

SECTION V:

ACCESS TO CARE

**CUMBERLAND COUNTY
MH/DD/SAS**

APRIL 1, 2003

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Cumberland County Mental Health, Developmental Disabilities and Substance Abuse Center
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, areadirector@mail.ccmentalhealth.org
Submission Date	April 1, 2003

Item: V. Access to Care

Goal: 1. The Local Business Plan describes the operation of a local access system in compliance with the uniform portal of entry and exit in the State Plan. (W)

Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a)</p> <ol style="list-style-type: none"> 1. The Local Business Plan Committees have been addressing the need to expand points of access for screening and referrals within the community. 2. Some providers have expressed interest in being trained on the process. 3. Data on where consumers live in the community are being analyzed to determine areas that are not accessible via public transportation and where it appears that large numbers of individuals needing services reside. 4. Currently we have not identified any 	<ol style="list-style-type: none"> 1. Work will continue with all stakeholders to determine other access points in the community. 2. Training and technical assistance will be provided to all providers involved in the uniform portal process to ensure consistency and compliance to standards. 	

<p>area within the County that is not within 30 minutes/miles of an access location.</p> <ol style="list-style-type: none"> 5. The Mental Health Center is modifying its intake system to allow cross disability assessments to be completed in one location for children and one for adults. This was in response to feedback from consumers, family members and other stakeholders. 6. There is an existing protocol used to determine emergent, urgent and routine status of a referral that has been in effect for many years. This protocol is in compliance with State Plan guidelines for access to care. 7. In response to problems encountered after hours, mental health psychiatrists are now on site in the emergency room each evening in addition to having a physician on call. 	<ol style="list-style-type: none"> 3. New system should be fully operational no later than July 2003. 4. Clinical Staff will become part of the after hours coverage with the physicians, in addition to continuing availability of case managers, diversion staff, residential clinical staff and home based services staff 24/7. 	
<p>See Attachment V. 1-a: Access to Care Plan</p> <ol style="list-style-type: none"> b) There is currently a contract with Contact for preliminary crisis response services 24/7. If the individual calling is a mental health center client or needs mental health services, they are routed to a mental health staff for follow-up services. c) Discussions are occurring in business plan meetings about the need for formal procedures to assure that individuals are 	<p>The Mental Health Center will expand the current availability of after hours and evening services through establishment of a 1-800 number. This information will be publicized using the newspaper, radio, community channel, flyers and public meetings. The information will also be distributed through e-mail and written correspondence with all City and County agencies, advocacy groups, providers and any other avenue determined appropriate to educate the community.</p> <p>Continue meetings to address procedures</p>	

<p>not inappropriately denied access during the initial screening, assessment and referral process. Such guidelines currently exist with the LME but not within all of the community provider system.</p> <p>Policy has been proposed to govern establishment of procedures on access to care.</p> <p>d)</p> <ol style="list-style-type: none"> 1. Consumers and family members, providers and other stakeholders have been involved in development of the proposed access to care plan. Based on recommendations, the agency is modifying its existing procedures to better meet the needs of the community. 2. The Agency Policy on the Consumer Family Advisory Committee (Section 67) outlines the importance of having meaningful involvement of consumers and their families in all decisions related to delivery of public behavioral healthcare services in the community. <p>e) A policy has been drafted that directs the tracking of service requests, referrals and disposition of requests.</p> <p><i>See Attachment V.1-c: Client Access, Follow-up and Waiting-Section 41</i></p>	<p>related to access to care.</p> <p>Obtain Area Board approval of policy.</p> <p>Develop procedures to assure appropriate access to screening, assessment and referral services for all residents in the community.</p> <p>Develop system to track all service requests, referrals and dispositions with the MIS department.</p>	
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	<p>Educate all access sites on protocols to be implemented for tracking all access services.</p>	
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Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County	Cumberland County MH/DD/SAS
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Program	
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, areadirector@mail.ccmentalhealth.org
Submission Date	April 1, 2003

Item: V. Access to Care

Goal 2: The Local Business Plan provides sufficient evidence of the capacity to support a system of uniform portal of access in compliance with the State Plan. (NW)

Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a)</p> <ol style="list-style-type: none"> 1. The Mental Health Center has been providing access to care using emergent, urgent and routine criteria for many years. The guidelines used by the area program meet State Plan requirements. 2. The CQI Committee is discussing performance indicators noting that access to care and waiting for services need further study. 3. The MIS department is currently analyzing data on access within the existing system, based on emergent, urgent and routine criteria as noted at the time of screening. 4. Emergent referrals are seen immediately upon presentation to the Agency with referrals for psychiatric consultation as indicated and admission into more 	<p>A system will be developed to monitor access to emergent, urgent and routine screenings. This system will further analyze waiting time for service, no show rates and denials for services based on the individual not meeting eligibility criteria for services, as defined by the State. The system will also note the types of individuals who are presenting for services that do not appear eligible, to determine needs for further education and outreach in the community.</p> <p>Two years of data will be provided by 2005 that will show access to emergent, urgent and routine care and follow up by age,</p>	

<p>intensive services when warranted.</p> <p>b) Program Directors are meeting with MIS staff to look at current system and any studies that have been done on no show rates, denials, etc.</p>	<p>race/ethnicity, and disability. This data will also show an analysis of denials of care, no show rates and wait times for access. There should be no wait times for access to emergent care.</p>	
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Reviewers Comments:

Local Business Plan: Strategic Plan Matrix

Area Program(s)/County	Cumberland County MH/DD/SAS
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Program	
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, areadirector@mail.ccmentalhealth.org
Submission Date	April 1, 2003

Item: I. Access to Care

Goal: 3. The Local Business Plan indicates the number and location of designated entry points into the system and the types of practitioners and programs that are being designated to perform such services. (NW)

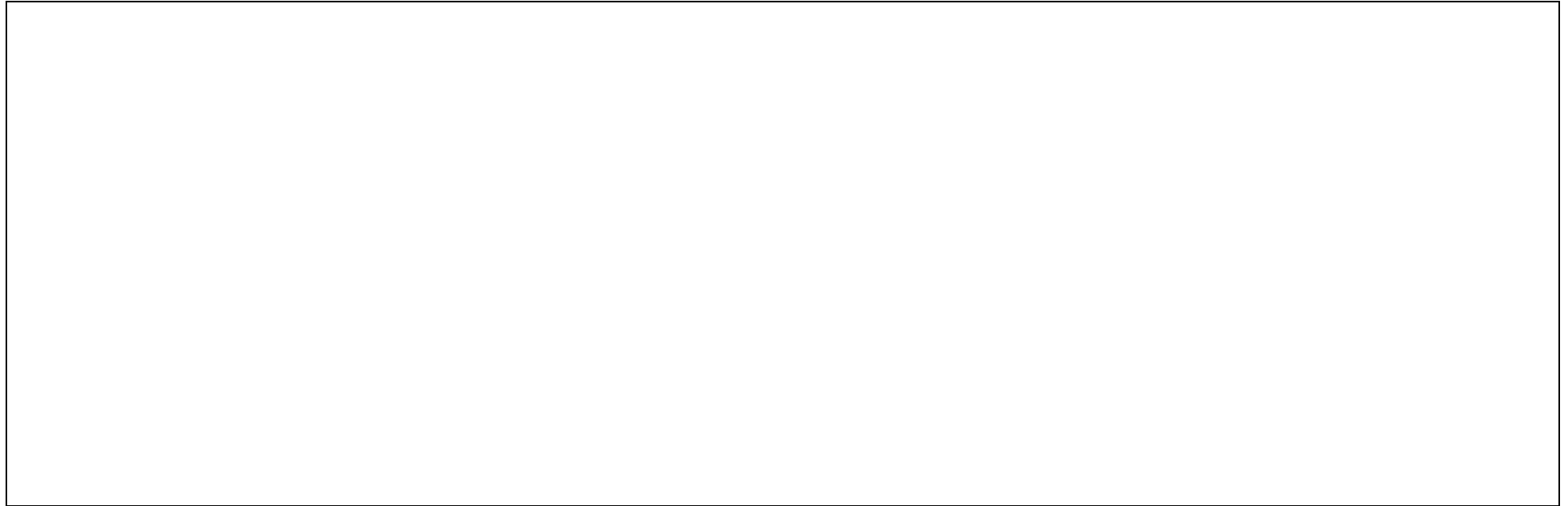
Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a)</p> <ol style="list-style-type: none"> 1. Currently access services are available at the following locations: Adult Services (109 Bradford Avenue); Child & Family Services (711 Executive Place); Department of Social Services, Public Health Department, Community Corrections Center, Juvenile Court Counselor's Office, Spring Lake Family Resource Center, CFVMC, Detention Center. Assessments can also be completed in the schools for children. 2. Assessments are also completed at the Salvation Army, Homeless shelters, transitional housing projects, etc. by the Adult and Child Homeless Coordinators. 3. Discussions have occurred with Stedman-Wade Medical Clinic about on-site mental health and psychiatric assessments for individuals. 4. All assessments are completed by 	<p>Based on analysis of existing sites and input from the CFAC and other stakeholders, additional access sites will be developed.</p> <p>Finalize protocol for assessments at Stedman Wade Medical Clinic and begin conducting assessments on site.</p>	<p>There are currently limited providers outside of the area program, who are trained to complete comprehensive assessments on individuals to determine target population eligibility.</p>

<p>qualified professionals for their specialty areas, including licensed clinical social workers, psychologists, licensed clinical counselors, and psychiatrists. Qualified mental health nurses and other qualified professionals are included in the screening and assessment process as appropriate.</p> <p>b) Please see geographic map noting locations of access points in the current system. Note that all current locations are accessible via public transportation.</p> <p>c) Access services are available within the community within 30 minutes/miles of locations currently identified.</p> <p><i>See Attachment V. 3(c) Draft Policy on Consumer Access to Services- Section 90</i></p> <p>d)</p> <ol style="list-style-type: none"> 1. The current inventory of crisis services is being discussed in business plan meetings as well as the utilization of crisis/emergency services over the past year by consumers. 2. Meetings have been held with Behavioral Healthcare of Cape Fear Valley Health Systems to determine best ways to incorporate an expansion of needed crisis services in the community. 3. The Hospital is in the process of down-sizing and has decreased adult inpatient beds from 32 to 16. The impact of this is not known at this time. 4. As part of the Hospital's assessment of psychiatric services and utilization of 	<p>Based on changes with the hospital's capacity for inpatient services and assessment of unmet crisis needs, discussions will occur on development of or enhancement of existing services to fill in the gaps.</p>	<p>Concurrent changes at Cape Fear Valley Medical System and the Mental Health Center will impact on the needs assessment and may invalidate the plans proposed to address concerns and gaps.</p>
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<p>the emergency room for assessments, a new triage system is being proposed for implementation at the hospital in April 2003. This system will focus more on comprehensive assessments across all domains by clinical staff, enhanced collaboration with community partners on access to other community resources (particularly for individuals presenting with a psychiatric crisis but who in reality are experiencing a life circumstance crisis), expansion of respite services and education of the community.</p> <p>5. Disability programs, consumers/family members and providers are assessing the needs for respite and short term stabilization services.</p> <p>e)</p> <ol style="list-style-type: none">1. There have been no exceptions thus far to the 30 minutes/miles access to care rule. Should such an exception present, this will be addressed with the CFAC.2. Discussions will also occur with neighboring area programs re: access to their systems for individuals who reside closer to another catchment area.		
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Reviewers Comments:



Local Business Plan: Strategic Plan Matrix

Area Program(s)/County Program	Cumberland County MH/DD/SAS
Contact	Hank Debnam, Phone 910-323-0601, Fax 910-323-0096, areadirector@mail.ccmmentalhealth.org
Submission Date	April 1, 2003

Item: V. Access to Care

Goal: 4. The Local Business Plan describes a mechanism for provision of interim services that: Ensures due diligence in the search for services and supports outside of the boundaries of a single network and works cross county lines to access services.

Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>There have been no formal decisions made about access to services across area program lines at this time as we are continuing our needs assessment. Our program is frequently contacted by individuals from Harnett, Hoke and Bladen Counties for services as Cumberland's services may be closer to their home than their area program, the individual works in Cumberland County and/or the service needed is not available from their home area program.</p> <p>Cumberland County is also contacted for services due to the military, with surrounding area programs not having accessible TriCare providers for services to military dependents.</p> <p>The Agency is committed to ensuring that there is a safety net for consumers should the service that is needed not be immediately available to the consumer and in circumstances that a provider may determine that the consumer is no longer eligible for services from the provider.</p>	<p>Communications will occur throughout the business planning process to assess the needs for specialized arrangements with other LMEs and providers when services needed by Cumberland County residents are not available at the time they are needed as well as to address needs of consumers in other catchment areas.</p> <p>Assessments on the frequency of such events occurring will be analyzed to determine if there are gaps in the continuum of services or if the event is a low incident service that perhaps needs to be available on a regional basis.</p> <p>Consumers and family members will be involved in the process of service delivery across LME lines that will ensure informed choice for the consumer.</p>	

Reviewers Comments:

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Submission Date	April 1, 2003

Item: V. Access to Care

Goal: 5 The Local Business Plan adequately addresses physical and programmatic accessibility issues including the following: limited English proficiency and other linguistic needs through the availability of language assistance services,, cultural and demographic needs of the community, visual impairments through written materials and signs translated into Braille , etc., alternative needs for community through the availability of an augmentative community specialist if needed and mobility challenges through accessible buildings and parking lots with sufficient designated parking for vehicles with handicap permits.

Effective Date: July 2004 and ongoing

Steps Taken	Steps Planned	Barriers
<p>a) The Mental Health Center currently has several clinical and support staff that are bilingual and available for individuals that have English as their second language. Currently there are staff available who speak Spanish, Korean, and Pakistani.</p> <p>b) The Mental Health Center has clinicians who serve as Coordinators for services to Deaf and Hard of Hearing Adults and Children and their Families. The agency also has contracts for interpreters at no cost to consumers and their family members.</p> <p>c) Written materials, including client rights information, appeals procedures, consents for treatment, informational brochures, etc. have been translated into Spanish for use by consumers.</p> <p>d) Public forums and focus groups were held specifically for the Hispanic population, coordinated by the Hispanic community, and Native Americans,</p>	<p>The assessment of the provider ability to meet the physical and programmatic accessibility needs of consumers will continue.</p> <p>A listing of providers who can meet the needs of consumers as outlined in this section will be compiled and made available.</p> <p>In areas in which there are no available providers that can meet the accessibility needs of consumers, work will be done to develop resources through partnerships with other agencies as appropriate. Input from consumers and family members will be sought on an ongoing basis to ensure that access and services are provided in a culturally competent manner.</p> <p>Collaboration will continue with the Latino Center, Bureau of Indian Affairs and the Rural Health Agency to continue outreach services to the Hispanic and Native American community.</p>	

<p>coordinated by the Bureau of Indian Affairs.</p> <ul style="list-style-type: none">e) The Agency has access to equipment for use by visually impaired individuals through MHC staff, who are visually impaired, as well as through the Center for the Blind.f) Augmentative communication devices are available through our DD program for consumers and family members.g) Buildings have handicap ramps, restrooms that are wheelchair accessible and elevators in buildings that are multi-story. There is also sufficient parking for vehicles with handicap permits. Our two primary locations are in the process of having automatic door openers installed for better accessibility by those consumers in wheel chairs.h) Discussions are occurring in Local Business Plan meetings with other stakeholders, including providers, to determine the availability of other resources to address physical and programmatic accessibility issues.		
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Reviewers Comments:



Cumberland County Mental Health Center Access to Care Plan

Cumberland County Mental Health Center is committed to ensuring that access to care in the public behavioral health system, which includes access for mental health, developmental disabilities and substance abuse services, is user friendly and convenient. In order to accomplish this, the Access to Care Plan is being developed with the following guidelines being considered:

- ✓ Access sites will offer screening, assessment, information and referral services across all age and disability areas.
- ✓ The access process must be efficient, culturally sensitive, prompt and accessible.
- ✓ Access sites in the community need to be near public transportation whenever possible. When this is not possible, information on other means of transportation or sites that are on the bus line, need to be included with information on the access sites.
- ✓ Access points will need to take into consideration demographics on the community. Demographic analysis of the community shows a large concentration of Hispanic, Native American and Asian citizens. Access points will need to ensure that accommodations are made to accommodate possible cultural and language barriers.
- ✓ All access points will have staff that are culturally competent.
- ✓ Information, screening and referral services will be available 24 hours per day/365 days per year by phone. This will necessitate expansion of the existing services with Contact Crisis line and creation of a 1-800 number for access to care.
- ✓ Crisis and emergency services will be available 24 hours per day/ 365 days per year. These services will be available for all consumers, regardless of their age or disability and will be networked with other community resources to ensure that needs, outside of the behavioral health field, can also be addressed as appropriate.
- ✓ All individuals (consumers, families, agencies, professionals, etc.) who come into contact with one of the access sites with a request for services will receive a prompt screening by a qualified professional. This screening will include:
 - A determination of the problem that led to the service request
 - An assessment of safety issues
 - A determination of urgency of need

Based on the screening, the individual could be referred for a more comprehensive face to face assessment, emergency or crisis stabilization services or will be linked to an appropriate community support or provider of services. Follow up will occur to ensure that the individual was able to receive needed services and/or supports as appropriate.

Face to face assessments may be completed by the LME but also may be completed by select providers in the community. These assessments need to be comprehensive enough

to determine the individual's eligibility for services based on the target population criteria. The assessments should be completed in an efficient manner and be brief but thorough. The following are the minimum data sets for an evaluation completed as part of access services:

- Presenting problem(s) and symptoms
- History of presenting problem/symptoms
- Risk/safety assessment
- History of past treatment and relevant social/family history
- Brief mental status exam
- Current/past medical problems; for children will include brief developmental history
- Determination of current functioning based on assessment tools identified by the State (currently would include GAF, CAFAS, NC-SNAP, ASAM)
- Target population determination
- Level of Care determination

Upon completion of the assessment, information will be provided to the consumer/family about service/support options. Based on the target population determination and level of care review, the consumer/family would be provided with a list of those included in the qualified provider network. LME staff would facilitate referral to the selected provider if requested by the consumer/family. LME staff would also follow up to ensure that the consumer was in fact able to access services, particularly for those who elected not to have the access staff directly facilitate the appointment. Authorization for the service would be included in the administrative functions of the LME.

For those consumers who did not meet the criteria to be a member of a target population, a referral would be made to appropriate community resources. Access staff would facilitate networking with the community supports and again would follow up as appropriate. Follow up would include assessing whether the community supports were helpful, accessible, available and responsive to the consumer's needs. This information would be analyzed as part of the quality management process to ensure that there is current and reliable information on community resources.

It will be critical to educate the community about the Access to Care system as it is being developed, enhanced and revised. Information will be publicized through a variety of ways. These will include direct notification (face to face and in writing) of the hospitals and medical community, particularly the emergency departments, law enforcement agencies (city, county, military), judicial system (judges, district attorneys, magistrates, public defenders, juvenile justice and community corrections), public and private organizations, schools, churches, human services agencies, community groups, providers and other professionals in the community.

A brochure detailing the Access to Care system will be developed and will include information on locations, hours, phone numbers, emergency numbers, procedures, description of services, brief information on target populations and eligibility

requirements. Materials will be developed for English and non-English speaking individuals, based on the community data analysis.

Information will be in the telephone book, Answer Book (resource guide compiled by the public library), Partnership for Children Family Focus Resource Guide, community directories, etc. The information will also be included on the community channel, the LME web site, and be publicized through public service announcements on the radio and television. Staff will work with the newspaper to include Access to Care guidelines on an ongoing basis in the community public service announcement section of the newspaper.

The Consumer Family Advisory Committee will review all aspects of the Access to Care Plan prior to implementation in 2004 and on an ongoing basis, to ensure that the system is meeting the needs of consumers, family members and the community. Information will also be reviewed on an ongoing basis in other local business plan committee meetings, by the Community Collaborative, Interagency Coordinating Council, and with Advocacy Groups to ensure that the uniform portal concepts are understood and implemented. Consumer satisfaction data on access will be analyzed by the LME as well as the CFAC. It will be critical for consumers and family members to be involved in the problem solving process when things are not meeting the needs of the community as well as to sustain efforts that are working well.

In response to community needs, the mental health center is modifying its internal access to care system to allow for individuals to receive assessments across all disabilities in two consolidated locations: one for consumers under the age of 18 and the other site for consumers 18 and older. Staff are being trained in assessment and eligibility tools across disabilities to ensure that the individual is linked with all appropriate services and supports from one comprehensive assessment.

Access Sites in the Community:

Currently there are mental health staff in various community locations, available to screen, assess and refer individuals for services. The following outlines the existing Access to Care System in Cumberland County:

- 109 Bradford Avenue: Adults 18 years and older
- 711 Executive Place: Children ages 0-17
- Department of Social Services
- Community Corrections Center
- Juvenile Court Counselors' office
- Public Health Department
- Spring Lake Family Resource Center
- Cape Fear Valley Medical Center.
- Detention Center
- Staff are also providing services in different schools, Homeless Shelters, Headstart Centers, day care centers (home and community based centers), and the local Children's Home. Work is being done with providers in the community to determine other possible access points to include as we are developing the Access

to Care Plan. As we identify other sites and providers, training will be provided to ensure that there is uniformity in the screening, assessment and referral process.

Persons who are deaf or hard of hearing can access services at any location using the Child and Adult Coordinators of Services for Deaf and Hard of Hearing Individuals.

The LME will track all components in the Access to Care system to ensure that there is timely and appropriate response to service requests and appropriate linkages to community supports or treatment services when indicated. Data will be included in the evaluation plan that is being developed. Documentation and tracking will occur on all requests for services, including emergent, urgent and routine as well as requests for information and requests for services from non-target population individuals. Clinical and MIS staff will work closely with the evaluation staff to develop standardized procedures and formats to collect relevant access data on triage, clinical decision making and to facilitate timely data entry into the computer system.

Monitoring Access to Emergent, Urgent and Routine Services

The Mental Health Center has been utilizing emergent, urgent, and routine criteria for access to care for many years, indicating this status as either a Priority 1, 2, 3 or 4, with 4 indicating that the person did not need behavioral health interventions but instead needed information and referral to another support in the community. The Access to Care Plan will include compliance to state adopted standards for emergent, urgent and routine.

The time of a service request is documented on the screening form. To track responsiveness, the form will be modified to include notation of the time of the response. The system will also track those individuals who “no show” or do not present for services.

All information will then be entered into Unicare. Timeliness of services can then be analyzed and evaluated, to include responsiveness to emergent, urgent and routine requests, time to initial assessment and time of first service, differences in responsiveness based on location of service, provider, race, age, etc... The specifics of how to analyze the data and report information will be included in the Evaluation Plan being developed by consumer, family members, providers and LME staff.

Crisis Stabilization Services

The Local Business Plan Committees continue to study community needs for emergency and crisis stabilization services as part of its planning process and needs assessment. It is agreed that having adequate and effective crisis stabilization services entails having a continuum of services for adults and children. A continuum of care allows the individual to be served in the least restrictive but most clinically appropriate community based setting. Without alternatives, individuals may be hospitalized or incarcerated, or left in settings that place the individual and others at risk when other services would have been

preferred from a clinical perspective and more cost effective. Currently there are some pieces of the continuum of crisis services available in the community. Where there are gaps, networking will occur with providers and community partners to fill the needs as well as to determine state funding potential for the LME in developing key components in the array of core services.

Adult Crisis Stabilization Services

- 24/7 Telephone Crisis Services: Currently CONTACT provides crisis telephone services for the community as well as operates a specific line for the Mental Health Center. When emergency services are needed by a MHC client, contact is made with the on call psychiatrist. The system is being modified to include clinical staff in this process. When the full Access to Care Plan is implemented, the MHC will have access to a toll free number 24/7 with a qualified professional answering the call. This staff person will have access to crisis plans developed on consumers.
 - The MHC currently has staff on call for certain high risk consumers. Most of these are consumers in the ADMRMI target population. Staff respond to crisis/emergency calls, providing face to face assessments, determining safety issues, triage based on urgency of need, crisis counseling and problem solving, and when appropriate, facilitates access to other crisis services, that could include changes in placement, access to psychiatric services, etc.
 - The MHC also has staff available 24/7 for consumers residing in the apartments operated by the Mental Health Association.

The capacity for 24/7 crisis telephone services will be expanded to be available for all consumers and potential consumers in the community.

- Crisis Stabilization Services: The Mental Health Center operates the Roxie Avenue Crisis Stabilization Unit. This facility provides facility based crisis services to adults who meet the level of care criteria for acute psychiatric stabilization as well as those needing non-hospital medical Detox. Length of stay varies with most consumers being discharged within 3 days. A determination will need to be made on how to best utilize this facility as the hospital is downsizing its adult psychiatric services.
 - The hospital is looking at how to provide 23 hour observation beds in the emergency room. Whether these will also be indicated at Roxie Avenue will be determined based on analysis of need.
 - The hospital now has psychiatrists on site in the hospital emergency room until 11:00 p.m. to facilitate better triage of emergency cases.
 - There is a need for case management services as part of the hospital and Roxie Avenue Services to ensure appropriate linkage with other community supports to avoid unnecessary hospitalization.
 - Case management, assessment services and networking with law enforcement are also needed 24/7 to avoid placement in jail/detention for

those individuals determined to need mental health interventions but who do not meet the level of care criteria for inpatient hospitalization.

- Assertive Community Treatment Team: The Mental Health Center is in the process of hiring staff for the ACT Team. This service will be closely integrated with other crisis services.
- Intensive Outpatient Treatment Services: Some consumers need intensive outpatient treatment services, particularly when stepping down from hospital or other residential programs. This includes individuals with mental health, substance abuse diagnoses as well as those dually diagnosed. The LME will assess consumers needing these services as part of their crisis stabilization services and how to develop these with qualified providers in the community as alternatives to more restrictive services.

Demands for all of these services will be analyzed and modifications made based on data analyzed.

Child and Adolescent Crisis Stabilization Services

There have been many services developed for children through partnerships with other agencies and identification of funding for specific populations. The process of resource identification will continue as part of the LME needs assessment with the data analysis including information on effectiveness and efficiency of the intervention provided. The following are key components in a crisis stabilization continuum for consumers under the age of 18.

- 24/7 Telephone Crisis Services: As noted above, CONTACT provides crisis telephone services for the community as well as operates a specific line for the Mental Health Center. When emergency services are needed by a MHC client, contact is made with the on call psychiatrist. It will be critical to have staff with child specific training accessible during non-business hours, to appropriately assess, triage and intervene in emergencies involving children. The crisis could require only telephone crisis intervention services but could also require a face to face assessment. A decision would need to be made about where to provide the assessment if it were not appropriate to go to the consumer's home to do this. The system would also need to have the capability to respond to emergency/crisis calls from the after hours social workers for the Department of Social Services.
- 24/7 On Site Emergency Services: Based on a telephone assessment, it may be necessary for a face to face assessment to be done with a consumer. At times this could be completed in the consumer's home or placement. At other times, it may be contraindicated to do this and the child will need to be transported to a community location for a more comprehensive face to face assessment. Consideration has been given to space in the Roxie Avenue Crisis Center. Attempts will be made to not have the family go to the Emergency Room unless it is reasonably certain that hospitalization is going to be needed. Once in the

Emergency Room, the child would have to receive a medical clearance through the ED medical services staff prior to anything else happening. This involves a lengthy wait in the Emergency Room as well as assessments that may not be needed and costs to the family. For cases involving DSS, the crisis may be related to a disruption in the child's home environment as well as residential placement. Having access to clinical assessments for these children when they are needed can help avoid placing a child and others at risk. For those consumers receiving home based treatment services, there is immediate access 24/7 to the clinician/case manager as well as the supervisor. We have clearly seen that being able to respond with the child and family during the crisis leads to a more positive outcome and often avoids placement in higher levels of care.

- Residential Treatment Level II: Therapeutic Foster Care: The Mental Health Center has historically provided crisis services for children through use of therapeutic foster care placements. In the past we were able to reimburse families for retaining beds for use during crisis times. Funding constraints have not allowed us to do this which has decreased the access to these much needed crisis services. Based on funding for crisis/emergency services for the LME, consideration will be given to paying designated families a retainer to hold beds for crisis purposes. Should the bed be accessed, the family would be reimbursed at the appropriate rate, based on level of care and the difficulty of care rating scale. Having access to these beds would also facilitate appropriate placement of children referred from DSS. Many of these referrals would involve children with sexually aggressive behaviors as well as those with sexually reactive behaviors that may be exhibited in response to victimization. Families used for crisis services would be trained and demonstrate competency in working with these high risk behaviors.
- Residential Treatment Level III: Group Home Services: There needs to be the availability of high management residential crisis services for those children determined to need 24 hour supervision. This is not possible in a therapeutic home level of care. Thus, the capacity for some high management crisis services will be needed. The Bacote Center was developed with the intention to maintain one of the nine beds for crisis stabilization and assessment purposes. Because of the demand for services for high risk offenders, the bed is often not available for crisis purposes. Consultation will occur with providers to determine their willingness to retain beds for crisis purposes. A bed retainer, similar to that paid for therapeutic homes, would need to be made available to the provider agreeing to maintain a bed(s) for crisis purposes. It will also be critical to ensure that providers agreeing to do this have staff well trained in crisis intervention and stabilization services. Group homes will also need to be available for step down services from more restrictive settings, such as detention centers, inpatient care and PRTF as well as step-up services from therapeutic home placements, home based services, etc.

- Inpatient Services: Behavioral Healthcare (BHC) of Cape Fear Valley Health Systems offers child and adolescent inpatient psychiatric services. The community also accesses Dorothea Dix Hospital for those youth determined to need a more restrictive setting and those who may have been unsuccessful in multiple admissions to BHC. The community historically has been a very low utilizer of state hospital services, with the referral to DDH truly being a last resort. We have seen children who have failed in all other hospitalizations and placements benefit from the services of DDH and able to return to the community. Part of this appears related to the length of stay at DDH being a little longer than that at other hospitals. Staff at DDH also appear more able to address the dual disabilities of children (MR/MI in particular) and have been more effective with youth with psychotic disorders, extreme aggressive behaviors and those with medical complications as well as serious psychiatric conditions. If there are no state hospital beds for these youth, it is not known what will happen to this special group of youth. As the state hospitals downsize and change, assessment will continue on the community impact as well as ability of private hospitals to meet the needs of consumers historically served by DDH.

The Access to Care Plan for crisis services will need to determine the adequacy of pre-crisis services as well as post crisis stabilization services. Key components for children in particular, but also some adults, will be intensive case management, community based services, home based interventions, school based services (for children), Assertive Community Treatment Teams (currently being developed for adults- need to determine capacity and need for children) as well as planned respite. Critical to success in all of these will be identifying responsible staff for care coordination in each service area.

Service monitoring of emergency/crisis services will include ensuring that the community has an appropriate match re: intensity of service needed. It will also be important to consider the age of the consumer, gender of consumer, specialized clinical concerns, provider skills, provider capacity, and others in the service being considered and how they will match with the consumer being considered for placement. Safety of the consumer and the community will always be an ongoing assessment component, with risks being re-evaluated throughout the process. Having a comprehensive and accessible Access to Care System, that address all components of the crisis services continuum should allow the community to maintain the majority of consumers in the catchment area. Financing will need to be adequate and flexible enough to respond to community needs.