

The Way Home

Child and Youth Access to Community-Based Services Post-
Psychiatric Hospitalization in the District of Columbia

Funded under the Maternal Child Health Title V Block Grant Services to Children
with Special Health Care Needs

UNIVERSITY LEGAL SERVICES, INC.
PROTECTION AND ADVOCACY PROGRAM FOR THE DISTRICT OF COLUMBIA
220 I STREET, NE, SUITE 130, WASHINGTON, D.C.
(202) 547-0198
(202) 547-2567 (TTY)
WWW.ULS-DC.ORG

March 1, 2015

Executive Summary

Children and youth leaving acute psychiatric hospitalization require timely and individualized access to services in the community to both increase mental health well-being following discharge and to decrease the risk of readmission. Accessing community-based services is especially important immediately following discharge, as the greatest risk of readmission to a psychiatric hospital occurs during the first 30 days after leaving inpatient care.

Distressingly, there are a number of barriers in the District that prevent children and youth from accessing timely and individualized community-based resources following acute psychiatric hospitalization. In fiscal year 2013, 29% of District children and youth discharged from psychiatric hospitals received no mental health services within a year of discharge.¹

University Legal Services (ULS) spent a year speaking with hundreds of stakeholders and closely examining District policies and practices. Through this research and collaboration with District stakeholders, ULS has identified and proposes the following recommendations to eliminate barriers to accessing services in the community:

- Improve the way that providers and District agencies monitor and track admissions and discharges.
- Invest in electronic record sharing.
- Ensure that children, youth, and families have the opportunity and are encouraged to meaningfully and knowledgeably participate in discharge planning through the use of flexible meeting times and additional family-focused resources and supports.
- Promote shared decision making and peer supports for children, youth, and families.
- Increase access to child and youth serving psychiatrists.
- Increase capacity of Department of Behavioral Health (DBH) care coordination efforts.
- Increase training and technical support for providers to promote and enroll children and youth in underutilized community-based services.

¹It is important to note that many mental health systems across the country face barriers to connecting children to timely community-based services following discharge from acute psychiatric care and many of these barriers are not unique to the District. Finding comparable data sets is difficult, and therefore this paper does not compare the District with other jurisdictions, but rather identifies barriers to care and highlights potential solutions to address District challenges.

Acknowledgements

University Legal Service (ULS) acknowledges the author of this report, Francis Nugent, Staff Attorney, and the editors, Jennifer Lav, Managing Attorney and Lyndsay Niles, Staff Attorney.

ULS also acknowledges and thanks leadership and staff from the following organizations for contributing to and for reviewing this report: District of Columbia Child and Family Services Agency, Department of Behavioral Health, Department of Health Care Finance, Department of Youth Rehabilitation Services, DC Choices, Children's National Medical Center, Psychiatric Institute of Washington, ParentWatch, Total Family Care Coalition, the Children's Law Center, the DC Behavioral Health Association, the Public Defender Service for the District of Columbia, Community Connections, Contemporary Family Services, Family Preservation, First Home Care, Maryland Family Resource, and Hillcrest Children and Family Center.

ULS extends a special thanks to all of the parents and youth who generously volunteered their insight and their time to assist in this project.

Commonly Used Acronyms

CBI	Community Based Intervention
CFSA	Child and Family Services Agency
CIT	Clinical Intervention Team
CSA	Core Service Agency
CSW	Community Support Worker
DBH	Department of Behavioral Health
DYRS	Department of Youth Rehabilitation Services
FFT	Functional Family Therapy
iCAMS	Integrated Care Applications Management System
MCO	Managed Care Organization
MHRS	Mental Health Rehabilitation Services
MST	Multi-Systemic Therapy
SAMHSA	Substance Abuse and Mental Health Services Administration
SDM	Shared Decision Making
ULS	University Legal Services

Table of Contents

I.	Introduction	6
II.	Methodology.....	7
III.	Discharge Planning Team Roles and the Continuity of Care Guidelines.....	8
A.	Defining the “Team”	9
1.	The Core Service Agency.....	9
2.	Department of Behavioral Health.....	10
3.	The Hospital	10
4.	The Family	11
IV.	Provider Collaboration and Information Sharing in Discharge Planning	11
A.	Challenge: Providers do not reliably receive notifications of admissions and discharges.	11
1.	Solution: Simplify and standardize the way that providers and District agencies monitor and share admission and discharge information.....	12
B.	Challenge: Providers do not share information in a reliable, timely, or substantive manner.....	12
1.	Solution: Invest in electronic record sharing	14
V.	Child, Youth, and Family Involvement	15
A.	Challenge: Parents are not meaningfully included in discharge planning meetings.....	15
1.	Solution: Providers must notify parents of meetings in a timely manner and be mindful of parent schedules.....	16
2.	Solution: Providers must help parents access Medicaid funded transportation assistance to help parents participate in discharge planning.	16
B.	Challenge: Families do not report feeling respected or involved in discharge planning.....	16
1.	Solution: DBH should invest in shared decision making models.	18
2.	Solution: DBH and providers should make peer advocates available for children, youth, and families.....	19
3.	Solution: Families must have the opportunity to provide feedback through a meaningful evaluation process.	21
C.	Challenge: Families do not feel prepared for the discharge process.	22
1.	Solution: Parents must have access to resource materials regarding the discharge process and available resources in the community.....	22
VI.	Community-Based Services.....	23
A.	Challenge: The District lacks sufficient child psychiatrists.....	24

1.	Solution: DBH should continue to fund and support the DC Collaboration for Mental Health in Pediatric Care.....	24
B.	Challenge: Parents and Access HelpLine staff do not reliably or effectively communicate and exchange information.....	25
1.	Solution: Hospital social workers should participate in all Access HelpLine calls.	26
C.	Challenge: Care coordination services in the District are underutilized.....	26
1.	Solution: DBH should increase coordination supports and provide supports proactively.....	26
2.	Solution: DBH should have a more active presence within psychiatric hospitals.	27
D.	Challenge: Children leaving psychiatric care do not have reliable and timely access to evidence-based services.....	28
1.	Solution: DBH should increase training and technical support for providers.	30
2.	Solution: DBH should work with managed care organizations (MCOs) to increase the provision of evidence-based services.	30
E.	Challenge: Children leaving psychiatric care need greater access to wraparound services.	30
1.	Solution: The District should expand the High Fidelity Wraparound Project to increase delivery to all children and youth in need of the service.	32
VII.	Conclusion.....	33

I. Introduction

A troubling number of District children and adolescents with emotional disturbance and/or mood disorders leaving acute psychiatric care face a myriad of preventable but unaddressed barriers when attempting to access community-based services following discharge. As a result, too many District youth end up receiving mental health care exclusively within the confines of acute psychiatric facilities and not from community-based providers.

The fact that a large population of District children and youth are not accessing services in the community is especially troubling considering that a strong connection to community-based services upon discharge helps maintain gains from inpatient care and cut down on readmission rates.² Additionally, community-based services are not only beneficial in terms of treatment, they are also cost-effective, as psychiatric hospitalizations are typically among the most restrictive and costly mental health services.³

For children and youth leaving acute psychiatric hospitalization, accessing these services in a timely manner is vital, as the risk of readmission is greatest during the first 30 days following discharge.⁴ It is essential then that children have the supports needed to access and engage with the community-based services, especially within this time frame.

Unfortunately, children and youth simply are not accessing community-based services following discharge at a sufficient rate. University Legal Services analyzed Medicaid claims data for children's mental health services in fiscal years 2010, 2011, 2012 and 2013.^{5,6} The chart below depicts a sobering picture. While the number of children getting connected to community-based services is trending upward, the chart illustrates that a substantial population of children are not using community-based services.

²Romansky JB, Lyons JS, Lehner RK, West CM. *Factors Related to Psychiatric Hospital Readmission Among Children and Adolescents in State Custody*. *Psychiatric Serv.*, 54(3):356-62 (Mar. 2003).

³Sheidow, A.J., Bradford, W.D., Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C., Schoenwald, S.K., and Ward, D.M. *Treatment Costs for Youths Receiving Multisystemic Therapy or Hospitalization After Psychiatric Crisis*. *Psychiatric Serv.*, 55(5): 548-554 (May 2004).

⁴James, S., Charlemagne, S.J., Gilman, A.B., *et al.* *Post-Discharge Services and Psychiatric Rehospitalization Among Children and Youth*, *Adm. Policy Ment. Health*, 37(5); 433-445 (Sept. 2010).

⁵Statistics received via FOIA from DHCF on file with ULS.

⁶ULS received several sets of statistics from the Department of Behavioral Health (DBH) concerning fiscal year 2013. Due to some discrepancies across data sets and because the numbers from DBH only reflected one year, ULS relied on statistics from the Department of Healthcare Finance that cover fiscal years 2010-2013, so that multi-year trends may be seen.

Year	Number of unique beneficiaries discharged from a psychiatric hospitalization	Number of unique children who NEVER received a non-crisis mental health service in a non-emergency community-based setting within 1 year (365 days) of discharge	Percentage NEVER receiving non-crisis mental health services in a non-emergency community-based setting within 1 year (365 days) of discharge
2010	361	234	65%
2011	477	247	52%
2012	426	169	40%
2013	365	105	29%

There are a number of factors that prevent children and youth from accessing community-based services following discharge, and while not exhaustive, the following challenges appear to be the most persistent and pervasive in the District:

- Community-based providers do not reliably receive notifications of admissions and discharges.
- Providers do not share information in a reliable, timely, or substantive manner.
- Parents are not meaningfully included in discharge planning meetings.
- Families do not report feeling respected or actively involved in discharge planning.
- Families do not feel prepared for the discharge process.
- The District lacks sufficient child psychiatrists.
- Parents and Access HelpLine staff do not reliably or effectively communicate or exchange information.
- Care coordination services in the District are underutilized.
- Children leaving psychiatric care do not have reliable and timely access to evidence-based services.
- Children leaving psychiatric care need greater access to wraparound services.

To ensure that these challenges are meaningfully addressed, that inpatient and community-based care is sufficiently bridged, and that children and youth have access to timely and patient-centered resources in the community, effective discharge planning in the District requires a three-pronged approach. First, all members of the discharge planning team must be able to effectively collaborate with one another and they must be able to efficiently share information in a timely manner. Second, providers must respectfully and meaningfully engage families, caregivers, and youth. Third, the District must ensure that timely community-based services that meet the needs of children and youth leaving inpatient settings are publicized, available, and accessible.

II. Methodology

To investigate why so many District children and youth are facing barriers to community-based services following discharge from acute psychiatric care, University Legal Services interviewed and/or received written comments from:

- 12 parents of children and youth discharged from D.C. psychiatric hospitals;
- 35 employees of child-serving core service agencies;
- Leadership from the District of Columbia Child and Family Services Agency (CFSA), the Department of Behavioral Health (DBH), Department of Health Care Finance, and the Department of Youth Rehabilitation Services (DYRS);
- Staff from Children’s National Medical Center (Children’s Hospital) and Psychiatric Institute of Washington (PIW) (the two main hospitals serving District youth in acute psychiatric care);
- Outpatient providers at D.C. Choices and Howard Road;
- Two parent and family advocacy groups; and
- Advocates at the Children’s Law Center, the D.C. Behavioral Health Association, the District of Columbia Public Defender Service, a law professor at the University of the District of Columbia David A. Clarke School of Law, and the Foster and Adoptive Parent Advocacy Center.

In addition, ULS observed 5 discharge planning meetings, and spoke informally to over 300 youth in psychiatric hospitals. ULS also reviewed relevant literature regarding best practices in discharge planning and closely reviewed District of Columbia law and policy regarding continuity of care.

III. Discharge Planning Team Roles and the Continuity of Care Guidelines

Before exploring barriers to accessing post-discharge community-based services in depth, it is helpful to understand District policy regarding service delivery to children and youth during and following acute psychiatric hospitalization as the policy is intended to operate. While providers and District agencies do not always adhere to the Guidelines, District policy outlines who is expected to participate in discharge planning, what responsibilities team members are expected to execute, and how these team members are supposed to collaborate with one another during discharge planning.

Failing to follow through on Guideline-assigned tasks can result in uncoordinated treatment team meetings, absences of key members from discharge planning meetings, children and youth being discharged before services are adequately arranged, and ultimately an increased likelihood that youth will reenter the community with inadequate or no services all together.

The following section outlines the Continuity of Care Guidelines as they are intended to operate, not necessarily as participants actually follow the policy in practice.

A. Defining the “Team”

In the District’s mental health system, a “team” of individuals are supposed to work together to deliver a child’s mental health services during hospitalizations and transitions, including discharge from a hospital. This team is called the “discharge planning team.” At the very least, DBH policy, via the Continuity of Care Guidelines,⁷ assigns roles to each of the mandated discharge planning team actors: DBH; the Core Service Agency (the community-based mental health provider); the hospital; and the parents or Child and Family Services Agency (CFSA) representatives if the youth is under CFSA’s custodial care (foster care) or if the agency is actively assisting the family.

While not required, an ideal discharge planning team includes a much more robust cast: teachers, professionals, extended family members, friends, representatives from District child-serving agencies, and other members of the community involved with a youth’s welfare. Each member provides a different perspective concerning the youth, and each should be willing to contribute unique knowledge to the youth’s treatment and success in the community.⁸ The child whose community support worker describes as refusing to engage in treatment or who acts out in the hospital may be the same child who willingly helps an elderly neighbor or who sings beautifully in a choir. Without diverse participation, the team will not gain a full picture of the child and his or her family, and cannot build a true strength-based plan for success in the community.

1. The Core Service Agency

The Core Service Agency⁹ (CSA) is intended to serve as the community-based provider and a mental health “home base” for a child or youth. Ideally, most children or youth would already be connected to a CSA before hospitalization (i.e. already receiving community-based services prior to admission to a short-term psychiatric hospital),¹⁰ and therefore, the CSA should already be familiar with the child and family, their needs, and the events precipitating hospitalization. In the event that the CSA is newly assigned, CSA staff are still responsible for meeting directly with the youth at least twice a week for the duration of the hospitalization, being involved as part of the treatment team, maintaining progress notes, developing a

⁷Continuity of Care Guidelines, Policy No. 200.5A (Jan. 2012) available at <http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL160.pdf>

⁸Child/Youth and Family Teaming, Policy No. 340.11 (Aug. 2011) available at <http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL152.pdf>

⁹All CSAs are certified by DBH as Mental Health Rehabilitation Services (MHRS) providers, which allows the District to bill for specialty mental health services in the community.

¹⁰There are, of course, times when it is perfectly legitimate for a child or youth’s first contact with the mental health system to be with psychiatric hospital, as may happen if the onset of a mental health issue or symptom, such as psychosis, is sudden and acute.

discharge plan in conjunction with the hospital, and scheduling and attending meetings with the youth post-discharge.

Involving the CSA in discharge planning is essential. Research shows that discussions about the discharge plan between inpatient and community-based clinicians increases treatment engagement of consumers post-discharge.¹¹ Similarly, consumer involvement with community-based programs during hospitalization is a key indicator associated with patients keeping their post-discharge appointments.¹²

2. Department of Behavioral Health

The Department of Behavioral Health's Division of Integrated Care is designed to perform a gatekeeper and a managerial role. As gatekeeper, DBH should notify a youth's CSA of hospitalization and notify the hospital if the youth is connected to a CSA. In the event that the youth is not connected to a CSA prior to hospitalization, DBH should help facilitate the connection. DBH should notify the hospital that the youth does not have a CSA, and ask the acute care facility to discuss enrollment with the youth's parent or guardian. If the guardian consents, DBH staff are supposed to enroll the child or youth with a CSA based upon the caregiver's choice via the Access HelpLine, a 24-hour, seven-days-a-week phone line staffed by DBH professionals who can refer callers to crisis and ongoing care. Additionally, a DBH employee, called a Care Manager, can help coordinate services between the CSA provider and the hospital. The Care Manager does not work with every child or adolescent entering a hospital, but instead should be available to help providers work through complex cases. Through the Access HelpLine and the Care Manager, DBH's role is intended to ensure that youth are connected to all necessary discharge planning team members, that the members communicate with one another, and that they carry out their respective responsibilities.

3. The Hospital

The hospital is intended to act as the host for a discharge planning meeting. Under the Guidelines, the hospital should extend invitations to the youth, families, and CSAs to all treatment and discharge meetings, provide any documentation necessary to assist CSA providers to help children and youth access community-based services, provide prescriptions or enough medication until the next scheduled medication appointment, and provide discharge summaries. If a youth is not already connected to community based mental health services, the hospital is required to discuss enrollment in a CSA with a parent or guardian and help the family call Access HelpLine and connect to a CSA.

¹¹Boyer CA, McAlpine DD, Pottick KJ, Olsson M, *Identifying Risk Factors and Key Strategies in Linkage to Outpatient Psychiatric Care*, Am J Psychiatry, 157(10):1592-8 (Oct. 2000).

¹²Id.

4. The Family

The family should play a vital role in the discharge process. The Continuity of Care Guidelines are designed to ensure that discharge planning involve families and provide mechanisms to establish a child, youth, and family-directed focus. Unless their parental rights have been terminated, most parents have the authority to authorize mental health services.¹³ Under the guidelines, the hospital is required to invite the parent/legal guardian to all treatment and discharge planning meetings.

For a more detailed examination of the role of additional government agencies in the discharge planning process, see Appendix A.

The Continuity of Care Guidelines includes a reliable and thorough process to help ensure that children and youth have access to time-sensitive and individualized treatment. Without this configuration, as evidenced in this report, even the best intentioned providers, children, youth, and families are likely to encounter unnecessary and burdensome complications stymieing child and youth well-being and decreasing opportunities for linkages to community based services.

IV. Provider Collaboration and Information Sharing in Discharge Planning

For discharge planning to occur in any meaningful capacity, discharge planning teams must actually meet and share information as required under District policy. As straightforward as this sounds, a large majority of parents, CSA staff, hospital staff, and advocates interviewed flagged the absence of key members from meetings, last-minute treatment planning, and the lack of effective and timely information sharing as primary challenges in discharge planning and connecting children and youth to services in the community. Fortunately, these more persistent barriers are actually some of the most manageable. Timely scheduling of meetings, attendance, and record sharing primarily require careful planning and logistical adjustments.

A. Challenge: Providers do not reliably receive notifications of admissions and discharges.

Of the six CSAs interviewed for this report, including over thirty-five staff members, none reported receiving consistent or timely admission and discharge notifications. CSA staff described receiving sporadic updates by DBH or from hospitals, but for the most part, CSA staff depended on direct notifications from parents or last minute notifications from hospitals.

¹³A parent may still have the rights to authorize mental health services even if the parent does not have legal custody of the child or youth, as parents often retain some residual rights (e.g. decision-making power) regarding consent for non-emergency inpatient psychiatric services and psychotropic medications. See generally *In re G.K.*, 993 A.2d 558 (D.C. 2010).

While one Community Support Worker (CSW) said having a parent share news about the hospitalization is great and likely suggests strong parental involvement in the youth's mental health care, the same CSW recognized that not all parents think or know to contact the CSA at the time of hospitalization or at all, often times expecting the hospital to coordinate care. One hospital social worker described CSAs as "key in maintaining momentum of inpatient progress," while a CSW explained that "an engaged case worker is one of the more important factors in determining whether a child will have a successful discharge outcome."

CSA staff explained that the absence of a reliable method of receiving admission and discharge information results in key staff members missing discharge planning meetings, delayed community-based appointments, and missed opportunities to work with children, youth, families, and inpatient providers. Ultimately, given the important role that community-based staff members have in the discharge process and the short amount of time most children and youth spend in the hospital, the absence of a reliable means to notify CSAs of admissions and discharges is particularly harmful.

1. Solution: Simplify and standardize the way that providers and District agencies monitor and share admission and discharge information.

DBH and hospitals must improve the way they collect and transmit information regarding admissions and discharges to ensure that all members of the treatment team have timely information and can maximize the utility of the time the child or youth is in the hospital. Under the Guidelines, the hospital is tasked with notifying DBH of all admissions and DBH is required to notify CSAs of hospitalizations of enrolled children and youth and notify hospitals of the CSA that the child or youth is enrolled in. Adhering to the Guidelines would improve notification practices. If both hospitals submitted a daily census of all new admissions each morning to DBH, DBH could then turn around and notify the CSA of a child or youth's hospitalization in no more than one business day following admission, decreasing the likelihood that a CSA would lack notice of an admission or discharge.

Having a designated CSA employee available to receive notifications from DBH on a daily basis would also help ensure that the child or youth's status is relayed to the appropriate staff member or a back-up staff member if necessary. This designated CSA employee could also help monitor provider availability to serve new youths, staff turnover, and inactive cases occupying available spots. A designated CSA coordinator would help streamline information and expedite CSA involvement with a child or youth in the hospital, two tasks that could have tremendous value in connecting children and youth to timely community-based services.

- B. Challenge: Providers do not share information in a reliable, timely, or substantive manner.

During stakeholder interviews, every CSA staff member referred to the lack of discharge documentation and medical records as an impediment to connecting children and youth to timely services. Despite the fact that the Continuity of Care Guidelines require the acute care

staff to provide “any documentation necessary, including the acute care facility’s psychiatric evaluation, to assist the CSA/CBI Provider¹⁴ with obtaining authorization for community-based services which require prior authorization” and “a discharge summary upon discharge,” this type of open, dependable, and substantive exchange simply does not occur.

Community-based providers noted that they were lucky to receive a bare-boned one-page discharge summary documenting the admission date, the medications prescribed, and the discharge date. While hospitals suggested that CSAs could make formal requests for more extensive medical information, one hospital’s policy said that this process could take up to 30 days, which, as previously mentioned, is the time period during which children are most at risk for readmission.

Without adequate discharge and treatment documentation (such as reason for admission, progress made in the hospital, the basis for medication changes, and basis for discharge), CSA staff contend that they cannot prepare individualized and appropriate treatment plans immediately following discharge. As a result, CSA staff are often required to conduct lengthy intakes, without the benefit of intensive medical/psychiatric treatment history. A number of families found this process especially frustrating. One parent explained how she and her child had an intake meeting at a hospital, then went to visit a CSA after discharge, only to be told to return several days later for an intake meeting, and then to return again on another occasion to meet with the psychiatrist. Exasperated families questioned what was actually being accomplished during discharge planning if providers did not even share the most basic intake information. Other children, youth, and families found that rehashing medical information, particularly regarding traumatic events that led to hospitalization, proved upsetting and unnecessary. Two CSA staff members noted that from their experience, when children have to continually repeat experiences of trauma or crisis, the stories shift from experiences to defining characteristics.

¹⁴Community Based Intervention (CBI) services are intensive, time-limited services for children and youth ages six through twenty-one with complex needs designed to decrease out-of-home placements. There are four levels of CBI services available to children and youth.

- (a) CBI Level I, delivered using the Multisystemic Therapy (MST) treatment model;
- (b) CBI Level II, delivered using the Intensive Home and Community-Based Services (IHCBS) model;
- (c) CBI Level III, delivered using the IHCBS model on a short-term basis; and
- (d) CBI Level IV, delivered using the Functional Family Therapy (FFT) model

DBH oversees CBI services and community-based mental health providers deliver care to children and youth.

Staff at both hospitals pointed to hospital policy and the sheer volume of treatment notes as obstacles to sharing information with community-based providers. The best way for CSAs and other parties to access information regarding treatment, they argued, was to attend discharge planning meetings when the content of treatment notes are discussed. However, attendance is not a substitute for access to the hospital's comprehensive records. CSA staff beyond the individual worker need to review the records, and not all information is presented orally. Furthermore, this type of work-around ignores the importance of information sharing and does not address incidents in which CSA staff need follow-up information after discharge.

1. Solution: Invest in electronic record sharing.

Proper transition to community-based services requires a mechanism to efficiently transfer treatment information from inpatient providers to CSAs in a timely manner. Uniform electronic hospital records would improve the speed in which information is shared, would address the concern about voluminous documentation, and would help community-based providers have a fuller picture of a child or youth during the discharge process.

One way to accomplish this would be to tap into a new DBH initiative for the purpose of discharge planning. In an effort to enhance administrative services provided through MHRS, the Department of Behavioral Health will implement Integrated Care Applications Management System (iCAMS), a web-based Care Management system that will capture clinical data "via a single care platform for authorizing, capturing, tracking, reporting and claiming for care provided."¹⁵ The system will be utilized by DBH and CSAs through human care agreements. While this roll-out is promising, DBH's failure to include hospitals and the Medicaid managed care organizations (MCOs) (where most children who receive Medicaid are enrolled) in the care management system is a missed opportunity, especially considering the fact that staff at both hospitals have at least expressed interest in exploring iCAMS use. Having one centralized system that could capture and track medical information could potentially improve information exchanges, treatment meeting scheduling, and solve many of the logistical barriers standing in the way of care coordination between discharge planning team members, and one that will almost assuredly perpetuate many of the delays and communication breakdowns that occur between hospitals and community-based providers. While DBH leadership states the agency has not closed the door on extending iCAMS to hospitals and MCOs, there is currently no plan to do so, and as a result one of the barriers to accessing timely care will remain.

¹⁵DMH Solicitation: RM-12-RFP-093-BY3-IT-iCAMS-TH (May 2012), available at http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/iCAMS_RM-12-RFP-093-BY3-ITiCAMS.pdf

V. Child, Youth, and Family Involvement

Child, youth, and family involvement in hospital discharge planning is critical for successful linkage to community-based services, yet fostering and encouraging this involvement remains an ongoing challenge in the District. Successful execution of discharge plans depends on the family's ability and willingness to help a youth physically access services, to emotionally support their child or youth in seeking assistance, and for some types of interventions, such as family-focused therapies, to actively involve themselves in the services. Developing this type of buy-in often requires that treatment teams work closely with the youth and family throughout the hospital admission to clearly design community-based treatment objectives, which in turn helps children, youth, and families develop a greater stake in following through with the discharge plan.

A majority of children, youth, and families interviewed expressed frustration over a lack of involvement during discharge planning. For the most part, families cited three general barriers to child, youth, and family engagement. First, families find it difficult to attend discharge planning meetings due to last minute notification and a lack of transportation. Second, judgmental and dismissive approaches by providers chill the prospect of true collaboration. Third, families often feel ill-prepared and uninformed about what to expect during hospitalization, often resulting in misguided expectations and a limited investment in following through with community-based treatment plans. Ultimately, without addressing barriers to child, youth, and family involvement, even the best discharge plan will fail.

A. Challenge: Parents are not meaningfully included in discharge planning meetings.

Nearly every parent and a majority of CSA staff interviewed cited flexibility of meeting times and transportation to meetings as key factors in determining whether or not they could attend treatment meetings. Meetings staged late in the hospitalization process deprive parents of the opportunity to meet with inpatient community-based providers and a forum to ask questions, learn about the hospitalization and discharge process, meet treatment planning team members, and anticipate when the discharge might occur.

Additionally, every parent interviewed cited the cost of transportation as a significant barrier to participating in the discharge treatment planning process. These parents explained that paying for transportation out of pocket proved particularly burdensome and that these costs could sometimes limit the number of times they could visit their children in the hospital. Several parents remarked that they chose one hospital over the other, simply due to geographic proximity and cost of transportation and without having the opportunity to weigh other factors. CSA and hospital staff both agreed that transportation costs adversely affected parental involvement with treatment plans, but offered no solutions for how to help parents negotiate the importance of attending treatment meetings in the hospital with the financial cost of attendance.

1. Solution: Providers must notify parents of meetings in a timely manner and be mindful of parent schedules.

Treatment planning teams need to acknowledge that parents juggle many obligations and schedule treatment planning meetings with this in mind. Most parents interviewed agreed that advanced warnings for meetings, providing meeting times outside of traditional work hours, and using video and telephone conferencing, which providers currently do not utilize frequently, could increase the likelihood of family involvement.

2. Solution: Providers must help parents access Medicaid funded transportation assistance to help parents participate in discharge planning.

For many eligible parents, Medicaid should cover the cost of transportation and other related travel expenses pertaining to child or youth treatment planning.¹⁶ These travel expenses cover a wide variety of services, including cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means; the cost of meals and lodging en route to and from medical care, and while receiving medical care; and the cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and if the attendant is not a member of the recipient's family, a salary.¹⁷ Parents and caregivers are key treatment team members; there is a strong argument that their participation should be considered medically necessary for the child, thus qualifying for transportation reimbursement for traveling to and from the hospital for treatment planning meetings.

Even though many parents are eligible for Medicaid funded transportation, few parents reported using Medicaid funds for transportation. Additionally, a number of providers had not even considered that Medicaid funds could potentially help parents attend discharge planning meetings. Due to the perceived lack of transportation supports, it is critical for inpatient and outpatient providers, particularly MCOs that already regularly provide transportation services for youth, to reach out to parents and inform them that they should be able to request assistance with transportation if transportation costs are preventing parents from participating in discharge planning.

B. Challenge: Families do not report feeling respected or involved in discharge planning.

It is essential for treatment planning to occur in an environment that fosters empowerment and respects each family's unique constellation and inherent strengths. Unfortunately, nearly every parent ULS interviewed experienced negative interactions with providers during the discharge planning process. As a consequence, parents report, provider

¹⁶42 C.F.R. §440.170(a)(1).

¹⁷42 C.F.R. §440.170(a)(3).

attitudes have stymied inpatient and family input, resulting in overly generic discharge plans that lack child and youth involvement and fail to address their family's unique strengths and needs.

A number of parents shared experiences where providers demonstrated unwillingness to learn from family members, ultimately hindering family involvement. Family members often described the tenor of the meetings as one-directional and condescending. Even when parents voiced strong opinions regarding community-based care options, providers have, on occasion, ignored these opinions. Looking back at past discharge planning meetings, three parents interviewed expressed frustration when planning teams ignored parent requests for specific therapeutic community-based activities without explanation, ignoring the parent's strong belief such interventions would prove beneficial.

Caregivers also commonly reported feeling blamed for their child's hospitalization during treatment planning meetings. This theme played out during a number of interviews, as parents often shared feeling under attack and reported that discharge planning team members rarely valued or focused on leveraging family contributions and resources. For example, after one parent explained how much work and energy she spent working with her child in an attempt to emphasize her commitment to her child's mental health, the discharge planning team focused on perceived family dynamic weaknesses instead of focusing on her strengths as a mother.

One finding proved simultaneously frustrating and promising: Parents of children with multiple hospitalizations suggested they were treated better at the hospital after several visits. After multiple hospitalizations, parents reported feeling more comfortable in the hospital setting, and more willing to assert their needs and actively participate in treatment planning, which in turn, parents reported, resulted in more robust and individualized treatment plans. This suggests that a collaborative approach is feasible with confident and engaged parents, but ideally, this should be accomplished during the first admission.

A large proportion of hospitalized youth also expressed peripheral to no involvement in treatment planning. A common refrain from children and youth is that providers do not value or even listen to them during treatment meetings. When asked directly about treatment planning, one girl explained "our opinions don't matter because staff don't listen to the kids." During another conversation, a number of boys laughed dismissively about the notion that providers should incorporate youth input into treatment planning.

This resigned perspective is not shared by all youth. One boy helped frame the ideal role that youth should play in treatment planning, suggesting that youth "should have a lot of say, but not necessarily the final say." Having once spent time in a Residential Treatment Center (RTC), the youth explained that while he could not control the fact that he would spend several months in an inpatient facility, he was able to explore his strengths and needs with his treatment team and help find a RTC that would align with his individual needs. This position reflects the precarious nature of a youth's experience in inpatient psychiatric care. Ultimately,

as minors, youth do not have the authority to make most of their own treatment decisions. But as this anecdote helps convey, even a youth placed in a restrictive setting can contribute to treatment planning and treatment planning teams can utilize and integrate these contributions.

1. Solution: DBH should invest in shared decision making models.

The District should invest in shared decision making models to encourage and energize family involvement in discharge planning. Studies show that mental health consumers and providers are more inclined to participate in designing and developing the treatment they help shape. This type of involvement spurs individualized and innovative treatment and improves mental health care and quality of life.¹⁸ Parental involvement is also a positive indicator of post-hospitalization success, as children with increased parental involvement in the discharge process are significantly less likely to be readmitted to acute care than those with minimal parental involvement.¹⁹ According to the 2003 President’s New Freedom Commission on Mental Health, successful mental health service delivery treatment “must be consumer and family centered” and “care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience.”²⁰

Shared Decision Making (SDM) is one approach to treatment where providers and consumers work as collaborators and collectively come to consensus regarding treatment options.²¹ The model is based on the premise that committing to sharing power in the doctor-patient or doctor-family relationship improves the outcome of decisions, including “patient adherence.” SDM models require providers to understand what is important to patients and families and what specific strategies will work in the home environment and result in families feeling comfortable and encouraged to participate in treatment planning.²² An SDM framework would address many concerns families have raised regarding inclusion in treatment planning

¹⁸President’s New Freedom Commission (2003). *Achieving the Promise: Transforming Mental Health Care in America: Final Report*.

¹⁹Bladder JC: *Symptom, Family, and Service Predictors of Children’s Psychiatric Rehospitalization within One Year of Discharge*, J Am Acad. Child Adolesc. Psychiatry. 43(4): 440–451 (Apr. 2004).

²⁰ President’s New Freedom Commission (2003). *Achieving the Promise: Transforming Mental Health Care in America: Final Report*.

²¹Capers, Melissa, (2007) HHS Publication No.SMA-09-4371. *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions*.

²²Id.

and would go far to dissuade families from disengaging from the process. Various decision aid tools could be integrated into the hospitalization process.²³

2. Solution: DBH and providers should make peer advocates available for children, youth, and families.

Peer advocacy models that incorporate the SDM framework can help improve youth and family involvement in treatment through providing advocacy, compassion, and mentoring.²⁴ Just as individuals with serious conditions such as addiction, trauma, or cancer can benefit from consumer-provided care, mental health peer supports have demonstrated improved recovery outcomes.²⁵ Peer advocacy models are associated with a number of favorable outcomes. Consumers often view information conveyed by peers as more credible than information shared by professionals,²⁶ and peer support programs have been shown to improve engagement with care, consumer empowerment, and lead to treatment models that reflect the needs of consumers.²⁷

DBH has three certified peer specialist programs – one focused specifically on youth, one on families, and another on recovery. These specialists are authorized to provide Medicaid-reimbursable mental health rehabilitation services to mental health consumers under the supervision of mental health professionals. Staff members at several CSAs and both hospitals have expressed appreciation for the value of peer advocacy. Children’s Hospital and PIW should all leverage these available resources and host a peer advocate to help families and youth navigate admissions and discharge. Alternatively, CSAs could hire a peer support worker and have that person work directly with new families linked to the CSA due to a child or youth’s

²³A number of commercial structured decision making tools are available for general healthcare. For psychiatric treatment, Common Ground is a web based application and training package available for purchase regarding mental health shared decision making. www.patdeegan.com.

²⁴Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., and Tebes, J.K., *Peer Support among Individuals with Severe Mental Illness: A Review of the Evidence*, Clinical Psychology: Science and Practice, (1999).

²⁵Fricks, L. *Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce*. DHHS Pub. No. (SMA) 05-8089. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

²⁶Woodhouse, A. and Vincent, A., *Mental health Delivery Plan—Development of Peer Specialist Roles: A Literature Scoping Exercise*, Scottish Recovery Network and the Scottish Development Centre for Mental Health, Edinburgh, (2006).

²⁷Chinman, Matthew, et al., *Peer Support Services for Individuals with Serious Mental Illnesses: Assessing the Evidence*, Psychiatric Services in Advance, (Feb. 2014).

hospitalization. DBH should encourage providers to utilize both of these options to promote peer advocacy for the purpose of improving service delivery following hospitalization.

Additionally, in FY 2013, DBH received a 4-year Substance Abuse and Mental Health Services Administration (SAMHSA) grant, the DC Gateway Project, to expand and strengthen the system of care for children and youth with SED and their families.²⁸ Peer support through the development of a Family Support Specialist training and certification process is one of the five primary areas of expansion and improvement for the DC Gateway Project.²⁹ The Total Family Care Coalition (TFCC), through a contract with DBH, is the lead family organization to support the Gateway Project and the implementation of the family peer support initiative.³⁰ TFCC has also hired a Youth Development Lead, who has organized and developed a Capital City Youth M.O.V.E.(Motivating Others through Voices of Experience) chapter to join the existing DC Uniquely M.O.V.E.s chapter.³¹ Each of these resources could provide additional peer support for children and families.

Case Study: Through an initiative between Carroll Hospital Center and Carroll County Health Department Partnership, Carroll Hospital Center now hosts a Peer Recovery Support Specialist (Peer Specialist). Located primarily in the hospital, the Peer Specialist is available to meet with patients in acute psychiatric care on a one-time basis, but they can also follow up with patients for months in the community.^{32,33}

²⁸ FY 14 Community Block Grant Application, available at <http://dbh.dc.gov/page/community-mental-health-services-block-grant>

²⁹Id. The other four primary areas are: improved access, integration of Primary Health Care and Behavioral Health, functional assessment, and reinvestment with an initial focus on reinvesting savings from reducing "high end" services into reintegrating youth in non-public settings back into their home school. It is unclear whether the District has any plans to reinvest dollars to expand the menu of peer supports and other services to facilitate engagement services. SAMHSA noted during a recent site visit to review progress with the Gateway Project that the District should enhance engagement of youth and families who are receiving services.

³⁰Id.

³¹The Youth M.O.V.E. chapters are part of Youth M.O.V.E. National, the only youth led national organization devoted to improving services and systems for mental health consumers. Youth M.O.V.E. National, available at <http://www.youthmovenational.org/mission-and-vision-statement>.

³²In the past year, the peer specialist has worked with consumers on a wide range of issues, including: education, work, relationships, stigma, childcare, leisure, financial, transportation, spirituality, housing, physical wellness, legal issues, mental wellness, recovery.

³³The position requires that the Peer Recovery Support Specialist self-identify as having personally experienced a mental illness, substance abuse disorder, or a co-occurring disorder and that they have successfully accessed treatment and resources necessary to build their own personal recovery. Additionally, the individual must have a high school diploma, 46 hours of training, documentation of two

The Carroll Hospital Center and Carroll County Health Department Partnership staff attribute a recent drop in readmissions partially to the peer’s work and availability at the hospital. In the past year alone, the Peer Recovery Support Specialist met with 312 adult patients. Out of the 312 patients the Peer Specialist met with, only 11% returned to the hospital within 6 months³⁴ (compared to 23.9% for the general population).³⁵

3. Solution: Families must have the opportunity to provide feedback through a meaningful evaluation process.

In order to improve family interactions with providers, DBH, CSAs, and hospitals should collectively solicit evaluations assessing family experience to identify areas that could be improved upon. As it stands, there is no meaningful way for families to provide feedback that providers are able to review.

Currently, DBH publishes Provider Scorecards for Mental Health Core Services Agencies and posts the results on the DBH website.³⁶ DBH updates the Scorecards annually and uses the results as a quality improvement measure for the Agency. The Scorecards results are based upon quality reviews and claims audits.³⁷ Although some advocacy groups in the District work to ascertain family satisfaction, DBH’s scorecard would be improved by including a measure of family satisfaction that would create a baseline of parental satisfaction based on feedback and offer parents an outlet to share their experiences, potentially improving family and provider interactions.

ULS is not alone in promoting family-focused evaluations. In August of 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA)³⁸ conducted a report

years of sustained recovery, 20 hours specialist specific continuing education earned every two years, and they must pass a certification test.

³⁴Maryland Hospital Association – Partnering at the Local Level to Reduce Inpatient Behavioral Health Readmissions, available at <http://www.mhaonline.org/quality/transitions-handle-with-care>.

³⁵Maryland 2012 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, available at <http://www.samhsa.gov/data/sites/default/files/URSTables2012/Maryland.pdf>.

³⁶The FY 2013 Provider Scorecard, available at <http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/FY%202013%20Provider%20Scorecard.pdf>.

³⁷DBH FY2013 Oversight Responses, Question 75.

³⁸The report was funded through the Comprehensive Community Mental Health Services for Children and their Families Program.

and suggested that the District should work on involving youth and families in evaluation metrics, specifically recommending that the District “create and implement a plan to engage and recruit youth and young adults to give feedback and make evaluation efforts relevant to that population.”³⁹ By adopting this proposed solution, the District could solicit more input from families while also supporting SAMHSA’s recommendation.

C. Challenge: Families do not feel prepared for the discharge process.

Many parents interviewed described the days leading up to and the days following discharge as particularly overwhelming, due in large part to the stress of new or additional responsibilities regarding care coordination. Several parents said that they attributed this stress to the fact that they were not told what to expect regarding post-discharge community-based treatment and providers had not ensured that they had the necessary supports to follow through with the discharge plan.

Parents repeatedly reported they were unprepared for their children’s discharge. Two parents expressed surprise at how their children reacted to medications immediately following discharge, suggesting the parents did not receive sufficient education regarding side effects to understand what to expect. Three parents were completely baffled when the hospital deemed their children were stable and ready for discharge, having instead assumed discharge was days or even weeks away. Instead, upon discharge, most parents reported receiving a list of appointments without having a thorough discussion with clinicians about the purpose and importance of the services, or a plan regarding how to coordinate services in the community. Finally, several parents felt abandoned when the hospital stopped providing supports immediately following discharge, having anticipated that the hospital would participate post-discharge.

These anecdotes underscore the problems associated with not adequately preparing families for what to expect following discharge, addressing what types of challenges they might face in arranging community-based care, and identifying supports for parents who anticipate struggling with care coordination.

1. Solution: Parents must have access to resource materials regarding the discharge process and available resources in the community.

Parents would benefit from having access to materials regarding the discharge process, giving them time to peruse the list and ask the treatment team questions about specific services early on the admission process. Advocates at two different child serving agencies, hospital staff, and staff at each of the CSAs interviewed agreed that a descriptive list of community-based programs and services would help parents brainstorm questions for

³⁹SAMHSA Center for Mental Health Services, Child, Adolescent, and Family Branch report conducted May 27th-29th, 2014 and issued August 18th, 2014.

providers about specific services early on the admission process, navigate available services, and prepare families for what to expect from community-based services. Hospitals currently provide parents with orientation materials concerning the process of inpatient treatment, but these materials generalize information regarding community-based care and could be improved.

Example: In 2004, the New York Lawyers for the Public Interest, through funding from the Skadden Fellowship Foundation, published a resource manual regarding discharge planning for parents of children.⁴⁰ The manual covers three general sections. The first section, 'Discharge Planning,' lays an overview of what discharge planning is, how plans are created, what parental involvement should look like, and what happens after the hospital creates a discharge plan. The second section, 'Complaints about Your Child's Discharge Process,' provides parents with information about how to complain about a discharge plan, what to do when a child is being discharged too quickly, and outlining the hospital's responsibilities following discharge. Finally, the third section, 'Resources,' provides parents with a list of resources to consider during the discharge process as well as a list of organizations that can provide support.

While the resource guide applies only to New York youth, the information is accessible for parents, it contains an easy to follow survey of what to expect during discharge, what types of services are available, and who to contact with questions.

VI. Community-Based Services

While communication, information sharing, and family empowerment are important for a successful discharge, care coordination requires accessible, readily available, quality services that meet youth and family needs.

The District does provide a number of useful services and resources that help children and youth leaving hospitals successfully transition into the community. However, during stakeholder interviews, CSA staff members, hospital staff, and youth advocates all emphasized the need for improved community-based services in the District with increased capacity and participation. These stakeholders shared concerns that many community-based services are stretched too thin, these services delivered are uneven and sometimes poor, and that effective services are often under-enrolled.

We posit three factors lead families, parents, hospitals, and providers to the presumption that D.C. does not have sufficient capacity to serve youth in the community. First, the District is lacking capacity in at least one key area: access to psychiatrists. Second, the District is not effectively leveraging the Access HelpLine, the DBH Care Manager position, and

⁴⁰New York Lawyers for the Public Interest Fact Sheets and Resources, available at <http://www.istandfor.com/images/FE/chain234siteType8/site203/client/DLC%20-%20Discharge%20Planning.pdf>.

Clinical Intervention Team meetings, three productive care coordination services. Third, the evidence-based specialty services that exist, and that are particularly appropriate for children and youth experiencing psychiatric hospitalization, are being underutilized prior to discharge. Fourth, even when evidence-based practices are sought out for children leaving psychiatric care, youth are not receiving reliable and timely access to these services.

A. Challenge: The District lacks sufficient child psychiatrists.

There is a nation-wide shortage of psychiatrists that serve children and youth with mental health needs.⁴¹ National attempts to bolster the number of children and youth psychiatrists such as recruitment efforts such as loan forgiveness programs that incentivize child mental health have shown marginal improvements, but ultimately, these strategies are likely to prove insufficient in the long run.⁴² Instead, experts insist that a broader and more flexible approach is needed, ranging from a greater presence in developmental and primary care settings, and improved training models to prepare psychiatrists for the reality of the shortage of care.⁴³

A report published by RAND underscored that the District similarly has a lack of child and adolescent serving psychiatrists, particularly east of the Anacostia River, and that the city needs to make efforts to increase the number of psychiatrists available to work with children and youth in the District.⁴⁴ Feedback from CSA and hospital staff suggest that providers generally have enough psychiatric staff to schedule and conduct timely appointments for children and youth following hospitalization. However, interviews also reflected a shortage of psychiatrists to meet the current realities and demands of children leaving psychiatric hospitals. Because each CSA psychiatrist has a limited number of hours and days they see children and youth, this limits CSA flexibility around seeing children and youth when a crisis or a missed appointment occurs, making balancing heavy case loads and adapting to shifting family needs a challenging proposition.

1. Solution: DBH should continue to fund and support the DC Collaboration for Mental Health in Pediatric Care.

One current promising approach in the District involves a collaboration between a number of child and youth serving agencies. The DC Collaborative for Mental Health in Pediatric

⁴¹Thomas, C. R., & Holzer, C. E., *The Continuing Shortage of Child and Adolescent Psychiatrists*, Journal of the American Academy of Child and Adolescent Psychiatry, 45(9), 1023-1031 (2006).

⁴²Id.

⁴³Id.

⁴⁴Chandra, A., Gresenz, C.& Blanchard, J.C., *Health and Healthcare Among District of Columbia Youth*, Rand Health; (2009).

Primary Care, initiated by Children’s Law Center and Children’s National Health System and partnered with DC Chapter of the American Academy of Pediatrics, Georgetown University, DBH, DHCF and the Department of Health has made progress in promoting the “rational utilization of limited psychiatric resources for the most complex and high-risk children.”⁴⁵ The program aims to integrate mental health supports in pediatric primary care for children and youth in the District in a variety of ways, including: integrating routine mental health screening in primary care, providing pediatricians with mental health supports, providing supports and care coordination for families, and policy-advocacy. This is especially promising considering it incorporates increased presence in developmental and primary care settings with DBH financial support in FY 2015.⁴⁶

B. Challenge: Parents and Access HelpLine staff do not reliably or effectively communicate and exchange information.

Many parents rely on the Access HelpLine to enroll their children into community-based mental health services, yet do not know what information is essential to share with HelpLine staff. For example, parents do not know to share and HelpLine staff do not always ask if the child is in acute care. As a result, interviews suggest that some children and youth are leaving hospitals with inadequate and delayed services. Despite DBH's claims that the Access HelpLine is the “easiest way to get connected” to DBH resources and other certified behavioral health care provider services,⁴⁷ staff at CSAs, both hospitals, and DBH have recognized that a number of parents have difficulty working with Access HelpLine staff, complicating effective community-based referrals.

A repeated complaint from CSAs is that HelpLine staff schedule outpatient appointments for children or youth with a CSA without actually knowing that the individual was hospitalized. As a result, community-based appointments occurred well outside of the seven-day window following discharge mandated under the Guidelines for hospitalized children and youth. Other complaints involved HelpLine staff connecting children and youth with CSAs that did not offer the specific services discussed by the discharge planning team, including timely appointments and appropriate language supports. These types of miscues unnecessarily result in costly delays, disrupt outpatient transitions, and can put children at increased risk of readmission.

⁴⁵2014 Children’s Mental Health Report Card, available at <http://childrenslawcenter.org/resource/2014-mental-health-report-card>.

⁴⁶According to the 2014 Children’s Mental Health Report Card, DBH Director Steve Baron has communicated to the Children’s Law Center via e-mail that DBH has money in the budget committed to the project.

⁴⁷Access HelpLine Website, available at <http://dbh.dc.gov/service/access-helpline>

1. Solution: Hospital social workers should participate in all Access HelpLine calls.

Social workers are well-situated to help parents convey crucial treatment information to operators, and making these staff available to all parents would help ensure that children and youth are connected to appropriate community-based services and appointments. Currently, some hospital staff help prepare parents for Access HelpLine calls or actually join the call to make sure that the conversation covers the most pertinent and anticipated needs for the youth and family. Despite the fact that social workers suggest that this involvement helps address miscues such as the examples described above, this involvement is not standardized and largely dependent on the hospital social worker's availability and initiative. By making social worker involvement a more normalized part of the process (presuming parental consent), these staff members would work with HelpLine operators to relay important, youth-specific, information such as whether the child or youth is in acute care could help bridge communication efforts.

C. Challenge: Care coordination services in the District are underutilized.

Hospitals and Community-based providers all agreed that poor care coordination in the District leads to unnecessary delays in services. Many of these same providers suggested that the DBH Care Manager and the DBH operated Clinical Intervention Team (CIT) meetings improved care coordination, but ultimately remarked that these resources required more direct outreach and expanded access.

As addressed earlier, the DBH Care Manager can help a discharge team in a number of ways. The Care Manager helps bridge communication barriers between providers, helps notify team members about child and youth treatment history, helps arrange community-based supports in time-sensitive situations, and can follow up with consumers and providers following discharge to ensure that discharge plans are followed through with. The DBH Care Manager also participates in CIT Meetings. Through the CIT process, DBH staff and clinicians collaborate with treatment planning teams to discuss challenges and treatment approaches for individual cases, particularly those involving children and youth with complex needs. The team consists of DBH staff members that include the DBH Care Manager, the Associate Chief Clinical Officer for Child and Youth, several clinical social workers and program staff. CIT recommendations are not mandates, but are instead provided as an outside clinical perspective capable of providing technical assistance and advice.⁴⁸

1. Solution: DBH should increase coordination supports and provide supports proactively.

To improve care coordination, DBH should provide Care Manager interventions and CIT technical assistance services as a matter of course, rather than as a responsive service that is brought in to troubleshoot. Despite the fact that most providers found DBH Care Manager

⁴⁸CIT Information Sheet on file with ULS.

involvement and CIT Meetings helpful, a majority of providers noted that they only used these services when cases reached critical points. DBH rarely initiated contact with providers regarding cases, suggesting that DBH's supports are generally reserved to address poor coordination of services instead of helping secure strong coordination of care from the onset.⁴⁹ Currently, DBH holds two CIT meetings a month. During each meeting, the CIT team reviews one case.

Requiring providers to work a certain number of cases with the CIT at least once could help model appropriate discharge planning, make the process and benefits of the CIT process more transparent, and provide DBH with more opportunities to work with a broader array of providers. Increased involvement would also promote specialty and other underutilized services, especially among less experienced CSWs. Providers interviewed found that CIT meetings help highlight the availability of under-utilized outpatient services, improve treatment planning team dynamics, and provide guidance for working with children, youth, and families. These outcomes are unquestionably assets for providers and children and youth. CSAs that participate in the most CIT meetings are generally providers who proactively seek out DBH assistance. Other CSAs, serving families with equally challenging needs, did not regularly participate with CIT meetings, and should be encouraged to do so.

While increasing the capacity of coordination services may require additional or a reallocation of funding, doing so has the potential to pay dividends in the future in the form of fewer rehospitalizations and improved connections for youth, and capacity-building within CSAs. Additionally, in August of 2014, SAMHSA recommended that the District leadership consider "conducting special staffing, more mental health consultation and/or more psychiatric consultation with youth and their families with complex needs" in order to address the District's lack of "consistent, effective services for youth who have experienced the out of home placements and attempting to re-engage in the community/family/independence."⁵⁰ Improving DBH care coordination efforts would address this recommendation and would likely have both short-term and long-term benefits for District children and youth leaving psychiatric hospitalization.

2. Solution: DBH should have a more active presence within psychiatric hospitals.

A more active presence by DBH within hospitals would also improve DBH-related care coordination. As recently as 2013, the DBH Care Manager attended regular meetings at a child-serving psychiatric hospital, often sitting in on meetings with Child and Family Services Agency staff members to discuss challenging cases. Multiple hospital employees remarked that this

⁴⁹Of concern is that staff interviewed at two CSAs had not heard of CIT meetings, and had limited to no involvement with the DBH Care Manager in a treatment context.

⁵⁰SAMHSA Center for Mental Health Services, Child, Adolescent, and Family Branch report conducted May 27th-29th, 2014 and issued August 18th, 2014.

collaborative effort proved particularly useful in creating effective discharge plans for youth with frequent readmissions. DBH also currently conducts, through the Institutions for Mental Disease (IMD) Demonstration project (a Medicaid-funded demonstration project limited to adults between the ages of 18-64), weekly meetings at a psychiatric hospital. Numerous hospital staff members stated that these meetings are helpful and appear to be improving continuity of care. DBH staff state that time restraints have made it difficult to maintain a physical presence in the hospital. If hospitals consistently find that DBH's physical presence in hospitals help ensure that providers have greater access technical assistance necessary to problem solve on difficult cases and if data from the IMD demonstration reflects improved care coordination and discharge planning, it would be a prudent investment for DBH to hold weekly care-coordination sessions on adolescent and child units with hospital and CSA/CBI staff.

D. Challenge: Children leaving psychiatric care do not have reliable and timely access to evidence-based services.

Despite the particular importance for youth leaving psychiatric hospitals to have evidence-based specialty services available in the community, these services are primarily being used by other groups of children; children leaving psychiatric hospitalization rarely utilize evidence-based practices.

Over the past few years, DBH has made a laudable and concerted effort to increase the number of evidence-based practice resources available for District children and youth in order to address children with complex and long-term challenges. There are currently ten active evidence-based therapies available in the District, and DBH plans to add two more evidence-based therapies. The two most highly utilized evidence-based services in the District for children leaving hospitalization (and in general) are Functional Family Therapy (FFT)⁵¹ and Multi-Systemic Therapy (MST).⁵² FFT and MST are administered by specialized staff trained in the respective evidence-based model and are designed in part to work with children and youth with complex mental health needs. In 2014, four providers⁵³ served 350 children and youth with FFT services.⁵⁴ Going forward into FY 2015, the annual capacity is 279 youth annually.⁵⁵ The need far exceeds capacity.

⁵¹FFT is a family focused intervention for at-risk and juvenile justice involved youth. The model works to identify challenges and strengths critical for the youth and their family.

⁵² MST is an intensive treatment for youth with complex issues. Emphasis is on empowering parents/caregivers effectiveness as they assist the youth in successfully making and sustaining changes in individual, family, peer and school systems.

⁵³The providers include First Home Care, Hillcrest Children and Family Center, Community Connections, and Department of Human Services (DHS) Parent and Adolescent Support Services (PASS) program. Community Connections stopped providing FFT in April 2014.

⁵⁴DBH FY2014 Oversight Response Question 83.

For MST, in FY 2014 one provider⁵⁶ served 100 children and youth, despite having an annual capacity of 84.⁵⁷ (The service and capacity is reduced from FY 2013, where the same provider served 122 children and youth, despite having an annual capacity of 105.⁵⁸) At the very minimum, these numbers suggest that the demand for FFT and MST at least exceed the annual capacity and that there is potential room for expanding services for both. Despite these robust numbers, not many youth leaving acute psychiatric care are using these services.

Youth leaving psychiatric hospitals are prime candidates for FFT and MST, yet these are not the youth are not enrolling FFT or MST services. In FY 2013, just under 50% of youth leaving hospitals are using CBI services. However, few of the CBI enrollees are accessing FFT or MST. In 2013, out of 688 discharges, 321 children used some form of CBI services within 90 days of discharge (157 who were linked after discharge and 164 who were linked prior to discharge). Of those previously linked to services, only 16 children (4%) used MST within 90 days of discharge and 20 children (6%) used FFT within 90 days of discharge. For those not previously linked, the number of children and youth enrolled was even lower with only 6 children (2%) enrolled in MST within 90 days and 9 children (3%) enrolled in FFT within 90 days.⁵⁹ The statistics are depicted in the chart below:

Total Discharges from Psychiatric Hospitals in FY 2013	CBI Enrollment for Youth Leaving Psychiatric Hospitalization within 90 Days of Discharge	MST Enrollment for Youth Leaving Psychiatric Hospitalization within 90 Days of Discharge	FFT Enrollment for Youth Leaving Psychiatric Hospitalization within 90 Days of Discharge
688	321 (47%)	22 (3%)	29 (4%)

While there is no absolute baseline for how many children and youth discharged from hospitals should enroll in FFT or MST, the usage rate of evidence based practices amongst District children and youth leaving acute psychiatric care is low.

Considering both evidence based practices are Medicaid eligible and are designed for at-risk youth and youth with serious emotional disturbance, the enrollment by children and youth leaving the hospital is surprisingly low. One staff member of a District advocacy organization

⁵⁵Id.

⁵⁶ Youth Villages provides MST services.

⁵⁷DBH FY2014 Oversight Response Question 83.

⁵⁸DBH FY2013 Oversight Response Question 77.

⁵⁹ DBH Statistics: Children/Youth Discharged Between 10/01/2012 and 9/30/2013 on file with ULS.

suggested that in spite of the benefits and applicability of evidence-based practices for children and youth leaving acute psychiatric care, that for many providers, these services remain a “deep secret.” A CSA staff member at a location that provides FFT services remarked that she was surprised more children leaving hospitals did not receive FFT referrals, while staff at all six CSAs interviewed criticized inpatient providers for failing to make referrals for specialized services.

1. Solution: DBH should increase training and technical support for providers.

DBH needs to increase outreach and technical services for providers and ensure that those who help connect children and youth to community-based services have a better sense of the full array of services available in the community. With available spots for children to receive specialized services in the community, DBH must do a better job to promote these options and to connect children to these services upon discharge. Should DBH increase active participation within the hospital setting as recommended in this report, the agency would be well positioned to help provide this support on a regular basis.

2. Solution: DBH should work with managed care organizations (MCOs) to increase the provision of evidence-based services.

DBH should make a concerted effort to ensure that all children leaving hospitals have access to community-based services upon discharge, regardless of whether they are MCO or Fee for Service (FFS) recipients. In 2012, children with MCOs were less likely to receive a service post-discharge than children in FFS Medicaid. While 76% of children with FFS Medicaid received at least one post-discharge service, only 62% of those with MCO Medicaid received services following discharge.⁶⁰ Furthermore, MCO reports of spending per member for mental health services are abysmally low, suggesting that MCOs are not even providing sufficient office-based mental health care, let alone specialty services. For this reason, DBH should vigorously enforce MCO contracts to make sure that all resources are explored and leveraged where appropriate.

E. Challenge: Children leaving psychiatric care need greater access to wraparound services.

An increase in wraparound services for all qualified youth leaving psychiatric hospitalization would help increase access to individualized and community-based services. The wraparound approach is most commonly defined as an “intensive, team-based individualized care planning and management process” for youth with complex mental health needs and their families.⁶¹ The child and family team includes individuals involved in the youth’s welfare, along with a wraparound “facilitator” who leads the process of developing, implementing, and

⁶⁰Statistics received via FOIA from DHCF on file with ULS.

⁶¹National Wraparound Initiative, available at <http://www.nwi.pdx.edu/wraparoundbasics.shtml>.

monitoring an individualized plan. Wraparound is an evidence-based process guided by 10 core principles.⁶²

Through DC's System of Care values and principles, DBH, CFSA, and DYRS have embraced the wraparound approach by developing a High Fidelity Wraparound Project through a contract with DC Choices.⁶³ Philosophically, DC Choices meshes well with the idea of individualized planning and a family-focused approach. DC Choices works to "keep the youth and family at the center of their plan of care, which focuses on their unique needs and strengths."⁶⁴ DC Choices is also uniquely able to provide a broad array of services and supports through flexible funding, including non-medical transportation, respite, one-time utility or rent bills, and sport and club registration, so long as the service meets the child's needs and the service is sustainable.⁶⁵

DC Choices targets District youth "at risk for or returning from an out-of-home residential treatment center placement and for youth who have experienced multiple placements and/or psychiatric hospitalizations."⁶⁶ DBH noted in its Children's Plan a goal to expand the capacity of wraparound, in part, by exploring "all feasible Medicaid funding options."⁶⁷ Currently, high fidelity wraparound is not a Medicaid reimbursable service in the District and is paid for solely with local dollars.⁶⁸

In practice, DC Choices is mostly used to support youth diverted and returning from PRTFs, and interviews with DC Choices staff suggested that it was rare for a child leaving a

⁶²The 10 core principles as defined by the National Wraparound Initiative are: (1) Family voice and choice; (2) Team based; (3) Natural Supports; (4) Collaboration; (5) Community Based; (6) Culturally Competent; (7) Individualized; (8) Strengths based; (9) Unconditional; (10) Outcome based. Resource Guide to Wraparound, available at <http://www.nwi.pdx.edu/NWI-book/pgChapter2.shtml>.

⁶³DC Choices provides wraparound services to the majority of families participating in the Project. DC also contracts with the Healthy Families/ Thriving Communities Collaborative Council for wraparound. Far SE Family Strengthening Collaborative and Georgia Avenue Family Support Collaborative through the Collaborative Council served 21.7% of families in the Project in FY 13. DBH FY13 Oversight Responses, Question 63.

⁶⁴DC Choices, available at <http://www.choicesteam.org/dc.html>.

⁶⁵Id; Interview with DC Choices, January 2014.

⁶⁶ The Children's System of Care Plan A Comprehensive 3 - 5 Year Plan for Redesign available at http://dmh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/childrens_plans.pdf.

⁶⁷The Children's System of Care Plan A Comprehensive 3 - 5 Year Plan for Redesign available at http://dmh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/childrens_plans.pdf.

⁶⁸DBH FY13 Oversight Responses, Question 66.

hospital to enroll in DC Choices. All but one of the six CSAs interviewed agreed that DC Choices can help youth in the psychiatric hospital discharge process by providing services more closely aligned with the youth's individual needs. The one remaining CSA was unfamiliar with the services that DC Choices provides.

But DC has a limited number of high fidelity wraparound slots and does not have the capacity to serve all of the youth who are in need of wraparound. In FY 12, DC served a total of 282 youth in both programs, school-based (full service schools) and community-based programs.⁶⁹ In FY 13, the total number of youth served in wrap increased to 337,⁷⁰ and in FY 14 it increased to 355.⁷¹ Despite the increased capacity, DC Choices staff explained that they rarely serve youth leaving hospitals.

1. Solution: The District should expand the High Fidelity Wraparound Project to increase delivery to all children and youth in need of the service.

The District should consider a 1915(i) State Plan Amendment to increase funding for wraparound so it can expand the High Fidelity Wraparound Project to serve all youth who need the service.⁷² The District can provide a variety of services under the 1915(i) State Plan Home and Community-Based Services (HCBS) benefit, including wraparound and the flexible funding needed to provide individualized and non-traditional supports to youth with serious emotional disturbance.⁷³ The District has already identified a target population for wraparound services to include children at risk of or returning from residential placement or acute-psychiatric care, and could craft needs-based criteria accordingly in its 1915(i) State Plan Amendment. Montana is an example of a state that covers High Fidelity Wraparound Facilitation, among other intensive

⁶⁹*Dixon* Settlement Agreement Quarterly Report, FY 2014 Third Quarter, available at <http://dbh.dc.gov/page/dixon-settlement-agreement>

⁷⁰Per the *Dixon* Settlement Agreement, the District was required to increase wraparound slots by 20%, or to 338. In FY 12, the District increased wraparound slots by 34%, or from 154 to 171, above the required 10% increase imposed by *Dixon*. DBH FY13 Oversight Responses, Question 93.

⁷¹DBH FY14 Oversight Responses, Question 63.

⁷²42 U.S.C. § 1396n. Unlike 1915(c) waiver programs, which allow states to provide home and community-based services to individuals with disabilities who meet the institutional level of care and to limit the number of participants in the state who may receive the services, the services offered under the 1915(i) State Plan benefit must be available to all individuals in the target population who meet the needs-based criteria.

⁷³Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (May 7, 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

community-based services, with Medicaid dollars through the 1915(i) State Plan benefit.⁷⁴ The Centers for Medicare and Medicaid Services also released guidance in 2013 promoting the use of this form of intensive care coordination and suggest that states utilize the 1915(i) State Plan Amendment to offer intensive care coordination to the targeted population of children and youth with significant mental health needs who are at risk of removal from their homes.⁷⁵ Thus, DBH should consider submitting a 1915(i) State Plan Amendment to improve access and utilization of wraparound services and incorporate the model into the discharge planning process from acute psychiatric care.

VII. Conclusion

All too often, children in the District enter and leave psychiatric hospitals without getting connected to individualized and timely post-discharge services in the community, resulting in decreased mental health well-being and stability in the community. Unless the District actively reassesses and improves upon the way it approaches discharge planning, some children and youth will continue to receive mental health care in crisis-based settings without access to critical and stabilizing community-based services. To do so, we recommend more efficient information sharing between providers immediately upon admission, increased support for parental involvement, improved access to child and youth service psychiatrists, expanded access to DBH care coordination, and a focus on increasing access to wrap-around care coordination and evidence-based practices following psychiatric hospitalization.

The recommendations in this paper are modest: for the most part, they do not require increased funding or staffing. Instead, we have identified breakdowns in efficient service delivery, and suggested improved support to children and youth's families, access to services that already exist in a timely manner, and creative solutions where service gaps do exist. With a concerted effort to focus to improve upon these areas, District children and youth will stand a better chance to both receive quality mental health services outside of the hospital setting and thrive in the community.

⁷⁴Montana 1915(i) Home and Community Based Services State Plan Program for Youth with SED Policy Manual, available at <http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf>.

⁷⁵Coverage of Behavioral Health Services for Children, Youth , and Young Adults with Significant Mental Health Conditions (May 7, 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Appendix A

A number of District children and youth are involved with District agencies other than the Department of Behavioral Health and these agencies play critical roles in their lives. This appendix outlines the roles that these child-serving agencies play for children and youth placed in acute psychiatric care.

Department of Youth Rehabilitation Services

The Department of Youth Rehabilitation Services (DYRS) is the juvenile justice agency for the District of Columbia. If a DYRS-committed⁷⁶ youth is hospitalized, DYRS will take a lead role in planning for discharge via a Youth and Family Team Meeting (YFTM).^{77,78} DYRS may link the youth to community-based services through their “YouthLink” program,⁷⁹ but there is no restriction on youth receiving DYRS-funded services and CSA services at the same time.

Additionally, DYRS youth that are hospitalized should be referred to a mental health provider within DYRS, if the youth is returning to secure confinement. If a youth is returning to the community from a hospital, but is committed to DYRS, DYRS Behavioral Health Staff are required to participate in a YFTM. If the youth has been in confinement for 30 days or less, they

⁷⁶ In the District, youth are committed to DYRS by a court. A youth that is committed can then be placed in a number of settings, including his or her own home, a community-based group home, a residential treatment center, or New Beginnings (the long-term juvenile detention facility). Youth can also be under the supervision of Court Social Services (CSS) which is part of the DC court system, and therefore federally funded. Many more youth are involved with CSS than DYRS, and CSS is responsible for youth awaiting trial and on probation.

⁷⁷ DYRS will initially hold a Youth Family Team Meeting (YFTM) to develop or update an Individual Development Plan (IDP). The YFTM team consists of youth, the youth’s family, facility staff, the case manager, and a representative from DC YouthLink to discuss appropriate treatment. The team then discusses and identifies appropriate services. The social worker then makes a referral to DC YouthLink. YouthLink does not directly contract with CSAs, as CSAs bill through DBH.

⁷⁸ DYRS is currently planning to replace the YFTM process with a Team Decision Making (TDM) process. These TDM meetings will expand the number of participants and include such people as the parents, the youth's family members and service providers (including other agencies) and the DYRS social worker, among others. TDM teams will collaborate to design a plan for every DYRS committed youth and will evaluate all information which relates to the youth, including but not limited to, mental health treatment. The team will meet every 90 days to review progress and make adjustments as deemed necessary.

⁷⁹ In 2009, DYRS and the Children and Youth Investment Trust (CYITC) collaborated to launch DC YouthLink, a coalition of community-based organizations that provide a diverse array of services to court-involved youth in their home neighborhoods. The initiative is based on the premise that youth are best served within the context of their home community and that building upon their strengths and the strengths of the community is the most effective way to enhance public safety.

must make efforts “to provide referral and linkage to community-based behavioral health services prior to their return to the community.” For youth that have been confined by DYRS for longer than 30 days, the behavioral staff, in collaboration with a youth’s case manager, will make “best efforts to secure enrollment with a community-based provider at least seven days prior to release for committed youth who have a YFTM action plan indicating the need for behavioral health services.”^{80,81,82}

Child and Family Services Agency

CFSA is the District’s child welfare agency. When a hospital admits a youth in CFSA custody who is not connected to a CSA, enrollment must be requested through the CFSA Placement Services Administration Clinical Services. In such an event, the CSA will become

⁸⁰DYRS Policy – 016 “Community Transition Planning and Services.” Available at <http://dyrs.dc.gov/sites/default/files/dc/sites/dyrs/publication/attachments/DYRS-016CommunityTransitionPlanningandServices.pdf>

⁸¹On August 8, 2013, ULS requested from DYRS, via Freedom of Information Act request: “Any and all policies, policy guidance, rules, trainings, and other instructions regarding continuity of care, discharge planning, and aftercare planning services from psychiatric hospitalization provided by DYRS staff, inpatient psychiatric hospitals and other mental health providers that serve children and youth in DYRS custody.” In response, ULS received four policies (DYRS Policy 016, Community Transition Planning and Services; DYRS Policy 018, Continuity of Care at Transfer of Youth Placed on Suicide Precaution Status; DYRS Policy 019, Routine Care Access, Treatment Planning and Counseling Services; and DYRS-020 Initial Behavioral Health Screening) relied on to formulate the above summary. Most of these policies address access to mental health services for youth in secure placement, and not for youth on community supervision. According to DYRS policy, youth that are staying in a secure facility may not necessarily be linked to a CSA, even if they are hospitalized. Instead, DYRS Policy 0018, Continuity of Care at Transfer for Youth Placed on Suicide Precaution Watch applies, which states that youth returning from a hospital are evaluated by mental health professionals for whether they remain at suicide risk. The emphasis of the policy is on preventing suicides, not on ensuring smooth discharge from hospitals. DYRS Policy 0019 addresses access to routine mental health care, the need for which would be re-evaluated every time a youth enters a secure facility from a hospital, but does not address coordination between the hospital and the secure facility, nor does it specifically require CSA or DBH involvement.

⁸²DYRS does not appear to report on data regarding youth enrollment with community-based providers prior to discharge, making it impossible to tell if youth involved with DYRS are receiving services faster, slower, or at about the same rate as youth not involved with DYRS. ULS requested “[a]ny and all reports and data collected by DYRS related to the timeliness of referrals to community-based mental health services and utilization of community-based mental health services post-discharge from psychiatric hospitalization by District children and youth in DYRS custody.” In response, DYRS stated: “DYRS does not possess this type of data.” To help clarify how services are delivered, DYRS responded “all DYRS are connected to services during their commitment to the agency. These services are in place following the youth's initial commitment and are reevaluated by the team (which includes DYRS staff, the youth, service providers, etc.) periodically throughout the young person's commitment.”

responsible for fulfilling the CSA responsibilities as detailed above. CFSA uses a “choice provider network,” which is a designated cohort of the District’s mental health rehabilitation services (MHRS) core service providers (CSAs). The child will connect to one of six choice provider CSAs: Community Connections, Family Matters, First Home Care, Hillcrest, Maryland Family Resource, or Universal Healthcare.

School and Probation Personnel

As noted above, many individuals and agencies touch a child/youth’s life, and participation of all significant players is ideal. Absent from many discharge teams are teachers, school placement officials, or Court Social Services (CSS), the federally funded juvenile probation agency for the District of Columbia. According to DBH Policy 340.11, Child/Youth Family Teaming, if another agency is involved, such as CSS, this other agency should arrange for most teaming meetings. Other agencies may put conditions on a child/youth’s return to the community, and therefore their participation is integral in supporting the child/youth to engage in positive supports and services. For example, a hospital could engage with a CSA, and services could be set up prior to discharge, but if CSS insists that the child needs a short term residential stay, and the link to community-based services is broken by sending the youth out of state, the efforts of the hospital and the CSA would be for naught.