization. A sobering center offers 12-hour stays to aid intoxicated individuals in recovery. Be Well OC is actively adding new services to include residential substance use treatment, withdrawal management, and co-occurring residential services for mental health and substance use.

Be Well OC identified six foundational pillars for establishing and sustaining an enhanced crisis care and mental health system:

- Systems Change: the community needs to be aligned with public, private, faith-based, education, health, business, housing, and others to create a coordinated and collaborative system.
- Responsive and Inclusive: access to care should be timely no matter the individuals' beliefs, needs, and culture, and have the care customized to fit their needs.
- Aligned and Accountable: promote and support private and public investment in public health and to engage residents in the new approach to public health.
- Integrative and Future Focused: supporting the new system by integrating where possible and advancing technology.
- Evidence-Based and Quality-Driven Care: provides services through person-centered teams, integrated care models, and creating a shared measurement system.
- Fueled by a Mind OC Wellness Fund: financial goals are established, and action plans are created to build financial resources.

The impact of this transformative model is already apparent in the Orange County community, with improved mental health awareness and understanding. In January 2023, 218 adults and 55 adolescents were admitted to the CSU, with an average length of stay of 35 hours for adults and 27 hours for adolescents. Hospital ED referrals accounted for 30% of adult admissions, while the OC Health Agency, a regional interdisciplinary health jurisdiction, referred 24% of adolescents. Although the model is in its early stages, it has already demonstrated success in aligning efforts, transcending fragmented systems, and establishing a coordinated approach to crisis care, promising a brighter future for Orange County's residents.

Revolutionizing Crisis Care: The Impactful Journey of Connections Health Solutions

Connections Health Solutions is a visionary medical and recovery-focused treatment organization dedicated to harnessing community-based resources for expedited patient recovery. Founded in 2009 by Dr. Chris Carson and Dr. Robert Williamson, this institution assumed operations of a county-owned Crisis Response Center (CRC) in Tucson, AZ, in 2014. This transition was prompted by the recognition that the county's CRC, which housed 30 adult chairs and 10 adolescent chairs, was primarily clinically oriented and lacked a holistic, person-centered approach, resulting in lower-than-expected service volume.

The Connections model made a tremendous difference in CRC operations. This approach is distinguished by its unique combination of medical and recovery-focused treatments. A crowning achievement of this model is its "no wrong door" policy, welcoming all individuals in need of treatment, regardless of their insurance status. The CRC has a "no-refusal" policy for law enforcement, accepting all clients and keeping law enforcement drop offs to ten minutes or less. This approach has gained recognition from esteemed institutions such as the SAMHSA and the National Council for Mental Wellbeing.

Connections Health Solutions offers an environment that fosters continual supervision for safety and encourages therapeutic interpersonal interactions. The crisis stabilization unit operates 24/7, delivering critical services including psychiatric evaluations, crisis stabilization, enrollment in outpatient therapy, emergency medication refills, and referrals to community resources. For those requiring further assistance, a 15-bed adult short-term unit provides 3-5 days of additional stabilization for both voluntary and involuntary admissions.

Furthermore, the CRC serves as the crisis call center for southern Arizona, functioning as an "air traffic control" hub that dispatches over a dozen mobile crisis teams across Pima County. A covered breezeway links the CRC to an acute care hospital emergency department and a 66-bed inpatient psychiatric hospital. Additionally, the CRC offers space for co-located community partners, including behavioral health clinics for immediate patient enrollment and a peer-run program delivering post-crisis wraparound services.

Thanks to the innovative model pioneered by Connections CRC, the organization was able to provide care to 30,000 individuals across its two facilities in Tucson and Phoenix in 2022. Of the 30,000 individuals served, an impressive 60-70% achieved stabilization and were successfully discharged back into the community through the 23-hour stabilization service at the CRC.

The Connections model has not only become an integral component of Arizona's crisis care system but has also left a lasting impact on a national scale. Key attributes driving the success of this model should be incorporated into the recommendations for a crisis facility serving Palm Beach County, including:

- Integration into the regional crisis care continuum including coordination with the regional call center and MRTs
- Co-location of crisis stabilization and short-term residential treatment accepting voluntary and involuntary admissions
- No wrong door policy accepting all individuals in crisis

By incorporating elements from the Connections model, Palm Beach County can enhance its crisis care system to provide holistic, person-centered, and efficient support to those in need.

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