## Children’s Behavioral Health Crisis Planning Team

## DRAFT Safety Net Vision from Community Partners
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## DRAFT Summary of the Crisis Team Tracker
## Proposed Recommendations/Action Steps

**Updated: July 29, 2025**

## DRAFT SAFETY NET VISION

*The concepts and recommendations presented below reflect the collective input and collaboration of community stakeholders with a focus on children's behavioral health. They are intended to foster constructive dialogue, encourage innovative thinking, and support ongoing system improvement. Some of the ideas expressed may challenge existing interpretations of federal or state laws; however, their inclusion does not constitute, nor should be construed as, an admission of liability, wrongdoing, or any prior or current failure to comply with established best practices on the part of the state. Furthermore, the state does not intend, by compilation of this presentation, to disregard or decline adherence to any applicable state or federal laws.*

*In addition, it is likely that the changes being proposed by the Federal government through H.R.1 and other policies and Executive Orders will have a continuing challenging impact on the State’s budget for health and human services programs over the next number of years. The State believes in the importance of a strong safety net; however, the inclusion of programs or ideas suggested by state community partners and reflected in the document below cannot guarantee their implementation.*

The State’s Community Partners have stated that the Children’s Behavioral Health Safety Net is made up of: Basic trauma-informed services, including emergency services, crisis stabilization, outpatient services, intensive community-based services, and services that prevent placement in foster care, residential settings, and juvenile justice involvement; as well as services for youth with special health care needs. To the extent possible, these services should be provided at families’ homes and always in the least restrictive setting possible. It is critical that early childhood services (e.g., Early Intervention, Healthy Families America) be a part of the safety net. And the Safety Net must include a coordinated continuum of services addressing substance use, for both youth and their caregivers, including community-based and school-based services – to address the significant gaps that currently exist.

These services should be integrated with:

- Social determinants of health, to address health related social needs including housing (creating a system at the state level to coordinate access with all these sectors)
- Youth and families involved in child welfare services
- Physical health services, including elevating the role of co-located and collaborative primary care and school-based health centers as core entry points for children’s behavioral health. Pediatric primary care is often where behavioral health needs are first identified—particularly in underserved communities. Similarly, school-based health centers serve as critical access points, especially for students who may not otherwise receive care.
- Schools/educational systems and recreational services (childcare and aftercare)

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- Prevention services in general, including focusing on the need to marry the improvement of our children's behavioral health system of care with the improvement of our education system – to help decrease higher acuity behavioral health needs in the first place.

These services should cover all children, including transition-aged youth, and be age-appropriate – and the State should continue to ensure that they are accessible, with non-complicated access to apply for them. For transition-aged youth, the safety net should ensure appropriate alignment and transitions between services for SED (Serious Emotional Disturbance, affecting youth) and SPMI (Severe and Persistent Mental Illness, affecting adults).

The Safety Net should be built with principles of equity and cultural responsiveness. Services should focus on children with particular needs, including youth who are LGBTQ+, those who are undocumented, and those living in rural areas. Services should include a focus on children and families with particularly intense needs, including youth who are uninsured and underinsured, those ineligible for Medicaid, those who are LGBTQ+, those who are undocumented or facing immigration-related fears of seeking services, and youth and families/caregivers involved with or at risk for involvement in child welfare and juvenile justice. Services should be provided in ways that ensure that families at the most risk feel safe in receiving them. For those living in rural areas experiencing access challenges, school-based care, tele-behavioral health, or mobile models can close gaps in geographically underserved areas

Those providing the services – as well as the State and other community partners – should recognize that as services are cut, more families may be referred to child welfare — not because of abuse, but due to poverty and lack of resources. Safety net services should not be an excuse to pathologize poverty.

The safety net should be adequately funded and sustained – and Rhode Island should think creatively when it comes to how to align funding streams and fully fund and sustain the safety net during lean budget years.

Specifically, the State should consider how it will be able to accomplish securing the safety net with any restrictions on its federal allocations, as well as with potential restrictions or requirements on non-profit organizations who receive (or used to receive) federal dollars directly. In addition, any potential funding cuts should not leave only crisis services available, with no upstream prevention services. Similarly, there should be a range of intensity of services available – not just low-acuity services or just high-intensity interventions.

Resources and supports should be available to the workforce carrying out safety net services. Staff need support and may be at emotional risk, needing reflective supervision and mental health services themselves. To ensure that the workforce has other resources they need, staff should also be given access to knowledge, and education around behavioral health and enhancing opportunities and requirements for culturally competent care delivery and the integration of physical and behavioral health care. Health care and service professionals cannot do more in these challenging times without getting more support.

The Safety Net depends on governance that includes Children and Family Voice – including leadership from youth and family members - participation from provider and other organizational partners, strong evaluation components, and effective statewide communication and outreach.

The Safety Net also depends on a strong cross-system approach, to coordinate services at the state and/or local levels. It also requires a cross-agency data system, standardized metrics, and agreed-upon targets to drive achievement toward shared goals – as well as improved integrative technology and communication systems between health care systems (medical and behavioral) and community-based services. The data system should be reflected in a public dashboard that can be used to carry out evidence-based crisis and long-term planning.

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## CBH SAFETY NET | DRAFT SUMMARY OF THE CRISIS TEAM TRACKER

The following is a summary list of the Children's Behavioral Health Crisis Team Tracker Proposed Recommendations, based on comments and input from the Crisis Team.

**Communication and Engagement:**

- Continuing to build on efforts to include families in the decision-making on and protection of safety net services
- Maximizing communication with people affected by the potential cuts

**Data Collection and Analysis:**

- Tracking impact of federal changes and challenges and related outcomes, etc.

**Policy and Regulatory Actions to Protect Funded Programs:**

- Protecting services:
    - Aiming to ensure that the state budget retains safety net service - places to live, food, transportation and basic health care and BH Services.
    - Retaining access to insurance whenever possible
- Monitoring program participation, enrollment, access to telehealth, and protection from disruption of services for the most vulnerable Rhode Islanders
- Protecting trauma informed care

**Protect and Support Providers and Safety Net Organizations:**

- Continuing rate review processes and protect from rate cuts
- Supporting providers with financial/solvency issues
- Supporting organizational staff who experience trauma as a result of their work = at all levels, including peer resource staff and community health workers

# APPENDIX

For reference: Here are the **Children's Behavioral Health System of Care: Values and Principles**

| Core Values | Systems of Care are: |
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| 1. Family and Youth Driven | Family and youth driven, with families and young people supported in determining the types of treatment and supports provided (with increasing youth/young adult self-determination based on age and development), and their involvement in decision-making roles in system-level policies, procedures, and priorities. |
| 2. Community Based | Community based, with services and supports provided in home, school, primary care, and community settings to the greatest possible extent, and with responsibility for system management and accountability resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community or regional level. |
| 3. Culturally and Linguistically Competent | Culturally and linguistically responsive, with agencies, services, and supports adapted to the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve to provide care that meets individual needs, including those shaped by culture and language, and to ensure equity in access, quality, and effectiveness of services |
| **Guiding Principles** | **Systems of Care are Designed to:** |
| 1. Comprehensive Array of Services and Supports | Ensure availability and access to a broad, flexible array of effective, high-quality treatment, services, and supports for young people and their families that address their emotional, social, educational, physical health, and mental health needs, including natural and informal supports. |
| 2. Individualized, Strengths-Based Services and Supports | Provide individualized services and supports tailored to the unique strengths, preferences, and needs of each young person and family that are guided by a strengths-based planning process and an individualized service plan developed in partnership with young people and their families. |
| 3. Evidence-Based Practices and Practice-Based Evidence | Ensure that services and supports include evidence-informed, emerging evidence-supported, and promising practices to ensure the effectiveness of services and improve outcomes for young people and their families, as well as interventions supported by practice-based evidence provided by diverse communities, professionals, families, and young people. |
| 4. Trauma-Informed | Provide services that are trauma-informed, including evidence-supported trauma-specific treatments, and implement system-wide policies and practices that address trauma. |
| 5. Least Restrictive Natural Environment | Deliver services and supports within the least restrictive, most natural environments that are appropriate to the needs of young people and their families, including homes, schools, primary care, outpatient, and other community settings. |
| 6. Partnerships with Families and Youth | Ensure that family and youth leaders and family- and youth-run organizations are full partners at the system level in policy, governance, system design and implementation, evaluation, and quality assurance in their communities, states, tribes, territories, and nation. |
| 7. Interagency Collaboration | Ensure that services are coordinated at the system level, with linkages among youth-serving systems and agencies across administrative and funding boundaries (e.g., education, child welfare, juvenile justice, substance use, primary care) and with mechanisms for collaboration, system-level management, and addressing cross-system barriers to coordinated care. |
| 8. Care Coordination | Provide care coordination at the service delivery level that is tailored to the intensity of need of young people and their families to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and that they can move throughout the system of services and supports in accordance with their changing needs and preferences. |
| 9. Health-Mental Health Integration | Incorporate mechanisms to integrate services provided by primary health care and mental health service providers to increase the ability of primary care practitioners and behavioral |

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| | health providers to better respond to both mental health and physical health problems. |
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| 10. Developmentally Appropriate Services and Supports | Provide developmentally appropriate services and supports, including services that promote optimal social-emotional outcomes for young children and their families and services and supports for youth and young adults to facilitate their transition to adulthood and to adult service systems as needed. |
| 11. Public Health Approach | Incorporate a public health approach including mental health promotion, prevention, early identification, and early intervention in addition to treatment in order to improve long-term outcomes, including mechanisms in schools and other settings to identify problems as early as possible and implement mental health promotion and prevention activities directed at all children, youth, and young adults and their families. |
| 12. Mental Health Equity | Provide equitable services and supports that are accessible to young people and families irrespective of race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; eliminate disparities in access and quality of services, and ensure that services are sensitive and responsive to all individuals. |
| 13. Data Driven and Accountability | Incorporate mechanisms to ensure that systems and services are data-driven, with continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of goals; fidelity to SOC values and principles; the utilization and quality of clinical services and supports; equity and disparities in service delivery; and outcomes and costs at the child and family and system levels. |
| 14. Rights Protection and Advocacy | Protect the rights of young people and families through policies and procedures and promote effective advocacy efforts in concert with advocacy and peer-led organizations. |

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