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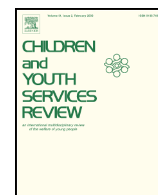

Mobile crisis services for children and families: Advancing a community-based model in Connecticut

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ABSTRACT

The purpose of this paper is to describe a best practice model of care for children's mobile crisis services in Connecticut: Emergency Mobile Psychiatric Services (EMPS). EMPS responds to homes, schools, emergency departments and other community locations to provide children and their families with mobile crisis stabilization, assessment and brief intervention, and referral and linkage to ongoing care. The system is comprised of a statewide network of contracted providers, a statewide Call Center to manage and triage incoming referrals, and a Performance Improvement Center to provide data analysis, reporting, quality improvement, and standardized training. Data collected since 2009 demonstrate high service utilization, consistently high mobility rates, and rapid response times as well as statistically significant improvements in child outcomes. The paper discusses the role of mobile crisis services within a comprehensive continuum of behavioral health care for children and families.

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1. Introduction

Children who come into contact with the mental health system for the first time often do so in the context of a crisis that occurs at home, school, or in the community (Christy, Kutash, & Stiles, 2006; Edelsohn, Braitman, Rabinovich, Sheves, & Melendez, 2003). Common examples of mental health crises experienced by children include suicidal or homicidal thoughts and behaviors, acute depressive symptoms, anxiety, traumatic stress reactions, and severe disruptive or oppositional behaviors. States and communities are increasingly looking to develop crisis-oriented services (e.g., telephone hotlines, respite care, hospital-based crisis services, mobile crisis teams) as critical components of a comprehensive behavioral health service array, with guidance and recommendations from federal entities on the design and delivery of such services (New Freedom Commission on Mental Health, 2003; Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). Development of a continuum of crisis-oriented services is bolstered by research supporting the potential for crisis-oriented services to improve outcomes and reduce costs (Kazdin & Blase, 2011; Kazdin & Rabbitt, 2013).

Many children's behavioral health services (e.g., outpatient care, in-home treatment models) include crisis safety planning as part of their clinical service delivery model; however, few of these services provide specialized, rapid mobile crisis response in home, school, and community locations. As a result, there is a continuing over-reliance on hospital emergency departments to resolve crisis situations for youth (Dolan & Mace, 2006; Mulkern, Isvan, Potter, & Huntington, 2007; Torio, Encinosa, Berdahl, McCormick, & Simpson, 2015). In addition to high rates of emergency department utilization, youth who experience a mental health crisis are more likely to be admitted to inpatient hospitals or psychiatric residential treatment facilities (Heflinger, Simpkins, & Foster, 2002; Hussey & Guo, 2002; Wilmshurst, 2002) and youth with mental health needs are more likely to experience arrest and incarceration (Shufelt & Cocozza, 2006). Emergency departments, inpatient and residential treatment facilities, and juvenile justice settings are among the most costly and restrictive settings available to youth and may not result in optimal outcomes (Heflinger et al., 2002; Hussey & Guo, 2002; SAMHSA, 2014; Torio et al., 2015; Wilmshurst, 2002). On the other hand, crisis-oriented services help to ensure that youth with mental health needs receive effective crisis stabilization services and ongoing care and are able to remain in their homes and communities whenever possible.

1.1. Benefits of mobile crisis services for youth

Among the various crisis behavioral health services for youth, community-based mobile crisis services possess important advantages. First, rapid mobile response and the provision of face-to-face crisis stabilization at the moment of crisis can help to prevent harm to self or

Abbreviations: EMPS, Emergency Mobile Psychiatric Services; DCF, Department of Children and Families; ED, Emergency Department; PIC, Performance Improvement Center; SFY, State Fiscal Year.

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others, as well as utilization of emergency departments, inpatient hospitalization, or arrest (Dolan & Mace, 2006; Guo, Biegel, Johnsen, & Dyches, 2001; Hugo, Smout, & Bannister, 2002; SAMHSA, 2014; Scott, 2000; Shulman & Athey, 1993; Tishler, Reiss, & Rhodes, 2007). Second, mobile crisis services reduce barriers to accessing care by providing initial responses and follow-up care primarily in homes, schools, and other community settings which may help to ameliorate the impact of stigma (Corrigan, Druss, & Perlick, 2014) and the difficulties of navigating an often fragmented system (Sturm & Sherbourne, 2001). Third, mobile crisis services are known to promote referral and linkage to ongoing care within the behavioral health service array (Allen, Forster, Zealberg, & Currier, 2002; Zealberg, Santos, & Fisher, 1993) as well as coordination with families, schools, police and hospitals (Geller, Fisher, & McDermitt, 1995). Finally, mobile crisis services are recognized as one of several innovative models that have the potential to significantly increase access to mental health care and control the costs of higher levels of care such as inpatient and residential treatment (Kazdin & Rabbitt, 2013).

Despite these advantages, there is little agreement on the required or optimal components of a mobile crisis program, the implementation supports that help to promote effective service delivery, or the degree to which specific models of mobile crisis response achieve desired performance benchmarks and outcomes (Christy et al., 2006; Kutash & Rivera, 1996; SAMHSA, 2014; Shannahan & Fields, 2016). Thus, the primary objectives of this paper include: 1) a description of the model of children's mobile crisis services currently provided in Connecticut, along with its alignment with known best practices, and; 2) a review of the data from that model pertaining to service utilization, client characteristics, performance measures, and outcomes.

1.2. The core elements of model mobile crisis programs

States and communities with long-standing mobile crisis programs often have developed these models based on the unique needs of youth, families, communities, and their own behavioral health system, resulting in variations in clinical approaches, eligibility criteria, funding sources, and implementation supports. Mobile crisis services may also lack a common approach to data collection, performance measurement, and outcomes evaluation that would allow programs to clearly demonstrate their effectiveness and continually monitor and improve performance and service quality (Garland, Bickman, & Chorpita, 2010). Further specification of mobile crisis model components along with data on performance measures and effectiveness can help establish a stronger evidence base for this important service category and guide states and communities looking to develop or enhance their own programs (Child Health and Development Institute, 2010; Dale, Baker, & Racine, 2002; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Garland et al., 2010; Huang et al., 2005; Vanderploeg, Franks, Plant, Cloud, & Tebes, 2009).

Shannahan and Fields (2016) reviewed well-established children's mobile crisis programs in New Jersey, Milwaukee County (Wisconsin), and King County (Washington). The review identified and described the common components of these mobile crisis programs, including: 24/7 availability; warm phone lines; rapid deployment to home, school, and community locations; assessment; crisis stabilization and short-term treatment; crisis safety planning; and linkage to ongoing care. Most models reviewed placed heavy emphasis on coordination and collaboration with other service providers and child-serving systems such as hospitals, pediatric primary care, schools, police, and the juvenile justice and child welfare systems. The review provides descriptions and examples of how mobile crisis programs are structured and implemented. Although the specific details varied from model to model, categories included: funding and oversight; eligibility and screening; staffing requirements and training; response protocols; financing; and quality assurance. Finally, the review identifies the most commonly assessed performance measures including service utilization, mobility rates, response time, rates of diversion from emergency departments and inpatient hospitals, length of stay, rates of connecting to community-based care, and compliance with other contracted requirements. Identification of the common elements of children's mobile crisis programs provides a basis of comparison for other models in the field; however, the review provided little indication of how any one of the model programs produced specific results on performance measures or outcomes.

1.3. Connecticut's Emergency Mobile Psychiatric Services model

Connecticut's Emergency Mobile Psychiatrics Services (EMPS) aligns well with the best practices and common elements identified in the Shannahan and Fields (2016) brief. EMPS is available 24/7, warm phone lines are used to transfer calls to providers, and clinicians are deployed rapidly to home, school, and community locations. When EMPS arrives on site, clinicians provide assessment and initial crisis stabilization, short-term treatment, crisis safety planning, and linkage to ongoing care. Additionally, there are a few important ways in which EMPS may differ slightly from other model programs. First, with respect to eligibility criteria, EMPS emphasizes the value that "crisis is defined by the caller" and not by the clinicians. This approach reduces the likelihood of callers being "screened out" from receiving a mobile response due to the perceived severity of the presenting concern, and places heavier emphasis on mobile response to most callers. As a result, EMPS may have a lower clinical threshold and be more broadly accessible than other mobile crisis programs. Further bolstering its accessibility, EMPS is available statewide and free of charge to families regardless of system involvement, insurance type, or ability to pay. Second, EMPS has two robust implementation supports that are provided outside the provider network. A single statewide Call Center manages all incoming calls and provides a warm transfer to the appropriate EMPS provider based on the location of the child. In addition, a "performance improvement center" is responsible for standardized training, data analysis, reporting, and quality assurance/improvement activities for all contracted EMPS providers. These implementation supports may reduce burden on EMPS providers while also providing enhanced accountability for performance.

The EMPS model appears to align significantly with current best practice standards, with a few possible departures from other models that are specifically intended to enhance the accessibility and quality of the service. It is therefore worthwhile to further consider the components of the EMPS model and whether it is effective in addressing the issues for which mobile crisis services were designed. The results summarized in the remainder of this paper are intended to provide further description and evidence for a best practice approach to children's mobile crisis services by: 1) reviewing in further detail the primary components of the EMPS model as well as eligibility, funding and clinical services available, and; 2) examining data on service utilization, client characteristics, performance measures, and outcomes.

2. Method

A number of source documents were gathered to form the basis of the EMPS model description, including documents from DCF (e.g., provider contract templates and scopes of work), EMPS data reports, and Connecticut legislative statutes pertaining to EMPS (An Act Concerning Community-Based Mental Health Care, 2005; An Act Concerning the Mental, Emotional, and Behavioral Health of Youths, 2013). The extant literature was reviewed to ascertain common model components and best practices in children's mobile crisis so that the EMPS may be compared and contrasted with known best practices.

The quantitative analyses were supported by data extractions from Connecticut DCF's Provider Information Exchange (PIE), the department's behavioral health data collection system. PIE was implemented in 2009 and is overseen by DCF's Office of Research & Evaluation, and made accessible to behavioral health and child welfare

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