

CCBHC-E National Training and Technical Assistance Center

CCBHC Crisis Services Learning Community

Session 6: Providing a Continuum of CCBHC Crisis Services for Children

June 27, 2024

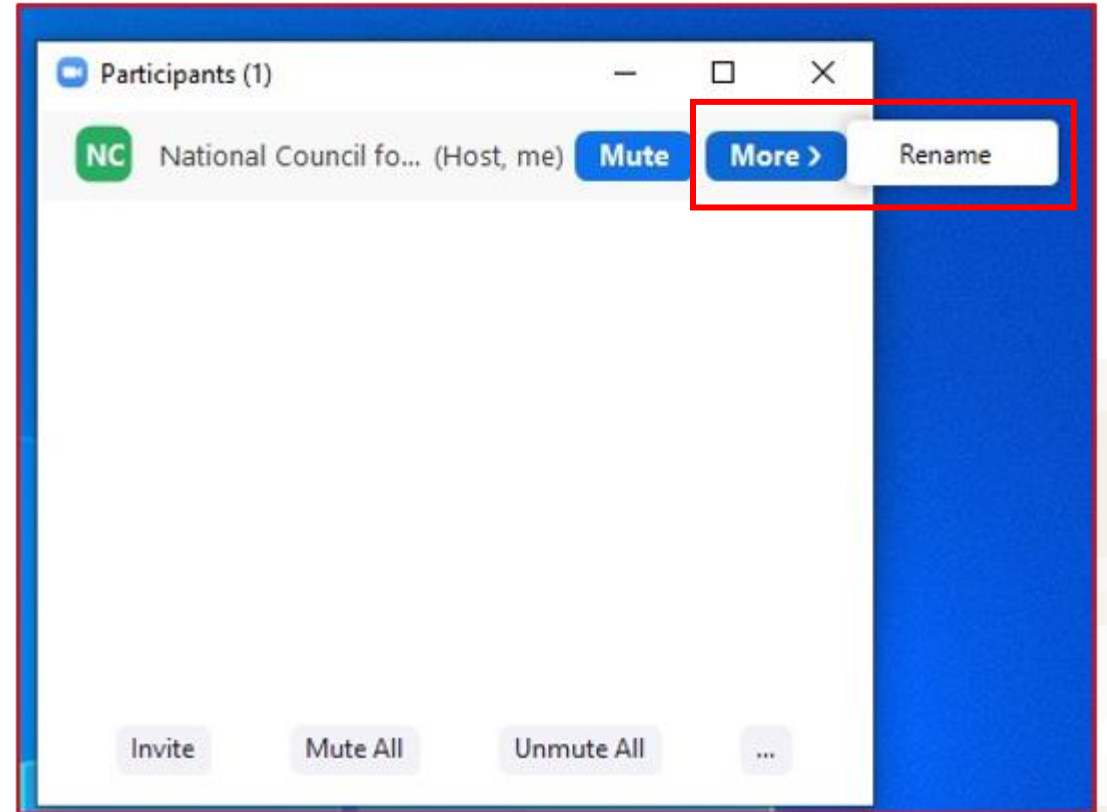
CCBHC-E National Training and Technical Assistance Center

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Logistics

- Please rename yourself so your name includes your organization.
- *For example:*
 - **Kat Catamura, National Council**
- *To rename yourself:*
 - Click on the **Participants** icon at the bottom of the screen
 - Find your name and hover your mouse over it
 - Click **Rename**
- If you are having any issues, please send a Zoom chat message to **Kat Catamura, National Council**

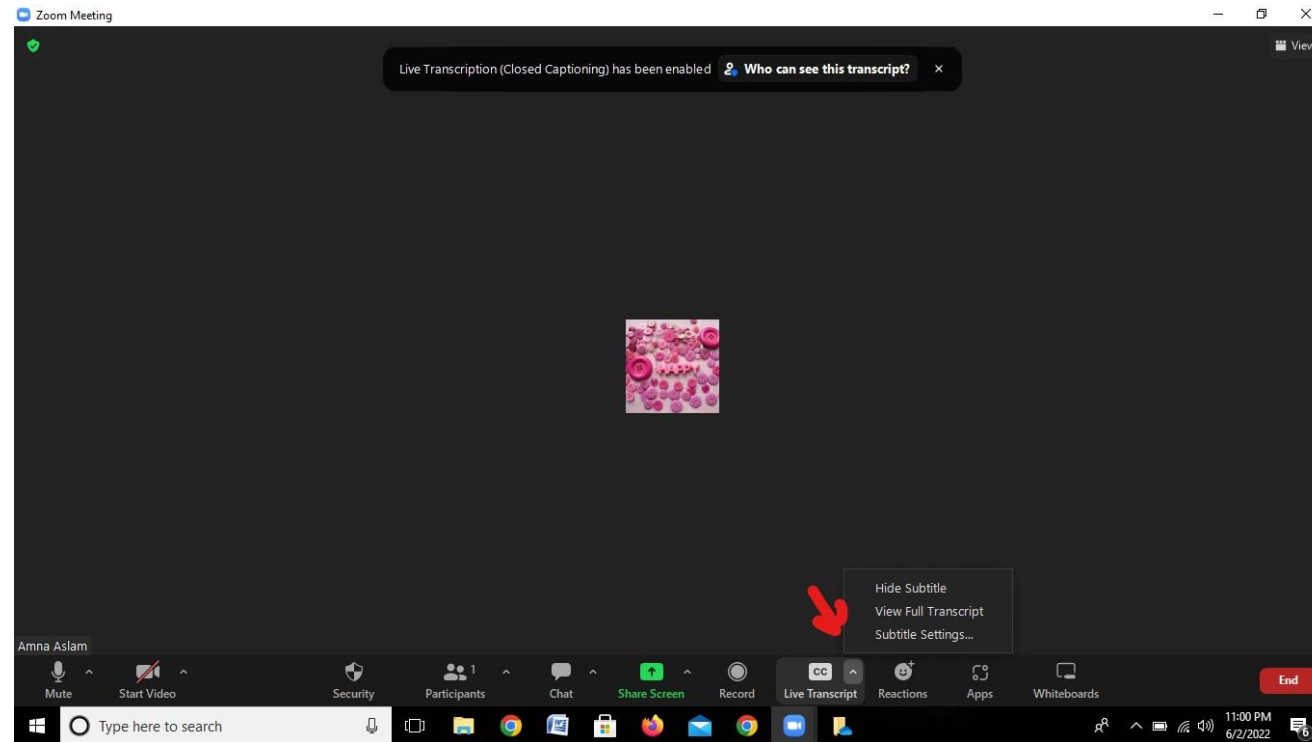


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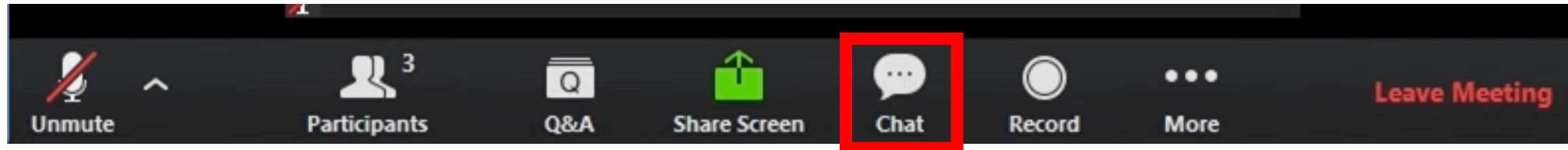


How to Enable Closed Captions (Live Transcript)

Next to “Live Transcript,” click the arrow button for options on closed captioning and live transcript.



How to Ask a Question



Please share questions throughout today's session using the **Chat Feature** on your Zoom toolbar. **We'll answer as many questions as we can throughout today's session.**

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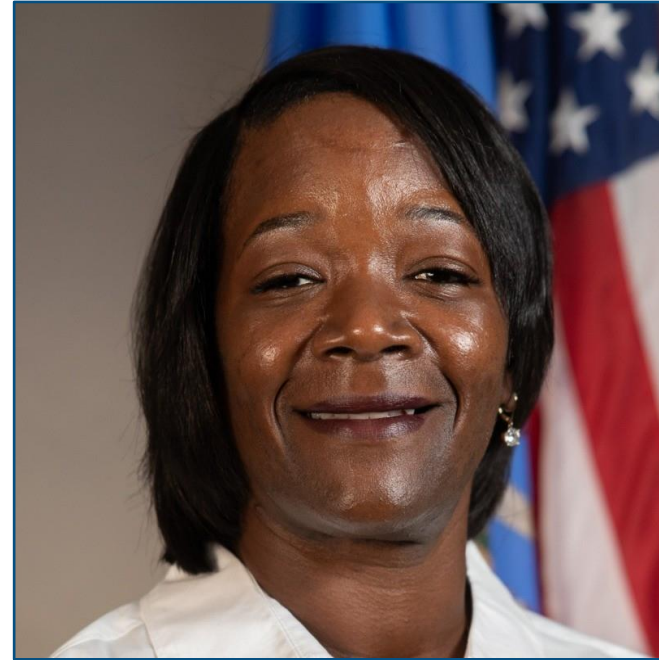
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Today's Guest Presenters



Stephanie K. White, LPC
CREOKS Mobile Crisis Director



Sheamekah Williams
President and CEO of Evolution
Foundation



Today's Agenda

1

Overview of Crisis Services for Children & The 6 Essential Elements

2

The 988 Crisis Model & The MRSS Model

3

Best Practices in the Field

Polling Question

1. Do you currently provide mobile crisis for children?

- a. Yes directly**
- b. Yes, by DCO**
- c. Planned and ready but not yet started**
- d. Still planning**

2. What is (or will be) your children's mobile crisis model?

- a. Separate MRSS team**
- b. A separate team not doing MRSS, but with follow up**
- c. Mixed adult and child team, with follow up**
- d. Not sure yet.**

3. Does your community have a 23-hour observation unit for youth?

- a. Yes - non-hospital based**
- b. Yes - hospital based**
- c. Plan completed, unit being developed.**
- d. Planning under way**
- e. Have not started planning**



CCBHC Crisis Services for Children

An Overview

- As a component of the CCBHC crisis requirements and continuum, the development and continued revisions of crisis services for children are key. Not every system needs to look the same and should incorporate cultural and regional-specific practices into the work. That said, there are evidence-based practices in children's crisis care that incorporate ongoing follow-up, family involvement, cross-system collaboration, the use of technology, and family choice.
- As always, any crisis continuum should be for anyone, anywhere, and anytime, including someone to talk to, respond to, and a safe place to get help.



CCBHC Crisis Requirements: Six Essential Elements – For Children and Youth

- Crisis System Needs Assessment – Including crisis services for children and youth
- Crisis System Collaboration and Partnership Development – including schools, child protection, and juvenile justice.
- Crisis Services Implementation –
 - Someone to Call (Connection to 988) - Call, Text, Chat for children and youth
 - Someone to Respond (Mobile Crisis) - mobile crisis team services for children and youth, possibly including MRSS.
 - Safe Place to be (Walk-in Urgent Care and Crisis Stabilization) - urgent care and crisis centers with observation for children and youth
- Crisis Services Best Practice Implementation – youth peers and family partners; in-home f/u for children/families; helping youth w/ co-occurring SUD and I/DD.



Title

PLACEHOLDER FOR SHEAMEKAH



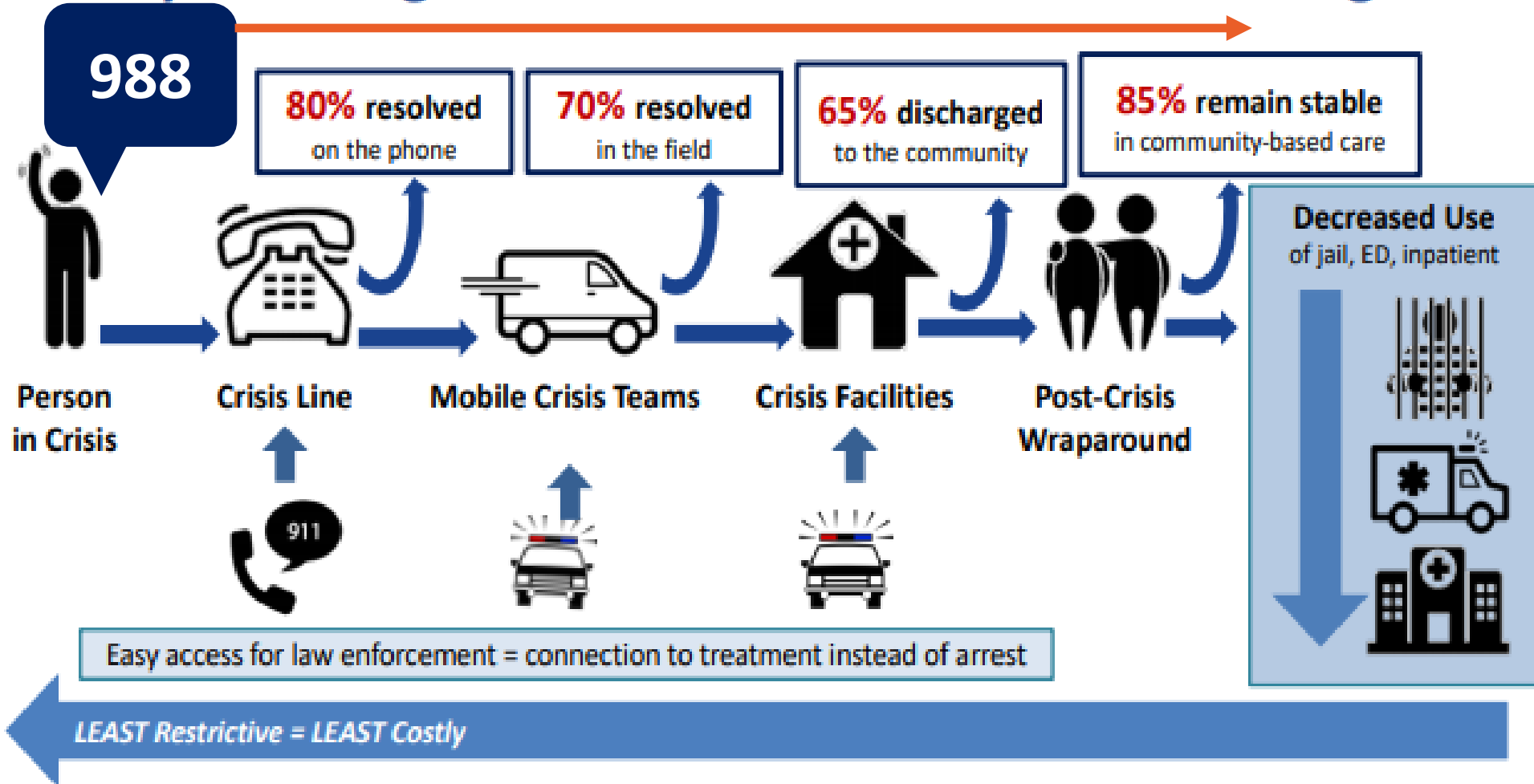
Getting help can be hard and confusing...



Addressing Parent/Caregiver Sense of Urgency

Overview of 988 Crisis System*

Crisis System: Alignment of services toward a common goal



*This example is for adults, not children. It is expected that 90% of children receive in-person assessments.

Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>

Child and Youth Crisis System of Care: Working Toward a Common Goal



Child
In Crisis



Parent
Caregiver
Call for
help



988
Crisis Line

Offers
Face to
Face
Mobile
Response
100%



Child Youth
Mobile
Response
Stabilization
Team

Arrives
Less
than
60 min



Child
Supported
stabilized
at Home

Over 95%
Resolved at
home in
community



23Hr-
Community
Stabilization
Less than 5%



Reduce
Arrests



Reduce
JJ Jail



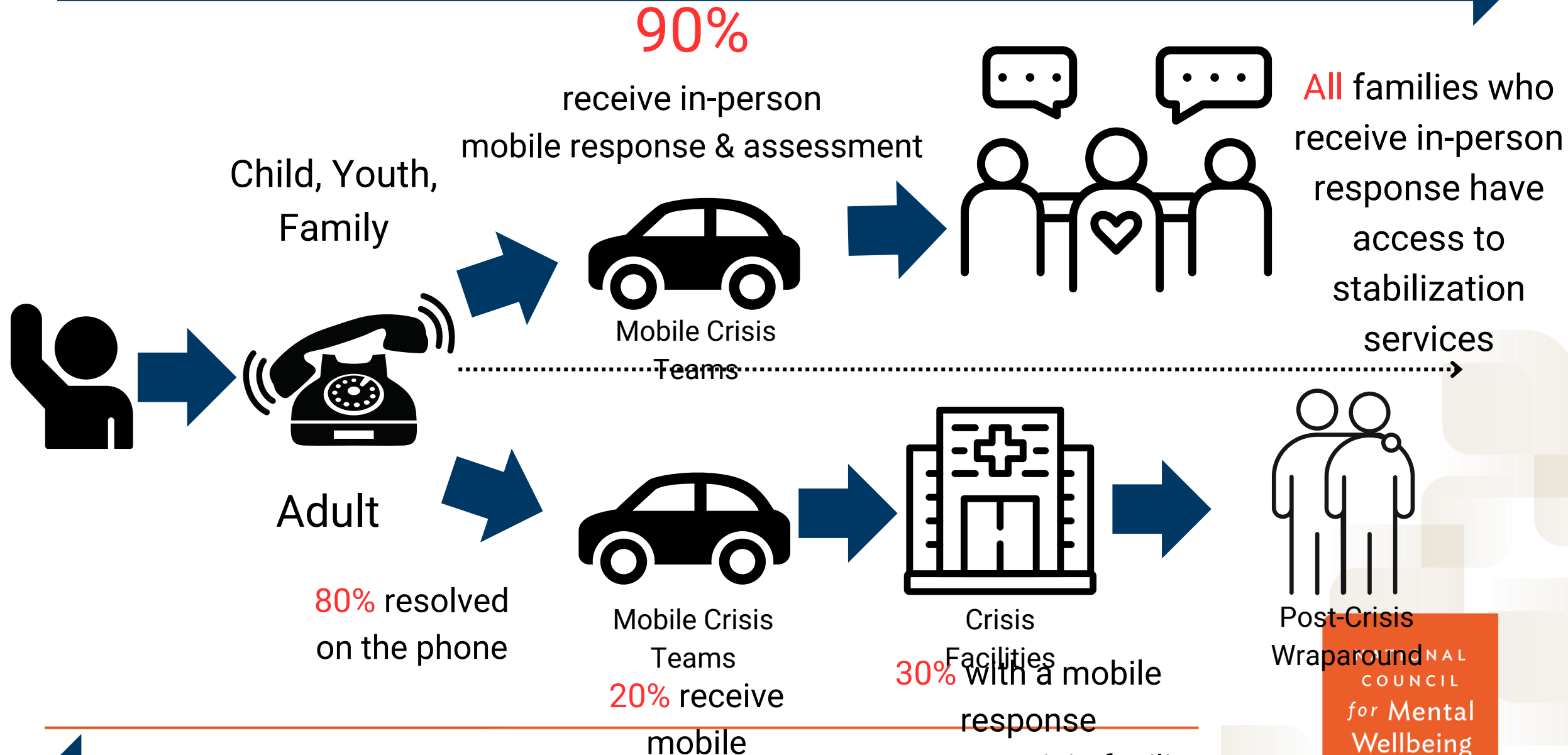
Reduce
Ambulance



Reduce
Hospital
ED
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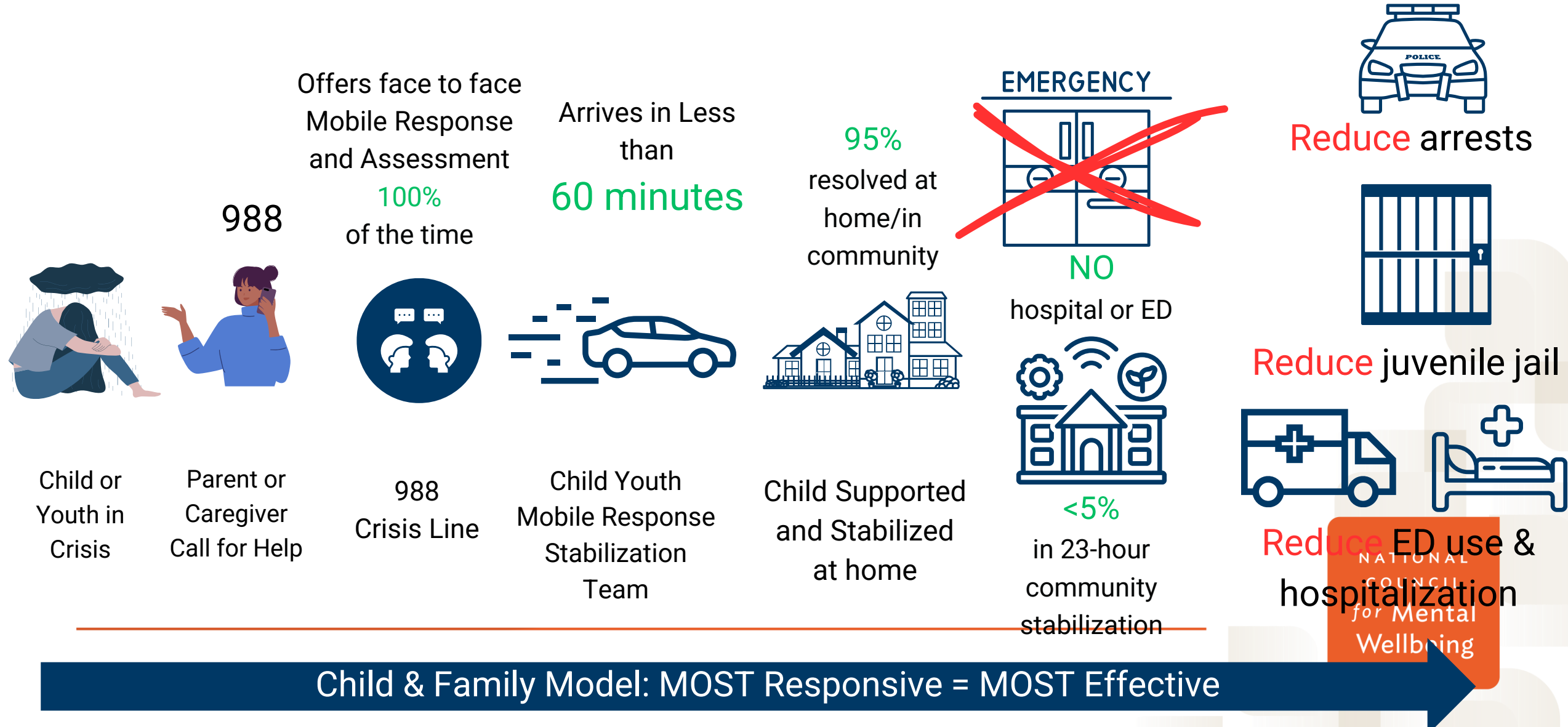


Child & Family Model: MOST Responsive = MOST Effective

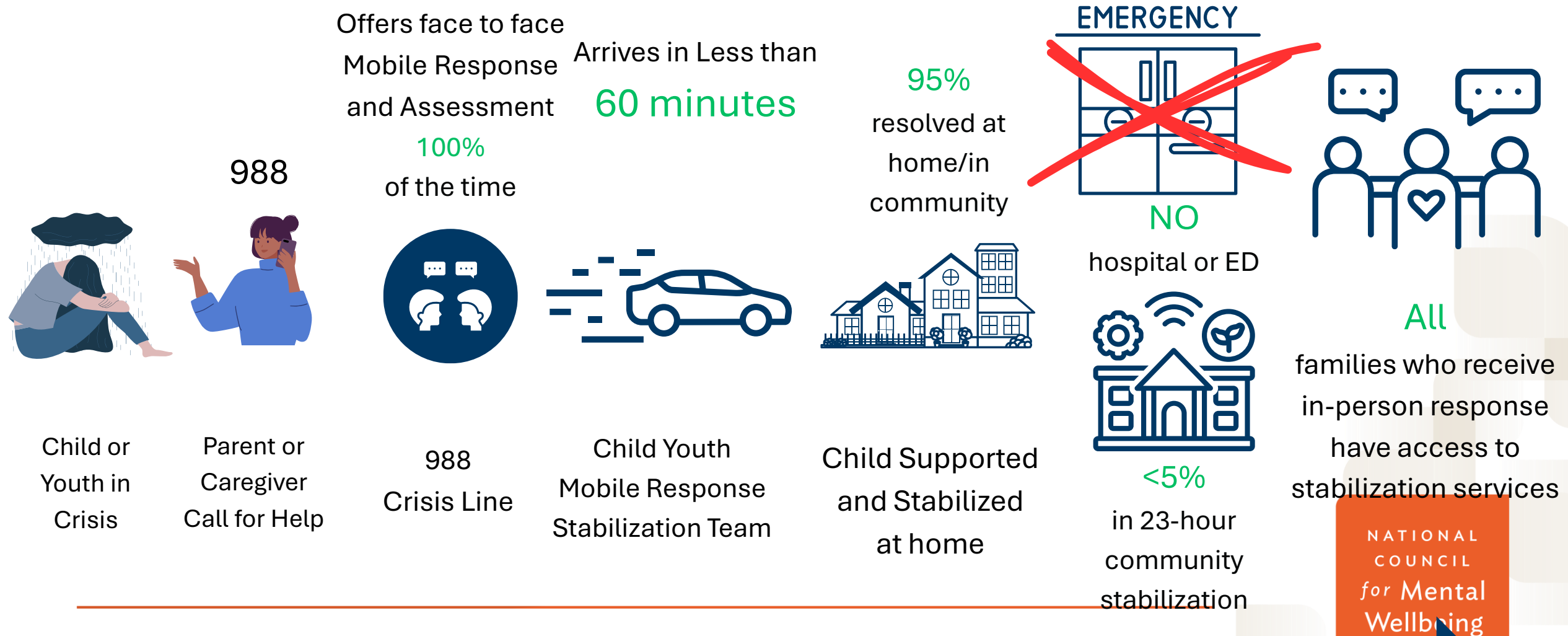


Adult Model: LEAST Restrictive = LEAST Costly

Child and Youth Crisis System of Care: Working Toward a Common Goal



Child and Youth Crisis System of Care: Working Toward a Common Goal



Child & Family Model: MOST Responsive = MOST Effective



What works best is anything that increases the quality and number of relationships in a child's life. People, not programs, change people.

Dr. Bruce Perry, Mind and Heart Foundation

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Mobile Response Organizing Principle:

Meets the Sense of Urgency with Urgency

- ✓ Single Point of Access
- ✓ Public Health Approach
- ✓ The crisis is defined by the parent/caregiver and/or youth.
- ✓ Requests are not screened in/out based on perceived acuity; uses a “just go” approach.
- ✓ Requests for help are attended to rapidly and consistently.
- ✓ Up to weeks of stabilization services.
- ✓ Connects to the child-serving systems.
- ✓ 24/7/365 face-to-face response



MRSS Goals

Maintain

- 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

- Support youth and families in providing trauma informed care.

Promote

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

Reduce

- Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.

Assist

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

Mobile Response



Response within one hour in person



Has capacity to respond with two person teams based on established protocols with consideration to safety as well as the needs of both responders and youth and families.



Responds without law enforcement, unless essential for safety reasons and as a last resort. Must include youth and family's input in the decision to use law enforcement and ensure youth/family is aware of use of law enforcement prior to arrival.



Allows for multiple 24/7/365 in-person responses for up to 72 hours, as needed.



Provides a warm handoff to identified supports and services, including pre-existing care coordination or referral to stabilization services, when needed.

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Stabilization Services

Provided in the home and community

Connection to community supports and services

Reconnection with activities such as sporting activities, arts such as acting and painting, extra curricular activities within the school as examples.

In-home clinical support for the youth and family

Connection to higher level of support if determined necessary





Customization for Kids: What I Know to Work.

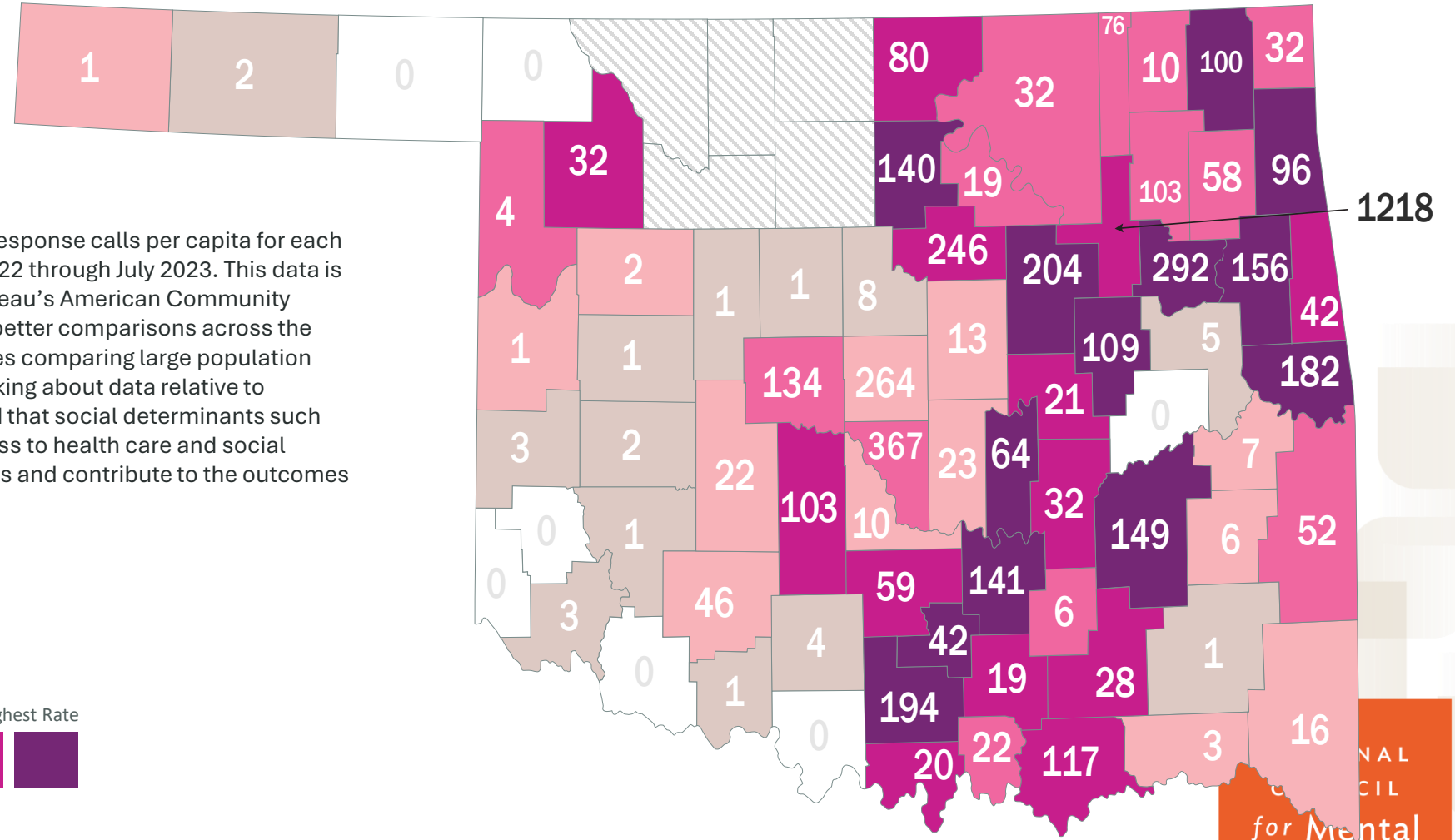
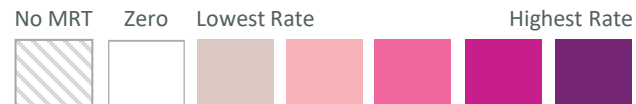
- Why MRSS?-Sense of Urgency
- Rural & Frontier Communities
- Telehealth, Workforce & Emergency Responders
- Prevention / Predictions
- Schools, CW and JJ
- Parent/Caregiver
 - Infant
 - School age
 - Young Adults

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Mobile Response by County

July 2022 – July 2023

This map shows the distribution of Mobile Response calls per capita for each county in Oklahoma for the period of July 2022 through July 2023. This data is normalized per capita based on Census Bureau’s American Community Survey 5-year Estimates (2020) to allow for better comparisons across the state’s diverse human geography. This makes comparing large population centers and rural communities easier by talking about data relative to population size. It is essential to understand that social determinants such as income, employment, housing, and access to health care and social services differ between urban and rural areas and contribute to the outcomes presented.

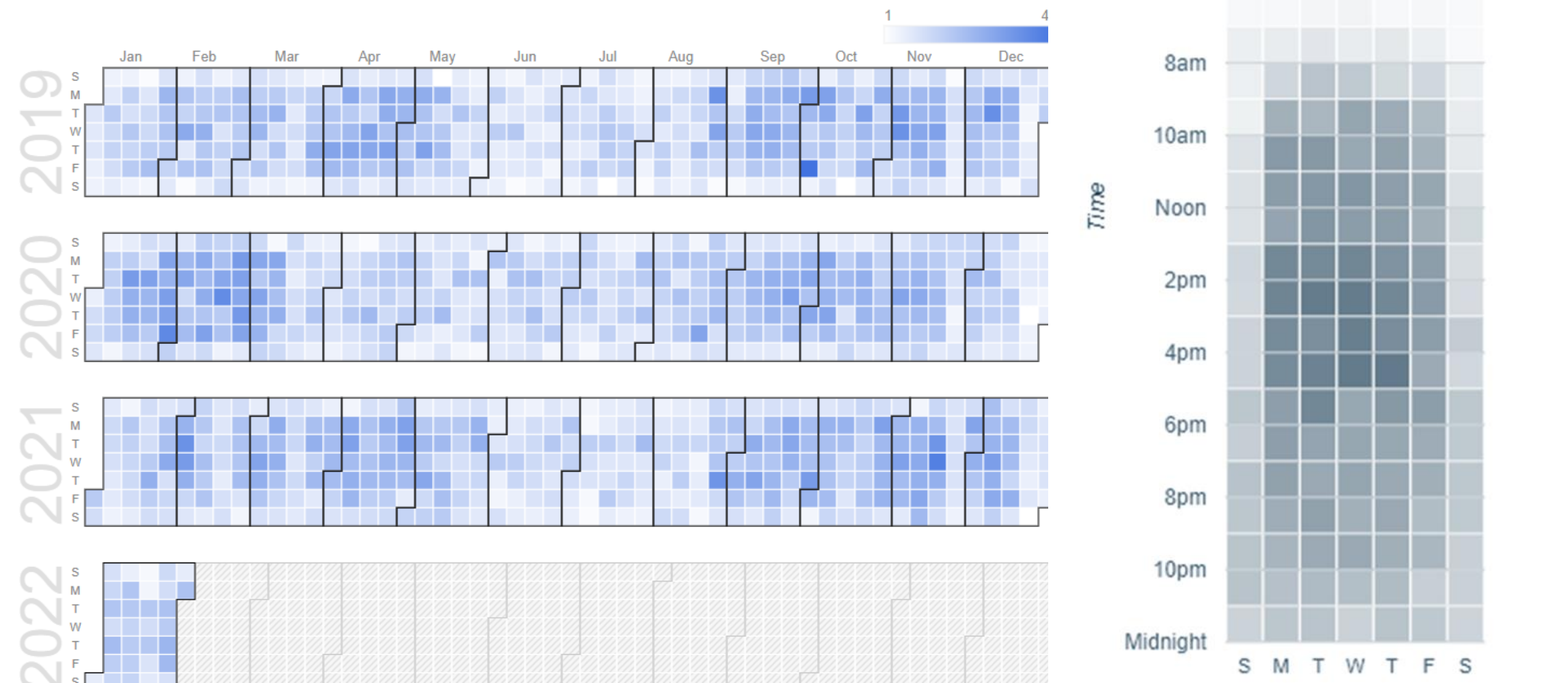


Using Technology to Support Workforce.

Technology
use
Increase 
900%

Over 600,000 minutes of services are
provided through mobile technology
established through CCBHC







Youth Crisis
MOBILE RESPONSE

Jan 2019 – Jan 2022

Total Calls = 19,493

A group of eight diverse young adults, four women and four men, are standing in a line against a light-colored, textured wall. They are all looking down at their smartphones, which they are holding in their hands. The group is diverse in terms of ethnicity and appearance. The ground they are standing on is made of cobblestones.

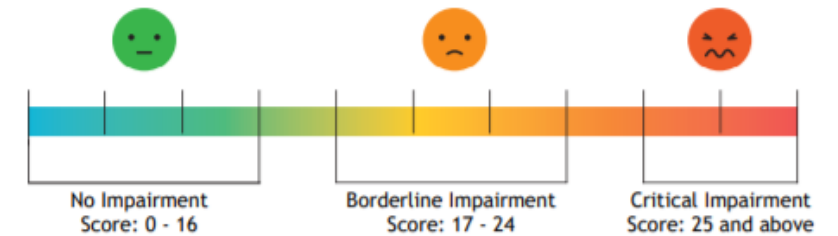
80% of children, youth, and young adults
were diverted
from a change in placement/living environment.

How I Know This is Working: Ohio Scales - Problems

Youth Problem Scale (Copyright © January 2000, Benjamin M. Ogles & Southern Consortium for Children)

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days		Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	Externalizing Subscale	0	1	2	3	4	5
2. Getting into fights		0	1	2	3	4	5
3. Yelling, swearing, or screaming at others		0	1	2	3	4	5
4. Fits of anger		0	1	2	3	4	5
5. Refusing to do things teachers or parents ask		0	1	2	3	4	5
6. Causing trouble for no reason		0	1	2	3	4	5
7. Using drugs or alcohol	Delinquency Subscale	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)		0	1	2	3	4	5
9. Skipping school or classes		0	1	2	3	4	5
10. Lying		0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	Internalizing Subscale	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)		0	1	2	3	4	5
13. Talking or thinking about death		0	1	2	3	4	5
14. Feeling worthless or useless		0	1	2	3	4	5
15. Feeling lonely and having no friends		0	1	2	3	4	5
16. Feeling anxious or fearful		0	1	2	3	4	5
17. Worrying that something bad is going to happen		0	1	2	3	4	5
18. Feeling sad or depressed		0	1	2	3	4	5
19. Nightmares		0	1	2	3	4	5
20. Eating problems		0	1	2	3	4	5

Produces a score of 0 - 100.



Clinically Significant Improvement =
Decrease of 11 or more points

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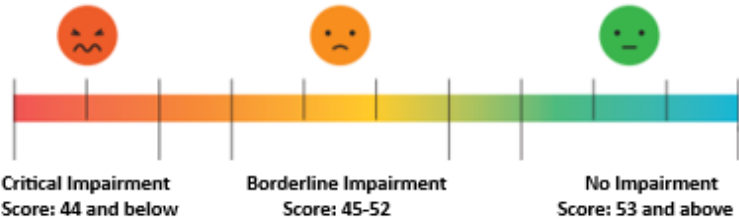


How I Know This is Working: Ohio Scale - Functioning

Youth Functioning Scale (Copyright © January 2000, Benjamin M. Ogles & Southern Consortium for Children)

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.		Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	Resiliency Subscale	0	1	2	3	4
2. Getting along with family		0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends		0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)		0	1	2	3	4
5. Keeping neat and clean, looking good		0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)		0	1	2	3	4
7. Controlling emotions and staying out of trouble		0	1	2	3	4
8. Being motivated and finishing projects		0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)		0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)		0	1	2	3	4
11. Completing household chores (cleaning room, other chores)		0	1	2	3	4
12. Attending school and getting passing grades in school		0	1	2	3	4
13. Learning skills that will be useful for future jobs		0	1	2	3	4
14. Feeling good about self		0	1	2	3	4
15. Thinking clearly and making good decisions		0	1	2	3	4
16. Concentrating, paying attention, and completing tasks		0	1	2	3	4
17. Earning money and learning how to use money wisely		0	1	2	3	4
18. Doing things without supervision or restrictions		0	1	2	3	4
19. Accepting responsibility for actions		0	1	2	3	4
20. Ability to express feelings		0	1	2	3	4

Produces a score of 0 - 80.



Clinically Significant Improvement =
Increase of 8 or more points

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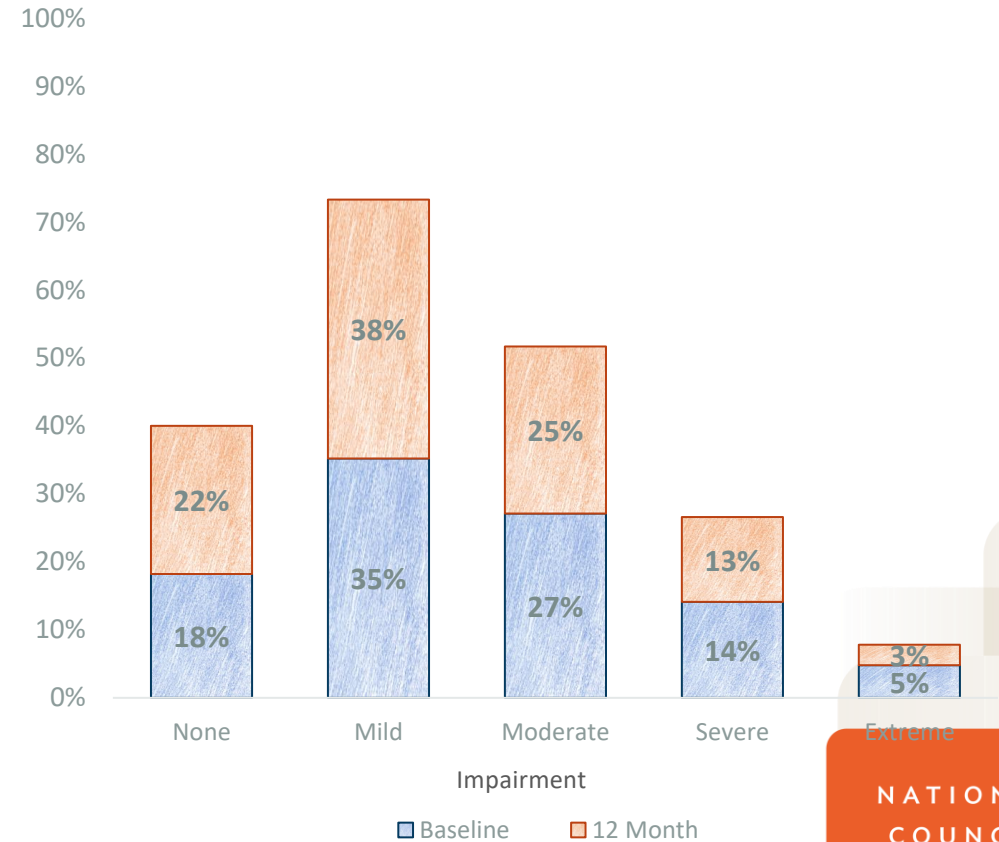


Caregiver Ratings of Family Dynamics

Most caregivers rated the impairment of their family functioning at the mild level.

Caregivers rated their family functioning as improving during their OKSOC enrollment.

- 18% of caregivers scored their family dynamics at no impairment at baseline, while 22% did so at 12-month follow-up.
- 5% of caregivers scored their family dynamics at extreme impairment at baseline, while 3% did so at 12-month follow-up.



(N = 9,220)



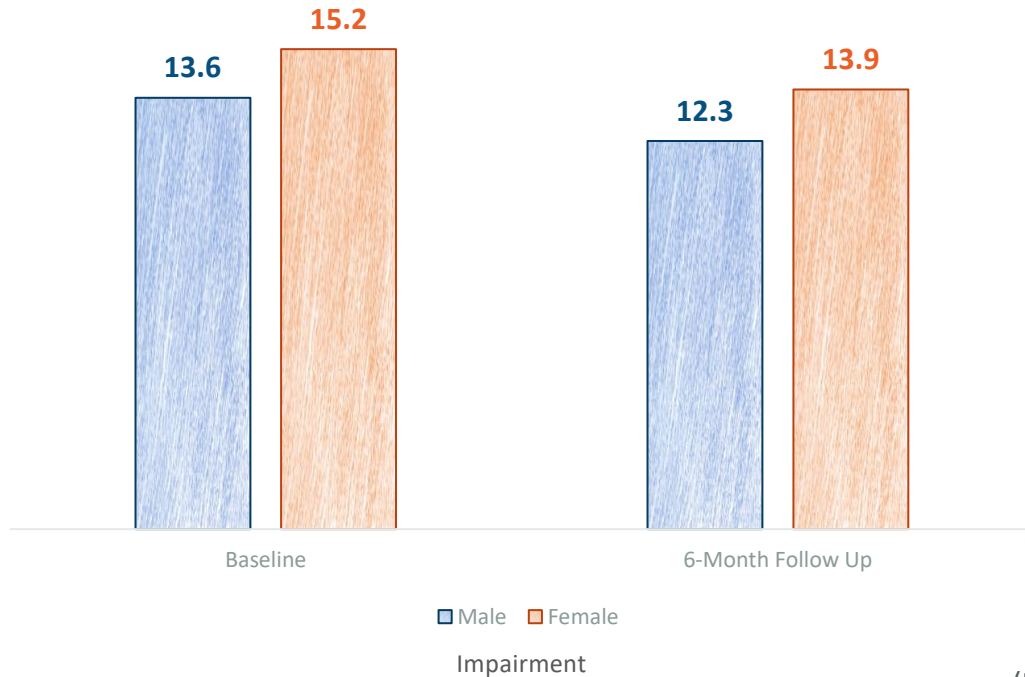
Differences in Caregiver and Youth/Young Adult Perspectives

- Youth and young adults report better family functioning than caregivers at both baseline and follow-up.
- Family Assessment scores improve for both youth/young adults and caregivers from baseline to follow-up.

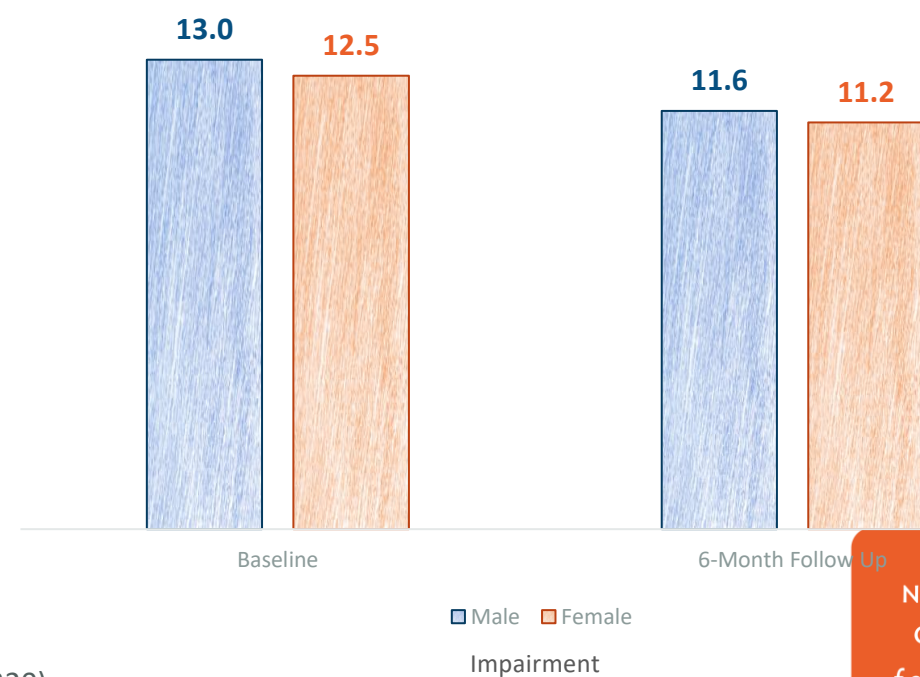


Differences in Caregiver and Youth/Young Adult Perspectives

Change in Family Assessment Score by Gender
(Caregiver)



Change in Family Assessment Score by Gender
(Youth/Young Adult)



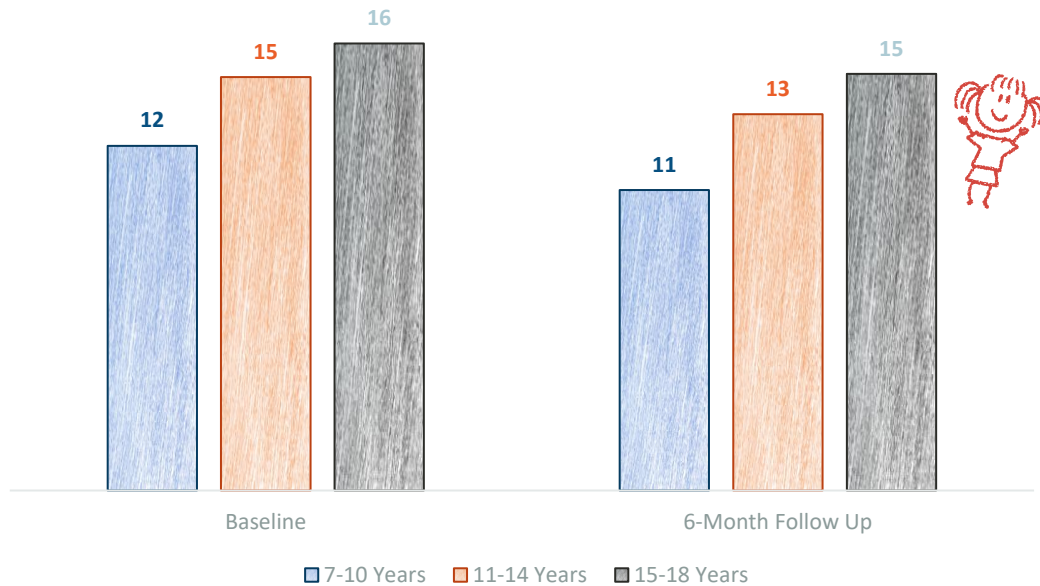
(N = 9,220)

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Differences in Caregiver and Youth/Young Adult Perspectives by Age and Gender

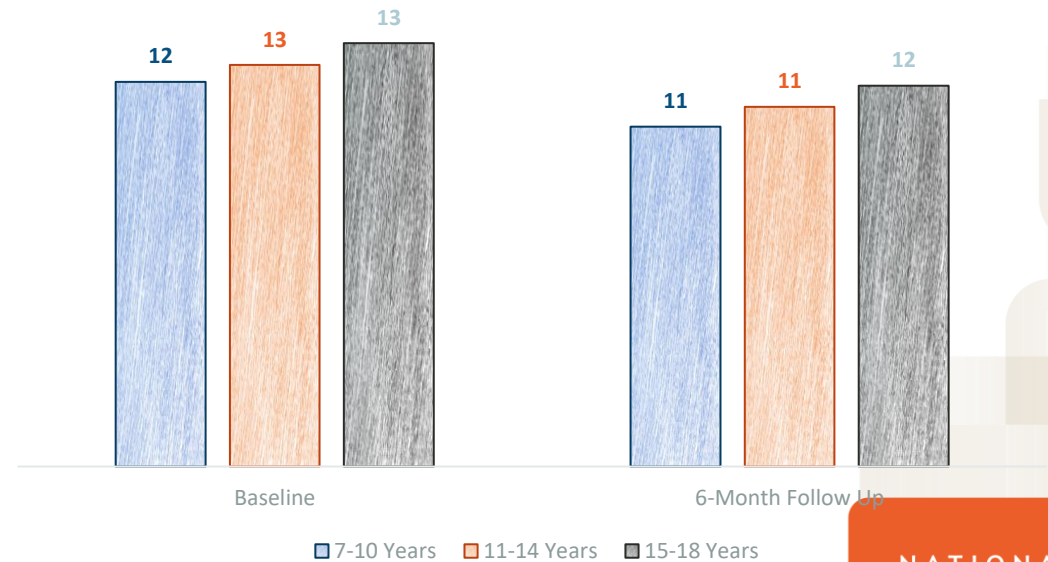
Change in Family Assessment Scores by Age
(Caregiver)



Impairment

(N = 9,220)

Change in Family Assessment Scores by Age
(Youth/Young Adult)



Impairment

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**Example of Mobile Crisis Services-
Oklahoma
Stephanie K White, LPC**

Introduction

- I have been with CREOKS Health Services for 10+ years and have been the Child Mobile Crisis Director since 2017.
- I am a graduate of Northeastern State University in Oklahoma and have worked in Oklahoma for the 14 years I have been working as a therapist. I found crisis services to be a calling and have enjoyed greatly getting to be a part of developing these programs from the ground up.
- In 2023 I became the Mobile Crisis Director for CREOKS Health Services and am now over 988 and emergency transport services for our 7 CCBHC counties and I am still over child mobile crisis in the 14 counties in Oklahoma. I also am over our crisis assessment therapists and our emergency transport services.
- The Assistant Mobile Crisis Director, Heather Threadgill, is the direct supervisor for emergency transport and is an integral part of helping oversee all our mobile crisis programs



CREOKS HEALTH SERVICES

- CREOKS is an established non-profit organization which provides comprehensive health, wellness, and social services.
- Our behavioral health division has 40 years of experience providing quality services and programs that benefit adults, adolescents, and children in our communities. We have 23 clinics across the state of Oklahoma that include a primary care clinic and many other services for our communities to utilize.
- Our Crisis Services are expanding greatly and we currently have 2 Spring Creek Recovery Center locations open for adult and we have many more opening in the future, including multiple kids units. We provide URC/CSU services at Spring Creek Recovery Center.
- Our Mobile Crisis Programs, called COMPASS, have grown significantly over the past few years



History of Crisis Services

- 2014- we opened Spring Creek Recovery Center in Sapulpa, OK to begin providing crisis stabilization and urgent recovery services
- We have had child mobile crisis teams since 2017 that operate in 14 counties across Northeastern Oklahoma
- In fall of 2021 we began our emergency transport services contract with the state of Oklahoma in our 7 CCBHC counties
- In summer of 2022 we started our 988 services in 7 counties for both adults and children/adolescents
- In 2023 we began officially utilizing COMPASS as the name for our all-encompassing mobile crisis services. It stands for Community Outpatient Mobile Psychiatric and Stabilization Services



Child Mobile Crisis At A Glance

How we structure our teams:

1. Crisis Response Specialists (CRS)- these are staff who are case managers or PRSS staff specifically trained in crisis services and are our frontline workers who physically respond to the crisis in the community or at one of our clinics. We have full time Child Mobile CRS staff for Monday through Friday 8a-5p who work as teams of 2. Then we have part-time CRS staff who are employed at CREOKS in another position for all the after-hours shifts.
2. Crisis Assessment Therapists- these are all licensed clinicians who do the assessments and screenings for our crisis services. We have 3 full time day therapists, two full time night therapists, and 12 part-time therapists who work after hours. The part time therapists are typically site directors, outpatient clinicians, or program directors who fill these roles.



What happens when you call our crisis line for child mobile crisis services?

- Dispatch- we have a dispatch center who is responsible for taking all the referrals, creating a referral (called an initial contact form) in our EMR system. This puts that individual in a queue which shows our crisis teams how many calls are being worked and allows us to track from beginning to end
- Dispatch will contact the child mobile crisis worker(s) on call in that county where the child is physically located at the time of the crisis and dispatch them out to the call
- We have one hour to respond in person, but we always try to respond as quickly as possible and our goal is under 30 minutes, if possible. Our staff during the day are located in our clinics so any calls that arise in the clinic are responded to immediately on sight.



Closing: Sharing and Preparing

- **Brave Volunteers: We need 2-3 volunteers to lead off the discussion next time**
- **Next Session: July 25, 2024: 3pm ET**
- **Topic:**
 - Questions to consider:
 - How do your crisis services welcome people with active SUD (with or without co-occurring MH conditions) – including those who may not want to stop using?
 - What strategies are you using to provide immediate connection to medication treatment or individuals with high-risk opioid use disorders?
 - To what extent do your crisis services teams provide integrated care for people with co-occurring MH and SUD?

All slides and recordings will be posted to our learning community website within 48 hours



CCBHC-Expansion Grantee National Training and Technical Assistance Center

We offer CCBHC grantees...



Virtual Learning Communities, Webinars and Office Hours

Regular monthly offerings that are determined based on grantees expressed needs.



Opportunities for Collaboration with Other Grantees

Monthly Peer Cohort Calls for CCBHC Program Directors, Executives, Evaluators and Medical Directors.



Direct Consultation

Request individual support through our website requesting system and receive 1:1 consultation.



On-demand Resource Library

Includes toolkits, guidance documents, and on-demand learning modules.



Access our website to register for upcoming events, submit a consultation request or scan our on-demand resource library:
<https://www.thenationalcouncil.org/program/ccbhc-e-national-training-and-technical-assistance-center/>

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Working to ensure that mental wellbeing is a reality for everyone.

[Our Vision & Values](#)



Hill Day at Home 2023
Oct 18, 1:00 pm – 4:00 pm

Register now for our Virtual Policy Institute, where we'll contact our elected officials and urge them to pass meaningful legislation supporting expanded access to mental health and substance use care.

[Read more →](#) **PUBLIC POLICY**

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Shaped by a Moment: My Journey to Mental Health First Aid
Sep 20, 2023
[Read more →](#)

Blog
Keeping Youth Mental Wellbeing in Mind (Part 2)
Sep 15, 2023
[Read more →](#)

Blog
Recovery Month: Let's Hear it for Peers
Sep 12, 2023
[Read more →](#)

National Recovery Month 2023
Sep 1, 2023
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How You Can Get Involved

Questions or Looking for Support?



Visit our website
and complete the [CCBHC-E
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