Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Mobile Response & Stabilization Services Peer Meeting
December 5-6, 2017
New Brunswick, NJ
Day 2
This peer small group meeting is hosted by the National Technical Assistance Network for Children’s Behavioral Health (TA Network), operated by and coordinated through the University of Maryland.

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Agenda: Day 2

- Adapting Clinical Best Practices and Strategies and What’s Next in the Evolution of MRSS
- Facilitated Individual Team Meetings
- Lunch (on your own)
- Facilitated Individual Team Meetings – Next Steps

MRSS Resource Material Library:
http://www.tanetworkmeetings.org/2017-mrss-resources
BEST PRACTICES AND NEW DIRECTIONS

Christopher Morano, Ph. D
Founding Director Emeritus, MUTT
Main Objectives

1. The importance of your staff:
   – Who to hire, how to help them be effective

2. Beyond CBT:
   – How to get really good at this

3. To hospitalize or not:
   – The right question

4. Technology:
   – Face it and embrace it

The future...
3 Big Ideas You Need to Know Before Starting

1. Your clients are everyone in the room:
   - Caregivers
   - Teachers
   - Other treatment staff
   - Law enforcement
   - Etc.

2. Stop saying “crisis” in a crisis:
   - Looking at something differently IS a strategy
   - If you change your thinking about a thing, you change that thing

3. Crisis response is NOT all about content, words, planning...
   - And it’s not even close...
Beginning a Program

• Understand your community – who are your stakeholders?
  – Meet with them, find out their needs
  – Make it clear you need and want to partner with them
  – Include families!
• Develop a mission statement (i.e. your intent for your community)
• Hire staff
  – Train them... but more importantly...
  • Guide, support, supervise regularly, encourage, role model for them, recognize THEIR needs!
  • Make routines for them (more on this later)
• Establish expectations, expected outcomes – Key
What is “Crisis Intervention?”

- A lifeline
- Emotional CPR
- Psychological First Aid (PFA)
- A strategy and service on the continuum of help
Crisis Intervention is Not a Math Equation…

• It is 1000, sometimes barely perceptible, interpersonal reactions/interactions subtly influencing each other, in one moment.
• It is “heart math”...it’s emotional, and...
• There is no one clear roadmap, as the actual road never really reflects the roadmap..

The important common factors in any therapeutic endeavor are universal, irrespective of the “model” one adopts, and includes “soft” non-clinical skills—empathy, presence, encouragement, respect, hope. - Frank (1973)
And Because Anxiety Rules the Day...

2014 World Health Organization (WHO) study shows anxiety disorders worldwide are 2x that of depression and more than any other mental health issue.
Hiring Staff:
What We Say We Want Vs. What We Really Want

- “Works with diverse populations”
- “Available flexible hours”
- “Explains ideas clearly”
- Knowledge of community resources
- Knows emergency laws
- “Effective interpersonal relationships…”
- Knows steps of de-escalation

- Calm in a crisis
- Non-judgmental
- Persistent – won’t give up
- Hopeful
- Strengths and solutions
- Big picture
- Outside of “self”
- Tolerant
- Exudes hope
Staff Needs

- Resilience, perspective and persistence

- “What’s in it for me?”
  - Hint: You’d better notice the small rewards...

- Using staff meetings, ritual and relying on each other

- Take care of yourself first
LASSIE!
GET HELP!!!
OK, Let’s Talk About Barriers: Burnout

• Hack into your own subconscious
• Elucidate your motives, wishes, fears, intentions
• Crisis/safety plan for yourself (if you haven’t already) – It’s about what works for you
• Trust and believe in your team
Crisis Work is Especially Hard on Staff

• Leadership really needs to ensure staff are healthy, balanced and get along.

• This puts them in a much more favorable place to help others.
Beyond CBT: The X-factor in Crisis Intervention

Engagement!
(The FBI’s secret to hostage situations and more = empathy and banter)
Begin With Engagement: Crush the 15 Feet

- Be in a good place (i.e. balanced, healthy)
- Feel the joy in your job
- “No Contempt Zone”
- Know you’re not alone
- Body language – to smile or not to smile?
- Resistance? Empathy and motivational interviewing
- Start with strengths
- Assume family wants to move forward
And When Responding, There’s Theory (Looks Easy Doesn’t It?)…

• Contact, establish relationships
• Define problem - assess dangerousness
• Explore past coping strategies
• Generate alternatives
• Develop and implement action plan
• Follow up
Then There’s Practice

• Crisis intervention is MUCH harder to do in real life (because of your “lizard brain!”)

• In a crisis, it is very hard to simply “follow the plan” that was written in a calm moment
  – In a “hot moment” families just want someone there who can take down the temperature in the room
Trauma Informed Crisis Intervention

• Impact of trauma comes out when emotions, stress are high

• Neurosequential Therapeutic Assessment and response

• Uses repetition of soothing multimodal strategies, like music, dance, physical activities, movement, etc.

Trauma Informed Care (Perry, 2009)
Hospitalization: Statutes and Medical Necessity Protocols Have Been Written Wrong So Far

• They all ask the wrong questions and focus on the wrong things.
• Almost invariably simply set “standards” for admission/detention.
• The key question is not about dangerousness, it’s **knowing the risks**: “*what would it take to keep this child safe in the community tonight/tomorrow?*”
Because It’s About Needs and Safety Planning, NOT About “Meeting Criteria”

• **Don’t** make it about whether someone does or doesn’t “meet criteria”
  – Puts focus, and the question on how spectacular, serious, significant the recent or past behavior was
  – Encourages escalation to convince that youth has “done enough” to justify hospitalization

• **Do** make it about safety and needs:
  – This discussion acknowledges risk behavior, but centers on reducing risk through strategies and a plan
  – Can we keep this person, and others, safe, with this plan?
  – Critical question is “what would it take to safely get this person through the next hours, day?”
Apps and Social Media: For Better or Worse...

- Teens are more likely to turn to social media, texting for support than to call a help or hotline
- Phones, texts set off powerfully addictive responses in the brain
- Texting is private and many kids find it easier to disclose
- They look like they’re just doing something normal – important to teens
- E.g., National Dating Abuse Hotline; National Human Sex Trafficking Center – both accessible by text = used often!
Social Media and Suicide Prevention: Help from Facebook

https://vimeo.com/160565004
CTL: The Crisis Text Line

What’s the Next Evolutionary Step?

• Yale Child Studies Center Model:
  – Law enforcement and mental health collaborate in response to community trauma involving kids
  – Emphasis is on training parents, caregivers as first responders in trauma, to lower risk of PTSD

• FAMILIES FIRST!
The “New” Science of Post Traumatic Growth: Trauma Does NOT Mean Permanent Pathology and Damage

Mild to Moderate Stress:
• Stanford University
• University of Buffalo

*Just like exercise, everyday stress, when manageable, is good for growth*

**But even severe stress can lead to growth:**
• Harvard, Hurricane Katrina and variants in the RGS2 gene
• Sarah Lowe, Montclair State University - importance of optimism and future orientation

**UPSIDE (Jim Rendon):**
• Only a small % get PTSD
• The 6 Essentials:
  – Your narrative makes/breaks
  – Community/support vital
  – Express yourself - communication of all types
  – Transformative power of Optimism
  – Faith can enhance growth
  – Creativity spurs change - Open up to new experiences
Because All Is Not Lost, Even in Trauma...
A Couple of Key Things to Keep in Mind...

Growth from trauma

Families are key
Let Me Leave You With This…

• Katiana, the South Bronx and tiny, significant things
• Helen Keller
• Do a small thing nobly...
THE EVOLUTION OF MRSS: WHAT IS NEXT FOR NJ

Elizabeth Manley
Assistant Commissioner
NJ Children’s System of Care
MRSS Dispatch Data

MRSS Service Dispatch Data (All Youth)
2011 - November 2016

Section 5: Page 3
NJ’s Mobile Response and Stabilization Services

9/1/2016 through 9/30/2016

( n = 1,064 )

Stayed in Current Living Situation
94%

Did not stay in Current Living Situation
6%
The Data Tells the Story of What Is Next

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

- We shared the data with DCF leadership
- Engaged in discussion regarding barriers
- Provided training and support to our 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 New Focus

• MRSS Child Welfare Project

• Promising Path to Success

• ARC Grow
Promising Path to Success

- NJ’s SOC Expansion Grant:
  - Six Core Strategies©
  - Nurtured Heart Approach®
  - Youth Partnerships
  - Return on Investment
New Populations

- Individuals with intellectual/developmental disabilities
- Substance Use Disorders
Questions???
CONNECTICUT’S MOBILE CRISIS INTERVENTION CLINICAL BEST PRACTICES

Adora Harizaj, B.S
Project Coordinator
Child Health & Development Institute of Connecticut

Tim Marshall, L.C.S.W.
Clinical Manager
CT Department of Children and Families
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
• .5 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
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
Goals (cont.)

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

- **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
Practice Model: Assessment (Phase One)

- Responding 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)

- First Mobile Response
  - Non-mobile initial response (upon family request)
  - Deferred mobile initial response (upon family request)
  - Mobile Response

- Acuity levels
  - 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: Assessment (Phase One) cont.

- 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
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
# 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)
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
Annual Quality Improvement Plan (QIP)

• Contractor will identify:
  – Areas of strength supported by data, i.e. areas of practice that the Contractor believes are being accomplished in the most beneficial way possible. In addition, the Plan will include a description of the internal practice the EMPS provider uses to achieve these successes. This information will be shared with DCF and when combined with that of other contractors, will form a "best practice" document;
  – A minimum of two areas of practice in which improvement seems needed. These areas should also be supported by data, and should be consistent with what the Department has identified as priority practice issues. The Plan should articulate strategies that the Contractor believes will have a positive effect on the identified areas; and
  – 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.
Facilitated Team Meetings

• Session One (11:30a-1:00p):
  – Review your identified objectives
  – Work with assigned faculty who will offer facilitation, support and targeted technical assistance related to your objectives

• Session Two (2:00-3:30p):
  – 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

- Alaska: *Ruby and Jessica*
- Colorado: *Chris and Stacy*
- Georgia & South Carolina: *Tim & Adora*
- Indiana: *Liz and Dayana*
- Kansas: *Jennifer and Wyndee*
- Tennessee: *Bruce*