Mapping the Crisis System of Care

Disclaimer

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Learning Objectives

- Participants will be able to articulate the ideal behavioral health crisis services continuum for all people.
- Participants will understand how to more efficiently and effectively meet the behavioral health needs of those in crisis, while diverting and reducing the number of individuals in need of emergency department care.
- Participants will learn how to incorporate best practice crisis continuum customizations to meet the needs of adult populations.
- Participants will learn how to incorporate best practice crisis continuum customizations to meet the needs of child, youth, and family populations.

Welcome to the Accident Room

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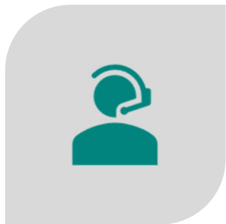
Crisis Services Provided by the Emergency Department

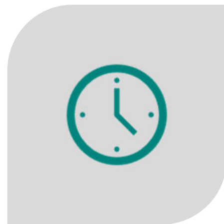
SCREENING

ASSESSMENT

MEDICATION STABILIZATION

MEDICAL CLEARANCE

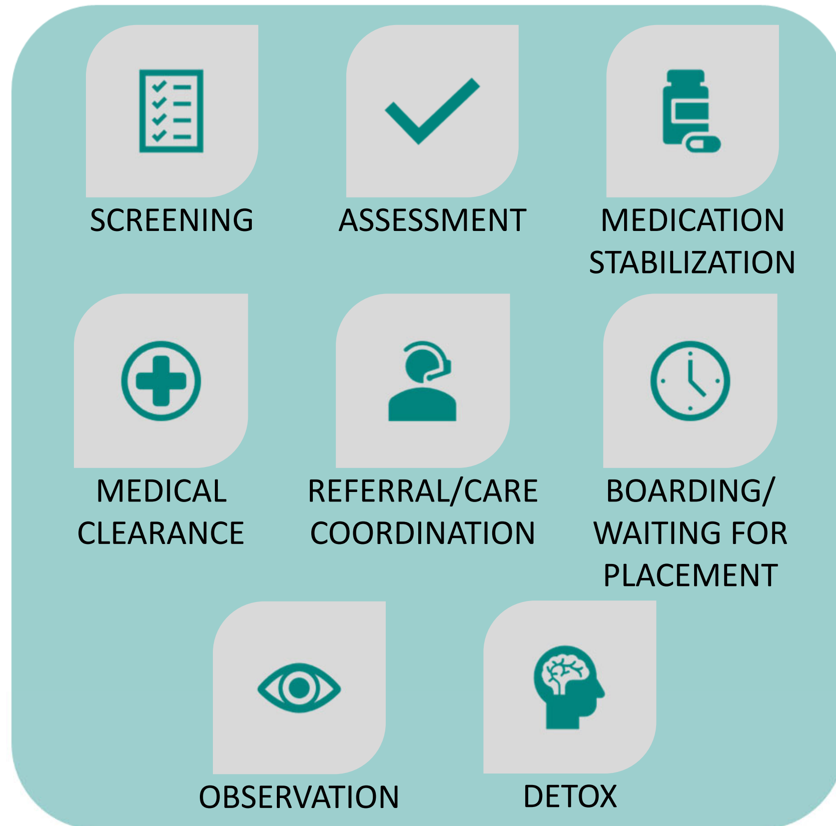

REFERRAL/ CARE COORDINATION


BOARDING/ WAITING FOR PLACEMENT

OBSERVATION

DETOX

Emergency Departments Provide these Crisis Services…



…But Don't Provide These Crisis Services

Why Change?

Emergency Departments (ED's) are often overcrowded and costly while also reporting being ill-equipped to address persons in mental health crises.

Defining Mobile Crisis

Mobile crisis team services offer a community-based intervention to individuals experiencing a behavioral health (BH) crisis wherever they are located.

Mobile crisis team services:

- Help individuals experiencing a crisis event to experience relief quickly and to resolve the crisis when possible.
- Meet individuals in an environment where they are comfortable.
- Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

Mobile Crisis as an Alternative

Mobile crisis services provide triage/screening, assessment, de-escalation/resolution, peer support, coordination with medical/Behavioral Health (BH) services, crisis planning and follow-up all in the community where the person is located.

Mobile crisis interventions provide individuals with less restrictive care, in a more comfortable environment, and can help to reduce ED utilization.

Mobile crisis teams work collaboratively with individuals in crisis to resolve their situation, so a higher level of care is not necessary.

Why a Community Based Response is Important

There are many aspects of traditional crisis response systems that can be traumatizing or retraumatizing for youth, adults, and families.

Out of home placements	Physical restraint	Experiences or fears of being harmed by law enforcement

Individuals experiencing a behavioral health crisis have experienced **iatrogenic harm**, the harm inadvertently caused by the process of treatment.

Common places where iatrogenic harm has been experienced include:

Emergency departments	Psychiatric hospitals	Poorly operated crisis services

Mobile Crisis

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DETOX

DE-ESCALATION

PEER SUPPORT

CRISIS PLANNING

WARM HANDOFF

EXTENDED OBSERVATION

DESIGNED FOR BH

MILIEU THERAPY

RECOVERY ORIENTED

Defining 23-Hour Observation

23-hour observation provides a safe & secure space with the capacity for ongoing evaluation, observation, & intervention by a multidisciplinary team for up to 23 hours during the acute phase of the crisis.

This service is available for all individuals who need it, regardless of age. Services are available for voluntary & involuntary individuals, & for individuals with intoxication.

23-hour observation has the capacity to initiate rapid assessment, crisis intervention, and transition planning to help persons served routinely stabilize & connect to the next appropriate service.

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23-Hour Observation as an Alternative

- **Effective crisis evaluation and planning takes time**
  - Observation units provide a safe space and adequate time for an effective crisis evaluation to be completed.
- **During a crisis, an individual's clinical presentation can be fluid**
  - Observation units allow the team adequate time to observe the individual’s clinical presentation, intervene, and avoid unnecessary hospitalization or inappropriate discharge.
- **Individuals in acute decompensation may need further evaluation**
  - Observation units allows individuals in crisis and those decompensating due to acute symptoms of mental illness to receive more thorough evaluation and treatment prior to determining the next step.

Location of 23-Hour Observation

- The location of 23-hour observation units **varies by community**, and ideally should be located outside a hospital setting.
  - The more crisis services are hospital-based the lower the percentage of people diverted from hospital admission.
- Common locations of 23-hour observation units include:
  - Freestanding buildings that are convenient for people served, and first responders.
  - Embedded in an emergency department.
  - Co-located with other crisis services, including behavioral health urgent care centers, crisis residential units, etc.

23-Hour Observation

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EXTENDED OBSERVATION
DESIGNED FOR BH
MILIEU THERAPY
RECOVERY ORIENTED

Defining Behavioral Health Urgent Care

BH urgent care centers provide access to a crisis response that does not initially require intensive or secure intervention.

BH urgent care centers have the capacity to engage and triage, prescribe medications, and link behavioral health and substance use clients with appropriate follow-up and community resources.

Individuals and families can access BH urgent care centers on their own or be directed to services through the call center or crisis line.

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BH Urgent Care as an Alternative

- BH urgent care provides a **valuable, cost-effective alternative** to ER utilization for BH crises, just as medical urgent care provides similar value for diverting individuals with urgent but non-emergent medical needs.

- BH urgent care serves as a **safety net** if a breakdown occurs in continuity of care; for example, a medication adjustment or refill is needed.

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Location of BH Urgent Care

- Most communities require multiple BH urgent care centers, due to population size.
- Communities should have the ability and flexibility to determine the location and distribution based on their unique needs and existing services array.
- BH urgent care centers can be freestanding or co-located with and/or embedded in other service settings.
  - Embedded in an existing physical health urgent care
  - Located in or proximal to a hospital emergency department
  - Co-located with a 23-hour observation unit
  - Embedded in an outpatient service setting

BH Urgent Care

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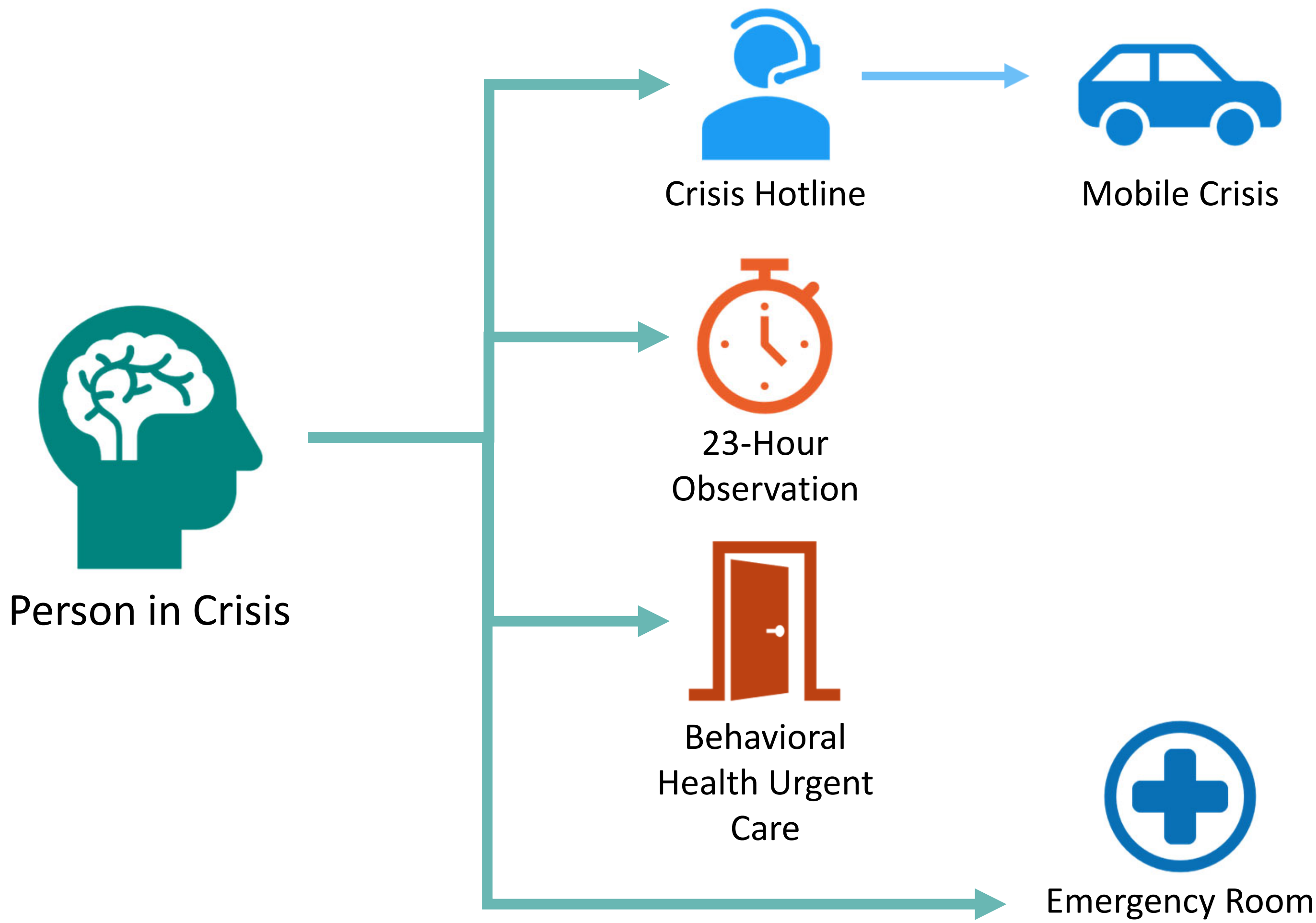
MILIEU THERAPY

RECOVERY ORIENTED



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We can maintain more children and adolescents at home and in the community with a more responsive behavioral health system

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Crisis System of Care should:

- Be responsive and validate parents/caregivers, children, youth and young adults
- Be responsive to major system partners: Education, Emergency Departments, Primary Care, law enforcement, Child Welfare, Juvenile Justice, Intellectual Disabilities/Developmental Disabilities, community providers and others
- Reduce inappropriate use of inpatient care
- Reduce inappropriate arrests- break the school to prison "pipeline" cycle.
- Reduce over-use of hospital Emergency Departments for Behavioral Health
- Coordinate with Emergency Departments
- Consistent response and improved accountability and quality
- Assess the "pain points" including overuse of law enforcement and too many school-based arrests should be treated as a crisis pain-point

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Potential or Partial Solutions to Reduce, Divert and Avoid ED

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1. More parents/caregivers, children, adolescents and young adults with lived experience to assist in developing the solutions
2. Mobile Response systems
3. Alternatives to Emergency Departments for behavioral health crisis assessments
4. More flexibility in walk-in outpatient clinics for crisis assessments
5. Crisis Care Coordination and High Fidelity Wraparound support to ED and areas of bottle neck in the system
6. Intensive In-Home services
7. Comprehensive Student Mental Health in schools
8. Reduce Racial and Urban Trauma-Urban Trauma Network

Potential or Partial Solutions to Reduce, Divert and Avoid ED

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Use your Statewide Family Organization

- In CT we use Family System Managers and our SOC grant:
  - Recruiting and supporting family and youth voice "to the table" for the crisis system of care
  - Building "Family Care Connections"
    - Increase collaboration between and among: Pediatric Primary Care, Behavioral Health Providers, and schools
  - Development of the "Green Form"
    - Pediatric Release of Information

Mobile Response Stabilization and Support Foundation of Crisis System of Care:

- Mobile Response Stabilization and Support (MRSS) is the first line of intervention, and is developed specifically for children, youth, young adults and their families
- Stabilizing the acute crisis and then assessing the needs of the family, including the caregivers, identified child and his/her siblings
- If the child or youth cannot be stabilized with a Mobile Response, every effort should be made to avoid the Hospital Emergency Department if possible - State or County jurisdictions should develop 23-hour crisis stabilization/assessment centers that are specifically designed to meet children and youth behavioral health need

Mobile Response System

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- Crisis call is not screened or triaged "just go" for face to face assessment
- Be Available: 24/7/365
- Be Highly Mobile: Go to where the youth is
- Be Responsive: Arrive within 60 minutes or less
- High Volume: Reach all in need
- Promote widespread community awareness that a rapid crisis response and stabilization is available
- Consistent, high-quality service

Maintain Child/Youth in Their Home

- Home with "crisis safety plan" and family support
- Home with crisis safety plan with caregiver-peer-support from family/friend/faith-based representative (unpaid)
- Home with crisis safety plan with caregiver peer support from professional (paid) peer support program
- Home with crisis safety plan and adolescent peer support for adolescent from family/friend
- Home with crisis safety plan with a community-based provider:
- Outpatient (or Intensive Outpatient) Treatment
- Care Coordination
- Intensive In-home Treatment (EBP)
- Extended Day Treatment
- Other Community-based services, support and care

Last Resort- only when absolutely necessary

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- Alternative home family/friend/faith-based
- Alternative community setting (e.g., group home)

- Short-term Crisis Care Coordination-Wraparound
- High Fidelity Care Coordination-Wraparound
- 23-Hour Crisis Stabilization- Alternative to ED
- Supporting 1-14 day bedded Short-Term Crisis Residential

- Hospital Emergency Department
- Psychiatric Residential Treatment Facility (PRTF)
- Inpatient Psychiatric care

Child vs. Adult Crisis Models

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Child Crisis Model

- Single Point of Access
- Crisis is Defined by Parent/Caregiver
- Comprehensive Children's Assessment
- Respond without Law Enforcement
- Specifically Trained to work Children & Families
- Designed to Interrupt Care Pathways
- Stabilization Services up to 8 Weeks
- Community Connections is Core to the Work

Adult Crisis Model

- Care Traffic Control
- Crisis is Defined by the Caller
- Crisis Assessment for Danger to Self & Others
- 911 Access Point & Police Respond with the Team
- Crisis Trained Individuals Respond, not Child Specific
- Designed to Address the Needs of the Adult
- Connection to Community Supports
- Provides Transportation

Customized for Children, Youth, Young Adults & their Families

- Parents/caregivers and youth have the most influence and say regarding all aspects of MRSS service delivery
- Components and practices for youth and their families remain even when embedded in a lifespan response system
- Includes identification of the youth and family's needs and strengths, risk factors and cultural considerations and preferences
- Employs trained and certified or credentialed providers, including parent and youth peers, with expertise and experience in child and adolescent behavioral health and family systems
- Provides routine outreach and educational activities to the community and system partners that is specific to the needs of youth and their families
- Prioritizes safety and de-escalation in community settings with connections to natural supports

Grounded in System of Care Values & Principles

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- Family- and youth/young adult-driven
- Strengths-based and individualized
- Equitable and accessible to all children, youth, young adults, and families
- Culturally humble and linguistically competent
- Trauma-responsive
- Data-driven and outcome oriented

Mobile Response Stabilization and Support Core Elements

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- Upstream Intervention – available for families in pre-crisis
- Single point of access (using child and family friendly language)
- Recognizes a family's sense of urgency
- Focuses on the shifting care pathways from high intensity services
- Recognizes natural intervention points
- Recognizes and support the natural support system
- Recognizes the healing potential within communities
- Available 24/7/365 face to face
- Recognizes that the exposure to higher intensity services can be trauma inducing (e.g., ED or Inpatient)

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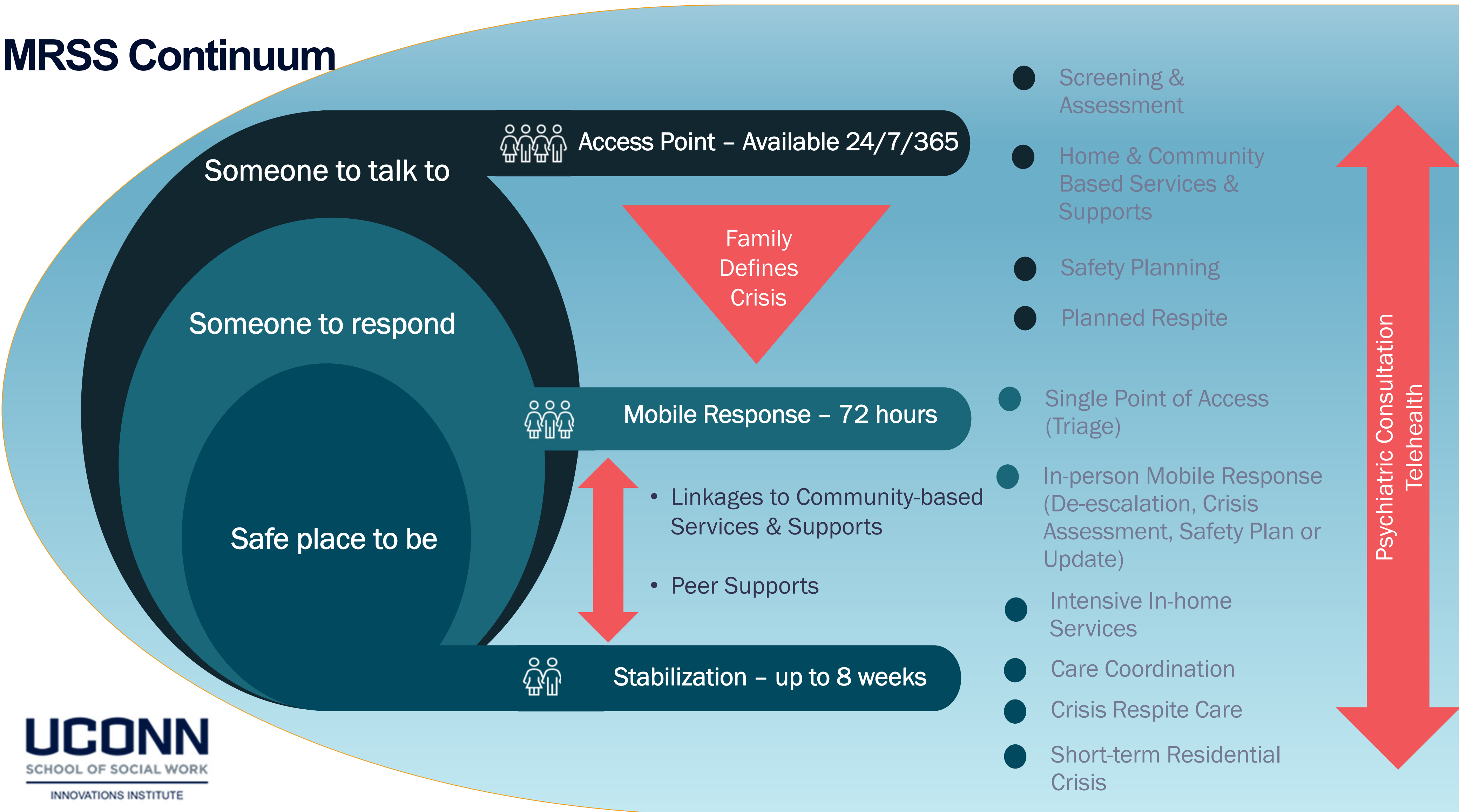
MRSS Continuum
Someone to talk to
Someone to respond
Safe place to be
Access Point – Available 24/7/365
Family Defines Crisis
Mobile Response – 72 hours
• Linkages to Community-based Services & Supports
• Peer Supports
Stabilization – up to 8 weeks
Screening & Assessment
Home & Community Based Services & Supports
Safety Planning
Planned Respite
Single Point of Access (Triage)
In-person Mobile Response (De-escalation, Crisis Assessment, Safety Plan or Update)
Intensive In-home Services
Care Coordination
Crisis Respite Care
Short-term Residential Crisis
Psychiatric Consultation
Telehealth
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Mobile Response

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- Face to face within 1 hour
- Family defines the crisis
- Crisis De-escalation
- Assessment and Stabilization

Stabilization: Key Tasks

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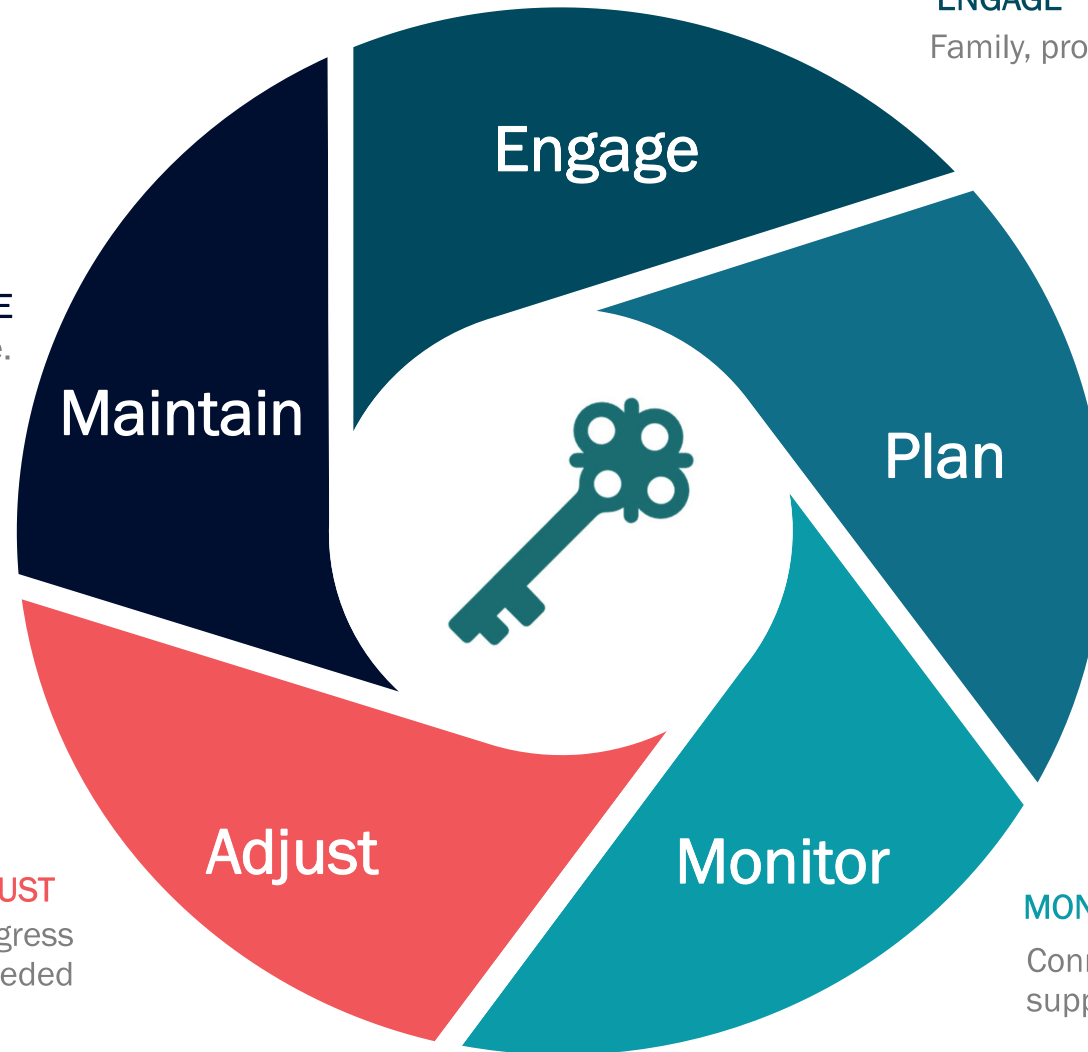
ENGAGE
Family, providers, and supports

MAINTENANCE
Ensure connections are in place.



PLAN
Continuity of care planning from 72-hr response

ADJUST
Based on satisfaction & progress data, plan is adjusted as needed

MONITOR
Connect with providers & supports as directed in POC

Stabilization Services

Connection to community supports and services

Reconnection with activities such as sporting activities, arts such as acting and painting, extra curricular activities within the school as examples.

In-home clinical support for the youth and family

Connection to higher level of support if determined necessary

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Mobile Response Stabilization and Support

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- MRSS and linkage to community-bases services and supports (least intensive to most intensive)
- Care Coordination with high fidelity wraparound
- Child and Family Team Process
- Peer Support Family/Caregiver and youth peer support if possible
- Outpatient or Intensive Outpatient services
- Intensive In-home Services preferably EBPs
- Extended Day or other Day Treatment
- Back to current provider

Potential or Partial Solutions to Reduce, Divert and Avoid ED

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Alternatives to the Hospital Emergency Department

- 23 Hour Crisis Assessment Centers
  - CT Urgent Crisis Centers (UCCs) crisis assessments- 3-4 hour best practice (Four-North South East West)
- Short-term Crisis Residential
  - CT Sub-Acute Crisis Stabilization Centers(SACS) 1-14 day bedded short-term sub-acute

Potential or Partial Solutions to Reduce, Divert and Avoid ED

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Enhanced Outpatient Care Clinics (or CCBHC Model)

- Emergent: seen within 2 hours
- Urgent: seen within 2 days
- Routine: seen within 2 weeks

- Or Crisis Assessment walk-ins accepted anytime during operational hours

Potential or Partial Solutions to Reduce, Divert and Avoid ED

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Accelerated evidence-based high-fidelity wraparound

- Intensive Transition Care Managers (ITCMs) with Crisis Outreach Family Peer Partner
  - Specific to Children and youth stuck in an ED or other intensive service
  - ED referral is made to the Family Peer Partner
  - Rapid: Wraparound, Plan of Care development, Crisis Safety Planning, Child and Family Meetings
  - 2-3 month LOS
  - Warm hand-off if needed to longer term (6 month) high fidelity Wraparound Care Coordination or other appropriate community behavioral health service

Potential or Partial Solutions to Reduce, Divert and Avoid ED

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Intensive In-Home Services and community-based EBPs

- IICAPS Intensive In-Home Child & Adolescent Psychiatric Services
- FFT-Functional Family Therapy
- MDFT-Multi-Dimensional Family Therapy
- MST-Multi-Systemic Therapy

Community-based:

- TF-CBT-Trauma-Focused Cognitive Behavioral Therapy
- MATCH-ADTC-Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems
- CBITS/BB-Cognitive Behavioral Intervention Trauma in Schools and Bounce Back

Potential or Partial Solutions to Reduce, Divert and Avoid ED

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Comprehensive Student Mental Health

- Support for School Climate:
  - Health Promotion and Suicide Prevention materials
- Support for Social Emotional Learning curriculum
  - Professional development trainings on teacher/school staff self-acre and student mental health
- Support for Multi-tiered Student Mental Health
  - Screening, identification, referral and linkage to mental health system
- Peer to Peer Student to Student support
  - Development of Student Peer to Peer support toolkit and support implementation
- Support Suicide Prevention Efforts and School Prevention Plan
- Direct linkage to service array
  - Mobile Crisis, Care Coordination, Youth Service Bureaus, Outpatient Treatment Providers and Intensive In-Home Services.

Potential or Partial Solutions to Reduce, Divert and Avoid ED

Urban Trauma Initiative

- Identified the most in need urban settings
- Recruited black and brown minority-owned and operated small grass roots organizations who are dedicated to reduce and eliminate urban and racial trauma (preferably with clinicians)
- All staff trained on Urban Trauma by Dr. Maysa Akbar from Yale and at least 3 clinicians trained in Dr. Steven Kniffley's clinical model of race-based trauma and stress from Spaulding University
- "Promising Practice" Clinical Model

MRSS to Ongoing Services and Supports

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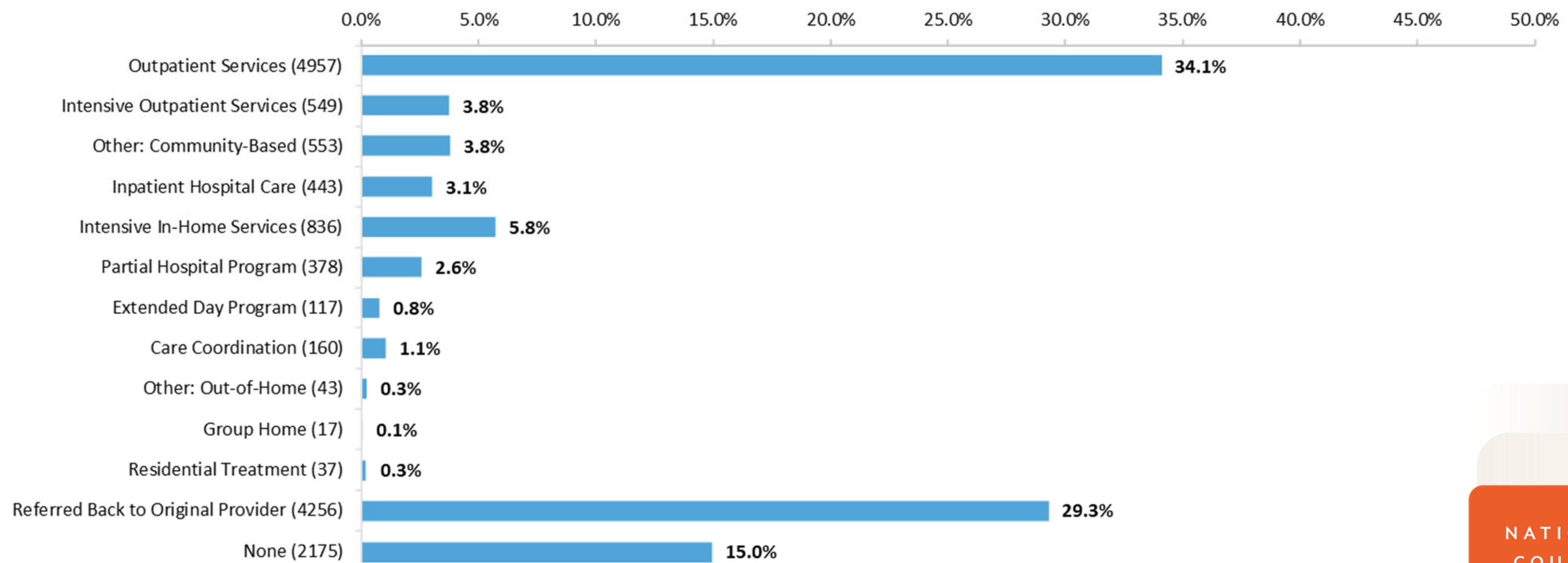

*Connecticut Mobile Crisis SFY 2022 Annual Report www.mobilecrisisempsct.org

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In Summary:

1. Your Mobile Response systems is the backbone and should develop good working partnerships with the major system partners **they will serve** and the community providers **they will refer** and connect children, youth and families to
2. Involve parents/caregivers, children, adolescents and young adults with lived experience to assist in developing all phases (design, planning, implementation and sustaining) crisis system of care
3. Be intentional about reducing, diverting and avoiding Hospital Emergency Departments for behavioral health crisis assessments
4. Develop more flexibility in walk-in outpatient clinics for crisis assessments (CCBHC)
5. If needed, develop additional supportive service types like Crisis Care Coordination and High Fidelity Wraparound support to ED and areas of bottle neck in the system
6. Use Intensive In-Home services and other community-based services
7. Assist and support schools in developing a comprehensive student mental health (AWARE like)
8. Address racial and urban trauma
9. Use quality data to track your Mobile Response System especially referrals to and from providers

SAMHSA Resource
National Guidelines for Child and Youth Behavioral Health Crisis Care

- **Someone to Talk To: Crisis Call Centers. Operating 24/7/365**, crisis call centers should offer developmentally appropriate assessment, sensitive de-escalation supports, and connections to ongoing care, when needed. Staff should include clinicians, family and youth peer support providers, and other team members with specialized training to respond to youth and families.
- **Someone to Respond: Mobile Response Teams.** Mobile crisis teams go where they are needed to respond to crises—whether in children's homes, their schools, or their communities. They should provide immediate supports, safety planning, and follow-up with qualified crisis responders, including family and youth peer support providers. They should prioritize keeping youth in their homes if it is safe to do so.
- **A Safe Place to Be: Crisis Receiving and Stabilization Services.** Stabilization supports for youth and families can include in-home services delivered over several weeks. When appropriate for the needs of the youth, supports can also include developmentally appropriate, trauma-informed care provided in crisis care facilities, emergency departments, and hospital settings.

National Guidelines for Child and Youth Behavioral Health Crisis Care

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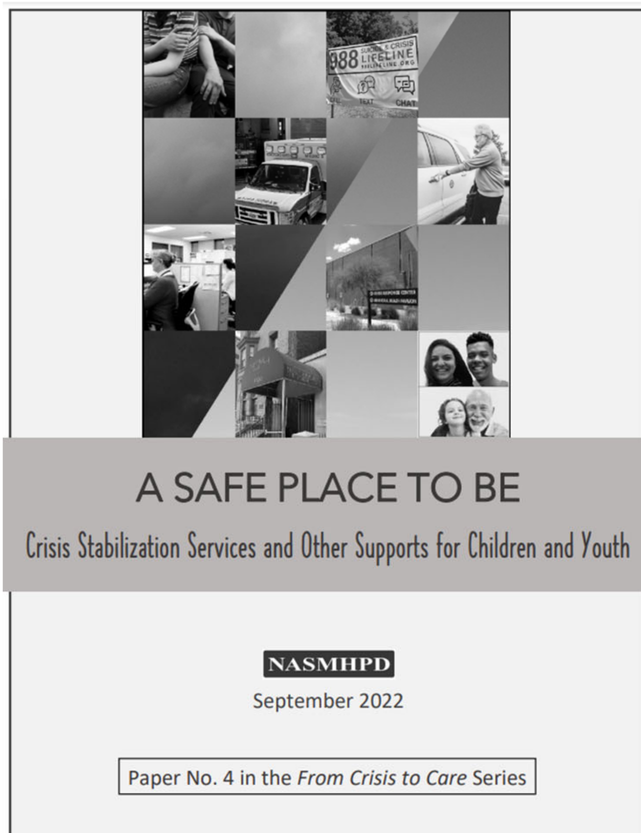

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Highlights:

- Amending or attempting to retrofit an adult crisis response system to serve the needs of youth and families is insufficient.
- 988 provides the opportunity to streamline the process for youth and families experiencing a crisis to obtain timely, necessary services and supports, reduce unnecessary use of emergency departments and police response, and provide equitable response and access for diverse populations.
- Crisis stabilization services include an array of services and supports for youth and families focused on de-escalation and stabilization within the home and community.
- Stabilization services are grounded in Systems of Care values and principles.

https://www.nasmhpd.org/sites/default/files/2022-11/Safe-Place-to-Be_Childrens-Crisis-and-Supports_NASMHPD-4.pdf

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MRSS Design & Intent

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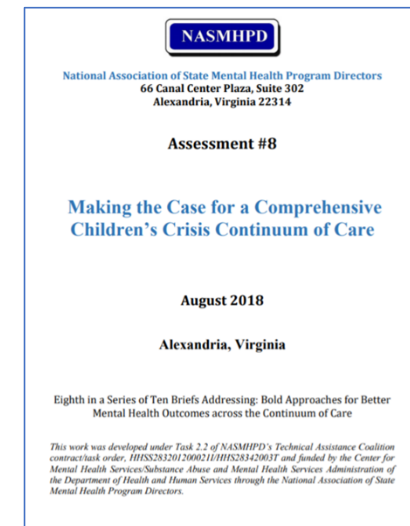
[Making the Case for a Comprehensive Children's Crisis Continuum of Care]

- Specifically designed as an upstream intervention to:
  - Meet the needs of children, youth and young adults, and their parents/caregivers
  - Deescalate and ameliorate a crisis before more restrictive and costly interventions become necessary
  - Ensure connection to necessary services and supports
- Key services that shift from overuse of high-end services and supports to home- and community-based services



NASMHPD

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Assessment #8

Making the Case for a Comprehensive Children's Crisis Continuum of Care

August 2018

Alexandria, Virginia

Eighth in a Series of Ten Briefs Addressing: Bold Approaches for Better Mental Health Outcomes across the Continuum of Care

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Questions
&
Answers

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