Approved by the Judicial Council on Dec. 1, 2017

REPORT OF THE JUDICIAL COUNCIL JUVENILE OFFENDER / CHILD IN NEED OF CARE ADVISORY COMMITTEE ON JUVENILE CRISIS INTERVENTION

DECEMBER 1, 2017

In May 2017, Representatives Blaine Finch and Russell Jennings asked the Judicial Council to study the topic of juvenile crisis intervention. (See Attachment #1.) In their study request, Reps. Finch and Jennings mentioned two bills recently enacted by the Legislature: the juvenile justice reform bill, 2016 S.B. 367, and the Crisis Intervention Act, 2017 H.B. 2240 (enacted as 2017 Sen. Sub. for H.B. 2053). As noted in the study request, the juvenile justice reform bill made a number of changes to the juvenile justice system, one of which removed the option of detaining a juvenile in a juvenile detention facility based upon a risk of self-harm. As a possible alternative to such detention, the study request asked the Council to consider whether it would be advisable to enact a version of the Crisis Intervention Act focused on juveniles.

The Judicial Council accepted the study and assigned it to its Juvenile Offender/Child in Need of Care (JO/CINC) Advisory Committee, adding four ad hoc members with expertise in juvenile mental health to assist the Committee during the study.

COMMITTEE MEMBERSHIP

The members of the Judicial Council JO/CINC Advisory Committee are:

Hon. Maritza Segarra, Chair, Junction City; District Court Judge in the 8th Judicial District and member of the Judicial Council.

Kathy L. Armstrong, Shawnee Mission; Assistant General Counsel for Preventive and Protection Services, Kansas Department for Children and Families.

Hon. Dan Brooks, Wichita; retired District Court Judge.

Charlene Brubaker, Hays; Assistant Ellis County Attorney.

Kathryn Carter, Topeka; Assistant Attorney General.

Jeff Cowger, Topeka; Deputy General Counsel with the Kansas Department of Corrections - Juvenile Services.

Mickey Edwards, Emporia; State Director of Kansas CASA Association.

Donald W. Hymer, Olathe; Assistant District Attorney in Johnson County.

Hon. Greg Keith, Wichita; District Court Judge in the 18th Judicial District.

Sandra Lessor, Wichita; Assistant Sedgwick County District Attorney.

Prof. Richard E. Levy, Lawrence; J.B. Smith Distinguished Professor of Constitutional Law at the University of Kansas School of Law.

Sen. Julia Lynn, Olathe; State Senator from the 9th District.

Rachel Y. Marsh, Lawrence; Attorney with Saint Francis Community Services.

Rep. Leonard Mastroni, LaCrosse; State Representative from the 117th District.

Dawn Rouse, Topeka; Court Improvement liaison, non-voting member.

Ad Hoc Members:

Randy Callstrom, Kansas City; President/CEO at Wyandot Inc.

Vickie McArthur, Wichita; Clinical Director, Reintegration, Foster Care and Adoption, Saint Francis Community Services.

Jody Patterson, Wichita; Licensed Clinical Psychotherapist.

Colin Thomasset, Topeka; Associate Director, Association of Community Mental Health Centers of Kansas, Inc.

EXECUTIVE SUMMARY

In discussing its charge, the Committee first recognized that S.B. 367 removed detention as a possible means of preventing youth from self-harm, which has left law enforcement and others involved in child welfare with few good options when youth are in crisis. The Committee agreed with the goal of S.B. 367, in that detention is not an ideal solution to this problem. Nonetheless, S.B. 367 did not provide any immediate alternatives and the resulting savings have not yet been used to develop effective substitutes at the community level. The Committee believes a short-term placement option that keeps youth safe, provides an opportunity for assessment, and facilitates longer term treatment or services is highly desirable. This entry point might take various forms, including community mental health centers (CMHCs), the restoration of assessment/observation units, or other intake and assessment options.

Ultimately, however, the Committee also concluded that differences between youth and adults make the adult crisis intervention model, without more, unsuitable. In particular, it is not effective to hold youth for a couple of days, getting them back on medications or allowing abused substances to clear their systems, and then return them to the community. Crisis intervention for youth is only the first step and, to be effective, must provide the opportunity for a comprehensive assessment, development of a treatment plan, and connection to a more robust array of services including longer term treatment for those who require that level of care. Accordingly, the Committee's recommendations take a broader view of the problem.

RECOMMENDATIONS

The Committee makes the following recommendations, all of which are explained in greater detail in the Discussion section of this report:

1) **Crisis Intervention** – A crisis intervention model for youth should be developed as one component of a broader effort to provide mental health services to youth with serious emotional and behavioral disorders.

2) **Access** - CMHCs should be restored to their former role as the single entry point for accessing mental health services. CMHCs are ideally positioned to perform the services of crisis intervention, assessment, and navigation of the mental health system.

3) **Capacity** – Lack of capacity and shortened length of stays in existing facilities should be addressed. More beds of all kinds are needed as well as longer stays, especially in psychiatric residential treatment facilities (PRTFs).

4) **Managed Care** - The current managed care model can present barriers to treatment for youth in crisis and should be changed. Improvements might include providing more guidance to managed care organizations (MCOs) on how to interpret the rules governing medical necessity for inpatient and residential care; having a single MCO cover a certain population of youth; creating a more flexible managed care model that involves some state oversight; or using a different model altogether.

5) **Funding** - The dollars saved by detaining fewer youth pursuant to S.B. 367 should remain protected and dedicated to establishing community-based resources for youth who need services. Also, funds should be made available to communities on a long-term basis rather than in the form of short-term grants.

6) **Collaboration** - As a long-term goal, the many groups that are studying the topic of youth mental health in Kansas should be collaborating so that they can learn from one another. A problem of this scale needs a more comprehensive approach.

DISCUSSION

Crisis Intervention - The Adult Model

The newly enacted Crisis Intervention Act, K.S.A. 59-29c01 *et seq.*, allows crisis intervention centers to hold adult patients who are experiencing a mental health or substance abuse crisis on an involuntary basis for up to 72 hours in hopes of stabilizing them and avoiding the need for commitment to a state hospital. The Act applies only to adults, and the Kansas Department for Aging and Disability Services has not yet written the regulations necessary to implement it. There are several facilities that would like to be licensed under the Act once the regulations have been published, and several more that are considering it. However, even when those crisis intervention centers are operational, it will not be feasible for them to treat youth alongside adults.

The Crisis Intervention Act was intended to help adults in crisis for whom short-term stabilization services can have a positive impact. For example, many adults in crisis need to get back on their medications and off alcohol or other substances in order to stabilize, and that can frequently be accomplished in 48 to 72 hours. For youth, however, crisis stabilization alone is not likely to be sufficient. Just medicating youth until they are no longer combative is not the answer. Not only are their brains still developing, but their crises often have multiple contributing factors. Most youth in crisis will need a more long-term intervention and assistance within the context of their family or other living arrangements. Up to 30 days may be required for a good assessment of their needs, crisis stabilization, and connection to other services if needed. For those reasons, the adult crisis intervention model is not appropriate for youth.

The Crisis Intervention Act was intended to fill a gap between taking a person in crisis to jail or an emergency room and filing a petition to commit them to the state hospital, and there were existing facilities that wanted to fill that gap and simply needed the authorization. In the context of youth, the problem is not a lack of statutory authorization to hold a youth involuntarily; rather, it is a lack of appropriate placements for that youth.

Mental Health Services Currently Available to Youth

As background, it may be helpful to understand the current options for youth mental health services. For youth in crisis, outpatient services may be available through their local community mental health center (CMHC). There are 26 CMHCs that operate across the state and provide services in every county. CMHCs offer an array of services to clients of all ages regardless of ability to pay. Services include mental health assessments, outpatient therapy, and psychiatric services. For youth identified as having a Severe Emotional Disorder (SED), they may also receive rehabilitative services including case management, attendant care, and psychosocial services. Rehabilitative services are typically provided in the community where the client lives, works, or goes to school. Many CMHCs have implemented "open access" models for intake appointments, meaning that someone can walk in and receive an intake assessment the same day, typically within 30 minutes. Per the CMHC licensing standard, anyone seeking treatment must be seen within 10 days for routine appointments.

Each CMHC also offers crisis services 24 hours a day, 7 days a week. CMHCs have 24/7 crisis lines for individuals to call when experiencing a mental health crisis, and emergency services are available if necessary. At a minimum, crisis services include assessments for the state psychiatric hospital or state hospital alternative (SHA) for youth and follow-up with any client not detained for inpatient treatment to determine the need for further services and referral to such services. These assessments also serve as an opportunity for crisis intervention and crisis planning to stabilize the individual in the least restrictive environment. Depending on the location, other crisis services may include a mobile crisis response team or a walk-in crisis clinic.

For some youth in crisis, however, outpatient services may not be sufficient. For a youth in need of inpatient services, acute hospitalization is generally the first option, if one can find available bed space. Acute hospitalization usually lasts from 3 to 5 days. State hospital alternatives (privatized programs for youth that emerged as alternatives to state hospitals) are another option, but again, bed space is limited.

The children and youth's state psychiatric hospital beds, once located at Rainbow Mental Health Facility, Osawatomie State Hospital, and Larned State Hospital, were privatized and are now operated by KVC. Because these inpatient psychiatric programs are not operated in a state facility, they are called state hospital alternatives. KVC operates state hospital alternative (SHA) programs for youth at their Kansas City and Hays locations. A youth must be assessed or screened by a CMHC to determine medical necessity for admission into an SHA; to meet that standard, the youth must be at risk of harm to themselves or others. These programs

are "no eject/no reject," and KVC accepts any youth screened for these programs, including those without a pay source. Often, youth admitted into an SHA require a slightly longer period of time for stabilization than in a typical acute setting, with a length of stay being 14 days as opposed to 3 to 5 days.

Finally, psychiatric residential treatment facilities (PRTFs) provide longer term mental health treatment for youth who have exhausted other community treatment resources and continue to present as a risk of harm to themselves or others. Typically, a youth will not be authorized by an MCO to receive treatment at a PRTF unless the youth has been hospitalized either in an acute setting or an SHA several times. A PRTF is not considered a crisis service and is typically thought of as a service for youth whose needs are chronic. However, a youth may be transferred from an acute hospital to a PRTF.

As discussed in more detail below, there are problems with the existing system that must be confronted. Accessing services is often difficult because there is no single point of entry into the system. There is a lack of capacity in existing facilities, and stays are often not long enough to be effective. Finally, problems with the managed care system need to be addressed.

Crisis Intervention for Youth

The Committee agreed that improving the options for youth in crisis is desirable but did not believe that the adult model was suitable to address the needs of youth in crisis. As discussed above, the needs of youth are different from the needs of adults, and crisis intervention, standing alone, is insufficient to address those needs. Accordingly, crisis intervention should be part of a broader effort to develop resources to address the needs of youth with significant mental health problems. Such an approach should include (1) a single point of access; (2) improving capacity and ensuring that lengths of stay are adequate to address the needs of youth; (3) improvements to the managed care model; (4) ensuring that funding for community solutions is available and stable; and (5) coordination of activities to develop a comprehensive long-term solution.

Single Point of Access – the Role of CMHCs

Accessing youth mental health services is often difficult, in part because there is no longer a single point of entry into the mental health system. In the past, CMHCs were the first stop for youth in need of services. They served as the single point of entry and provided both a

navigator and gatekeeper function in the mental health system. That is no longer true, as the screening process for mental health services has become decentralized in recent years.

Before October 2015, CMHCs were responsible for assessing youth to determine whether they met criteria for admission to an acute hospital setting, an SHA, or a PRTF. CMHCs discontinued the screening assessments for PRTFs and acute hospitalization in October 2015 due to a state policy directive. Now, CMHCs only assess for purposes of admission to an SHA. For youth covered by KanCare, the MCO decides whether to approve an acute hospitalization or admission to a PRTF.

With CMHCs now screening only for admission to an SHA, there is no longer a single starting place to figure out what treatment is needed and access that treatment. While a change has begun to a new assessment process involving a community staffing team consisting of the MCO, the CMHC and the family, the MCO still makes the admission determination. And, with the system still in flux, it is difficult even for professionals, much less families, to figure out how to access services.

Before S.B. 367, the Department of Corrections (DOC) also served as a navigator of sorts because youth who came into detention could be placed in the temporary custody of the Juvenile Justice Authority or the DOC. Those entities then figured out where to obtain services for the youth, whether that was a PRTF or somewhere else.

The Committee agreed that there needs to be a single point of access to the mental health system, no matter who is presenting the youth in need of services, and that families need help navigating the system. If it were easier for families to access mental health services, a youth might never need to enter the juvenile offender or child in need of care system. CMHCs previously served as navigators and are experts in what services are available in their communities. CMHCs are best suited for this critical role.

Capacity and Length of Stay

Currently, the availability of youth mental health services varies depending upon where the youth lives. For example, acute hospital beds are not available at all in some areas of the state. In addition, there are capacity issues with all of the facilities that provide services, both inpatient and outpatient.

Both acute hospitals and PRTFs often have waiting lists. While youth wait for inpatient treatment, there may be community-based services available but those are often inadequate to fully meet their needs.

Waits for admission to a PRTF can be long, as much as 2 to 3 months, and once admitted, stays in PRTFs are typically shorter than they once were. Admissions to PRTFs used to be automatically approved for 90 days with the possibility of an extension pending the outcome of another screen at the 90 day mark. Today, MCOs determine medical necessity, and admissions are immediately turned over to the MCO's utilization review team. Length of stays today is generally 14 to 21 days.

The reduction in availability of PRTF beds goes back as far as 2011. It was believed by state officials at the time that PRTFs were being over-utilized and the lengths of stay were too long. As a result, the authorization period for PRTFs began to be shortened. As KanCare was implemented, the MCOs also began to use their utilization review process to shorten the length of stay. The end result of the state and MCO policy and practice changes meant that Kansas began to see some PRTFs close and others began to accept more youth from other states. Today, there are fewer PRTF beds available and lengths of stays have been reduced so that youth who may truly need a longer period of residential treatment do not have any resources available to them.

Part of the solution must be to extend the length of stays, especially in PRTFs. When PRTF stays were longer, stabilization and treatment were more effective resulting in more youth able to be successfully returned to their families or a family-like setting. This view is supported by testimony recently presented to the Child Welfare System Task Force by Cheryl Rathbun, Chief Clinical Officer at Saint Francis Community Services. (Attachment #2.) Ms. Rathbun's testimony indicated that, since 2013, at the same time that the average length of stay in a PRTF declined, the percentage of youth discharged from a PRTF who were successfully returned to a family-like setting also declined from 80% to 20%. In addition, youth being discharged today are more likely to need subsequent treatment in a PRTF.

Another part of the solution must be to rebuild capacity in all forms of existing treatment facilities. The problems with capacity can be traced back to various factors over the last decade. For facilities to be willing to rebuild capacity, they will need to see a commitment from the state to long-term funding for mental health services.

In addition to rebuilding capacity in existing treatment facilities, the Committee discussed whether other types of facilities might be used to provide services. For example, short-term assessment/observation beds were previously available at some facilities in Kansas. If those were reestablished, it could be helpful.

Improving the Managed Care Model

The Committee discussed how KanCare has affected youth in need of mental health services. There are three different MCOs making decisions about what services will be covered. These MCOs are not consistent in how they interpret the applicable rules, with the result that some youth are approved for services while others in similar circumstances are not.

One example of a problem in the interpretation of medical necessity is the introduction of the "baseline" concept in the mental health context. Under the baseline concept, when a condition is not subject to improvement, treatment is not considered a medical necessity. Some MCOs have said that aggression or suicidal tendencies constitutes a baseline condition, so residential treatment is not a medical necessity and is not covered. The baseline concept should not be applied in a way that limits treatment options for a youth in need of mental health services.

The Committee identified several options that might help to improve the consistency in the array, intensity and frequency of services authorized by MCOs. First, the Legislature could direct the Kansas Department of Health and Environment (KDHE) to provide more guidance to the MCOs about how to interpret KDHE rules. For example, the Legislature could require KDHE to adopt policies regarding length of stays in PRTFs. Some committee members favor a 90-day length of stay, as that is what treatment models were originally based on.

Second, moving from three MCOs to just one for a certain population of youth could be an improvement. If only one MCO were interpreting "medical necessity," that would lead to more consistency in the treatment options for youth.

Third, the state could create a more flexible managed care model that might include, for example, increased accountability measures for MCOs based on outcomes and elimination of the need for prior authorizations before youth in crisis can obtain services. A new managed care model might also include more state oversight of the treatment authorization process. One reason the current managed care model is problematic is the inherent conflict of interest in having the same entity that is responsible for paying for services determining whether those services are necessary. Long stays in PRTFs can be expensive, so MCOs have incentive to deny coverage or only authorize short stays. For these kinds of high-cost services, having a state agency involved in determining whether such services are necessary would avoid the conflict of interest MCOs face in making that determination.

A final option would be to exempt a certain population of youth from the managed care system entirely. This exemption could be accomplished through the use of waivers, as some other states have done.

The last three options would all require the Legislature to decide what population of youth should be carved out for different treatment. That population might be all youth in state custody, or it might be a subcategory of high-risk, high-needs youth.

Funding after S.B. 367

The Committee is concerned that S.B. 367 eliminated resources like detention and youth residential centers but didn't replace those resources with other options. While the bill contained language indicating that the cost savings from detaining fewer juveniles should be redirected to communities, it is not clear that funding is being redirected to communities in an effective way.

The Committee reviewed a letter from Deputy Secretary of the DOC Randy Bowman to Rep. Leonard Mastroni (Attachment #3) regarding the cost savings and redirected funding that resulted from S.B. 367. The letter stated that roughly $12 million has been deposited into the evidence based juvenile programs fund for expenditure in FY 2018 and that the Juvenile Services Division of the DOC has obligated $7.5 million of that fund so far toward a variety of contracts and programs, most of which has been or will be paid out in the form of grants.

The letter confirmed Committee members' individual experience that a relatively small percentage of funds has actually been made available to develop community-based resources. Also, to the extent that cost savings from S.B. 367 are being redirected in the form of grants, the Committee does not believe that a sustainable system can be built with grant funding. Rather, the state needs to make a long-term commitment to provide funding to communities who are now expected to provide services.

Finally, it is important to ensure that the funds that result from S.B. 367 cost savings remain protected and not be swept into the state general fund or used for purposes unrelated to preventing out-of-home placements. Any money saved as a result of detaining fewer youth under S.B. 367 should remain dedicated to establishing community-based resources devoted to the population of youth who need services.

Multiple Independent Groups Studying Youth Mental Health

The Committee found that there are a number of different committees, task forces, and working groups that have studied or are studying various aspects of youth mental health in Kansas, but it doesn't appear that these groups are collaborating and communicating with one another. The Committee believes it would be helpful for these groups to come together in

some way to make sure that they are not duplicating each other's work and to ensure a more comprehensive approach to the problem.

As of the date of this report, a nonexclusive list of groups that are currently studying or have recently addressed some aspect of youth mental health includes:

- Children's Continuum of Care Committee
- Mental Health Task Force
- Juvenile Justice Oversight Committee (hosted by DOC and OJA)
- Children's Subcommittee of the Governor's Behavioral Health Services Planning Council
- Justice Involved Youth and Adult Subcommittee of the Governor's Behavioral Health Services Planning Council
- High Needs Foster Care group (hosted by KDHE and DCF)
- Child Welfare System Task Force
- Legislative Post Audit
- Joint Committee on Corrections and Juvenile Justice Oversight

CONCLUSION

To be effective, a crisis intervention model for youth must provide the opportunity for a comprehensive assessment, development of a treatment plan, and connection to an array of services including longer term treatment and services. As described in this report, the current system faces a number of problems that need to be addressed in order to provide effective crisis intervention for youth. Resolving those problems will require the dedication of state resources; however, investing those resources now will improve outcomes and reduce the risk of youth requiring even more state services in the future.

Attachment # 1

STATE OF KANSAS
HOUSE OF REPRESENTATIVES

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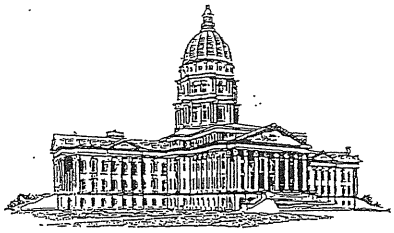

COMMITTEE ASSIGNMENTS
CHAIRMAN: JUDICIARY
RULES & JOURNAL
MEMBER: CORRECTIONS & JUVENILE JUSTICE
ENERGY, UTILITIES & TELECOMMUNICATIONS

BLAINE FINCH
59TH DISTRICT

May 2, 2017

Nancy Strouse, Executive Director
Kansas Judicial Council
301 SW 10th Avenue
Topeka, Kansas 66612

Dear Nancy:

We are writing to request Judicial Council study of the topic of juvenile crisis intervention. As you are aware, the topics of crisis intervention and juvenile justice reform have received a great deal of attention and consideration in our committees and by the Legislature over the last two sessions. We greatly appreciated the Judicial Council's efforts and recommendation regarding crisis intervention over the past interim, and this Judicial Council recommendation is now making its way through the Legislature as HB 2240, the Crisis Intervention Act.

The comprehensive reforms of the Kansas juvenile justice system passed by the Legislature last year in SB 367 removed some of the means by which authorities could intervene in circumstances where a juvenile might be susceptible to self-harm. While this change represented a deliberate policy choice by the Legislature based upon the work of the 2015 Juvenile Justice Workgroup, we also want to be sure that the mental health needs of juveniles are being properly addressed.

To that end, we would appreciate the Judicial Council's consideration of and recommendations regarding the topic of juvenile crisis intervention in light of the Legislature's recent work in HB 2240 and 2016 SB 367, including whether it would be advisable to enact a version of the Crisis Intervention Act focused on juveniles.

Please let us know if we can provide any further information or answer any questions regarding this request.

Thank you.

Sincerely,

Representative Blaine Finch
Chairman, House Committee on Judiciary

Representative J. Russell Jennings
Chairman, House Committee on
Corrections and Juvenile Justice

Saint Francis Community Services®
Serving Children and Families Since 1945

Access to Psychiatric Residential Treatment Services by Foster Youth

Cheryl Rathbun, LSCSW, Chief Clinical Officer, Saint Francis Community Services

At the meeting of the Kansas Child Welfare Task Force on September 19, 2017, questions were asked related to access to Psychiatric Residential Treatment Facilities (PRTF) by children in foster care. SFCS provides the following information:

Background on requested PRTF information:

The mental health system for foster children experiencing severe behavioral health challenges involves many agencies: **DCF** as the agency responsible for foster care; **SFCS and KVC** as contractors providing child welfare case management services; private **Child Placing Agencies and residential providers** that provides homes for foster youth; **KDHE** as the agency responsible for implementation of KanCare; the three Medicaid **private managed care organizations (MCOs); KDADS** as the agency overseeing behavioral health care services; local **Community Mental Health Centers (CMHCs); private acute hospitals; and private PRTFs.**[1]

PRTF programs provide mental health treatment to children and youth who, due to **mental illness, substance abuse, or severe emotional disturbance,** are in need of treatment and all other resources available in the community have been identified, and if not accessed, have been determined to not meet the immediate treatment needs of the youth. PRTF programs were designed to offer a **short term, intense, focused mental health treatment to promote a successful return of the youth to the community. The PRTF works actively with the family, other agencies, and the community to offer strengths-based, culturally competent, and medically appropriate treatment designed to meet the individual needs of the youth.** The purpose of such comprehensive services is to **improve the child's condition or prevent further regression so that the services will no longer be needed.**

Because of the medical / treatment nature of PRTF programs, PRTF stays are a covered Medicaid service. **When authorized, federal Medicaid dollars are accessed to cover the cost of the PRTF.** The costs of PRTF placements range from approximately $500 - $700 per night per youth. Medicaid covers the full cost.[2]

There are currently eight PRTF facilities in Kansas, with a total bed capacity of 272. In 2011 there were seventeen PRTF facilities.

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[1] These are agencies and providers most directly involved in the interplay between child welfare and child mental health. Of course, law enforcement, corrections, public health, education, and other critical services make up part of the larger system of care.

[2] Where required for immediate child or public safety where even extraordinary options have been exhausted, SFCS pays privately (without Medicaid funds) for children awaiting authorization, found to not meet medical necessity, diverted, or discharged without a stable placement.

DATE	Total Number of Kansas PRTF Licensed Beds
March 2011	780
November 2011	621
September 2013	450
July 2015	357
May 2016	304
January 2017	304 – 65 dedicated to IDD only
August 2017	272 – 65 dedicated to IDD only

Summary of PRTF access and length of stay over time:

	2013	2017
Average length of stay	120	45
Initial number of days authorized	90	14
Renewal number of days authorized	60	7
Percent of children discharged from PRTF to family like setting	80%	20%
Percent of foster children authorized for PRTF	5.9%	5.1%

Who decides to request authorization for PRTF?

SFCS has a Clinical Care Utilization Unit that is supervised by a Licensed Clinical Marriage and Family Therapist. In each region there is a Clinical Care Supervisor who is a Licensed Mental Health Provider who works directly with a foster child's Case Manager to make the initial determination if SFCS will seek authorization for PRTF.

Within the SFCS system, due to the complex administrative procedures and standards of PRTF authorization, and the importance of clinical oversight of any request for residential treatment, **only the Clinical Care Supervisor may request an authorization for a foster child for PRTF.** SFCS understands and agrees that the "least restrictive environment" is best practice for foster children.

What is the process for requesting authorization for PRTF?

Within the SFCS system, the Clinical Care Supervisor has access to information on children and youth that are struggling behaviorally.

- daily placement list
- nightly on-call logs
- mental health on-call logs
- team staffings regarding stability
- critical incident reports
- acute hospitalizations

Together, the Clinical Care Supervisor and Case Manager review current services, available services in community, and treatment options for the child. Once a decision is made to seek PRTF, the case worker completes screening information including:

- current situation
- mental health background
- therapist, location, duration of treatment and whether they support PRTF treatment
- diagnosis
- timeline of events over the past 90 days
- interventions utilized to counteract and/or support behaviors

This information is submitted to make a request an authorization from the child's MCO.

The MCO will use a paper review or a face-to-face evaluation with the CMHC. Once all the information is gathered by the MCO, **the MCO makes the decision of whether medical necessity is met.** If medical necessity is met, the decision is made to either divert from PRTF or authorize PRTF. If diversion is chosen, the MCO makes recommendations to SFCS and the CMHC regarding services to utilize in the community.[3]

The authorization request, information gathering, and determination process may take two weeks to one month from the start of the SFCS process to the final decision from the MCO.

If there is disagreement between SFCS and the MCO regarding whether a foster child meets medical necessity or is diverted, there is a process with each MCO for appealing the decision. SFCS notifies the MCO and requests a review of the decision.

<u>How many screens are requested versus screens denied?</u>

SFCS has tracked data related to PRTF screens requested, authorized, and appealed since 2013 for the Wichita and West Regions. [The current contract began in July of 2013.]

- In July 2013, screening responsibility was with the **local CMHCs.**
- In October 2015, screening responsibility was with **the MCOs.**
- In July 2017, screening responsibility stayed with **the MCOs with CMHC involvement.**

SFCS has averaged 48 authorization requests per quarter since July 2013. **The percent of screens authorized over time has remained relatively constant** at around 76%, ranging between 89% in the third quarter of 2014, to 59% in the first quarter of 2016.

The average total number of screens requested has not increased despite increasing numbers of children in foster care. Screens are not requested where criteria expressed and precedent experienced indicate PRTF will not be authorized.

The percent of foster youth authorized for PRTF for any length of stay was 5.9% in 2013 and is 5.1% today.

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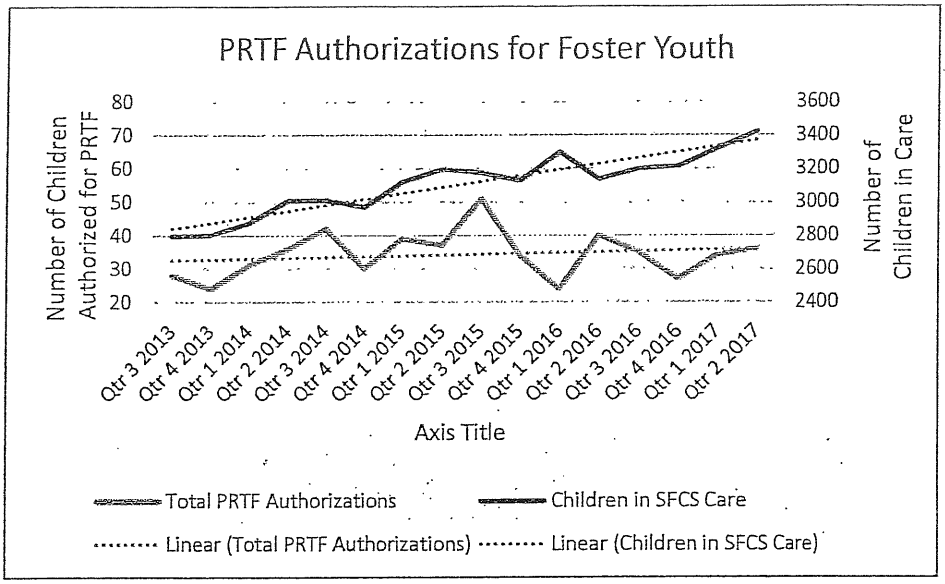
[3] For a child who is found to meet medical necessity for PRTF, but for which diversion is chosen, placement options are limited. These children may move from placement before recommended services can be delivered. Where placement is available, recommended services may not be available.



Has the length of stay authorized changed over time?

In July 2013, the average length of stay at a PRTF was 120 days. Initial authorizations were for 90 days, with renewals every 60 days. **Eighty percent of SFCS youth authorized for PRTF discharged to a family like setting.** Most youth authorized for PRTF did not need to re-authorize for subsequent PRTF treatment.

Over time, the average length of stay has declined to between 30 to 60 days. **Eighty percent of SFCS youth authorized for PRTF discharge to congregate care.** Many youth authorized for shorter stays in PRTF are discharged and later rescreened because of challenges functioning in community placements.

What are PRTF access waitlists for foster youth?

SFCS requests a foster child be added to the wait list for appropriate PRTF's at the same time we request a PRTF screening. If the child is authorized, **the wait is currently two weeks. Some children wait up to two months depending on the child's needs and demographics.** There are fewer numbers of beds for females and pre-adolescents. Some PRTFs do not accept children due to the severity of their behavior problems. **Girls, younger children, and the most severely-in-need children may wait the longest for treatment.**

How do PRTFs prioritize admission?

PRTFs prioritize admission differently. Some admit youth based on first-on-the-list, first-to-get-admitted. Other PRTFs prioritize based on need or severity of problem, and others based how well a particular youth will fit in the treatment approach.

For further questions related to access of foster youth to PRTF services, please contact Cheryl Rathbun, Chief Clinical Officer, at cherylr@st-francis.org.

Attachment # 3

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Department of Corrections

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Joe Norwood, Secretary

Sam Brownback, Governor

October 11, 2017

Representative Leonard A. Mastroni
102 Fairway Dr,
Lacrosse, Kansas 67548
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Re: Senate Bill 367, Evidence Based Programs Fund

Dear Representative Mastroni,

Thank you for your visit to the Department of Corrections Central Office on October 6, 2017. I enjoyed our discussion and the opportunity to meet you.

I appreciate your interest in the important work happening in the Kansas juvenile justice system, and I look forward to working with you as implementation continues in the next few years.

As follow up to our conversation, the information below shows the reduced cost resulting from the decreased reliance on incarceration in the juvenile correctional facility and placements in youth residential centers of juveniles.

- From state fiscal year 2017 appropriations, state general funds in the amount of $12,146,953 were deposited into the Evidence based juvenile programs funds and appropriated for expenditure in fiscal year 2018. On the date of our discussion, I asked our finance staff to confirm that no "sweep" or transfer from that fund has occurred.

- The Kansas Department of Corrections, Juvenile Services Division has obligated $7.5 million from this fund in FY18 to provide community based services for juvenile offenders and their families as follows:

    - Awarded contracts for statewide services (Functional Family Thetapy, Sex Offender Assessment and Treatment, Moral Reconation Therapy) and additional regional/pilot projects with some counties (Youth Advocate Program, Aggression Replacement Training), at $2.5 million.
    - New Reinvestment Grants to each local Board of County Commissioners (BOCC) who currently receives state aid for operation of juvenile justice programs as an individual or for a group of counties, of $4.0 million. Applications will be received at KDOC-JS on or before October 20, 2017 with award anticipated by the end of the calendar year.
    - Regional Collaboration Grants, which those same BOCC's may competitively apply for one of four awards of up to $250,000, for a total of $1.0 million. These applications are also due October 20th.

- This past June, Corrections Secretary Joe Norwood asked the Juvenile Justice Oversight Committee (JJOC) to discuss and solicit input on additional priorities and needs for services from this funding source. The Chair and Co-Chair included a discussion of additional priorities and needs on September 25, 2017.

- The September discussion centered around needing additional data to inform needs. It is unknown how many of those needs will be filled by grant applications not yet submitted to the Department. Local Juvenile Corrections Advisory Boards also had not yet submitted their 2nd annual report to the JJOC and Department on needed services.

- No recommendations were identified, but there was a consensus around the need to see the results and data to be able to make good recommendations on any additional spending. Juvenile Services anticipates this discussion will continue in future meetings.

- The Department continues to project cost avoidance in FY18 by providing funding to sustain these community based services. In fact, in the 2017 legislative session, HB2002 transferred $8.0 million dollars to this fund. The Department also anticipates additional funds will be eligible for certification and transfer on or before the end of the fiscal year.

I hope this summary is helpful in your work. If I may be of further assistance now or in the future, please feel free to contact me using the information I provided in our discussion.

Sincerely,

Randy Bowman, Deputy Secretary
Kansas Department of Corrections, Juvenile Services Division