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COMPREHENSIVE MOBILE RESPONSE AND STABILIZATION SERVICES (MRSS) SYSTEM IN MARYLAND

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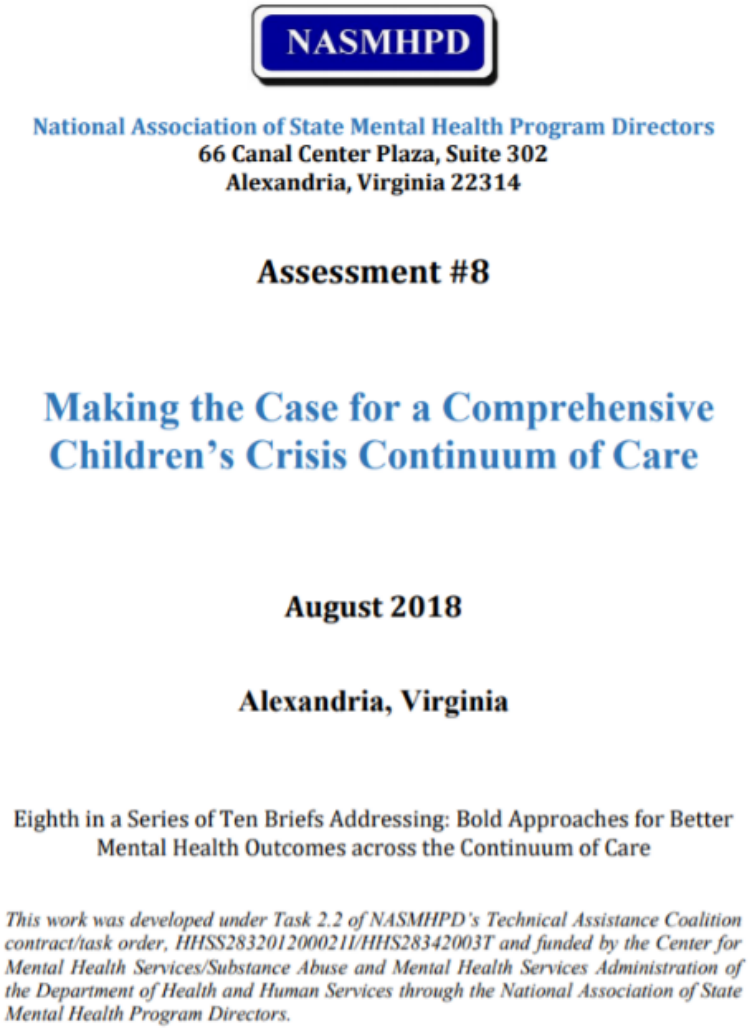

NASMHPD

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

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

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

MRSS Design and Intent

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*

Available Funding Streams

- **Insurance Carriers:**
  - Medicaid & Children's Health Insurance Program (CHIP)
  - Private Insurance (including Tricare)
- **Federal Funding:**
  - Medicaid & CHIP
    - CMS State Planning Grants for Qualifying Community Based Mobile Response Crisis Intervention Services
  - American Recovery Plan Act
  - State Opioid Response Grants
  - COVID-19 Supplemental Funding
  - State Block Grants – SUD
  - State Block Grants – MH
- Maryland State Funding
- Maryland Local Funding
- Maryland Non-Profit Funding

Children vs. Adult's Crisis Models

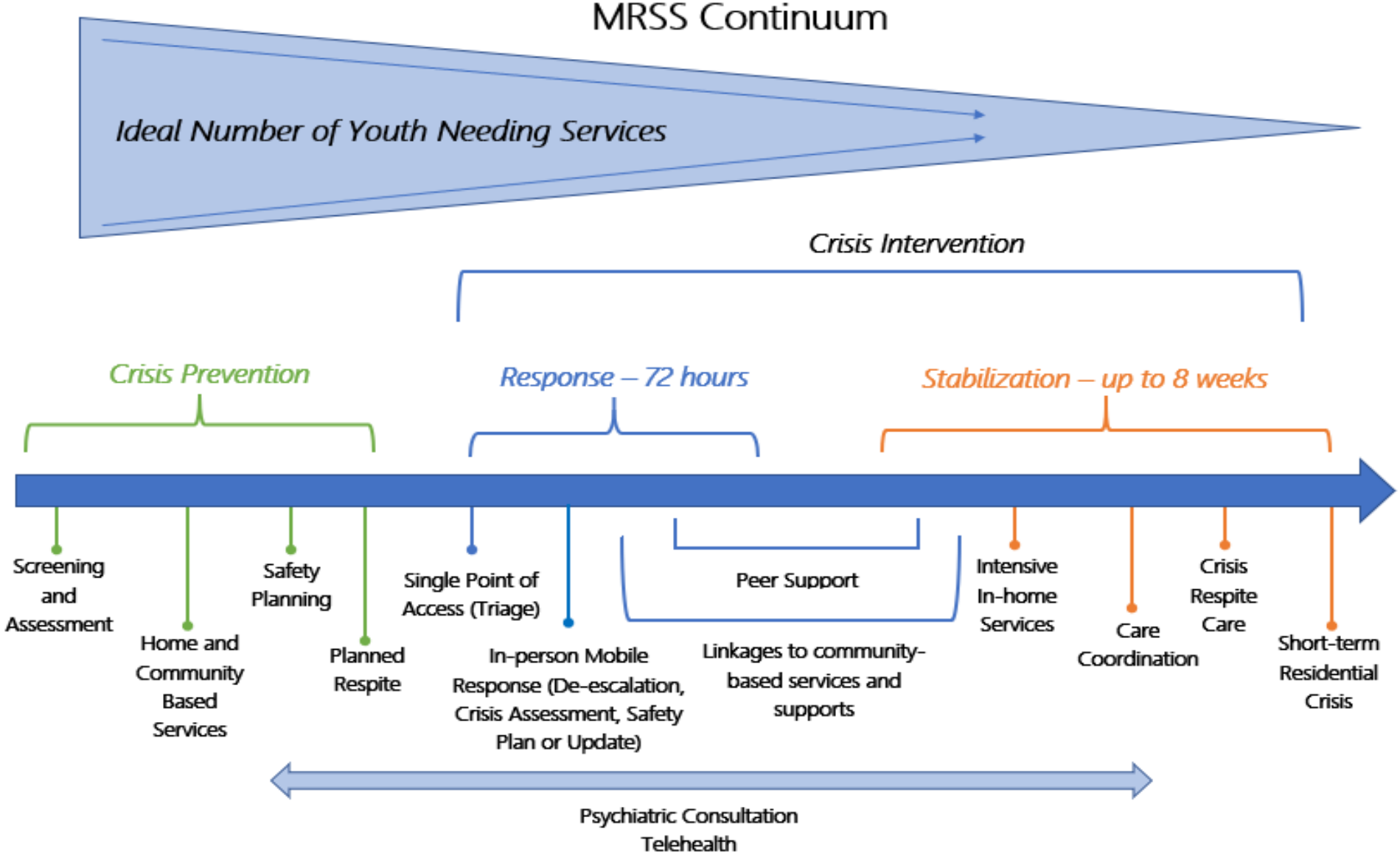
CHILD & ADOLESCENT CRISIS MODEL

- Single Point of Access
- Available 24/7
- Crisis is Defined by Parent/Caregiver/Adolescent
- Comprehensive Developmentally Appropriate 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

MRSS Continuum



Source: Adapted from the Wisconsin Office of Children's Mental Health. (2015). 2015 Report to the Wisconsin Legislature. Appendix D4.
Retrieved from: http://www.wisccap.org/docs/OCMH%202015%20Annual%20Report.pdf

Single Point of Access

- Call Center – 24/7 Access
- All Calls are Answered
- Parent/Caregiver Calls and Teams Go
- Initial Triage and Warm Hand-Off to Teams
- Centralized
- Connection to Mobile Teams
- Data Collection

MRSS Core Components

72 Hour Component

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

Up to 8 Weeks of Stabilization

- 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

MRSS Collaborative

Center for Excellence Funded by the Children's Bureau

System of Care Expansion Grants in Anne Arundel and Prince George Counties

HB1092 Established Behavioral Health Crisis Response Grant Program

DHS Mental Health Stabilization Grants

Greater Baltimore Regional Integrated Crisis System Regional Partnership (GBRICS)

Maryland's Mobile Response and Stabilization: Building on Success

The Goal of MRSS:

Support and maintain	Support and maintain youth in their current living situation and community environment, reducing the need for out-of-home placements, which reduces the need for inpatient care and residential interventions.
Engage	Engage youth and families by providing trauma informed care.
Promote and support	Promote and support safe behavior in home, school, and community.
Reduce	Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.
Assist	Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.

Benefit of a MRSS Model

- Upstream Intervention – available for families in pre-crisis
- Single point of access
- Recognizes a family's sense of urgency
- Recognizes natural intervention points
- Recognizes and support the natural support system
- Recognizes the healing potential within communities
- Available 24/7 face to face

Collaborating with MD School Mental Health Response Program

- Strive to align with MSDE on their implementation of regional crisis response and clinical support teams
- Collaborate on development of the 3 MSDE initiative components to include: clinical support for student, families and schools; professional development and crisis response
- Follow progress of the State Superintendent's Mental Health Advisory Committee

MRSS State Examples

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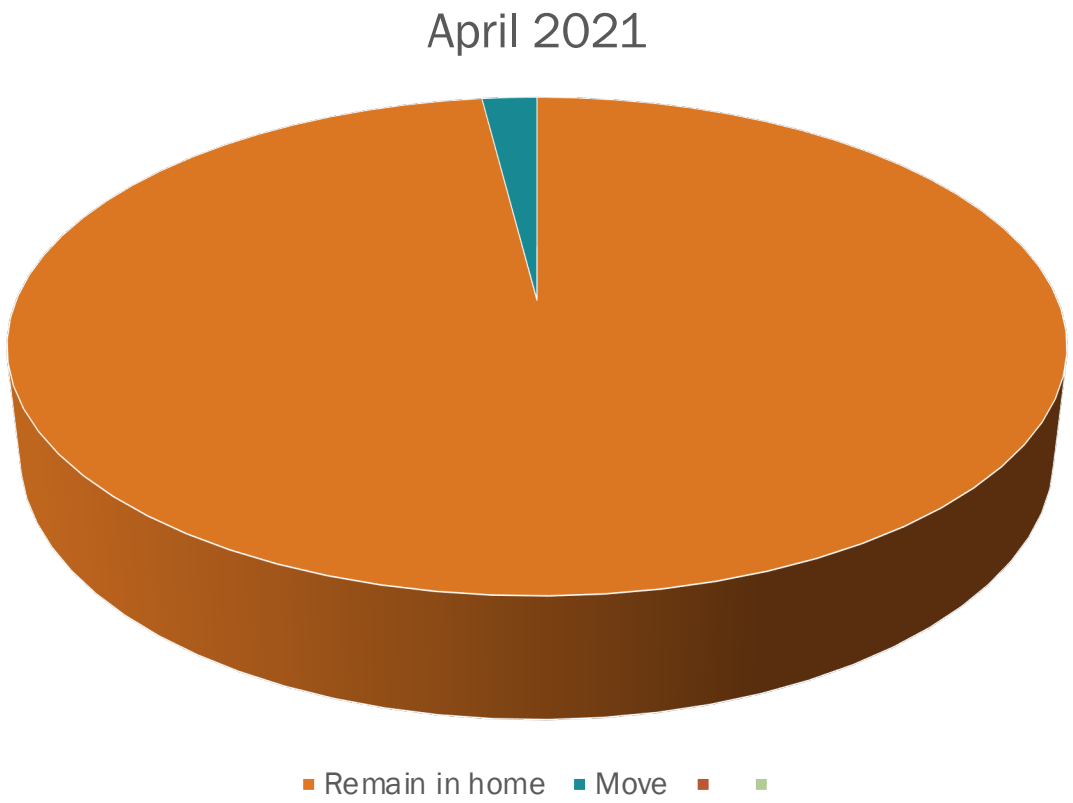
NJ Data: MRSS Living Situation

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.

Manley, E., Polakowski, A. (2020). *Considerations for System of Care Leaders in Implementing a Continuum of Crisis Services.*[PowerPoint slides]. The Institute for Innovation and Implementation.

NJ MRSS 2021 Data



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CT Data: Estimated Medicaid Cost Savings

EMERGENCY DEPARTMENT (ED) USAGE OF Mobile Crisis FOR INPATIENT DIVERSION

- EDs referred to Mobile Crisis **1,167 times** in FY 2017
- ED staff coded 449 referrals as **"inpatient diversions"**
- Approximately 62% (278) of those were for youth enrolled in Medicaid
- 278 inpatient diversions X $10,646 (avg. cost savings between inpatient and Mobile Crisis episode) **= $2,959,588**
- Other possible savings: ED diversion; arrest/incarceration diversion; higher level of care diversion; savings to commercial insurance

CT Data: Cost vs. Cost Savings

- Costs for developing important component of a comprehensive system of care
- There have been only a few studies of the cost offsets associated with mobile crisis--possible cost savings exist in the following areas:
  - Diversion from hospital-based emergency services
    - Emergency department (ED)
    - Inpatient hospitalization
  - Diversion from Highest Levels of Care in BH System
    - Psychiatric residential, group homes
  - Diversion from arrest/incarceration
  - Depending on eligibility, savings to public system (Medicaid) as well as commercial insurance providers

FY2020 SMR Key Outcomes:

1,538 Families served by **Triage Services** - 87% INCREASE from 2019

870 Families served by **Mobile Response** - 76% INCREASE from 2019

58% of the **870** served, **Remained at home** throughout the mobile response phase

362 Families served by **Intensive Stabilization - 128% INCREASE** from **2019**

48% of the **362** served, **Remained at home** throughout the Intensive Stabilization phase

69% of Children/Youth involved with SMR avoided interactions with law enforcement

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Parents of **123** of the Children/Youth who had no police interaction reported that without SMR, they would have called law enforcement to address the challenge.

Parents of **123** Children/Youth who remained home indicated that without SMR, they would have taken the child to the hospital to address the challenge.

YTTD 2019 through April 2021(year still in progress): # Served by Phase

Triage	Mobile Response	Stabilization
3,829	2,212	868

* **424** Deterred from **Emergency Departments**
* **322** Deterred from **Law Enforcement**

What Steps Should Maryland Consider Next?

Next Steps

- Scan of existing mobile response services in each of the 24 jurisdictions
- Leverage existing programs
- Select standardized assessment tool
- Establish MRSS curriculum training plans
- Develop outcome metrics and tracking systems
- Integrate this work within the MRSS Learning Collaborative hosted by the University of Maryland, School of Social Work

Questions?

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Resources

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- Maryland highway photo: https://images.app.goo.gl/3TwALXxreeTxPNhg6
- Maryland flag photo: https://images.app.goo.gl/vbAgJ9SE5NyJkPcGA
- 988 Map developed by Melissa Schober, MPM
- Manley, E., Williams, S., Marshall, T., & Walters, C. (2021). *Implementing Mobile Response and Stabilization Services* [PowerPoint slides]. The Institute for Innovation and Implementation.
- Mobile Response and Stabilization Services (MRSS) Best Practices for Youth & Families: https://theinstitute.umaryland.edu/media/ssw/institute/md-center-documents/MRSS-Best-Practices.pdf
- Additional resources can be found on The Institute for Innovation and Implementation's website: https://theinstitute.umaryland.edu/our-work/national/network/cbps/resources
- Manley, E., Polakowski, A. (2020). *Considerations for System of Care Leaders in Implementing a Continuum of Crisis Services.*[PowerPoint slides]. The Institute for Innovation and Implementation.
- New Jersey Child Welfare Data Hub: https://www.nj.gov/dcf/childdata/protection/hub/
- Beacon Health Options. (2019). *Addressing Emergency Department Overuse among Youth with Behavioral Health Conditions: Characteristics of Frequent Visitors, the Impact of Mobile Crisis, and System Development Efforts.*[PowerPoint slides]. University of Connecticut School of Social Work, Child Health and Development Institute of Connecticut, Inc., & Connecticut Department of Children and Families.

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