Articulating the Need for Child MRSS Versus Adult Mobile Crisis Models

MRSS Affinity Group Call
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

February 6, 2020
12:00—1:00 PM EDT

1

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Elizabeth Manley
Clinical Instructor for Health and Behavioral Health Policy
Institute for Innovation and Implementation

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3

Articulating the Need for Child MRSS Versus Adult MRSS

- When a child has a medical need we do not call the gerontologist, we call the pediatrician.
- Adults and children each have unique needs that require different approaches.

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Articulating the Need for Child MRSS Versus Adult MRSS

- Children and youth are developmentally different and require different approaches
- Children and youth are connected to different systems, such as education, child welfare, juvenile justice and pediatricians

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Why A Crisis Continuum of Care for Children?

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.

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6

Mobile Response and Stabilization Services

- Can effectively *deescalate, stabilize,* and *improve treatment outcomes*.
- Are specifically designed to *intercede before urgent behavioral situations become unmanageable emergencies* and *are instrumental in averting unnecessary emergency department visits, residential interventions and placement disruptions, and in reducing overall system costs*.

Technical Assistance Collaborative. (2005).
A Community-Based Comprehensive Psychiatric Response Service: An Informational and instructional monograph.
Retrieved from http://tacinc.org/media/13106/Crisis%20Manual.pdf

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7

Why Include MRSS In a Crisis Continuum?

- Children, youth, young adults and families can initiate care based on a self-defined crisis
- 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

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

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8

Crisis Continuum:

MRSS Common Elements:

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

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9

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10

Crisis Continuum: System Coordination and

- Primary and Psychiatric Care Providers
- Child Welfare
- Law Enforcement
- Schools/Education
- Emergency Departments
- Juvenile Justice and Family Courts
- Community Organizations

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11

Financing a Crisis Continuum of Care

- Potential sources include:
  - Medicaid,
  - commercial insurance,
  - local and state educational funds,
  - child welfare,
  - mental health state general funds,
  - and/or federal grants.

Often used in combination

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12

Chris Morano

Please insert your title here

MRSS in Natural Environments: Strategies that Work – Helping Youth When They Need It, Where They Need It

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13

Effective Systems/Organic Community Solutions

Traditional Resource Intensive

- Bricks and Mortar
- Out of home
- Heavy emphasis on professional, non-sustainable intervention
- Less family involvement

Systems of Care

- Reliance on family, community
- Children remain at home
- Change is sustained, and sustainable
- Cost effective, community supported

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14

Child Caring System Approach Versus Adult Individual Person Models

Family/Systems View	Individual Person View
• Multiple broad determinants	• Pathology based
• Team, family, community centered focus, solutions	• Child focused approach
• Not necessarily medical	• Medical model
• Strengths based	• Leads to labeling, narrow focus

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15

Yale Child Studies Center and The One-Foot Rule

If the one in need is a wee one….

Then the onus to support, guide, and lead behavior change is on the taller one, AKA the caregiver

Trauma + Law Enforcement + Professional Guidance + Caregivers = less PTSD in children/youth

16

Children are not Little Adults

The adult verbal psychotherapy model falls far short of the breadth and depth of strategies and supports necessary to help youth.

17

Positivity, Play and Development

- Harvard Child Development Center – Importance of play for brain development, impulse control, and ability to inhibit responding
- LiiNK Program – Rhea, TCU
  - Modeled after Finnish school program, emphasizing recess
  - Triple recess time = higher scores, less disruption, less meds
- Neuronurturing – Lynne Kelly

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18

And YES to Movement, Meditation, & Yoga as Healing

- Baltimore's Coleman School
- Mindful Moment
- 5 minutes of discussion, 15 minutes of meditation
- Behavior improvements

- Bessel Vander Kolk
  - Studied 9/11 trauma victims
  - Guess how most preferred to heal?

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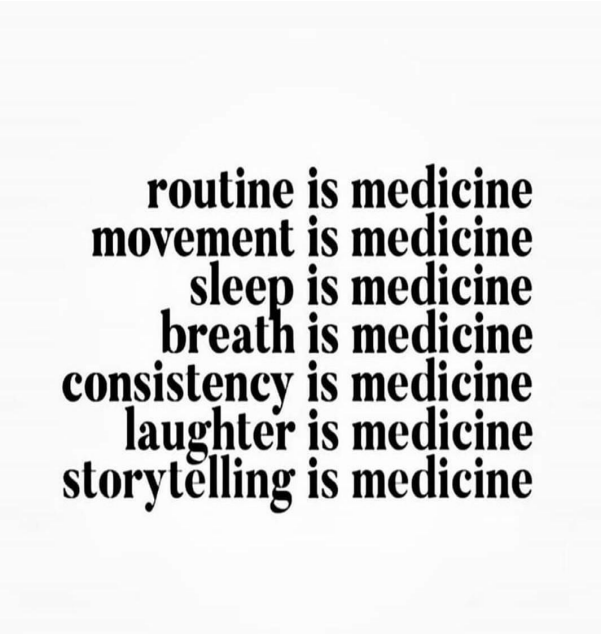
19

Especially useful for youth who have experienced trauma

– Perry, Vander Kolk

- Multisensory experiences facilitate more immediate and enduring changes, useful in a crisis
  - e.g., weighted blankets lower BP, heart rate and anxiety



20

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Chris Morano
cjasizm@aol.com

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1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

21

21