



**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, HHSS2832012000211/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.

Making The Case for a Comprehensive Children’s Crisis Continuum of Care

**Technical Writers:
Elizabeth Manley, L.S.W., Melissa Schober, M.P.M.,
Dayana Simons, M.Ed., Michelle Zabel, M.S.S.**

National Association of State Mental Health Program Directors



66 Canal Center Plaza, Suite 302, Alexandria, VA 22314
703-739-9333 FAX: 703-548-9517

www.nasmhpd.org

August 2018

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

Table of Contents

Executive Summary	5
Introduction	6
The Value of MRSS within a Children’s Crisis Continuum.....	7
Cost Savings and Avoiding Unnecessary Care	8
Crisis Continuum Infrastructure, Components, and Services	9
Single Point of Access.....	9
No Wrong Door	9
Crisis Hotline	10
Electronic Health Record	10
Triage	10
Mobile Response and Stabilization Services.....	11
Assessment	11
Crisis Intervention and Initial Identification.....	12
Crisis Stabilization	12
Residential Crisis Stabilization	13
Recovery and Reintegration	13
System Coordination and Community Collaboration	13
Primary and Psychiatric Care Providers.....	14
Child Welfare.....	14
Law Enforcement.....	14
Schools/Education.....	14
Emergency Departments (EDs).....	15
Juvenile Justice and Family Courts.....	15
Community Organizations.....	15
Workforce Strategies.....	16
Telehealth.....	16
Co-Location.....	16

Satellite Locations.....	17
Broad-Based Teaming.....	17
Financing a Crisis Continuum of Care	17
Conclusion.....	18
References.....	20

Executive Summary

When children, youth, and young adults experience a behavioral health crisis, parents and caregivers may not know what to do, or who is available to help meet the family's needs. A crisis continuum of care – designed specifically to meet the needs of children, youth, and young adults, and their parents/caregivers – is necessary to deescalate and ameliorate a crisis before more restrictive and costly interventions become necessary, and to ensure connection to necessary services and supports.

A high-quality child and youth crisis continuum should be available 24/7 to all children, regardless of payer. A comprehensive crisis continuum features screening and assessment, ideally using a validated screening tool; mobile crisis response; crisis stabilization services, and residential crisis services, where necessary; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination.

Within a crisis continuum, mobile response and stabilization services (MRSS) can effectively deescalate, stabilize, and improve treatment outcomes. MRSS are specifically designed to intercede before urgent behavioral situations become unmanageable emergencies and are instrumental in averting unnecessary emergency department visits, out-of-home placements, and placement disruptions, and in reducing overall system costs.¹

The research base on the effectiveness of MRSS for children and their caregivers is growing. In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Medicaid and CHIP Services (CMCS) recognized Mobile Crisis Response and Stabilization Services as “not only clinically effective but cost effective as well.”² As states and communities shift their children's behavioral health delivery systems toward a more upstream, public health approach, they are keenly interested in models that can prevent unnecessary use of acute care settings, such as emergency departments, psychiatric hospitals, and residential treatment facilities. Examples of the efficacy of crisis services, including MRSS, from diverse communities such as Milwaukee, Seattle, and Pima County, Arizona are included, as are adaptations such as telehealth for rural and frontier communities.

From a quality and clinical perspective, children, youth, young adults, and families benefit from MRSS because they get to initiate care based on a self-defined crisis. “Crisis” means different things to different families; it is important to use the family's own definition, based on their own needs and strengths. A significant percentage of persons seen by MRSS providers have not previously received behavioral health treatment. A first experience in receiving crisis services can be daunting. Engaging families in a culturally and linguistically competent crisis response is essential, not just for reducing risk in the current crisis and preventing future crises, but also for developing trust; if a family's priorities are not respected, they may choose not to seek services in the future.³

Introduction

When a child, youth or young adult experiences a behavioral health crisis, families and caregivers frequently turn to law enforcement, hospital emergency departments (ED), and inpatient treatment for help. Using data from the National Hospital Ambulatory Medical Care Survey, researchers found that pediatric psychiatric ED visits nationwide increased from an estimated 491,000 in 2001 to 619,000 in 2010.⁴ ED usage rates for publicly insured children and children without any health insurance were *four-fold* above those who are privately insured.⁵ Such trends demonstrate the need for community-based services to meet the urgent needs of children, youth, and young adults who are at-risk for

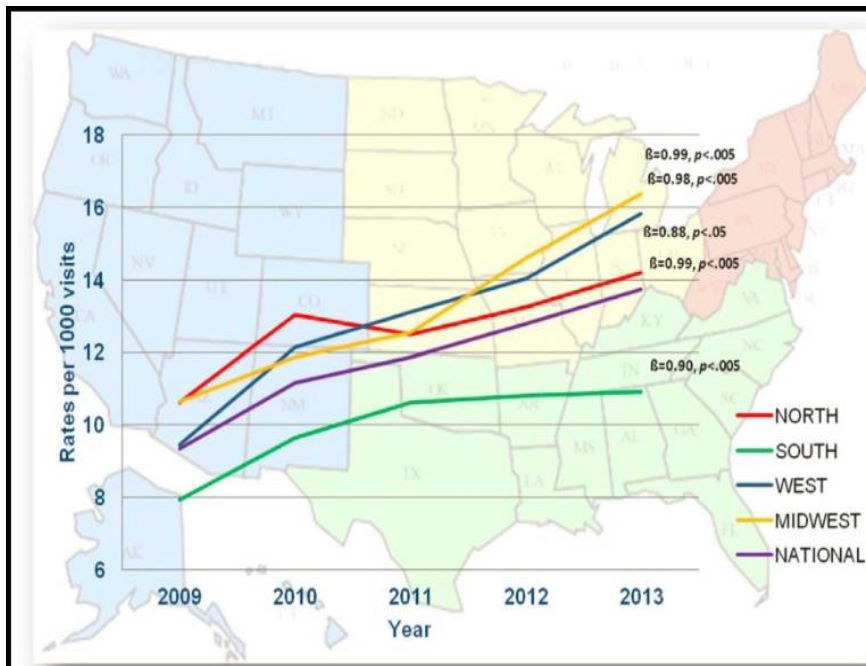


Figure 2: Published in: Steven C. Rogers; Christine H. Mulvey; Susan Divietro; Jesse Sturm; *Clin Pediatr (Phila)* 56, 488-491.

or are experiencing a behavioral health crisis.

When a crisis occurs, the established response has been to recommend the child go to an ED. Unfortunately, EDs often lack the specialized expertise to effectively respond to a pediatric psychiatric emergency, leading to children being “boarded” in

the ED for hours, or even days, until an appropriate placement becomes available.⁶ Care in the ED is expensive for payers⁷ and time-consuming for the parent and child who will have to wait to access care a second time after being discharged from the ED.⁸

Inpatient psychiatric treatment is an important component of a children’s behavioral health system, particularly for a child experiencing suicidality or psychosis. However, reductions in lengths of inpatient stays have led to increases in ED visits and re-hospitalizations among children, youth, and young adults, further raising concern over the effectiveness of inpatient treatment and the availability of quality community-based alternatives.⁹ Better outcomes in both cost and quality of care are achievable through community-based initiatives that redefine the meaning of ‘crisis’ and address and stabilize behaviors prior to escalation to the level of requiring inpatient care.

As the field of children’s behavioral health continues its trend toward treatment in the least restrictive environment possible, it is critical for states to develop high-quality

comprehensive crisis continuums available to all children, regardless of payer, within the public behavioral health system, which are crucial to achieving two goals:

1. Diverting unnecessary ED admissions; and
2. Instituting evidence-based home- and community-based services that provide meaningful alternatives to inpatient treatment.¹⁰

In 2013, CMCS and SAMHSA released a joint informational bulletin outlining Medicaid reimbursable home and community-based services for children and youth with complex behavioral health needs. The Joint Bulletin named several services critical to developing a high-quality crisis continuum, including mobile crisis response and stabilization and residential crisis stabilization: “Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on-call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise. Residential crisis stabilization provides intensive short term, out-of-home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services.”¹¹

The Value of MRSS within a Children’s Crisis Continuum

Designed specifically to intercede upstream, before urgent behavioral situations become unmanageable emergencies, MRSS are instrumental in averting unnecessary ED visits, out-of-home placements and placement disruptions, and in reducing overall system costs.¹² Operating within a high quality, culturally and linguistically competent children’s crisis continuum, MRSS work to keep a child, youth, or young adult safe at home, in the community, and in school whenever possible. MRSS are a viable alternative to acute care and residential treatment because they consistently demonstrate cost savings while simultaneously improving outcomes and achieving higher family satisfaction.

Interdepartmental Serious Mental Illness Coordinating Committee Charter (ISMICC)

ISMICC was established on March 15, 2017, in accordance with the 21st Century Cures Act ([Pub. L. 114-255, § 6031](#)).

ISMICC is required to report to Congress on serious emotional disturbance (SED) research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of SEDs.

In its [first report to Congress in December 2017](#), ISMICC's [recommendations included](#):

- Define and implement a national standard for crisis care
- Develop an integrated crisis response system to divert people with SMI and SED from the justice system
- Crisis intervention team training for those in criminal justice

Cost Savings and Avoiding Unnecessary Care

Connecticut: An evaluation of the state's Emergency Mobile Psychiatric Services (EMPS) found that the 2014 average cost of an inpatient stay for Medicaid-enrolled children and youth was \$13,320, while the cost of MRSS was \$1,000, a net savings of \$12,320 per youth. In Fiscal Year (FY) 2013, EDs referred to EMPS 1,121 times and 553 referrals were coded as "inpatient diversions." Of the 553 referrals, approximately 60 percent (or 332) were Medicaid-enrolled for a cost savings of over \$4 million.¹³

Seattle/King County, WA: Since October 2011, the Children's Crisis Outreach Response System (CCORS) has served 4,445 unique youth with a total of 5,438 service records. Out of the 5,438 total service records, only 15 (fewer than 1 percent) indicated that the CCORS encounter ended with a foster care placement.¹⁴ Between 2013 and 2015, CCORS was successfully able to divert 91 to 94 percent of hospital admissions. An evaluation of CCORS estimated that it saved \$3.8 to 7.5 million in hospital costs and \$2.8M in out-of-home placement costs.¹⁵

Texas: In 2007, \$82 million was appropriated by the Texas state legislature to address gaps in the state's behavioral health crisis service delivery system for children and youth, including the need for MRSS. The initiative resulted in declining hospitalization (1 of every 6 crisis episodes resolved via hospitalization pre-redesign, compared to 1 of every 8 post-redesign) which translated into direct and measurable cost savings of \$1.16 to \$4.51 return on every dollar invested.¹⁶

Pima County, AZ: In 2006, voters approved two bond packages to create the Crisis Response Center (CRC) and Behavioral Health Pavilion with the Community Partnership of Southern Arizona, the regional behavioral health authority. The CRC opened in 2011 and provides 24/7 services, including MRSS, family and youth peer support, and a crisis hotline. The Pima County Sheriff's Office and the Tucson Police Department receive Crisis Intervention Team training, including how to contact the Mobile Acute Crisis (MAC) teams. MAC teams receive about 200 calls per month, about half of which are from local law enforcement. In FY 2014, there were 4,433 adult and juvenile law enforcement transfers that saved 8,800 hours of law enforcement time, the equivalent of four full-time officers. Similarly, in FY 2015, 1,101 adults and children were transferred

from the ED to the CRC after initial stabilization to receive additional crisis services, rather than being admitted, saving \$456,138.¹⁷

Crisis Continuum Infrastructure, Components, and Services

Services for children and youth experiencing a behavioral health emergency exist along a continuum of care, the primary goal of which is to evaluate the situation for safety, followed by efforts to de-escalate behavior and stabilize the family. As the crisis stabilizes, a well-developed continuum is able to refer (via warm hand-off) to other supports and services and, in conjunction with other providers and the family, develop a plan of care to address the underlying difficulties that led to crisis. The essential components of a crisis continuum are detailed below.

Single Point of Access

Creating a single point of access streamlines the process and removes barriers to obtaining timely, necessary services and supports for children, youth, and young adults experiencing a behavioral health crisis. A single phone number for parents/caregivers and child serving partners (e.g. child welfare, juvenile justice, schools, pediatricians, etc.) to call with a ‘no wrong door’ approach simplifies what has historically been a time consuming and complicated process.

A single point of access provides one phone number, answered by live staff, 24 hours a day, seven days per week, who are responsible for direct linkage to either a specific service or to supports in the community that ensure the child’s and family’s needs are met. Various entities (e.g. MCO, service provider, etc.) may perform this function; however, capacity for collecting and analyzing data using metrics such as call answer times and time to connection to care initiation, for example, is critical, as these are essential quality indicators for access that must be regularly monitored for continuous quality improvement.

No Wrong Door

From whatever child-serving agency a parent or caregiver requests assistance, there is a mechanism and protocol in place by which to connect that agency to the single point of access. For children, youth, and young adults engaged with juvenile justice or child welfare, a warm hand off to the single point of access is coordinated with the referring agency.

In New Jersey, for example, the state’s Children’s System of Care uses a single contracted systems administrator (currently PerformCare), to authorize MRSS as part of a comprehensive, high-quality children’s behavioral health delivery system. Care management and family support organizations, schools, and other community partners can access a 24/7 toll-free number and follow the menu prompts provided for an urgent situation. The help-line staff ask a series of questions to determine if the child should be evaluated for hospitalization; if so, the family or caregiver is referred to a local screening center.¹⁸

In New Jersey, 94 percent of youth accessing MRSS are able to stay in their current living situation, in part because the single point of access (PerformCare) authorizes other home- and community-based services to stabilize the youth and family.¹⁹

Crisis Hotline

Available 24/7 and continually staffed by trained and qualified specialists, crisis hotlines are the primary entryway to MRSS services. Hotline operators field referrals from a variety of sources (parents/caregivers, schools, law enforcement, etc.), triage the call, and dispatch mobile intervention teams when necessary.

In Massachusetts, the Children’s Behavioral Health Initiative maintains a statewide 24/7 toll-free number. To access services, a caller enters their zip code to receive the number of the closest Mobile Crisis Intervention (MCI) provider. MCI services are available to children covered by MassHealth (Massachusetts Medicaid), Medicare, and some commercial insurance plans, as well as the uninsured; the toll-free number assists families with insurance/coverage questions. MCI service providers coordinate with the child’s primary care provider, other care management programs, and/or other behavioral health providers in the delivery of MCI services.²⁰

Electronic Health Record

Helpful, though not essential, is an accessible electronic health record (EHR) that serves as a mechanism for collecting and quickly sharing pertinent information ... subject to appropriate privacy protections and informed consent. An EHR minimizes the need for a child and family to repeat their story to multiple care providers, which is potentially re-traumatizing. An EHR is also useful in documenting the delivery of services necessary to submit claims for reimbursement to public and private payers.

Triage

Triage involves conducting a review to determine the risk of harm and then calibrating calls according to the level of threat, ranging from an immediate response (typically within one hour) to a scheduled visit (typically within 48 hours). In best practice examples, triage is part of the responsibility of the single point of access.

An ideal triage process is thoughtful, thorough, child- and family-centered, and considers:

- the child and family’s social environment;
- history of the crisis;
- current stressor(s) and known triggers; and
- previously employed de-escalation strategies (including previous treatment modalities), if any.

Answering questions such as “What prompted the parent/caregiver to call today?” and “What do the child and family need?” are critical in developing an individualized plan of care that addresses the needs of the child and family and averts future crisis. A warm handoff is an important part of the triage process and includes a three-way conversation between the single point of access, the parent/caregiver and the MRSS provider. During this conversation, details such as what the family can expect from the visit, and determining the level of risk and safety of the child and others in the home, are the priority.²¹

Mobile Response and Stabilization Services²²

While the exact design of MRSS should reflect the specific and unique needs of the state or community in which the program operates, best practice programs share common elements:

- the crisis is defined by the caller;
- services are available 24 hours a day, 7 days a week;
- they are able to serve children and families in their natural environments, for example, at home or in school;
- they include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers;
- they build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems; and
- they connect families to follow-up services and supports, including transition to needed treatment services.²³

MRSS are defined more broadly than traditional crisis intervention services and are not limited solely to crisis screening, triage, and referral. Driven by a commitment to provide services in the least restrictive setting while ensuring the safety of child and family, MRSS play a vital role in preventing future crises and provide an effective alternative to the historical ED screening response for children, youth, and young adults experiencing behavioral health crises.

Assessment

Comprehensive screening and assessment are fundamental to determining the need for behavioral health services and supports. For both quality and cost reasons, many states have chosen to use standardized tools as part of the assessment process to determine eligibility for Medicaid-covered behavioral health services, develop plans of care, and/or to report outcome measures. Use of a standardized screening and assessment tool, such as the Child and Adolescent Strength and Needs (CANS)²⁴ or the Child and Adolescent Service Intensity Instrument (CASII),²⁵ can help to ensure that services are delivered appropriately and effectively. A common assessment tool can assist in identifying children, youth, and young adults who present with high-risk behaviors, uncovering the child’s and family’s strengths and needs, and determining which services and supports are most appropriate to meet identified needs. Moreover, within a comprehensive

children’s behavioral health delivery system, a common assessment tool allows various child-serving agencies to “speak” the same language, and ensures a common understanding of the child’s and family’s strengths and needs.

Crisis Intervention and Initial Identification

Families are often best at identifying early behavioral changes in their children, before the changes rise to the level of recognition or need for intervention by child-serving systems. However, the family may not know when or how to seek assistance in managing the changes. In a well-developed children’s crisis continuum, MRSS provide a readily available intervention at the time the family first determines it needs assistance.

On site, face-to-face intervention from a mobile team of crisis professionals at the location of the crisis (i.e. the child’s home or school or another community setting), is a hallmark of MRSS. Comprehensive assessment is a core component of MRSS initial intervention, which also includes immediate de-escalation/stabilization and development of an individualized, strengths-based safety/crisis plan with the child and family. MRSS teams conduct assessments to determine the safety of the child and family and level of risk for harm to self or others, and to determine the services and supports necessary for resolving the current crisis and keeping the child, youth or young adult in the least restrictive environment (i.e. at home and in the community). MRSS teams have immediate access to psychiatric consultation for clinical support and medication review, and they coordinate care with existing providers. They also provide linkage and referral to new services and supports and may serve as gatekeepers for admission to higher levels of care, such as inpatient care. An initial crisis response/intervention is often limited to no more than 72 hours.

In Seattle/King County, WA for example, the Children’s Crisis Outreach Response System (CCORS) provides immediate services for children and youth ages 3 to 18. CCORS “staff will come to a private home or other community setting to assess and stabilize children and youth who pose a risk of harm to self or to others. [The staff also] works to provide immediate stabilization, same-day and next-day appointment coordination, emergency psychiatric assessment and medication review, in-home support services, school coordination, parent education, and linkage with long-term services.”²⁶

Crisis Stabilization

Referral and linkage to formal services can take time and, in most cases, the underlying reasons or root cause of a behavioral health crisis necessitate ongoing support. Consequently, MRSS often provide stabilization services subsequent to the initial acute intervention. These services may include in-home supports, respite care, and short-term care coordination. This stabilization component of MRSS may be provided over the span of a few days or over several (up to eight) weeks, depending on the needs of the family.

Residential Crisis Stabilization

Intensive short term, out-of-home placement for the child and family may avert the need for psychiatric inpatient treatment or lengthy out-of-home placement. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time, concomitant with high-quality home- and community-based services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.²⁷

Recovery and Reintegration

Unlike traditional crisis intervention, MRSS are responsible for facilitating the child's or youth's transition from acute intervention or crisis stabilization to the community. To do so, they may provide behavioral health education, help identify and develop relationships with formal and/or natural supports, assist the family with navigating the system, and provide medication management services.

Oklahoma, for example, uses behavioral health aides (BHA)²⁸ as part of the MRSS team to focus on community stabilization. The BHA builds a relationship with the youth, and provides behavioral skills development services, securing natural supports, and assisting with respite services to families as needed. The BHA also provides stabilization services to the youth and family by assisting the child and family team following the incident or stressor that precipitated the crisis.²⁹

System Coordination and Community Collaboration

Effective coordination of child-serving system partners in addressing the needs of children, youth and young adults, and their families in crisis is an essential function of a children's crisis continuum of care. When a child experiences a behavioral health crisis, the family is apt to engage with multiple child-serving entities (e.g. pediatricians, mental health clinicians, schools, child welfare, juvenile justice, law enforcement, etc.), and coordination of these system partners is required to maximize access to necessary care and minimize risk of re-traumatization and duplication of services and cost.

Engaging community partners early in the process of developing MRSS is critical in identifying which services are likely to meet the community's needs. In addition to direct services, mobile response teams provide education to local police departments around trauma and crisis response specific to children, and may assist in developing protocols to meet community-specific challenges.³⁰ MRSS teams also train child-serving system partners on topics such as Mental Health First Aide, trauma, crisis intervention, and suicide prevention activities.

Strategies for encouraging coordination and collaboration include: co-location of MRSS teams with system partners like community mental health centers and/or law enforcement agencies; use of crisis text lines, warm lines, and suicide hotlines; locating staff in a separate location from the organization's headquarters, preferably in the community; and

the use of paraprofessionals on MRSS teams who understand the culture of the community and/or can provide peer support.

Primary and Psychiatric Care Providers

When parents do not know where to turn, they often ask for assistance from their pediatrician or other primary care provider.³¹ Partnerships between pediatric primary care and behavioral health are an important component in the continuum of care.³² In a children's crisis continuum, an MRSS team's ability to connect a family with a child and adolescent psychiatrist or psychiatric nurse practitioner who can consult with the child's primary care provider around diagnosing, treating, and managing behavioral health concerns is extremely valuable, particularly in health professional shortage areas.³³ Psychiatric consultation can assist the primary care provider in determining whether referral to specialized care is necessary and provides timely introduction or continuation of psychotropic medication, if required.

Child Welfare

Children engaged in the child welfare system are at higher risk of experiencing complex trauma and demonstrating negative behaviors associated with trauma.³⁴ Engagement with the child welfare system itself can cause or exacerbate trauma. Trauma-informed crisis intervention must be available to children in foster care, and to foster parents, to maximize safety and minimize harm. Cross-systems training and coaching, data collection and analysis, and regular cross-agency communication and collaboration are important in minimizing the number of disrupted placements within the foster care system.

In New Jersey, for example, the child welfare agency's use of MRSS for children ages 4 and older who are removed from home to foster care has shown outcomes that include zero placement disruptions due to behavior.

Law Enforcement

Law enforcement may unknowingly identify children, youth, or young adults who are in need of support. However, when law enforcement lacks appropriate resources or training, identified children—and young adults especially—are at risk of being placed in

Coordination and Community Collaboration

Milwaukee, Wisconsin: The Mobile Urgent Treatment Team (MUTT) was developed in 2002, following the inception of Wraparound Milwaukee, the county's system of care for children with serious emotional and mental health needs.

- In 2005, Wraparound Milwaukee entered in a contract with child welfare for creation of a dedicated foster care crisis team due to excessive placement disruptions and as a response to a federal lawsuit. The result has been that 90 percent of referred youth have been stabilized in their foster homes.
- From 2006 to 2010, Wraparound Milwaukee had a contract with Milwaukee Public Schools for a specialized crisis team to service students in grades 6 to 12, designed to respond to aggressive or disruptive behavior. The contract ended in 2010 due the loss of state funds.
- In 2015, the MUTT/Milwaukee Police Department crisis team was developed based on the [Yale University Child Development-Community Policing Program](#). MUTT provides crisis prevention and intervention training to all Milwaukee Police Department officers.

unnecessarily restrictive settings, beyond what is necessary for maintaining their safety, or the safety of the community. Ongoing training, communication, and support for law enforcement personnel is essential to a well-coordinated crisis continuum. In some states and communities, MRSS providers train and support local law enforcement, and the partnership results in better coordination, identification, and connection to appropriate supports and services.³⁵

Schools/Education

Schools are natural partners in the work of a children's crisis continuum. Schools see children on a daily basis and may be able to identify early behavioral change. However, school personnel may not know how to connect a child and family to appropriate services and supports. Schools have historically used the ED and law enforcement as crisis intervention for children demonstrating concerning behavior. When schools collaborate with partners of the crisis continuum, alternatives to the ED can be used to address concerning behavior in lower intensity settings using home and community-based interventions.³⁶

Emergency Departments (ED)

Although EDs are part of a children's crisis continuum of care, they are designed primarily to address physical (not behavioral) health needs and tend to be adult-oriented. Training ED personnel to address the needs of children experiencing a behavioral health crisis, specifically in dysregulation and acting out behaviors related to trauma, is critical to appropriate treatment. Connecting an ED to community-based services such as MRSS can help prevent future crises and the need for emergent care.³⁷

In Massachusetts for example, crisis assessments are conducted in a hospital ED if the youth presents an imminent risk of harm to self or others, if youth and/or parent/caregiver refuses required consent for service in the home or an alternative community setting, or if a request for Mobile Crisis Intervention (MCI) services originates from a hospital emergency department. In instances in which a youth is sent to an ED, the MCI team mobilizes to the ED. The number of hospital-based interventions are closely monitored to ensure that MCI services are delivered primarily in community settings.³⁸

Juvenile Justice and Family Courts

Engaging juvenile justice and family courts as partners in the crisis continuum assists children, youth, and young adults with behavioral health needs in connecting to appropriate services and supports. The potentially traumatic impact of juvenile justice and the court system on children can be ameliorated if the connection to appropriate services and supports is the court's primary driver.³⁹

Community Organizations

Parent and youth peer organizations, faith-based organizations, and other community groups should not be overlooked as partners in a children’s crisis continuum of care. The ability to connect to high quality, sustainable community supports is key to preventing crisis and escalating behavior.⁴⁰

Workforce Strategies

Despite the high prevalence of behavioral health disorders – more than 40 percent of youth ages 13 to 17 experience a behavioral health problem by the time they reach seventh grade⁴¹– there is a significant shortage of mental health professionals across the United States. A 2013 report to Congress found that

*55 percent of U.S. counties, all rural, have no practicing psychiatrists, psychologists, or social workers ... [and] that 77 percent of counties had a severe shortage of mental health workers, both prescribers and non-prescribers, and 96 percent of counties had some unmet need for mental health prescribers. ... The two characteristics most associated with unmet need in counties were low per capita income and rural areas.*⁴²

Given the challenges associated with recruiting and retaining staff amid national workforce shortages, states and localities have adapted in a variety of ways, including:

Telehealth

In designing a children’s crisis care continuum – and more specifically, MRSS – travel, time, and existing system capacity must be considered. In communities where a face-to-face assessment is not viable due to workforce shortages and geographic distance, using a secure video connection to link a professional in one location with the child and family at another location can help, and is used in states like Oklahoma and Nevada.

In Nevada,⁴³ The Rural Mobile Crisis Response (RMCRT) team began taking calls in November 2016. By September 2017, the RMCRT had served 243 youth and families across Rural Nevada; 86 percent of youth were successfully diverted from the hospital. Many of the schools, hospitals, and Juvenile Detention Centers in Rural Nevada are now equipped with the telehealth program that RMCRT uses for interventions, allowing for more efficient response times during crisis calls. The RMCRT also developed an agreement with the Nevada Rural Hospital partners in which the team is contacted for youth in EDs. Under the agreement, RMCRT connects via video or in-person to reduce unnecessary inpatient care, which otherwise can involve hours-long transit to Reno or Las Vegas.⁴⁴

Co-Location

The MRSS team can be housed with system partners such as community mental health partners (as in Oklahoma), community organizations such as the YMCA/YWCA, or the police department.

Satellite Locations

MRSS staff may be located in a site or sites physically distant from their organizational headquarters to reduce travel time to remote communities.

Broad-Based Teaming

MRSS teams may include paraprofessionals, as in Oklahoma (see above), with deep community ties to facilitate access to local supports and/or peer support services. In Oakland County, Michigan for example, Oakland Community Health Network, the local behavioral health authority,⁴⁵ works with Common Ground, a community mental health agency to provide 24/7 crisis services, which include peer support.⁴⁶

Financing a Crisis Continuum of Care

Potential funding sources for MRSS and other home- and community-based services include Medicaid, commercial insurance, local and state educational funds, child welfare, mental health state general funds, and/or federal grants. These are often used in combination and strategies to build a continuum of appropriate services and supports.. States and localities may also elect to blend or braid funding to address the needs of children, youth, and young adults.⁴⁷

Braided funding brings funding streams together under a coordinated agency or single entity. It streamlines the provision of service by eliminating the need for an individual to enter separate programs to obtain each component identified in a single plan of care. Although a single entity oversees all expenditures, each stream is maintained to allow for the careful accounting of how every dollar from each stream is spent. Most federal funding streams require careful tracking of staff time, with requirements for allocation of personnel hours and other revenue-specific accounting and allocation requirements. Consequently, when multiple funding streams are paying for a single program or system, the system needs to be carefully designed and monitored to ensure compliance with all applicable federal and state statutes and regulations.

Blended (or pooled) funding combines revenue from multiple funding streams into one "pot" to maximize flexibility, but precludes the ability to report which funding stream incurred a specific expense. This can be politically challenging, as funders must accept reports on services provided across the population served, rather than services provided to specific children, youth, and young adults using their own revenue stream. In addition, some federal and state statutes may prohibit the blending of some funds.⁴⁸

Whichever method – blended or braided – reinvesting savings garnered by avoiding more restrictive, expensive care settings into the crisis continuum of care promotes the sustainability of partner child-serving agencies charged with providing home- and community-based services and supports.

Capacity to provide MRSS across subpopulations of children, youth, and young adults without regard to payment source is critical to ensuring consistency of practice and keeping children, youth, and young adults in their homes. Creating payer-specific eligibility criteria can unnecessarily direct some children to more restrictive settings that are more expensive and less effective than home- and community-based services.⁴⁹ This practice also creates confusion for child-serving systems on when and how to access care. Furthermore, the ability to access the crisis continuum of care when the situation is still manageable at home reduces the burden on already overburdened EDs and inpatient units.

States and communities that have adopted a whole-population approach that provides care for children with demonstrated emergent needs regardless of a family's ability to pay have demonstrated a reduction in overreliance on more restrictive environments such as inpatient care, juvenile detention, and residential treatment programs.⁵⁰ Such states and communities have seen a return on investment, realized as reduced caseload size in the child welfare and juvenile justice systems.⁵¹

Conclusion

Over the past decade, driven either by necessity or innovation, states and communities have begun to shift from the historical response to children's behavioral health crisis--consisting of screening and referral to higher levels of care and out of home placement--to a more upstream, public health approach to defining and addressing the urgent and emergent needs of children, youth, young adults and their families in their homes and communities.

A challenge for the children's behavioral health system is not only to know when clinical intervention *is* required, but when it is *not* – and most importantly, when and which interventions could be (re)traumatizing. Connecting to the right service, at the right time, for the right duration is particularly important when parents/caregivers first interact with the behavioral health system. A caregiver's first impression of the behavioral health system is likely to shape their experience and perception of its helpfulness for years to come. Ensuring a timely, appropriate, family- and youth-driven, individualized response to crisis is key to effective de-escalation and stabilization.

Evidence supports that, within a comprehensive crisis continuum of care, MRSS are not only clinically effective, but also cost-effective. From a fiscal perspective, MRSS can divert children, youth, and young adults from higher, more expensive levels of care. Additionally, they may be used across populations and financed through a variety of funding streams. MRSS play an important role in preventing ED use, psychiatric hospitalization, residential treatment, and placement disruptions among children, youth, and young adults experiencing a behavioral health crisis, contributing to improved cost and quality outcomes.

From a quality and clinical perspective, children, youth, young adults, and families benefit from MRSS because they not only get to define what the crisis is, but also are allowed to remain in the least restrictive safe environment – in their homes and communities - for assessment, treatment, and follow up.

MRSS teams serve as resources in educating the public and in responding to and de-escalating crises in homes, schools, and the community. They bridge partners in children’s behavioral health delivery systems, providing access points for linkage and referrals to services and supports (both formal and informal), such as care management entities, faith-based and family/youth organizations, and other behavioral health service providers.

As part of a comprehensive crisis response system for children, youth, and young adults, MRSS are valuable in preventing and diverting from higher, more expensive levels of care and improving the overall cost and quality of behavioral health care for this population.

References

- ¹ Technical Assistance Collaborative. (2005). A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph. Retrieved from http://tacinc.org/media/13106/Crisis_percent20Manual.pdf
- ² Mann, C. & Hyde, P. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. Joint CMCS and SAMHSA Informational Bulletin. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>
- ³ Massachusetts Parent/Professional Advocacy League. (2011). Crisis Planning Tools for Families: A Companion Guide for Providers. Retrieved from https://www.masspartnership.com/pdf/Crisis-Planning-Tools_Guide_for_ProvidersFinal.pdf
- ⁴ Pittsenbarger, Z.E., Mannix, R. (2014). Trends in Pediatric Visits to the Emergency Department for Psychiatric Illnesses. *Academic Emergency Medicine* (21)1, 25-30. Retrieved from <https://onlinelibrary.wiley.com/doi/epdf/10.1111/acem.12282>
- ⁵ Pittsenbarger, Z.E., Mannix, R. (2014). Trends in Pediatric Visits to the Emergency Department for Psychiatric Illnesses. *Academic Emergency Medicine* 21(1), 25-30. Retrieved from <https://onlinelibrary.wiley.com/doi/epdf/10.1111/acem.12282>
- ⁶ Hazen, E.P., & Prager, L.M. (2017). A Quiet Crisis: Pediatric Patients Waiting for Inpatient Psychiatric Care. *Journal of the American Academy of Child & Adolescent Psychiatry* 56(8), 631-633. Retrieved from [https://www.jaacap.org/article/S0890-8567\(17\)30226-5/abstract](https://www.jaacap.org/article/S0890-8567(17)30226-5/abstract)
- ⁷ Lippert, S.C., Nesper, A., Jain, N., Fahimi, J., Pirrotta, E., & Wang, N.E. (2016). Mental Health Emergency Department Visits: 24 Hours and Counting, Characteristics Associated With Prolonged Length of Stay. *Annals of Emergency Medicine*, 68(4), S57. Retrieved from <https://doi.org/10.1016/j.annemergmed.2016.08.154>
- ⁸ Lippert, S.C., Jain, N., Nesper, A., Fahimi, J., Pirrotta, E., Wang, N.E. (2016). Waiting for Care: Differences in Emergency Department Length of Stay and Disposition Between Medical and Psychiatric Patients. *Annals of Emergency Medicine* 68(4): S97. Retrieved from <https://doi.org/10.1016/j.annemergmed.2016.08.263>
- ⁹ Leon, S.L., Cloutier, P., Polihronis, C. Zemek, R., Newton, A.S., Gray, C. & Cappelli, M. (2017). Child and Adolescent Mental Health Repeat Visits to the Emergency Department: A Systematic Review *Hospital Pediatrics* 7(3), 177-186. Retrieved from <http://hosppeds.aappublications.org/content/7/3/177>
- ¹⁰ Shannahan, R., & Fields, S. (2015). Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services. The National Technical Assistance Network for Children's Behavioral Health.
- ¹¹ Mann, C. & Hyde, P. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. Joint CMCS and SAMHSA Informational Bulletin. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>
- ¹² Technical Assistance Collaborative. (2005). A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph. Retrieved from http://tacinc.org/media/13106/Crisis_percent20Manual.pdf
- ¹³ Marshall, T. & Vanderploeg, J. (2014). Connecticut's Emergency Mobile Psychiatric Services. Retrieved from https://gucchdtcenter.georgetown.edu/Activities/TrainingInstitutes/2014/Resources/Inst19_PPT1_CTEMP_S.pdf
- ¹⁴ King County Department of Community and Human Services, Mental Illness and Drug Dependency Advisory Committee. (2016). Mental Illness and Drug Dependency, 9th Annual Report. Retrieved from https://www.kingcounty.gov/~media/depts/community-human-services/MIDD/Reports/170814_MIDD_Ninth_Annual_Report.ashx?la=en
- ¹⁵ Salomon, S., Nakatsukasa-Ono, W., Winters, A., Lutz, O. (2014). Project SAFE: A review of a family systems model to prevent teen homelessness in Snohomish County. CARDEA. Retrieved from https://kingcounty.gov/~media/elected/executive/constantine/initiatives/best-starts-for-kids/Levy_percent20Information/21_Project_SAFE_and_CCORS.ashx?la=en

- ¹⁶ Carpenter, R. A., Falkenburg, J., White, T. P., & Tracy, D. K. (2013). Crisis teams: Systematic review of their effectiveness in practice. *The Psychiatrist*, 37, 232-237.
- ¹⁷ National Association of Counties. (2016). Mental Health and Criminal Justice Case Study: Pima County, Ariz. Retrieved from http://www.naco.org/sites/default/files/event_attachments/Pima_percent20County_percent20- percent20Mental percent20Health percent20and percent20Jails percent20Case percent20Study.pdf
- ¹⁸ NJ's Children's System of Care. (2018). Emergency Services for Children. Retrieved from <http://www.performcarenj.org/families/emergency-services.aspx>
- ¹⁹ Manley, E. (2016). Children's System of Care, 15th Anniversary. New Jersey Department of Children and Families. Retrieved from https://www.nj.gov/dcf/about/divisions/dcsc/CSOC_15.Year.Conference.Presentation.pdf
- ²⁰ Massachusetts Behavioral Health Partnership. (Undated). Emergency Services Program Mobile Crisis Intervention. Retrieved from <https://www.masspartnership.com/member/ESP.aspx> See also Commonwealth of Massachusetts, Executive Office of Health and Human. (2012). Mobile Crisis Intervention Performance Specifications Services. Retrieved from <https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf>
- ²¹ Sowar, K., Thurber, D., Vanderploeg, J.J., & Haldane, E.C. (2018). Psychiatric Community Crisis Services for Youth. *Child and Adolescent Psychiatric Clinics* 27(3), 479-490. Retrieved from <https://doi.org/10.1016/j.chc.2018.03.002>
- ²² Shannahan, R. and Fields, S. (2015). Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services. The National Technical Assistance Network for Children's Behavioral Health.
- ²³ Pires, S. (2010). Building Systems of Care, A Primer. 2nd Ed. National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. Retrieved from https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf
- ²⁴ Lyons, J.S., Weiner, D.A., & Lyons, M.B. (2004). Measurement as communication. The Child and Adolescent Needs and Strengths tool, In M. Mariush (Ed.) *The use of psychological testing for treatment planning and outcome assessment*. 3rd Edition, Vol. 2: Lawrence Erlbaum Associates, Inc, Mahwah, New Jersey: 461-476.
- ²⁵ CASSII was developed by the American Academy of Child and Adolescent Psychiatry's Work Group on Community Systems of Care, see: http://www.aacap.org/cs/root/member_information/practice_information/casii
- ²⁶ King County. (2017). Children's Crisis Outreach Response System (CCORS). Retrieved from <https://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/services/Youth/CrisisOutreach.aspx>. See also YMCA of Greater Seattle. (Undated). Immediate Crisis Support for your Child & Family. Retrieved from https://www.kingcounty.gov/~media/health/mentalHealth/DocumentsAndPDF/130624_CCORS_Brochure_Green_FINAL_English.ashx?la=en
- ²⁷ Mann, C. & Hyde, P. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. Joint CMCS and SAMHSA Informational Bulletin. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>
- ²⁸ Oklahoma Department of Mental Health and Substance Abuse. (2018). Services Manual. Retrieved from http://www.odmhsas.org/picis/Documents/Manuals/FY2018_ODMHSAS_Services_Manual.pdf
- ²⁹ Oklahoma Department of Mental Health and Substance Abuse. (Undated). Enhanced Children's Mobile Crisis. Retrieved from https://ok.gov/odmhsas/Mental_Health/Enhanced_Childrens_Mobile_Crisis.html
- ³⁰ Cf. Balfour, M.E., Winsky, J.M., & Isely, J.M. (2017). The Tucson Mental Health Investigative Support Team (MHIST) Model: A Preventive Approach to Crisis and Public Safety. *Psychiatric Services* 68(2), 211-212. Retrieved from <https://doi.org/10.1176/appi.ps.68203>
- ³¹ Strickland, B., Jones, J., Ghandour, R., & Newacheck, P.W. (2011). The Medical Home: Health Care Access and Impact for Children and Youth in the United States. *Pediatrics* 127(4): 604-611. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/21402643>
- ³² Back to the Basics: What You Need to Know about Primary and Behavioral Health Care Integration. (2016). SAMHSA-HRSA Center for Integrated Health Solutions (Webinar). Retrieved from <https://www.integration.samhsa.gov/about-us/webinars>
- ³³ Cf. Health Resources and Services Administration. (2018). Shortage Areas. Retrieved from <https://datawarehouse.hrsa.gov/topics/shortageareas.aspx>

- ³⁴ Pires, S. (2008). Building Systems of Care: A Primer for Child Welfare. National Technical Assistance Center for Children’s Mental Health Center for Child and Human Development, Georgetown University. Retrieved from https://gucchd.georgetown.edu/products/PRIMER_ChildWelfare.pdf
- ³⁵ National Center for Mental Health and Juvenile Justice. (2012). Law Enforcement-Based Diversion. Strategic Innovations from the Mental Health/Juvenile Justice Action Network: Retrieved from <https://www.ncmhjj.com/wp-content/uploads/2013/07/CIT-Y-Brief-2012.pdf>
- ³⁶ National Center for Mental Health and Juvenile Justice. (2018). School-Justice Partnership Program. Retrieved from <https://www.ncmhjj.com/projects/school-justice-partnership-program/>. See also, Center for School Mental Health. (2017). State of School Mental Health. Briefing Document Prepared for Expert Panel on School Mental Health Meeting. Retrieved from <http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Reports/State-of-School-Mental-Health-Initial-Briefing-Documents---September-2017-9.5.17.pdf>
- ³⁷ Luthra, S. (2016). Scarcity Of Mental Health Care Means Patients — Especially Kids — Land In ER. Kaiser Health News. Retrieved from <https://khn.org/news/scarcity-of-mental-health-care-means-patients-especially-kids-land-in-er/> See also, American Psychiatric Association. (2016). Position Statement on Psychiatric Hospitalization of Children and Adolescents. Retrieved from [https://www.psychiatry.org/File percent20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Psychiatric-Hospitalization-of-Children-and-Adolescents.pdf](https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Psychiatric-Hospitalization-of-Children-and-Adolescents.pdf); Steinman, K.J., Shoben, A.B., Dembe, A.E., & Kelleher, K.J. (2015). How Long Do Adolescents Wait for Psychiatry Appointments? *Community Mental Health Journal* 51(7), 782-9. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/26108305>
- ³⁸ Massachusetts Behavioral Health Partnership. (Undated). Emergency Services Program Mobile Crisis Intervention. Retrieved from <https://www.masspartnership.com/member/ESP.aspx> See also Commonwealth of Massachusetts, Executive Office of Health and Human. (2012). Mobile Crisis Intervention Performance Specifications Services. Retrieved from <https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf>
- ³⁹ National Center for Mental Health and Juvenile Justice. (2018). Specialty Courts. Retrieved from <https://www.ncmhjj.com/topics/specialty-courts/> See also, Office of Juvenile Justice and Delinquency Prevention. (Undated). Model Programs: Specialty/Problem-solving Courts. Retrieved from <https://www.ojjdp.gov/mpg/Topic/Details/75>
- ⁴⁰ Robshaw, S. & McGarrie, L. (2016). Flexible Funds for Customized Goods and Services. The National Technical Assistance Network for Children’s Mental Health. See also, Marcenko, M., Brown, R., DeVoy, P. R., & Conway, D. (2010). Engaging parents: Innovative approaches in child welfare. *Protecting Children*, 25(1), 23-34; Stroul, B. A., Friedman, R. M. (2011). Effective Strategies for Expanding the System of Care Approach: A Report on the Study of Strategies for Expanding Systems of Care. Atlanta, GA: ICFMacro.
- ⁴¹ SAMHSA. (2018). Age and Gender-Based Populations. Retrieved from <https://www.samhsa.gov/specific-populations/age-gender-based>
- ⁴² SAMHSA. (2013). Report to Congress on the Nation’s Substance Abuse and Mental Health Workforce Issues. Retrieved from <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>
- ⁴³ Nevada Department of Child and Family Services. (2018). Rural Children’s Mental Health Consortium, Annual Progress Report for Ten-Year Strategic Plan. Retrieved from <http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Programs/CMH/SOC/RuralChildrensMHConsortiumTenYrStratPlan.pdf>
- ⁴⁴ Messerly, M. (2018, March 11). An ‘ugly’ process: Sheriffs, hospitals shoulder burden of crisis mental health care in rural Nevada. *The Nevada Independent*. Retrieved from <https://thenevadaindependent.com/article/an-ugly-process-sheriffs-hospitals-shoulder-burden-of-crisis-mental-health-care-in-rural-nevada>
- ⁴⁵ Oakland Community Health Network. (2018). Resource and Crisis Helpline. Retrieved from http://www.occmha.org/index.php?option=com_content&view=article&id=78&Itemid=482
- ⁴⁶ Heincelman, A., Lyons, P., & Rae, H. (2014). Community Crisis Center, An Urban Model. Oakland Community Health Authority. Retrieved from [https://www.macmh.org/sites/default/files/attachments/files/Workshop percent209 percent20Community percent20Crisis percent20Center percent20MACMHB percent20Presentation percent20thumb.pdf](https://www.macmh.org/sites/default/files/attachments/files/Workshop%20percent20Community%20Crisis%20Center%20MACMHB%20Presentation%20thumb.pdf)
- Making the Case for a Comprehensive Children’s Crisis Continuum of Care, August 2018**

⁴⁷ Clary, A. & Riley, T. (2016). Braiding & Blending Funding Streams to Meet the Health-Related Social Needs of Low-Income Persons: Considerations for State Health Policymakers. National Academy of State Health Policy. Retrieved from <https://nashp.org/wp-content/uploads/2016/02/Jean1.pdf>

⁴⁸ See, e.g., the challenges associated integrating federal early childhood funds and state pre-K/early intervention funds in: U.S. Government Accountability Office. (2016). Child Care: Information on Integrating Early Care and Education Funding, GAO-16-775R Child Care. Retrieved from <https://www.gao.gov/assets/680/679764.pdf>

⁴⁹ Stroul, B.A., Pires, S.A., Boyce, S., Krivelyova, A., Walrath, C. (2014). Return on Investment in Systems of Care for Children with Behavioral Health Challenges. National Technical Assistance Center for Children's Mental Health. Retrieved from

https://gucchdtcenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf

⁵⁰ SAMHSA, (2016). The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress, 2015. Retrieved from

https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

⁵¹ McGill, K. (2015). Redressing the Emperor: An Implementation Framework in Bridging Cross Youth Service Delivery Planning for Children/Youth with Multiple Systems Involvement in a System of Care, Residential Treatment for Children & Youth, 32 (3), 208-223. Retrieved from

<https://doi.org/10.1080/0886571X.2015.1102481>