HB 1140 Favorable - WRITTEN TESTIMONY

My name is Elizabeth Manley and I am a subject matter expert on children's behavioral health services. I am a Clinical Instructor for Health and Behavioral Health Policy at the Institute for Innovation and Implementation, at the University of Maryland School of Social Work. I am here today to talk to you about the importance of developing and implementing a comprehensive mobile response and stabilization system for children and families. This is based both on my experience in leading this work for years in New Jersey as well as my work with other states and communities. In my role with the TA Network, the federally funded National Training and Technical Assistance Center for Children's Behavioral Health, I assist states in addressing the critical needs presented by the overuse of emergency departments, inpatient psychiatric units, and residential services in response to crises. States and communities that have invested in a children's specific Mobile Response and Stabilization within the continuum of a care have benefitted from decreases in the over-reliance of the highest intensities of service including inpatient care.

Prior to joining the University of Maryland School of Social Work in 2017, I served as Assistant Commissioner for NJ's Children's System of Care, the division within the state that has direct oversight of the public mental health system for children. I was in that role for 5 years and was engaged in multiple in the implementation of the system of care in New Jersey. In 2006, New Jersey mobile response and stabilization system statewide implementation was completed. Since then, 94 percent of children have been able to stay in the same living situation they were in at the time the crisis service was received, reducing the number of youth entering emergency department. Mobile response and stabilization has contributed to the stability of children in foster care, reducing the number of behavioral driven moves in foster care.[1] In New Jersey, Mobile Response and Stabilization is available at the request of parents and caregivers and is responsive to law enforcement, education, juvenile justice and child welfare systems.

For years now, we have known that mobile response and stabilization services are a national best practice to address crises, maintain children in a family-setting in the community, and reduce utilization of emergency departments, inpatient hospitals, and residential treatment. In 2013, the Centers for Medicare and Medicaid Service (CMS)[2] and the Substance Abuse and Mental Health Services

[1] https://www.nj.gov/dcf/about/divisions/dcsc/CSOC_15.Year.Conference.Presentation.pdf
[2] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-05-07-2013.pdf

Administration (SAMHSA) recognized mobile response and stabilization services as an essential service for consideration within a children's behavioral health continuum. In September 2018 the National Association of State Mental Health Program Directors recognized Mobile Response and Stabilization is a core element within a children's crisis continuum of care.[3]

New Jersey built a system where Mobile Response was available to any family, anywhere at any time. 24 hours a day, 7 days a week, 365 days a year, Mobile Response by providing immediate support to any family in crisis because of a child's escalating emotional or behavioral health needs. It can be the families' first time calling or a repeat request for help. The response operates through a trauma informed lens to quickly understand what the child has experienced and then help the child stabilize and feel better. New Jersey's guiding and fundamental philosophy is that "When a child feels better, they do better". Mobile response in New Jersey has one hour response time and with a single point of entry toll free line and provides this 4-pronged approach:

1. Onsite intervention to deescalate, shift dynamics and provide education.
2. Assessment, planning, skill building, psycho-education and resource linkage to stabilize presenting needs.
3. Assistance to the child and family to return to baseline or routine functioning and prevention of further escalation.
4. Provision of prevention strategies and resources to cope with presenting issues and create a plan to avoid future crises.

Maryland already has been working on a shared vision. For the last 4 years, my colleague Jennifer Lowther, has been gathering and leading a group of invested professionals through Maryland Mobile Response Stabilization Services that are comprised of representatives from all of Maryland's child servicing sister agencies to include BHA, GOC, DHS, DJS, DDA, MSDE, Medicaid, various core service agencies, local mobile response providers, advocates, University of Maryland researchers. All members would agree that diverting youth from higher intensity services such as inpatient and residential care; facilitating the coordination of stabilizing youth in their community; providing acute care to children and

[3] https://nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

youth in rural areas with limited resources and community programs; reducing length of stay in residential programs and ultimately increasing cost-savings as a result of increased hospital diversions.

There are several states that have been have invested in building a comprehensive systems for children. Two of these states include Nevada and Oklahoma who have both demonstrated a return on investment that included reduction in inpatient stay and visits to emergency departments and increase satisfaction of families whose needs were met when their immediate crisis was stabilized, which allowed children to stay in school and with their families. With the support of leadership to take action to better serve the children and families struggling today to access the right service at the right time for the right duration.

Thank you for time and interest in children's mobile response and stabilization.

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