BRIEF

Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services

Caregivers and families often have limited options when their child or youth experiences a behavioral health crisis and frequently turn to law enforcement, hospital emergency departments (EDs) and inpatient treatment for help. From 2001 to 2010, the nation saw a 26 percent increase in the number of children and youth treated in emergency departments for psychiatric problems. This increase was attributed solely to publicly-insured youth[1], signaling not only a greater burden for EDs, but for states' public behavioral health systems as well.[2]

It is common for children and youth to be hospitalized in an inpatient unit following their visit to the ED for psychiatric problems. Hospitalization rates for children ages 5 through 12 grew from 155 per 100,000 children in 1996 to 283 per 100,000 children in 2007. Hospitalization rates among teenagers also increased, from 683 per 100,000 youth in 1996 to 969 per 100,000 youth in 2007. These increases occurred even as the number of psychiatric beds in the nation's hospitals declined.[3] Such findings demonstrate the urgency to strengthen community-based service arrays to meet the needs of children and youth who are at-risk for or are experiencing behavioral health crises.

EDs generally are considered inadequate settings for children and youth experiencing behavioral health crises. Because they are responsible for serving all patients with a critical health care need, EDs lack the specialized expertise necessary to effectively respond to a child's psychiatric problems. Wait times for youth presenting in the ED with behavioral health conditions may exceed five hours and can last twice as long as their counterparts presenting with physical health conditions.[4] In addition, inpatient-ready children may be "boarded", meaning they are held for lengthy periods of time in the ED while waiting for psychiatric beds to become available.[5]

Inpatient psychiatric treatment is an important component of a children's behavioral health system, particularly when a child is experiencing suicidality or psychosis. However, it is often used in situations where community-based interventions may be more appropriate. Inpatient treatment is expensive and highly disruptive for children and families and studies have yielded conflicting arguments of its effectiveness for preventing future behavioral health crises. Additionally, the reduction in lengths of inpatient stays has led to increases in rehosptalization among children and youth, further raising concern over the effectiveness of inpatient treatment and the availability of quality community-based alternatives.[6] As the field of children's behavioral health continues its trend toward treatment in the least restrictive environment possible, inpatient beds are becoming scarcer and inpatient stays are becoming shorter. Consequently, it is becoming critical for states to develop innovative strategies within their public behavioral health systems to achieve two goals: Diverting ED admissions and instituting home and community-based services (HCBS) that provide meaningful alternatives to inpatient treatment.

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Mobile Crisis Response and Stabilization Services (MRSS) are one example of a cost-effective alternative to the use of EDs and inpatient treatment. MRSS provide mobile, on-site and rapid intervention for youth experiencing a behavioral health crisis, allowing for immediate de-escalation of the situation in the least restrictive setting possible; prevention of the condition from worsening; and the timely stabilization of the crisis. The mobile crisis component of MRSS is designed to provide time-limited, on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and EDs. Depending on the needs of the child, the stabilization component may include a temporary, out-of-home crisis resolution in a safe environment. A growing body of evidence points to MRSS as a cost-effective method for improving behavioral health outcomes; deterring ED and inpatient admissions; reducing out-of-home placements; reducing lengths of stay and the cost of inpatient hospitalizations; and improving access to behavioral health services. In addition, families often report greater satisfaction with MRSS when compared to the ED.

In May 2013, the Centers for Medicaid and Medicare (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a joint informational bulletin providing guidance to states on designing HCBS, including MRSS, to help states meet their obligations under Title II of the Americans with Disabilities Act[7] (ADA) and Medicaid's Early Periodic Screening, Diagnostic, and Treatment[8] (EPSDT) requirements. As the federal government encourages more states and communities to include MRSS in their benefit/service designs, there is a need to better understand what these services look like from an operations perspective. Information on service definitions, rate setting methodology, provider qualifications, financing strategies and quality measures for performance management is needed by states and localities to improve the availability of MRSS and to help them implement MRSS in their jurisdictions.

This publication is intended for use by state and local entities responsible for the purchase, design, implementation and delivery of MRSS. MRSS looks different from state to state with variability dependent on the purchaser, the financing environment and the population served. In order to help guide planning, design and implementation efforts in other states and jurisdictions across the country, this resource provides examples of how MRSS are utilized in counties and states including: Milwaukee County; Wisconsin; King County, Washington; the Commonwealth of Massachusetts; and the State of New Jersey.

Mobile Crisis Response and Stabilization Defined

In the May 2013 joint informational bulletin, CMS and SAMHSA described MRSS as follows:

> "Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise. Residential crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family."

MRSS ensure timely access to supports and services (e.g., one-hour mobile response time to the location of the crisis or continually staffed "warm" lines) from adequately trained crisis professionals. These professionals are driven by a commitment to provide services in the least restrictive manner while ensuring the safety of the child and family. They also play a vital role in prevention of future

crises. In general, MRSS are involved in five key phases of crisis intervention within their state or community, including:

1. **Crisis prevention**. MRSS often collaborate and engage in training with law enforcement, child welfare, schools and other entities that have relationships with children or youth who are at-risk for behavioral health crises. They also have a role in identifying and addressing gaps in the service system and reinforcing a coordinated, systemic approach in planning, delivery and policy and outcome-management practices.

2. **Early intervention**. MRSS may train service providers in identifying risk factors for crises before symptoms become acute and warrant more intensive levels of intervention. They commonly provide guidance on implementing crisis plans, rapid access to treatments and referrals and linkages to appropriate resources. In addition, MRSS staff may attend child and family team meetings with care coordinators or case managers to establish a relationship with the family and develop a preemptive crisis plan.

3. **Acute intervention**. MRSS providers are tasked with providing specialized and timely intervention in the setting where the crisis is occurring. In some cases, they may triage and de-escalate crises via crisis hotlines; in others, the situation may warrant face-to-face intervention from a mobile team of crisis professionals at the location of the crisis, which may include the home, school, congregate living facility or elsewhere. Teams conduct evaluations and assessments to determine the danger a child poses to him/herself or others, and to determine the services and supports necessary for resolving the crisis and preventing placement in higher, more restrictive, levels of care. MRSS providers also assist in the development of an individualized, strengths-based safety or crisis plan with the child and family, and often serve as gatekeepers for inpatient admissions.

4. **Crisis treatment**. In most cases, behavioral health crises are not one-time events and require ongoing support. Consequently, MRSS often provide stabilization services subsequent to acute intervention. These services may include in-home supports, short-term care coordination, and residential crisis stabilization (e.g., crisis respite beds). This stabilization component of MRSS may be provided over the span of a few days or several weeks, depending on the needs of the family.

5. **Recovery and reintegration**. MRSS providers are responsible for facilitating the child or youth's transition from acute intervention or crisis treatment to the community. To do so, they may provide behavioral health education, help identify and develop relationships with formal or natural supports, assist the family with navigating the system, and provide medication management services.

In this brief, we will discuss in detail the structure and components of four model programs and their roles in the above stages of crisis intervention and stabilization. Specifically, we will investigate oversight and purchasing, eligibility and screening, crisis response protocol, service definitions, staffing qualifications, financing, and quality monitoring and evaluation. First, we will explore the case for investing in MRSS as a viable intervention.

MRSS: A Cost-Effective Alternative

MRSS have a particular advantage over EDs in that while ED staff, perhaps necessarily, focus on determining whether criteria for inpatient treatment is met, a MRSS team has the potential to effectively intervene in early and acute stages of a crisis, offer an array of brief treatment services, facilitate movement to a higher level of care if needed, assure continuity of treatment and address any number of behavioral health risk factors.

In addition, MRSS are considered a viable alternative to EDs and inpatient treatment because they consistently demonstrate potential for cost-savings while helping to improve or maintain the level of functioning for children and youth. When compared to ED and inpatient admissions, MRSS tend to achieve better outcomes at lower cost, and with higher family satisfaction. To illustrate, an evaluation

of Connecticut's Emergency Mobile Psychiatric Services (EMPS) received 1,121 referrals from EDs in 2013, 533 of which were inpatient diversions. Sixty percent (332 youth) of the inpatient diversions were youth enrolled in Medicaid. The average cost of an inpatient stay for Medicaid-enrolled youth was $13,320, while the cost of the MRSS was $1,000, equating to an average net savings of $12,320 per youth, or about $4 million total for that year.[9]

Wraparound Milwaukee's Mobile Urgent Treatment Team (MUTT) program demonstrated similar cost savings. Since the program was implemented in 1994, the annual costs of hospitalization for adolescents declined by 50 percent, from $10.5 million to $5 million. In the first quarter of 2010, 84 percent of youth who were at immediate risk of inpatient psychiatric hospitalization were instead diverted to alternative community resources. Additionally, the small number of youth who did go on to be hospitalized after being treated by the MUTT typically experienced significantly shorter lengths of stay. Children who are hospitalized after seeing the MUTT average 2.2 days per stay, while their counterparts average 5.1 days.[10] [11]

In King County, Washington, the Children's Crisis Outreach Response System (CCORS) diverted 81 percent of child hospitalizations at local emergency departments in 2012, which translated into a savings of about $1 million in inpatient costs. It was also reported that in 2011, 62 percent of previously unengaged families were linked with community providers at the conclusion of the CCORS intervention.[12] Texas provides another example of the potential cost savings resulting from MRSS. In 2007, $82 million were appropriated by the Texas state legislature to address gaps in the state's behavioral health crisis service delivery system for children and youth. In addition to crisis hotlines and psychiatric urgent care, MRSS was funded as part of the crisis service array. The initiative resulted in declining hospitalization (1 of every 6 crisis episodes resolved via hospitalization pre-redesign, compared to 1 of every 8 post-redesign) which translated into direct and measurable cost savings of $1.16 to $4.51 return on every dollar invested.[13]

Empirical literature further supports MRSS as a cost-effective alternative. For example, a recent meta-analysis of mobile crisis teams by Carpenter, et al. (2013) concluded that among 12 pre- and post-mobile crisis comparison studies, 8 showed reduced admission rates post-introduction of the service, and that the reduction in inpatient utilization easily covered the cost of implementing the service.[14]

What makes MRSS particularly valuable in a system of care is its utility for realizing cost-savings and other benefits in multiple child-serving systems, including child welfare and juvenile justice. It was estimated that the King County, Washington CCORS team saved their state's child welfare system roughly $2 million from 2008 to 2011 by preventing out-of-home placements. In addition, Connecticut's MRSS affected cost-savings for the juvenile justice system by diverting youth from arrest and juvenile detention. Among 200 foster families served by the MUTT team in Milwaukee County, 93 percent of the children and youth were sustained in their planned placement.

Implementation Essentials

This section outlines best practices for implementing and delivering quality MRSS services. The information was synthesized from operational profiles of four model MRSS programs, including: 1) Mobile Urgent Treatment Team (MUTT) in Milwaukee County, Wisconsin; 2) Children's Crisis Outreach and Response System (CCORS) in King County, Washington; 3) New Jersey MRSS; and 4) Mobile Crisis Intervention (MCI) in Massachusetts. These programs were selected because they form a representative sample of effective MRSS programs for children and youth that serve both communities (e.g., counties) and the entire state. These four programs are introduced below.

Milwaukee County, Wisconsin

Milwaukee County in Wisconsin has a nationally respected and effective crisis model for children in their region. The program is called the Mobile Urgent Treatment Team (MUTT) and its primary focus is to keep children at home with families and out of hospitals. MUTT provides MRSS services for children and adolescents (up to age 18), and addresses a family's immediate concerns about their child by

phone or by responding to them in the community or in their home. Services are available 24 hours a day, seven days a week.

Once called, the MUTT team immediately travels to the location where a crisis may be occurring. The team assesses the situation, including the potential for danger that the child poses to himself or others. Based on the assessment, the team weighs intervention options, including keeping the child home (with adequate support services), temporary placement in a crisis group home or other emergency setting, or hospitalization in a psychiatric facility. The team can provide short-term case management services as necessary and frequently acts as a liaison between the family and available community services. In addition, MUTT operates an eight-bed crisis/respite group home for boys (licensed as a residential care center), which can serve as an alternative to inpatient hospitalization and as a resource for a child transitioning from an inpatient facility.

King County, Washington

The Children's Crisis Outreach Response System (CCORS) in King County, Washington provides crisis outreach and stabilization services 24 hours a day, 7 days a week to all residents of King County regardless of income. Specific services include mobile crisis outreach, which consists of specially trained teams available to respond in the child or youth's natural environment to de-escalate the situation. The team conducts mental health and suicide risk assessments and works with the family to implement ongoing services and supports to prevent future crises. CCORS also provides non-emergency outreach appointments, available within 24-48 hours for families who are not in immediate crisis but require timely support and linkages to services. Crisis stabilization services in the form of in-home support are available for up to 8 weeks following the initial acute crisis. Intensive crisis stabilization services (90 day in-home support) and crisis stabilization beds are also available to specialty populations. Crisis stabilization beds provide a family-like home setting and are used short-term (up to 14 days) to stabilize youth who cannot be safely maintained in their homes.

State of New Jersey

The Mobile Response and Stabilization Services (MRSS) System delivers mobile response services to children/youth/young adults experiencing escalating emotional and/or behavioral reactions and symptoms that are impacting the youth's ability to function typically (at baseline) within their family, living situation, school and/or community environments. Mobile response services are available 24 hours per day, 7 days a week, year round, are delivered by MRSS staff and include both initial (within 1 hour) face-to-face intervention wherever the youth's need presents, and follow-up interventions, services and coordination for up to 72 hours subsequent to the initial intervention. If at the end of initial mobile response services, a youth continues to exhibit patterns of behavioral and emotional needs that require continued intervention and coordination to maintain typical functioning and prevent continued crisis reaction, a child/youth may be transitioned to Mobile Response Stabilization Management Services.[15]

MRSS program model components include on-site intervention for immediate de-escalation of presenting behavioral and emotional symptoms. Assessment, planning, skill-building and resource linkage are provided to stabilize presenting needs, assist the youth and family in returning to baseline (routine) functioning, and provide prevention strategies and resources to cope with presenting behavioral and emotional needs and/or avoid future crisis reactions. MRSS are delivered by applying crisis intervention principles and core System of Care values and principles within the described program model. Care is strengths-based, youth-centered and family-driven, community-based and culturally and linguistically mindful. Care planning is individualized, collaborative and flexible based on youth and family need.

State of Massachusetts

In Massachusetts, Mobile Crisis Intervention (MCI) is provided to youth (under the age of 21) by all emergency service program (ESP) providers. MCI provides a short term service that is a mobile, on-

site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, where one exists. This service is provided 24 hours a day, 7 days a week.

The service includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more crisis planning tools (e.g., Safety Plan; Advance Communication to Treatment Providers; Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family; up to 7 days of crisis intervention and stabilization services including on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

MRSS: Components

Components of MRSS include oversight and purchasing; eligibility and screening; staffing structure, provider qualifications and training; response protocol and services provided; financing; utilization management and quality monitoring; and other considerations such as marketing and interfacing with child-serving systems.

Oversight and Purchasing

Purchasers of MRSS for youth with serious behavioral health challenges include state Medicaid authorities, state or county behavioral health authorities, child welfare agencies, administrative services organizations (ASOs), managed care organizations (MCOs), care management entities (CMEs), and hospital/health systems. Purchasers may choose to provide MRSS themselves or contract for some or all of the services to non-governmental, private, nonprofit agencies to provide via direct or sole source contracting or a Request for Proposals (RFP) process.

Eligibility and Screening

As states and communities design and implement MRSS, it is important that they employ a uniform definition for a behavioral health crisis to determine when intervention is appropriate. Historically, crises have been narrowly defined as a situation in which the child or youth presents a danger to themselves or others. While this may be appropriate for establishing legal precedent for involuntary psychiatric hospitalization, crisis definitions should be broadened to minimize barriers to care and allow MRSS to intervene before an episode reaches such levels of severity. As such, most states and communities specify that MRSS intervention is warranted when a crisis significantly interferes with the ability to function and is severe enough to place the child or youth at a risk for placement disruption or treatment in higher levels of care. The clinical threshold for crisis may include aggressive behaviors; suicide attempts/ideation; drug and alcohol overdose or abuse; or disruptive symptoms related to mood and anxiety disorders (e.g., panic, hopelessness, anger, depression). It may also present as an overt change in functioning, or be prompted by traumatic life events.

In addition to a clinical threshold, eligibility criteria for MRSS may also include specific age ranges and geographical catchment areas. Many MRSS use a "No Reject" policy, where children and youth presenting with a crisis are treated regardless of insurance status. Although MRSS may only provide face-to-face crisis intervention when specific eligibility criteria is met, they will still offer guidance and assistance to anyone seeking crisis services, even if they fall short of the threshold for intervention or live outside the particular catchment area.

To reliably determine whether children and youth satisfy the criteria for intervention, it is critical for MRSS to institute the use of standardized assessments. Assessments are used initially when the MRSS is contacted, to determine whether face-to-face intervention is necessary, and are conducted face-to-

face with children and families to determine strengths, needs, and optimal necessary interventions, including home and community-based services or hospitalization. Further, assessments are an essential tool in determining the safety of the situation and can be used to make appropriate referrals to other community services.

Assessments often include elements such as mental status exams, crisis precipitants, risk and safety issues, and parent/caregiver strengths and resources. MRSS providers may design their own tools specific to their program, or use adapted versions of standardized tools, such as the Child and Adolescent Strengths and Needs Assessment (CANS) or the Child and Adolescent Service Intensity Instrument (CASII, formerly called CALOCUS).

Staffing Structure, Provider Qualifications and Training

MRSS must be delivered by individuals with appropriate training and established competence for effective crisis intervention. Further, it is necessary for MRSS staff to possess comprehensive understanding of children and youth at-risk for experiencing crises, expanding beyond a clinical perspective to include a solid grasp of systems of care principles. Purchasers of MRSS are responsible for defining the type of training, qualifications and expertise required for crisis response and stabilization staff. It is common for states to designate the type of provider that can deliver MRSS and to specify staffing requirements, standards of qualification and core clinical competencies for crisis response and stabilization services. In addition, states outline the roles and responsibilities expected of all staff providing each component of MRSS. Intensive staff orientation and ongoing training is critical. Such training is usually tailored to the state or community and may include current best practices on crisis response and child/youth assessment and treatment, systems of care philosophy, child welfare populations, cultural competence, quality assurance, parent training and utilization of decision-making tools.

Most MRSS employ a multi-disciplinary team of behavioral health professionals, paraprofessionals and community and family members. Trained staff operates phone lines to triage crisis calls and make decisions to dispatch mobile response teams. Mobile response teams often include two staff members; one behavioral health professional and one paraprofessional. Psychiatrists and/or registered nurse practitioners are usually available to provide consultation when needed. In addition to clinical and psychiatric expertise, MRSS providers must be able to demonstrate to purchasers that they have staff and infrastructure necessary to support and ensure quality assurance, utilization management, electronic data collection, and cultural and linguistic competency.

Response Protocol and Services

In order to successfully remediate behavioral health crises in the community, MRSS must implement effective response protocols and offer a menu of specialized services that can be tailored to a child's individual needs. Moreover, they must have capacity to allow for timely access to supports and services 24/7. MRSS routinely serve as "gatekeepers" for inpatient hospitalization, meaning they are either involved in or responsible for authorizing inpatient admissions, and purchasers align and streamline service definitions and/or protocols with other child serving systems to ensure seamless transition and coordination. MRSS set staffing levels according to data trends in call volume and ensure 24/7 coverage by designating shifts or rotating teams.

The specific services and supports offered by MRSS generally fall within three overarching categories of intervention: 1) crisis hotlines; 2) mobile crisis intervention; and 3) crisis stabilization.

1. **Crisis Hotlines.** Available 24/7 and continually staffed by a trained and qualified specialist, crisis hotlines are the primary entryway to MRSS services. Hotline operators field referrals from a variety of sources, including parents/caregivers, schools, and law enforcement; triage the call, and dispatch mobile intervention teams when necessary. Triaging a call involves conducting an assessment to determine the risk of harm and then calibrating calls according to the level of threat, ranging from an immediate response to a scheduled visit (typically within 48 hours). MRSS

make concerted efforts to ensure that their hotline number is well-advertised and known to as many potential referral sources within their catchment area as possible.

2. **Mobile Crisis Intervention.** When deemed appropriate, MRSS will dispatch mobile crisis teams to the location of a crisis. The target response time for most MRSS is one hour from the time of the call. MRSS may coordinate with law enforcement to provide additional safety. Guardian consent and background checks or fingerprinting of MRSS staff may be required prior to responding to crises in locations outside the child's home, such as schools or detention centers. Once at the scene of the crisis, the team immediately de-escalates the crisis by addressing the behaviors and situation impacting the child's functioning and by identifying and providing the crisis services and referrals necessary to return the child to a more stable level of functioning. Mobile crisis intervention also includes behavioral health, functional, and risk assessments to evaluate the potential risk a child poses to him or herself and to others, and to identify crisis precipitants (e.g., psychiatric, educational, social, or environmental factors that may have triggered the crisis). Mobile crisis intervention includes debriefing with parents/caregivers after the crisis is resolved, as well as the development of an individualized crisis plan in partnership with youth (as age appropriate) and parents/caregivers which uses the information gathered through the assessments.

Crisis plans are intended to be working documents that are continuously revised throughout the period of intervention. Components of a crisis plan may include demographic information, contacts or resources that would be helpful in a crisis, child and family/caregiver strengths and needs, relevant medical information, risk factors/crisis precipitants, appropriate community services and supports, action steps identified by the family, and a safety plan. MRSS work with the youth and family to further develop crisis resolution strategies and may, with their permission, engage service providers and/or natural supports identified by the family to share in the development and execution of the plan.

Mobile crisis intervention services may be provided up to a 72 hour period after the initial contact, during which the MRSS providers deliver immediate and direct clinical intervention (either in-person or telephonically), facilitate "warm hand-offs" to community services, and other follow-up supports.

3. **Crisis Stabilization.** Crisis stabilization is provided to either mitigate the risk for placement in higher levels of care or to assist in transitioning the child to a less restrictive setting. Typically available for a period of weeks following the initial contact, crisis stabilization services may involve intensive in-home supports (e.g., parent coaching, skill building) and/or referral to crisis stabilization beds, offered in a residential setting as a form of respite. Medication management may also be provided. MRSS sometimes provide these services themselves, or will coordinate with others such as intensive care coordinators.

Financing

Financing a broad array of appropriate services and supports including MRSS is essential for helping youth with behavioral health challenges remain in the community. Medicaid, private insurance, child welfare and mental health general revenue, public school systems, and federal grant funds are all potential sources of funding for MRSS. Exploring different funding streams and sources and pooling, blending or braiding these funds together is an effective strategy for making MRSS available to diverse groups of youth with behavioral health challenges (e.g., uninsured youth, those with co-occurring disorders, youth involved with multiple child-serving systems, etc.). MRSS are most effective when states and communities purchase capacity, meaning states and communities fund the service at a level that ensures it is available to children and youth regardless of how often it is accessed (similar to a fire department). Challenges do arise in fee-for-service funding approaches during periods of low demand, making it critical to establish dedicated funding streams to support the consistent availability of this response capacity.

Utilization Management and Quality Monitoring

To ensure accountability and improve program practices, MRSS are often required to develop continuous quality improvement plans and take part in utilization management activities. MRSS must participate in the collection, analysis and dissemination of key data elements to measure the success of their implementation and the quality of the service intervention. In some states, quality data and improvement plans are developed and implemented via a collaborative process across several organizations that are accountable for providing care and oversight. This is particularly important given that MRSS must be linked to other services and supports in order to effectively address a youth's crisis. Linking of data across services and supports also allows ongoing monitoring of the impact of the service to divert crises and connect youth to needed services. Included in these plans are specific performance measures such as MRSS service utilization rates (including the number of calls received, number of mobile responses, etc.), average response time to crises, diversion rates from EDs and/or juvenile detention, duration of follow-up and stabilization services, community-based service utilization following intervention, and rates and lengths of stay of inpatient psychiatric hospitalizations. States and communities also monitor MRSS compliance to contract requirements and state regulations. In addition, youth and family satisfaction is a standard component in most MRSS quality improvement plans.

Other Considerations

MRSS should coordinate and collaborate with hospitals, treatment providers, community services, schools, juvenile justice and law enforcement agencies, child welfare systems and primary care. Successful MRSS programs attribute their effectiveness at least in part, for diverting ED visits and preventing inpatient admissions to strong relationships and Memoranda of Understanding (MOU) with the hospitals in their communities. MOU with hospitals enable MRSS teams to assess children and determine the appropriate level of treatment at the time the family presents at the ED. MOU also allow EDs to call on MRSS to assist youth and families with crisis prevention, discharge planning, and linkage to community-based services after they have been admitted.

Building relationships and establishing MOU with school systems is also paramount, as children and youth frequently experience behavioral health crises in their schools. In many schools, the de facto response to behavioral health crises is to engage law enforcement and have the child or youth emergency petitioned to the ED. Newly implemented MRSS programs must market their models to schools as a viable alternative, and establish MOU with superintendent offices that articulate appropriate use of their services. In addition, the MRSS should identify at least one school official to serve as a liaison with their program.

Forging partnerships with law enforcement agencies is also critical for MRSS programs. It is well-established that many youth arrested due to a behavioral health crisis are better served by mental health services than the juvenile justice system. MRSS programs should implement MOU with law enforcement that define protocols for ensuring that the crisis team assesses youth and facilitates linkages to behavioral health services as an alternative to an arrest, when appropriate. In King County, CCORS meets regularly with law enforcement to educate them about behavioral health crisis and the availability of community-based services and supports. Such practices have prevented youth in King County from unnecessarily entering the juvenile justice system. In Milwaukee County, MUTT has taken part in the training of over 1,800 police officers to raise awareness and understanding of the behavioral health needs of youth.

MRSS should also provide focused attention to the child welfare population in the communities they serve. Children and youth in foster or group homes are commonly referred to EDs and are at increased risk of placement disruption as a result of behavioral health crises. As mentioned previously, in Milwaukee County MUTT contracts with foster care and group homes to provide dedicated crisis response to the child welfare population. This practice has contributed to greater placement stability among foster youth in Milwaukee County.

Given that 70% of primary care visits among youth involve some type of behavioral health need,[16] it is also important for MRSS to have linkages with primary care clinicians (PCC). For example, Massachusetts MCI teams maintain MOU with primary care practices in their communities, to provide onsite crisis support and referrals to needed services.

States, communities and agencies that are introducing or expanding the use of community-based MRSS may notice that the delivery of MRSS is influenced by long standing decisions and practices within broader public system sectors. Established "protocol" may prevent a police officer from calling a mobile response team to a family home in lieu of transporting the child to the ED. School administration may question the effectiveness of a mobile service if the child isn't admitted" somewhere for treatment. The medical community may be concerned that crisis intervention is sub-standard when provided in the home by a masters-level clinician instead of in the ED by a physician. Initiation of involuntary evaluation procedures may be seen as the best way to assure a child is safe and receives quality treatment. Children and families can find themselves stuck in the middle of contradictory and deeply held systemic beliefs and recommendations about the best course to take. Systemic discord can compound an already stressful crisis event, delay resolution, and even cause harm. Systemic work is necessary to ensure coordinated protocols across these different sectors. For example, Massachusetts MCI providers work closely with local schools, law enforcement and hospitals to establish MOU and protocols to ensure consistent and coordinated response to children and families in crisis.

Conclusion

Rates of psychiatric ED admissions and inpatient hospitalizations among children and youth are increasing in the United States. Regarded as costly adverse events that disrupt continuity of care, these indicators are proxies for the adequacy of outpatient services and the overall quality of behavioral health systems in states and communities. Rising rates signal the need for greater investment in community-based alternatives that intervene early when a child experiences a crisis and reliably prevent future crises from occurring. MRSS are one such alternative, with well-established effectiveness for reducing unnecessary ED and inpatient admissions and improving the delivery of behavioral health services. Further, MRSS are a key component of a "good and modern" behavioral health system with demonstrated potential for cost-containment.

Care in the least restrictive setting possible is a touchstone of quality behavioral health systems in the United States, and our present overreliance on ED and inpatient units represents a deficiency in meeting this standard. States and localities are thus compelled to invest in cost-conscious strategies, like MRSS, that will enable them to maintain their commitment to effectively treating the behavioral health needs of children and youth in their homes and communities.

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