



[External] Public Comment Submission – 55 Pa. Code Chapter 5250 (Docket #14-557)

From Morgan Miller <morgan.miller987@gmail.com>

Date Mon 11/3/2025 8:42 AM

To PW, CrisisServicesRegs <RA-PWCRISISSRVSREGS@pa.gov>

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Great day,

Please accept the attached public comment letter regarding the proposed regulation *Licensure of Crisis Intervention Services* (55 Pa. Code Chapter 5250, Docket #14-557) and confirm receipt. My comments are submitted as both a parent and advocate with direct lived experience navigating Pennsylvania's behavioral health system.

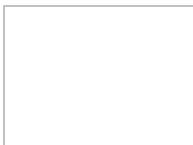
Thank you for your time, attention, and dedication to improving crisis intervention services for all Pennsylvanians.

*Please note - I respectfully request my personal address be omitted for privacy; I will provide it to OMHSAS upon request.

Sincerely,

Mrs. Morgan Miller

Parent & Advocate



PUBLIC_COMMENT_#14-557_55 Pa. Code Chapter 525...

MORGAN MILLER

Parent & Advocate | Reading, Pennsylvania

(personal address omitted for privacy; available to OMHSAS upon request)

Date: November 3, 2025

Office of Mental Health and Substance Abuse Services (OMHSAS)**Department of Human Services**

Attention: Tara Pride, PA3,

Commonwealth Tower,

303 Walnut Street, 11th Floor, Harrisburg, PA. 17105

Thank you for the opportunity to comment on the proposed regulation #14-557 - *Licensure of Crisis Intervention Services* (55 Pa. Code Chapter 5250), published in the *Pennsylvania Bulletin* on October 18, 2025.

As a parent and advocate with lived experience navigating Pennsylvania's behavioral-health crisis system, I strongly support OMHSAS's effort to establish clear oversight, consistent standards, and genuine accountability across all crisis-intervention programs.

I wish these protections had existed before my family endured a deeply traumatic experience at a behavioral-health facility in Pennsylvania (Brooke Glen Behavioral Hospital) under the care of psychiatrist Dr. Reddy.

Lived Experience: Why These Reforms Matter

From April 23 to 28, 2025, my family's request for trauma-informed help became a crisis that permanently altered our trust in the system.

- Our minor son was voluntarily (201) admitted for what should have been short-term stabilization.
- Instead, a non-clinical intake worker performed a subjective assessment, misdocumented information during a panic episode triggered by a school-related trauma, and forwarded that inaccurate report to a psychiatrist who never personally evaluated my child before authorizing hospitalization.
- We were told, *"If you go today (Wednesday), you'll be home by the weekend (Saturday)."*
- Over that weekend, our child was held against our wishes, over-medicated without guardian consent, and coerced into rescinding a 72-hour discharge request while heavily sedated—simply because administrative staff were off until Monday.
- This experience was labeled "trauma-informed care." In truth, there was no trauma-informed care, only system-inflicted trauma. The phrase existed in brochures, not in practice.

I am grateful to OMHSAS and the Department of Human Services for hearing the public's call for meaningful oversight and reform. These proposed standards are a vital opportunity to ensure that no other family experiences what ours endured.

Respectfully submitted,

Morgan Miller

§ 5250.3 Purpose and Scope (p. 5)

Clarify and Document Trauma-Informed Care Standards

The proposed regulation recognizes trauma-informed care as a core value. It may strengthen implementation and oversight if OMHSAS also specified how trauma-informed care will be documented and reviewed in practice.

Documenting Evidence-Based Trauma-Informed Care During Each Episode of Care

It may be helpful for OMHSAS to require that each episode of care — meaning any interaction from admission to discharge — include clear documentation of the trauma-informed techniques that were actually used in that interaction.

Please consider asking providers to document, for each episode of care:

- **Technique Applied.** The specific evidence-based practice or de-escalation method used (for example: grounding exercise, sensory modulation, cognitive reframing, motivational interviewing, reflective listening).
- **Purpose and Rationale.** The clinical reason that technique was chosen, connected to the individual's emotional state, trauma trigger, or presentation in that moment.
- **Response and Outcome.** How the individual responded (for example: settling, redirecting, remaining distressed, escalating), and what follow-up occurred.
- **Staff Credentials.** The name and title of the staff person who applied the technique, with confirmation that the staff member has current training in trauma-informed care.
- **Family Involvement.** When applicable, a short note stating if and how the parent or guardian was included, what information was shared, and what consent was obtained.
- **Debrief Summary.** A short entry within 24 hours describing what staff observed, and any opportunities identified for a more trauma-sensitive response.

This type of documentation could be maintained as a “Trauma-Informed Care Log” in the patient’s record, similar to how facilities already track medication administration or the use of restraints. That log could then be reviewed as part of quality management.

Measurable Indicators OMHSAS Can Require

To support consistent application, OMHSAS could also consider requiring:

- **Periodic audits** (for example, quarterly review of a sample of charts) to confirm that trauma-informed care is being documented as delivered.
- **Annual observation or competency review** reflecting whether staff are using trauma-informed approaches in real time.
- **Patient and family feedback surveys** focused on whether the individual felt heard, respected, and safe. To protect integrity, those surveys could be submitted directly to OMHSAS rather than filtered through the provider.
- **Tracking restraint use, seclusion, and 30-day readmission rates** as indicators of whether trauma-informed approaches are reducing escalation.

These elements are measurable, and they align with the stated intent of the regulation to build consistency, safety, and accountability in crisis response.

§ 5250.22 Emergency Preparedness (p. 25)

Clarify Safety Standards During Police or Security Interventions

The proposed regulation requires each crisis program to maintain an emergency-preparedness plan. It may further protect minors and families if OMHSAS also clarified expectations for how law enforcement and private security are used during a behavioral health crisis.

Please consider asking providers to:

- State in their emergency-preparedness policy that security personnel and/or law enforcement may not restrain or detain a minor without concurrent medical supervision and immediate clinical documentation by a licensed behavioral health professional.
- Adopt and maintain a non-law-enforcement crisis response protocol (for example, verbal de-escalation, sensory reduction, and regulated space) and include that protocol in annual inspection.
- Track and summarize, for inspection purposes, any incident in which restraint or police involvement occurred, including who was present and how safety was monitored.

This type of clarity helps ensure that physical control is not used in place of clinical care.

§ 5250.31 Definitions; § 5250.61 Staff Training and Professional Conduct (pp. 17–22, 65)

Clarify Qualified Training, Certification, and Ethical Standards

The regulation appropriately defines credential requirements for each staffing category in §5250.31. It may be helpful if OMHSAS also clarified which of those credentialed roles are authorized to perform certain critical functions, such as crisis intake, admission determination, and medication initiation. Aligning role, license, and authority would help ensure that decisions affecting legal status, medication, and level of care are made by licensed behavioral health professionals.

Please consider asking providers to:

- Assign crisis intake, assessment, and admission decisions to credentialed, trauma-informed-trained behavioral health professionals, rather than general administrative staff.
- Verify annual trauma-informed re-training through an external or state-recognized accrediting body, rather than internal HR sign-off alone.
- Maintain an updated registry of staff credentials and assigned responsibilities, available for review during inspection.

Ensure Ethical Clinical Practice and Diagnostic Integrity

To support clinical integrity and reduce the risk of unsupported or billing-driven labeling, it may be helpful for OMHSAS to ask providers to:

- Document that each psychiatric diagnosis is based on a complete clinical interview, direct observation by a licensed professional, and consultation with known treating providers when reasonably available.
- Replace copy-forward or recycled notes with an updated evaluation that reflects the current

crisis presentation.

- Note in the record that the parent or guardian of a minor was informed and included, when the guardian is actively involved in care.
- Identify a corrective process if patterns emerge suggesting that diagnoses are being assigned primarily to support insurance billing or extended hold.

This would help prevent situations where a serious diagnosis is assigned to a minor without full assessment, history, or parental involvement.

§ 5250.41–§ 5250.43 Crisis Assessment and Admission Criteria (p. 33–36)

Clarify Youth Consent Rules and Limit Subjectivity in Admission

These sections are central, because they govern how an individual, including a minor, is assessed and brought into services, and under what conditions they remain.

It may be helpful for OMHSAS to clarify the difference between (1) a minor's ability to seek help and (2) a parent or guardian's role in directing ongoing care and major decisions.

In practice, some facilities in Pennsylvania have cited the Mental Health Procedures Act (§§ 7103–7104) to state that a youth aged 14 and older can independently consent to all treatment decisions, including medication changes and withdrawal of a 72-hour notice to discharge, without parent participation. This interpretation allows facilities to hold, medicate, and pressure minors while limiting access to the parent.

A youth aged 14 and older may request or accept mental health services. That is not the same as eliminating the rights of a parent or legal guardian who is available, actively involved, and responsible for that minor's care. When parental involvement is present, decisions such as admission status, medication administration, and discharge planning affect the whole family and should not occur in isolation from the guardian.

Please consider asking providers to:

- Obtain joint consent from both the youth and the parent or guardian for admission, medication decisions, and any withdrawal or rescission of a discharge request, when the guardian is present and actively involved in care.
- Provide a clear written notice at admission that explains parental rights and the limits of minor self-consent under Pennsylvania law.
- Ensure that the individual is directly evaluated by a licensed behavioral health professional, and not solely by an intake coordinator or other administrative staff member.
- Document the criteria used for admission and obtain signatures from both the clinician and the guardian.
- Notify the parent or guardian within one hour of any admission, transfer, or request for medication change.

Clarifying these expectations would help prevent fear-based retention of minors and ensure that "age 14 consent" is not used to exclude families from decision-making.

§ 5250.51 Resident Rights and Visitation Policy (p. 42)

Clarify Visitation Transparency and Consider Audio Monitoring for Safety

The regulation appropriately outlines resident rights and visitation policy; however, it may be helpful if OMHSAS also considered how families and patients can safely verify and report interactions during supervised visits. Current policy prohibits any form of audio recording, and most facilities require visitors to lock personal belongings, including phones, in secure lockers before entering visitation rooms. This practice protects privacy but leaves families without an objective record of communication—particularly when conflicting reports arise.

Please consider allowing:

- Secure, time-stamped audio monitoring in visitation areas to protect both families and staff, ensuring privacy while providing verifiable accountability.

In my family's experience, as the parent of a 201-admitted minor, I was told that if I attempted to discharge my child at the expiration of his 72-hour notice, law enforcement would be called, I would be arrested, and my child would be reclassified under a 302 involuntary hold, actions that would have lasting consequences. Such statements go unchecked because no recording is allowed, giving facilities unilateral control over the narrative.

§ 5250.53 Discharge Planning and Continuity of Care (p. 45)

Ensure 24/7 Licensed Professional Access and Fair Discharge Rights

The regulation establishes the importance of continuity of care but could be strengthened by clarifying discharge procedures over weekends and holidays. It may be helpful if OMHSAS ensured that patients are not held simply because their treating psychiatrist is “off until Monday.”

Please consider requiring providers to:

- Maintain continuous access to licensed behavioral-health professionals—not solely administrative or overnight staff—capable of authorizing discharge or medication review.
- Document continuity between weekday, overnight, and weekend shifts.
- Implement real-time supervisory review of medication and restraint decisions, including weekends and holidays.
- Allow discharge authorization by any licensed behavioral-health professional on duty, not exclusively the primary physician.

This would help prevent unnecessary delays and uphold patient rights under voluntary 201-admission standards.

§ 5250.71–§ 5250.73 Quality Management and Performance Improvement (pp. 88–91)

Increase Transparency Through Real-Time Data and Public Reporting

Sections 22–24 and 71–73 outline internal quality management but could further strengthen public confidence through data transparency and timely record access.

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Please consider requiring providers to:

- Submit quarterly public reports summarizing restraint use, family-notification times, and 30-day readmission rates.
- Maintain certified electronic medical record (EMR) systems that provide patients and guardians real-time access to treatment notes, medication orders, and updates.
- Prohibit facilities from delaying or denying access to records by citing “paper-only systems” or withholding until discharge or physician sign-off.
- Publish compliance findings and sanctions on a public-facing dashboard.
- Provide families with copies of incident or debriefing reports upon request.
- Require EMR systems to timestamp all entries and edits to ensure accountability and prevent retroactive documentation.

Access to accurate, current information is an essential form of trauma-informed transparency. It helps families advocate before harm occurs rather than after. In my case, repeated denial of record access under the claim “we don’t have a portal” prevented early intervention and allowed overmedication and misdiagnosis to go unchecked. Real-time transparency could have prevented long-term damage.

Fiscal Impact (Regulatory Analysis Form, p. 118)

Balance Cost and Accountability

The Regulatory Analysis Form estimates \$35 million in local-government costs for 24/7 coverage. While significant, this investment directly supports patient safety and public trust.

Please consider establishing:

- A waiver process allowing rural or small providers to subcontract medical or laboratory functions rather than duplicating infrastructure.
- Protections to prevent large corporate operators from displacing county-based, family-driven programs.
- Funding adjustments tied to measurable improvements in patient outcomes, not only compliance metrics.

This approach balances fiscal responsibility with genuine reform.

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Implementation Timeline (p. 147)

Establish a Standing Stakeholder Panel

Please consider including:

- Representation from OMHSAS, licensed medical professionals, parents, youth with lived experience, and independent advocates to review outcomes annually and propose amendments.

The Real Benefit of Reform

True trauma-informed crisis care is prevention, not burden. When individuals in crisis feel heard, respected, and stabilized at first contact, the system prevents countless downstream costs in law enforcement, hospitalization, and state-funded programs. This is compassionate governance and sound fiscal policy.

With these proposed clarifications, OMHSAS can help ensure Pennsylvania's behavioral health system is not only compliant but also credible, humane, and protective of the families it serves.

Thank you for the opportunity to contribute and for your commitment to meaningful reform.