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Youth Crisis Stabilization
A Full Crisis Continuum

Disclaimer

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Learning Objectives

- Participants will learn how the developmental, social, and clinical needs of children and youth are different from those of adults.
- Participants will learn state examples of crisis system enhancements to meet the needs of children and youth with/at risk for serious emotional disturbance and their families in their homes and communities whenever possible.
- Participants will learn how states are using Mobile Response & Stabilization Services (MRSS) to ensure children and families have a "Safe Place to Be" during crisis stabilization.
- Participants will learn application of national best practices for youth crisis stabilization design and implementation from a provider in New Jersey.

Overview

Developing National Guidelines for Behavioral Health Crisis Care was a great advance and desperately needed.

*"Crisis services are for **anyone, anywhere and anytime."**[1]*

Someone to Contact
Someone to Respond
A Safe Place for Help

(1 National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit p. 8)

Someone to Contact
Someone to Respond

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Crisis Call Centers and Mobile Response Teams

- Needs of children and families differ from adults

- Most calls for children are 3rd party

- Call Specialists are at a disadvantage in trying to telephonically assess the child's and their family's crisis need
- The Crisis for a child and their family may appear to be less serious then a "typical crisis"

National Mobile Response and Stabilization Services Quality Learning Collaborative, a partnership of Innovations Institute, University of Connecticut School of Social Work; Child Health and Development Institute (CHDI)
Innovations Institute, University of Connecticut School of Social Work. (2023). A Guide for MRSS Leaders: Articulating the "Why." In Partnership with Child Health and Development Institute.

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Child & Family Needs:

Someone to contact/Someone to respond

Crisis Call Centers and Mobile Response Teams

- If *"Crisis services are for* ***anyone, anywhere and anytime"***[2]
- The Crisis Call Center's response has to be different for children and their families
- What works best for children, youth and their families?

(2. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit p.8)

State Enhancements to:
Someone to talk to/Someone to respond

- ***Crisis Call Centers and Mobile Response Teams*** *adjust to "Just Go"*

- All callers for children and youth are always offered a rapid, face to face mobile response

- Use of Mobile Response and Stabilization Services (MRSS) National Best Practice for children, youth and their families

Innovations Institute, University of Connecticut School of Social Work. (2023). Mobile Response & Stabilization Services National Best Practices. In Partnership with Child Health and Development Institute.

CHILD AND YOUTH CRISIS SYSTEM OF CARE: Working Toward a Common Goal

When a child or youth is in crisis, a parent or caregiver can call 988 for help

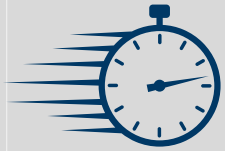
988 does not "screen out"; instead the crisis is defined by the family and mobile response is always offered

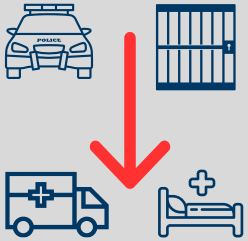
Youth Mobile Response Teams head out to meet the family where they are, arriving in less than 60 minutes

Child is stabilized in the community Designed for 95% resolution in the home Eliminates inappropriate use hospital Emergency Departments

System Provides Support All families who receive in-person response have access to stabilization services

Improved Outcomes And reduced rates of arrest, juvenile detention, emergency departments, and hospitalization





Child & Family Model: MOST Responsive = MOST Effective

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Innovations Institute, University of Connecticut School of Social Work. (2023). A Guide for MRSS Leaders: Articulating the "Why." In Partnership with Child Health and Development Institute. MRSS Leader's Guide (uconn.edu)

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MRSS Enhances Opportunity to "Talk" and "Respond"

- ✓ Crisis is defined by the family/young person recognizing family sense of urgency with a single point of access
- ✓ Youth specific triage and connection to mobile teams available 24/7/365 with face-to-face response
- ✓ Immediate mobile response by teams trained to work with youth, young adults, and families
- ✓ Response does not include law enforcement unless deemed necessary after risk/safety screening
- ✓ Developmentally appropriate assessment

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MRSS Enhances Opportunity to "Talk" and "Respond"

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Call Center

- 24/7/365 – engagement is a priority
- Family/Young Adult defines the crisis (mobile response always sent)
- Briefly screen for risk of harm to self/others
- Warm handoff to youth-specific mobile response

72 Hour Component

- Face to face within 1 hour
- 24/7/365
- Crisis de-escalation
- Developmentally appropriate assessment

Up to 8 Weeks of Stabilization

- Connection to home, school, and community supports and services
- Reconnection with activities such as sporting activities, arts such as acting and painting, extra curricular activities within the school
- In-home clinical support for the youth and family
- Connection to higher level of support if determined necessary

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Enhanced- Someone to Contact

Just Go Approach Crisis Call Center: Key Tasks

A

SCREEN

Assess safety and risk, including imminence of harm

B

LISTEN

Recognize and understand family/youth defined crisis

C

ENGAGE

Building alliance and agreement that a response will be helpful

D

DETAILS

Identify family/youth preferences, household information, and needs

E

MOBILIZE

Warm handoff to mobile team **OFFERED 100%** to child and Family Crisis Callers

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Enhanced-Someone To Respond Mobile Response: Key Tasks

FIRST VISIT

Up to 72 HOURS

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Enhanced- “Someone To Respond” MRSS Stabilization Up to 8 weeks

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- Symptom- and solution-focused goals integrated into an individualized plan of care
- Plan of care empowers youth and families to be active partners in and guides the service delivery process
- Reconnection with activities such as sporting activities, arts such as acting and painting, and extra curricular activities within the school
- Home, school, and community-based services including in-home/school clinical support and peer support
- Connection to community supports and services
- Connection to higher level of support only when determined necessary

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Stabilization: Key Tasks

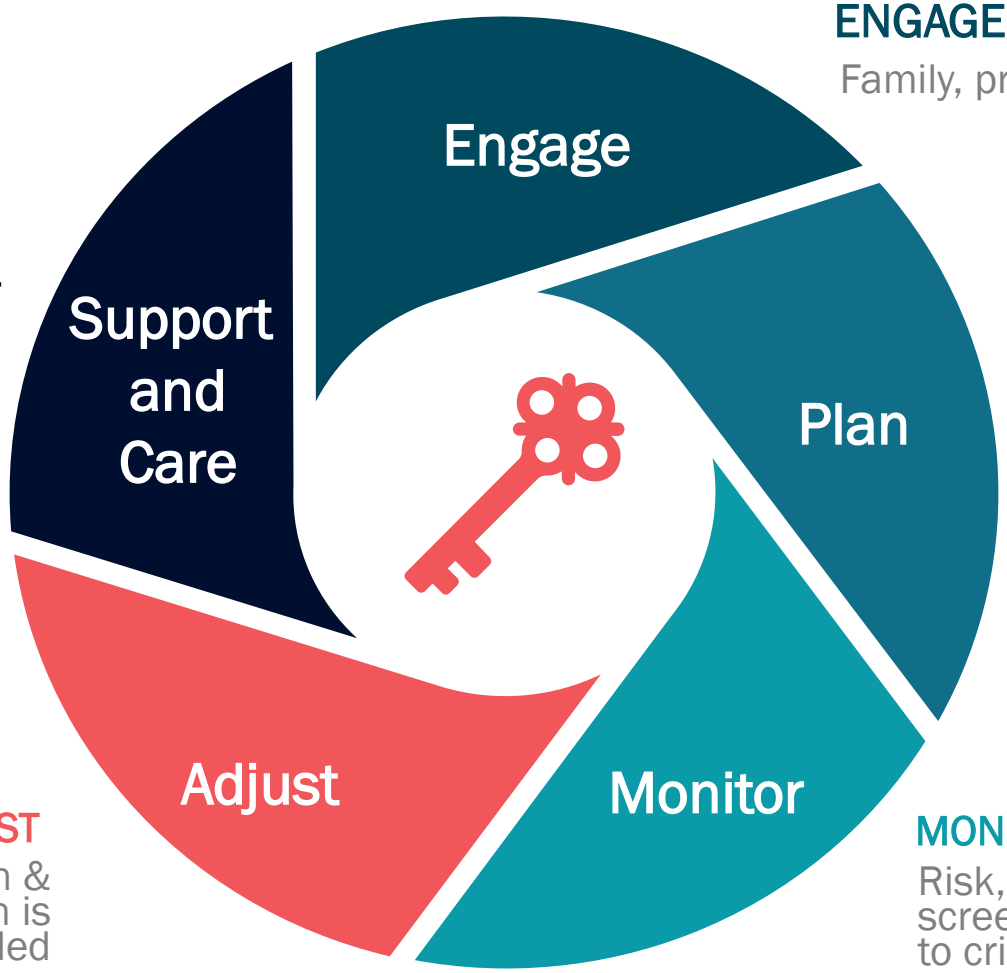
ENGAGE
Family, providers, and supports

PLAN
Continuity of care planning from 72-hr response

MONITOR
Risk, ongoing suicide screening, attention to crisis and care plan

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

SUPPORT
Connections, skill building, and support to implement the plan.



Innovations Institute, University of Connecticut School of Social Work. (2023). Mobile Response & Stabilization Services National Best Practices. In Partnership with Child Health and Development Institute.

Enhanced "Safe Place to Be" with "A System to Support"

Innovations Institute, University of Connecticut School of Social Work. (2023). Mobile Response & Stabilization Services National Best Practices. In Partnership with Child Health and Development Institute.

- The Safe Place to Go for children **is their home**, **in their community and in their school**
- Maintaining a child safely at home, in their community and in their school can be safely done with a "System to Support"
- **Crisis stabilization system** includes an array of services and supports for youth and families focused on de-escalation and stabilization within the home, school and community and are **grounded in Systems of Care values and principles**
- *The "Safe Place to Go"-When out of their home is absolute last resort*

A "System to Support" Youth Crisis System Values

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- **Keeping youth within their homes and communities**, when safe and appropriate to do so, is of paramount importance. Out-of-home placement should be avoided unless necessary...
- Services must be developmentally appropriate and must treat youth as youth, not as small adults.
- People with lived experience, including **family and youth peer supporters, must be integrated into service planning**, implementation, and evaluation.
- Services must promote behavioral health equity. They should be culturally and linguistically responsive and designed to meet the needs of diverse youth and families (including racially, ethnically, linguistically, and sexual orientation and gender diversity).[4]

(4 National Guidelines for Child and Youth Behavioral Health Crisis Care p.29)

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"A System to Support"

Youth Crisis System

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Youth Crisis System that maintains children and youth at home should:

- Respond to and validate parents/caregivers, children, and youth
- Respond to major system partners **beginning with schools** and includes: emergency departments (EDs), primary Care, law enforcement, child welfare, juvenile justice, intellectual/developmental disabilities, and community providers
- Reduce over-use of EDs **especially from schools**
- Reduce school-based arrests
- Reduce inappropriate use of inpatient care
- Coordinate with EDs
- Support high fidelity-crisis Wraparound

"A System to Support"

Responsive to Schools

Youth Crisis System that maintains children and youth in school:

- Early childhood and pre-school ages 0-5
- Elementary school ages 5-12
- Middle school ages 11-14
- High school ages 14-18 (and older)
- Inclusive of intellectual, developmental disabilities, special education or mental health needs
- Special attention should be given to transitioning students including graduating from one school to another and transitioning after graduation from high school

"A System to Support"

Responsive to Schools

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Multi-tiered Student Support and Comprehensive Student Mental Health

- Support for School Climate:
  - Health Promotion and Suicide Prevention materials
- Support for Social Emotional Learning curriculum (SEL)
  - 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
- Direct linkage to in-school clinical services and support (e.g., Cognitive Behavioral Intervention Trauma in Schools and Bounce Back (CBITS/BB))
- Direct linkage to service array
  - Mobile Crisis, Care Coordination with High fidelity wraparound, Youth Service Bureaus, Outpatient Treatment Providers and Intensive In-Home Services

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Enhanced "System to Support" At Home

Intensive In-Home Services and Supports

- Care Coordination with High-fidelity Wraparound
- Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS)
- Functional Family Therapy (FFT)
- Multi-Dimensional Family Therapy (MDFT)
- Multi-Systemic Therapy (MST)

Intensive In-Home Foster Care

- Functional Family Therapy Foster Care (FFT)

Enhanced "System to Support" In the Community

Enhanced Outpatient Care Clinics with ability to provide crisis care to children and families who walk-in or need to be seen quickly

- 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.

Intensive Outpatient or other Outpatient services

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

A Safe Place to Be

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Best Practices to Operate Crisis Receiving and Stabilization Services

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Function as a 24 hour or less crisis receiving and stabilization facility;
2. Offer a dedicated first responder drop-off area;
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; and
5. Coordinate connection to ongoing care.3

(3 **National Guidelines for Behavioral Health Crisis Care** – A Best Practice Toolkit *Knowledge Informing Transformation*.)

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Enhanced- “Safe Place to Be”

Develop alternatives to the Hospital Emergency Department

- 23 Hour Crisis Assessment Centers
  - Operating specifically for children and their families.
  - Parents/Caregivers should remain with the child as safe and appropriate
  - Focus should be stabilizing and safely planning for return home and school with Mobile Response Teams
- Short-term Crisis Residential
  - Prioritizing discharge back home, to school and community.

CHILD AND YOUTH CRISIS SYSTEM OF CARE:
Working Toward a Common Goal

When a child or youth is in crisis,
a parent or caregiver
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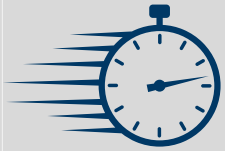
Youth Mobile
Response Teams
head out to meet the
family where they
are, arriving in less
than 60 minutes

Child is stabilized in
the community
Designed for 95%
resolution in the
home
Eliminate
inappropriate use of
hospital Emergency
Departments

System Provides
Support
All
families who receive
in-person response
have access to
stabilization services

Improved Outcomes
And reduced rates of
arrest, juvenile
detention,
emergency
departments, and
hospitalization



Child & Family Model: MOST Responsive = MOST Effective

MRSS Has a Role in Suicide Prevention Across the Continuum

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Summary

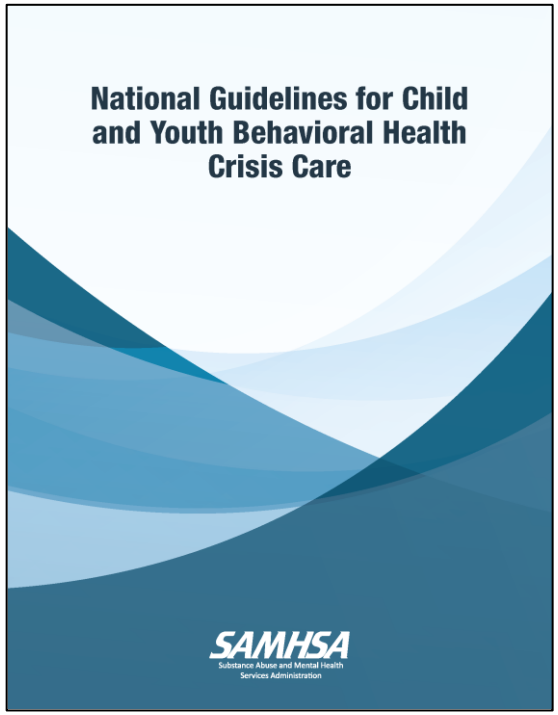
1. More parents/caregivers, children, and adolescents with lived experience to assist in developing the solutions
2. Mobile response systems
3. Comprehensive and multi-tiered support for student mental health in schools
4. Care coordination and use of high-fidelity Wraparound
5. More flexibility in walk-in outpatient clinics for crisis assessments
6. Intensive In-Home services
7. Alternatives to EDs for behavioral health crisis assessments
8. Crisis care coordination and high-fidelity Wraparound support to ED and areas of bottle neck in the system

Staying at home, and in school with reduced rates of:

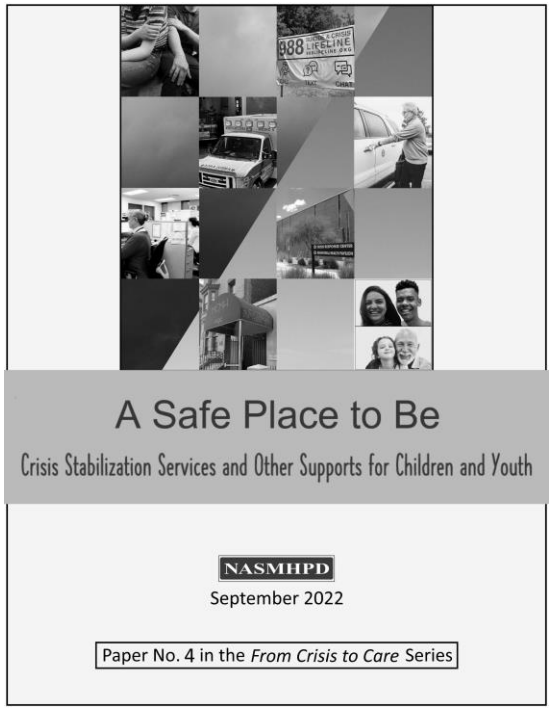
- Juvenile arrest
- Juvenile detention
- Emergency departments visits
- Hospitalization

National Resources

SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care



NASMHPD's A Safe Place to Be: Crisis Stabilization and Other Supports for Children and Youth



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Children's Mobile Response & Stabilization Service in New Jersey

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What is Children's Mobile Response & Stabilization Services (CMRSS) in New Jersey?

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- A program to *literally and figuratively* meet a youth and family where they are when they are having a behavioral or mental health concern.
- A program that allows individuals to define their crisis. A crisis is subjective and CMRSS recognizes this and allows families to tell their story and define their crisis.
- CMRSS is available to meet with a family at a place of their convenience at any time of the day or night- 24/7/365.
- The initial meeting is very productive and looks to identify and address needs:
  - a crisis assessment is completed to highlight needs
  - A safety plan is developed to address safety concerns and provide soothing and coping skills to bridge the gap until the youth and family can be linked to therapeutic services
- Depending on level of need, CMRSS offers either:
  - 72 Hour Stabilization service
  - 8-week stabilization

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When is it appropriate to call?

- Families **struggling to meet the needs** of your developmentally disabled or intellectually disabled (I/DD) child or adolescent.
- Your child **refuses to attend school** or has **repeated lateness or skipping**, or if you have other concerns about his or her school performance.
- Your child shows **physical and/or verbal aggression**, **bullies others**, **or is being bullied.**
- You observe **family conflict**, including **youth substance use** or refusal to comply with rules.
- When a youth is **experiencing significant changes in behavior** and/or mood that impacts their ability to function at home, at school, and in the community.

In order to assure that needs are appropriately addressed,

families should expect the initial phone call to take 30-40 minutes.

How to access New Jersey's Children's System of Care

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- Parent/legal guardian calls Central System Administrator (CSA) directly when seeking services for a youth up to the age of 21.
  - Police can call on behalf of a family
  - Schools can assist w/ a conference call
  - Youth over 18 can self-refer
- (CSA) is available 24 Hours a day, 7 days a week, 365 days and triages the initial call and determines next steps.
- CSA dispatches Children's Mobile Response & Stabilization Services (CMRSS) and/or connects the youth and family to their local care management organization (CMO) office if clinically appropriate.
- Enrolling in Children's System of Care Services are voluntary and at will*1-877-652-7624

24 hours a day, 7 days a week

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What is helpful for families to know or say when they call to request assistance?

- When explaining CMRSS, remind families that a crisis is subjective and whatever they are experiencing need not be compared to others.
- Give as much detail as possible, even if you feel that you as the caregiver are not highlighting the youth's best assets. During the assessment, we will inquire about strengths, and we will utilize those strengths in developing a plan.
- Be sure to make your needs as the caregiver known too. If you feel you need immediate assistance for your child and cannot wait for an outpatient appointment in 4-5 weeks, say so!

Concrete Interventions

- This idea started with an idea to leave written information for parents and grew from there…
- We knew that so much is discussed during a dispatch & caregivers might feel overwhelmed and might not remember all that was discussed. So, in addition to our safety plan, we would leave resources that contained information about coping tools or resources.

- But then we thought, why not leave some concrete interventions too.
- So, we did!
- Books about grief or anxiety
- Play-doh and stress balls
- Spheres to assist with deep breathing exercises
- Safety equipment for doors

Example Safety Plan

CPC BEHAVIORAL HEALTHCARE
Children's Mobile Response and Stabilization Services
Safety Plan

Date: Today's date

Youth Name: _____ **Caregiver Name:** _____

What happened with your child that made you call Mobile Response? Celia told her teacher that she wants to go to sleep and not wake up. She was sent to the E.R. & they told us to call you.

Identified risk factors: Celia has self-injured w/ a razor. Celia is failing 2 classes. Celia broke-up with her boyfriend.

What would youth like to change? Celia said that she would like to feel happy and get better grades.

What would caregiver(s)/family like to change? Celia's Mom said that she would like her daughter to be able to enjoy high school and be happy.

Prevention and Support Strategies in Place Currently: ① Supportive teacher Mrs. G - that Celia talks to @ school. ② Aunt Charlene is supportive to Celia & Mom ③ Celia's best friend "Amy." ④ Softball teammates

Additional Prevention and Support Strategies to Use: ① When has urge to self-injure w/ razor - use ice instead. ② Journal each night before going to sleep --- recall two positive parts of the day. ③ Tutoring is set to begin next week ④ Talk to Mrs G, Aunt Char or Mom when feeling upset.

*****If youth is at risk of self harm or harming others contact local emergency services or call 911.****

Outcome of visit: Celia and Mom are in agreement that counseling would be helpful. CMRSS will link family with a therapist.

Youth's signature	**Date**
Parent/Caregiver's signature	**Date**
MRSS Staff(s)' signature	**Date**

Signatures indicate Emergency Procedures were explained and safety plan was reviewed.

In-Home Services: Focused Intensive Brief -8 weeks Decreases barriers

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Intensive In Community (IIC)

Licensed therapist who meets in the community to help the youth and family reach treatment goals.

Behavioral Assistant (BA)

Certified individual works individually with the IIC and youth to practice what is discussed in sessions.

***IIC and BA services are available to families enrolled with CMRSS*
*they do not come at a cost to the family***

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What makes CMRSS a successful approach?

- A single point of access for families that is available 24/7/365 and has a toll-free phone number for the entire state
- The use of Information Management Decision Support (IMDS) tools which are based upon the Child and Adolescent Needs and Strengths (CANS) tools developed by Dr. John Lyons (2004, 2009)

What are these tools?

- Valid and reliable/ staff are trained and certify every year
- Assesses life domains regarding strengths and needs of the youth and the caregiver(s)

Successful Implementation of a Mobile Response Program

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If one of the goals of your Mobile Response Program is to keep youth in their homes and community, as well as out of Emergency Department & Hospitals then…

- You need to nurture community partnerships
  - Who and How?
    - School
    - PESS Department
    - Law Enforcement
    - Family-Based Organizations, Parent/Teacher Associations

The HOW…

*Introduce yourself to school staff, offer to attend in-service days to explain the program.

*Visit Police Departments and explain how they can call you instead of attending to a parent/child conflict

*Attend PTA meetings to explain the service to parents.

*Visit local pediatricians, explain how they can refer if a patient answers positive to depression screening