# Transforming the Crisis System

988 Crisis

Community Based Mobile Crisis Intervention Services

and

Mobile Response and Stabilization Services (MRSS)

Oregon Health Authority

# HB 2417 passed July 2021

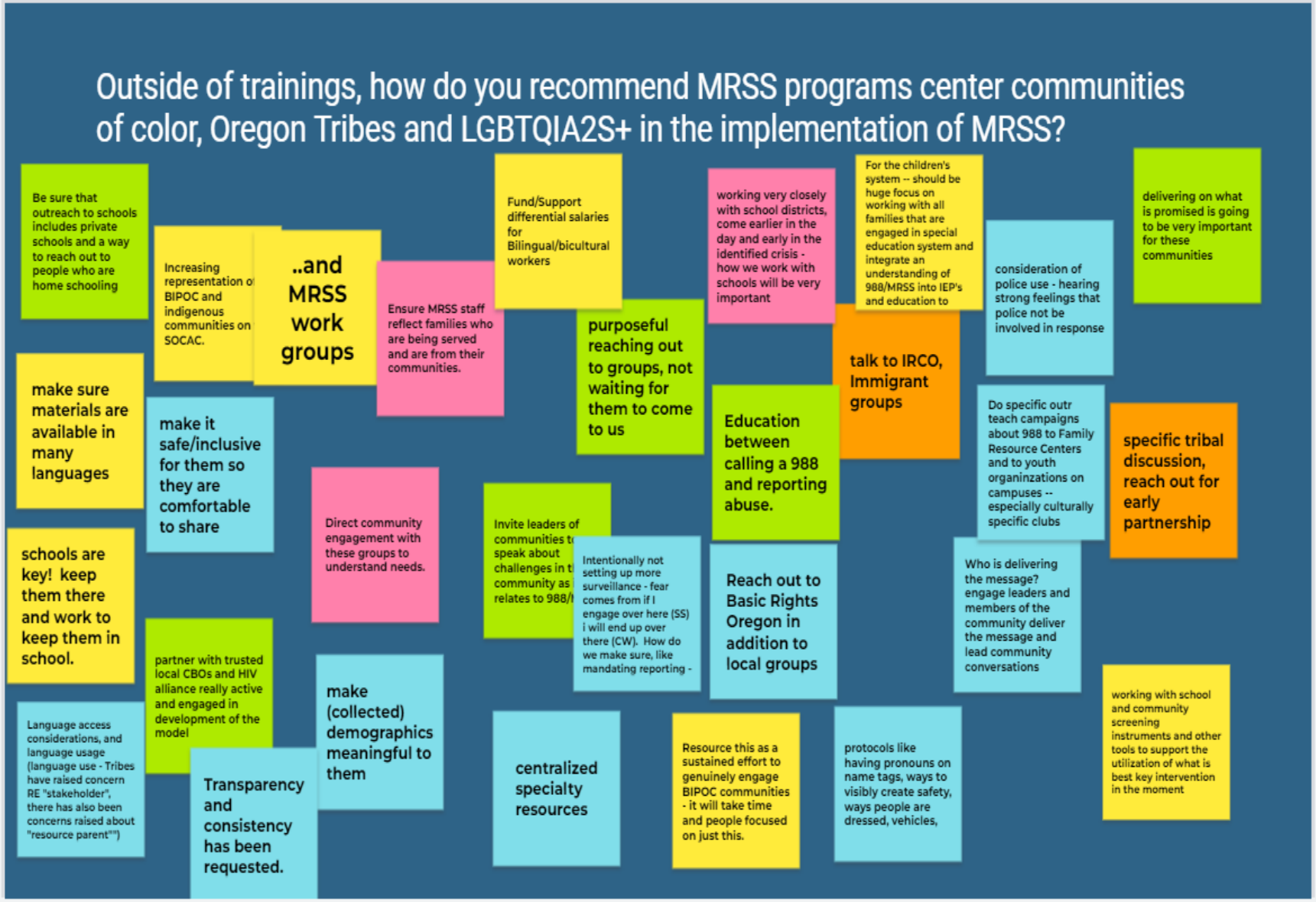
- Stand up 988 as an alternative to 911 for **all Oregonians**
  - Across the lifespan
  - Regardless of insurance

- Expand and enhance current mobile response services across the state

- Create stabilization services and community resources

# 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


Outside of trainings, how do you recommend MRSS programs center communities of color, Oregon Tribes and LGBTQIA2S+ in the implementation of MRSS?
Be sure that outreach to schools includes private schools and a way to reach out to people who are home schooling
Increasing representation o BIPOC and indigenous communities on SOCAC.
..and MRSS work groups
Ensure MRSS staff reflect families who are being served and are from their communities.
Fund/Support differential salaries for Bilingual/bicultural workers
working very closely with school districts, come earlier in the day and early in the identified crisis - how we work with schools will be very important
For the children's system -- should be huge focus on working with all families that are engaged in special education system and integrate an understanding of 988/MRSS into IEP's and education to
consideration of police use - hearing strong feelings that police not be involved in response
delivering on what is promised is going to be very important for these communities
make sure materials are available in many languages
make it safe/inclusive for them so they are comfortable to share
purposeful reaching out to groups, not waiting for them to come to us
talk to IRCO, Immigrant groups
Education between calling a 988 and reporting abuse.
Do specific outr teach campaigns about 988 to Family Resource Centers and to youth organinzations on campuses -- especially culturally specific clubs
specific tribal discussion, reach out for early partnership
schools are key! keep them there and work to keep them in school.
Direct community engagement with these groups to understand needs.
Invite leaders of communities t speak about challenges in t community as relates to 988/
Intentionally not setting up more surveillance - fear comes from if I engage over here (SS) i will end up over there (CW). How do we make sure, like mandating reporting -
Reach out to Basic Rights Oregon in addition to local groups
Who is delivering the message? engage leaders and members of the community deliver the message and lead community conversations
partner with trusted local CBOs and HIV alliance really active and engaged in development of the model
make (collected) demographics meaningful to them
centralized specialty resources
Resource this as a sustained effort to genuinely engage BIPOC communities - it will take time and people focused on just this.
protocols like having pronouns on name tags, ways to visibly create safety, ways people are dressed, vehicles,
working with school and community screening instruments and other tools to support the utilization of what is best key intervention in the moment
Language access considerations, and language usage (language use - Tribes have raised concern RE "stakeholder", there has also been concerns raised about "resource parent"")
Transparency and consistency has been requested.

# HB 2417 Strengthening Oregon's Crisis Care System

- HB 2417 allocated $5 million for call center resources
- For mobile crisis, OHA has identified an opportunity to braid together funding to bring up the total mobile crisis investment to $31 million

- $10 million from HB 2417 for mobile crisis services
- $11 million from the mental health block grant supplemental funds
- $10 million through current CFAA funding

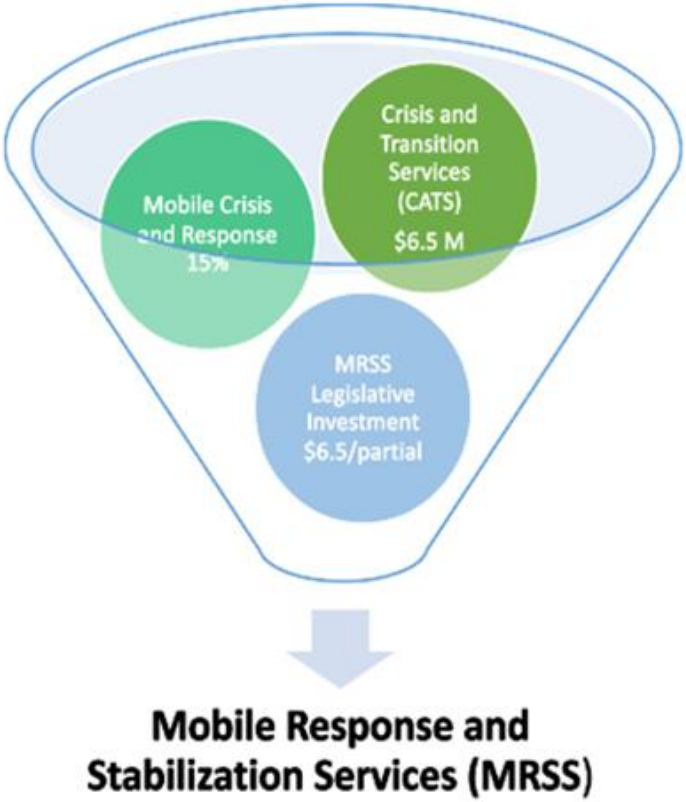
*An additional $6.5 million for the customized model for children: Mobile Response and Stabilization Services (MRSS)

- This is the estimated cost to fully fund mobile crisis services by community mental health programs
- CY22 transition to Medicaid reimbursable mobile crisis model

# MRSS Financial Breakdown

| | |
|---|---|
| Current Service Element 25 | Youth and their families make up about 15% of total Mobile Response in the state.<br>**Recommendation: 15% of total funds should be used to support the system providing youth and family specific crisis response.** |
| Current CATS Contracts | Current General Funds **6.5M/Biennium** for 12 sites.<br>**Recommendation: CATS funding invested into building youth and family specific crisis response system which includes stabilization services**. |
| Child and Family Behavioral Health- MRSS Budget | **6.5M/partial biennium** approved**.** (13M estimated for 2023-2025)<br>**Recommendation: Funds to be used to build out child and family specific crisis response system.** |

# Envisioning and Investing in the Future!



# Equitable funding formula for MRSS

- Using data to determine how funds are distributed to counties
  - Funding directed to those counties that need it most.
  - Funding targeted towards children, youth, young-adults and their families.

- Expanding and enhancing crisis response services and moving towards ensuring all counties offer the same quality of care.

# 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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# Someone to call

# Oregon's 988 Call Centers

- Oregon's 988 Call Centers
  - Northwest Human Services serve Marion and Polk Counties
  - Lines for Life serves the remainder of the state

- Both 988 Call Centers must meet established national standards
  - National Suicide Prevention Line (NSPL)
  - National Emergency Number Association (NENA)
  - Substance Abuse and Mental Health Services Association (SAMHSA)

# 988 Crisis Line provides services and supports

- **Evolution of suicide prevention lines**
  - Expanded to cover the needs of those in crisis
  - Provides services and supports for behavioral health issues, beyond suicide prevention
- **Provider and Resource Directory**
  - 988 Call Centers maintain a directory of providers, services and supports
  - Work collaboratively with local CMHPs, sharing information so all are aware of services and supports at a local and state level
- **Routing capabilities**
  - Public safety access points (PSAP)
  - County Mental Health Programs (CMHP)
  - Warm lines
  - Community-based services

# 988 Centralized Call Center

- **Large majority of calls resolved by the call center**
  - crisis counseling and safety planning
  - triage and screening
  - connection to community services and supports
- **Crisis Response Teams* provide face to face response to the community for all Oregonians**

  **Adult Response: Mobile Crisis Teams (MCT):** teams with specialized training working and responding to adults

  **Youth and Young Adults: Mobile Crisis and Stabilization Services (MRSS):** teams with specialized training in responding to children, youth, young adults and their families, in home stabilization services

* *May be the same team or separate team depending on the county*

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# 988 Call Center Staff

- **Crisis Intervention Specialist (crisis call-taker)**
  - Competencies and trainings meet national standards established by SAMHSA and NSPL for 988 Call Centers
  - Trained to de-escalate and triage callers using tools such as Psychological First Aid
  - Provide Culturally Specific and Developmentally Appropriate (CLAS) Services
- **Clinical Supervisor**
  - Minimum background includes 2 years of crisis intervention experience
  - Graduate degree is required
  - Oversees Crisis Intervention Specialist ensuring interaction with callers are clinically appropriate

# Crisis call work-flow

**911**

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

Calls are transferable, so callers connect to appropriate resources.

**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.

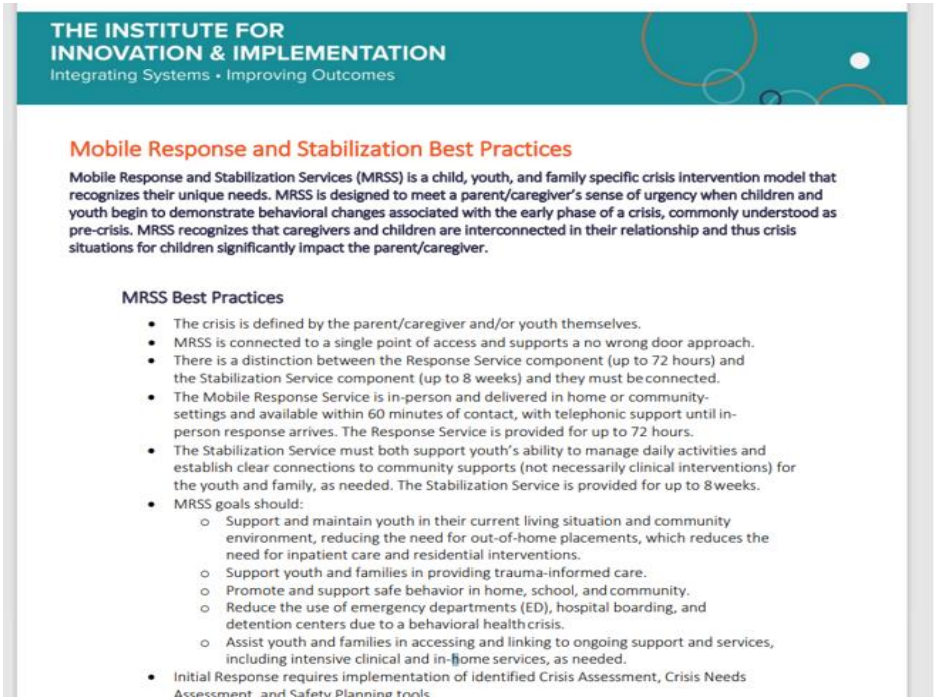
A community of support.

# Someone to respond

# Established Best Practice standards for Oregon's Crisis Response

Reviewed national best practices on crisis response for youth and families.

Consulted with Liz Manley, a national expert on children's behavioral health services, to create Oregon's standards.



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## Mobile Response and Stabilization Best Practices

**Mobile Response and Stabilization Services (MRSS) is a child, youth, and family specific crisis intervention model that recognizes their unique needs. MRSS is designed to meet a parent/caregiver's sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis. MRSS recognizes that caregivers and children are interconnected in their relationship and thus crisis situations for children significantly impact the parent/caregiver.**

### MRSS Best Practices

- The crisis is defined by the parent/caregiver and/or youth themselves.
- MRSS is connected to a single point of access and supports a no wrong door approach.
- There is a distinction between the Response Service component (up to 72 hours) and the Stabilization Service component (up to 8 weeks) and they must be connected.
- The Mobile Response Service is in-person and delivered in home or community-settings and available within 60 minutes of contact, with telephonic support until in-person response arrives. The Response Service is provided for up to 72 hours.
- The Stabilization Service must both support youth's ability to manage daily activities and establish clear connections to community supports (not necessarily clinical interventions) for the youth and family, as needed. The Stabilization Service is provided for up to 8 weeks.
- MRSS goals should:
  - Support and 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 youth and families in providing trauma-informed care.
  - Promote and support safe behavior in home, school, and community.
  - Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.
  - Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.
- Initial Response requires implementation of identified Crisis Assessment, Crisis Needs Assessment, and Safety Planning tools



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# Goals of MRSS National Best Practices

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Maintain and support youth in their current living situation and community, reducing the need for out-of-home placements, inpatient care, residential interventions, ED boarding and hospital admissions.

Support youth and families in providing trauma-informed care.

Promote and support safe behavior in home, school, and community.

Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.

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# Current Oversight for Mobile Response

## 309-019 0150 (6-9)

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Health Systems Division: Behavioral Health Services - Chapter 30

Division 19
OUTPATIENT BEHAVIORAL HEALTH SERVICES

309-019-0150
Community Mental Health Programs (CMHP)

(1) Crisis services shall be provided directly or through linkage to a local crisis services provider and shall include th following:

(a) Twenty-four hours, seven days per week telephone or face-to-face screening within one hour of notification of t crisis event to determine an individual's need for immediate community mental health services; and

(b) Twenty-four hours, seven days per week capability to conduct, by or under the supervision of a QMHP, an assessment, resulting in a plan that includes the crisis services necessary to assist the individual and family to stabili and transition to the appropriate level of care.

(2) Case management services shall be provided to assist individuals with the following:

(a) Gaining access to and maintaining resources such as Social Security benefits, general assistance, food stamps, vocational rehabilitation, and housing;

## HB 2417

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-**

## Service Element MH 25

2019-21 MHS 25 Community Crisis Services for Adults and Children

a. Service Name: **COMMUNITY CRISIS SERVICES FOR ADULTS AND CHILDREN**

Service ID Code: **MHS 25**

(1) **Service Description**

(a) Purpose:

Community Crisis Services for Adults and Children (MHS 25 Services) are immediately available behavioral health crisis assessment, triage, and intervention Services delivered to Individuals and their families experiencing the sudden onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning. MHS 25 Services are of limited duration and are intended to stabilize the Individual and prevent further serious deterioration in the Individual's mental status or mental health condition.

(b) Definitions:

i. **Care Coordination** means an assessment-driven, process-oriented activity to facilitate ongoing communication and collaboration to meet multiple needs. Care Coordination includes facilitating communication between the family, natural supports, community resources, and involved Providers for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services. It addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes and efficient delivery of health-related services and resources both within and across systems. Care Coordination contributes to a patient-centered, high-value, high-quality care system.

ii. **Community-based** means that Services and supports must be provided in an Individual's home and surrounding community and not solely based in a traditional office-setting.



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# Service Element 25 and 25a
# Community Crisis Services for Adults and Children

- Historically overseen by the Adult Unit at OHA
- Mobile response is available across the lifespan
- Looks different in different counties
- Does not include youth and family best practices
- Service Element and OARs need to be updated

- Collaboration between Adult Behavioral Health and Child and Family Behavioral Health
- Mobile response available across the lifespan
- Consistent quality of care across all counties
- Includes youth and family best practices

# 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

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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 LGBTQ2SIA+ youth
- Screening for Drug and Alcohol use with youth
- Familiarity and relationship with the continuum of care for children and community resources

# 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

# Community to support

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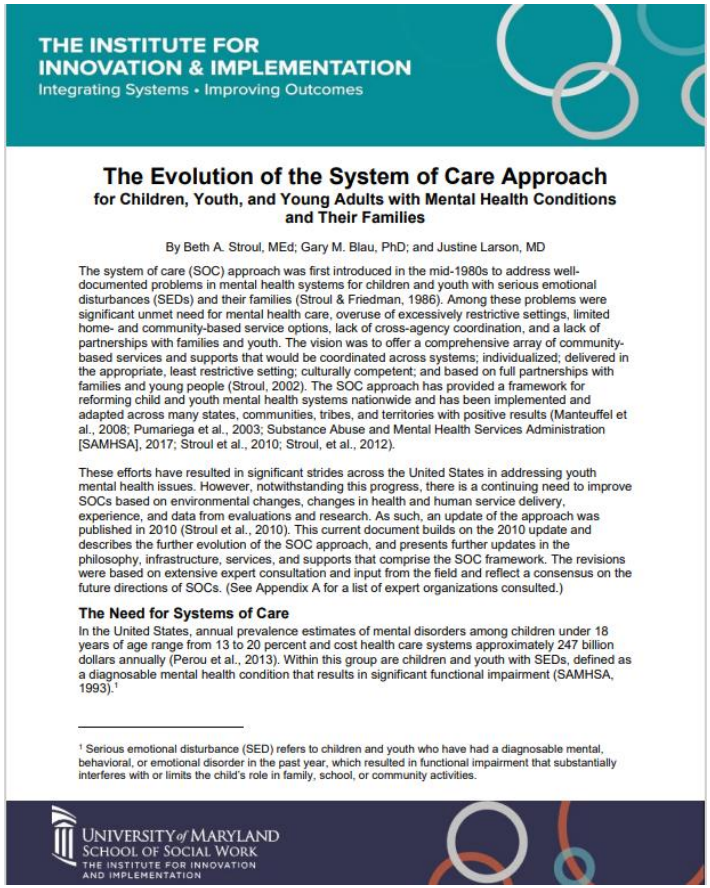
# The Evolution of the System of Care Approach



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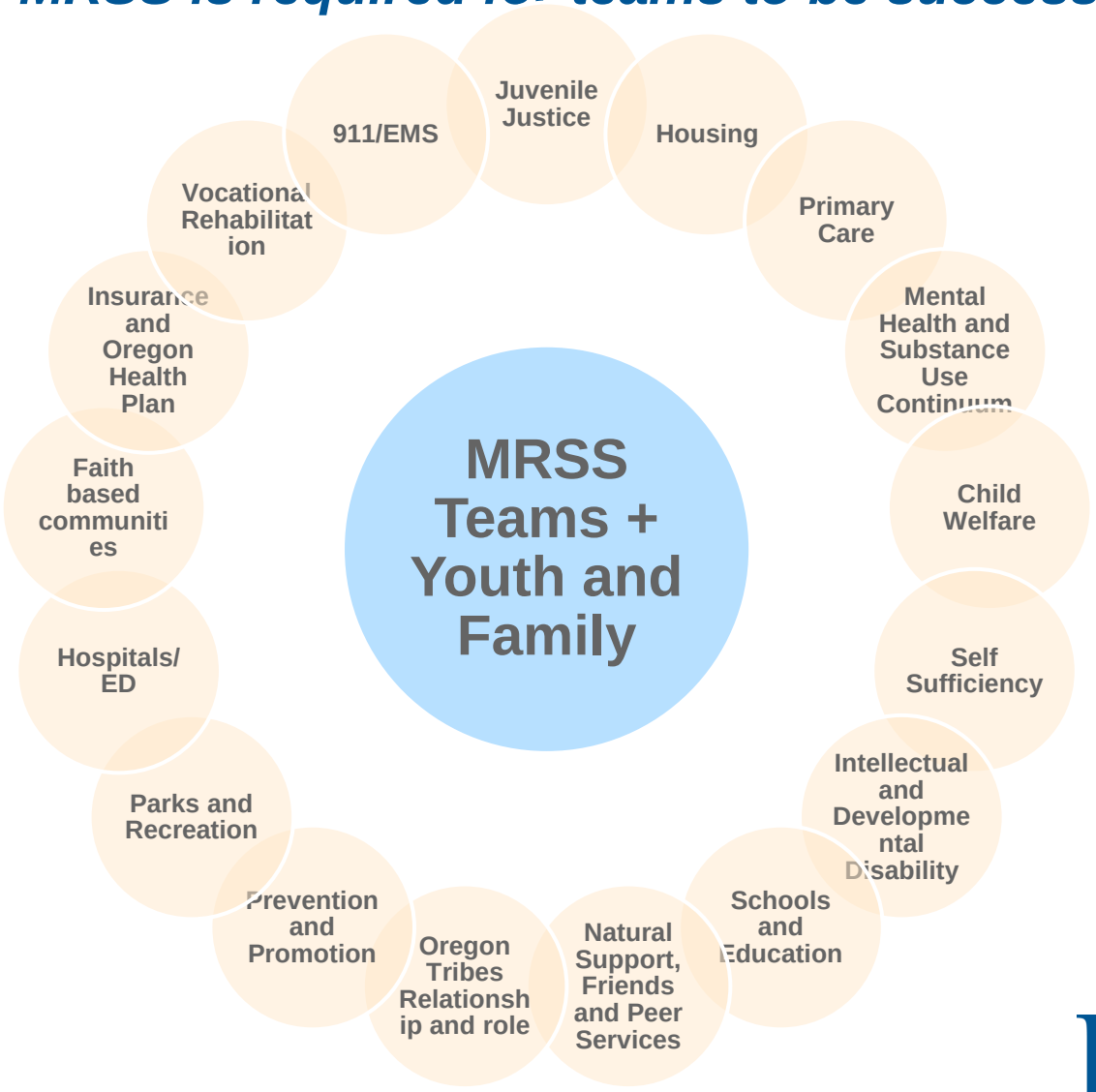
# *Local Children's System of Care commitment and involvement for MRSS is required for teams to be successful.*



# 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
- Additional positions within OHA
- RI International Consultation
- Training recommendations

## What is in process...

- Revised 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
- Learning Collaboratives for community partners and providers are ongoing



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# Community Feedback

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

# Oversight and Monitoring

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

# 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).

- Education and outreach campaign being developed for January**.**

# 988 Call Center data

## 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

# 988 Call Volume Since Implementation

| Lines for Life Call Volume | |
|---|---|
| **Dates** | **Calls** |
| 7/22/2022 - 7/28/2022 | 924 |
| 7/29/2022 - 8/4/2022 | 832 |
| 8/5/2022 - 8/11/2022 | 853 |
| 8/12/2022 - 8/18/2022 | 837 |
| 8/19/2022 - 8/25/2022 | 856 |
| 8/26/2022 - 9/1/2022 | 931 |
| 9/2/2022 - 9/8/2022 | 860 |
| 9/9/2022 - 9/15/2022 | 883 |

# 988 Text and Chat

| Lines for Life Text and Chat Volume | | |
|---|---|---|
| 7/15/2022 - 7/21/2022 | Offered | Answered |
| OR Chat | 107 | 72 |
| OR Text | 50 | 38 |
| 7/22/2022 - 7/28/2022 | | |
| OR Chat | 117 | 85 |
| OR SMS | 118 | 83 |
| 7/29/2022 - 8/4/2022 | | |
| OR Chat | 132 | 93 |
| OR SMS | 101 | 73 |
| 8/5/2022 - 8/11/2022 | | |
| OR Chat | 104 | 79 |
| OR SMS | 117 | 92 |
| 8/12/2022 - 8/18/2022 | | |
| OR Chat | 118 | 91 |
| OR Text | 108 | 78 |
| 8/19/2022 - 8/25/2022 | | |
| OR Chat | 100 | 78 |
| OR Text | 93 | 74 |

# QUESTIONS

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# Thank You

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