FLORIDA BEHAVIORAL HEALTH ASSOCIATION
CENTRAL RECEIVING FACILITY (CRF)
&
CRISIS STABILIZATION UNIT(CSU)/DETOX UNITS/INPATIENT PSYCH
Operations and Best Practices Compendium

Central Receiving Facility/Central Receiving System Guidebook

Central Receiving Facilities, Crisis Receiving Systems, Stand-Alone Models, and Co-Locations

Purpose: An operational guide aligned to Florida Administrative Code 65D and 65E concepts, using the attached CRF subcommittee materials, provider roles, medical exclusionary criteria, law-enforcement protocols, CARE Team model, and operating examples.

This guide was developed by the Florida Behavioral Health Association's Inpatient Residential Division, Central Receiving Facility Subcommittee, under the leadership of co-chairs, Shannon Robinson, Aspire Health Partners and Terence Thomas, SMA Healthcare. It supports planning, policy alignment, training, quality review, and partner collaboration. It is not legal advice.

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TAB 1 **What is CRS/CRF**

Definition and Purpose

- CRF/CRC means a Central Receiving Facility or Central Receiving Center: a single access point for behavioral health and substance use crisis screening, stabilization linkage, and disposition planning.
- CRS means a Crisis Receiving System: the coordinated network connecting CRF/CRC, CSU, ARF, detox, SRT, hospitals, law enforcement, EMS, mobile response, jails, courts, care coordination, and community services.
- The model may be stand-alone, co-located with a CSU/ARF/detox/hospital, or integrated across a campus. Best practice is a clear, safe, documented pathway matched to legal status, acuity, staffing, capacity, and local designation.
- 65D-30 governs substance abuse service components, including common licensing standards, clinical records, rights, staffing scope, ARF, detox, and residential standards.
- 65E-5 governs Mental Health Act regulation, including forms, transportation, voluntary and involuntary processes, emergency treatment orders, receiving facility designation, rights, and discharge.
- 65E-12 addresses public mental health CSUs, SRTs, and integrated CSU/ARF services where applicable.

Concept	Standard for Use
Stand-alone CRF	Independent access, screening, law-enforcement entrance, triage, transfer, and disposition workflow.
Co-located CRF	Shared clinical, nursing, medical, safety, or bed resources with a CSU, ARF, detox, hospital, or SRT under written protocols.
Integrated CSU/ARF	Dual mental health and substance use receiving capability with aligned 65D/65E procedures.
Expected Outcome	Rapid, safe linkage to the least restrictive clinically appropriate care and reduced inappropriate ED/jail use.

TAB 2 **Systems of Care and Care Pathways**

Core System of Care Pathway

- 1. Referral or arrival from law enforcement, walk-in, hospital, EMS, jail, mobile response, court, family, or community provider.
- 2. Identify legal status: voluntary, Baker Act, Marchman Act, protective custody, court order, jail-based Baker Act/PC, or no legal status.
- 3. Complete immediate safety and nursing/medical screen for medical instability, intoxication/withdrawal, violence risk, elopement, self-harm, harm to others, and infectious risk.
- 4. Complete clinical assessment and determine least restrictive clinically appropriate care.
- 5. Disposition to CSU, ARF/detox, 23-hour respite/observation, hospital/ED transfer, jail/court coordination, discharge with resources, or community linkage.
- 6. Complete warm handoff to treatment team, peer/care coordination, benefits, discharge planning, and aftercare.

Entry Point	Required Pathway Controls	Common Disposition
Law enforcement	Verify legal form, observed behavior, violence/medical concerns, transport documentation.	CRF screening, CSU/ARF admission, release, ED transfer.
Voluntary/walk-in	Confirm willingness and capacity for voluntary assessment and treatment.	Community linkage, observation, CSU/ARF/detox.
Hospital transfer	Require medical stability documentation, nurse-to-nurse report, and legal paperwork if applicable.	CRF/CSU/ARF/detox or decline pending stability.
Jail/court	Coordinate capacity, transport order, open case hold, and discharge limits.	CSU treatment, return to jail, court-approved discharge.
MRT/CCT/community	Use collateral, risk assessment, and continuity plan.	CRF, outpatient linkage, CSU/ARF, family stabilization.

TAB 3 **Capacity**

Capacity Management Standard

Operating Standard: Capacity includes licensed beds, operational beds, open beds, assigned-pending arrivals, gender/age restrictions, acuity, staffing, medical capability, transportation, and specialty support.

Capacity Element	Minimum Tracking Requirement
Licensed and operational beds	Track licensed capacity separately from operational beds for CSU, CCSU, ARF/detox, SRT, hospital, and CRF observation/respite.
Census and pending arrivals	Track actual census, assigned but not arrived, projected census, open beds, and percent filled.
Acuity constraints	Flag 1:1 observation, aggression, medical complexity, pregnancy, withdrawal risk, isolation, youth/adult separation, and elopement risk.
Referral source volume	Track LEO, walk-in, hospital, EMS, jail, mobile response, and other sources.
Disposition volume	Track CSU admit, ARF admit, released with resources, transferred, unable to accept/reason.
LEO processing time	Track minutes from arrival to officer release and analyze monthly.
Governance	Review data during daily huddles, monthly QI, and quarterly advisory councils.

Example Capacity Metrics from Subcommittee Materials

- Meridian reported 2,100+ unique individuals served in 2025, with legal status split among Baker Act, voluntary, and Marchman Act referral.
- Meridian screening dispositions included CSU admission, ARF admission, transfer to another facility, and release with resources.
- Aspire sampler census reporting tracked bed allotment, actual census, assigned-pending arrivals, open beds, male/female open beds. And precent filled across CSU, SRT, intensive inpatient, and ARF.

TAB 4 Staffing

Staffing Model Standards

Model	Observed Pattern	Best-Practice Application
CRF/ARF and CSU housed in CRF	Examples include 1 BHT/Safety Tech:6 adults, 1:10 BHT, 1:15 nursing, APRN/psychiatrist, RN/LPN, clinicians, discharge planners, peers, UM, medical records, nurse managers, directors, judicial coordinator.	Set minimum staffing by acuity and census, with higher staffing for mixed CSU/ARF or high-aggression areas.
CRF front door to inpatient/CSU	Examples include 1 BHT:6-7 by acuity, 1:15 RN, team lead, APRN, BHTs, RNs, case managers, screeners, AAs, MRT/CCT.	Separate screening volume from inpatient bed staffing and maintain a shift supervisor/team lead.
Stand-alone CRF	Licensed director, clinical manager, RN manager, RNs, licensed/masters/bachelor screeners, coordinators, MHT/drivers, care coordinators, APRN/psychiatrist support.	Ensure independent 24/7 coverage, dedicated transport plan, and direct provider escalation.
Campus continuum	RN manager, charge RN, unit coordinator, LPN, BHT/PCT/CNA, physician, PMHNP/FNP, universal caseloads.	Use cross-functional staffing while respecting licensure/service distinctions.
CARE Team overlay	Experienced BHTs on 12-hour shifts across CRF/CSU/ARF for rapid support.	Use as specialty overlay, not substitute for unit minimum staffing.

Scheduling Standards

- Use 12-hour shifts for BHT/safety techs and nurses where 24/7 consistency is needed.
- Use 8 to 10-hour shifts for screeners, clinicians, peers, providers, discharge planners, and administrative roles based on arrival peaks.
- Build overlap on high-volume intake shifts and use on-call clinicians/providers for risk assessments, voluntary admissions, and medical/provider questions.
- Use staggered weekends, PRN pools, incentives, cross-training, and 30/90-day new-hire check-ins to address vacancies and call-outs.

TAB 5 **Responsibilities**

Role Responsibility Matrix

Role	Core Responsibility in CRC/CRS
Psychiatrist/Medical Director	Psychiatric admissions/discharges, certifications/recertifications, ETOs, complex follow-ups, opinions, competency/ROR, court testimony, medication management, clinical supervision.
PMHNP/APRN	Admissions/discharges within scope, reconciliation, psychiatric/physical assessments, standing orders, follow-ups, opinions if eligible, weekend/on-call coverage.
FNP/Primary Care	H&P, medical consults, chronic condition review, medical follow-ups, ED transfer recommendation, stabilization support.
RN/Charge Nurse	Health assessment, vitals, medication administration, nurse-to-nurse report, screening, emergency intervention, code leadership.
LPN	Medication support, vitals, observation, nursing tasks within scope, documentation.
Clinician/Screener/Counselor	Risk assessment, clinical assessment, diagnosis/formulation, treatment plan, disposition, documentation.
BHT/MHT/Safety Tech	Observation, safety checks, searches, belongings, triage support, admission/discharge support, transport, de-escalation.
Peer/Care Coordinator	Recovery support, warm handoff, appointments, benefits, housing, transportation, referrals, discharge linkage.
Director/Administrator	Resource allocation, staffing, compliance, partner relationships, dashboard review, escalation, policy maintenance.

TAB 6 **Collaboration with Law Enforcement**

Law Enforcement Collaboration Standards

- Maintain regular meetings with law enforcement agencies and municipalities.
- Use CIT training partnerships and provide Baker Act/Marchman Act quick-reference support.
- Track officer processing/drop-off time and use the data to improve handoff workflows.
- Require complete Baker Act, Marchman Act, protective custody, transportation, and medical documentation.
- Use call-ahead expectations for combative, violent, medically uncertain, or high-risk arrivals.

Warm Handoff for Violent or Potentially Violent Individuals

- 1. LEO/dispatch calls before arrival with name/DOB if known, observed behavior, restraints, weapons, medical condition, and violence risk.
- 2. Facility alerts RN/charge nurse, assessor, response/CARE team, security, and leadership.
- 3. RN evaluates for medical emergency or ED/EMS need before secure-area acceptance.
- 4. Team clears pathway, stages approved equipment, and agrees on movement plan from vehicle to secure room/nurse station.
- 5. RN determines restraint/medication need and consults MD/APRN as required.
- 6. Facility verifies legal documentation, releases LEO as soon as safe, and completes debrief.

e-Baker Act and Transport Documentation

- Required e-Baker Act elements include demographics, supporting opinion, involved persons/emergency contacts, transportation, supervisor approval, and PDF transmission to the receiving facility.
- Downtime procedures should allow handwritten forms with delayed electronic entry when the system returns.
- Transport documentation must follow the approved county transportation plan and accompany the individual.

TAB 7 **Standing Medical Orders**

Standing Medical Orders and Medical Screening

Policy Standard: Standing orders must be approved by medical leadership, aligned to scope of practice, and reviewed annually or when service capability, contracts, accreditation, or 65D/65E requirements change.

Domain	Required Content
Hypertension/cardiac	Parameters, medication continuation, provider notification, ED transfer, cardiac clearance.
Diabetes/metabolic	Accu-check triggers, hypo/hyperglycemia steps, insulin self-management, supplies, ED criteria.
Seizures	Medication verification, therapeutic levels, seizure-free criteria, post-seizure transfer.
Withdrawal/intoxication	Withdrawal scales, overdose/over-sedation, BAL/LOC/ambulation, delirium tremens, detox level of care.
Infection	Temperature threshold, TB/COVID/flu/MRSA/pneumonia, isolation capacity, clearance.
Pregnancy	OB/GYN clearance, complications, viability/monitoring, maternal/fetal safety.
Wounds/tubes/DME	Dry dressing limits, complex wounds, Foley/feeding tube/ports, oxygen/CPAP/BiPAP, assistive devices.
Emergency transfer	Call 911 for life-threatening emergency; use approved transport for non-emergent conditions beyond capability.

Medical Exclusionary Criteria Framework

- Attach local medical exclusionary criteria and share a plain-language version with hospitals, LEO partners, EMS, and referral sources.
- Require nurse-to-nurse report and written stabilization verification for hospital transfers.
- Use provider/administrator override for case-by-case exceptions and document rationale.

TAB 8 **Specialty Staffing**

Specialty Staffing Model

Specialty Role	Best-Practice Function
CARE/De-escalation Team	Experienced BHT/safety staff with advanced CPI, trauma-informed care, scenario practice, radio/panic response, code response, and debriefs.
Peer Support	Engagement, recovery connection, warm handoff, client experience, community linkage, and discharge support.
Benefits Specialist	Benefits screening, Medicaid/entitlement assistance, documentation support, resource linkage.
Judicial/Jail Diversion Coordinator	Open case coordination, court approval issues, misdemeanor transfer protocols, jail return/community discharge coordination.
Navigator/Intake Coordinator	Front-door triage, referral routing, bed/resource awareness, and partner communication.
MRT/CCT Embedded Teams	Continuity between crisis response, CRF screening, and community stabilization.
Driver/MHT Transport	Safe transfers and appointment/community transport per policy.

CARE Team Qualifications

- Minimum two years direct mental health care experience for selected CARE Team members.
- Demonstrated strength in verbal de-escalation and crisis management.
- Proven CPI proficiency and advanced CPI certification when available.
- Professionalism, leadership, trauma-informed practice, monthly supervision, post-incident debriefing, and scenario training including elopments.

TAB 9 **Staffing Competencies, Onboarding, and Training**

Required Competency Domains

- Baker Act, Marchman Act, voluntary status, protective custody, transport forms, and legal-status documentation.
- 65D and 65E service component requirements relevant to role.
- Medical screening, emergency transfer, vitals, glucose, withdrawal/intoxication, infection control, pregnancy, and chronic condition awareness.
- Suicide and violence risk, de-escalation, trauma-informed engagement, contraband/search, safety checks, restraint/seclusion prevention, and code response.
- Role-specific documentation, confidentiality, rights, grievances, informed consent, and discharge planning.
- BHT/MHT: monitoring, behavior management, transportation, searches, belongings, client engagement, documentation.
- RN: health assessment, medication administration, infection control, emergency intervention, patient education, medical coordination.
- Counselor/screener: DSM formulation, assessment, treatment planning, co-occurring symptoms, family/collateral work.
- Provider: pharmacology, psychiatric assessment, medical consults, ETOs, court opinions/testimony, reconciliation, discharge summaries.

Phase	Focus	Validation
Day 1-7	Orientation, facility safety, radios/panic buttons, legal status, rights, documentation basics, shadowing.	Checklist and sign-off.
Day 8-30	Role-specific intake, triage, medical screen support, LEO handoff, EMR documentation.	Observed practice.
Day 31-90	Independent practice with coaching, cross-training, scenarios, high-risk handoff, discharge.	30/90-day checks.
Ongoing	Annual refreshers, CPI/advanced CPI, incident learning, policy updates, QI findings.	Training log and evaluation.

TAB 10 **Provider Caseloads**

Provider Caseload Assignment Standard

- 1. Review census by unit and identify total patients, new admissions, and follow-ups.
- 2. Identify assigned psychiatrists, PMHNPs/APRNs, FNPs, and other providers by unit or campus.
- 3. Allocate new admissions first. Use a local maximum for new admissions per psychiatrist per day.
- 4. Assign FNPs/medical providers to new patient physical assessments or consults.
- 5. Calculate follow-ups by subtracting new admissions from total census.
- 6. Assign follow-ups equitably, considering discharge summaries, medication changes, prescriptions, peer review, and court responsibilities.
- 7. Finalize and distribute daily caseload to providers, nursing/medical/clinical leadership, and charge nurse.

Task	Suggested Time/Workload Assumption
Psych admission	45 minutes
Medical admission/H&P	30 minutes
Follow-up	15 minutes
Discharge	20 minutes
1st/2nd opinion or competency	15 minutes
Discharge priority	Orders, notes, and summaries should support discharge by 12 p.m. when possible.
Medication discharge planning	Order discharge medications at least 24 hours before discharge when possible.
Weekend consistency	Discharges should occur consistently throughout the week, including weekends.

TAB 11 **Cross-functional Responsibilities**

Cross-functional Operating Model

- Use standardized protocols regardless of location, staff, model, or funding source while respecting licensure and designation differences.
- Support staff to practice at the top of license or training with clear delegation, role clarity, supervision, and escalation.
- Integrate supportive services into core operations: case management, peer support, care coordination, intake navigation, benefits, and discharge planning.
- Use universal medical/provider caseloads when appropriate to balance workload, reduce bottlenecks, and improve continuity.
- Use real-time dashboards, daily huddles, and power staffing protocols for dynamic resource allocation.

Function	Shared Responsibility	Owner/Lead
Daily huddle	Census, staffing, pending arrivals, high-risk persons, projected discharges, exclusions, transports.	Operations Director / Charge RN
Safety response	Codes, de-escalation, restraint if needed, LEO handoff, debrief.	RN lead with CARE Team
Bed flow	Admissions, discharges, transfers, open beds, medical barriers.	Director, Access, Nursing, Providers
Documentation quality	Forms, legal status, rights, transport, medical clearance, disposition.	Compliance/QI
Community collaboration	LEO, hospitals, EMS, jails, courts, advisory council, CIT.	Director/LEO Liaison
Staffing flexibility	Cross-training, PRN pool, call-out response, cross-functional support.	Operations/HR
Quality improvement	Metrics, incidents, feedback, root causes, action plans.	QI/Leadership

APPENDIX **Implementation Checklists and Source Notes**

Daily Readiness Checklist

- Staffing grid confirms RN/charge nurse, BHT/safety tech, screener/clinician, provider/on-call, care coordination, and leadership coverage.
- Secure entrance, radios, panic buttons, cameras, communication devices, and response-team assignments checked.
- Bed/census dashboard updated by service line, gender, age, acuity, assigned-pending arrivals, and open beds.
- Medical supplies, vitals equipment, glucose supplies, PPE, emergency supplies, and medication room checked.
- LEO, EMS, hospital, jail/court, transport, and administrative on-call contacts available.
- Baker Act, Marchman Act, protective custody, voluntary, and transport forms available electronically and in downtime format.
- Prior shift incidents debriefed and action items assigned.

Sources Used

- Florida Behavioral Health Association Central Receiving Facility Subcommittee slide packet and meeting materials.
- Provider roles, job descriptions, provider assignment guide, exclusionary criteria, law enforcement protocols, CARE Team model, and members presentations.
- Chapter 65D-30 Substance Abuse Services Standards, Florida Administrative Code.
- Chapter 65E-5 Mental Health Act regulations and Chapter 65E-12 CSU/SRT and integrated CSU/ARF Standards, Florida Administrative Code.

Crisis Stabilization Unit/Detox Unit/Inpatient Psych Guidebook

Purpose: An operational guide aligned to Florida Administrative Code 65D and 65E concepts, using the attached CSU subcommittee materials, provider roles, medical exclusionary criteria, law-enforcement protocols, CARE Team model, and operating examples.

This guide was developed by the Florida Behavioral Health Association's Inpatient Residential Division, CSU/Detox Unit/Inpatient Psych Subcommittee, under the leadership of co-chairs, Rick Hankey, LifeStream Behavioral Center and Tracy Smith, Ibis Healthcare It supports planning, policy alignment, training, quality review, and partner collaboration. It is not legal advice.

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TAB 1 Staffing Models and Ratios

Subcommittee members reported substantial variation by service type, licensed and operational capacity, age group, census, acuity, and observation requirements. Common disciplines included psychiatrists, psychiatric APRNs/PMHNPs, RNs, LPNs, BHTs/MHTs/CNAs/PCTs, clinicians, intake staff, discharge planners, recovery specialists, peers, recreational therapists, care coordinators, and nursing/clinical leadership.

Representative setting	Reported direct-care pattern	Additional/shared support
Adult CSU, 20 beds	Days and nights: minimum 3 MHTs, including 1 float, plus 2 nursing staff; at least 1 RN.	Shared psychiatrists, physician, counselors, discharge planners, nurse managers, recreational therapy, peer support.
Children's CSU, 10 beds	Days and nights: minimum 2 MHTs plus 1 RN or LPN.	Shared child psychiatry, counselors, discharge planning, children's care coordination, and leadership.
Adult/Child CSU, 28 beds combined	Minimum 3 MHTs, including 1 float, plus 2 nursing staff; at least 1 RN onsite.	Psychiatrist, psychiatric APRN, counselors, discharge planners, nurse managers, recreational therapy, peer support.
CSU, 30 beds: 20 children/10 adults	Adult: 1 RN and 1 Tech/CNA per 10 beds. Children: 1 RN and 2 Techs/CNAs for 20 beds.	Recovery specialist and discharge coordinator assigned per 10 beds; child provider for pediatric capacity.
Campus CSU, 47 operational beds	Per campus: RN nurse manager, charge RN, unit coordinator, LPN, and 3 BHT/PCT/CNA positions.	Physician and PMHNP/FNP per campus; universal medical-provider caseload approach.
Adult crisis, 30 beds	2 nurses, at least 1 RN, and 6 BHTs.	Psychiatrist and 2 psychiatric APRNs shared with child CSU; 4 discharge planners.
Child CSU, licensed 16 beds	1 RN and 2-3 BHTs.	Shared psychiatric coverage and 3 discharge planners.
Hospital/CSU/Detox multi-unit system	A reported full-census day pattern across five units was 11 RNs/LPNs and 20 MHT/HUC/PCS staff, excluding added staffing for high acuity.	Intake staffed by at least 2 workers; 8 psychiatric providers and 8 social workers with PRN supplementation.

Acuity-Based Staffing Controls

Adjust staffing each shift for 1:1 observation, line-of-sight monitoring, frequent checks, aggression, elopement risk, seclusion monitoring, medical complexity, and pediatric/adult separation.

Do not count specialty response teams or float staff as a substitute for required unit coverage unless local policy and regulation permit.

Review both licensed capacity and operational capacity; available beds may be constrained by staffing, gender/age separation, or clinical acuity.

Use charge nurse and administrative escalation when census or acuity exceeds the planned staffing grid.

TAB 2 Scheduling Practices

Role/group	Reported scheduling practices	Operational consideration
RN/LPN/BHT/MHT/CNA/Tech	Twelve-hour shifts were the predominant model. Some full-time direct-care staff worked three 12-hour shifts and one 8-hour shift per pay period.	Improves continuity but requires fatigue controls, reliable relief coverage, and call-out plans.
Clinical staff	Commonly 8-hour shifts.	Stagger schedules around admission, assessment, treatment planning, family contact, and discharge peaks.
APRNs	One provider reported 8-hour shifts.	Align coverage with H&Ps, admissions, discharges, follow-ups, and on-call escalation.
Psychiatrists	A 7-days-on/7-days-off model was reported as helpful for retention.	Define handoff, weekend discharge, court, certification, and backup expectations.
On-call coverage	Administrative, physician/medical, and licensed-clinician schedules were maintained after hours, seven days per week.	Publish a single escalation roster and test response expectations.
PRN/flexible coverage	PRN pools, flexible schedules, and staff sharing were used to address census and acuity fluctuations.	Maintain competency, orientation, and unit-specific readiness for infrequent PRN staff.

Scheduling Readiness Check

Confirm planned census, pending admissions, expected discharges, 1:1 or enhanced observation assignments, and transport needs before each shift.

Identify the charge RN, medical/provider coverage, licensed clinician coverage, administrator on call, and backup direct-care staff.

Build overlap for high-volume intake periods and avoid relying exclusively on overtime for predictable coverage gaps.

Reassess staffing after significant changes in acuity, seclusion/restraint use, or multiple simultaneous admissions.

TAB 3 Workforce Challenges

Challenge	Reported impact	Suggested local monitoring
Call-outs, no-call/no-show, punctuality, dependability	Coverage instability, overtime, supervisor burden, and increased reassignment.	Attendance trends by unit/shift; overtime; vacancy coverage; corrective-action consistency.
Enhanced observations and high acuity	Multiple 1:1 or line-of-sight assignments can quickly exceed the base BHT plan.	Daily enhanced-observation hours; BHT variance to grid; safety events.
RN recruitment and retention	Persistent vacancies and reliance on overtime or temporary coverage.	Time to fill, turnover, agency use, vacancy rate, exit/stay interview themes.
PRN pool readiness	Steep training curve and limited familiarity with unit procedures.	Orientation completion, competency validation, hours worked, cancellation and fill rates.
Physician onboarding	Difficulty onboarding physicians across complex organizations.	Credentialing cycle time, payer enrollment, privileges, technology access, time to independent practice.
BHT certification uptake	Limited interest despite reported incentives; some staff view the position as short-term rather than a career path.	Certification rate, incentive participation, tenure, internal promotions, training completion.
Workplace violence	Risk to staff and patients, lost work time, turnover, and operational disruption.	Assaults/injuries, workers' compensation, security response, debrief completion, corrective actions.

Workplace Violence Roadmap: I. Specify the problem. II. Gather data and research. III. Identify potential solutions and recommendations. IV. Conduct additional information gathering. V. Finalize recommendations for submission through appropriate FBHA governance channels.

TAB 4 Recruitment and Retention Strategies

Strategy	Reported application	Implementation notes
BHT/MHT tier system	Higher pay based on education, certification, and behavioral health or medical experience.	Publish objective criteria and a visible career ladder; pair pay progression with competencies.
Certification incentive	A $2 increase was discussed as an example; reported BHT wages in residential settings ranged roughly from $15 to $18, depending on education/certification and setting.	Validate current local market rates and budget impact before adoption.
Attendance policy and point system	Progressive discipline, including potential termination, reportedly improved avoidable call-outs and punctuality.	Apply consistently, account for protected leave, and coordinate with HR/legal review.
Twelve-hour shift conversion	Reported as a staffing and retention improvement in some settings.	Evaluate preference data, fatigue, schedule equity, and weekend coverage.
Recognition and engagement	Quarterly appreciation, town halls, stop-light reports, employee awards, and stay interviews.	Close the loop on staff feedback and publish action owners and timelines.
Flexible scheduling and benefits	Scheduling flexibility and active promotion of the full benefits package during recruitment.	Use structured flexibility standards to preserve fairness and safe coverage.
Leadership development	Focused development of nurse managers and timely action when roles were not a good fit.	Train managers in coaching, attendance management, safety, staffing, and retention analytics.
Psychiatrist model	7-on/7-off scheduling and use of residents consulting with an offsite psychiatrist were reported.	Confirm supervision, privileges, scope, billing, and facility requirements.
Physical environment and talent acquisition	Facility upgrades and dedicated HR/talent acquisition support.	Track candidate conversion, time to hire, and new-hire retention.

BHT Career Path Priorities

Clarify certification value, eligibility, training time, financial incentive, and advancement opportunities.

Address boundary management, accountability, documentation, de-escalation, trauma-informed care, and observation competency in training.

Explore how other states structure or register comparable entry-level behavioral health roles while maintaining Florida-specific compliance review.

Use mentoring, cross-training, and internal promotion pathways to position BHT work as a sustainable career entry point.

TAB 5 Cross-Functional Operating Models

Operating feature	Subcommittee practice	Expected benefit
Standardized care pathways	Roles delineated by discipline and supported by standardized protocols across location, staffing, and funding differences.	Role clarity, accountability, team buy-in, and more consistent care.
Universal medical-provider caseload	Patients distributed across the medical team rather than rigidly siloed by unit when appropriate.	Balances workload variability, reduces overextension, and supports timely service.
Integrated supportive services	Case management, peer support, care coordination, intake navigation, recovery specialists, and discharge planning embedded in operations.	Addresses social needs, strengthens engagement, and improves continuity.
Cross-training	Staff trained across compatible functions and program areas while maintaining scope and regulatory requirements.	Improves flexibility and coverage during shortages.
Daily huddles and dashboards	Real-time dashboards, daily huddles, staffing reviews, and power-staffing protocols.	Proactive deployment, transparency, and collaborative problem-solving.
Shared support across programs	Psychiatry, medical, counseling, discharge planning, recreational therapy, peers, and leadership shared across colocated services.	Efficient use of specialty resources with clear prioritization and escalation.

Daily Interdisciplinary Huddle

Census and licensed versus operational beds by program.
Pending admissions, discharges, transfers, court or legal-status deadlines, and transport needs.
High-risk individuals, enhanced observations, seclusion/restraint follow-up, medical concerns, and staff-safety alerts.
Staffing against grid, call-outs, float/PRN assignments, provider caseload distribution, and after-hours coverage.
Discharge barriers, community appointments, medication access, benefits, housing, family/caregiver coordination, and warm handoffs.

TAB 6 Workforce Development Priorities

Priority	Questions raised in materials	Recommended organizational action
Staff safety and workplace violence	How should the problem be defined, researched, and advanced into recommendations?	Create a multidisciplinary prevention plan, trend incident data, assess environment and response protocols, and track action completion.
PMHNP/APRN practice	Training, supervision, practice, billing, interstate practice, statutes/codes, and relevant AHCA/DCF policies.	Maintain a current scope, supervision/collaboration, credentialing, billing, and escalation matrix reviewed by legal/compliance leadership.
Psychiatrist/APRN role design	Future availability of psychiatrists and appropriate use of APRNs versus psychiatrists.	Define responsibilities for admissions, discharges, certifications, ETOs, opinions, court functions, H&Ps, follow-ups, and backup coverage.
Workforce pipeline	Need for current data, mentoring, recruitment, and career-path development.	Participate in statewide workforce initiatives, use retention surveys, and create student/intern/mentor partnerships.
Regulatory and operational innovation	Streamlining licensing/contract requirements while maintaining accountability and quality.	Document duplicative requirements, quantify operational impact, and elevate recommendations through FBHA channels.
ARF designation and service integration	ARF designation and coordination across CSU, detox, SRT, and inpatient services.	Review designation, staffing, medical capability, legal pathways, and handoffs across the continuum.

Implementation Checklist

Compare the local staffing grid to census, acuity, observation hours, age groups, and service design.
Define minimum coverage, escalation thresholds, and approval authority for staffing above grid.
Review nursing, BHT, clinician, and provider scheduling against admission and discharge demand.
Create a workforce dashboard covering vacancies, turnover, overtime, agency/PRN use, attendance, injuries, certification, and training.
Assess BHT career ladders, nursing pay tiers, recognition programs, stay interviews, and leadership development.
Complete a workplace violence gap assessment and establish a recommendation timeline.
Validate PMHNP/APRN role, supervision/collaboration, billing, credentialing, and interstate-practice requirements with qualified compliance and legal resources.
Use quarterly subcommittee review to share results, barriers, and scalable practices.

CSU Source Notes

Integrated source material: Florida Behavioral Health Association, Inpatient Residential Division, CSU/Detox Units/Inpatient Psychiatry Subcommittee materials dated May 2025, July 2025, October 2025, January 2026, and February 2026. Topics included comparative staffing and schedules, BHT wages and certification, workforce recruitment and retention, cross-functional models, staff safety/workplace violence, APRN and psychiatrist roles, and workforce-development resources.

Document use notice: This guide supports planning, policy alignment, training, quality review, and partner collaboration. It does not establish a universal staffing mandate and is not legal advice. Organizations should verify current laws, rules, contracts, accreditation standards, payer requirements, and local policies before implementation.