HEALTHY MINDS
POLICY INITIATIVE

The State of Children's Crisis Care in Oklahoma

Needs and treatment capabilities in the COVID era

Already increasing before the pandemic, the number of children and youth struggling with poor mental health in Oklahoma has surged during the pandemic. Stressors unique to the COVID-19 era—including deaths in the family, financial hardship and social isolation because of the disease, and virtual schooling—have weighed heavily on children and youth and intensified youth mental health crises. This increased need has exposed gaps in Oklahoma's mental health continuum of care, leading to higher emergency room utilization for children with suicidal thoughts and other mental health crises.

Moving forward, the state needs a full and robust continuum of mental health services for its children and youth. In this report, we examine the current state of Oklahoma's array of crisis services for children and youth and discuss the services needed to ensure Oklahoma children and youth have access to the services they need, when and where they need them. A robust array of crisis services anchored in a strong behavioral health continuum can save lives, decrease the use of more restrictive care such as emergency rooms, inpatient beds and the justice system, and improve the mental health and wellbeing of Oklahoma's children and youth.

Key Findings

- **COVID-19 has revealed gaps in the mental health treatment system for youth**. This is evident in an increasing number of children with suicidal thoughts and other psychiatric conditions who present at hospital emergency rooms.
- **Oklahoma's plan for crisis care is strong, but not fully realized**. The state's vision for children's crisis services aligns with national standards, but implementation of the vision is fragmented across the state and complicated by funding limitations.
- **After-crisis care is often missing.** Oklahoma lacks a complete array of home and community-based supports for children who need intensive and ongoing support following a crisis.
- **2022 is a year of opportunity**. New state and federal funding and ongoing work to implement the new 988 crisis number by July 2022 provide an unprecedented opportunity to build out Oklahoma's ability to respond to youth mental health crises.

Background

Healthy Minds' fall 2021 update on the impact of COVID-19 on children's mental health in Oklahoma provides a broad overview of increasing suicidality, mental health crises and emergency room utilization in 2020 and 2021. According to the latest data, Oklahoma's mental health prevalence estimates indicate that in any given year more than 54,600 children and youth

between the ages of 6 and 17 will experience a major depressive episode (MDE), almost 51,500 will struggle with a serious emotional disturbance (SED) and more than 24,800 will attempt suicide (see table below).

Data collected in schools early in the pandemic point to increasingly severe levels of crisis. In the 2019-2020 school year, Oklahoma Prevention and Needs Assessment survey results indicate that of the students who responded to the survey, almost 60% were struggling with high (approximately 30%) or moderate (28%) psychological distress.[1] Almost 78% of students indicated that they experienced high (8%) to moderate (approximately 70%) depressive symptoms. **In addition, 17% of the students indicated that they had seriously considered attempting suicide in the past 12 months, almost 15% said that they had planned to attempt suicide, and almost 10% reported having "actually" made at least one suicide attempt.** This is an increase in the number of students who were identified as experiencing psychological distress, as well as an increase in the number who reported experiencing depressive symptoms and thoughts of suicide, compared to the total from the 2017–2018 school year.[2]

Oklahoma County, Tulsa County and Statewide Mental Health Prevalence Data			
Conditions	**Children and Youth (6–17) Estimates**		
	OK County	**Tulsa County**	**Oklahoma**
Total Population (6–17)	**132,223**	**107,577**	**643,415**
Ages 6–11	68,397	54,815	322,382
Ages 12–17	63,826	52,762	321,033
Mental Health Conditions			
Major Depressive Episode[3]	9,826	7,952	54,609
Bipolar[4]	1,468	1,214	7,384
PTSD[5]	1,915	1,583	9,631
Co-Occurring MDE and SUD[6]	1,147	929	6,376
First Episode Psychosis (16–17)[7]	9	8	49
Serious Emotional Disturbance (Ages 6–17)[8]	10,578	8,606	51,473
Attempted Suicide[9]	4,864	4,030	24,833

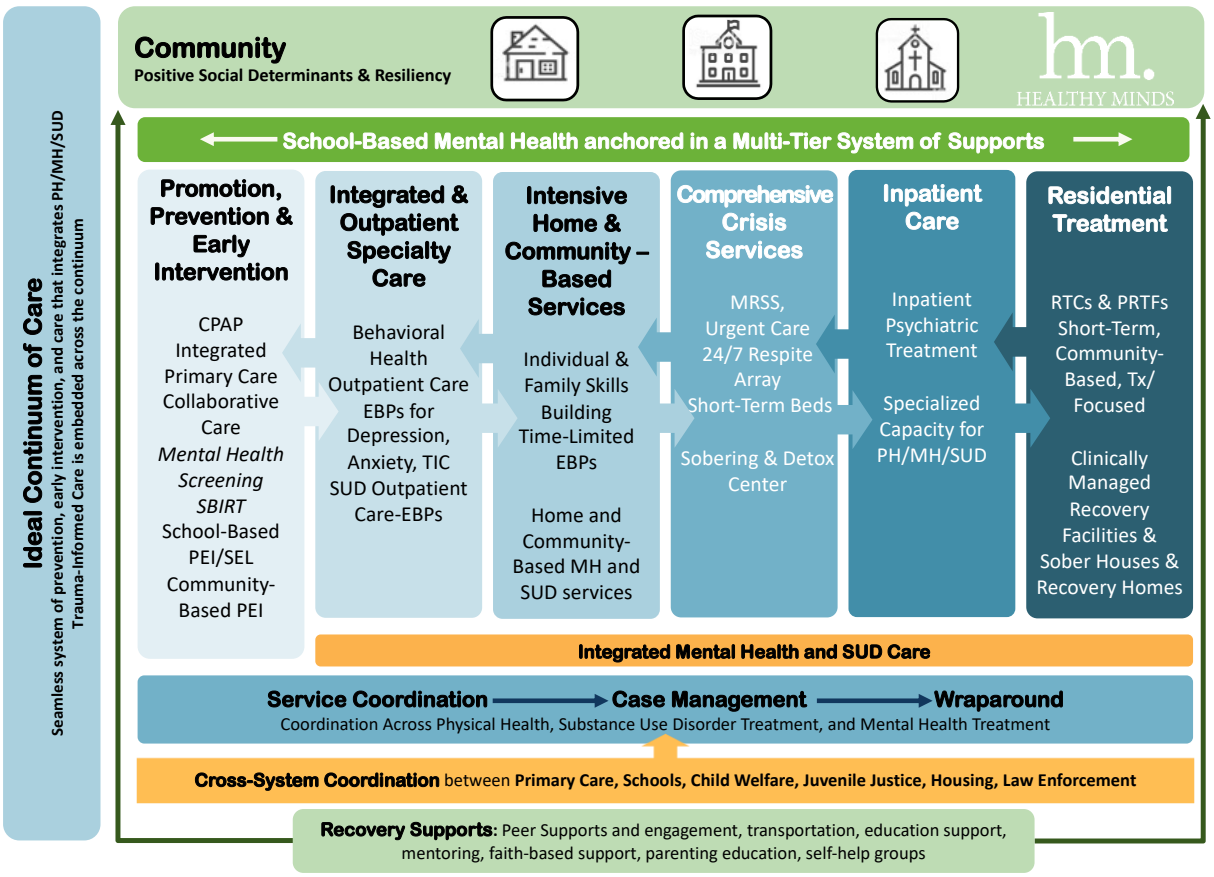
The Children's Behavioral Health Continuum of Care

The ideal children's behavioral health continuum of care lays out a seamless, comprehensive, array of services and supports linking promotion and prevention services with physical health, mental health, and substance use disorder treatment. This continuum of care takes a population-based perspective and describes a comprehensive array of services and supports for all children, including those with emerging, low to moderate, and complex behavioral health needs. [10] The continuum includes six components that range from promotion and prevention services to the

most intensive interventions and provides an overview of recommended practices for each component.

The ideal system of care includes a continuum of crisis service components that range in intensity from crisis services to residential treatment services and includes inpatient care. The crisis care continuum includes mobile crisis response teams that can address urgent needs outside of care delivery. It includes an array of crisis placements (such as in-home crisis respite, crisis stabilization, and acute inpatient care) tailored to the needs of the community. More importantly, the crisis continuum is an adjunct, not a substitute, for a robust array of outpatient and intensive community-based services. It also includes time-limited follow-up care, coordination with emergency medical services, and short-term residential treatment care as the last option. **However, in the ideal system, most children and youth would have their mental and behavioral health needs identified prior to reaching a point of crisis.** Developing a strong community-based services continuum that includes mid-level, time-limited services (e.g., Multisystemic Therapy, Functional Family Therapy, Therapeutic Foster Care or the Youth Villages Intercept model) and urgent crisis care options that children, youth and their families can access prior to crisis is a critical factor in preventing crises and maximizing efficient use of the available crisis services.

The ideal children's mental health continuum of care



Comprehensive Crisis Service Components

Children, youth, and their families experiencing a crisis (as defined by the child, youth and family) benefit from comprehensive crisis care. Within this continuum and in coordination with the community and natural supports, crisis service providers work closely with the child or youth and family to decrease distressing symptoms, address risky behaviors, identify potential triggers, and learn skills to effectively deal with future crises. For many children, youth, and their families, crisis services act as the front door to mental health services, making the availability of a continuum of quality crisis services extremely important.[11] Services in this system component include crisis hotlines available 24 hours a day and seven days a week, mobile response and stabilization services, 23-hour crisis observation, crisis stabilization, crisis respite and peer services.

Mobile Response and Stabilization Services (MRSS) is considered a best practice for supporting children, youth and families in crisis.[12] MRSS is designed to maintain children and youth in their current living situation and community environment by reducing the need for out-of-home placement. It promotes and supports safe behaviors at home and in school, and it reduces visits to emergency departments and admissions to inpatient facilities, detention centers and residential treatment centers. MRSS also helps families access ongoing supports, including intensive home and community-based services. The MRSS model differs from traditional mobile crisis response team services in that the child, youth or family defines the crisis. In-person mobile response services are provided within 60 minutes to all families who call the crisis line, unless otherwise requested by the family. Stabilization services help the child or youth maintain daily activities, link the family to community and clinical supports, and are provided for up to eight weeks.

The Oklahoma Landscape

The Oklahoma State Department of Mental Health and Substance Abuse Services (ODMHSAS) serves as the state's safety net mental health and substance use treatment system, funding and regulating prevention and treatment services.[13] The state's mental health crisis system — the specific services that fall on the continuum between intensive home-based/community supports and inpatient, such as the crisis hotline and mobile crisis response — are provided through the ODMHSAS system of providers. This includes ODMHSAS-certified Certified Community Behavioral Health Clinics (CCBHC), which are charged with offering robust continuums of care for geographic regions of the state with an overall goal to provide whole-person care in the least costly, least restrictive settings of care. Oklahoma's CCBHCs have reduced the proportion of clients seen in emergency departments by 18-47% and those admitted to inpatient care by 20-69%.[14]

Crisis services in Oklahoma are currently funded through Medicaid and state funding but the infrastructure was created through a SAMHSA System of Care grant in the past.[15] Providers received 60% of their funding from state funds and can use funding for training, technology, and

on-staff call mileage. Medicaid reimburses the remaining 40% and covers the mobile crisis response and stabilization services. Call center and evaluation services are state funded. A statewide evaluation of mobile crisis response allows for data-driven decision making for training, allocation of resources, monitoring of outcomes and sustainability.

Children's Mobile Response and Stabilization System (CMRS)

ODMHSAS oversees the state's children's mobile crisis response (MRSS) model. In Oklahoma, this level of care is called the Children's Mobile Response and Stabilization system (CMRS).[16] The purpose of this system is to provide rapid, community-based mobile crisis intervention for children, youth and young adults ages 25 and younger who are experiencing behavioral health or psychiatric emergencies. It is designed to de-escalate crisis; prevent possible inpatient hospitalization, detention and homelessness; and restore youth to a pre-crisis level of stabilization.[17, 18] The following core components are key to CMRS's design:

- Child, youth or family defines the crisis.
- All families who contact the crisis line receive a face-to-face or telehealth visit between 60 minutes to 72 hours after contact, unless declined by the family.
- The mobile response team comprises peer support specialists, care coordinators and a licensed clinician.
- Eight weeks of stabilization services are offered. These can include behavioral health aids, family support and training, case management, therapy, psychiatric consultation, medication management and consultation, and health and wellness counseling.

Data Spotlight: Children's mobile crisis response during the pandemic[31,32]

Between January 2019 and January 2021, the Children's Mobile Response and Stabilization system received a total of 13,079 calls. Mobile Responses were made to 12,021 calls. Calls were mostly from parents followed by school personnel and hospital, ER or clinic staff. The majority of crisis calls were suicide related followed by family conflict. Seventy-nine percent (79%) of these children, youth and young adults were diverted from a placement change. Eighty-two percent (82%) of the remaining 21% youth who were not diverted went to inpatient hospitalization. Of the youth at risk of school disruption, 90% returned to class. Of the youth experiencing a crisis and who received mobile response, 2,032 were enrolled in OKSOC. Upon follow-up, 71% of callers reported that their crisis was resolved and 73% were satisfied with their youth's progress.

Data from fiscal year 2020 showed that COVID-19 impacted mobile response by reducing volume by 7.5% and a 90% decrease in responses to schools.[1] There was a 30% decrease in calls from DHS staff and a 30% decrease in mobile response for DHS. There was an increase in calls from law enforcement (35%) and an increase in "family conflict" (15%) leading to the call.

ODMHSAS has been working to expand the Children's Mobile Response and Stabilization system since it was initially implemented in three counties in 2017. **To date, 20 counties in Oklahoma are providing mobile response through the CMRS system**.[19] During FY 2020, 5,974 children, youth, and their families in Oklahoma—and an additional 1,370 children and youth in

Department of Human Services custody—received mobile response services. As designed, the CMRS model aligns with MRSS national best practices for crisis services for children, youth and families.[20]

The Children's Mobile Response and Stabilization system was founded on the Oklahoma System of Care (OKSOC) values and principles and is an important component of the system of care. The services are available in Oklahoma through a toll-free call line operated by Heartline, the state's suicide prevention line, and in Tulsa by Family and Children's Services (FCS). Both hotlines are available 24 hours a day and seven days a week and can connect families to crisis supports, mobile crisis response, or 211 for basic needs support. When a family or youth calls the hotline, a warm transfer is made to Mobile Response Teams (MRT) by the Crisis Call Center staff. The team can respond (in-person or virtually) within an hour if there is an immediate need or within 24 hours if the need is not imminent. Follow-up services last up to 72 hours when the youth is stable, or up to eight weeks if additional support is needed, in which case the youth is transferred to another level of care under the supervision of a licensed behavioral health professional.

After a mobile crisis intervention children, youth, and young adults may be referred to the state's larger System of Care, outpatient therapy, community-based stabilization, psychiatric consultation, or medication management and inpatient hospitalization if a clinician determines that a more restrictive placement is needed. Flexible funds may be used to help with transportation and respite services may be provided. Crisis safety plans are developed with youth and their families to help them identify warning signs and coping methods and prevent future crisis or safety issues. Twelve contracted agencies provide Mobile Response services in 72 Oklahoma counties.

<u>Children's Crisis Stabilization Unit</u>

Oklahoma currently has two children's crisis stabilization units: Counseling and Recovery Service of Oklahoma's CALM Center and Red Rock Behavioral Health Services Children's Crisis Unit.

- The Child and Adolescent Life Management (CALM) Center provides support, assessment, and stabilization for youth ages 10 to 17 with an emotional, behavioral or substance abuse crisis.[21] The facility is operated by Counseling & Recovery Services of Oklahoma and fills a gap between outpatient and inpatient care. Crisis situations addressed include suicidal thoughts and defiant and dangerous behaviors.
- Red Rock Behavioral Health Services' Children's Crisis Unit is a community-based stabilization unit that fills a critical gap in the present continuum of care to children in Oklahoma. It serves children ages 10 through 17 and provides services to assess a child in crisis, stabilize the crisis, and then refer to an appropriate level of care.[22]

ODMHSAS is exploring opportunities to use the Certified Community Behavioral Health Clinic and Community Mental Health Center models to develop a continuum of urgent care options

to de-escalate and divert families from more intensive/restrictive levels of care and maintain children and youth in their community. Models supported across the state include the use of crisis telehealth, 23-hour urgent care, family-based urgent care and youth crisis stabilization units.

Considerations and Opportunities

A strong continuum of crisis services that is anchored in a full array of behavioral health services is critical to an ideal continuum of care, and the ODMHSAS vision for CMRS services aligns with national best practices. Oklahoma has committed state and federal resources to build the statewide infrastructure necessary to develop, support, and sustain local mobile crisis response service capacity. ODMHSAS has rolled out these services in 20 counties, and with the Oklahoma Department of Human Services is working with community mental health centers and Certified Community Behavioral Health Clinics to expand the state's capacity to provide urgent crisis care including family crisis care centers. **However, in many areas of the state, the crisis system vision and a full continuum of crisis and intensive services has not yet been actualized, resulting in a high number of emergency department admissions**. The State of Oklahoma's legislative appropriation in Fiscal Year 2022 for crisis system expansion included $7.5 million in funding for urgent care crisis centers and $3 million for mobile crisis response expansion across the state, which will support the rollout of a new phone number for crisis intervention nationwide, 988.[23] Such expansions are not limited to the children's crisis system, and should begin to fill gaps there.

<u>After crisis: Home and community-based intensive services</u>

As work to expand the traditional crisis system gets underway, the state continues to lack the necessary array of targeted, time intensive, skills-building services for children and youth who are at risk of out-of-home placement or transitioning back to the community and their families. This significant lack of mid-level, intensive home and community-based supports could increase the number of children and youth accessing mental health services through the crisis continuum and the number of children and youth with complex mental health needs who require more intensive and restrictive levels of care.

Intensive home and community-based services serve as step-down services for children and youth who have experienced a crisis or are returning from more restrictive placements such as residential treatment or inpatient treatment. Individualized intensive services help to ensure that children, youth, and their families experience stabilization and are at less risk for another crisis episode. For children and youth with these intensive needs, Oklahoma's intensive home and community-based service continuum includes local systems of care, wraparound, transition age youth services, juvenile court services, and first episode psychosis care.

Key informants interviewed for this research indicated that there is a need for additional intensive home and family- based services and other evidence-based practices throughout the

state. They indicated that children and youth often end up in more restrictive settings such as emergency rooms, inpatient, and residential settings. We did not find evidence of enough intensive therapies such as Functional Family Therapy and Multisystemic Therapy. Key informants reported reductions in Medicaid behavioral health rehabilitation services and more stringent qualification requirements to access these services. For example, many providers reported improvements in the youth they served who participated in the rehabilitation skill building interventions, which now are not as available. Workforce gaps, highlighted in recent research by Healthy Minds, also contribute to the challenges of bringing evidence-based practices and intensive home and family-based services to scale. This is especially true in rural areas.

Funding considerations

Key informants indicated that coordinating care for children and youth with the highest needs and who are served by multiple agencies is a challenge, despite the common recognition that it is critical for all providers to be on the same page. **There is not a Medicaid billing code for participation in interdisciplinary teams beyond programs that are grant funded and the time that professionals from different agencies take to participate in client meetings is not reimbursable.** Informants added that competing programs do not work collaboratively together and families end up confused about the care they are receiving.

Further, the current financing strategies are not adequate to promote the sustainability of intensive home and family-based services and evidence-based practices. Many intensive home and community-based services and other evidence-based practices are funded through Medicaid and state or foundation grants. Commercial insurers have not generally paid for mental health services for children and youth, relying on state agencies and school systems to carry the financial and moral burden. Often providers are expected to find other sources of funding, typically Medicaid and commercial insurance, to sustain the programs. When the grants end and no additional funds are available, providers may have to eliminate the service or change the model to such an extent that it does not meet the fidelity requirements for providing the evidence-based practice. As a result, the outcomes are not as positive.

Opportunities in 2022

The American Rescue Plan Act of 2021 (ARPA) included initiatives to improve mental health services.[24] For states that choose to cover mobile crisis intervention services, the legislation provides an 85% enhanced federal matching rate under Medicaid for three years. To help states apply for the option, the ARPA includes $15 million in planning grants. **Oklahoma is a recipient of a planning grant to obtain enhanced match for mobile crisis intervention services, and with additional ARPA funding, the state has a major opportunity to improve crisis services.** ARPA will provide additional resources for home and community-based services, including mental health services. Oklahoma DMH has already received community mental health services block

grant funding in the amount of $1.5 billion and $122 billion for schools to address children's mental health, social, emotional, and academic needs.

Oklahoma's 988 planning efforts provide a particularly strong opportunity to overhaul and expand the system. As part of this planning, intensive home and community-based services can be expanded to be used as the stabilization component in a Mobile Response Stabilization Service (MRSS) model. Furthermore, Oklahoma's Certified Community Behavioral Health Clinics and Community Mental Health Centers that offer crisis services should provide support and guidance on the design of the newly required 988 crisis system, and the planning grant for ARPA funds including alignment of current crisis services with the new 988 requirements and enhancement of mobile crisis response for children and youth in schools, at home and in other community settings. Because Certified Community Behavioral Health Clinics are required to offer services for children and families as part of their certification, it is essential to include these providers in planning crisis services for children and youth and ask for their help in addressing federal guidance on use of these funds.

The Substance Abuse and Mental Health Services Administration provided guidance to states on the use ARPA funding.[25] The allocation for the Mental Health Block Grant (MHBG) requires a ten percent allocation to first-episode psychosis or early serious mental illness programs. The guidance encourages states to focus on supporting a behavioral health crisis continuum that meets needs anytime, anyplace and for anyone. SAMHSA recommends partnerships with the emerging 988 systems, and other organizations that have a role in the crisis continuum and utilizing five percent of funds for crisis services, per the appropriations language. **For children, they recommend a 24/7 crisis continuum, which includes screening and assessment, mobile crisis response and stabilization, residential crisis services, psychiatric consultation, referrals, and warm hand-offs to home and community-based services and ongoing care coordination**.

Other recommendations from SAMHSA include:

- Same-day or next day appointments to outpatient care for those in crisis.
- Promotion of access to care for children with SED, and support for crisis and school-based services.
- Outpatient intensive Crisis Stabilization Teams to address or avert crisis.
- Telehealth opportunities to expand crisis services for rural, frontier and hard to reach areas.
- Planning for Certified Community Behavioral Health Clinics to enhance treatment and recovery support.

Examples of how states are prioritizing the use of ARPA funds follow.

- **New York State Office of Mental Health** has prioritized four key areas: statewide crisis services; child, youth, and family services; adult ambulatory services; and mental health workforce/system capacity building.[26] Some of their crisis service priorities include 988 call center preparation, supporting start-up costs for statewide expansion of regional mobile crisis teams, funding for new and existing crisis residences, and crisis stabilization startup and expansion. Child, youth, and family services priorities include developing a coordinated system of care across systems, comprehensive crisis services, screening and early identification of children and youth, developing a Youth Assertive Community Treatment program, expanding short term services to address COVID-19 pandemic related needs as well as the needs of high-risk populations, improving access to the service array for all youth, and expanding school-based and college-based mental health capacity.
- **Vermont** will make ARPA funds available through the Department of Mental Health (DMH) providing $4.6 million in federal funds to local and other service agencies throughout the state.[27] Grants will focus on strengthening existing services and piloting a Mobile Response and Stabilization System that takes services to children and families in Rutland County. The county has the highest crisis response in emergency departments and the highest average emergency department visits by children with mental health needs in the state.
- **Massachusetts** is proposing to use enhanced federal funding for Medicaid home and community-based services (HCBS) to retain and build a high-quality workforce; improve access to and promotion of HCBS services through navigation, transitions, family supports, diversion and enhanced care models; and employ HCBS technology and infrastructure to improve care coordination, access, and delivery.[28]

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[1] Psychological distress was calculated using the K6 scale that was developed with support of the National Center for Health Statistics for use in the National Health Interview Survey. The tool screens for psychological distress by asking students how often they have felt nervous, hopeless, restless, depressed, worthless, or like everything is an effort in the last 30 days.

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