A Primer on Maryland's Mental Health System of Care for Youth and Families

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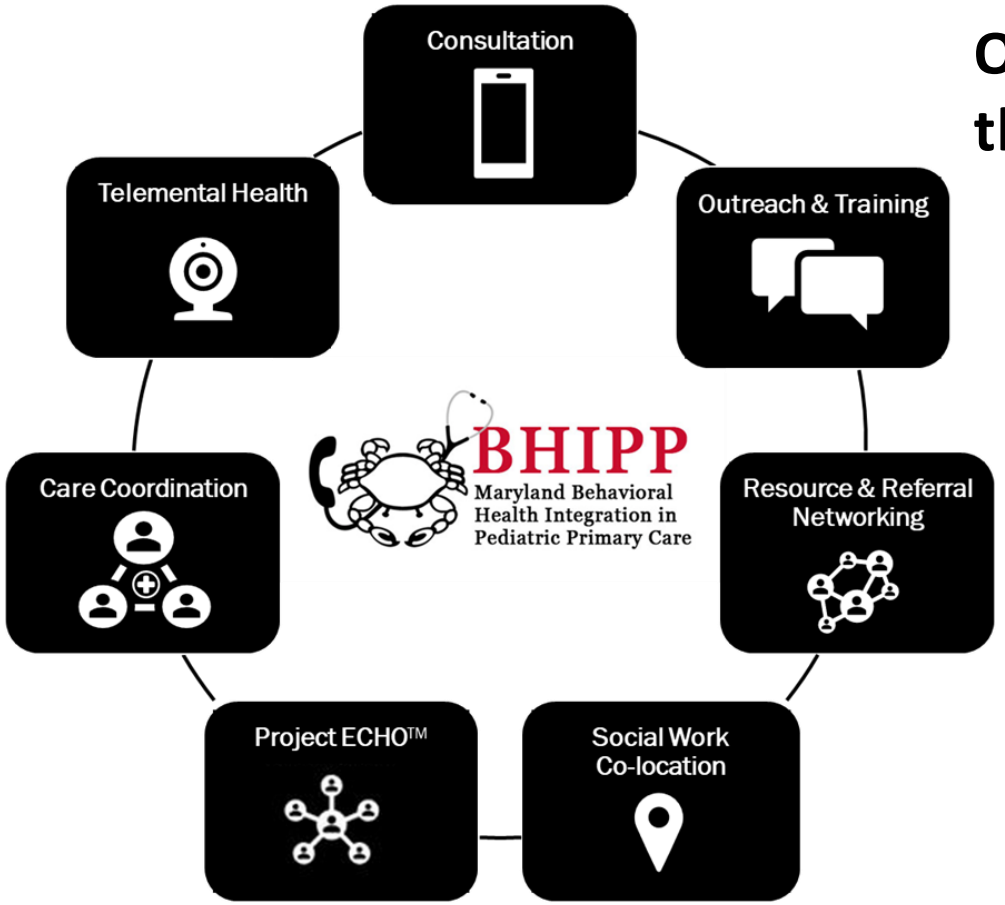
Who We Are – Maryland BHIPP



Offering support to pediatric primary care providers through free:

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & education
- Regionally specific social work co-location (Salisbury University and Morgan State University)
- Project ECHO®
- Direct telemental health services:
  - Care coordination
  - Psychiatry
  - Psychology
  - Counseling

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Partners & Funding

- BHIPP is supported by funding from the **Maryland Department of Health, Behavioral Health Administration** and operates as a collaboration between the **University of Maryland School of Medicine**, the **Johns Hopkins University School of Medicine**, **Salisbury University** and **Morgan State University**.

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Disclosures

- None

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Learning Objectives

- Identify 3 differences between high, medium, and low acuity services for youth
- Identify at least 2 situations that allow a youth to access high acuity services
- Identify what resources can be combined to support youth and families

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Outline

- Dilemmas
- Review the various providers & levels of care
- Define (as best is possible) what each level can/cannot offer
- Review movement between levels
- Case scenario

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Dilemmas

- Variety of providers/settings
  - Different disciplines contributing
- Funding streams may change
  - Programs open/close
- Availability/affordability of care
  - Tele/in person
  - In/out of networks
- No centralized source of state-wide information
  - State oversight but County specific
- How does a clinician know what the options are for any given youngster & family??

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Maryland Hospital Association

In April 2019, MHA's Behavioral Health Task Force launched a study of factors that contribute to discharge delays for behavioral health patients in emergency departments.

The study found that:

- 42% of behavioral health ED patients experienced a delay being discharged or transferred
- These patients were delayed for 1,676 days—an average of 20 hours per patient
- Delays account for 48% of the time those patients spend in Eds
- Three of the top five causes for a delay were related to actions taken by the prospective receiving "agency" or placement site
- **Children and teenagers were delayed twice as long as adults; discharge planners cited age as a contributing factor to the delay**

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Maryland Hospital Association

"Heightening the hospital crisis is a **lack of placement options for children**. One hospital leader recently attributed "an alarming increase" in the lengths of stay for young behavioral health patients to **an inability to transfer them to more appropriate settings of care, in turn causing longer wait times in the emergency department.**

Some hospitals report children being hospitalized more than 100 days beyond what is medically necessary; others have experienced their entire pediatric unit being filled with behavioral health patients. Many hospitals report that when transfers of pediatric and adolescent patients do take place, they are increasingly being sent to an out-of-state facility. "

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Providers who care for youth and families

- Licensed Clinical Professional Counselor (LCPC, LGPC)
- Licensed Certified Social Worker – Clinical (LCSW-C, LGSW)
- Psychiatric Nurse Practitioner (PNP)
- Psychologist (MA, PhD)
- General Psychiatrist (MD)
- Child & Adolescent Psychiatrist (MD)

- Overlapping skills but with important differences in type of training, focus, and scope of practice

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Types of Mental Health Providers

While not exhaustive, the below list identifies several common types of mental health providers and gives a brief overview of their focus and level of training.

	Life Coach	Licensed Marriage & Family Therapist (LMFT)	Licensed Professional / Clinical Counselor (LPC / LPCC)	Licensed Clinical Social Worker (LCSW)
State regulated:	No	Yes	Yes	Yes
Focus:	Coaching	Therapy	Therapy	Therapy
Description:	Help achieve personal, academic, and professional goals	Social and relationship dynamics; Couples and family issues	Psychological and social development; Wide scope of practice	Social worker trained in psychotherapy; Case management
Minimum schooling:	None required	Masters	Masters	Masters
Prescribe medication:	No	No	No	No

	Art Therapist	Play Therapist	Licensed Psychologist (PsyD, PhD)	Psychiatrist (MD) (DO)
State regulated:	Yes	Yes	Yes	Yes
Focus:	Therapy	Therapy	Therapy; Assessment	Medication
Description:	Integrates therapy with creative process to improve well being	Leverage therapeutic power of play to resolve psychological difficulties	Mental and emotional health challenges; Psychological testing	Prescribe medication; Medication management; May provide therapy
Minimum schooling:	Masters	Masters	Doctorate	Medical Degree Doctorate
Prescribe medication:	No	No	No*	Yes

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Figure modified from: https://igda.org/resources-archive/mental-health-providers-what-the-hck-is-the-difference/

Horizontal Levels of Mental Health Care

- Office practice
- Community Clinic
  - Non-specific/specific to funder
- School Based Mental Health
- After School Program
- Intensive Outpatient Program
- Partial Hospitalization Program
- Inpatient Hospitalization
- Residential Treatment
- Mobile treatment
- Urgent Care/Crisis Centers/Walk in clinics
- Emergency Departments

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Vertical Provider Systems

- One overarching organization that has multiple levels of care
  - Sheppard Pratt, Catholic Charities, University of Maryland, Johns Hopkins/Bayview, others across the state
  - May have all elements of the horizontal continuum or subset

- Single levels of care
  - Specific programs/clinics

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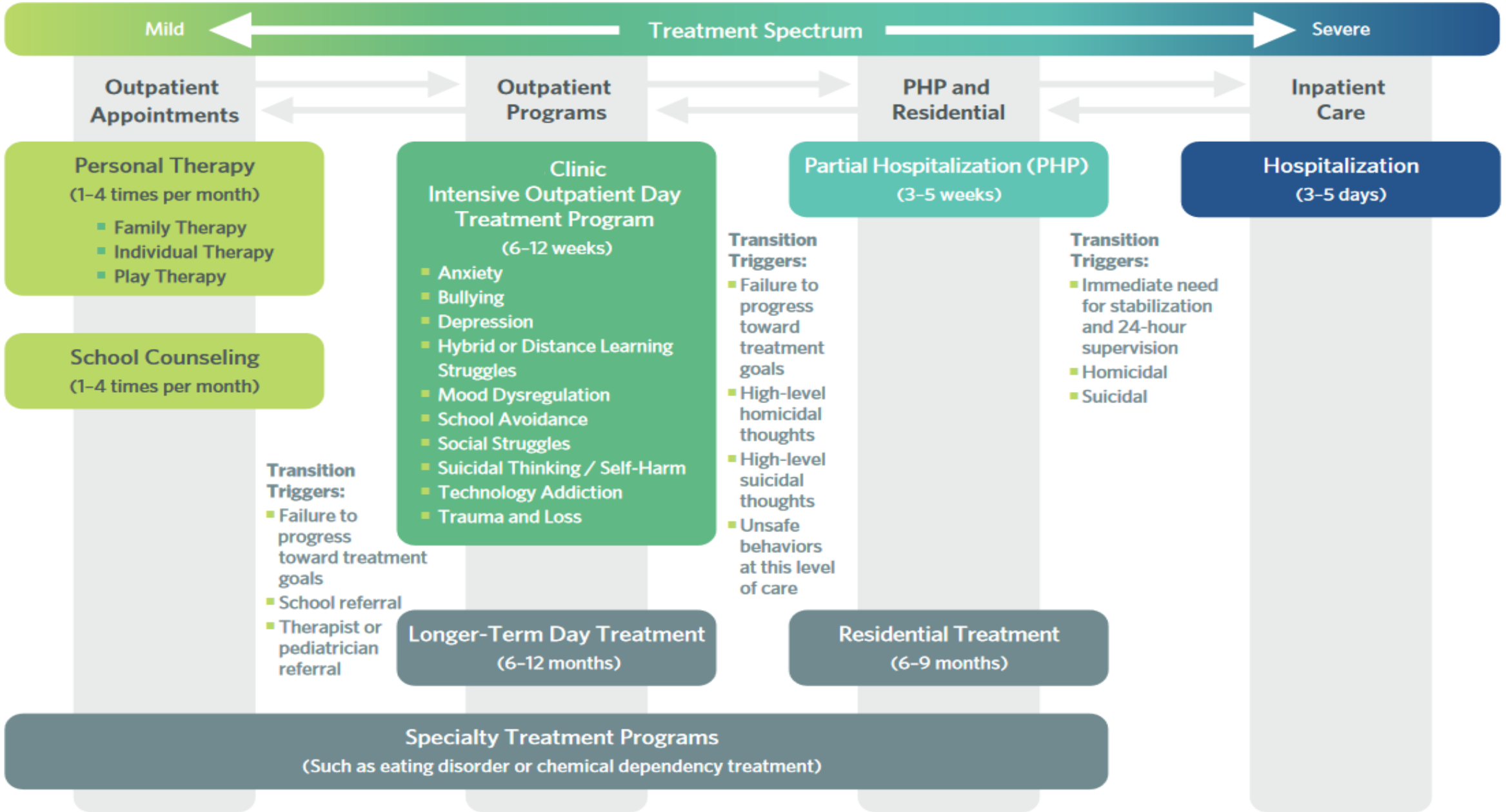

Figure modified from aris-clinica.com

Levels of care

- Office Practice
  - Fee for service, Insurances, Different disciplines, Solo vs group
- County or Community Clinic
  - Insurances, Medicaid, Sliding Scale,
  - Different disciplines
  - May be seen for long time
  - May have variable availability for access and/or frequency of follow up
  - May have capacity for multiple providers to collaborate

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County Resources

- https://www.mhaonline.org/transforming-health-care/healthy-hospitals-healthy-communities/behavioral-health/maryland-behavioral-health-resources-services-directory

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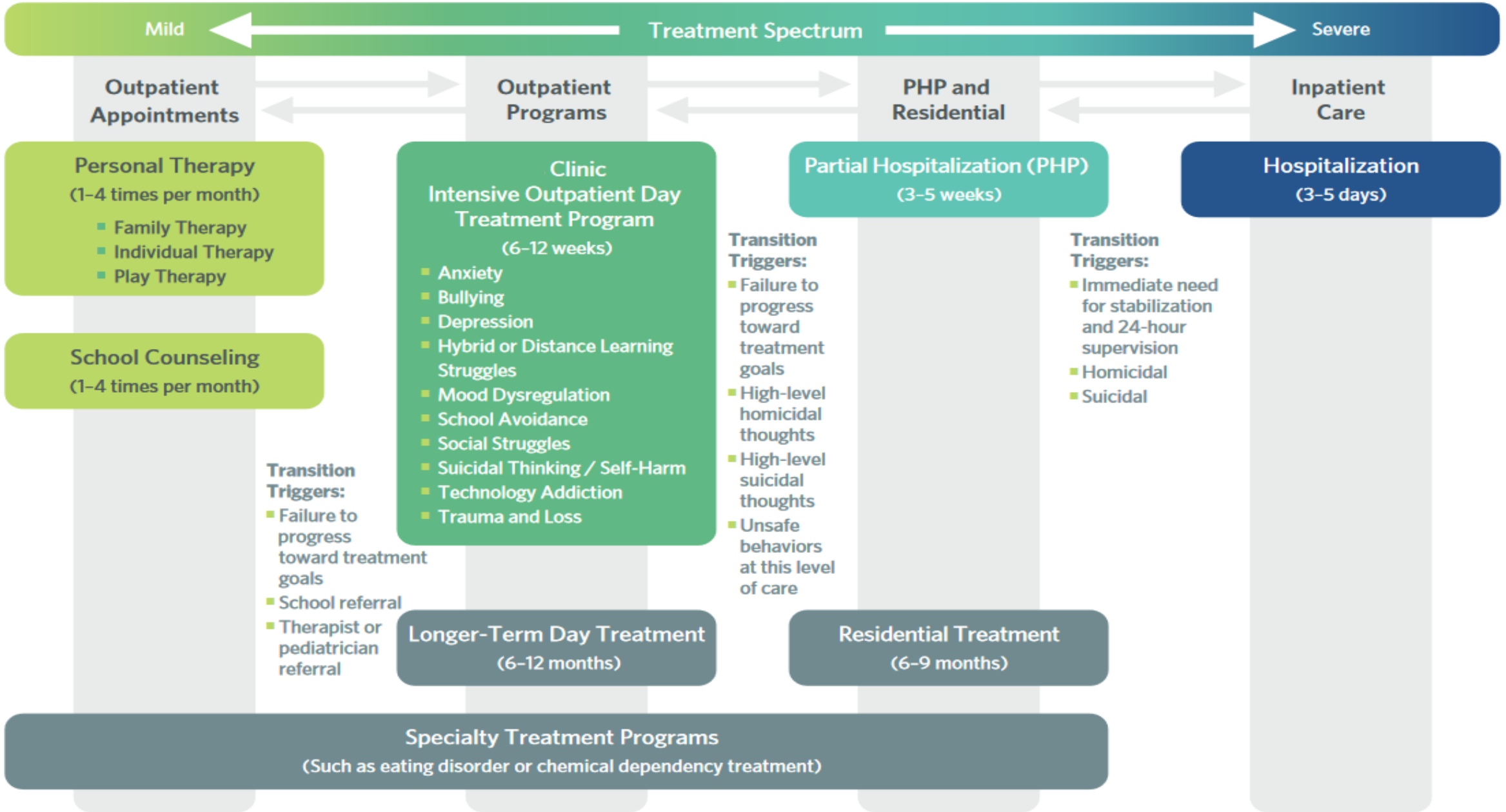

Figure modified from aris-clinica.com

Levels of care

- School based Mental Health Services (SMH)
  - School clinicians (counselors and social workers) provide direct care in the school
  - Some schools have access to prescribing from CAP or NP/PNP
  - Provides primary, secondary, tertiary prevention efforts
- Afterschool/Intensive Outpatient Program
  - A few hours/day (staring ~2P, ending ~6p), variable therapeutic activities
  - 2-5 days/week
  - May see PNP/PhD/CAP MD once/week
  - LOS ~2weeks -12 weeks typically, with variation in average length of stay by program
  - Step up or step down service

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MARYLAND PUBLIC SCHOOLS

ABOUT US

- State Superintendent of Schools
- State Board
- Our Programs and Initiatives
- Year 1 Priorities (2021-22)
- Directory
- Offices/Divisions
- Local Education Agencies
- Strategic Planning Survey

Maryland College Application Campaign

- Maryland College Application Campaign

School Mental Health

The mission of the Student Services and Strategic Planning Branch (SSSP) is to provide leadership, support, and accountability for effective, local programs of student services that promote the social-emotional, psychological, behavioral, and physical health of all students. SSSP promotes healthy development, prevention, early intervention, and systems of care.

In Focus

Caring for Every Child's Mental Health

Student Services and Strategic Planning

- SSSP Homepage

Resources

- Governor's Office for Children
- Mental Health Association of Maryland
- Behavioral Health Administration
- School-Based Health Alliance
- National Assembly on School-Based Health Care
- Department of Juvenile Services
- Maryland Coalition of Families for Children's Mental Health

- https://marylandpublicschools.org/about/Pages/DSFSS/SSSP/SMH/index.aspx

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Culture & Climate

- Bullying Prevention
- Disproportionate Discipline
- Positive Behavioral Interventions and Supports
- Student Discipline
- Restorative Approaches Collaborative

Mental Health

- School Mental Health
- A Trauma-Informed Approach for Maryland Schools
- Guidance for COMAR 13A.07.11 Student Suicide Prevention and Safety Training
- Preventing Opioid Use and Abuse
- Suicide Prevention

School Safety

- Model Policy: Student Registered Sex Offenders - Entry on School Property
- Physical Restraint and Seclusion Reports
- Maryland Center for School Safety
- Student Arrest Data Collection
- Emergency Planning and School Safety

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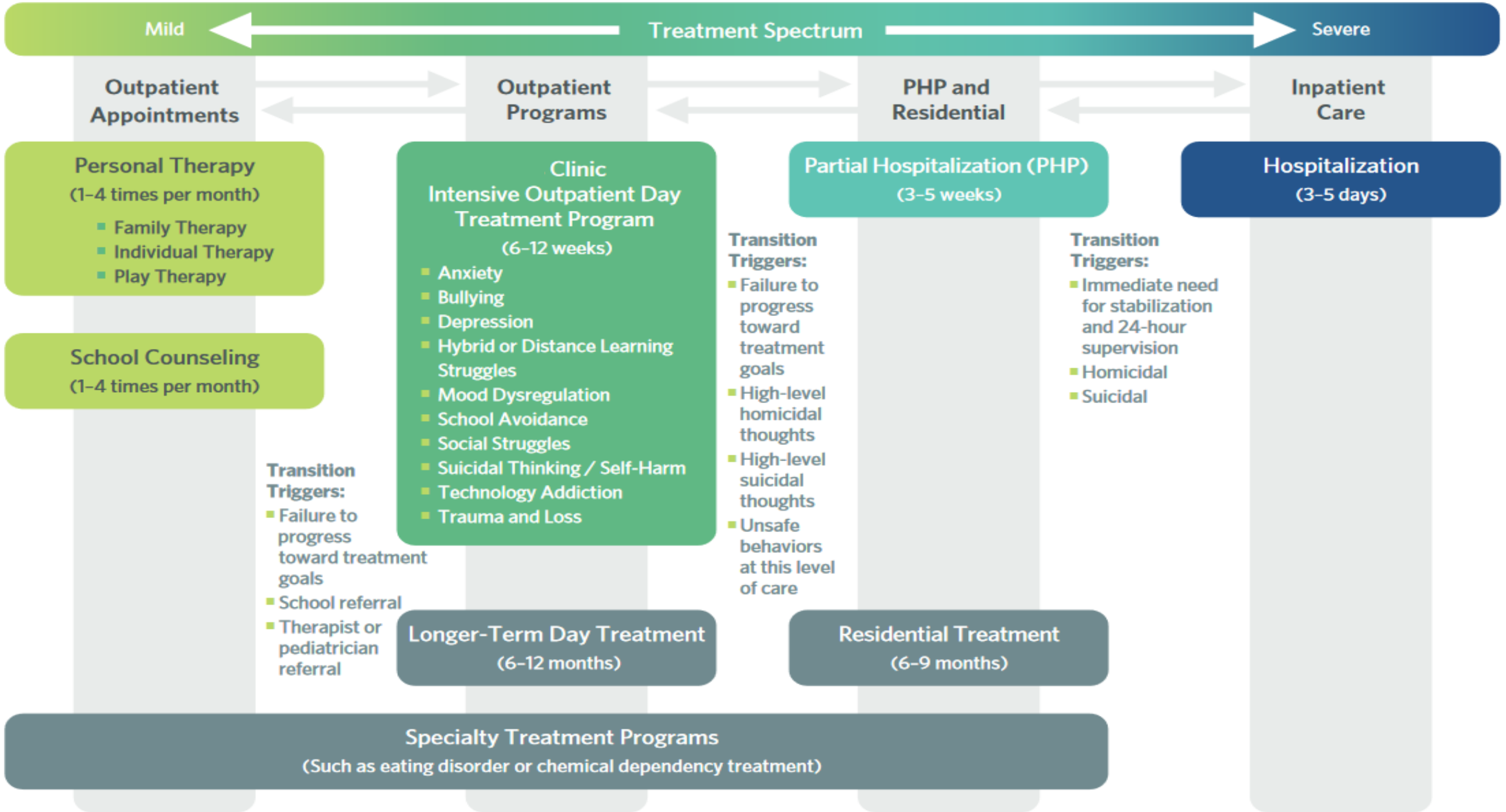

Figure modified from aris-clinica.com

Levels of care

- Partial Hospitalization Program ("Day Hospital")
  - School day hours (~8-3p) 5 days/week, M-F
  - Marked "present" in school
  - Sees PNP/PhD/CAP MD once/day
  - Family participation required
  - LOS ~1-3 weeks typically
  - Multidisciplinary team—may include MD, PhD, MA, LCSW, OT, others
  - Step up or step down service
  - Planned/urgent admission not emergent admission

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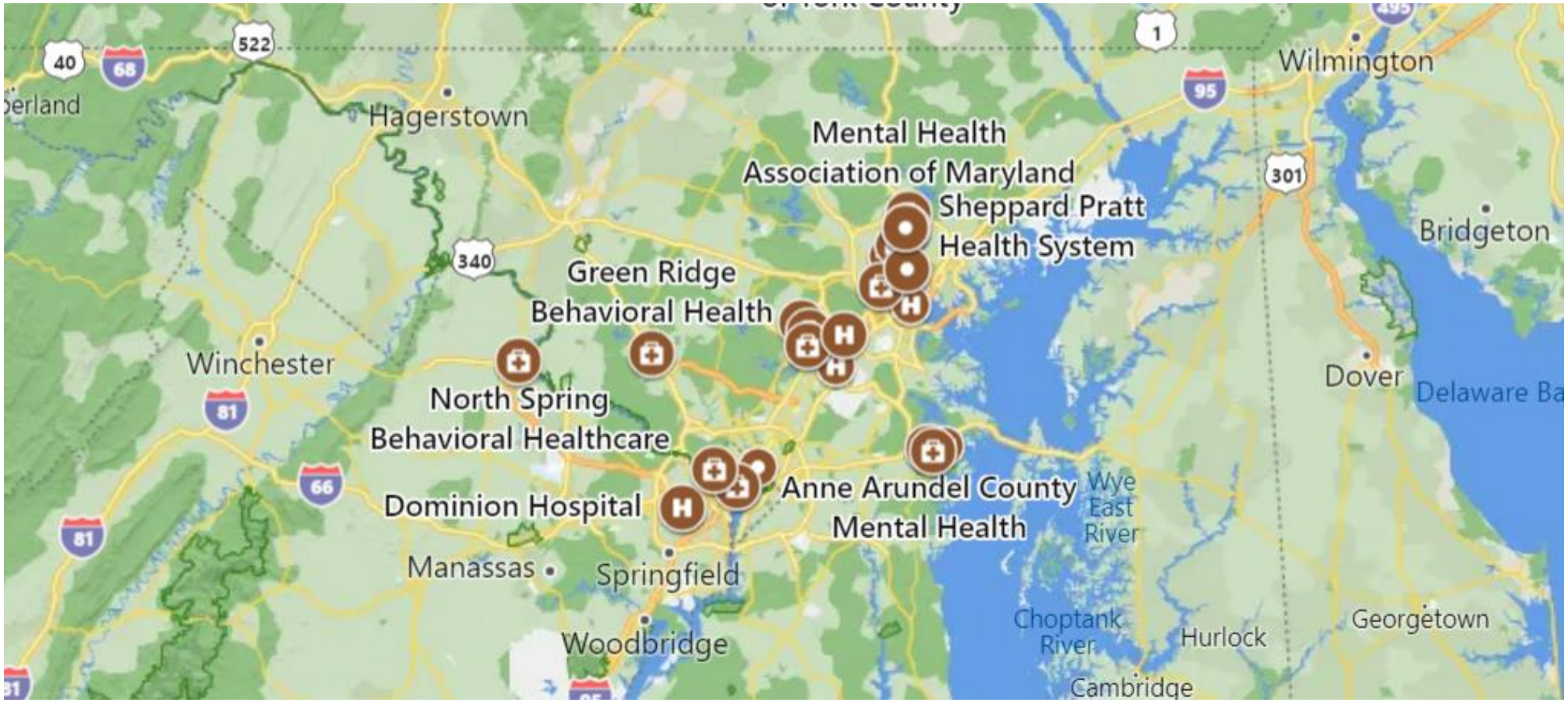
PARTIAL HOSPITALIZATION PROGRAMS & DAY HOSPITAL PROGRAMS



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Levels of care

- Urgent care/Crisis Center/Walk in
  - Vary by county
  - Can sometimes be 1x can be ongoing can be referral/connector

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COUNTY/REGION	# EMERGENCY DEPARTMENTS	# URGENT CARE CENTERS
Anne Arundel	2	4
Baltimore City	16	2
Baltimore County	6	5
Central Maryland (Frederick, Howard, Carroll, Harford)	7	8
Eastern Shore (Caroline, Cecil, Dorchester, Queen Anne's, Somerset, Talbot, Wicomico, Worchester)	8	9
Montgomery	17	13
Prince George's	7	5
Southern Maryland	3	1
Western Maryland	3	1
Total	69	48

SHEPPARD PRATT URGENT CARE SERVICES

[Psychiatric Urgent Care | Care Finder | Sheppard Pratt]

Psychiatric Urgent Care

Sheppard Pratt's Psychiatric Urgent Care is specially designed for people who need an immediate psychiatric triage.

PEOPLE CARED FOR
- Children
- Adolescents
- Young Adults
- Adults
- Older Adults

LEVEL OF CARE
- Crisis

PAYMENT TYPE
- Medicare
- Medicaid
- Private Insurance
- Self Pay

CONTACT US

Psychiatric Urgent Care

TELEPHONE
410-938-5302

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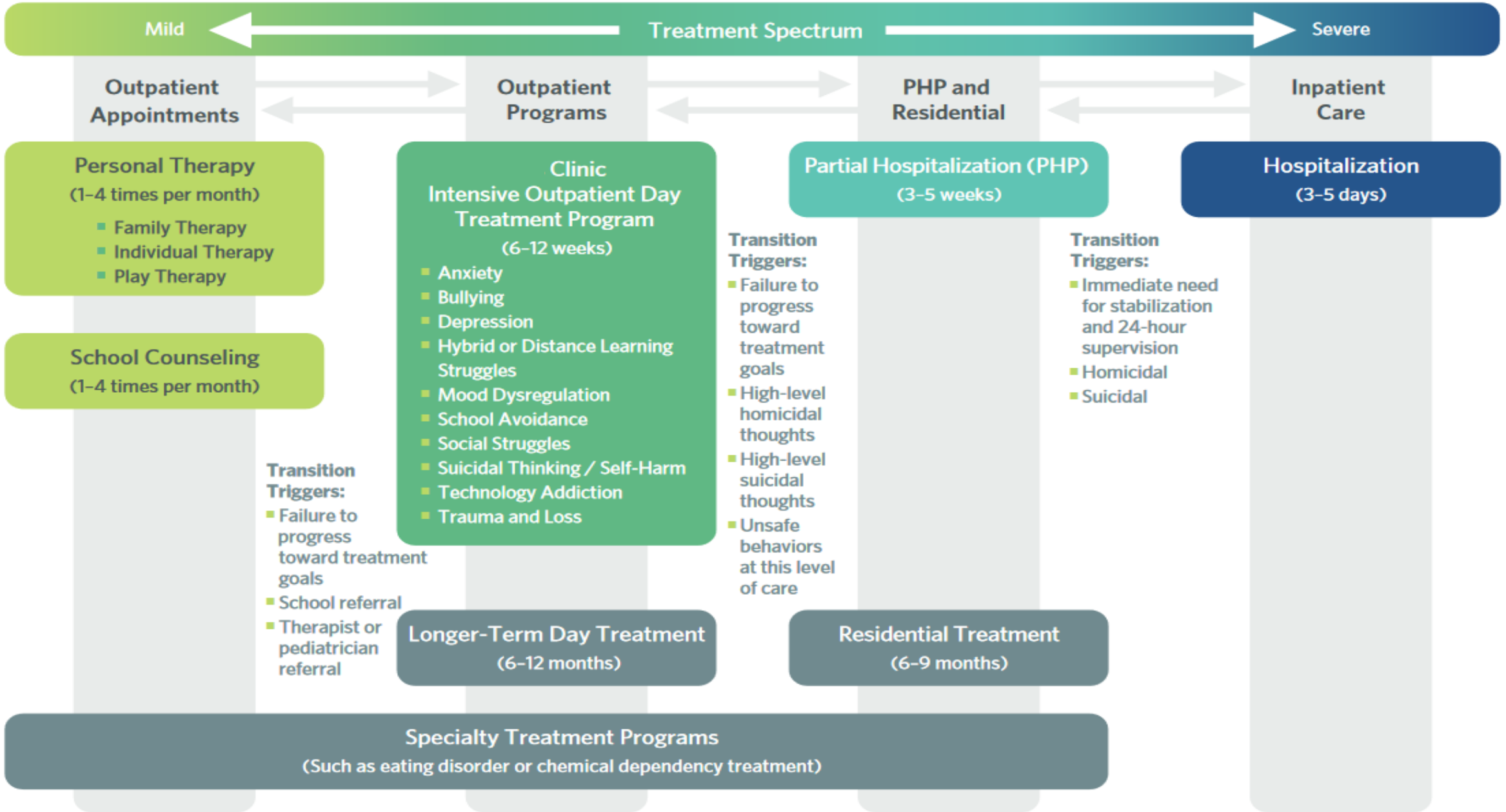

Figure modified from aris-clinica.com

Levels of care

- Inpatient Hospitalization
  - 24/7 care for acute illness/safety concerns
  - Multidisciplinary team
  - LOS 5-10 days typically “ICU” model, leave when less acutely ill vs well
- Residential Treatment Center
  - 24/7 care for **non-acute** situation in which youth is unable to be maintained in the home and community—requires a primary agency to sponsor

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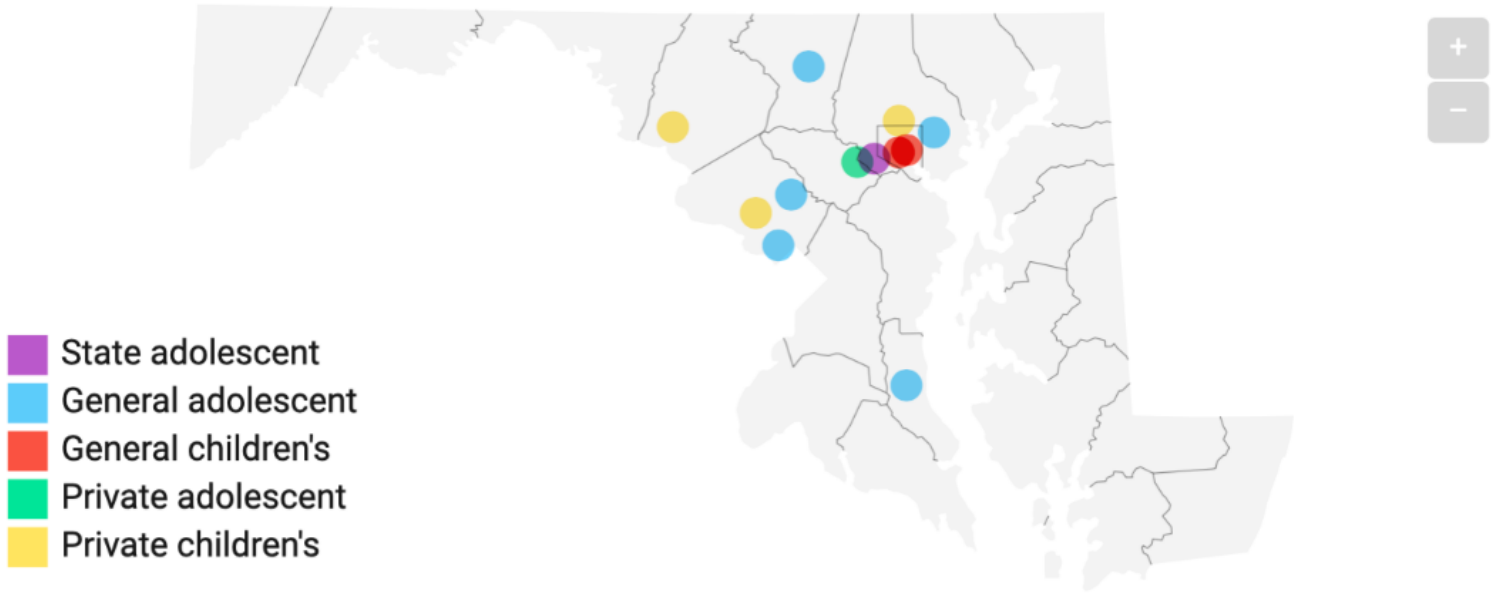
INPATIENT PSYCHIATRIC SERVICES

Maryland child and adolescent acute psychiatric care units

Across the state, there are only five units that provide inpatient psychiatric care for children, and only seven units that provide inpatient care for adolescents. All of the units are located within central Maryland, leaving gaps in care for the Eastern Shore, western Maryland and parts of southern Maryland.



Map: Natalie Jones • Source: Maryland Health Care Commission • Get the data • Created with Datawrapper

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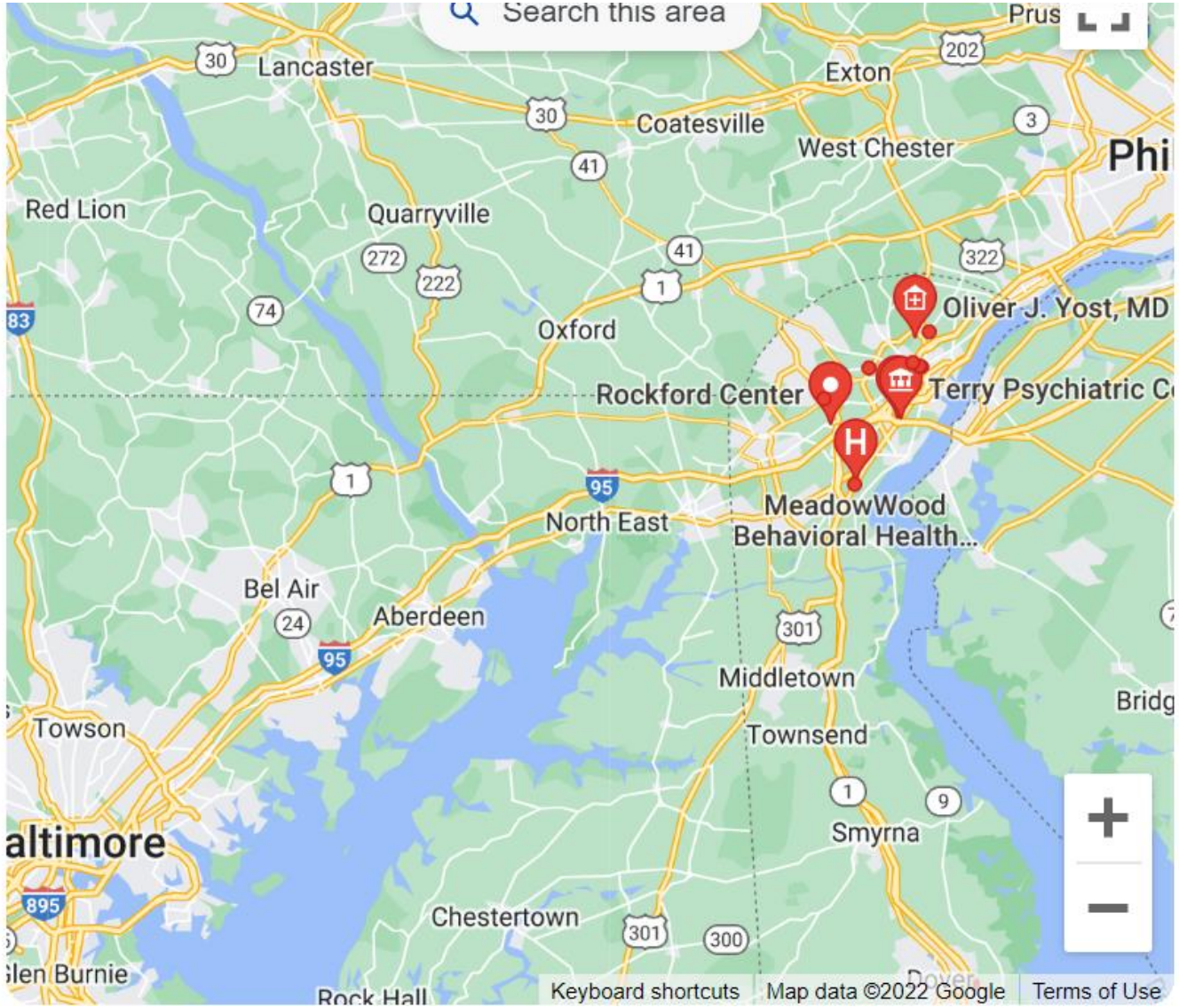
Delaware Child and Adolescent Inpatient Services



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Hospital	Age Range	Legal Status	Number
Medstar Franklin Square Hospital	12-17	Vol/Certs	443-777-7207 or 2718 Fax: 410-350-7590
Johns Hopkins Hospital	6-17	Voluntary only	410-955-5280 After hours: 443-287-2798 Fax: 410-502-5283
Sheppard Pratt Hospital	3-17	Vol/Certs	410-938-3800
Medstar Montgomery General (Mixed with adults)	13+	Voluntary only	301-774-8888 Fax: 301-570-7422
Carroll County (Mixed with adults)	13+	Vol/Certs	410-871-6971 Fax: 410-840-4015
Calvert Health Medical Center (Mixed with adults)	13+	Vol/Certs	410-535-4000 or 8144 Fax: 410-535-8136
Adventist Behavioral Health Shady Grove	13-17	Vol/Certs	301-251-4545 Fax: 301-251-4519
Brooklane	5-17	Vol/Certs	301-733-0330
Children's National Hospital	2-12 13-17	Voluntary only	202-476-4085 After hours Child: 202-476-5166 Adolescent: 202-476-3867
PIW	10-17	Voluntary only	202-885-5610 Fax: 202-885-5614

Emergency Departments

- Setting of “last resort”
  - After hours
  - Acute safety
  - Delays in accessing other services
  - Uncertainty of what else can be done/how to do it
  - Repeated use can unintentionally reinforce maladaptive behaviors
- Staffing
  - May or may not have behavioral health staff
  - Few have in house child psychiatrists
- Resources
  - May have social workers who can make referrals/connections
  - BHIPP
- ED’s Purpose
  - Admit/discharge vs diagnose/treat
  - Dilemma of waiting for other levels of care, especially inpatient

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New Approach

Framing the Work

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

Mobile Response and Stabilization Services (MRSS) is an evidence-based child, youth, and family-specific intervention model designed to meet the youth and caregiver's 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 the caregiver and wider circle of family and friends because of the nature of their relationship.

Emergency Room Diversion

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.[2,3]

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New Approach

Maryland
DEPARTMENT OF HEALTH

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

Issued by the Maryland Department of Health,
Behavioral Health Administration

Fall 2021

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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New Approach

[Pages - 988md (maryland.gov)]

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988

Calling 988 connects callers directly to the National Suicide & Crisis Lifeline which encompasses **all behavioral crisis services, to include all mental health and substance use (problems with drug and alcohol use).**

- The 988 Suicide & Crisis Lifeline replaces the National Suicide Prevention Lifeline AND expands services to cover all behavioral health crisis services.

What does this mean for Marylanders?

- When someone in Maryland calls 988, they routed to one of the state's eight call centers. These centers provide phone-based support and information regarding local resources. Marylanders can also text 988.
- Maryland has been operating its own crisis hotline, 211 press 1, and that number will remain in operation and accessible to Marylanders throughout the transition period and beyond.

Who can call 988?

- Anyone in need of assistance with behavioral health related needs can call 988.
- The new 988 feature is available nationwide for call (multiple languages), text or chat (English only). Both "211, press 1"
- The existing Lifeline phone number (1-800-273-8255) will remain available throughout the transition period and beyond.

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988

What can you expect when calling 988?

- Callers will hear a greeting message while their call is routed to the Maryland Lifeline network crisis center (based on the caller's area code)
- A trained call specialist will answer the phone, listen to the caller, understand how their problem is affecting them, provide support, and share resources if needed
- If the Maryland crisis center is unable to take the call, the caller will be automatically routed to a national backup crisis center
- The Lifeline provides live crisis center phone services in English and Spanish and uses Language Line Solutions to provide translation services in over 150 additional languages for people who call 988

How does 988 help Marylanders?

- 988 call specialists located at crisis call centers around Maryland can immediately provide phone-based support and connections to local resources.
- By directing cases to 988 when a behavioral health crisis (mental health and substance use) isn't life threatening, the response provided by public services, such as law enforcement and EMS, can be reserved for situations in which lives are endangered.
- In 2020, Congress designated the new 988 calling code to be operated through the existing National Suicide Prevention Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) sees 988 as a first step towards a transformed crisis care system in America.

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Why might care escalate to a higher level?

- **Anxiety**—someone is worried…might be the youth, caregiver, clinician, teacher…something about what is going on is increasing distress in the system surrounding the youth.
  - This might be related to illness (whose?) or temperament (whose?) or behavior (whose?) or life events (whose?)
- **Anger**—someone is angry…might be the youth, caregiver, clinician, teacher…something about what is going on needs to be interrupted to ensure safety.
  - This might be related to illness (whose?) or temperament (whose?) or behavior (whose?) or life events (whose?)
- **Ability**—someone is not able to manage what is going on, despite best efforts…might be due to competing demands, inadequate resources, caregiver distress/illness, etc.
  - This might be related to illness (whose?) or temperament (whose?) or behavior (whose?) or life events (whose?)

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How do youth move to a higher level of care?

- Acute event
  - Suicide attempt or serious threats with impulsive/unpredictable behavior, aggressive/markedly disruptive behavior, other acutely unsafe behavior
- Failure of progress/worsening of symptoms
  - Despite various efforts, persistent and potentially worsening psychiatric sxs
    - E.g. affective illness that starts to impact eating/drinking and may be sliding into catatonia
- Diagnostic dilemma
  - Similar to prior bullet—when nothing is working, patient is decompensating, and it is unclear what to do next

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What can a provider expect from a higher level of care?

- IOP/Afterschool
  - Planned admission
  - Several days/week for several weeks at a time
  - Group activities
- PHP/Day Program
  - Planned admission
  - Multidisciplinary team
  - Therapeutic groups
  - Individual and family meetings
  - Medication adjustment
  - Discharge planning
- Urgent Care/Crisis
  - One time contact typically
  - Referral resources

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What can a provider expect from a higher level of care?

- Inpatient Psychiatric Hospital
  - Admitted from an ED or other care setting—they may or may not be connected to outpatient care
  - 3-10 day stay
  - Multidisciplinary team
  - Diagnostic assessment, medication adjustments, individual and group work, family meetings, therapeutic milieu
  - Discharge planning with aftercare including formalized safety plan
- Residential Treatment Center
  - Requires lengthy process to be accepted (at times an interview)
  - Requires multiple failed other placements/levels of care
  - Requires funding from DHMH, PS, or DSS (or private pay…)
  - LOS may range from 6 weeks to 6 months depending upon type of facility
  - Multidisciplinary team
  - Medication adjustments, family meetings, therapeutic milieu
  - Discharge planning with aftercare including safety plan

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How do youth move to lower level of care?

- Less clear…
- Depends upon variety of factors
  - Target sxs—are they present in care setting? If not…harder to keep
  - Adherence to program—is family participating? Youth coming to PHP?
  - Insurance constraints—”Doc to Doc” reviews
  - Program’s own parameters
  - Progress—best reason!

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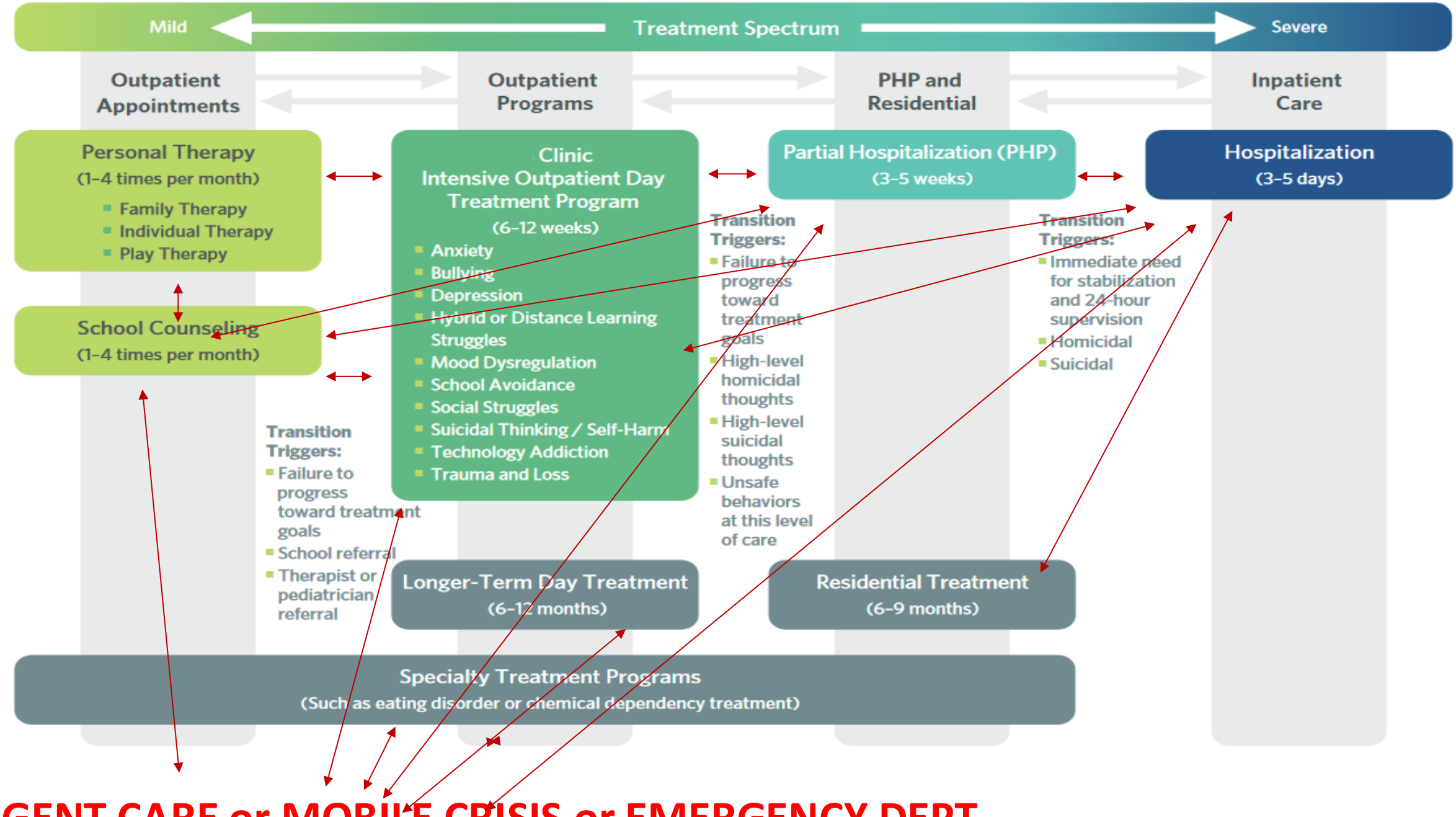

URGENT CARE or MOBILE CRISIS or EMERGENCY DEPT

Figure modified from aris-

Added Dilemmas

- Waiting lists
- Inclusion/exclusion criteria
- Insurance barriers
- Geographic barriers
- Youth/family barriers
- Fit of need/skills
- And many more…

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Case Example

- 13yo cis-gender boy, + family hx of maternal anxiety, + personal hx of delayed language development, repeated 2nd grade for failure of majority of classes leading to IEP for speech/language and SW support, family moved mid academic year last year due to financial stressors and now in new middle school, IEP did not continue, and he now presents with escalating disruptive behaviors at school and at home. He has been diagnosed with ADHD/Depressive Disorder NOS in the past, but is not on any medication currently.
- Had fallen out of treatment with family move, however, his new middle school has School based Mental Health who saw him weekly for several few weeks, but has gotten worried about his mood as he seems really angry and short-fused and referred him to an afterschool program
- He attended the afterschool program and initially seemed to be doing better—or at least no worse. After about 1 week of participating, he skipped the transportation to the program and decided to walk home, stating he didn't want to go back. He then refused to go to school the rest of that week.
- Given this, he was referred to a Day Program and began the next week.

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Case Example

- There, he was noted to be sullen and minimally cooperative with group activities. His mother missed the first family meeting, was late for the 2nd one. He appeared more irritable on the day his mother did not come for the meeting. He was marginally cooperative in individual sessions, appeared easily confused/overwhelmed by group activities but did seem to engage more with art-based activities.
- In week 2, he did not come to the program on Monday, outreach to the family led to learning he had stayed out all night Friday (unknown whereabouts) and had come home Saturday refusing to say what had happened. His mother was distraught and took him to the closest ED and he was waiting there for an evaluation.
- His mother stated she cannot handle him at home, sharing he has been increasingly aggressive with his younger sister who is actually in the same grade in school (they are 1 year apart but he repeated a grade).

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Case Example

Services used…

- Outpatient
- School Mental Health
- After school + School Mental Health
- Day Program
- Emergency Department

Reason for movement…

- Adherence/improvement
- Anxiety/Anger/Ability

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Summary

- Complex, multilayered system that is both rich with resources in some ways and hard to navigate in other ways
- Matching services with youth and families in the locations needed and timeframe needed are significant barriers
- BHIPP is a great resource to help connect and identify options

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Questions & Discussion

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Links

- https://www.mhaonline.org/transforming-health-care/healthy-hospitals-healthy-communities/behavioral-health/maryland-behavioral-health-resources-services-directory
- https://health.maryland.gov/bha/Documents/MDH%20MRSS%20Document%20-%20Spring%202022.pdf
- https://health.maryland.gov/bha/Pages/988md.aspx
- https://health.maryland.gov/bha/Documents/2022%20Suicide%20Prevention%20Toolkit.pdf

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