Maryland
DEPARTMENT OF HEALTH

MARYLAND'S STRATEGIC VISION FOR COMPREHENSIVE MOBILE RESPONSE & STABILIZATION SERVICES FOR CHILDREN, YOUTH, YOUNG ADULTS & FAMILIES

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Framing the Work

Maryland is committed to supporting children, youth, young adults, and families (referred to as "children and families" hereafter) in being safe, healthy, and successful in their homes, schools, and communities. Maryland is designing and implementing a full continuum of crisis services for all families in support of this goal.

Emergency rooms (ERs) are being used as an access point for mental health services due to insufficient community crisis response services currently available to all youth throughout Maryland. ERs are not designed to provide adequate care for children and youth experiencing a mental health crisis. This practice is expensive, inefficient, and potentially traumatizing for both youth and families.[1,2] Across the U.S., there has been an increase in the number of youth presenting at ERs for mental health needs, particularly for deliberate self-harm. During the COVID-19 pandemic, the proportion of children's mental health-related visits to the ER among all pediatric visits increased beginning in April 2020 and continued to remain high through the following fall.[3] These are not new concerns, however: The prevalence of chronic behavioral health concerns continues to grow among youth, doubling in the past decade, and impacting 20–25% of school-aged youth. Suicide is currently the second most common cause of death in young people (ages 10–24) in the U.S., and suicide rates in youth have increased 56% over the past decade.[4] These increases are uneven across populations: "Between 1991 and 2017, suicide attempts among Black adolescents increased by 73 percent, while attempts among White youth decreased, according to an analysis of more than 198,000 high school students nationwide."[5]

> **"When children, youth, and young adults experience a behavioral health crisis, parents and caregivers may not know what to do, or who is available to help meet the family's needs. A crisis continuum of care — designed specifically to meet the needs of children, youth, and young adults, and their parents/caregivers — is necessary to deescalate and ameliorate a crisis before more restrictive and costly interventions become necessary and to ensure connection to necessary services and supports."**
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> Manley, Schober, Simons & Zabel, 2018, p.1 (emphasis added)[17]

Youth involved with the child welfare and/or juvenile justice systems often have mental health and/or substance abuse problems. Maryland's most recent data indicate a need for clinical behavioral health assessments, treatment planning, and services for some children who are involved with the child welfare and/or juvenile justice systems. The majority (60-75%) of youth involved with the juvenile justice system have a diagnosable mental health disorder; significant numbers of justice-involved youth have a history of trauma, emotional, and behavioral problems.[6] The Maryland Juvenile Justice Monitoring Unit notes that the "majority of youth in the juvenile justice system"[7] have experienced mental health concerns and trauma and that the State's "continued overreliance on incarceration for young people is both expensive and ineffective. Numerous studies have demonstrated that community-based alternatives to confinement cost less, reduce recidivism, and produce better youth outcomes."[8] In September 2019, 70 youth in the custody of the Maryland Department of Human Services/Local Department of Social Services (DHS/LDSS) and/or the Maryland Department of Juvenile Services (DJS) were assessed and treated in an

emergency room for a psychiatric need.[9] Additionally, 140 youth in child welfare placements were in residential treatment centers (RTC; aka psychiatric residential treatment facilities) during that month.[10] DJS had an average daily population of 68.1 youth in RTCs during FY 2020 (7/1/19–6/30/20).[11] During FY 2020, there were 144 requests for a Voluntary Placement Agreement (VPA) to obtain behavioral health and/or developmental disability services that could not be met in the community or with the parents' resources. Fifty-three of these requests were approved.[12]

A good, modern children's crisis system is the most cost effective and efficient way to interrupt pathways to ERs while supporting youth to remain in their homes, schools, and communities. In Maryland, Mobile Response and Stabilization Services (MRSS) will serve as an anchor for the crisis continuum by operating as a coordinated and individualized intervention to deescalate a family-defined crisis and address significant behavioral concerns in a community setting.

Setting the Vision

Maryland is committed to designing and implementing an MRSS that:

- Is customized to meet the needs of children, youth, young adults, and families;
- Provides timely, relevant services and supports to prevent escalation of challenges and poor outcomes;
- Uses the child and family's definition of a crisis and recognizes children, youth, young adults, and families as experts on their own needs;
- Provides individualized, trauma-responsive services and supports to meet needs across life domains, including peer support and in-home services;
- Recognizes and addresses challenges posed by structural and historical inequities and oppression and continually assesses systems, processes, and services for problems associated with implicit bias and racial and ethnic disparities;
- Is culturally and linguistically responsive and connects families to appropriate community-based services; and,
- Leverages the strengths of children and families, providing services and supports that are aligned to their identified needs.

MRSS is a child, youth, and family-specific intervention model designed to meet the youth and caregiver's[a] sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis. Children's crisis situations significantly impact and involve the caregiver because of the nature of their relationship.

MRSS may be a family's first contact with the behavioral health system. As such, the MRSS team must begin building a trusting relationship. This relationship is foundational to developing an individualized care plan (ICP) with goals jointly developed by the youth, family, and treatment providers. MRSS for children and families experiencing a behavioral health crisis must exist along a continuum of care.

Maryland's MRSS will be one in which the crisis is defined by the caller — that is, by the youth, parent, or caregiver — rather than a professional or call taker. A crisis is best defined by the person or family experiencing it; the workforce at point of contact should give full weight to the

[a]The term "caregiver" is used throughout in a broad sense to refer to the child or youth's parent (biological or resource parent) or other caregiver or guardian.

perceptions and experience of the parent/caregiver, youth, or other caller. Mobile response is dispatched when the caller requests it. This allows mobile responders to provide intervention services for emotional and behavioral concerns at the earliest opportunity; prevent further deterioration in clinical functioning; avoid seeking care at the ER where children are likely to be "boarded" — the practice of holding children and youth in the ER until an inpatient bed becomes available;[13] or involve police. Avoidance of unnecessary police involvement is critical for children and youth of color who are more likely to be face poor outcomes from this intervention, from school exclusion[14,15] to arrest,[16] than their White peers.

"Crisis services for mental health should be like a fire department with services available in every neighborhood. Anyone can experience a mental health crisis in their family."

Jane Walker, Founding Executive Director, Maryland Coalition of Families for Children's Mental Health; Founding Executive Director, Family-Run Executive Director Leadership Association; and, Parent, 201318

The MRSS needs to be available to "anyone, anywhere and anytime."[1] MRSS must be accessible through a call center able to deploy the response (lasting up to 72 hours from first intervention) and the ongoing support or stabilization services (lasting up to an additional eight weeks). Maryland's MRSS will ensure that these components are delivered by the same provider to ensure consistency and continuity of care. Services initiated during the response and built upon and implemented during the stabilization period include conducting an assessment; developing or updating an ICP; providing key services, which may include but are not limited to family and youth peer support, respite care, and intensive in-home services; and connecting to community supports and referring to ongoing care as needed. Each of these components are delivered in partnership with the youth and family.

Where Does Maryland Go From Here?

The Maryland Behavioral Health Administration (BHA) seeks to redesign and expand MRSS to be available in each of Maryland's 24 jurisdictions.

BHA intends to leverage existing opportunities and initiatives to provide consistent, high quality MRSS for children and families, including identifying how and when to customize interventions and approaches to meet the developmental needs of children and families. BHA will be partnering with families, youth, provider organizations, and state and local public child- and family-serving agencies to design, install, implement, evaluate, and sustain MRSS for children, youth, young adults, and families.

This work will be supported through:

- Family and youth engagement and partnership;
- Technical assistance, including national best practices in MRSS that are customized to meet the needs of children, youth, young adults, and families;
- Development and implementation of a strategic framework and implementation plan, including definitions of terms, timelines for installation, key activities and benchmarks, and communication strategies; and

- A Maryland MRSS Quality Improvement Collaborative to enable peer learning, provision of subject matter expertise and technical assistance on best practices and sustainable financing, shared data collection and analysis, and cross-jurisdictional work.

Initial next steps will include:

- Conducting an environmental scan of existing mobile response and stabilization services in each of the 24 jurisdictions to inform immediate and long-term action steps with data obtained, in part, from the Local Behavioral Health Authorities and Core Service Agencies;
- Prioritizing strategies for MRSS in regions without any existing crisis response capacity;
- Selecting a crisis assessment tool and MRSS training curriculum to ensure consistent approaches and decision-making statewide;
- Selecting performance and outcomes measures to support continuous quality improvement and evaluation activities;
- Identifying opportunities to leverage and align with federal initiatives, including implementation of 988: The National Suicide Prevention Hotline; and
- Communicating with partners developing Maryland's adult crisis response system to ensure all Marylanders receive consistent information, referrals, and access to services and support.

BHA envisions Maryland's MRSS playing a critical role in providing care in the least restrictive environment appropriate to meet clinical needs, maintaining children safely at home and in the community, and avoiding out-of-home placement whenever possible.

The equitable, sustainable design and implementation of MRSS for children, youth, young adults, and families is an urgent priority for Maryland.

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