



**THE 2016 INTERIM REPORT OF
THE BEHAVIORAL HEALTH ADVISORY
COUNCIL – CLINICAL CRISIS WALK-IN
SERVICES AND MOBILE CRISIS TEAMS
STRATEGIC PLAN**

**House Bill 682/Ch. 406 and
Senate Bill 551/Ch. 405 of the Acts of 2016**

December 2016

Overview: Maryland Clinical Crisis Walk-in Services and Mobile Crisis Team Services Interim Report

Strategic Plan Update:

The Maryland Behavioral Health Advisory Council's charge, as stated in House Bill (HB) 682/Senate Bill (SB) 551, is as follows - The Council, "in consultation with local Core Service Agencies (CSAs), Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHAs), community behavioral health providers, and interested stakeholders shall develop a strategic plan for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide and operating 24 hours a day and 7 days a week." Among other things, the bill states that the plan should include "a design that ensures that the Maryland Behavioral Health Crisis Response System is accessible to individuals in need of mental health and substance use crisis services."

The bills also state the strategic plan shall include:

- Consideration of regional models;
- Measures to monitor services and outcomes;
- Methods for recovering payment for services delivered to individuals with private health insurance;
- An update on the development of the Maryland Clinical Crisis Walk-in Services and Mobile Crisis Team Services Strategic Plan on or before December 31, 2016; and
- Submission of a strategic plan as part of the Annual Report on or before December 31, 2017.

This Interim report, as an attachment to the Council's 2016 Annual Report, satisfies bullet #4.

The Council officers decided that it would be more efficient to form a steering committee, consisting of the officers and the Co-Chairs of each Council committee to guide the process of making recommendations and developing a strategic plan. The Behavioral Health Administration (BHA) supported this process by providing a consultant, to assist with the process and the collection of background data. At the first meeting on July 29, 2016, in concert with the consultant, some of the process activities for this work were delineated as follows:

- Use of a clear definition of services, population eligibility;
- Determination of what already exists in Maryland;
- Establishment of a timeline for all tasks;
- Administration of a survey to receive input from a wide range of individuals across the state including all current state providers of crisis services, community and stakeholder input, core service agencies, local addiction authorities, the local behavioral health authorities, and other possible sources of referral;
- An Environmental Scan will be conducted to look at local and national models, of crisis services systems, including best and promising models, use of incentives, existing collaborations such as connections with Crisis Intervention Teams (CIT), what and how staff are utilized, and training requirements;
- Look into methods of sustainability; and

- Develop a draft plan for public comment and submittal to the legislature by December, 2017.

The process began with coordination and circulation of documents and data of current Maryland crisis services, provided by Marian Bland – Deputy Director of Clinical Services for BHA – who currently oversees crisis services for the Public Behavioral Health System (PBHS).

The first order of business was to formulate a definition for clinical crisis walk-in services and mobile crisis teams. The Steering Committee developed the following:

Crisis Services Defined

Definition of Clinical Crisis Walk-In Services:

A direct service that assists with the de-escalation of a person’s clinical behavioral health crisis and, if applicable, his or her possible diversion from emergency departments, hospital admission, the criminal justice system, or out of home placement by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability delivered in a timely manner and leading to stabilization. Anyone experiencing a mental health and/or substance related crisis is eligible for acceptance regardless of age, insurance status, ethnic, cultural or linguistic preference (such as use of spoken language interpreting or certified American Sign Language (ASL) interpreter). The service setting, whether free standing or attached to a hospital, will serve, as needed, as an entry point to long-term, ongoing service delivery and care.

Definition of Mobile Behavioral Health Crisis Services:

Community-based mobile crisis services provide 24/7 availability of face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, whether at home or wherever the crisis may be occurring, to begin the process of assessment and definitive treatment outside of a hospital or health care facility. A multi-disciplinary team, including peer support workers, works to de-escalate the person’s behavioral health crisis, engages the person in other therapeutic interventions, and assists with continuity of care by providing support that may continue past the crisis period.

(The definition of Mobile Crisis Services that was identified in the **Crisis Now document, Section 2, page 18: Community-Based Mobile Crisis Teams, “What is Mobile Crisis”**).

Survey Developed and In Process

The Behavioral Health Advisory Council Executive Committee met again on September 23, 2016 to further develop a survey to gather certain information from CSAs/LAAs/LBHAs, interested stakeholders, and the public at-large. The questions have been designed to generate feedback related to the availability of clinical crisis walk-in services and mobile crisis teams and to help identify priorities that will be used in guiding decision-making as we work to expand these services. The survey questions were uploaded to a “Survey Monkey” and the links were placed on two Department of Health and Mental Hygiene (DHMH) Web sites, one on the home page and another on the page highlighting Behavioral Health Integration.

Initially, the survey was piloted for Council members and then went live for the public from mid-October 2016 to January 31, 2017. Information about the survey and the links were widely disseminated through agency, advocate, and community networks throughout the state.

Environmental Scan

This survey will inform an environmental scan to be performed by the consultant to the project, early in 2017. There is still much to learn and much to consider, either included in or in concert with the environmental scan, such as:

- Accessibility – as few barriers as possible including age. Encouragement of one stop or one place serves all in PBHS possibly through inclusion of various components within the site;
- Capacity for Diversion from emergency departments and police/incarceration;
- Identifying statutory barriers regarding arrest diversion (which needs to be timely so police find the process user friendly);
- Variations from jurisdiction to jurisdiction - consider differences between rural and regional access issues – rural services are often far and few between and access is not always timely;
- Population served – Accessible to anyone (experiencing a mental health and/or substance-related crisis) regardless of age, insurance status; consideration of needs of specific populations such as children and adolescents;
- Finding ways for relevant public and community systems/entities to know and use the crisis service resources;
- Connection with a hotline or 911 resources;
- Stabilization, assessment, diagnosis, and treatment capability;
- Timely access to treatment; time between arrival and time when individual is seen;
- Models (freestanding or connected to hospital) - Need to look at regional models, yet localized needs;
- Funding source(s);
- What process for emergency petition;
- What is the capacity, staff client ratio, up to date referral resources when full;

- Availability of withdrawal management or detox services;
- Where do referrals come from; what linkages exist to other systems; ability to be an entry point to long-term, ongoing service delivery and care; and
- What unmet needs exist – what, if any, needs assessments were conducted.

Committee Members seemed to hold many of the elements included above as separate from the definition of the services.

Next steps:

- Tally the results of the survey to inform the environmental scan process;
- Conduct an Environmental Scan to look at existing local and national models, including best and promising models, use of incentives, existing collaborations such as connections with Crisis Intervention Teams (CITs), what and how staff are utilized, training requirements, etc.;
- Use results of Survey and Environmental Scan to inform components of the Strategic Plan;
- Look into methods of sustainability; and
- Develop a draft plan for public comment and submittal of final to the legislature by December, 2017.