Children's Mobile Crisis Team Model: Lessons Learned

A listening session

Presenter:
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Co-Director of Social Work
KIPP, NYC
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New England (HHS Region 1)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Disclaimer

At the time of this release Tom Coderre served as Acting Assistant Secretary for Mental Health and Substance Use at SAMHSA. The opinions expressed herein are the views of the speakers, and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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Housekeeping Information

Participant microphones will be muted at entry – you will be able to unmute during the discussion portion of our webinar.

This session is being recorded and it will be available on the MHTTC website within 24 hours of the close of this presentation.

If you have questions during the webinar, please use the chat or use the “raise hand” feature during discussion to have your microphone unmuted.

Information about CEUs will be sent in a follow-up e-mail

If you have questions after this session, please e-mail: newengland@mhttcnetwork.org.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Respectful, clear and understandable
- Healing-centered and trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Meet Our Presenter: Meeta Gandhi, LCSW-R

Co-Director of Social Work and Counseling
KIPP, NYC

Meeta currently serves as Co-Director of Social Work and Counseling with Student Support Services KIPP NYC where she supports K-12 school leaders and social workers in their social/emotional programming.

She has more than 15 years of experience as a social worker and program director for child and adolescent mental health services in community psychiatry. During her community psychiatry tenure, Meeta co-piloted NYC's first Children's Mobile Crisis Team with the Department of Health & Mental Health. Through this project, she became increasingly interested in and passionate about providing services to children, adolescents, and their families in their school communities.

Year 1: Lessons Learned

Research Design

Advantages:

- True partnership with funders
- Through partnership, access to significant stakeholders, i.e., ACS, School MH Services, NYC DOE
- Ample focus groups with these stakeholders before launch
- Consultation with other states MCT's including inter-visitation with NJ

Disadvantages

- Budgeting parameters only allowed serving highest risk Bronx districts in Phase I
- Insufficient focus groups with students & families regarding follow-up care

Program Design

I. Access

II. Staffing

III. Services

I. Access

Program promoted itself as:

1. 24/7, 7 days a week to provide rapid response within 2 hours
2. Serviced Bronx school and home districts 1-12
3. Ages 0-18 years
4. Centralized referral system
5. 1-4 follow up visits conducted by LMSW and Family Advocate

II. Staffing

- 2 FTE LMSW's
- 2 FTE Family Advocates (a person with lived experience)
- 1 FTE Program Coordinator
- Program Director (.5)

Primary role of LMSW: Conduct safety assessment and plan, develop a relapse prevention plan and work with family

Primary role of Family Advocate: De-stigmatize mental health, provide psychoeducation, advocacy and conduct up to 4 follow up visits

III. Services

Crisis Assessment, Crisis Stabilization, Prevention Planning, Caregiver Support

Can Do:

- Evaluate Root Cause
- Engage with and Advocate for Family
- Stabilize Crisis
- Connect to Resources
- Develop Relapse Prevention Plan

Can't Do

- Replace a call to ACS or police
- Locate a missing child
- Escort a child to hospital
- Offer long term treatment
- Offer follow up visits without consent

Implementation Design

- Spent a lot of time on norming of term suicide
- Centralized referral
- Guardian consent
- Staff provided the below training- MI, CPI, CANS, Families Together, Family Peer Advocate

Program Investments

- Family advocates with the tenet of staff having lived experience and training
- Proactive arrangement with our Centralized Referral partnership
- Management of expectations regarding obtaining consent
- Rapid and Mobile response allowed for real time coaching
- Motivational Interviewing allowed for enhanced partnership
- Leveraged Respite programs, Faith Based Organization, Medical Clinics, Family Resource Centers, Resources for Children with Special Needs
- Child and Adolescent Needs and Strengths tool allowed for strength-based assessment

Year 1: Data

- Median Age of Student was 10.6 years
- 58% referrals came from schools between 10-2:30pm
- 62% reported as exhibiting “aggressive” behavior
- Primary diagnoses: ADHD and Mood Disorders
- 66% had never been in prior MH treatment
- 100% response rate within 2 hours

Interesting Anecdote:

67% families had previous and/or current ACS involvement

Did investments work?

- Bronx Team served 175 total, 12 hospitalized with only 2 repeat students

Sustainable Change Through Meaningful Engagement

Lessons Learned

Lessons Learned

Access

- We were doing a very good job in psychoeducation about how to utilize MCT
- Consent to follow up was difficult
- Difficult to get survey feedback post service
- Families needed booster shots

Staffing

- Family Advocates were key

Services

- Repair work between families and schools
- Capacity Building for CPI or TCI at schools
- Management of expectations regarding MCT escort to hospitals

- **Added Brooklyn & Queens**
  41% referrals came from schools
  23% from family or care givers
  20% came from ACS or preventative services
  16% from other sources (clinics, juvenile justice services)

Year 1 to Year 2

- *Creation of Crisis Coordinator *(*indicates for Bronx only)*
  3 social workers and 3 Family Advocates
  Added ages 0-5 years

Epilogue

- Bronx (full borough), Brooklyn & Queens are thriving
  - An annual total served is 503
  - Number of Psychiatric ER - 26
  - Number of Psychiatric Admissions - 11
  - Prevented Psychiatric Hospitalizations – 466 (92.6%)
- Elimination of Crisis Coordinator
- Enhanced staffing to include 3 social workers and 3 Family Advocates
- 1-800-Lifenet to 1-800-NYCWELL

Design Approaches to Consider

- Community Linkages
- Feedback Surveys from Consumers
- Centralized Referral System
- How to Engage Police Departments
- Capacity Building in Schools


OPEN
FORUM
Q&A

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THANK YOU!

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SAMHSA
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Childhood-Trauma Learning Collaborative (C-TLC)

Is your school trauma-informed?
Are you/your colleagues looking for mental health resources to better support your students?

- Join our “live” virtual training and technical assistance webinars and listening sessions.
- View our video archive.
- Check out our recent publications and stay posted for announcements of new releases and upcoming events.

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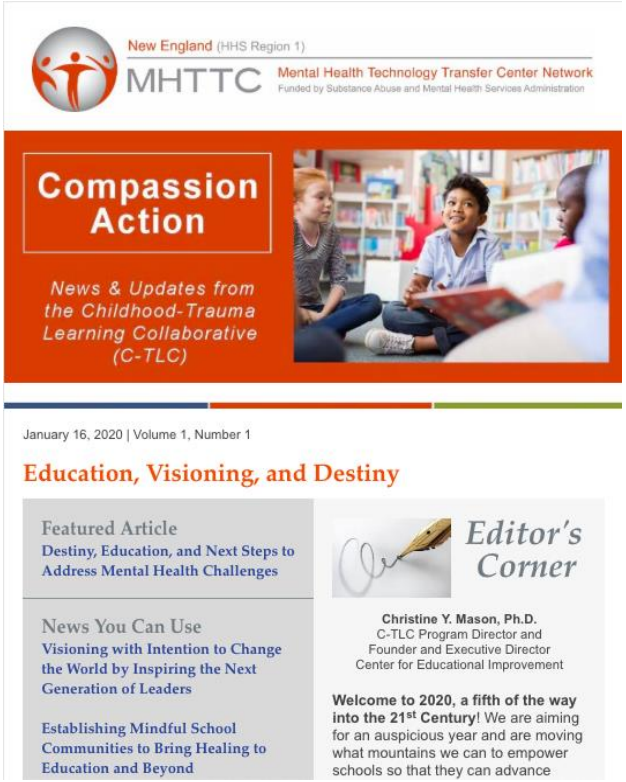
Childhood-Trauma Learning Collaborative (C-TLC)

Contact Us: Martha Staheli, PhD | martha.staeheli@yale.edu

Join Our Work!

Educators, school staff, and district leaders, as well as mental health professionals working in schools in the New England region, are invited to contact our Education Coordinator Dana Asby (dasby@edimprovement.org; 800-994-6441) for information about and membership opportunities with the C-TLC.

- C-TLC Members receive a monthly eNewsletter on schools and mental health, technical assistance, and opportunities to participate in our series of related webinars.
- Event participants, like you, can join affinity groups and resource teams on our Basecamp platform.



MHTTC School Mental Health Curriculum *Always and Now* 8-Part Learning Series

The MHTTC Network is hosting an 8-part training series using the **National School Mental Health Curriculum: Guidance and Best Practices for States, Districts, and Schools**. The Curriculum was developed by the MHTTC Network in partnership with the National Center for School Mental Health (NCSMH). It is intended to help states, districts and schools advance comprehensive school mental health and engage in a planning process for implementation.

Each session will be conducted as a 60-minute "live" event held on the 2nd and 4th Tuesdays of each month at 1:00 p.m. EDT.

Next Session: Module 4: Screening
Tuesday, March 23, 2021

Learn more about the curriculum and upcoming events at
https://mhttcnetwork.org/centers/global-mhttc/school-mental-health-curriculum-always-and-now-learning-series