Expanded Mobile Response & Stabilization Services Peer Meeting: DAY 2

MAY 23-24, 2018
PISCATAWAY, NJ

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Day 2 Agenda: First Time Participant Teams

- 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
- Joint Wrap Up and Next Steps

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<tr>
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# Alumni Track Meeting Rooms

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Connecticut’s Mobile Crisis Intervention
Clinical Best Practices

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.
Milwaukee’s MRSS System
Lessons Learned, Best Practices and New Directions

Bruce Kamradt MSW,
Administrator Emeritus, Wraparound Milwaukee

Chad Meinholdt LCSW,
Director of Community Centers, Milwaukee County Behavioral Health Division
Lessons Learned From A System Of Care Perspective

• Mobile Crisis:
  – First component of our system of care developed because of need to reduce inpatient hospital and other institutional care
  – Allowed redirection of saved monies (“Gatekeeper Function”)

• Advantageous to integrate Mobile Crisis with the Wraparound Milwaukee system of care because it works so closely with the care coordinators and child & family team in developing and supporting crisis/safety plans

• Challenging to integrate the Children's Mobile Crisis team with the county’s adult crisis programs due to different goals, philosophy and operations.
  – That is changing with some new leadership in Adult Crisis
Lessons Learned from System of Care Perspective (cont.)

• Must have an array of crisis stabilization services (i.e. in-home stabilizers, crisis beds, etc.) to support crisis plans and alternatives to out of home care

• Need good relationships with inpatient psychiatric facilities including Memoranda of Understanding (MOU) to avoid arguments over medical necessity

• CMC has probably the highest visibility of any piece of the SOC - high name recognition

• Been critical to partner with child welfare, juvenile justice, courts, schools, police and advocacy groups to get buy-in and support and to expand new service models.

• Need to integrate mobile crisis team notes and plans with care coordinator notes, plans of care in one electronic health record
Hiring Staff: What we say we want v. 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
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.
What Is *Crisis Intervention*?

- A lifeline

- Emotional CPR

- Psychological First Aid (PFA)

- A strategy and service on the continuum of help
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
The X-factor in Crisis Intervention

**Engagement!**

The FBI’s secret to hostage situations, and more = *empathy and banter*
Hospitalization:

Statutes and Medical Necessity Protocols Often Focus on Wrong Thing:

• They all ask the wrong questions
• Almost invariably there are 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 “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 hospital

• **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?”
New Directions in Expanding Child Mobile Crisis (CMC)

TRAUMA RESPONSE TEAM (TRT)

– Milwaukee Police Dept. and Wraparound Milwaukee CMC team joint venture to respond to children in the community that have been exposed to community or domestic violence or stressful experiences

– Emphasis is on training parents, caregivers as first responders in trauma, to lower risk of PTSD

– Funded by City of Milwaukee-$200,000
Crisis Assessment and Response Team (CART)

- Partnership between law enforcement and crisis services
  - Started with adult team and planned expansion to youth
- Co-responder program comprised of clinician and officer dyad responding to calls where police intervention may be needed
- Officers receive Crisis Intervention Training (CIT) and one month of additional crisis training with Milwaukee Crisis Services
- Funded through Milwaukee County and police departments
- Goal to reduce involuntary detentions, stigma, use of force, increase service linkage
- 90% of people served in 2017 stabilized in the community or voluntarily received treatment
  - Over 1200 calls and 600 face to face assessments 1/1/2017 – 12/31/2017
Coordinated Opportunities for Recovery and Empowerment (CORE)

- CORE team supports youth/young adults who have experienced their first episode of psychosis
- Part of CMC team
- Five-person team blending care coordination, therapy, supported employment/educational support, peer support, and medication management
- Serves youth/young adults 12-24
- Strength-based, individualized service planning
Proactive Outreach for Sexually Exploited Youth (POSEY)

• 1 in 12 adolescents seen by CMC have been victim of sexual exploitation
• 33% of all trafficking victims are children
• Average age for entry for boys is 11-13, for girls it’s 12-14
• Mental health issues: PTSD, aggression, suicide, trauma
• POSEY develops appropriate screening tools to identify victims, specialized crisis mentoring, drop-in center operated by Wraparound Milwaukee
• Health care clinic co-located with CMC
Youth Living Out Loud Mentoring Program

- Mentoring program focused on serving sexually exploited children
- Specialized training in the topics of sexual exploitation, medical and legal protocols, trauma informed care, and warning signs
- Mentor Action Plan developed to support the goal of the youth and ensure their voice is heard
- Partnership with community crisis stabilization agency, medical college, Rethink Resources (training and consultation), and LGBTQ resource
- Initial funding provided by Office of Juvenile Justice and Delinquency Prevention
Expanded Use of Peer Support

- Increased utilization of Certified Peer Specialists on crisis teams
  - Engage youth in their care and recovery
- Parent Peer Specialist Model
- Young Adult Peer Specialists share lived experience and mentor youth
- Learn from adult models:
  - Community Linkages and Stabilization Program (CLASP)-community based program for adults
  - Peer Run Respite Initiative
  - Peers in stabilization house, crisis resource centers, and inpatient units

Peer support is a Medicaid reimbursed service and part of the system of care
Discharge Follow-Up Team (Team Connect)

- Team comprised of clinician and Certified Peer Specialist
  - started in adult crisis services and expanding to youth team
- Follow up with people at discharge from ER, inpatient units, and observation unit
  - follow up 24 hours via phone following discharge
- Includes:
  - Zero Suicide* initiative screening (PSQ-9 and Columbia)
  - mobile crisis response
  - linkage to service
  - services based on individual needs
- Goals are to:
  - reduce recidivism and self harm,
  - increase post discharge follow up care
- Expanded to 4 teams based on utilization and needs of the people being served

* https://zerosuicide.sprc.org/
Future Direction

• Integration of all crisis services - adult and youth teams
  – one integrated team to increase efficiencies
  – clinicians with additional, specialized training in working with specific populations (adults, youth, IDD, geriatric, substance use, law enforcement)
• Set expectations across team for quality, productivity, training, supervision, etc.
• Increase revenue and staff productivity (areas of overlap)
• Integrate best practices into one team
• Explore new service areas and expanding use of peer support
• Focus on serving and collaborating
• 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!
CTL: The Crisis Text Line

Social Media and Suicide Prevention:

https://vimeo.com/160565004
The Evolution of MRSS: What Is Next for NJ

Wyndee Davis
Assistant Director
NJ Children’s System of Care
MRSS Dispatch Data
NJ’s Mobile Response and Stabilization Services

12/1/2017 through 12/31/2017
(n = 2,439)

- Stayed in Current Living Situation: 97%
- Did not stay in Current Living Situation: 3%
Integrating Care for Individuals With:

- Intellectual /Developmental Disabilities
- Substance Use Disorders
Promising Path to Success - NJ’s SOC Expansion Grant

• Six Core Strategies©
• Nurtured Heart Approach®
• Youth Partnerships
• Return on Investment
NJ’s Trauma Informed Care: Youth in Foster 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

- 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 Trauma Informed Care

• Strengthening Supports for Youth Involved With Child Welfare
  – MRSS/Child Welfare Project
  – Functional Family Therapy -Foster Care (FFT-FC)

• ARC Grow

• Ensuring MRSS connection to acute care is supportive to families, systemically and on an individualized basis
Facilitated Team Meetings

- **Session One (10:30a-12:00p):**
  - Review your identified objectives
  - Work with assigned faculty who will offer facilitation, support and targeted technical assistance related to your objectives

- **Session Two (1:15-3:00p):**
  - 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
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Wrap Up and Next Steps