

Mobile Response & Stabilization Services

Peer Curriculum:

DAY 2

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Day 2 Agenda

- Adapting Clinical Best Practices and Strategies and What's Next in the Evolution of MRSS: CT and NJ
- Facilitated Individual Team Meetings:
 - Part I: Work on Identified Objectives
 - Working Lunch
 - Part II: Identifying Next Steps and Actionable Goals
- Report Out, Wrap Up and Next Steps

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President & CEO
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Connecticut's Mobile Crisis Intervention Clinical Best Practices



Best Practice Components

- Crisis defined by caller
- Clearly defined goals and outcomes
- Robust staffing
- Ongoing outreach and education activities
- Good working relationships with: Emergency departments, schools, foster care, law enforcement and other key stakeholders
- Core intervention skills
- Annual workforce development and standardized training activities
- Routine reporting, data analysis and ongoing quality improvement
 - Annual quality improvement plan

Accessing Mobile Crisis

- Why provide a mobile response vs. telephone?
 - Crisis situation and mobile response might be **first system introduction**
 - Making a **face-to-face connection, assessing strengths and needs in person**
 - **Addresses access barriers** that impact disadvantaged populations
 - Mobile response facilitates being a **resource not just to the family, but to the community**

Staffing

- 170+ full and part time/per diem clinicians statewide
- Most Mobile Crisis teams housed within large community-based mental health clinics with full service array
- Clinicians are typically master level (MSW, LPC, or LMFT), licensed (or license-eligible) clinicians
- .50 to 1.0 FTE directors at each site (MA or doctoral level)
- Each contract includes capacity for psychiatric consultation and medication management
- Family partners used on some teams, primarily for parent engagement and follow-up
- Team responses are preferred, but less likely to occur as volume has increased over time



Child & Family and Provider Goals

Child and Family:

1. Stabilize the presenting crisis
2. Promote/enhance emotional and behavioral functioning
3. Link to existing provider or facilitate linkage and transfer to appropriate services and supports
4. Empower children and families to monitor, manage and cope with situations that may lead to further crises

Provider:

1. Deliver behavioral health crisis-oriented services that are highly mobile and responsive to child and family needs
2. Provide appropriate screening, early identification and assessment of suicide risk, trauma exposure, substance use, exposure to and risk of violence, eating disorders and other clinical presentations
3. Include family members and informal supports in all aspects of the planning and treatment process, whenever possible



System Goals

System:

1. Ensure that all children and their families have access to crisis, prevention, and intervention services and supports
2. Whenever possible, maintain youth in their homes and communities and prevent placement in restrictive care settings such as emergency departments, inpatient hospitalization and arrest/incarceration
3. Increase community awareness of behavioral health needs by providing prevention and treatment-oriented education and outreach to families, schools and communities

Available Services: Clinical

- **Mobile response** to homes, schools, EDs, community locations
- **Crisis stabilization**
- **Diversion from the ED, collaboration** with ED, inpatient hospitals, law enforcement intervention, schools
- Clinical **assessment** using standardized instruments
- **Follow-up services** for up to 45 days (and unlimited episodes of care)
- Access to **psychiatric evaluation** and medication management
- **Collaboration** with families, schools, hospitals, other providers
- **Referral and linkage** to ongoing care as needed

Available Service: Screening

- Standardized Assessment Measures
 - Uniform crisis intake assessment
 - Acuity assessment
 - Emergency Certificate
 - SAVRY
 - UCLA-PTSD-RI or Child Trauma Screen (CTS)
 - GAIN-SS
 - Eating Disorders Inventory
 - SBIRT (CRAFFT, S2BI)
 - Ohio Scales

Available Services: Outreach Activities

- Minimum 24 formal outreach activities per year for all providers
 - Priority will be given to schools, law enforcement, foster care providers and identified high volume referrers to local Emergency Departments.
- 52 outreach activities for those below the per 1000 service reach benchmark



Practice Model: Assessment - Phase One

- **Respond to the first call of a new episode of care**
 - Screen out inappropriate calls (i.e., transfer to 911, 211 Information Only)
 - Warm transfer to Mobile Response
 - 211 clinician response after mobile hours (follow up next mobile hours)
- **Provide First Mobile Response**
 - Non-mobile initial response (upon family request)
 - Deferred mobile initial response (upon family request)
 - Mobile Response
- **Determine Acuity Level**
 - High (face to face every 1-2 days)
 - Intermediate (face to face every 2-3 days)
 - Low (face to face 1 time a week)
 - Balance need for follow-up with new referrals



Practice Model: Crisis Stabilization and Transition - Phase Two

- Initial and ongoing crisis stabilization
- Review results of assessment measures
- Develop a Care Plan
- Address factors contributing to or maintaining the crisis
- Address trauma exposure and symptoms of traumatic stress
- Develop and review reactive and proactive crisis plans
- Ongoing acuity/risk assessment
- Refer for psychiatric evaluation as indicated
- Provide coordination of care
- Enhance motivation to participate in ongoing care
- Communicate with original referrer (as needed)
- Facilitate transition to ongoing services and supports

Supporting the Practice Model: Standardized Training

Core Modules – 1 (4x/year)

1. Crisis Assessment, Planning and Intervention
2. Traumatic Stress and Trauma Informed Care
3. Emergency Certificate Training
4. Assessing Violence Risk in Children and Adolescents

- **Parents are paid co-trainers and members of agency Quality Improvement teams**
- **Parents are also welcomed to take part in the in-house trainings**

Core Modules – 2 (3x/year)

1. 21st Century Culturally Responsive Mental Health Care
2. Disaster Behavioral Health Response Network (DBHRN)
3. An Overview of Intellectual Disabilities and Positive Behavioral Supports
4. Question, Persuade and Refer (QPR) (in-house training)
5. Strengths-Based Crisis Planning
6. Columbia Suicide Severity Rating Scale (C-SSRS) (Online training)
7. Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT)(in-house training)
8. Autism Spectrum Disorder (added in FY2018)



Supporting the Practice Model: Annual Quality Improvement Plan

- Contractor will identify:
 - Areas of strength supported by data
 - description of internal practices used to achieve successes
 - shared with DCF and when combined with that of other contractors, forms "best practice" approaches
 - A minimum of two areas of practice in which improvement is needed.
 - Also be supported by data
 - consistent with what DCF has identified as priority practice issues
 - Plan should articulate strategies that the Contractor believes will have a positive effect on the identified areas
 - A Data Quality Monitoring process that ensures that data entry is efficient, effective and minimizes the possibility of data errors. The process will include the review of critical data at least weekly if not daily.



Research and Innovation

Impact of Mobile Crisis on ED Utilization

- Funded by The Children's Fund of Connecticut, with additional funding from DCF, and technical support from Beacon Health Options
- Study conducted by Dr. Michael Fendrich and colleagues at University of Connecticut School of Social Work

- Mobile Crisis data merged with Medicaid claims data
- Propensity score match to construct comparison sample (non Mobile users)
- ED utilization during 18 month follow-up period
- **Mobile Crisis users had 25% lower ED utilization than comparison sample**

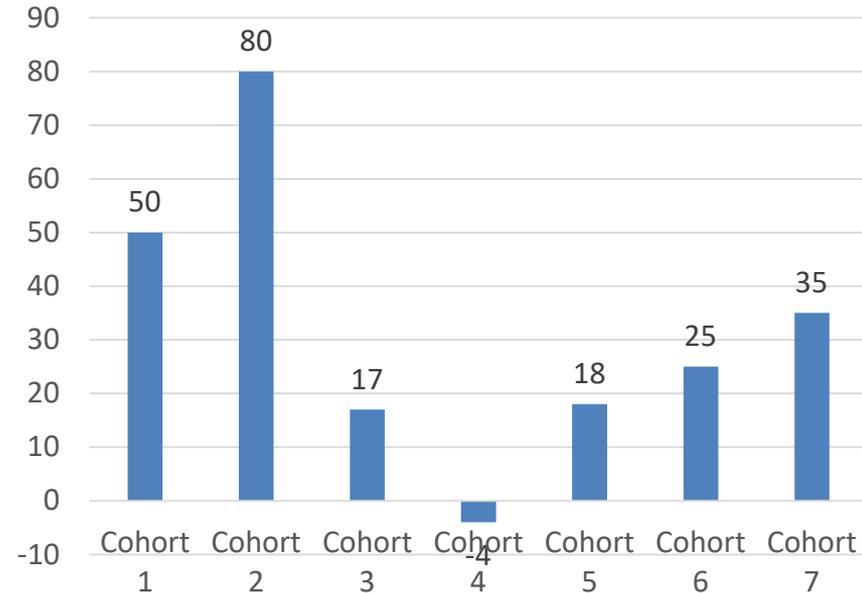
- Among Mobile Crisis users, the following factors increased risk of ED use:
 - Prior ED/inpatient use; # prior Mobile episodes; White, non-Hispanic; Adjustment Disorder Dx; lower Functioning rating (Ohio Scales); higher Problem Severity rating (Ohio Scales); shorter Mobile length of stay

Research and Innovation

The School Based Diversion Initiative

- Initially funded by MacArthur Foundation grant
- Implemented in nearly 40 schools since 2009
- Core elements include:
 - Professional development for school personnel
 - Disciplinary policy and practice revisions (e.g., graduated response)
 - **Crisis stabilization via Mobile Crisis**
 - Linkage to ongoing supports and services (e.g., restorative practices, youth service bureau, clinical services (outpatient, intensive in-home services))
- www.ctsbdi.org

Percent Reduction in Juvenile Court Referrals



Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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Wyndee Davis

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New Jersey Children's System of Care

The Evolution of MRSS: What Is Next for NJ



NJ MRSS Mission and Goal

Mobile Response and Stabilization Services (MRSS):

- Help youth and their families who are experiencing an emotional or behavioral stressor by interrupting the family-defined crisis and ensuring youth and their families are safe and supported.
- Provide on-site assessment, intervention support and skill building necessary to stabilize a youth's behavior towards improved functioning, living situation stability and community involvement.
- Collaborate across youth-serving systems to support youth and family engagement and coordinate supports to help youth and families feel better.

Populations

Integrating Care for Individuals With:

- Intellectual / Developmental Disabilities
- Substance Use Challenges
- Physical Health

Trauma-Informed Care

- Departmental Initiative
- Do not focus on “surface behavior”
- Interventions should address underlying trauma reaction
- Implicit trauma indicators
- Safe, consistent, nurturing environment at all system levels
- Promising Path to Success-SAMHSA SOC Expansion Grant
 - *A statewide initiative that combines the evidenced based approach of Six Core Strategies® with the Nurtured Heart Approach® to build inner wealth in youth and families while supporting system partners in creating safer & more trauma informed environments*



NJ's Trauma Informed Care

Promising Path to Success - NJ's SOC Expansion Grant

- Six Core Strategies©
- Nurtured Heart Approach®
- Youth Partnerships
- Return on Investment

Six Core Strategies© To Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint

1. Leadership toward organizational change
2. The use of data to inform practice
3. Workforce development
4. Full inclusion of individuals and families
5. The use of seclusion and restraint reduction tools, which include the environment of care and use of sensory modulation
6. Rigorous debriefing after events in which seclusion and restraint might have been used

Nurtured Heart Approach®

- Intense youth have learned that they get more connection from adults when things are going wrong (using their **intensity** in negative ways)
- Create new **portfolios** that are energetically aligned
- Build **inner wealth** in youth
- NHA asks us to alter our lens, create first hand experiences of success, & make miracles out of molecules



NJ's Trauma Informed Care

NJ CSOC quality drill down of data for youth in foster care who required out of home treatment due to behavioral challenges experienced in care recognized that MRSS was not utilized as designed with child welfare partners:

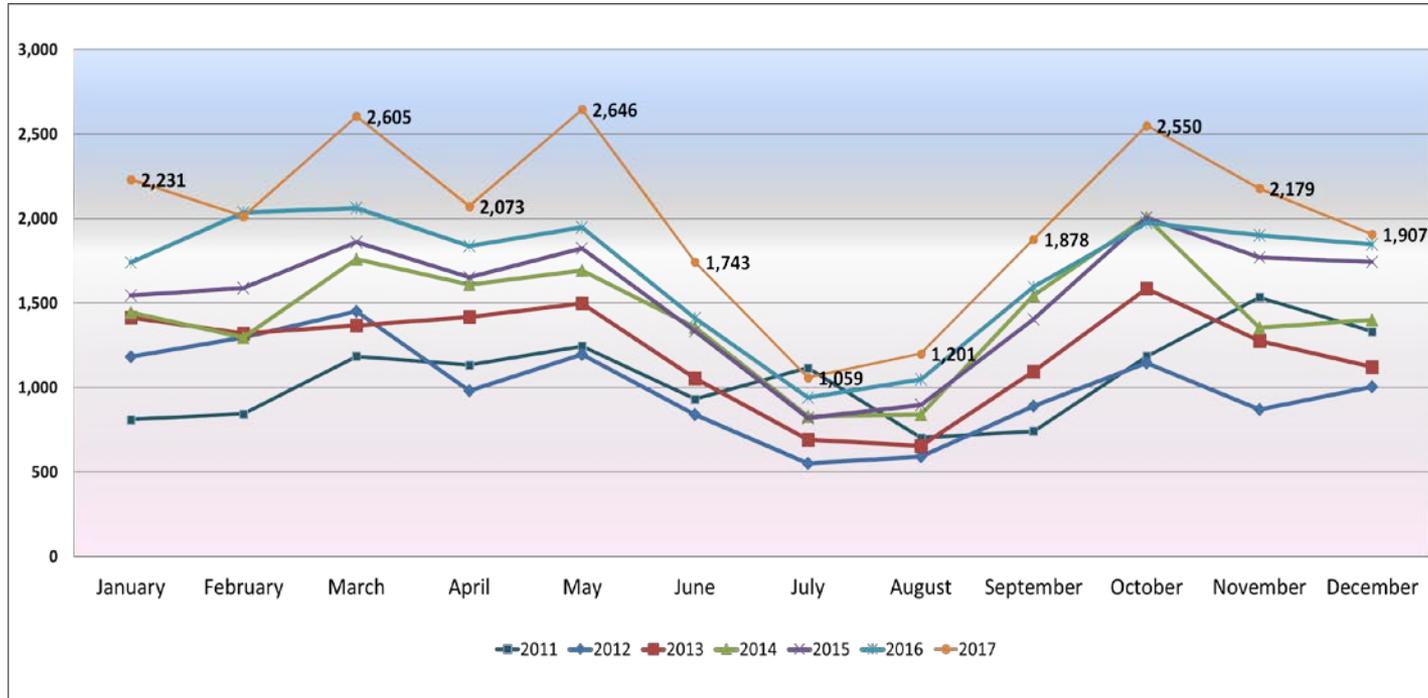
- Shared the data with DCF leadership
- Engaged in discussion regarding barriers
- Provided training and support to system partners
- Developed and implemented a pilot to address the issue
- Reviewed the results of the pilot and now are implementing strategies statewide

CSOC continues to monitor the impact of this practice change.

NJ's Trauma Informed Care (cont.)

- Strengthening Supports for Youth Involved with Child Welfare
 - MRSS/Child Welfare Project
 - Functional Family Therapy -Foster Care (FFT-FC)
- Attachment, Regulation, Competency (ARC) Grow
- Ensuring MRSS connection to acute care is supportive to families, systemically and on an individualized basis
- FCIU and Station House Adjustments

MRSS Dispatch Data

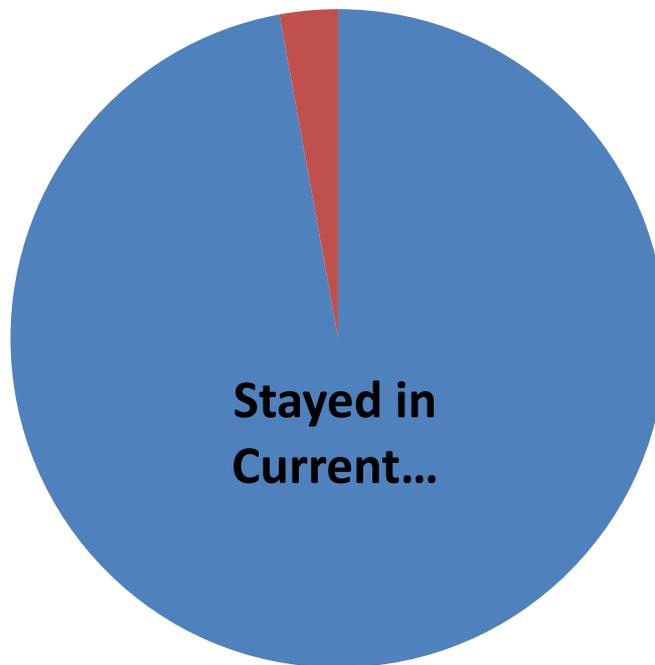


NJ's Mobile Response and Stabilization Services

12/1/2017 through 12/31/2017

(n = 2,439)

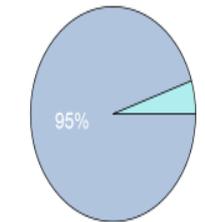
Did not stay
in Current...



Stayed in
Current...

MRSS Data

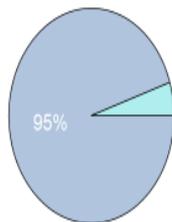
CY 2014



■ Remained in Current Living Situation
■ Changed Living Situation

Total Assessments	Remained Count
34,530	32,806

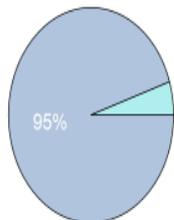
CY 2015



■ Remained in Current Living Situation
■ Changed Living Situation

Total Assessments	Remained Count
37,593	35,756

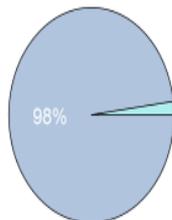
CY 2016



■ Remained in Current Living Situation
■ Changed Living Situation

Total Assessments	Remained Count
38,693	36,863

CY 2017



■ Remained in Current Living Situation
■ Changed Living Situation

Total Assessments	Remained Count
47,264	46,467

Since its inception in 2004, MRSS has consistently maintained 94 % of children in their current living situation, at the time of service, including children who are involved with the child welfare system. Families have reported high satisfaction with services, with a 250% increase in families accessing MRSS.

Thank You

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Facilitated Team Meetings: 10:45a – 2:00p

- **Session One (10:45a-1:00p – includes working lunch):**
 - Review your identified goals and objectives
 - Work with assigned faculty who will offer facilitation, support and targeted technical assistance related to your objectives
- **Session Two (1:00-2:00p):**
 - Work in your team with assigned faculty to identify:
 - Actionable goals and strategies to implement when you return home
 - Immediate and longer term TA needs

Faculty Team Meeting Assignments

Team	Faculty	Room
Osceola County	Stacy	
Louisiana	Ann & Jeff	
Muskegon County	Ruby	
Vermont	Sheamekah & Liz	
West Virginia	Wyndee & Dayana	