Customizing the Crisis Response System to Meet the Needs of Children, Youth, Young Adults and their Families
Mobile Response and Stabilization Meets the Unique Needs of Children, Youth, Young Adults and Families
Unique Needs of Children, Youth, Young Adults and their Families

Developmental Parents/Caregivers Service Delivery Systems
MRSS Basics

1. Screen in, not out
2. Callers know why and when they need help; we believe them

Crisis is defined by the family/YA

Responses are face to face

Customized for children, youth, and families

1. Workforce is trained specifically to respond to children, youth, and caregivers
2. Support occurs in homes and communities

1. Available 24/7/365
2. Face to Face within 1 hour
MRSS Core Components

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 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
Interruption Points

Places in the pathway(s) that system leaders need to intervene to change the experiences of families and address the identified problem. Interruption points are opportunities for system leaders to change care pathways and/or create new pathways.
MRSS Goals:

Maintain
• 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.

Support
• Support youth and families by providing trauma informed care.

Promote
• Promote 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.
MRSS Peer to Peer 2016 to 2018

- Alaska
- California
- Colorado
- Florida
- Georgia
- Guam
- Illinois
- Indiana
- Kansas
- Louisiana
- Maryland
- Michigan
- Nevada
- New York
- North Carolina
- Ohio
- Oklahoma
- Pennyslvania
- South Carolina
- Tennessee
- Utah
- Washington
- West Virginia
- Vermont
- Ohio
- Minnesota
- Virginia
Oklahoma
Oklahoma’s Youth Crisis Mobile Response is an integral component of Oklahoma Systems of Care (OKSOC) and founded on OKSOC values and principles, which provide the driving force for the provision of behavioral health services to Oklahoma’s children, youth, young adults, and families.

Youth Crisis Mobile Response provides statewide rapid, community-based mobile crisis intervention services for children, youth, and young adults up to the age of 25 who are experiencing behavioral health or psychiatric crises.
What we know to be different

• A crisis is defined by the caregiver and youth or young adult.

• A crisis can be any circumstances, beliefs and perceptions that overwhelm our ability to cope effectively with stress.

• The youth or young adult is not able to resolve the situation with the skills and resources available.

• Their behavior may put them at risk of harming themselves or others and/or placement change.
Children, youth, young adults, and their families will access services early to remain in their own homes and in their own communities safely and successfully with hope and resilience for the future.
• Temporary break from situation resulting in crisis call
• No change in custody or placement, so living environment remains stable
• Can be an appropriate strategy for MRT
• Can include both formal and informal arrangements:
  • Informal: Staying overnight, for the weekend, or an extended temporary time with other family members or friends
  • Formal: Making a Respite Request through Oklahoma Systems of Care with payment vouchers to Respite Providers
2,032 youth experiencing a crisis and mobile response were enrolled in OKSOC.

- 75% of those youths were clinically impaired* at enrollment.
- 52% of those youths who reached 6-month follow-up showed clinically significant improvement*.

*As measured by the OKSOC psychometric assessment: the Ohio scales

Enrolled in OKSOC & Accessing Youth Crisis and Mobile Response

Jan 2019-Jan 2022
Total Calls = 19,493
• 78% of callers reported that they would use the Crisis Call Center again.
• 71% of callers reported that the crisis was resolved.
• 74% of callers reported that their experience with the Crisis Call Center was good/great.
• 61% of callers reported that their experience with the MRT was good/great.
• 73% of callers reported that they were satisfied with their youth’s progress since their call.

Unintended Consequences
E-TEAM at the University of Oklahoma has served as the Oklahoma Systems of Care evaluators since 2002. E-TEAM provides ongoing design and implementation of OKSOC’s statewide evaluation, including development of the OKSOC evaluation portal—EON—a secure web-based application which provides real-time access to evaluation and program monitoring data. E-TEAM gathers and assesses evidence documenting service utilization; program effectiveness for children, youth, young adults, and their families; and system costs.

E-TEAM also partners with OKSOC on eLearning and in-person trainings to facilitate continuing professional education for children’s behavioral health provider staff across the state. This partnership provides meaningful interactions for learners, promotes and fosters fidelity to OKSOC core values, and reduces travel costs and time away from work.
Connecticut
What changed CT Model

Complaints
- “They do not come out.” “We stopped calling.” (50%)
- Inconsistency—No standardized approach for screening or assessment
- Inadequate coordination—EDs, Law Enforcement, Schools and Families
- Inadequate quality performance
- Confusion 12 different crisis
- Limited capacity – Limited hours

Goals
- Increase face to face Mobile Response to community & families
- Increase calls
- Ensure competent crisis assessment
- Expand use for: families, Schools, EDs, Police, Foster Families
- Reduce Beh. Health visits to ED
- Divert use of Inpatient to community
- Improve public awareness & confidence
- Improve linkage to community network
What CT needed

Be Responsive
- no telephonic screening - “your crisis isn’t a crisis”
- Quick response (CT average 30 min.)
- Listen to caller-not just what was being said-
  - “My son will not eat his peanut butter and jelly sandwich.”
- Structured, consistent EBP like Model
- Re-assure the caller- “I am on the way.”... any dogs, guns or specific directions
- Linkage and connection to longer more appropriate care but offer support while waiting.
CT Core Elements

• Statewide Call Center with one number- 211-1-1- now 988
• Community based, family supportive clinical intervention
• Free of charge to all youth and families regardless of insurance type
• Rapid acute stabilization (45 min. response) as well as short-term follow-up stabilization services (up to 45 days). Connections to ongoing services as needed
• Staffed by licensed Master level (or license eligible) with consulting Psychiatric APRN or Child/Adol. Psychiatrist. Use of Peers is encouraged.
• Statewide Performance Improvement Center (PIC)
CT Lessons Learned

- Engage and include parents/caregivers, youth and family in process.
- Engage and include the community and stakeholders in the process.
- Statewide/Countywide single Call Center, standardized screening, assessment and stabilization, including linkage to on-going support.
- Be Responsive
  - Face to Face assessment
  - Be quick
  - Be Strength-based and Family Centered