Transforming the Crisis System

988 and Mobile Response and Stabilization Services (MRSS)

Beth Holliman

Brian Pitkin

Oregon Health Authority

Centering Health Equity

Oregon will have established a health system that creates health equity where all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

The equitable distribution or redistribution of resources and power; and

Recognizing, reconciling and rectifying historical and contemporary injustices.

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The Health Equity Committee definition framework draws attention to the concepts of fairness and justice in the distribution of resources.

Furthermore, it highlights the idea that social inequities in health are avoidable through collective action and that inaction is no longer acceptable.

Identifying and implementing effective solutions to move the dial on health equity demands:

- Recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities.
- Engagement and meaningful collaboration of a wide range of partners representing diverse experiences and points of view.
- Direct involvement of affected communities and individuals with lived experience as partners and leaders in change efforts.

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There are specific opportunities to build the structure and advance health equity through:

- Centering health equity in every policy and decision-making arena.
- Adopting a shared vision for health equity.
- Aiming for greater alignment and amplification of existing efforts to advance health equity.
- Building collective capacity and infrastructure at the organization and committee level for change.
- Create and advance systems changes and policies that result in reallocation of resources and power

To see full presentation:

https://www.oregon.gov/oha/OEI/HECMeetingDocs/Health%20Equity%20Definition_October%202019%20HEC%20Presentation%20to%20OHPB.pdf

OHA Health Equity Definition

https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx

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OHA Accountability

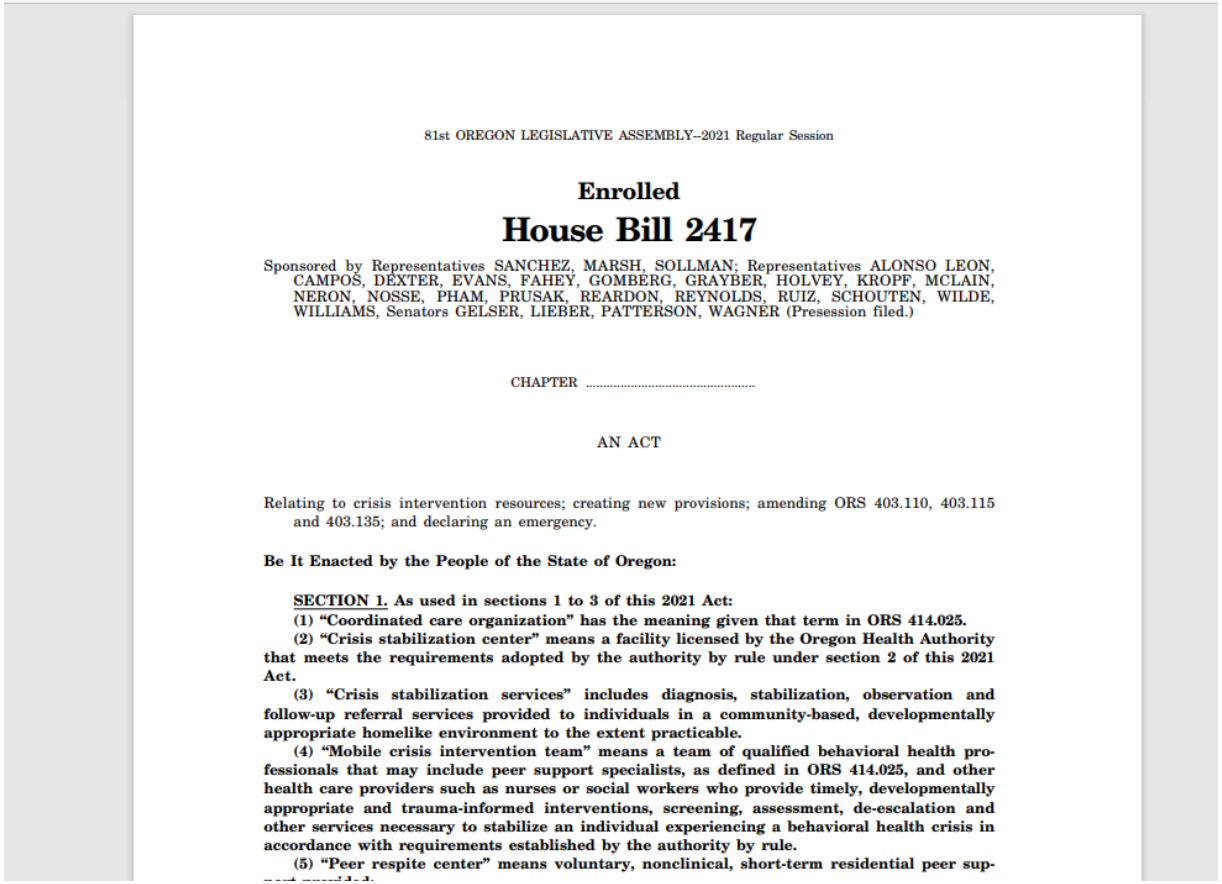
We will be coming back to these at the end to discuss

- **How can OHA proactively plan to address concerns from priority populations, which includes communities of color, LGBTQIA2+, young adults and their intersecting identities, who historically have experienced systemic racism and mistreatment ?**

  - Ideas for how OHA can better center health equity during implementation and roll out of MRSS?

  - How can OHA begin to repair and build trust with the community?

House Bill 2417
July 2021



81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Enrolled

House Bill 2417

Sponsored by Representatives SANCHEZ, MARSH, SOLLMAN; Representatives ALONSO LEON, CAMPOS, DEXTER, EVANS, FAHEY, GOMBERG, GRAYBER, HOLVEY, KROPF, MCLAIN, NERON, NOSSE, PHAM, PRUSAK, REARDON, REYNOLDS, RUIZ, SCHOUTEN, WILDE, WILLIAMS, Senators GELSER, LIEBER, PATTERSON, WAGNER (Presession filed.)

CHAPTER .....

AN ACT

Relating to crisis intervention resources; creating new provisions; amending ORS 403.110, 403.115 and 403.135; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. As used in sections 1 to 3 of this 2021 Act:

(1) "Coordinated care organization" has the meaning given that term in ORS 414.025.

(2) "Crisis stabilization center" means a facility licensed by the Oregon Health Authority that meets the requirements adopted by the authority by rule under section 2 of this 2021 Act.

(3) "Crisis stabilization services" includes diagnosis, stabilization, observation and follow-up referral services provided to individuals in a community-based, developmentally appropriate homelike environment to the extent practicable.

(4) "Mobile crisis intervention team" means a team of qualified behavioral health professionals that may include peer support specialists, as defined in ORS 414.025, and other health care providers such as nurses or social workers who provide timely, developmentally appropriate and trauma-informed interventions, screening, assessment, de-escalation and other services necessary to stabilize an individual experiencing a behavioral health crisis in accordance with requirements established by the authority by rule.

(5) "Peer respite center" means voluntary, nonclinical, short-term residential peer sup-

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HB 2417 Highlights

- ✓ Stand up 988 as an alternative option to 911 for Oregonians
  - ❑ For any Oregonian needing behavioral health support
  - ❑ Regardless of age
  - ❑ Regardless of insurance
  - ❑ Available 24/7/365 to all communities
- ✓ Expand and enhance current mobile response services
- ✓ Provide stabilization services for children and families (MRSS)
- ✓ Build community resources and partnerships

What we hear from the community…

- Fail up system
- Not feeling heard
- Wisdom and experience is not trusted
- Emergency Department is the front door
- Emergency Department is not designed to treat children's behavioral health crises, needs are often left unmet
- Families left to prove how bad things are
- Shame and blame throughout the lifespan of the concern/emergency
- Lack of access to support navigating the system
- Lack of access to peer support
- Concerns and emergencies often started in school and when children were very young

SOCA 3/31/22 Jam Board

Community Engagement

July 2022

- Crisis System Advisory Work Group (CSAW)
- Rules Advisory Committee started on July 12, 2022
- Oregon MRSS Learning Collaborative July 11, 2022

Child and Family Behavioral Health Unit Initiatives

- Crisis System Advisory Work Group (CSAW
- MRSS Community Conversations
- Youth Think Tanks
- CFBH Workgroup includes youth and family peers
- System of Care Advisory Committee (SOCA)
- Children's Association of Community Mental Health Programs (AOCMHP) Workgroup

Someone to call

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988 Centralized Call Center

- **Roughly 80% of calls resolved by the call center**
  - crisis counseling and safety planning
  - triage and screening
  - connection to community services and supports

- **CMHPs report that 10-15% of Mobile Response to the community is currently for children and families**

Program Updates

Preliminary 988/Lifeline Phone Volume Summary

	Calls Answered	Calls Abandoned	Total Received	% Increase Total Received (From Previous Week)	Abandonment Rate	Answer Rate
7/16/2022	135	8	143	27% (From 113 calls received on 7/9/2022)	5.59%	94.41%
7/17/2022	112	4	116	38% (From 84 calls received 7/10/2022)	3.45%	96.55%

Excludes 20 second short abandons.

There were 76 calls received on 7/16/2021, resulting in an 88% single-day increase over last year.

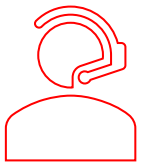
Preliminary 988 Chat/Text Volume*

	Answered
7/16/2022	12
7/17/2022	36
Total	48

*Time in EST, Pure Connect Data

What happens after someone calls 988?

Calls are transferable, so callers connect to appropriate resources.



911

911 can dispatch if public safety concerns dictate, or if MRSS team is concerned for their safety.

988

Assessment, triage, de-escalate.

Unable to de-escalate, or response requested.

Mobile Response and Stabilization Services respond, offering 72-hour crisis stabilization services and up to 56 days of additional care and support.

Crisis de-escalated, referral to services and resources (80% of calls).

A community of support.

Enhanced Crisis Services
Coming January 2023

Community Based Mobile Response Interventions Services (CBMRIS)

Mobile Response and Stabilization Services (MRSS) for youth, young adults and their families

Someone to respond

National Resources, Research and Models for Children's Crisis Services

#CrisisTalk

CRISIS NOW
Transforming Crisis Services

NASMHPD

TA NETWORK

SAMHSA
Substance Abuse and Mental Health Services Administration

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https://talk.crisisnow.com/wp-content/uploads/2021/12/988-Crisis-Learning-Community-Weekly-Call-20211215-edited.mp4?_=2

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MRSS

National Best Practices

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

Goals and Objectives

1. Reduce the use of law enforcement for behavioral health emergencies
2. Offer face to face support when youth and families are asking for help
3. Reduce Emergency Department usage and boarding times for youth and families
4. Provide support and services to all families regardless of insurance
5. Offer both clinical and peer services
6. Keep youth in the community and with their families
7. Provide bridge services for families while they are waiting for other services

Customized Mobile Response and Stabilization Services for children, youth, young adults and their families

2-person teams, with specialized training working with children and youth, will provide face to face response

- Family Support Specialists
- Youth Peer Support Specialists
- Qualified Mental Health Professionals*
- Qualified Mental Health Associates

position required to receive enhanced rate under Medicaid

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Mobile Response teams receive *customized* training

- Trauma Informed Care
- Neurobiology and child development
- Effective engagement strategies for working with children and youth
- Partnering with parents and caregivers
- Youth and Family specific crisis and safety planning
- Cultural considerations when working with youth and their families
- Supporting LGBTQ2S+ youth
- Screening for Drug and Alcohol use with youth
- Familiarity and relationship with the continuum of care for children and community resources

Recommendations?

What other types of trainings do you think are important for MRSS staff responding to youth, young adults and their families?

MRSS Teams

Initial Response may include:

- ✓Crisis resolution and problem solving
- ✓Risk assessments
- ✓Crisis and Safety Planning
- ✓Substance Use Screening
- ✓Mental Health Assessment
- ✓Connection to community-based services, natural resources and supports

MRSS Teams

Stabilization Services for up to 8 weeks may include:

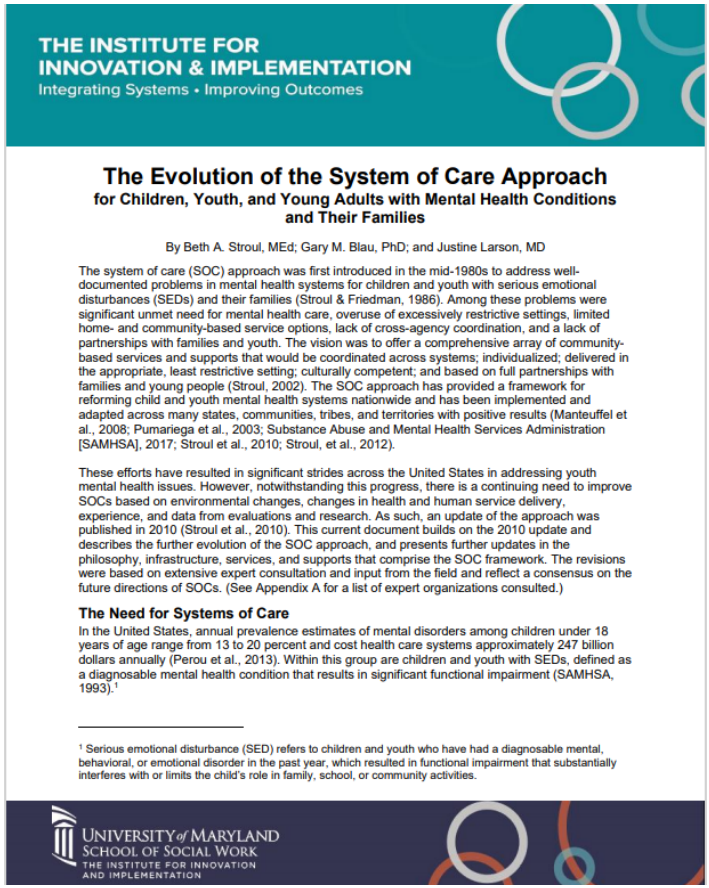
- ✓Parenting support and advocacy
- ✓Brief individual and family therapy
- ✓Skills Training
- ✓Peer Delivered Services
- ✓Connection to community services with a warm hand off

Thoughts?

What do you think about this model of connecting families to both a Family Support Specialist and a Qualified Mental Health Professional during stabilization services?

Community to support

The Evolution of the System of Care Approach



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The Evolution of the System of Care Approach
for Children, Youth, and Young Adults with Mental Health Conditions and Their Families

By Beth A. Stroul, MEd; Gary M. Blau, PhD; and Justine Larson, MD

The system of care (SOC) approach was first introduced in the mid-1980s to address well-documented problems in mental health systems for children and youth with serious emotional disturbances (SEDs) and their families (Stroul & Friedman, 1986). Among these problems were significant unmet need for mental health care, overuse of excessively restrictive settings, limited home- and community-based service options, lack of cross-agency coordination, and a lack of partnerships with families and youth. The vision was to offer a comprehensive array of community-based services and supports that would be coordinated across systems; individualized; delivered in the appropriate, least restrictive setting; culturally competent; and based on full partnerships with families and young people (Stroul, 2002). The SOC approach has provided a framework for reforming child and youth mental health systems nationwide and has been implemented and adapted across many states, communities, tribes, and territories with positive results (Manteuffel et al., 2008; Pumariega et al., 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2017; Stroul et al., 2010; Stroul, et al., 2012).

These efforts have resulted in significant strides across the United States in addressing youth mental health issues. However, notwithstanding this progress, there is a continuing need to improve SOCs based on environmental changes, changes in health and human service delivery, experience, and data from evaluations and research. As such, an update of the approach was published in 2010 (Stroul et al., 2010). This current document builds on the 2010 update and describes the further evolution of the SOC approach, and presents further updates in the philosophy, infrastructure, services, and supports that comprise the SOC framework. The revisions were based on extensive expert consultation and input from the field and reflect a consensus on the future directions of SOCs. (See Appendix A for a list of expert organizations consulted.)

The Need for Systems of Care

In the United States, annual prevalence estimates of mental disorders among children under 18 years of age range from 13 to 20 percent and cost health care systems approximately 247 billion dollars annually (Perou et al., 2013). Within this group are children and youth with SEDs, defined as a diagnosable mental health condition that results in significant functional impairment (SAMHSA, 1993).[1]

[1] Serious emotional disturbance (SED) refers to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities.

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Core Components for a Comprehensive Service Array in SOC:

- ❑ Intensive Care Coordination using Wraparound
- ❑ Intensive In-home Mental Health Treatment Services
- ❑ Parent and Youth Peer Support
- ❑ Mobile Response and Stabilization Services
- ❑ Respite Care

https://wraparoundohio.org/wp-content/uploads/2021/06/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

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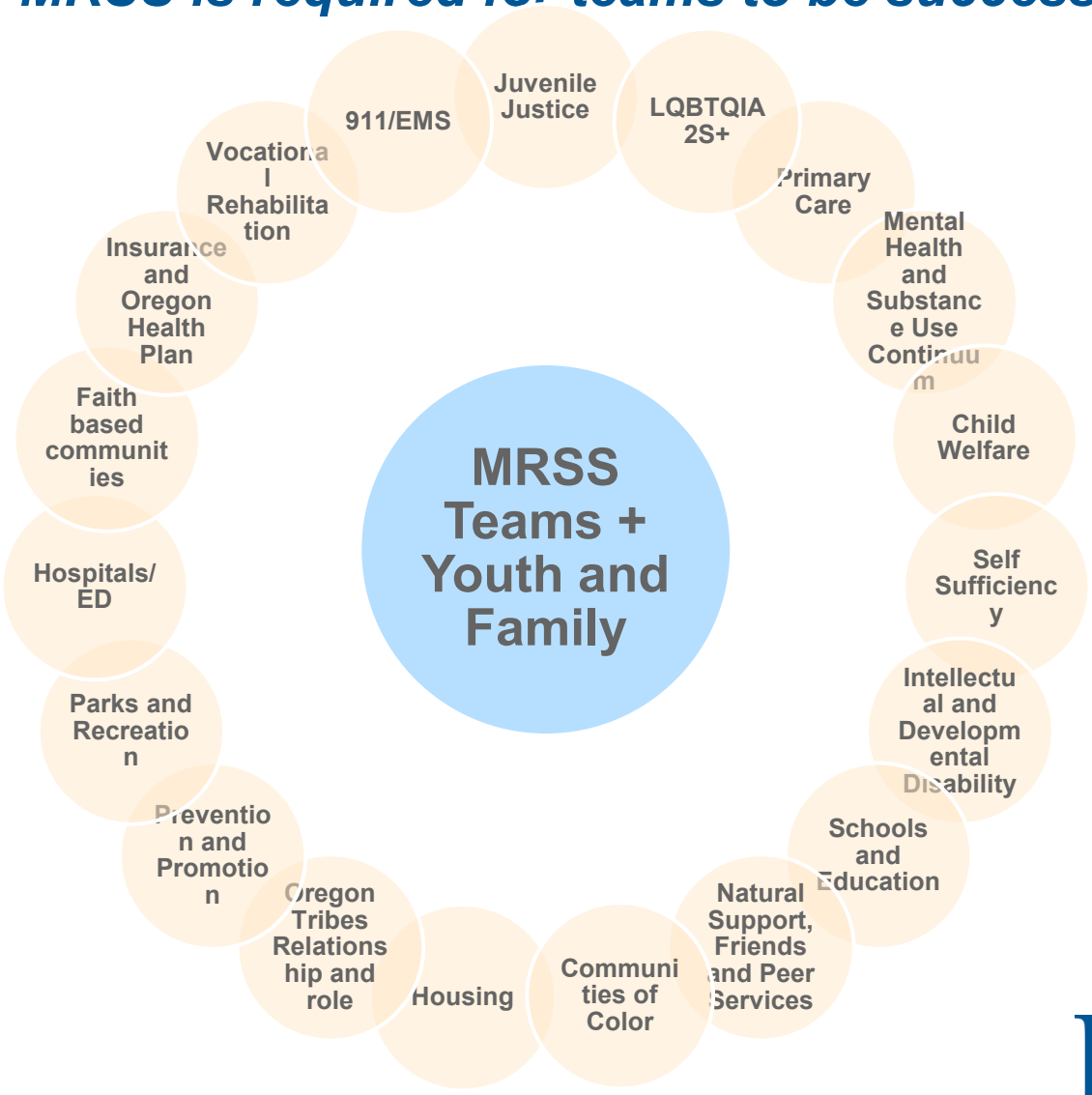
Local Children's System of Care commitment and involvement for MRSS is required for teams to be successful.



Who else needs to be at the table?

Group Discussions and Recommendations

- **How can OHA proactively address concerns from priority populations, which includes communities of color, LGBTQIA2+, young adults and their intersecting identities, who historically have experienced systemic racism and mistreatment ?**

  - Ideas for how OHA can better center health equity during implementation and roll out of MRSS?

  - How can OHA begin to repair and build trust with the community?

2022 Transitional Year

Starting Jan. 2023 each county will be responsible for providing **stabilization services in partnership with their county mobile response teams.**

Funding for MRSS will be routed through a new service element (SE 25A) starting in January 2023. Development of an equitable funding formula is in process.

Oregon Administrative Rules (OARS) will include a new chapter for Crisis Response Services (in process).

Oversight and Monitoring

- Crisis Services Advisory Workgroup
- Crisis Services Steering Committee
- Quality Learning Collaborative
- Key Performance Indicators
- OHSU Technical Assistance Team: CMHP level Quarterly Reports

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Recommendations

How would you like to be updated throughout the implementation of this project?

NEXT STEPS

What has already happened...

- Community Conversations and Youth Think Tanks
- Community System Advisory Workgroup (CSAW)
- OHA awarded a CMS planning grant
- Counties hired a project manager to oversee implementation, working with OHA
- 3 additional positions within OHA
- RI International Consultation
- Training recommendations
- Public comment on 988 Call Center Contract
- Rules Advisory Committee is underway

What is in process...

- Revise Service Elements 25 and 25a to include Mobile Response and Stabilization Services (MRSS) specific to children, youth and their families for 2023
- Build out community resources and create expedited pathways to care
- Work with counties to establish what steps are needed to get from where we are now to developing a customized youth and family MRSS state-wide model
- Partner with schools to establish protocols

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QUESTIONS

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Thank You

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