Managing Now for a BETTER TOMORROW

Addressing Equity During COVID-19

A Conversation on Mobile Response and Stabilization: Supporting Children, Youth and Families during COVID-19

November 10, 2020

Resources:

- Link to webinar recording
- Register for How to Talk About Racism: Advancing our Work to Support Children, Youth, and their Families during COVID-19
- COVID-19 Resources for Children's Services
- Resources for Families During the COVID-19 Outbreak
- Family Support Organization
- Nevada Department of Health & Human Services Division of Child & Family Services
- Children's Mobile Crisis Response Team
- Utah Department of Human Services: Stabilization and Mobile Response
- What is New Jersey's Mobile Response and Stabilization Services intervention?
- Resources for Clinical Best Practices, Wraparound, & Workforce Development
- Children and COVID-19: State-Level Data Report
- Mental Health-Related Emergency Department Visits Among Children Aged<18 Years During the COVID-19 Pandemic
- Mobile Response and Stabilization Overview of NJ, CT, and Milwaukee
- Improving the Child and Adolescent Crisis System: Shifting from 9-1-1 to a 9-8-8- Paradigm
- Making the Case for a Comprehensive Children's Crisis Continuum
- SAMHSA CMS Joint Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions

Chat organized by themes:

The current state of MRSS

Stress levels are really high do to this pandemic. Parents are staying in crisis more with their youth/young adults.

We are seeing exponential growth in crises of all ages in Barry County MI.

In the state of WV we are giving the options to the families but we are seeing families in person if requested with proper distancing and PPE

In MI, my understanding was families could request face to face and we need to accommodate that with use of PPE and social distancing.

Initially, we stopped f2f visits due to not having PPE but started back up after one month. We got our wrist slapped a bit-- state of MI. We were offering the family to choose, and lately it has been fully face to face. Cases in Kent Co. are way up so we are working to get back to offering family choice.

Just to clarify some MRSS programs have been providing in person since May 2020 and are still continuing to do so.

Are families also driving triage of service delivery? How does this happen with immediate problems?

In Virginia we are mostly doing in person as well. We have a high demand and need for in person, though we are using PPE and asking screening questions and social distancing as much as possible.

Hi in Southern NJ we have needed to continue majority of dispatches F2F due to connectivity and lack of technology or resistance to telehealth. 75 % are F2F We have all the PPE equipment including thermal temp scanners

If people are interested in learning about the Child and Family Traumatic Stress Intervention (CFTSI), which is currently the only evidence-based, early, brief (5-8 session) trauma-focused mental health treatment that is meant to be implemented after a recent traumatic event, please contact me, Carrie Epstein (co-developer of CFTSI): carrie.epstein@yale.edu or Epstein.carrie@gmail.com. This model can be implemented in-person, or via telehealth.

How can intimate partner violence survivor's children get more access to devices that can help with education? Where can we go for help?

We're also rural-We've provided our agency wi fi to families and provided use of ipads to use to do zoom with clients from different offices. We've had families use our wi fi from the parking lot to be able to connect. We've sent phone cards as well. We've met in parking lots and back yards/drive ways.

We have also seen an uptick in more urban areas in Mobile Crisis Response. In the more rural areas he have seen quite a reduction in use.

We found many families were very fearful of utilizing CMRSS but with educating community and schools that the dispatch team practices and screens following CDC guidelines for their safety and staff safety and it has our dispatch number up even higher than normal right now.

In Utah, 6-8 weeks of follow-up (a minimum of 1-2x week as determined by the family

The SafeUT app uses licensed clinicians to communicate with the user. Peer support specialists are able to assist with sub-acute level situations and have clinician back-up.

SafeUt app links with the state crisis line in Salt Lake City. The clinicians can deploy local MCOT/SMR supports as needed.

Federation of Families of SC-fedfamsc.org. We support parents/caregivers/youth/young adults with varies mental health challenges, emotional, behavioral health as well as community issues and how to navigate systems of care.

It has been very hard for me to find Respite Care for families here in SC. If you have any open resources please share with fedfamsc.org

In south jersey we are working /partnering w/ CSTeams as most school have the youth going to school to help normalize their day rather than forcing them to use virtual learning. That is going well!

We have established "clean rooms" in our providers that have a computer and desk so people can come in and do telehealth without tech barriers or rural internet issues. They actually do teletherapy with a clinician in the building and the room is aggressively sanitized between clients.

NJ has a 877 # for everyone to call and fund a CSA to triage the calls and they would then 3 way Parent CSA and Mobile on the call needing CMRSS dispatches.

YES I LOVE THE INITIATE DISPATHING! We definitely have seen a significant reduction in the need for replacements

Yes also most resource parents are willing to engage in learning the ARC GROW trauma sensitive parenting curriculum that we will offer and put in place.

In Warren County, Ohio, our MRSS began serving newly placed foster children about a year ago. Children's services has embraced this service and it has been successful. We are preparing to expand to another county soon.

Addressing disparities and gaps in care

The disparities include education and tech access. Do you intervene with providing access in light of the fact that schools are unable to provide widespread access to devices? These issues exacerbate mental health stressors for children and parents.

Broad question: Can 'healing' and the response to crises be mitigated by education curriculum being more inclusive and culturally informative? In my opinion, yes. Do you advocate cross settings, multi-disciplinary services for integration into schools?

Great topic. Mental illness is viewed differently from culture to culture. Especially in the African American and Africans culture. AA and native born African view mental health as being crazy or they are being punish from God. Most police officers are not trained to approach individuals who are experiencing mental health crisis. My question is there culturally specific trainings for police officers? Are there AA clinicians providing these training?

Can someone speak to any creative staffing models to support rural and frontier communities? We have our rural and frontier communities struggling to adopt SMRS or IIBHT as they don't see the risk/benefit equation making sense.

Resources to Support Adults and Parents During the COVID-19 Pandemic:
1) "Understanding and Coping with Reactions during a Pandemic": developed for adults during the COVID-19 pandemic, developed by the Childhood Violent Trauma Center at the Yale Child Study Center:
https://medicine.yale.edu/childstudy/communitypartnerships/cvtc/Understanding%20%26%20Coping%20with%20Reactions%20in%20a%20Pandemic_386176_284_28977_v1.pdf

2) Spanish translation of "Understanding and Coping with Reactions during a Pandemic":
https://medicine.yale.edu/childstudy/communitypartnerships/cvtc/Comprender%20y%20Lidiar%20con%20las%20Reacciones%20en%20una%20Pandemia_386175_284_28977_v1.pdf

My 15 year biracial son with some intellectual disabilities has been boarding for 36 days (at home). We are in MA. The emergency services here has engaged with us by Telehealth only. As a family we are receiving the message that we are not accessing a bed because we are not boarding in an ED even though he continually meets level of care. It is frustrating to be put in the impossible place of choosing to have my son’s mental health needs met by potentially exposing him to COVID in an ED or allow him to struggle at home.

I have also heard that boarding is becoming more common, both in Massachusetts and nationally, as more children and teens have gone into BH crises.

Massachusetts has a range of services known as CBHI services which are available to all children with Medicaid and most recently the Division of Insurance is requiring commercial carriers in Massachusetts to provide and pay for these services.

First-year follow-up of the Psychiatric Emergency Response Team (PAM) in Stockholm County, Sweden : A descriptive study - https://www.tandfonline.com/doi/full/10.1080/00207411.2016.1264040

Parents and families are also seeing more of the special needs of their children since being home with them during COVID. This has made families who are not usually accepting of these service are more receptive so we must take advantage of this time especially being culturally sensitive to population who are more vulnerable during the pandemic.

We are also having monthly diversity and inclusion monthly zoom mtg for all staff at Atlanticare so that we do a self-assessment.

We have accessed all the CBHI services (I've worked in that service system as well for years) and are actually meeting with folks at MassHealth. There is a huge gap that is happening with different processes hospitals have with their criteria on accepting kids because of the COVID pandemic.

I am very interested in the use of Mobile Response at the time of removal/entry into foster care. Is not something we have done in Nebraska but you have peaked my interest.

It is very challenging and there is a service gap for children/youth with developmental needs across the service delivery system in Massachusetts.

On police involvement in crisis response

Thanks for these tips. Glad we're discussing the viral pandemic. Will we also discuss alternatives to involving police in mobile crisis response? (Writing from Philly, where this is all too sensitive given the police shooting of a young black man experiencing a mental health crisis). If not in this session, can this be a topic for a future training?

How can we as individual providers collaborate with mobile crisis response resources during COVID to strategically plan on how we can support law enforcement in preventive measures and training to reduce the amount of mentally ill youth from having a negative experience with police?

I have worked with the mobile crisis response team Baltimore City uses most and we as staff would explain to the families what a youth safety plan looks like with and without police response.

We have found with our agency that as our mobile crisis interventions increased our inpatient utilization and use of law enforcement has dropped quite a bit.

In Houston we are diverting police from some 911 calls....sending behavioral health providers instead. All 911 calls do not need a police/EMS/fire response.

We need a universal collaboration model for working with the police and our children and families.

In NJ we are a FCIU CMRSS combined unit that does work with police

As an administrator of an MRSS program, I am very concerned about the idea of responding to domestic violence calls - handled by police typically- “with crayons” ... currently we have the funding for 1 responder at a time, as my understanding MOST MRSS and mobile crisis programs have, it seems too high liability to have mobile responders in those situations alone. This means we rely on law enforcement to assist with our own safety. If we do not provide for the safety of our responders, we will not be able to find people to fill positions.

I always ask the parents I serve to make a connection with their local department so that they will have some information about the diagnosis and to how the youth or young adult may or may react once confronted. Having that parent to community relationship is important to our family’s health.

The one I worked for was one where the family could call directly whatever medical mental health educators could also make the referral. Police can also make the referral.

How MRSS is funded

We used Juv Justice Reform to seed

Here, we are funded through our local mental health board tax levy.

We used a System of Care Grant to bring up YMCR. Still working through the ongoing sustainability of the program.

MRSS specifically is totally grant funded - currently will not be sustainable when the grant ends.

Nebraska is looking at Medicaid for the CAP session piece of Crisis Response. Also working with system partners (Child Welfare and Juvenile Justice) for additional funding.

We will bill thru the NJ Family Care Ins that is dependent upon the affordable care act staying in place.

MRSS is a fundable service through Medicaid. MA has also required private insurances to fund the service as well.

Utah has funded with seed from reform, through re-investments in reductions in residential services, through grants, and now through Medicaid rate for the intensive stabilization potion of the program.

In Ohio, MRSS does not exist as a service thru Medicaid - we can only bill psychotherapy or TBS. which, when give. The intensity of service, is not sustainable - Medicaid is currently covering about 17% of our cost for MRSS.