Emergency Services Program
Mobile Crisis Intervention

Practice Guidelines

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Purpose of the Mobile Crisis Intervention Practice Guidelines

This document outlines components of the service and guidelines for the provision of Mobile Crisis Intervention in furtherance of the Children's Behavioral Health Initiative (CBHI) and is intended for use by Emergency Service Programs (ESP) and Mobile Crisis Intervention (MCI) Providers. The minimum performance specifications for MCI Providers are contained in their contracts with MassHealth's Managed Care Entities. The contents of these Service Guidelines represent current "best practices" for MCI and related expectations for provider performance and service delivery. The guidelines detail professional standards, as well as information about and recommendations for youth and family-centered practices, beliefs, and quality services consistent with the CBHI mission, values, vision and strategic priorities. Many documents referenced throughout the guidelines are found in the Appendices and are also available as a resource to providers in the CBHI section of the Massachusetts Behavioral Health Partnership (MBHP) website at www.masspartnership.com. Additional CBHI resources such as links to training materials can also be found in the Appendices. MCI is one of six CBHI services. A brief description of all of these services can be found in *Appendix A*.

The Children's Behavioral Health Initiative (CBHI)

Mission
The Children's Behavioral Health Initiative (CBHI) is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care to ensure that families and their children with significant behavioral health conditions, including emotional, mental health and substance use needs obtain the services necessary for success in home, school, and community.

Values (Systems of Care Philosophy)

- **Child-Centered and Family-Driven**
  Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.
- **Strengths-Based**
  Services are built on the strengths of the family and their community.
- **Culturally Responsive**
  Services are responsive to the family's values, beliefs, and norms, and to the socioeconomic and cultural context.
- **Collaborative and Integrated**
  Services are integrated across child-serving agencies and programs.
- **Continuously Improving**

Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence, and best practice.

Vision
The Children's Behavioral Health Initiative places the family and child at the center of our service delivery system and builds an integrated system of behavioral health services that meets the individual needs of the child and family. Policies, financing, management, and delivery of publicly funded behavioral health services will be integrated to make it easier for families to find and access appropriate services and to ensure that families feel welcomed and respected, and receive services that meet their needs, as defined by the family.

Strategic Priorities
1. Increase timely access to appropriate services
2. Expand array of community-based services
3. Reduce health disparities
4. Promote clinical best practice and innovation
5. Establish an integrated behavioral health system across state agencies
6. Strengthen, expand, and diversify workforce
7. Mutual accountability, transparency, and continuous quality improvement

Emergency Services Program (ESP) Description

There are 21 locally based ESPs covering every city and town across the Commonwealth. Seventeen of the ESPs are managed by MBHP, and four are operated by the Department of Mental Health (DMH) in the Southeast Region. See *Appendix C-6* for a link to the ESP/MCI Statewide Directory. It lists the ESP/MCIs, the catchment areas they serve, the cities and towns included in each catchment area, and contact information, such as addresses and phone numbers.

The ESPs provide behavioral health crisis assessment, intervention, and stabilization services, 24 hours per day, seven days per week, and 365 days per year. Each ESP offers the following service components, which make emergency behavioral health services accessible in the community, offering alternatives to hospital emergency departments (EDs) for individuals seeking behavioral health services when use of the ED may be avoided and/or is not voluntarily sought.

- Mobile Crisis Intervention (MCI) for youth (age 20 and younger)
- Adult Mobile Crisis Intervention
- Adult Community Crisis Stabilization
- Community-Based Location Services
- 24/7/365 Crisis Triage

The mission of the Emergency Services Program is to deliver high quality, culturally competent, clinically and cost effective, integrated community-based behavioral-health crisis assessment, intervention, safety planning and stabilization services that promote resiliency, rehabilitation, and recovery. See *Appendix C-5* for a link to ESP Performance Specifications.

ESP services are available to individuals of all ages who are uninsured, as well as those covered by the following public payers: MassHealth plans (PCC Plan/MBHP, MassHealth-contracted Managed Care Entities (MCEs), and MassHealth fee-for-service); DMH only; Medicare; and Medicare/Medicaid. Many ESPs are also contracted with various commercial insurance companies to provide similar services.

Mobile Crisis Intervention (MCI) Program Description

Mobile Crisis Intervention is the youth[1]-serving component of an Emergency Services Program (ESP) provider. MCI teams provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week, and 365 days a year. Between the hours of 10pm and 7am, Mobile Crisis Intervention staff may be on-call and dispatched by pager. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to 7 days, based on the individual needs of the youth served.

The service includes a crisis assessment; engagement in a crisis planning process, which may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including on-site, face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology Intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff coordinates with the youth's ICC care coordinator throughout the delivery of the service. With consent, Mobile Crisis Intervention also coordinates with the youth's parent(s)/caregiver(s), primary care clinician, any care management program provider, other behavioral health providers, and/or any state agencies that are providing services to the youth throughout the delivery of the service.

As part of the CBHI, MCI services are carried out in concert with the mission and values of CBHI (see *above*). All components of MCI as described below are to be delivered in a way that is child-centered and family-driven. MCI services are strengths-based, culturally responsive, collaborative and integrated, and continuously improving. The youth and his/her caregiver should always be encouraged to participate in discussions and meetings regarding the care and treatment of the youth.

[1] Age 20 and younger

Mobile crisis intervention services are designed to optimize clinical interventions by meeting clients in home or school settings where they are more comfortable, where strengths and cultural differences are more apparent, and where caregivers are more available. Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing many youth and families to bypass the stigma of hospital settings, as well as the trauma and disruption of an emergency out-of-home placement. This is accomplished by safety planning in an actual site where long-term safety will most matter, and with the people who are crucial to the plan. MCI services optimally produce more holistic evaluations, solutions and referrals. They are also intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intrusive manner. The nature and anticipated benefits of a community-based crisis intervention should be discussed with the youth and parent at the earliest stages of the MCI encounter, in order to ease anxiety or safety concerns, support informed consent and decision-making by the youth/caretaker, and clarify the intended purpose of the service.

MCI services are available to individuals age 20 and younger who are uninsured and individuals age 20 and younger who are enrolled in MassHealth[2].

MCI Team Staffing

Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff and maintains staffing levels as warranted by data trends and in compliance with the Performance Specifications. This includes assuring that staffing is sufficient to respond within 60 minutes to new requests for MCI services AND to provide continued crisis stabilization and care coordination services as indicated for up to 7 days.

Mobile Crisis Intervention is staffed with

- *Master's Level Clinicians* trained in working with youth and families, and
- *Bachelor's Level* or *Paraprofessional staff*, many of whom are *Family Partners*.

In addition, a board-certified or board-eligible child psychiatrist or child-trained Psychiatric Nurse Mental Health Clinical Specialist must be available to provide

- Phone consultation to the MCI team within 15 minutes of a request from Mobile Crisis Intervention staff; and
- Face-to-face appointments with the youth within 48 hours of a request if the youth has no existing provider.

Please note that the intent is to maintain the youth's existing treatment relationship. However, if the existing provider cannot provide a face-to-face appointment within 48 hours, or as indicated to meet a youth's urgent needs, the MCI program should arrange an appointment with its on-call child psychiatrist or psychiatric nurse/mental health clinical specialist.

[2] See *Appendix H* for a listing of Availability of CBHI Services to Members in Various Benefit Plans.

Medical Necessity Criteria for Admission

All of the following are necessary for admission to the MCI level of care.

1. The youth must be in a behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage. For youth in ICC, efforts by the care coordinator and Care Planning Team (CPT) to triage and stabilize the crisis have been insufficient to stabilize the crisis and ESP/Mobile Crisis Intervention has been contacted.
2. Immediate intervention is needed to attempt to stabilize the youth's condition safely in situations that do not require an immediate public safety response.
3. The youth demonstrates impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community.

In addition to the above, at least one of the following must be present.

1. The youth demonstrates suicidal/assaultive/destructive ideas, threats, plans, or actions that represent a risk to self or others.
2. The youth is experiencing escalating behavior(s) and, without immediate intervention, he/she is likely to require a higher intensity of services.

In addition to the above, at least one of the following must be present.

- The youth is in need of clinical intervention in order to resolve the crisis and/or to remain stable in the community.
- The demands of the situation exceed the parent's/guardian's/caregiver's strengths and capacity to maintain the youth in his/her present living environment and external supports are required.

See *Appendix C-9* for a link to the MCI Medical Necessity Criteria.

Access to MCI Services

Telephonic requests for Mobile Crisis Intervention are triaged through the established phone triage system of the ESP/MCI program. All calls are answered by a live ESP staff person 24 hours a day, 7 days a week. An answering machine or answering service is not permitted, including those directing callers to call 911 or to go to a hospital emergency department (ED). Each ESPMCI maintains its own toll-free phone number. In addition, there is a statewide toll-free number: 877-382-1609. An individual can call the statewide number and enter his/her zip code to get the number for the local ESP provider.

If the ESP/MCI determines that the situation warrants intervention by police or EMT personnel, MCI calls and coordinates with them to ensure safety. The ESP/MCI team will then dispatch to meet emergency responders at the location of the crisis and immediately work to de-escalate the situation and intervene to ensure the safety of all individuals in the environment, utilizing the MCI interventions and services.

Referral Sources

MCI teams receive referrals from a number of sources including families, CBHI service providers, other behavioral health service providers, schools, Primary Care Clinicians, and providers from other systems such as Law Enforcement, Department of Youth Services (DYS), Department of Mental Health (DMH), the Department of Children and Families (DCF), and the Department of Mental Health (DMH). Many requests for services come through the ESP 24/7/365 triage line/toll-free line. Families may also walk into the ESP's Community-Based Location (CBL) without advance notification. (Hours vary by CBL.)

Catchment Area Protocol

For any number of reasons youth may live in one ESP/MCI service area but receive an MCI intervention in another service area. This most often happens when youth attend schools or treatment programs in other service areas or when families choose to go to a regional or specialty hospital's emergency department. In the event that a crisis encounter begins in one service area but must continue in another, the responding MCI team will conduct all applicable assessments, provide interventions necessary to stabilize the immediate crisis, and engage in any required safety planning at the site of the crisis event. With appropriate consent, the MCI team will then make a direct referral to the MCI provider in the youth/family's area of origin, facilitating exchange of relevant assessment information and documenting any specific follow-up care or service referrals that may be necessary, including a second on-site visit to the youth/family home, telephonic support, and assistance with more detailed safety planning and service referrals.

Note emphasis on the experience and perception of the service requester(s) in the Medical Necessity Criteria

"…a behavioral health crisis that was unable to be resolved to the caller's satisfaction by phone triage"
"…demands of the situation exceed the parent/guardian/caregiver's strengths and capacity"

ESP/MCI programs are advised to avoid challenging the "legitimacy" of a request for MCI services and instead to seek to understand the essence/importance of the situation from the perspective of the caller in a manner that offers rapid empathy and rapport building. This will at times result in diminishment of the crisis without need for an MCI service or perhaps the offer of a different timely service will fit the family's needs. Below are two examples of traps to avoid.

1. Efforts to determine whether a child is having a "behavioral problem" or a "mental health crisis," or whether or not the need for the MCI service is "real" or if parents are "just looking for a break." The common factor in each situation is that a family is in distress. Understanding the essence of the distress (for child and for parent/caregiver) is the path towards resolution regardless of the presence/absence of a formal diagnosis.
2. Confusing criteria for MCI service with criteria for hospital admission. The criteria for an MCI service lie under a broader umbrella. Below is an excerpt from SAMHSA's Practice Guidelines.[3]

Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether or not an individual is dangerous or immediate psychiatric hospitalization is indicated.

While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior), or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late, or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good.

[3] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

MCI Crisis Systems of Care Outreach Responsibilities

It is important that MCI teams continuously analyze referral source data and note trends in requests making note of who IS and who IS NOT making referrals and how families are instructed to access MCI services. Specific attention is paid when youth and families are routinely directed to hospital emergency departments, when law enforcement officers are called as a rule in addressing a crisis, or when involuntary (Section 12) procedures are routinely initiated. MCI team leaders provide education and support and outreach to providers/systems in developing alternative, less restrictive crisis response protocols including accessing MCI services.

Through collaborative, ongoing, and strategic relationships with hospitals, treatment providers, schools, Primary Care Clinicians, and youth serving systems, MCI teams promote system-wide development of crisis prevention, early identification of crisis symptoms, and crisis intervention and hospital diversion strategies. These strategies empower other providers to build their own comfort and competency in crisis prevention and planning and in offering a first-level early crisis response. MCI teams collaborate with schools, residential treatment facilities and Primary Care Clinicians offering education, 1:1 consultation, and brief in-services to help promote practice changes such as a decrease in sending youth to emergency departments. MCI teams establish tools or protocols with system partners to support the development and maintenance of strategic, collaborative relationships aimed at crisis prevention and planning. (See samples in *Appendix E*.)

These ongoing, broadly adopted Crisis System of Care efforts diminish the need for and use of law enforcement, hospital emergency departments, and inpatient treatment services—services that though sometimes necessary, are not without risk. Out-of-home services are more restrictive, intrusive and intensive; and may leave a residuum of stigma, anxiety, isolation, lowered self-esteem, disengagement from services, and non-adherence. Although effective for many and providing intensive services and containment, hospitalization may be experienced by some youth as uncomfortable, embarrassing, isolating or frightening. Hospitalization can disrupt school, family, job and social activities, and may not be available close to home. A robust Crisis System of Care is about expanding options and does not limit or block access (when criteria are met) to services that a youth and parent(s)/caregiver(s) might choose, including services such as hospitalization.

MCI teams are active participants in regional Systems of Care initiatives and use those forums to promote Crisis System of Care efforts. MCI Family Partners prioritize empowering parents and caregivers (and young adults) to self-refer for CBHI services and other services across systems, sharing relevant information and resources, and offering the personal support and encouragement needed to successfully navigate service systems. MCI clinicians, while prioritizing crisis evaluation and referral, have a secondary goal of empowering community-based treaters, and natural supports in prevention and harm-reduction.

Service Location

ESP services are designed to deliver interventions within the context of the environments where youth live and spend time, to increase likelihood of community tenure and minimize any unintended risk related to transporting a youth to another location and to minimize the potential for a youth to experience discomfort, upset or escalation in another location (*i.e*., hospital ED or CBL). Accordingly, ESP services may be delivered in homes or other natural community or living setting such as schools or residential treatment facilities.

Youth/family location preference, along with clinical consideration of the youth's condition, will influence the location of the MCI intervention. If a family has not opted to go directly to an ED or CBL and has instead called the triage line, the MCI team offers a mobile response to the home. Exceptions to this include medical or physical emergency, excessive risk in the home setting, and family preference that the service not take place in the home.

Assessing and Mitigating Risk in Community-Based Interventions

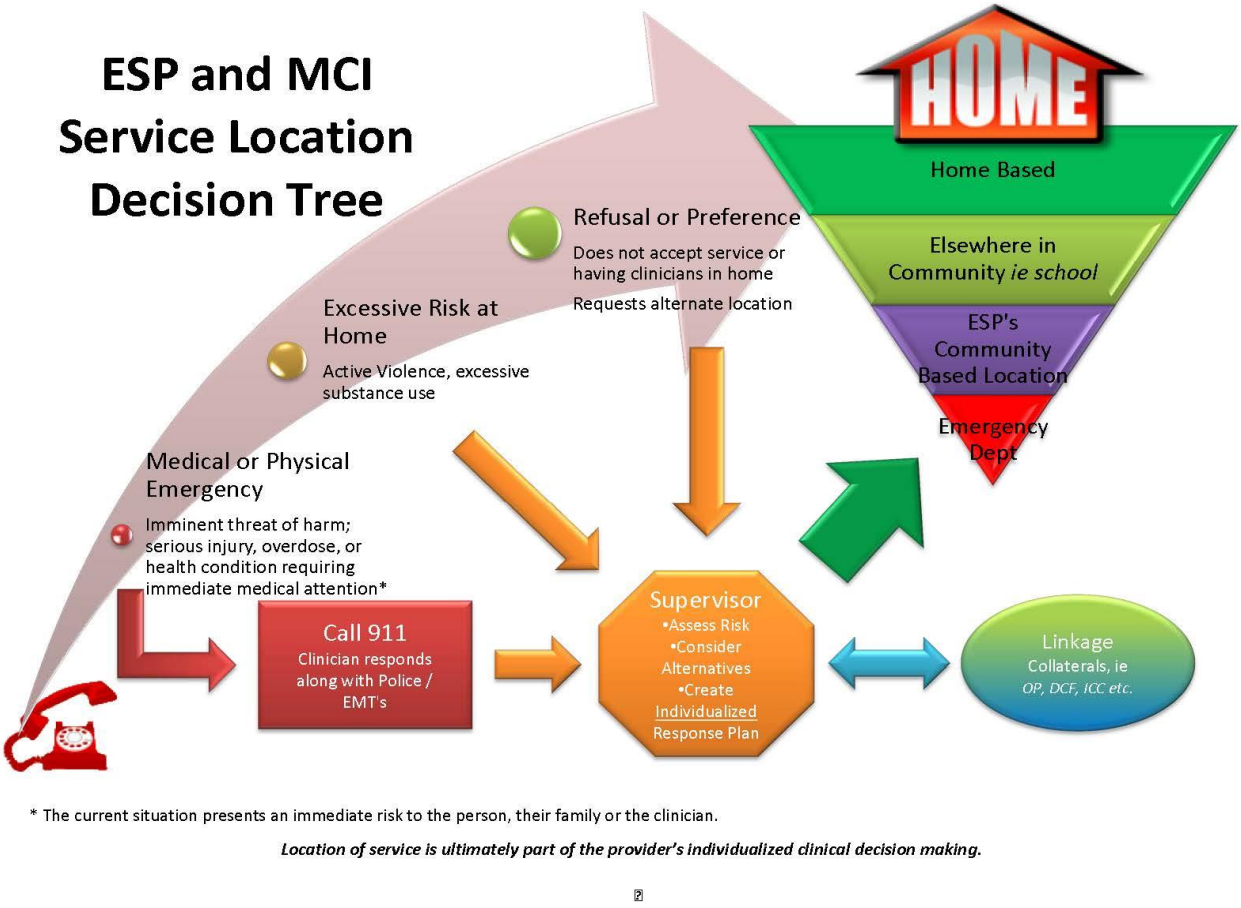
During the triage process, MCI staff may be required to determine, together with the caller, when a medical or physical emergency exists or if other excessive risk requires the involvement of emergency responders, in addition to a mobile crisis response. If a caller describes a serious injury or other medical emergency, or there is reason to believe the youth or those around him/her are at imminent risk of harm, it is appropriate for the MCI to call 911 and *to coordinate* with emergency responders to ensure safety. The ESP/MCI team will then dispatch to meet emergency responders at the location of the crisis, and work to further de-escalate the situation.

However in the absence of imminent risk and in their exercise of professional judgment, MCI teams should begin with the assumption that a community-based crisis intervention is an appropriate response. MCI staff training prepares teams to respond to the range of suicidal, assaultive, and destructive ideas, threats or actions that often characterize a behavioral health crisis. The presence of these threats or actions does not automatically lead to a determination that community-based mobile crisis intervention is inappropriate.

To determine if an exception to mobile response exists, triage staff gather sufficient detail from the caller regarding the present status of the youth and the imminence of any perceived risk of serious harm to self or others. If the caller is someone familiar with the youth and his or her pattern of crisis behavior, he/she can often provide valuable contextual information regarding the seriousness of the situation, the caller's own feelings of safety, and the degree of any potential risk of harm. For example, if the caller reports that the youth has engaged in hitting behavior or damaging property, but is no longer aggressive and is taking space in another room, triage staff/supervisor may assess the level of risk as decreasing in intensity and dispatch a team to provide intervention.

If any Safety Planning Tools have been filed with the MCI team, information may be available about the youth's typical crisis behaviors, as well as the types of de-escalation strategies that might be employed to mitigate any increasing safety risk while an MCI team is dispatched to the location. This allows the

MCI provider to make a highly individualized assessment of risk, based on existing information about the youth and his or her needs.



* The current situation presents an immediate risk to the person, their family or the clinician.

Location of service is ultimately part of the provider's individualized clinical decision making.

For any crisis event, the triage call offers a first and very important opportunity to listen, join and collaborate. These actions alone can have a positive effect on the crisis event. Developing a mutually acceptable and informed plan for the intervention means that a parent/caregiver, school administrator, treatment provider or other concerned caller has been engaged and activated as a credible and important participant who can continue to use his/her judgment to de-escalate the crisis, reduce potential for harm, and reassess any need for emergency response, even as the MCI team is on the way to the community-based location.

Response Timeframe

MCI is an urgent treatment service and timely response is critical. At least one member of the MCI team arrives within 60 minutes of receiving a telephone request, 24 hours a day, 365 days a year.

On an exception basis, when it has been requested and when both the requester and the MCI provider do not feel the delay will compromise safety, the team MCI team may respond outside of the one (1) hour time from when the service was first requested. For example,

- School personnel may request that the service does not begin until a particular point in the school day
- A parent may request that service be delayed until childcare can be arranged for siblings
- Absent overwhelming safety concerns, a parent may prefer to arrange a home visit after school instead of the youth receiving a full evaluation at the school or vice versa.

NOTE: There are certain circumstances when an MCI request is made and the youth's parents cannot be reached to give consent for the intervention. The most common example is a referral from the school. It is expected that schools and/or the MCI team will make every effort to reach a parent and gain consent for an intervention. However, this cannot delay a team's response on-site to the school while efforts continue to reach a parent. The MCI team should assist in stabilizing the situation and assessing immediate risk. A complete assessment and planning for any next service should be delayed until parents are reached.

What MCI Teams Do

MCI teams provide crisis assessment, resolution-focused intervention and stabilization services. MCI teams provide rapid response to youth (age 20 and younger) and their parent(s)/caregiver(s), and in collaboration with the systems that serve youth and have a goal of stabilization or resolution of a mental health or substance use crisis event in the least restrictive, least intrusive, most natural and most comfortable manner for the youth and parent(s)/caregiver(s). MCI is not simply a screening service with a limited purpose of determining if criteria are met for hospitalization or other services. MCI is a specialized and individualized treatment level of care that includes the completion of a comprehensive assessment. The team then delivers a course of youth and family-centered intervention, which is designed to stabilize the crisis, relieve symptoms, mitigate risk, and diminish the need for/offer alternatives to higher levels of care such as inpatient psychiatric hospitalization or CBAT. (See pages 22-24 for more information on resolution-focused interventions.)

MCI is a "teamed" response by a Master's-Level Clinician and a Family Partner or Bachelor's-Level staff person. The use of a 2-person team is not primarily about safety. It is about employing a bi-disciplinary, dual-priority intervention. Except for the reasons described below, youth in eligible categories must be provided with this bi-disciplinary, up-to-7-day MCI service regardless of where they initially receive the service. This includes youth who receive this service in a hospital emergency department. When delivered in an emergency department setting, MCI services can support timely and effective discharge planning to the least restrictive appropriate level of care by strategies such as

1. Using time with the youth and family to focus on crisis support, resolution and planning (not simply assessment and level of care determination. Included in this is a discussion (when the

risks and circumstances of the crisis permit it) of natural, informal, and formal options for addressing any continued risk)

2. Parent Partner engagement of parent(s)/caregiver(s): understanding the essence of the crisis for parent(s)/caregiver(s) and offering support in ways that bring relief and help the parent to be fully engaged in the intervention, and capable of articulating and advocating for the preferences and needs of the child and family
3. MCI clinician is prepared to articulate a sound alternate plan to hospital physicians and other personnel with specifics on how the MCI team will follow through with providing direct and timely services and supports, or how the MCI team will assure that others will provide those direct and timely services.
4. Using on-call supervisors and on-call psychiatrist/psychiatric nurse mental health clinical specialist for consultation and arranging consultation with ED physician as indicated.

MCI is a service that focuses on the crisis experience of the youth but also on the experience of the parent or guardian whose (minor or young adult) child is in crisis. For this reason and on an exception basis, MCI services may opt to send only a clinician when no parent/caregiver is involved. Some teams choose to send a Certified Adult Peer Specialist with a clinician in lieu of a Family Partner for Transition-Age Youth who might benefit from the peer-to-peer support.

In addition, the MCI team offers consultation to and collaborates with other responsible persons who are on scene such as school personnel, residential care staff or foster parents whose understanding of the circumstances, risks, resolution and safety planning is paramount. This might include understanding and addressing the nature of the crisis from their perspective (*i.e*., *"The behavior is disrupting my classroom"* or "*I have lost patience with his acting out in the group home"*) and collectively sorting out and understanding the essence of the crisis for the youth, possible triggers, possible strategies and plans to diminish the risk of another crisis. It is often a welcome opportunity for professionals who do not provide crisis intervention on a regular basis to watch and learn from MCI teams. This has benefit not just for the youth currently experiencing the crisis but for other youth in the school/facility/foster home and can raise internal awareness of environmental factors (rules, ways of interacting, facility/comfort/privacy) that may be having an unintended negative effect.

MCI is primarily delivered in the community where youth live and participate in school and other activities or at the ESP Community-Based Location (CBL). Parent(s)/caregiver(s) may alternatively choose to go to a hospital emergency department. However, youth and parent(s)/caregiver(s) should not be directed to the hospital by the ESP/MCI unless that level of care is medically or behaviorally indicated to assure safe and effective treatment.

In all circumstances and with consent, the MCI team collaborates purposefully with any existing service provider: CBHI service providers, outpatient practitioners, Primary Care Clinicians, state agencies and their service providers, or others whose participation in decisions on resolution, referrals and service continuity is critical and who may be able to arrange the support necessary to consider alternatives to hospitalization or other 24 hour level of care service. This collaboration can include, for example, identification of immediate resources and supports and mutual responsibilities; *ad hoc* team

(youth/family-inclusive) meetings; safety planning and crisis prevention; or discussion of facility/ environmental-specific strategies to support youth in his/her current environment.

The length of the initial assessment and intervention will vary widely based on the unique needs and preferences of the youth and family. Some MCI encounters will be completed in as little as 1-3 hours. Others will consist of a series of contacts and interventions over a course of up to 7 days. The length of the encounter is mutually determined by the MCI provider and the youth/family, following a discussion of identified needs, desired supports, and services available from the MCI team over the 7-day intervention period. Examples of interventions that may be offered to the youth/family during an extended MCI encounter include

- Ongoing crisis counseling;
- Assistance in implementing new or revised safety plans;
- Consultation and collaboration with other responsible parties or settings where the youth's safety plan may be used;
- Assistance identifying unmet service needs;
- Facilitating connections with responsive services/providers;
- Providing resources and information on behavioral health, educational and other relevant service systems;
- Parent/Caregiver partnering and support; and
- Pragmatic activities: gathering resources, applications for services, getting immediate needs met.

The chart below further details what MCI is and what it is not.

WHAT MCI IS	**WHAT MCI IS NOT**
• An active treatment service • Based on Medical Necessity Criteria • Based on individualized strategy for intervention/stabilization • A service that varies in intensity and duration • A service that focuses on resolution and decreasing the need for out of home treatment • A service delivered in collaboration with families • A service delivered in collaboration with existing care providers • Delivered by a specialized team that can lend expertise by joining with, but not substituting for, an existing treatment provider/team	• Passive observation/monitoring • On-demand (without meeting Medical Necessity Criteria) • Respite • Staffing augmentation in school or residential settings • Delivered in the home in the absence of a parent/guardian • A substitute for an existing service • A requirement or waiting period before a "next" service can begin • Intended for the purpose of transportation • Limited to daily 'follow up' or 're-evaluation'

Roles & Responsibilities

See *Appendix C-5* for a link to MCI Performance Specifications.

The MCI clinician is primarily responsible for Clinical Evaluation, including

- Conducting a mental status exam
- Assessing crisis precipitants, including psychiatric, substance use, educational, social, familial, legal/court related, and environmental factors that may have contributed to the current crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication)
- Assessing the youth's behavior and the responses of parent/guardian/caregiver(s) and others to the youth's behavior
- Assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the youth's behavioral health needs
- Taking a behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care
- Assessing medication compliance and/or past medication trials
- Assessing safety/risk issues for the youth and parent/guardian/caregiver(s)
- Taking a medical history/screening for medical issues
- Assessing current functioning at home, school, and in the community; Identifying current providers, including state agency involvement
- Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the youth and parent/guardian/caregiver(s)
- Solution focused crisis counseling; Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support
- Clinical interventions that address behavior and safety concerns, delivered onsite or telephonically for up to 7 days
- Arranging for psychiatric consultation and urgent psychopharmacology intervention (if current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face, or by phone from an on-call child psychiatrist or Psychiatric Nurse Mental Health Clinical Specialist

The Family Partner or Bachelor's Level Clinician is primarily responsible for

- Increasing the credibility of the team by diversifying the apparent experience, culture, gender, age or styles offered.
- Focusing primarily on the parent/caregiver. This is the priority relationship. Any work that this team member does with the child is peripheral. It is easy to lose focus on the parent experience and when that happens, it has an impact on resolution for the youth. For example, if both team members put their attention on the youth's experience, parents may feel "double-teamed" or as if they are being "talked into" something. This may lead to resistance about a recommended decision or it may compromise parent/caregiver trust in the recommendations.

- Attending to the experience of parents and caregivers as they navigate the crisis services process and support/make decisions for their children;
- Helping parents/caregivers process the trauma of having a child in crisis and the isolation of having cared for such a child or adolescent for some time, so the adult caregiver can function more comfortably in choosing disposition and safety planning.
- Empowering the parent/caregivers by emphasizing their agency in decisions made for minor children, and sometimes advocating for parental rights vis-à-vis other systems.
- Collecting and disseminating information on non-categorical resources such as special education advocates, insurance free social services, legal aid, psychoeducational websites, free and fun community activities – all this to reinforce family strengths, enable Masters level clinicians to focus on clinical matters.
- To advocate within the agency for parental voice and choice in general and in specific cases where cultural or clinical prejudice may be holding back the participatory decision-making process.
- This team member assures that at least some discussion of self-care is offered to every parent/caregiver.

Although the primary focus of the Bachelor's Level Staff person during an MCI intervention is attending to the experience of the parent/caregiver, the use of the title "Family Partner" is reserved for a person with lived experience as parent/caregiver of a child with a behavioral health condition and who uses that experience to inform their intervention and support.

- Supporting the parent/caregiver so that they may obtain needed information, consider viable options, meet the families' needs and make informed decisions during the crisis intervention.
- Understanding the situation through the parent lens and assuring that perspectives/information and preferences are understood and honored when possible. Parents/ caregivers are experts on the needs of their children and families and listening carefully to and understanding what is behind any emotion, stance or strongly-held belief is important in crisis resolution and treatment planning.
- As applicable, Family Partners are responsible for using selective disclosure with the intent of supporting the parent/caregiver.

The experience of the parent(s)/caregiver(s) when a child is in crisis is very different from, and is as important to understand as the crisis experience of the child. It can be an overwhelming, unfamiliar, confusing process and parents may have little experience making decisions about mental health and substance use treatment. Yet the nature of crisis means they are often asked to do so in a short period of time. Attending to the parent(s)/caregiver(s) experience, immediate needs and current (crisis-impacted) state of functioning is critical.

- Crises are often unexpected and, in addition to supporting the child who is in crisis, parents and caregivers may be simultaneously trying to figure out child care for siblings, transportation

arrangements, and permission to be away from work among other significant and time-sensitive priorities.

- Parents may be feeling frightened, stunned, angry, sad or relieved. They may be questioning providers and disbelieving of what they are told. They may be wondering if they missed signs of a pending crisis.
- Overwhelming emotions (guilt, confusion, wariness, and trauma) combined with unfamiliar events can make it hard for parents to fully participate in informed decision making, so efforts to lessen the emotion and to help them regain high cognitive functioning is a priority.
- This specific attention to the experience of parents within the MCI service is stabilizing and can be change-activating. When parents/caregivers are activated to take a lead in their child's care, there is more effective use of and adherence to any subsequent treatment or safety plans.
- The experience of parents/caregivers is very individual and is based on a number of factors including whether this is a first crisis experience or one of a series of crisis experiences; previous experience and satisfaction with the behavioral health system, the age of the child (this can be particularly complex for parents of children who are 18 and older); cultural factors, and experiences of other stigma or support.
- Parents/caregivers who are not connected to existing service providers may need additional support and assistance from the MCI team in making those connections and identifying appropriate and preferred next steps in accessing needed care.

The unique expertise of the Family Partner

Family Partners bring a unique perspective to MCI interventions because an essential qualification for the role is that a person must have "lived experience" as a parent/caregiver of a child with a mental health condition.

- Family Partners have experience navigating the behavioral health treatment system and have often had personal contact with other youth-serving systems.
- Family Partners understand common experiences of parents/caregivers because they have been in similar shoes.
- They have likely felt the impact of stigma, blame and shame.
- They may have had periods of isolation and limited social supports and resources.
- Family Partners understand the chronicity of conditions and symptoms that children can experience, such as sleeplessness, sadness, unpredictable behavior, falling behind or being disruptive at school, having thoughts about harming themselves or actual attempts to do so.
- Family Partners also learned through their own experiences strategies for coping and self-care, for finding peer support and advocacy, for accessing resources, and finding hope in the midst of crisis.
- Family partners may have experienced the intermittence of behavioral health symptoms, and understand that parents/caregivers cannot predict behavior or identify triggers that clinicians and others may expect them to know.

Family Partners purposefully use and share their lived experience when it is useful to a parent/guardian of a child in crisis. *It can be incredibly helpful and for some parents/caregivers, as it is rare to talk to someone else who has lived it. This type of peer-to-peer support is an innovation in the behavioral health crisis field and is supportive, stabilizing, empowering and change-activating.*

Signs that the Family Partner role when delivering MCI services is off-track

- Quasi clinician (double-teaming)
    - When a Family Partner assumes a clinical role a parent can feel double-teamed/ganged up on
    - A parent partner may be expected to "talk a family into" a disposition that the family doesn't want
    - The family misses the opportunity to receive real support
- Assistant to the clinician
    - The role is feeling secretarial/administrative
    - The strategy was to divide up the clinicians historical tasks rather than to build out the new set of parent partner tasks (i.e. the parent partner being responsible for making all referrals)
- Assuming hierarchical roles
    - Yes, each team member has unique responsibilities and ultimately there are decisions that have to be made
    - But, it is risky to hold one discipline's perspective as higher than another
- Family Partner assuming a parent should address crisis the way he/she did
    - Children and families need to find their own best solutions—what seems doable, achievable, aligned with preferences
    - Goal is to create a climate for change as it is meaningful for the parent/family
- Taking sides
    - Blaming
    - Holding to positions (it is important explore what is behind position, seek higher level understanding)
    - Voting
- Failure to prep, intervene and debrief as a team
    - Silos of thinking inside the team are inefficient and irritating
    - Avoid "going around"—commit to collaborating with and working through the rough spots

Resolution and Relief as Goal of MCI Service

The goal of MCI is that youth and their family members experience crisis relief as early as possible and achieve some resolution to the crisis. Crisis <u>resolution</u> and crisis <u>disposition</u> are not the same thing. Disposition is about what happens next—it is important, but it is not in and of itself resolution. Resolution is about youth and families experiencing relief, feeling better, gaining new understanding or insight, feeling more hopeful, coming up with ideas for solving problems, and getting clearer about

what to do next. Resolution is evident in body language, in reported and visibly improved mental state and functioning. Language changes will be evident as well and may include expressions of hopefulness, creative problem solving, future positive planning, and change/activation talk (*i.e.,* "I am ready to do this" or "I am capable of /feel good about taking this action").

MCI teams use a number of intervention techniques to create the climate for crisis resolution. Common elements of effective interventions include

- Strength-Based Interventions
- Use of change-promoting language
- Strategies to avoid power struggles
- Frameworks for understanding phases or stages—and using interventions that are stage-consistent
- Person and family-centered approaches
- Culturally-informed approaches
- Shared Decision-Making
- Empowerment of youth and parent/caregiver to navigate the system more easily in the future

Resolution-focused interventions are a key in shifting practice away <u>from</u> a level-of-care determination and <u>toward</u> an intervention that, when effective, reduces the need for higher levels of care. Effective teams seek to understand and address the nature of the crisis—not so much the facts, but the essence (grief, anger, pain, loss, desperation, helplessness, boredom). When solution-focused and problem-solving techniques are woven into the assessment and mental status exam, the intervention becomes focused not on "pathologizing" but on identifying solutions. The approach promotes exploration of context and increased awareness about the essence of the crisis and aids a person in shifting from an emotive (overwrought, stuck, numb, chaotic) state to a cognitive (learning, planning, problem solving) state. If the shift is NOT sufficiently forthcoming and risk remains high, it can serve to clarify to all parties the potential need for a more intensive level of care.

Effective teams believe in the ability of people to recover and they consistently seek to harness the strength and expertise that exists within each child and family member. They understand that the optimal resolution is the one that feels right to the youth and family—it is aligned with personal values, preferences and priorities as well as cultural values. Effective teams strive to preserve youth and family dignity, even in the toughest moments by respecting perspective, stage of readiness, and choice. MCI teams understand the <u>human</u> elements of any situation.

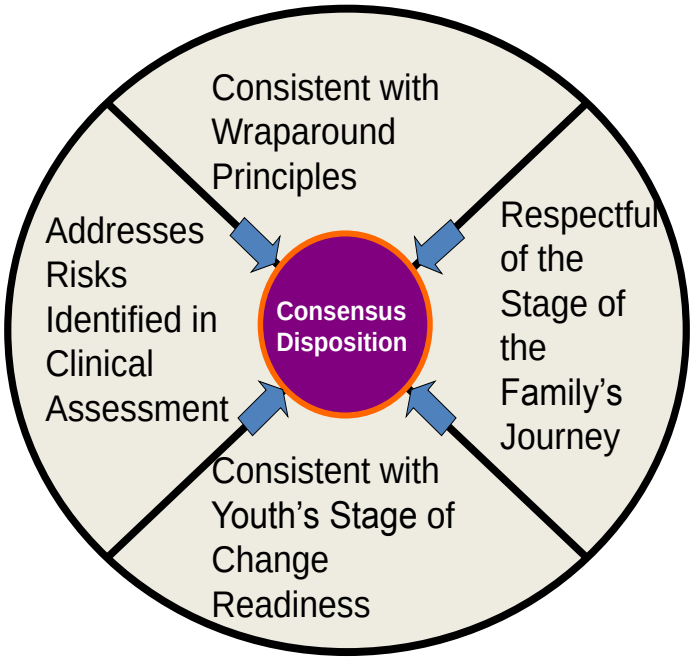
By abandoning an "I, the expert, know best" model of care, effective teams are consistently moving toward becoming collaborative and consultative. They promote Shared Decision Making and preserve the rights of individuals to consider the pros and cons of any formal, informal and natural treatment/support options and to take risks. The result is mutual responsibility.

MCI teams are asked to pay attention to multiple considerations simultaneously. Certainly, they are attending to the <u>risk</u> identified in the clinical assessment. MCI teams understand that risk evaluation is

complex and related not just to the presenting problem but also to the risks and benefits of any considered solution or treatment. Hospitalization, for example, is often used with the intention of reducing risk. So it is important for the team to consider, together with the youth and family, if there are any potential risks of hospitalizing the youth, and then consider if the potential safety gains outweigh those safety risks. This starts a new level of conversation: are there alternatives—formal, informal, or natural—that could be considered instead of hospitalization, which feel to the youth and parent(s)/caregiver(s) like a better fit? Is there consensus agreement (including clinical agreement) that the alternative is likely to aid crisis resolution while reducing risk to a level that is acceptable to all?

Teams also consider the family context and journey of the parent(s)/caregiver(s) and youth. In addition to the crisis itself and any presence of a mental health or substance use condition, might there be grief, trauma, depression, anger, shock about the situation or illness? Doubt or denial about a diagnosis? Are the parent/caregiver and/or youth leery of using formal treatment services? Is instinct telling the parent/guardian that this is primarily a school issue and thus something that cannot be solved with formal treatment services? Has one or more family members had previous negative crisis or treatment experiences? Do youth and family members have other thoughts on how to address the condition that are more in keeping with their own traditions, beliefs and preferences?

The MCI team identifies and explores issues such as the above and recognizes the significance of barriers, such as a low level of trust, treatment ambivalence, resistance, and not agreeing with a diagnosis. These are normal, protective, instinctual human reactions. Teams recognize that these reactions are not an indication of parental neglect, a youth's disinterest in getting better or willful "non-compliance." Teams increasingly recognize that these are signs that there is something important—from the viewpoint of the youth or parent/caregiver—that must be understood, and that any success in doing so has a direct and positive impact on both crisis resolution and adherence to any future care.



[1] Parent/caregiver readiness, especially with younger children, is very important and can be positively impacted when the MCI intervention is skillful and effective, recognizes and addresses parent/caregiver concerns, and offers collaborative solutions and next steps.

Another simultaneous consideration for teams is the youth's readiness for change. Lasting change cannot be externally imposed. And as much as the team (and parents/caregivers, schools, etc.) would

like behavioral change to be instant, it just isn't how human beings are wired. The "Stages of Change" Model was originally developed in the late 1970s and early 1980s by James Prochaska and Carlo DiClemente[4]. The model recognizes that change is a multi-step process that is highly individualized. Change occurs at a different pace for different people and is connected to complex thoughts, beliefs and behaviors. For the intervener, the challenge is to recognize the current stage of change and to use interventions and set goals that are stage-consistent. Teams are careful not to push youth and families into treatment for which they are not ready or interested, and thus are not likely to stick with or benefit from it.

If a youth is "pre-contemplative" (unaware, uninterested) in making a change, likelihood is low that he/she will participate meaningfully in formal treatment even when it is inpatient or forced. When imminent risk is not a factor, MCI teams may take a more longitudinal view and deliver stage-consistent interventions, such as helping a youth see the discrepancy between how he/she would like life to be and how it is. It may be that after a couple of crisis encounters, motivation for change and interest in treatment will be stronger. Meanwhile, the team has met the youth "where he/she is" and hopefully built some credibility and rapport that will pay future dividends. Engagement at a level that fits the family/youth may be a better investment in future outcome than a trial of more intensive response that is a "deal-breaker." NOTE: when risk is high, placement in a 24-hour, staff-secure setting may be necessary even if likelihood of sustained change is low.

Finally, MCI teams are delivering the work in the context of Wraparound Principles of Care.[5] The principles are woven through all CBHI services and represent a framework that promotes youth and family-centered and family-driven care. They are important in MCI whether the family is actively involved in a service such as Intensive Care Coordination (ICC) that provides fidelity Wraparound Care Planning; or if it is a youth/family experiencing a crisis situation for the first time.

The Principles are

1. Family Voice and Choice
2. Team-Based
3. Natural Supports
4. Collaboration
5. Community-Based
6. Culturally Competent
7. Individualized
8. Strengths-Based
9. Persistence
10. Outcome-Based

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[4] For more information on the Stages of Change model (also called the Transtheoretical Model or TTM) and links to a summary of Prochaska and DiClemente's work go to www.samhsa.gov/co-occurring/topics/training/change.aspx.

[5] U.S. National Wraparound Initiative http://nwi.pdx.edu/

Paying attention to each of the considerations described in this section–risk, youth/family journey, change-readiness in the context of wraparound-consistent principles of care–increases the likelihood of crisis resolution and consensus on any future plans. The bi-disciplinary makeup of the team promotes adherence to this sophisticated model of care.

MCI Services for Transition-Age Youth (18-20)

CBHI Services
All CBHI services are designed for persons up to the age of 21, so if the service is covered by the person's MassHealth plan and medical necessity criteria are met, the MCI team in conjunction with the young adult should consider the full array of CBHI treatment options.

Delivering MCI services to Transition Age Youth is different. In most circumstances, individuals ages 18-20 are not under guardianship and therefore are able to sign consent for treatment, have the right to determine if and how their parents (or others) participate in their treatment, and will make decisions about future treatment. If the individual experienced a childhood full of "forced" treatment (*i.e.*, DCF or DYS system involvement, prescribed unwanted/not useful medications, received diagnoses that didn't make sense) then there may be significant treatment reluctance. For individuals newly diagnosed, stigma can be a significant factor leading to a significant gap in treatment involvement that may last many years and cause cumulative harm.

Collaborative, authentic engagement and empowerment are important outcomes. Developmentally synchronous priorities of transition-age youth often boil down to vocation/employment, independence, stable housing, healthy relationships and community participation. Reconnecting with parents and family can be a priority for youth who were removed from home during childhood. All of these "non-traditional" priorities can lay the groundwork for stabilization. Decisions on formal treatment are made by the individual—so it can promote trust to put that on the table up front: *"I can let you know what services you qualify for, if you would like to hear about them. The choices are yours. What seems right for you right now? What would you like to hear more about? This is not a one-time opportunity—we are ready when you are ready to explore options…"*

Access to Adult Community Crisis Stabilization (CCS) Service
Each ESP operates an adult CCS program that provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older; including youth ages 18-21, under the Children's Behavioral Health Initiative (CBHI).

Guided by the treatment preferences of the individual, CCS staff actively involves family and other natural supports at a frequency based on individual needs. Treatment is carefully coordinated with existing and/or newly established treatment providers. In the case of Transition-Age Youth who are

involved with, or who are referred for, CBHI services – including ICC – CCS staff will accommodate and participate in team meetings. (See *Appendix C-1* for a link to adult CCS Performance Specifications.)

Collaboration with State Agencies

Transition-Age Youth may be receiving or may be eligible to receive services from the Department of Mental Health (DMH) or the Bureau of Substance Abuse Services (BSAS), which is a program under the Department of Public Health (DPH). MCI teams collaborate with these service agencies to mutually assure that needs of Transition-Age Youth are met. This type of collaboration should actively include the person receiving services in a shared decision-making process so that he/she has an understanding of options, pros/cons of the various choices and can decide on the "right fit" for him/her.

ADDITIONAL RESOURCES

See *Appendix C-14* for a link to additional resources for Transition Age Youth.
In addition the Parent Information Network (PIN) has an extensive repository of Massachusetts resources for transition age youth. The website is www.tayatpin.org.

See *Appendix C-15* for a link to the Department of Mental Health Guide to New and Current MassHealth Behavioral Health Services and Protocols.

See *Appendix C-16* for a link to the Department of Public Health Guide to New and Current MassHealth Behavioral & Bureau of Substance Abuse Services Protocols.

Safety Planning / Crisis Planning Tools

Each ESP/MCI team has five primary responsibilities related to safety planning and use of Crisis Planning Tools.

1. Introducing youth and parents/guardians to the concept of safety planning and assisting them in the completion of tools that are meaningful to them
2. Receiving and storing any of the Crisis Planning Tools or similar documents received from ICC, IHT or other service providers OR received directly from youth and parent(s)/caregiver(s)
3. Retrieving any of these tools or similar documents and using them during triage calls and MCI intervention services
4. Updating tools during subsequent crisis encounters, or if a youth is linked to treatment, recommending updates to the lead service provider
5. Providing Safety Planning services outside of an MCI encounter as requested. Examples of when this may be requested include
    a. Youth who are discharging from a 24-hour level of care;
    b. Youth residing in a staffed treatment or detention facility; and
    c. When parent(s)/caregiver(s) or outpatient treatment providers recognize risk of a future crisis.

As part of each MCI encounter, teams assess and explore the safety needs of the youth and family. With the consent of and in collaboration with the youth and family, the MCI team guides the family through a crisis planning process that is in line with the family's present stage of readiness for change. This includes introducing the three components of the Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan) where appropriate and in accordance with the Companion Guide for Providers.

See Appendix C-4 for a link to the Safety Plan that is used for all youth newly enrolled in ICC, MCI, and IHT, as well as for the other Crisis Planning Tools (Advance Communication to Treatment Provider, Supplements, and the Companion Guide for Providers that details strategies for planning with families and includes sample plan documents).

As the family chooses, Mobile Crisis Intervention engages existing service providers and/or other natural supports to share in the development/update of the Crisis Planning Tools (*e.g.*, ICC, In-Home Therapy Services, outpatient therapist). The tools are reflective of action the family believes may be beneficial. This may include, but is not limited to, the following.

- Contacts and resources of individuals identified by the family who will be most helpful to them in a crisis, including emergency contacts and other non-guardian family members;
- Goal(s) of the Safety Plan or other Crisis Planning tools as identified by the family;
- Action steps identified by the family; and
- An open format (the Safety Plan) that the family can choose to use as needed.

If a youth has an existing set of Crisis Planning Tools, MCI teams help the youth/family to utilize the tools as they apply to the current situation and/or reassess the tool's effectiveness. There should never be duplication of Safety Plans—one youth, one plan. MCI may, however, collaborate with the youth and parent /caregiver(s) and other provider(s), to build consensus for revisions to the tools and to share them as directed by the family. It is then the job of the lead (ICC, IHT, etc.) provider to work with the youth and parent(s)/caregiver(s) to make any revisions.

The Safety Plan details the youth and parent(s)'/caregiver(s)' chosen approach to crisis prevention and management. It is reflective of action the family believes may be beneficial. The goal of the Safety Plan is to support and promote a family's competencies in reducing risk in a manner that is authentic and individualized to them. The Safety Plan is consistent with a family/youth's readiness for change, insight into behavior, and self-defined priorities, and it incorporates their interest and comfort with the use of natural and clinical supports. The Safety Plan is a tool used by families to reduce or manage worsening symptoms, promote wanted behaviors, and prevent or reduce the risk of harm or diffuse dangerous situations.

The provider is not the "leader," "expert," or "the one who knows best" about how to manage risk in a particular family. Rather, the provider's role here is to facilitate, guide, and empower the youth/family in the creation of a Safety Plan that reflects not what the provider necessarily wants the youth/family to do but rather what the youth/family will actually do in the event of a crisis. Here is where the provider must work jointly and collaboratively with the person/family to reconcile the clinical "best

case scenario" with a customized Safety Plan based on the youth's/family's natural ecology and culture. As such, providers are the collaborators in the creation of a real working tool – not just another paper, which then must be completed as part of a crisis episode or assessment process.

The result should be a Safety Plan that is authentic, meaningful, usable, and "person/family-owned." As applicable, the planning process and the Safety Plan should serve to strengthen bridges within the family, the informal support network, and the formal treatment network—and leave a person, parent/guardian, or young adult optimistic that they have a better strategy for "next time."

It is the youth's/family's Safety Plan developed through their eyes, for their benefit, and in accordance with their own strengths, resources, and perceptions of what they reasonably think might work now. Safety self-management skills develop over time, and Safety Plans will evolve accordingly as children, parent(s)/caregiver(s) and Transition-Age Youth figure out what works and what doesn't work—uniquely, idiosyncratically, "for me, for now." Most Safety Plans will not work perfectly, especially the first time, and it is important that families are empowered to understand this. There are so many variables in circumstances and human behavior is complex, so it is reasonable to expect that things will not go as planned. The instinct of family members to use what works remains a valuable ingredient in managing the current crisis, and, in retrospect, their observations of what worked and didn't work are invaluable in improving the Safety Plan for next time.

In summary

1. MCI teams must be equipped to offer and provide safety planning and development of any or all of the Crisis Planning Tools 100% of the time as laid out in performance specifications.
2. Individual/family voice and choice guides the “if, when, what, and how” of using any of the Crisis Planning Tools.
3. Though a copy should be kept in the clinical record, Crisis Planning Tools are <u>family tools</u> rather than part of required standardized clinical documents.
4. As such they can be flexibly used to meet the person’s/family’s needs, or replaced by an alternative format that is meaningful to the person/family.
5. Plans that are filled with things that the provider thinks they should do will give them a false sense of confidence that the risk of harm is reduced.
6. If the family won't do it in a crisis, it does not reduce risk of harm and it should not be on the Safety Plan. This means that some plans are very brief and some youth/families don’t have plans.
7. Filling the plan with actions that a child (or anyone else) is unlikely to take diminishes the authority of the parent, as well as the credibility of the plan. Attempts to implement this kind of plan may actually escalate the household rather than reduce risk or unwanted behaviors.
8. Remember
    - If a family is not ready for much, the plan should not include much.
    - The choice belongs to the family.
    - Build an authentic relationship that respects where the family members are now.

    - When the family members are ready for more, our program/resources/etc., are ready too.
9. A wide range of ways exists
    - to decrease unwanted behaviors,
    - to improve management of a crisis, and
    - to reduce risk of harm.
10. The "right" solutions, actions, strategies are unique to an individual/family.
11. What I think is "good" for you and what you think is "good" for you are often very different.
12. Safety plans can and often should be revised over a multi-day MCI intervention. A family may only be able to do a partial plan on day 1 or a plan for 24 hours, and then may be able to revise and more fully participate in short, medium, and long-term crisis planning after they have experienced some relief.

NOTE: If the youth and/or family choose to not use any of the crisis planning tools (and they do not already exist) an explanation of their choice must be documented in the ESP Child/Adolescent Comprehensive Assessment Tool.

Additional Crisis Stabilization Services for up to 7 Days

Following the initial intervention, the MCI team in collaboration with the youth, parent/guardian and existing service/system providers may decide on a continued course of MCI team services for up to 7 days. This expanded period allows families and teams considerable flexibility to develop a youth/family-specific strategy for crisis resolution, safety planning and practicing, exploration of options and care coordination. If at any point during that period the intervention is not sufficiently resulting in relief/reduction of risk, a referral to a more intensive level of care may be necessary.

The MCI service definition (see *Appendix C-11* for a link to the definition) is written to allow wide flexibility in providing services to youth and families beyond the initial assessment and course of resolution-focused interventions. MCI encounters can and should vary in length and intensity as indicated by the need and plan.

In order to determine the appropriate length of service, MCI providers should describe the range of supports and service options available during an extended MCI encounter, thereby supporting youth and families ability to understand and evaluate the benefits of these interventions and make an informed decision about whether to avail themselves of these options.

The service's flexible timeframe allows MCI providers to

- Deliver repeated, face-to-face crisis counseling and telephonic support to avoid a re-escalation of the initial crisis
- Initiate and support referrals to new service providers
- Consult with existing providers regarding the outcome of crisis interventions
- Test drive strategies; and practice de-escalation techniques with youth and families
- Evaluate, refine and disseminate the Safety Plan

- Harness natural supports to assist in crisis prevention
- Provide assistance and resources to support navigation of service systems

Extended MCI services can also benefit youth and families who may be unsure about the need for or appropriate course of future treatment interventions, by

- Deferring decision-making until needs and preferences are clear
- Considering and exploring various treatment options
- Gaining clarity/resolving ambivalence about important decisions such as using a particular treatment service
- Receiving engagement services (perhaps over several crisis episodes), for children/families/Transition-Age Youth who may be reluctant to enter formal treatment

Extended MCI services allow the youth/family-inclusive team to

- Consult with MCI staff and discuss future strategies for crisis prevention
- Meet with treatment providers, schools or other systems regarding updated safety plans and crisis prevention tools
- Do some "watchful waiting" before making a decision to hospitalize to see if the crisis will diminish or resolve using a less-restrictive strategy

Throughout the episode, the MCI service remains bi-disciplinary and either or both team members can deliver services within the scope of their role and licensure as it fits the need. The extended service remains inclusive of a wide array of face-to-face and telephonic assessment, stabilization, and intervention, collaborative and resolution-focused activities. Teams should not be in the habit of assigning all post-initial intervention services to one discipline (*i.e.*, *"Family Partners are responsible to provide the follow up services")* or the other as it narrows the options and may impact results for youth and families.

Routinized or perfunctory follow-up (for example, making a follow-up call to <u>every</u> family as a business rule, rather than as individually determined) is to be avoided. It is a habit/practice that

- Is agency-centered, not family-centered
- Conflicts with Wraparound Principles of Care
- Can be experienced as artificial, unhelpful and even bothersome by families
- May reduce a family's willingness to seek future crisis services

At any point during the "up to 7 day" episode, MCI teams may seek psychiatric consultation and urgent psychopharmacology services when indicated and not otherwise available.

<u>There are no daily caps on the number of hours provided during the "up to 7 day" service episode as long as the activity is eligible based on the Service Definition and Medical Necessity Criteria.</u> The nature and scope of MCI services beyond the initial assessment and course of crisis intervention are determined through Shared Decision-Making (youth, parent/guardian, MCI team, and other providers). In general the decision to extend the service episode is

- Mutual
- In the service of the child and parent (Youth/family-centered rather than program-centered)
- Individualized
- Refined and reframed along the way as clarity is reached and progress is made

Ending the MCI Encounter

The MCI encounter ends when

- The youth and family have experienced sufficient relief and resolution.
- A discussion of next steps has occurred and any agreed-upon follow up has been arranged.
- An existing provider is in place and able to continue the stabilization work with the family.
- There is no longer a crisis context for delivering the services.
- Consent for treatment is withdrawn and there is no court order requiring such treatment.
- The youth is admitted to a hospital or other 24-hour level of care.
- Medical Necessity Criteria is no longer met.

See *Appendix D* for a Decision Algorithm on continuing/ending the encounter.

At the conclusion of an MCI encounter, teams should ensure that the youth, parent/caregiver have copies of any revised Safety Plan, that the plan has been disseminated to other providers or entities requested by the youth/guardian, that the youth has access to desired home-based services; and that the parent/caregiver understand how to request crisis services again, as needed.

Referrals for Treatment or Other Services

Although MCI teams must be prepared 100% of the time to offer referrals and linkage to aftercare services as a part of the MCI encounter, it will not and should not happen 100% of the time—either because there is no need or because the youth and parent(s)/caregiver(s) choose otherwise. The need for or interest in additional services must be discussed and not assumed—this is a fundamental part of delivering youth and family-centered care, and very different from a "provider knows best" approach. At times MCI can be an effective "end service," having sufficiently addressed risk and resulting in resolution. As an outcome of the "resolution" youth and parent(s)/caretaker(s) will often have gained new knowledge and insights, identified new strategies and/or have changed the way they look at a situation, and they may feel ready to carry through on their own.

> *"We would like to discuss this further and try out these ideas ourselves before making a decision about formal treatment."*
>
> *"Now that it is clear to all of us that the problem times are the hours right after school, we would like our daughter to explore some after-school activities she thinks she would enjoy. This will reduce the period of time when she is home alone, in a way that is fun."*

That a youth meets criteria for a particular level of care does not compel his/her participation in it. Nor is it inherently neglectful of a parent to decline a treatment service. No behavioral health services

have proven to be 100% effective, so the use of Shared Decision-Making is very applicable. Yes, youth and parent(s)/ caregiver(s) should receive the information so they can make an informed choice. However, if they choose to address the issue differently—such as through the use of informal or natural resources, self-education, self-care strategies, or homeopathic approaches—that is their prerogative.

> *"It is clear our son finds the idea of counseling embarrassing and we want to respect his feelings and see if we can foster relationships with trusted adults that can serve some of the same purpose."*

Listening to, exploring the reasons behind, and respecting the wishes of youth and parents in the current episode makes it more likely they will choose to come back if needed in the future. At that point, they may be more open to exploring treatment options.

The ESP Child/Adolescent Comprehensive Assessment Tool has a section for the clinician to document. These options include

- No services needed at this time
- (Youth family choose) Natural/community supports
- Youth/guardian decline future services at this time

MCI teams should note services that are offered and declined, but avoid using language such as "family refused," which can be misconstrued as a sign of neglect or non-compliance instead of a youth or parent/guardian choice.

Many if not most youth and parent(s)/guardian(s) will need and be interested in further services and MCI teams work with them to consider an array of formal, informal and natural services and facilitate conversation about youth/family-specific pros and cons of the options. This may include topics such as concerns around privacy, what to tell schoolmates, fears, program structure, rules, costs, treatment participation, etc. Exploration of these topics allows youth and parent(s)/caretaker(s) to explore ambivalence, gain clarity in purpose, and get prepared to participate in a meaningful, informed fashion.

Some are MassHealth-covered CBHI services, and some are provided by private practitioners, social service agencies, religious organizations, or peer or family-run businesses, to name a few.

24-Hour Level of Care

If the disposition from the MCI intervention is a medically necessary, acute 24-hour behavioral health level of care (e.g., Crisis Stabilization, acute inpatient hospital, community-based acute treatment (CBAT), or intensive community-based acute treatment (ICBAT)), MCI

- Explains the recommended disposition to the youth and parent/caregiver and educates them about the level of care, choices of service providers and what they can expect, etc.
- Obtains authorization as needed
- Arranges transfer and admission to an appropriate facility

- Consults with the receiving provider to assist the receiving provider to develop a plan for stabilizing the crisis that was addressed by the Mobile Crisis Intervention
- Sends the comprehensive assessment to the hospital or other 24-hour level of care ASAP

Community-Based Acute Treatment (CBAT)
CBAT, as it is currently delivered and defined in the medical necessity criteria and performance specifications, can assist MassHealth Members age 17 and younger who are experiencing a psychiatric crisis and require a short out-of-home placement. Existing CBAT program specifications require that CBAT services are delivered to children/adolescents based on medical necessity, and therefore the course of treatment and corresponding length of stay is based on the youth's clinical presentation and progress. The program specifications also require CBATs to be actively involved with the parents/ guardians/caregivers and community-based providers to successfully transition the youth back to the community.

See *Appendix C-3* for a link to CBAT Performance Specifications.

Community Crisis Stabilization (CCS)
As indicated earlier, CCS provides voluntary, staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that serves as a medically necessary, less restrictive and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18 to 21, under the Children's Behavioral Health Initiative (CBHI).

Treatment in the Community
If the plan is for a referral to a CBHI hub service such as **Intensive Care Coordination, In-Home Therapy, or Outpatient therapy,** the MCI team

- Arranges an appointment with the hub service provider in the youth's service area;
- Coordinates with the hub service provider for up to 7 days to ensure that the youth is receiving the medically necessary services.

In addition, if the youth may benefit from one of the hub-dependent services, including In-Home Behavioral Services (IHBS), Therapeutic Mentoring (TM) or Family Support and Training (FS&T), the MCI team consults with the current hub provider and the parent/caregiver and makes a recommendation for consideration of the hub-dependent service.

Other Services

- MCI teams have a working knowledge of the medical necessity criteria and performance specification for all MCE's levels of care, including the CBHI service, and provide families and youth with information about what to expect from services they are linked to.

- Mobile Crisis Intervention identifies all other necessary referrals and takes necessary steps to assure linkage to medically necessary behavioral health services and supports (such as services through DMH natural supports, parent support services, community resources) and facilitates referrals and access to those services.

- Mobile Crisis Intervention also works with the youth's health plan to arrange for dispositions to all levels of care, including inpatient and 24-hour services, diversionary services, outpatient services, and ICC.

Simply making a referral for an aftercare service does not meet the criteria for ensuring that the youth and his/her parent/guardian/caregiver(s) have established a connection with a provider. Rather, MCI providers should strive[6] to (1) identify aftercare providers with available capacity; (2) confirm that an intake meeting is scheduled consistent with applicable service access standards; and (3) follow-up with both the family and provider to ensure that services will be delivered promptly. Finally, MCI providers should determine, in conjunction with the family and aftercare service provider, whether any additional information or safety planning/crisis support is needed to support the intake and assessment process. If the parent or guardian declines aftercare supports and services, this must be clearly documented in the youth's behavioral health record.

With required consent, the MCI provider should send copies of these documents to all necessary providers, as identified by the youth and parent/guardian/caregiver. This might include state agency, school, and juvenile justice personnel. It is especially important that these documents are sent to receiving providers of 24-hour level of care services and/or aftercare treatment providers ASAP.

Massachusetts Behavioral Health Access (MABHAccess) website

The MABHAccess website is designed to enable behavioral health and health care providers to locate potential openings in mental health and substance use services for the purpose of referring individuals to those available services. ESP/MCIs and hospital emergency department staff are able to search for available 24- hour levels of care. Youth, families and other stakeholders such as state agency staff are also welcomed to utilize the website to locate those CBHI services that they can access directly from the community.

There are currently two groups of services that are available on this website: CBHI Services and 24-hour levels of care. Please refer to each of these sections below for details about who can search for openings in these services and how to do so. The services that are able to locate using this website may expand over time. See *Appendix F* for the link to the MABHAccess website Users Guide.

[6] It is acknowledged that this is not fully in the control of MCI teams. However, there is mutual responsibility among MCI teams, CBHI, and other ongoing service providers to address issues of referral practices, capacity/demand, and wait-list management, including developing strategies to secure follow-up specific appointment dates and times during the course of an MCI service.

MCI Care Coordination

MCI teams are highly dependent upon relationships of the cross-system/sector group of professionals that refer TO and receive referrals FROM the team. MCI teams are expected to develop and continuously build upon relationships with key partners.

Building cross-system/sector knowledge

- Developing mutual protocols for communication, transfer of information referral practices, and what to do if there is a break down in the process
- Establishing point-person relationships across programs/systems/sectors

"Crisis System of Care" thinking is woven into CBHI service definitions and performance specifications in a number of ways. First, all of the services are delivered in accordance with Wraparound principles of care. Secondly, there are cross-cutting themes and expectancies across services in two key areas, Care Coordination and Crisis Management. By level of care, there are crisis-specific Performance Specifications related to

- Access
- Responsibility for Providing Intervention
- Continuity of Care
- System Collaboration
- Post-hospital services

For Youth engaged in an ICC or IHT hub service

ICC and IHT teams are available to provide face-to-face crisis response to youth and parent(s)/caregiver(s) from 8AM to 8PM, Monday through Friday, and offer telephonic crisis support during other hours. If the crisis isn't sufficiently resolved or addressed, ICC or IHT team members may then initiate an MCI referral as needed.

NOTE: This should not be construed as a requirement that families must go through ICC or IHT teams before accessing MCI services.

If an ICC or IHT-connected youth/family is first seen by an MCI team, the team, with consent, contacts the ICC and IHT team as soon as possible so they may participate in the intervention and planning ICC; and IHT providers are available 24/7 by phone or pager to answer calls from Mobile Crisis Intervention. Mobile Crisis Intervention coordinates with the ICC provider throughout the intervention. MCI teams should generally defer any decision to add new services to the youth/family-inclusive Care Planning Team. Minimally, MCI conducts at least one phone call or face-to-face meeting with the ICC or IHT hub provider and the family to coordinate care. If the hub provider is not responsive to MCI requests, or unable to put necessary services in place in a timely way, the MCI team should contact the youth and family's MCE for further guidance.

For Youth engaged in Outpatient Therapy hub service
For youth with Outpatient Therapy Services (or whom Mobile Crisis Intervention has referred for In-Home or Outpatient Therapy Services), Mobile Crisis Intervention conducts at least one phone call or face-to-face meeting with the provider and the family to facilitate the transition. If the hub provider is not responsive to MCI requests or unable to put necessary services in place in a timely way, the MCI team should contact the youth and family's MCE for further guidance.

MCI Collaboration with State Agencies

MCI teams will interface with a number of state agencies in the course of providing intervention, stabilization and linkage services to youth and parent(s)/caregiver(s). Careful planning and coordination is indicated when youth served by the MCI team are in the custody of, or receiving services from a state agency. Practices should promote least-restrictive treatment that is delivered early in the crisis in order to stabilize the crisis, preserve any placement, and reduce the need for movement to a higher level of care.
NOTE: Please refer to *Appendix C-13* for a link to the document that describes this protocol in full and entitled, *Protocol for Accessing Acute Behavioral Health Care Services for Youth Involved with the Department of Children and Families (DCF)*

For Youth involved with the Department of Children and Families (DCF)

a) General principles

- ESP/MCI is intended to assist with stabilizing and maintaining youth in their current living situation. The ESP/MCI provider will remain involved, as needed, for up to 7 days to support the youth and family in achieving this goal, when clinically appropriate. This may include providing services and supports to youth in foster homes or residential programs.
- The person(s) with legal custody (which may be DCF) has the authority to make decisions about a youth's psychiatric care.
- If the youth is enrolled in IICC or IHT hub, the ICC and IHT providers should be contacted immediately and involved throughout the Safety Planning and ESP/MCI processes.

b) Safety Planning

- Efforts should be made to avoid potential behavioral health crises by anticipating them through Safety Planning and related communication.
- For any youth in advance of a behavioral health crisis, the parent(s)/guardian/caregiver may contact the local ESP/MCI provider to request the development of a Safety Plan to assist in safely maintaining the youth in his or her current setting.
- MCI develops, in collaboration with the youth/family's team, a Safety Plan if the youth does not already have one. (See *Appendix C-4* for a link to Crisis Planning Tools, including the Safety Plan.)

c) Early Identification "Alert"

- Early contact should be made by the family, DCF staff, or provider with the local ESP/MCI provider, even before the parent/guardian/caregiver and/or members of the youth/family's team have decided that an ESP/MCI intervention is needed.
- The purpose of this advance communication is to identify youth who may require an ESP/MCI intervention in the near future. This enables the parent/guardian/caregiver and the ESP/MCI provider to engage in consultation around strategies to safely support and maintain the youth in his or her current location and plan for the potential ESP/MCI intervention, should it need to occur.

d) Location of Service

- The preferred location for the ESP/MCI encounter is the setting in which the youth is currently located, i.e., his or her home, school, foster home, residential program, etc.
- Another community-based option is the ESP/MCI community-based location. (See *Appendix C-6* for a link to the ESP/MCI Directory.)
- If the ESP/MCI provider and the caller agree that the ESP/MCI encounter with a youth needs to take place in a hospital emergency department (ED) for any reason, the parent/ guardian/caregiver will arrange transportation with the assistance of the ESP/MCI provider if needed.

e) Communication with residential staff

- For youth in DCF residential programs, it is expected that the ESP/MCI clinician will talk to the residential program staff, i.e., clinical and/or program director both before and after they assess the youth, to ensure there is clear communication, as well as an understanding regarding next steps.
- Maintaining a youth's continued stay in the residential or foster care program is the priority. MCI teams work with the staff or foster parents to identify stabilization strategies and safety plans that will allow youth to stay in his/her current treatment or foster care setting.

For Youth Involved with the Department of Youth Services (DYS)

NOTE: Please refer to *Appendix C-2* for a link to the document that describes this protocol in full and entitled, B*ehavioral Health Care Access, Quality, and Discharge Protocol for DYS and MBHP.*

a) General principles

- Though a youth may be in its **physical** custody, DYS never has **legal** custody.
- Parent usually retains legal custody although DCF may have legal custody of a youth who is also involved with DYS.
- The legal custodian needs to consent to treatment, medication, etc., if the youth is age 17 or younger.
- The location of the youth will influence the scope of the encounter

- DYS youth in the community will benefit from the full range of service provided by ESP/MCI.
- Those in DYS residential programs will primarily be provided with an assessment, recommendations for stabilization and crisis intervention, and disposition planning.

- DYS may request an ESP/MCI encounter in response to any behavioral health crisis in which they may identify a youth as being at risk to self or others. DYS most frequently will request an ESP/MCI encounter when a youth is suicidal or psychotic.

b) DYS Target Populations

DYS youth who require an ESP/MCI encounter, and possibly inpatient mental health services, may be described in the following three groupings. These descriptions of the youth and their circumstances may inform the actions taken by DYS and the response warranted by the ESP/MCI provider, such as the ESP/MCI's selection of a clinician to provide the ESP/MCI encounter to a given youth, the level of staff who need to be involved from DYS, the likelihood that the ESP/MCI will need assistance from MBHP in access an inpatient admission for the youth, etc.

Group #1 - This group includes those DYS youth who may soon need an ESP/MCI encounter and be at risk for hospitalization, but for whom DYS has not yet reached a definitive clinical opinion themselves regarding the need for hospitalization. Further, if an inpatient admission is determined to be medically necessary by the ESP/MCI provider, there are no anticipated barriers to getting the youth admitted, i.e., no current or history of violence, etc. If DYS decides there is a need to request an ESP/MCI encounter, this group will generally be well served through standard ESP/MCI and inpatient admission procedures.

Group #2 - Similar to Group #1, this group includes those DYS youth who may soon need an ESP/MCI encounter and be at risk for hospitalization, but for whom DYS has not yet reached a definitive clinical opinion themselves regarding the need for hospitalization. If an inpatient admission is determined to be medically necessary by the ESP/MCI provider, Group #2 differs from Group #1 in that youth in Group #2 also have risk factors, such as behavioral issues, history of violence or sexual perpetration, etc., which may make securing an inpatient admission more difficult. Similar to Group #1, if DYS determines there is a need to request an ESP/MCI encounter for a youth in Group #2, the youth will generally be well served through standard ESP/MCI procedures. However, if an inpatient admission is required, there may be a need for additional communication and collaboration among the ESP/MCI, DYS, and potentially MBHP and the inpatient provider to give them a notification that there may be the possibility of a potential admission.

Group #3 - This group includes those DYS youth in which the need for hospital level of care is clear to DYS, but due to risk factors such as behavioral issues, history of violence, or sexual perpetration, etc., it is anticipated that finding an inpatient admission will be more difficult. This group will require additional communication and collaboration among the ESP/MCI, DYS, and potentially MBHP and the inpatient provider, from the time of the request for an ESP/MCI encounter through the point of discharge from an inpatient facility.

c) Safety Planning

- Efforts should be made to avoid potential behavioral health crises by anticipating them through safety planning and related communication.
- For any youth, in advance of a behavioral health crisis, a DYS clinical coordinator or designee may contact the local ESP/MCI provider to request the development of a Safety Plan to assist in safely maintaining the youth in his or her current setting.

See *Appendix C-4* for a link to Crisis Planning Tools including the Safety Plan.

d) Early Identification

- It is generally appropriate for DYS staff to inform ESP/MCI of a youth being placed on elevated watch status when DYS staff believes there is a strong likelihood that DYS will eventually need to call the ESP/MCI to request an ESP/MCI encounter.
- This enables DYS and the ESP/MCI provider to engage in consultation around strategies to safely support and maintain the youth in his/her current location and plan for the potential ESP/MCI encounter, should it need to occur.
- The ESP/MCI provider may also alert the MBHP Clinical Access Line, especially if they feel that particular assistance may be needed from MBHP.

e) Location of Service

- During the initial call requesting ESP/MCI services, the ESP/MCI provider will determine, in consultation with DYS and the parent(s)/guardian/caregiver, the most appropriate location for the MCI encounter. Factors to consider in triaging to the most appropriate location for the crisis intervention include family choice, consideration of clinical acuity and at risk behaviors, most appropriate and safe setting for the youth.
- Due to security and safety concerns, the preferred location for the ESP/MCI encounter for most youth in DYS residential programs is at that DYS facility.
- For most youth in the community, the preferred location is the youth's home or another appropriate community based location, such as the school or the ESP/MCI location, etc.
- If an ESP/MCI encounter with a DYS youth does take place in a hospital emergency department (ED), such as when there is an acute injury or other medical presentation, DYS staff will make appropriate staffing arrangements in order to transport and supervise the youth in this setting.

f) Communication with facility staff

- The ESP/MCI provides a behavioral health crisis assessment, as well as crisis intervention designed to stabilize the youth and enable him/her to safely remain in his/her current setting if clinically appropriate.
- DYS will request the assessment and recommendations from the MCI provider. The recommendations for stabilization and crisis interventions will most frequently be implemented by DYS residential staff rather than the MCI team.

- Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to seven (7) days.
- It is expected that the ESP/MCI clinician will talk to the DYS clinical staff or the shift administrator at the DYS program, both before and after they assess the youth, to ensure there is clear communication, as well as an understanding regarding next steps.

For Youth Seen in a Juvenile Court Clinic

NOTE: *Please refer to Appendix I: Juvenile Court Clinics Procedures and General Policy.*

In general, a MassHealth member must be evaluated by an Emergency Services Program in order to be admitted to an acute level of care, such as Inpatient or Community-Based Acute Treatment (CBAT). For youth referred to a Juvenile Court Clinic, however, the evaluation may also be performed during court hours by a Certified Juvenile Court Clinician (CJCC) or Designated Forensic Professional (DFP) within the Juvenile Court Clinic. This arrangement was described in MBHP Network Alert #73, dated September 1, 2000. (Note, however, that this alert, which predated the creation of the CJCC credential, refers instead to a Senior Child-Trained Clinician. The reader of this alert should read "CJCC" in place of Senior Child-Trained Clinician.)

In 2009, the Division of Forensic Mental Health at the Department of Mental Health issued guidance on how Juvenile Court Clinics should interact with CBHI services (*Appendix I*). MCI clinicians and Juvenile Court Clinicians should be familiar with this document, which is titled "CBHI Services and the Interface with Juvenile Court Clinics and Other Court Personnel: Guidelines to Frequently Asked Questions," addresses numerous contingencies regarding emergency evaluations and referral for services of court-involved youth and their family members.

For Youth Involved with Other State Agencies

Department of Mental Health (DMH)
See *Appendix C-15* for a link to the Department of Mental Health Guide to New and Current MassHealth Behavioral Health Services and Protocols.

Department of Public Health (DMH) and Bureau of Substance Use Services (BSAS)
See *Appendix C-16* for a link to the Department of Public Health Guide to New and Current MassHealth Behavioral & Bureau of Substance Abuse Services Protocols.

Department of Transitional Assistance (DTA)
See *Appendix C-17* for a link to the Department of Transitional Assistance Guide to New MassHealth Behavioral Health Services and Protocols. www.masspartnership.com/provider/pdf/DTAProtocols11.5.10.pdf

Department of Developmental Services (DDS)
See *Appendix C-18* for a link to the Department of Developmental Service Guide to New and Current MassHealth Behavioral Health Services and Protocols.

MCI Documentation Requirements

The "ESP Child/Adolescent Comprehensive Assessment" (Rev.04-02-12) is completed for every MCI encounter. MCI providers must follow Medicaid and MCE documentation standards and guidelines.

Providers of ESP/MCI services are expected to have the following in the youth's behavioral health record.

1. A copy of the completed comprehensive crisis assessment for the youth they serve
2. Documentation of all contact they have with the youth/family they serve and, with the family's consent, of their collaboration with relevant providers who are also involved with the youth/family, as noted within the MCI Performance Specifications.
3. A copy of any Crisis Planning Tools selected by youth/families for use

See *Appendix J* to see the ESP Child/Adolescent Comprehensive Assessment.

Staff Training

Master's Level Clinicians have experience/are trained in
Mobile Crisis Intervention includes both a master's level clinician trained in working with children and families with experience and/or training in nonviolent crisis intervention, crisis theory/crisis intervention, solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de-escalation techniques; and a paraprofessional or a Family Support and Training staff (Family Partner) experienced or trained in providing ongoing in-home crisis stabilization services and in navigating the behavioral health crisis response system, which supports brief interventions that address behavior and safety.

- Working with youth and families
- Nonviolent crisis intervention
- Crisis theory
- Crisis intervention techniques including solution-focused intervention, motivational interviewing, behavior management, conflict resolution, family systems, and de-escalation techniques

Bachelor's level, Paraprofessionals and Family Partners are trained in

- In-home crisis stabilization services
- Navigating the behavioral health system
- Brief interventions that address behavior and safety

Advanced and specialized skills useful to MCI Teams include

- Safety planning/practicing: expanded use of Crisis Planning Tools
- Parent Support, advocacy and coaching
- Psychoeducation: relaying knowledge about a condition, symptoms, treatment options, *etc*.
- Orientation to parent support network across the state: Groups, on-line resources, opportunities to get engaged
- Family-centered resource development: cultivating natural, informal and formal supports
- Addressing substance use-related crises
- Addressing school-involved crises or complexities
- Specialized intervention for children in crisis with intellectual or developmental disabilities and their parents/caregivers
- Specialized interventions for transition-aged youth Transition-Age Youth and their parents/caregivers
- Information to promote positive family activities and non-school interests or hobbies (some of which may be vocational) of youth
- Shared decision making
- Sharing the Family Partner parenting journey with intention
- Application of evidence-based practice tools within a crisis context
    - Trauma-informed Interventions
    - Dialectical Behavioral Therapy
    - Illness Management and Recovery

Culturally Relevant Practice

Culturally relevant services include respectful recognition of differing values and culture of the youth, family, school, and other providers. This includes, but is not limited to, recognition of economic status, gender, sexual orientation, ethnicity, race, language, religion/spirituality and the unique values and goals of each youth and family. It utilizes the strengths of all in order to provide comprehensive care to families. To ensure that effective care is provided, agency staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers impacting the delivery of care. Providers will make every effort to recruit staff who represent the diversity of the youth and caregivers/families served and deliver services in the primary language of the youth and caregivers/families served.

Culturally relevant practice is an ongoing learning process that should be viewed as a goal that agencies can strive towards, and there will always be room for growth. It accepts and respects differences, emphasizes the dynamics and challenges arising from cultural and linguistic differences in planning and delivering services to diverse populations, and is committed to acknowledging and incorporating the following.

- Importance of cultural awareness
- Sensitivity to cultural diversity brought by a variety of factors including ethnicity, language, lifestyle, age, sexual orientation, and society status

- Sensitivity to many kinds of families
- Bridging linguistic differences in appropriate ways
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Adaptation of services to meet the specific cultural needs of the consumers
- Access to non-traditional services

MCI provider agencies will utilize the strengths of all in order to provide comprehensive care to youth and their caregivers/families. To ensure that effective care is provided, providers will seek consultation and additional services when necessary to overcome barriers impacting the delivery of care.

The following language describes provider responsibilities regarding cultural competence (*e.g.*, the same responsibilities as for outpatient providers).

1. The program provides services that accommodate the youth, consider the youth's family and community contexts, and build on their strengths to meet his or her behavioral health, social, and physical needs.
2. The program staff will have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care.
3. The provider ensures access to qualified staff to be able to meet the cultural and linguistic needs of all families served in their local community.
    a. Providers ask the family's language of choice.
    b. Because staff with linguistic capacity is preferable to interpreters, providers offer the youth a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so.
    c. The provider has access to qualified interpreters/interpreters and interpretation services, experienced in behavioral health care, appropriate to the needs of the local population served. In case the program must seek interpretation services outside of the agency, it must maintain a list of qualified translators to provide this service. Interpreter services are provided at a level that enables a youth to participate fully in the provider's clinical program.
4. Any written documentation should be available in the family's primary language when requested, including discharge documents.
5. Programs will provide ongoing, in-service training that will include cultural competency issues pertaining directly to the client population served.
6. Programs will include cultural competence in their ongoing quality assessment and improvement activities.

Access for Non-English-Speaking Youth

MCI providers should ensure access to care for all youth and families seeking MCI services. All MCI providers are expected to have access to qualified interpreters, including for the Deaf and Hard of Hearing, to provide services in the event the MCI provider needs to access interpretation services outside of their organization. Because staff with linguistic capacity is preferable to using interpreters, providers are expected to offer the family/youth a staff person who speaks their language of choice whenever possible, or refer him/her to a provider who can do so. If there are no providers with staff who speak the family/youth language of choice within a reasonable distance from the family's residence, then the family's preferred provider is expected to use qualified interpreters/interpreters and interpretation services, experienced in behavioral health care, appropriate to the needs of the local population. Interpretation services should be used in a manner that enables the youth/family to participate fully in the MCI service.[7]

The Worcester Recovery Center and Hospital offers inpatient mental health services for deaf persons, including older adolescents (by special arrangement) and young adults. See Appendix B for additional information and criteria for admission.

See *Appendix C* for link to training on Understanding Deaf Culture and Resources.

[7] The Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq*. (ADA) and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 prohibits discrimination against individuals with disabilities, including depriving them of the full and equal enjoyment of the goods, services, facilities, or accommodations of any place of public accommodation, including hospitals and other health care providers. To ensure an equal opportunity to use their services, hospitals and other health care facilities must provide "effective communication" to individuals who are Deaf or hard of hearing by providing appropriate "auxiliary aids and services," including the provision of qualified American Sign Language (ASL) interpreter services and assistive-listening services.

Appendices

Appendix A: Description of Other CBHI Services

Intensive Care Coordination (ICC) is delivered by a Community Service Agency (CSA) and provides care coordination through the *Wraparound* care planning process for youth age 20 and younger who have been diagnosed with a serious emotional disturbance (SED). A Care Coordinator works with the youth, family/caregiver(s), supports, providers, schools, state agencies, and others who play a key role in the youth's life. The Care Coordinator works with those identified to facilitate the development of a Care Planning Team (CPT) for the youth, and together this team comes up with an Individual Care Plan (ICP) to address the youth's needs and support the goals identified by the youth and family/caregiver.

Family Support and Training (FS&T) provides a structured, one-to-one, strengths-based relationship between a Family Partner and a parent/caregiver of a youth age 20 and younger. The purpose of this service is to resolve or ameliorate the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth. FS&T aims to improve the youth's functioning in the community or support the youth's return to the community via work with the caregiver. Services may include education; assistance in navigating the child-serving systems (DCF, education, mental health, juvenile justice, *etc*.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal/community resources (*e.g*., after-school programs, food assistance, summer camps, etc.); and support, coaching, and training for the parent/caregiver.

Mobile Crisis Intervention (MCI) is the youth-serving (age 20 and younger) component of an emergency services program (ESP) provider. MCI provides a short-term service that is a mobile, onsite, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if one exists. This service is provided 24 hours a day, 7 days a week, and includes a crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 7 days of crisis intervention and stabilization services including onsite, face-to-face, therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to services along the behavioral health continuum of care. For youth who are receiving Intensive Care Coordination (ICC), MCI staff will coordinate with the youth's ICC Care Coordinator throughout the delivery of the service. MCI also will coordinate with the youth's primary care Clinician, any other care management program, or other behavioral health providers providing services to the youth throughout the delivery of the service.

In-Home Behavioral Services (IHBS) addresses a youth's (20 and younger) behaviors that interfere with successful functioning in the community. Services are delivered by one or more members of a team consisting of professional and paraprofessional staff via a combination of Behavior Management Therapy and Behavior Management Monitoring.

Behavior Management Therapy includes a behavioral assessment (observing the youth's behavior, antecedents of behaviors, and identification of motivators) and the development of a highly specific behavior plan with interventions that are designed to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s). Supervision and coordination of interventions, and training other interveners to address specific behavioral objectives or performance goals are provided.

Behavior Management Monitoring includes implementation of the behavior plan developed by the Behavior Management Therapist, as well as monitoring of the youth's behavior and reinforcing implementation of the behavior plan by the caregiver(s). Also included is progress reporting to the Behavior Management Therapist on implementation of the behavior plan, as well as progress toward behavioral objectives or performance goals so that the behavior plan may be modified as needed.

In-Home Therapy Services (IHT) is a structured, consistent, strength-based therapeutic relationship between a licensed[8] clinician and the youth (age 20 and younger) and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. Interventions are designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment setting. The IHT team develops a treatment plan and uses established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused interventions and behavioral techniques to enhance problem-solving, limit-setting, risk management/safety planning, communication, building skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; and/or develop and maintain natural supports for the youth and parent/guardian/caregiver in order to promote sustainability of treatment gains.

Therapeutic Mentoring (TM) is provided to youth (age 20 and younger) in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and in other community settings such as school, childcare centers, or respite settings. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. Therapeutic Mentoring services include supporting, coaching, and training the youth in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution, and relating appropriately to other children and

[8] This language is taken from the IHT Performance Specifications dated June 25, 2009; however, additional clarification regarding the requirements of providers who provide both components of IHT services was communicated in a Provider Alert disseminated in early November of 2009. Please refer to each MCE's website for that specific Provider Alert for additional information.

adolescents, as well as adults, in recreational and social activities. TM promotes a youth's success in navigating various social contexts, learning new skills, and making functional progress in the community. Referrals are made solely through one of the Clinical Hub Services of Intensive Care Coordination, In-Home Therapy, or Outpatient Therapy.

Appendix B: Worcester Recovery Center and Hospital Inpatient Mental Health Services for Deaf Persons

309 Belmont Street, Worcester, MA 01604
Operator: (508) 368-4000 Referrals: (508) 368-3423
Referrals Fax: (508) 363-1515
Deaf Services Unit: (508) 948-0409
Call Unit to arrange for VP calls

mass.gov/eohhs/docs/dmh/services/deaf-unit-referral-form.doc

INPATIENT DEAF SERVICES

Accepts individuals who

- Require inpatient hospital level of care
- Utilize a signed language *or* visual-gestural communication

Serve

- Deaf
- Hard of hearing
- Deaf-blind
- Late-deafened individuals
- Massachusetts residents
- Non-Massachusetts residents by special arrangement
- Adults
- Adolescents older than 14 years old by special arrangement

Provide

- Acute Stabilization
- Evaluation
- Evidence-based approaches to psychosocial rehabilitation
- Discharge planning
- Court-ordered forensic evaluations
- Short-term and continuing care

Accessible Treatment

Evidence-based Treatment – We offer interventions based on Cognitive Behavior Therapy (CBT), Illness Management and Recovery (IMR) and Dialectical Behavior.
Medication Management – For people in need of psychiatric or medical medications, emphasis is placed on education about symptoms, medication use, and side effects.
Communication Strengths and Language Dysfluency – Each patient's communication strengths are identified and interventions are adapted to meet communication needs.
Pictorial Communication Tools – More than 3,000 pictorial communication tools have been developed, covering the full range of Mental Health topics from symptom and side effect identification to skills recognition and development.

Referrals

All admissions are pre-arranged and occur Mondays through Fridays between 8:30am and 5pm. Inquiries are welcome also before the Emergency Services evaluation or formal referrals. This allows for advance planning in relation to bed availability.

1. Call WRCH and provide basic referral information.
    - Business hours: 508-368-3423 (v)
    - Non-Business: 508-368-4000 (v) and ask for a Nursing Supervisor

2. Fill out the referral packets. Referral packets are available
    - By fax, call #s above and request
    - Online at mass.gov/eohhs/docs/dmh/services/deaf-unit-referral-form.doc

3. Fax packet and other assessments or reports to the Deaf Admissions Coordinator at 508-363-1515. Include your contact name and number.

4. Someone will contact you for a follow-up consultation within one business day.

5. Call the business hours number if you have not heard back in a timely way.

Appendix C: Links to Web-Based Documents and Resources

C-1: Adult Community Crisis Stabilization (CCS) Program Performance Specifications

http://www.masspartnership.com/provider/PerformanceSpecs.aspx

C-2: Behavioral Health Care Access, Quality, and Discharge Protocol for DYS and MBHP

Alert 116 with this information can be found on the page link below.

https://www.masspartnership.com/provider/ArchivedAlerts.aspx

C-3: Community-Based Acute Treatment (CBAT) for Children and Adolescents

http://www.masspartnership.com/provider/PerformanceSpecs.aspx

C-4 Crisis Planning Tools

http://www.masspartnership.com/provider/CrisisPlanning.aspx

C-5: Emergency Services Program (ESP) Performance Specifications

http://www.masspartnership.com/provider/PerformanceSpecs.aspx

C-6: ESP Statewide Directory

http://www.masspartnership.com/provider/ESP.aspx

C-7: Massachusetts Behavioral Health Access (MABHAccess) Website

www.mabhaccess.com

C-8: MCE CBHI Health Record Documentation Standards

https://www.masspartnership.com/provider/CBHIProviderResources.aspx

C-9: MCI Medical Necessity Criteria

https://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx

C-10: MCI Performance Specifications

https://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx

C-11: MCI Service Definition

https://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx

C-12: MCI Training Materials

Delivering Resolution-Focused Interventions: November 2010

http://www.masspartnership.com/provider/CBHITrainingArchive.aspx

Supporting Families in Crisis: February 2011
http://www.masspartnership.com/provider/CBHITrainingArchive.aspx

Effective Crisis Planning with Families: April 2011
https://www.masspartnership.com/provider/CrisisPlanning.aspx

Crisis Planning Tools Training for Managers: June 2011
https://www.masspartnership.com/provider/CrisisPlanning.aspx

Crisis Systems of Care—Building Competency across Services: October 2011
https://www.masspartnership.com/provider/CrisisPlanning.aspx

Building Team Competence in Strengths-Based Treatment: November 2011
http://www.masspartnership.com/provider/CBHITrainingArchive.aspx

MCI Model Enhancement Regional Trainings: April/May 2012
http://www.masspartnership.com/provider/CBHITrainingArchive.aspx

Understanding Deaf Culture and Resources Training: April 2012
http://www.masspartnership.com/provider/CBHITrainingArchive.aspx

Family Partner Forum: January 2012 (link to numerous presentations)
http://www.masspartnership.com/provider/CBHITrainingArchive.aspx

The Impact of Trauma on Children: Developmental Impact, Evidence-Based Treatments, and Cultural Considerations *http://www.masspartnership.com/provider/CBHITrainingArchive.aspx*

C-13: Protocol for Accessing Acute Behavioral Health Care Services for Youth Involved with the Department of Children and Families (DCF)

Alert 113 with this information may be found on the page link below.
https://www.masspartnership.com/provider/ArchivedAlerts.aspx

C-14: Transition-Age Youth (TAY) Resources

https://www.masspartnership.com/provider/CommunityResources.aspx

C-15: Department of Mental Health Guide to New and Current MassHealth Behavioral Health Services and Protocols

http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html

C-16: Department of Public Health Guide to New and Current MassHealth Behavioral & Bureau of Substance Abuse Services Protocols

http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html

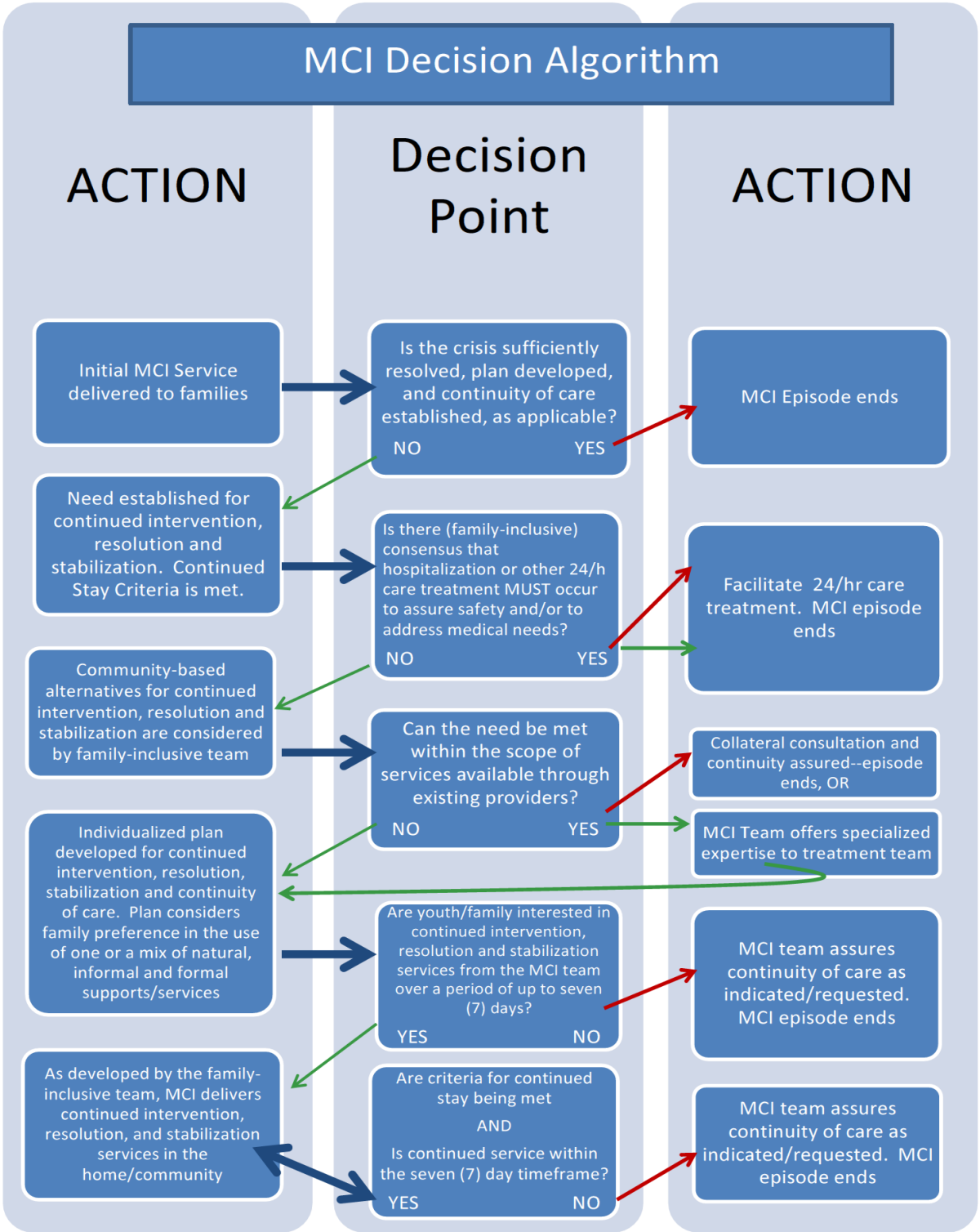
C-17: Department of Transitional Assistance Guide to New MassHealth Behavioral Health Services and Protocols

http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html

C-18: Department of Developmental Service Guide to New and Current MassHealth Behavioral Health Services and Protocols

http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html

Appendix D: MCI Decision Algorithm



Appendix E: Sample MCI Information for Schools

SAMPLE: Mobile Crisis Intervention (MCI) Service Information for Schools

East Overshoe Psychiatric Emergency Services
100 Main Street, Somewhere MA 12345
24/7 Crisis Line: 800-333-4444
Fax: 333-444-5555
ESP Director – Pat Smith
MCI Manager—John Brown
Cities/Towns Served: Paris, Lakeville, Smithville, Tiny town, Wonderland, Mt. View, London, Tinsel town, Rome, Cape point

When calling the MCI team,
Keep in mind that the timeframe for an MCI team to respond is 60 minutes.

The team will want to know if there is immediate danger (for example, imminent threats of harm, injuries to self or others, situations that seem unstable/volatile).

If there is immediate danger, the MCI Team can assist in coordinating with emergency responders to safely transport a person to the nearest emergency department for medical attention and assessment.

If there is no immediate danger, the MCI Team will work with the family and/or with school personnel to determine the least restrictive, preferred location for the assessment.

Mobile evaluations to the home or school are often most comfortable, but the location of service is ultimately part of clinical decision making with the family.

In the school,
Anyone can call the Emergency Service line for support, consultation, and resources. If requesting MCI services for a particular youth, the school principal or his/her designee must be informed and approve of the referral.

If it is nearing the end of the school day, a school staff member must be able to stay and assist with, for example: communicating with parents or coordinating transportation home.

The MCI team will need parental approval for a comprehensive evaluation to occur (if a parent cannot be reached the clinician will assess immediate risk).

Having a natural support such as a family member, friend, or ongoing provider respond with the MCI team is ideal.

Any provider or referral source can call the MCI to place an individual on Alert. The MCI's Alert System allows the MCI clinician a chance to gather information on an individual, provide treatment suggestions, and crisis plan. This information is available to the MCI team if a crisis should arise.

MCI staff can attend team meetings to assist in the development of crisis plans when appropriate.

When referring an individual, the MCI clinician will ask for the following information:
- Student's name
- Date of birth
- Address
- Parent/Caregiver names and phone numbers
- Social Security Number (if available)

And for information about the current crisis and known history:
- Presenting problem, including on-set and duration of symptoms
- Current safety issues, including plan and means
- History of safety issues
- Medications (including dosages), allergies and medical problems
- Support system and outpatient providers
- Substance abuse (current use and history)
- Legal history
- What interventions have already been tried but haven't worked
- If there is a crisis plan in place, what it involves, and what has been tried so far.

Mobile Crisis Intervention (MCI)

Mobile Crisis Intervention (MCI) Teams provide mobile, short term, face-to-face, therapeutic response to youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger. MCI services are designed to be delivered through the systems-friendly, wraparound process of engaging the family, convening the team, developing the plan, implementing the plan, and transitioning the youth to the appropriate level of care. The wraparound process should incorporate a plan that is designed to be culturally competent, strengths based, and organized around family members' own perceptions of needs, goals, and likelihood of success of specific strategies.
While the extended MCI is only available for MassHealth-insured, or uninsured children and adolescents, the team will see provide crisis intervention for anyone regardless of age or insurance.

MCI service components include:
- Assessment
- Telephonic psychiatric consultation
- Use of a parent partner to provide support and navigation through mental health system.
- Development of Crisis Planning Tools
- Collateral contacts
- Additional crisis intervention and stabilization services for a period of up to 7 days
- Solution oriented crisis/transitional counseling: teaching coping skills, behavior management skills, mediation, parent support and psycho-education
- Phone support to the youth and family
- Urgent psychopharmacology, as needed
- Referrals and linkages to all medically necessary services and supports
- Intensive case management services, as needed
- Strategies for de-escalation
- Care Coordination with: Intensive Care Coordination, pediatrician, behavioral health providers (existing or new).

SAMPLE: CRISIS DECISION TOOL FOR LAW ENFORCEMENT OFFICERS

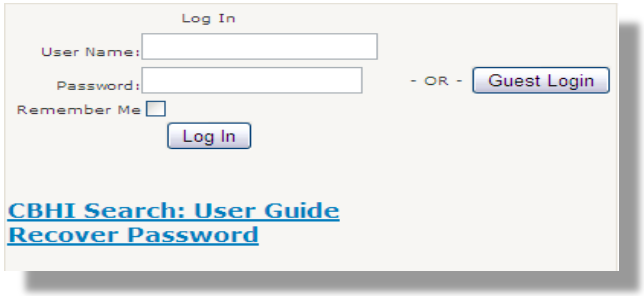
Law Enforcement Officers can access a crisis clinician 24/7/365 when: Person is experience mental health or substance use-related distress/crisis AND Person will not be jailed or charged with a crime 24-hour Crisis Line: XXX-XXX-XXXX Address: XXXXXX	**LOCATION OF SERVICE**		
	Home or Neutral Community Site	**Walk-in Crisis Center**	**Nearest Emergency Department**
	Person in distress: ➢ Agrees to mobile crisis service ➢ Is comfortable with receiving the service in the home or neutral community site, AND Officer: ➢ Confirms the site is suitable/safe for crisis clinician response ➢ If indicated, remains at the location until a warm handoff to crisis clinician occurs	Person in distress: ➢ Agrees to service ➢ Is comfortable with receiving the service at the walk-in center AND Officer: ➢ Makes warm phone referral to crisis program ➢ Transports or assures safe transport to program site	Person in distress: (one or more applies) ➢ Requests this service location ➢ Reports or appears to have an urgent medical issue or complaint ➢ Is not stable (i.e. intoxicated, impulsive, agitated or disoriented) to a degree that ED setting is needed for safety ➢ Will not consent to service and Officer completes an involuntary certificate
	EXCEPTIONS Community location not secure OR person prefers office location Possible medical complications, degree of risk necessitate transfer to emergency department		

Appendix F: MABHAccess Website User Guide

Search Guide

1. Navigate to the site at www.mabhaccess.com.
2. Click on the Login menu at the top of the page.

3. Enter login credentials.

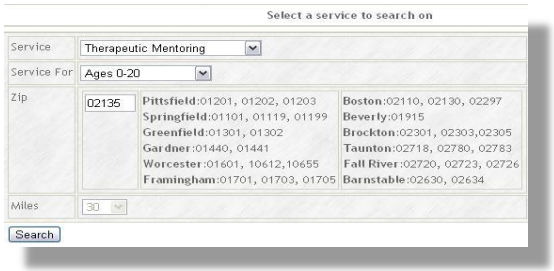


You may use your provider login credentials for this function.

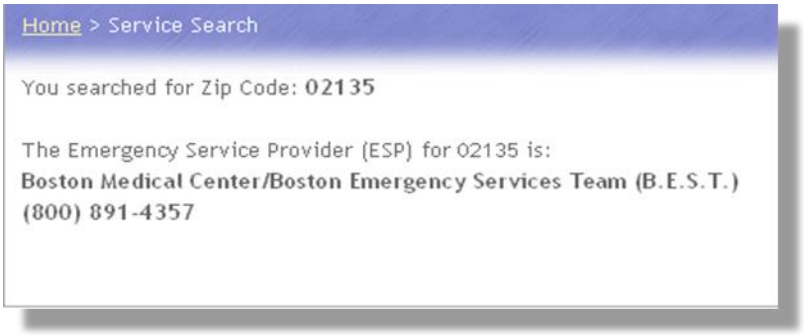
Clicking on the Guest Login button to the right of the username and password fields will automatically take you to the search page as a guest user. You may also use *Guest-CBHI* as both username and password to log in. Guest users have the ability to search for CBHI levels of care (In-Home Therapy, Therapeutic Mentoring, In-Home Behavioral Services, Intensive Care Coordination) and Emergency Services Providers (ESPs) only.

4. After successfully logging in, the navigation menu at the top of the page updates to include a Service Search link and a Logout link.
   Click on the Service Search link.

5. Enter search criteria – all fields are required. Choose the level of care (IHT, IHBS, TM, ICC, or ESP) from the dropdown menu that you would like to search. Input your zip code (example: 02135). The default miles (the radius search from the center of the entered zip code) is 30 for all CBHI levels of care. Click the Search button.



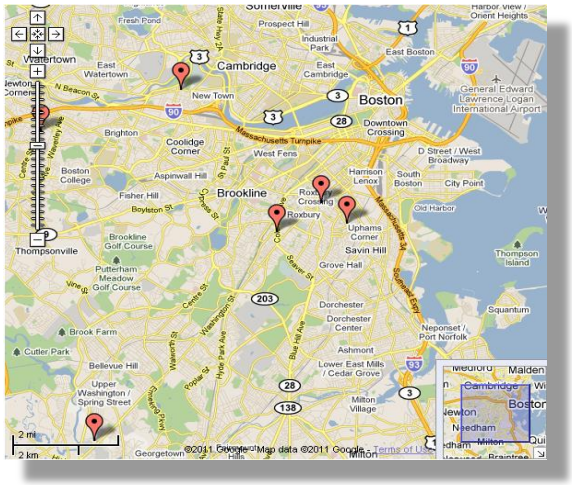
6. The search results page is separated into several parts.
   a. When searching for an ESP, the result of your search will be the ESP that is specific to your zip code.



b. When searching for CBHI services, your search will generate a list of facilities within a 30-mile radius of your zip code, their available capacity, and when they last updated, ordered closest to the farthest from your zip code. **To view the details** (including referral phone number) **of a given site, click the Select link to the left of the facility name. Scroll down the page to view this information;** it will appear below the facility list and before the map.

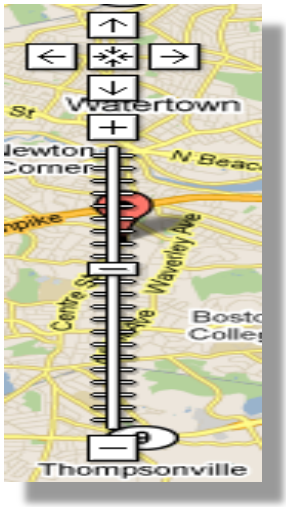
	Facility	City	Available Capacity	Comments	Gender	Distance (Miles)	Last Updated
Select	Arbour Counseling Services, Allston - TM	Allston	5	Male mentors available. We cover the entire metro boston region.	All	0.80	20 hours ago
Select	Brookline Community Mental Health Center-TM	Brookline	0		All	1.39	22 hours ago
Select	Riverside Community Mental Health & Retardation Center-TM	Cambridge	0		All	1.96	1 week ago
Select	The Home For Little Wanderers-TM	Somerville	0		All	2.29	22 hours ago
Select	Riverside Community Mental Health & Retardation Center-TM	Somerville	0		All	2.29	1 day ago
Select	Justice Resource Institute, Inc.-TM	Boston	0		All	2.75	23 hours ago
Select	Pyramid Builders Associates, Inc-TM	Boston	5		All	2.95	17 hours ago
Select	Somerville Mental Health -TM	Somerville	0		All	3.35	22 hours ago

c. The next part is the Google map that shows the locations of the found facilities. By default, the map centers on the first facility in the list.

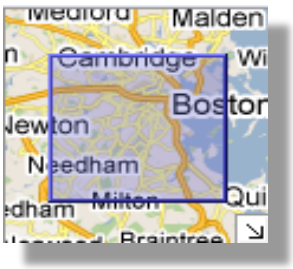


d. Users can adjust the map view in several ways.

i. Use the Google Map navigation tools on the tops left of the map. The cluster of four arrows pointing at the four cardinal points will move the focus of the map in the direction selected. The slider anchored with + and – will zoom the map in and out.



ii. Use the Google map navigation tool at the bottom right of the map. The blue-shaded square shows the area covered by the larger map view. Sliding the blue-shaded box around will adjust the larger map view.



iii. Left-click on the map (icon will change from an open gloved hand to a closed gloved hand) and, holding the left-mouse button down, drag the entire map in any direction.

7. The next part of the search results page is the right-menu navigation bar, next to the Google Map.

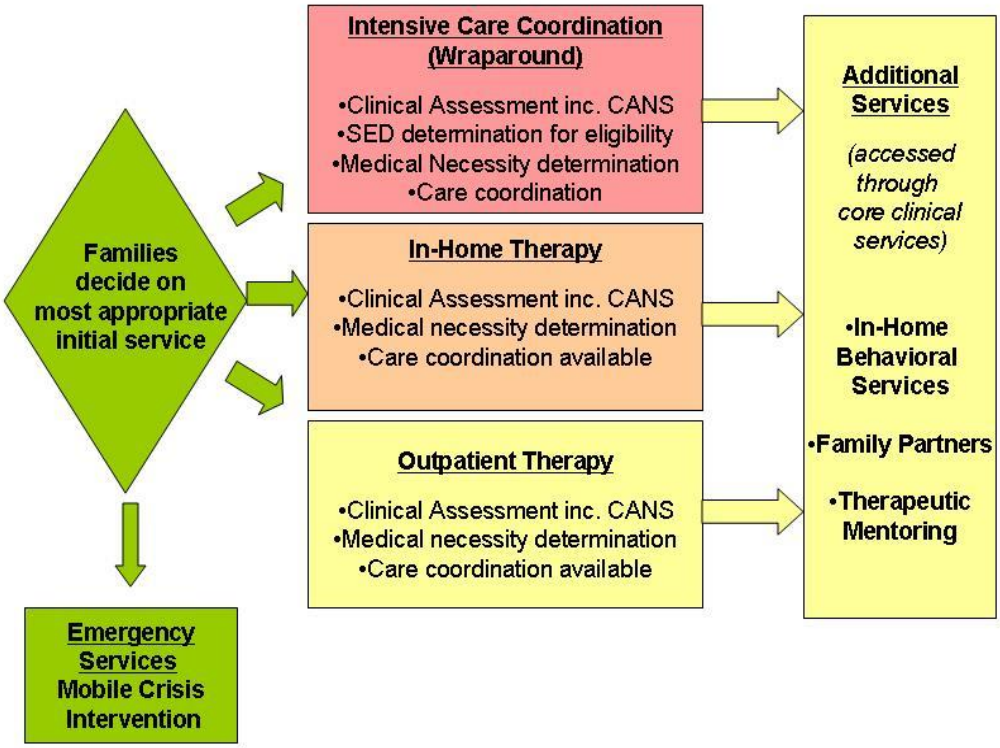
a. Clicking on any facility will re-center the Google Map on that facility.
b. Clicking the Print link will print the entire page.

8. To search again, simply click the Service Search link in the navigation bar again.

If you are searching this website for a CBHI service and are unable to obtain access, please contact the MassHealth Managed Care Entity (MCE) that is insuring the youth for further assistance.

- Massachusetts Behavioral Health Partnership Access Line: 800-495-0086 (*select prompts 1, 4, 2, 1*)
- Health New England-Be Healthy: 800-495-0086 (*select prompts 1, 4, 2, 2*)
- Network Health: 888-257-1985
- Neighborhood Health Plan: 800-414-2820
- Boston Medical Center HealthNet Plan: 866-444-5155
- Fallon Community Health Plan: 888-421-8861

Appendix G: CBHI Clinical Pathways Grid



Appendix H: Availability of CBHI Services to Members in Various Benefit Plans

Eligibility

The implementation of the Children's Behavioral Health Initiative (CBHI) signaled a major expansion of behavioral health services for children and youth, who are younger than 21 and have MassHealth. MassHealth now provides health insurance for a large percentage of the Commonwealth's children.

Even if a family earns too much money to be income-eligible for MassHealth, a child in that family with a disability may be eligible for MassHealth benefits, including a child with a mental/behavioral health diagnosis. This type of MassHealth coverage, called CommonHealth, is available, regardless of family income, with a sliding fee scale for premiums.

Children and youths younger than 21* who are enrolled in either MassHealth Standard or MassHealth CommonHealth may access medically necessary MassHealth behavioral health services. Approximately 85% of MassHealth-enrolled children and youths have either Standard or CommonHealth coverage. Children and youths younger than 21 enrolled in MassHealth Family Assistance—a smaller program developed to expand health care to more individuals—may be able to access certain behavioral health services, if the service is medically necessary.

Below is a summary of MassHealth behavioral health services** for children and youths younger than 21. Next to the service are the types of MassHealth coverage available for them. NOTE: This list of services covered by MassHealth provides only general information. Parents and youth should call their MassHealth health plan for the most up-to-date, accurate information.

Behavioral Health Service	MassHealth Coverage Types
Outpatient Therapy	Standard, CommonHealth, Family
Mobile Crisis Intervention	Standard, CommonHealth, Family
Structured Outpatient Addiction Program	Standard, CommonHealth, Family
In-Home Therapy	Standard, CommonHealth, Family
Intensive Care Coordination	Standard, CommonHealth
Family Support and Training (Family Partners)	Standard, CommonHealth
In-Home Behavioral Services	Standard, CommonHealth
Therapeutic Mentors	Standard, CommonHealth

*Note: Some members younger than 19 who are eligible for Family Assistance receive premium assistance as their only MassHealth benefit. For these members, MassHealth pays the premium for commercial insurance but does not reimburse providers directly for services. These members are not eligible for MassHealth behavioral health services.
**MassHealth lists the services and benefits currently available. To access the list, visit the MassHealth website at www.mass.gov/masshealth or call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648).

Additionally, some families with Family Assistance also have commercial health insurance coverage. As a result, their children are not eligible for enrollment in any of MassHealth's managed-care programs, nor are they eligible for community-based MassHealth behavioral health services (with the exception of Mobile Crisis Intervention). Families can call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) to learn more.

Appendix I: Interfaces with Juvenile Court Clinics

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
25 Staniford Street
Boston, Massachusetts 02114-2575

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

BARBARA A. LEADHOLM, M.S., M.B.A.
Commissioner

(617) 626-8000
TTY (617) 727-9842
www.state.ma.us/dmh

Memorandum

To: Juvenile Court Clinicians

From: Debra A. Pinals, M.D., Assistant Commissioner, Forensic Services, DMH

Re: CBHI Services and the Interface with Juvenile Court Clinics and Other Court Personnel: Guidelines to Frequently Asked Questions

Date: September 23, 2009

The following questions and answers have been developed to provide guidance to Juvenile Court Clinicians and other court personnel working with youth who present with behavioral health issues. The intent of this memo is to provide a framework related to CBHI services as they relate to Court activities.

Question #1: A Youth who is enrolled in MassHealth (or who is uninsured) presents to the Juvenile Court. The youth has no court clinic involvement; the youth appears in distress, and says to her/his attorney that s/he is suicidal. What would be the interface with Mobile Crisis Intervention (MCI) in this situation?

Answer: The current practice of a Juvenile Judge's request to the Juvenile Court Clinician (JCC) for an emergency evaluation will continue. It is anticipated that the JCC may continue to perform many evaluations as the designated emergency services. Additionally, for MassHealth (or uninsured) youth not held on bail, the JCC now has the option, with consent of the Judge, to refer to MCI to perform the evaluation and decide the disposition. The JCC may arrange for the MCI team to evaluate the youth at the courthouse in suitable space arranged by the JCC, or at another appropriate location in the community. In this case the level of care determination will be made by the MCI team, ideally in consultation with the JCC, rather than by the JCC. Once the

1

emergency evaluation is completed, the Court Clinician will report back to the judge on the MCI's recommendations for the case.

In those cases of behavioral health emergency or crisis in which the Court Clinician believes that the youth requires hospital level of care, the JCC may retain its role as the designated emergency services evaluator. The JCC will follow the steps outlined in the MBHP Network Alert 73(L) issued in FY 2000 which states that, at the conclusion of the Emergency Evaluation Process, the Court Clinician, who has determined that Hospital Level of Care (HLOC) is needed, will adhere to the Network Alert process to secure a hospital bed. The same protocol will apply for youth who have MassHealth not through MBHP, but through one of the MassHealth managed care organizations (currently BMC HealthNet, Fallon Community Health Plan, Neighborhood Health Plan, or Network Health). The same protocol will apply for youth who are uninsured. If the bed search process is not concluded by 2:00 pm, the Court Clinician will **contact the local Emergency Services Program (ESP) / Mobile Crisis Intervention (MCI) team** in order to exchange information gathered thus far, and for the MCI team to meet the youth and parent(s)/caregiver(s) at a designated location determined by the MCI team to complete the bed search process. If the youth is not safe for the parent(s)/caregiver(s) to transport, the Court Clinician will consult with the MCI team and arrange transportation to a safe location designated by the Mobile Crisis Intervention team. A copy of the MBHP Network Alert 73(L) is attached to this document.

If the JCC determines that HLOC is not required, then the JCC may decide that the child is nonetheless in crisis and appropriate for MCI, and refer to MCI, assisting the family to arrange a meeting with MCI team at the courthouse or at another appropriate location in the community. Or, as events unfold, the JCC may decide that the child is no longer in crisis, and, for MassHealth enrolled youth, may refer to other MassHealth services as appropriate. The family of a MassHealth enrolled youth has the right, at any point, to self-refer to any MassHealth service that they believe would be helpful for the youth in their custody.

As an additional resource, youth with Serious Emotional Disturbance (SED) who are enrolled in MassHealth Standard or CommonHealth may be eligible for Intensive Care Coordination (ICC).* A Court Clinician may contact the Community Service Agency (CSA) for the local area to obtain consultation about ICC and Family Support and Training (which is delivered by Family Partners). A statewide list of the CSAs is attached.

Once the emergency evaluation is completed by either the JCC or the MCI provider, the Court Clinician will report back to the judge on the JCC's recommendations for the case.

Question #2: What happens if a MassHealth enrolled youth (or an uninsured youth), who is held on bail in court lock-up, is thought to be experiencing a behavioral health crisis?

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*ICC is a strengths-based family-driven process for planning and implementing services for children and youth with complex behavioral health needs. ICC follows the Wraparound model of care coordination. ICC is not therapy and is a voluntary service in which a youth/family must consent to participate. Length of stay for many children and youth falls in the range of six to twelve months, although for each child or youth the need for ICC is determined on an individual basis.

Answer: The MCI team will not assess youth held on bail in Juvenile Court Lock Up. Upon judicial order, the JCC will provide an emergency evaluation. In those circumstances when the Court Clinician believes the youth is in need of HLOC **the JCC will function in its role as the designated emergency services evaluator.** The JCC will follow the steps outlined in the MBHP Network Alert 73(L).

Once the emergency evaluation is completed, the Court Clinician will report back to the judge on the JCC's recommendations for the case.

Question #3: What happens if a MassHealth enrolled youth, who is held in court lock-up without a bail determination is thought to be experiencing a behavioral health crisis?

Answer: The MCI team will not assess a youth while the youth is held in Juvenile Court Lock Up. Upon judicial order, the JCC will provide an emergency evaluation.

Alternately, with consent of the Judge, in those cases where the youth may be removed from the lockup, the JCC now has the option for youth with MassHealth to refer to MCI to perform the evaluation and decide the appropriate intervention and service referrals. The JCC may arrange for the MCI team to evaluate the youth at the courthouse in suitable space arranged by the JCC, or at another appropriate location in the community. In this case, the level of care determination will be made by the MCI team, ideally in consultation with the JCC, rather than by the JCC. Once the emergency evaluation is completed, the Court Clinician will report back to the judge on the MCI's recommendation for the case.

If the evaluation is being done by the JCC, and the youth can be seen outside of the lock-up, then the Court Clinician will make arrangements to complete a further assessment. If the JCC determines that HLOC is required, then **the JCC will function in its role as the designated emergency services evaluator.** The JCC will follow the steps outlined in the MBHP Network Alert 73(L) issued in FY 2000.

If the JCC determines that HLOC is not required, then the JCC may decide that the child is nonetheless in crisis and appropriate for MCI, and refer to MCI, assisting the family to arrange a meeting with MCI team at the courthouse or at another appropriate location. Or, as events unfold, the JCC may decide that the child is no longer in crisis, and, for a MassHealth enrolled youth, may refer to other MassHealth services as appropriate. The family of a MassHealth enrolled youth has the right, at any point, to self-refer to any MassHealth service that they believe would be helpful for the youth in their custody.

Youth with SED who are enrolled in MassHealth Standard or CommonHealth may be eligible for Intensive Care Coordination (ICC). A Court Clinician may contact the CSA for the local area to obtain consultation about ICC and Family Support and Training (which is delivered by Family Partners). A statewide list of the CSAs is attached.

Once the emergency evaluation is completed, the Court Clinician will report back to the judge on the JCC's recommendations for the case.

Question #4: A youth who is not eligible for MassHealth, and not uninsured, is determined by the Court Clinician to need hospital level of care. Should the Court Clinician contact the Mobile Crisis Team as above?

Answer: No. The JCC should work with the youth's parent / legal guardian and insurer in order to determine the insurer's process for accessing emergency services and hospital level of care.

On conclusion of the episode, the Court Clinician will report back to the judge on the JCC's recommendations and on disposition of the case.

Question #5: A youth undergoes a Probation Intake and the Probation Officer (PO) determines that the youth with MassHealth is not in a behavioral health crisis, but does have unmet behavioral health needs. How should the PO proceed?

Answer: The PO may have sufficient knowledge of the youth and of MassHealth behavioral health services to recommend specific services to the family, and to assist them in accessing the service. Probation may wish to consult with MassHealth behavioral health providers in the community regarding available services; the JCC is also available as an informational resource to Probation regarding MassHealth services. A PO may also contact the youth's MassHealth Managed Care Entity (MCE) to get consultation about appropriate MassHealth services. For DMH involved youth, the DMH CBHI liaison may also be a useful informational resource.

Youth with SED who are enrolled in MassHealth Standard or CommonHealth may be eligible for Intensive Care Coordination (ICC). A PO or Court Clinician may contact the Community Service agency (CSA) for the local area to obtain consultation about ICC and Family Support and Training (which is delivered by Family Partners). A statewide list of the CSAs is attached.

Alternately, the PO may wish to request a formal consultation with the JCC. Upon judicial order, the JCC will meet with the youth and family to determine the youth's behavioral health needs and to provide service recommendations and assistance in accessing services.

If the Court Clinician feels confident that a specific behavioral health service is needed, the Court Clinician working with the youth (and his / her parent / caregiver) may recommend that the youth and parent / caregiver self-refer to a provider of the specific MassHealth behavioral health service. If there uncertainty about which service may be medically necessary or most appropriate, the clinician should assist the youth and parent / caregiver in contacting a provider of MassHealth outpatient behavioral health services. The provider will assist the youth and parent / caregiver in determining if outpatient services or other MassHealth behavioral health services are appropriate, and will assist the youth and parent/caregiver in accessing the

appropriate service.** A Court Clinician may also contact the youth's MassHealth Managed Care Entity (MCE) to get consultation about appropriate MassHealth services. For DMH involved youth, the DMH CBHI liaison may also be a useful informational resource.

Question #6: A youth enrolled in MassHealth is seen in court; the youth appears to have unmet behavioral health needs but does not appear to require HLOC; the youth is in the custody of his parents but the family is reluctant to have him / her return home and the Juvenile Court Judge does not want him / her to go to detention. The Judge requests a JCC evaluation to make level of care and treatment recommendations. Should a referral be made to MCI?

Answer: A referral to MCI should only be made if the youth is experiencing a behavioral health crisis.

In the situation described above, if the reason that the youth cannot return home is that the family will not allow the youth in the home (and if the Court has no reason to restrain the youth from entering the home), then this situation requires a call to DCF for consultation and possible placement of the youth in the custody of DCF. If the court places the youth in the custody of DCF and the youth is experiencing a behavioral health crisis, then DCF is responsible for calling MCI; the JCC should assist with this process if needed.

JCC level of care and treatment recommendations may include recommendations for referral to MassHealth behavioral health services. Youth with SED who are enrolled in MassHealth Standard or CommonHealth may be eligible for Intensive Care Coordination (ICC). A Court Clinician may contact the Community Service agency (CSA) for the local area to obtain consultation about ICC and Family Support and Training (which is delivered by Family Partners). A statewide list of the CSAs is attached.

Once level of care and treatment recommendations are completed, the Court Clinician will report back to the judge on the JCC's recommendations for of the case.

Question #7: A youth with behavioral health needs who is not eligible for MassHealth, does not require HLOC, and is not in a Juvenile Court Lock Up, is referred to the JCC for evaluation (non-emergency). Should the Court Clinician contact the MCI for consultation?

Answer: No. A referral to MCI should only be made if the youth is experiencing a behavioral health crisis, and consideration also needs to be given as to whether the youth has insurance coverage appropriate to MCI. The JCC should work with the youth's Parent(s) / Legal Guardian(s) and other relevant parties to determine whether services through the family's insurer, state agency, or other resources is appropriate.

** This is not likely to happen in "real time" that day but rather the outpatient provider would schedule an appointment with the youth and parent/caregiver for another day.

Question #8: The previous questions refer to youth who are formally involved with the court on Care and Protection, CHINS, or Delinquency matters. What if a family member of the youth, who is not involved with the court, experiences a behavioral health crisis?

Answer: For any family member (e.g. Sibling or Parent/Guardian) who might require emergency services, the Parent or Legal Guardian for the sibling can self refer to emergency services. If the person has any MassHealth plan, Medicare, Medicare/Medicaid, DMH only or is uninsured, they should self-refer to the local Emergency Services Program (which will provide MCI for members under 21 as well as emergency services for individuals age 21 and over). If the person has commercial insurance, they should self-refer to the emergency service contact designated by their insurance, which can usually be identified on the back of their insurance card. If the Parent/Guardian is the person in crisis and is unable to make contact with emergency services, upon Judicial order, the Juvenile Court Clinic can evaluate and assist the family member in accessing emergency services in accordance with the MBHP Network Alert 73(L) or designated insurer for the family as appropriate.***

Attachments:

1. MBHP Network Alert 73(L) issued in FY 2000
2. Statewide list of the Community Services Agencies

*** If a crisis occurs with a sibling or parent who is a person 21 or over, it is still appropriate to contact the Emergency Services Provider (ESP) for adult emergency services rather than MCI. The ESP has the capacity to meet with the adult at their home or other community based locations between the hours of 7 am-8pm, 7 days per week. The ESP may also meet with an adult in a residential program or a hospital Emergency Department if needed, 24/7/365. Finally, an ESP may meet with an adult in the ESP's community based location which is open a minimum of 12 hrs/day weekdays and 8 hrs per day weekends. Please refer to the ESP Directory at www.masspartnership.com for details about ESP and MCI phone numbers, locations, and hours.

Appendix J: ESP Child/Adolescent Comprehensive Assessment

Name (First, MI, Last):	**Record #:**	**DOB:**

ESP name:	**Location of service:**	**Date:**	**Time:**

YOUTH RECEIVING SERVICES
Name: **Gender:** ☐ **Male** ☐ **Female** ☐ **Transgender**
Street address:
City, State, Zip:
Phone:
Primary language: **Interpreter used:** ☐No ☐ Yes
Is anyone accompanying the youth?
☐No ☐ Yes; name: Relationship: Phone:
Were the parents/guardian/family available to participate in this assessment and intervention? ☐Yes ☐ No; explain:
Did parent/guardian give consent to treatment? ☐ Verbal ☐ Written ☐ None; explain:

Custody, Legal, and Living Situation

☐ **Self-custody:** ☐**Youth is 18 years or older** ☐ **Mature minor (16-18 years old)**

☐ **Parent** ☐ **Guardian** ☐**Caretaker** ☐ **Legal custody** ☐ **Physical custody** ☐ **No custody**
Name:
Street address: **City, State, Zip:**
Home phone: **Cellphone:**

☐ **Parent** ☐ **Guardian** ☐**Caretaker** ☐ **Legal custody** ☐ **Physical custody** ☐ **No custody**
Name:
Street address: **City, State, Zip:**
Home phone: **Cellphone:**

☐ **DCF caseworker** ☐ **Legal custody** ☐ **Physical custody** ☐ **No custody**
Name: **Phone number:**

☐ **DYS caseworker** ☐ **Legal custody** ☐ **Physical custody** ☐ **No custody**
Name: **Phone number:**

Does the youth have a history of, or current involvement with, the legal system (i.e., legal charges, parole/probation, registered sex offender)? ☐ No ☐ Yes; describe or attach:

What is the youth's current living situation? (check one)
☐ Parent's/guardian's home ☐ Other relative's home ☐ Friend's home ☐ Temporary housing ☐ Homeless
☐ Shelter ☐ Other:

Residential care/treatment facility:
☐ Hospital ☐ Residential program ☐ Supported Housing ☐ Foster care home ☐ Respite care ☐ Jail/prison ☐ Other:

Residential contact name and phone number:

Is the youth at risk of losing current housing? ☐ Yes ☐ No
Comments:

Referral source (include name/organization):
Referral telephone:

Presenting Concerns (Including Youth's/Family's Own Words)

Presenting problem:

Precipitating factors:

Primary concern and desired outcome of intervention:
Youth:

Parent/Guardian:

Name (First, MI, Last):	**Record #:**	**DOB:**

Medical/Physical

Acute/Chronic Medical Conditions: (Please note any special medical considerations (pregnancy, unstable diabetes, infectious diseases, IV, tubes, CPAP, catheters, etc.)

Mobility problems: ☐ No ☐ Yes; explain: **ADL problems:** ☐ No ☐ Yes; explain:

Allergies reported: ☐ **No known allergies**
Food: **Medication:** **Environmental:**

Crisis Planning

Crisis Planning Tools: Does the youth have a Safety Plan? ☐ Yes ☐ No
If no, was a Safety Plan completed during the course of this intervention? ☐ Yes ☐ No; explain:

Has the youth or parent/guardian completed an Advance Communication to Treatment Provider? ☐ Yes ☐ No
If yes to any of the above, please indicate how the tool(s) were used during this encounter to impact the assessment, intervention, and disposition:
☐ Reviewed ☐ Expanded ☐ Use of contacts/resources ☐ Use of identified stabilization strategies
☐ Consideration of treatment preferences
☐ Tool(s) saved in ESP system ☐ Plan forwarded to: ☐ ICC ☐ IHT ☐ Outpatient ☐ other:

Is the youth in Intensive Care Coordination? ☐ No ☐ Yes
If yes, indicate Care Planning Team's assessment, interventions, and disposition recommendations:

Collaterals

Contact	Name	Telephone	Contacted	Date and Time
PCP			☐ Y ☐ N	
Clinician			☐ Y ☐ N	
Psychiatrist			☐ Y ☐ N	
DMH/DDS			☐ Y ☐ N	
DCF			☐ Y ☐ N	
DYS			☐ Y ☐ N	
School/residential			☐ Y ☐ N	
Guardian			☐ Y ☐ N	
	Indicate Type of Guardianship:			
Family/sig. other			☐ Y ☐ N	
Other			☐ Y ☐ N	
Outcome:				

Family

Significant family history and functioning, including extended family, family/parental strengths and needs, etc.

Developmental

Significant history regarding developmental functioning: ☐ Within normal limits
Comments:

Current impact of developmental needs:

Name (First, MI, Last):	**Record #:**	**DOB:**

Trauma History

Is there trauma history? ☐ Yes ☐ No
If yes: ☐ Victim ☐ Perpetrator ☐ Both
If yes, how does it influence current presentation or disposition?

Substance Use/Addictive Behavior History

Is there a history of, or current, substance use or other addictive behavior? ☐ No ☐ Yes
If no, skip to MH/SU Service History section. If yes, complete below.
Source of information: ☐ youth served ☐ clinician/observation ☐ other; describe:

Have you Ever used	Age of First Use	Date of Last Use	Frequency	Amount	Method
☐ **Alcohol**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily or Multiple/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Opiates**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily or Multiple/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Cocaine**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily or Multiple/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Marijuana**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily or Multiple/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Prescription:**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily or Multiple/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:
☐ **Other:**			☐ No use past 30 days ☐ 1-3x past 30 days ☐ 1-2x/week ☐ 3-6x/week ☐ Daily or Multiple/day		☐ Oral ☐ Smoked ☐ Inhaled ☐ Injected ☐ Other:

Was a tox screen performed? ☐ No ☐ Yes; results: **BAL:**

Additional information:

Mental Health/Substance Use Service History

☐ None reported

Dates of Service	Type of Service	Name of Provider/Agency	Goal/Outcome

Additional Information:

Name (First, MI, Last):	**Record #:**	**DOB:**

Medication ☐ None reported	**Dosage/Route/Frequency**	**Last Dose (Date, Time)**	**Adherence** WA = *With Assistance*	**Prescriber**
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
			☐ No ☐ Yes ☐ WA	
Comments on medications (past medications, side effects):				
Is medication a contributing issue to current presentation? ☐ No ☐ Yes; explain:				

Mental Status Exam		
	(WNL = Within Normal Limits)	**Comments**
Appearance:	☐ WNL	
Clothing	☐ WNL	
Eye Contact	☐ WNL	
Build	☐ WNL	
Posture	☐ WNL	
Body Movement	☐ WNL	
Behavior	☐ WNL	
Speech	☐ WNL	
Self-Reported Mood	☐ WNL	
Emotional State-Affect	☐ WNL	
Facial Expression	☐ WNL	
Perception:	☐ WNL	
Hallucinations	☐ None Noted ☐ None Reported	
Thought Content:	☐ WNL	
Delusions	☐ None Noted ☐ None Reported	
Other Content	☐ WNL	
Self-Injurious Thoughts	☐ None	
Suicidal Thoughts	☐ None	
Aggressive Thoughts	☐ None	
Thought Process	☐ WNL	
Cognitive Functioning	☐ WNL	☐ Intellectual Disability ☐ Other; describe:
Orientation	☐ WNL	**Disoriented to:** ☐ Person ☐ Time ☐ Place ☐ Situation
Memory	☐ WNL	
Insight	☐ WNL	

Name (First, MI, Last):	**Record #:**	**DOB:**

Judgment	☐ WNL	
Impulsivity	☐ None Noted ☐ None Reported	
Comments:		

Risk Assessment & Protective Factors

Assess each risk factor and rate from 'None' to 'High' and check each row

Clinical Risk Factors	✓	**None**	✓	**Low**	✓	**Moderate**	✓	**High**
Harm to Self	☐	None Reported	☐	No Plan	☐	Vague Plan	☐	Specific Plan
Means Accessibility	☐	None Reported	☐	Poor Access	☐	Accessible	☐	Possesses
Lethality Of Means	☐	None Reported	☐	Low Lethality	☐	Potentially Lethal	☐	Lethal
Suicidal History	☐	None Reported	☐	Ideation/Threat(s)	☐	Gesture(s)	☐	Attempt(s)
Lethality Of Attempts	☐	None Reported	☐	Non-Lethal	☐	Injurious	☐	Potentially Lethal
Last Attempt	☐	None Reported	☐	>2 Years	☐	6 Months To 2 Years	☐	Less Than 6 Months
Family History	☐	None Reported	☐	Ideation/Threat(s)	☐	Suicide Attempts	☐	Death(s) By Suicide
Male Age Suicide Risk	☐	0-12	☐	35-49	☐	13-34	☐	50+
Female Age Suicide Risk	☐	0-12	☐	39-59	☐	13-38	☐	60+
Harm to Others	☐	None Reported	☐	No Plan	☐	Vague Plan	☐	Specific Plan
Means Accessibility	☐	None Reported	☐	Poor Access	☐	Accessible	☐	Possesses
Lethality Of Means	☐	None Reported	☐	Low Lethality	☐	Potentially Lethal	☐	Lethal
Assault History	☐	None Reported	☐	Ideation/Threat(s)	☐	Single Assault	☐	Multiple Assaults
Lethality Of Assaults	☐	None Reported	☐	Minor Injuries	☐	Moderate Injuries	☐	Severe Injuries
Last Assault	☐	None Reported	☐	>2 Years	☐	6 Months To 2 Years	☐	Less Than 6 Months
Family History	☐	None Reported	☐	None	☐	Periodic Violence	☐	Persistent Violence
Male Age Homicide Risk	☐	1-8	☐	9-12/60+	☐	13-16/30-60	☐	17-30
Female Age Homicide Risk	☐	0-12	☐	45+	☐	13- 16/26-44	☐	17-25
Anxiety	☐	None Reported	☐	Minimal	☐	Moderate	☐	Severe
Agitation	☐	None Reported	☐	Minimal	☐	Moderate	☐	Severe
Sleeplessness	☐	None Reported	☐	Minimal	☐	Moderate	☐	Severe
Future Orientation	☐	Hopeful/Immediate and Distant Future Oriented	☐	Predominantly Hopeful and Future Oriented	☐	Minimal Hope and Sense of Efficacy	☐	Hopeless/Helpless
Physical Condition	☐	Excellent	☐	Good	☐	Fair	☐	Poor
Substance Abuse	☐	None Reported	☐	Social Use	☐	Substance Abuse Hx Not Under Influence	☐	Substance Dependence and/or Under the Influence/Withdrawal
Fire-setting	☐	None	☐	Ideation/Minimal	☐	Single Event	☐	Severe/Multiple Events
Gambling	☐	None Reported	☐	Occasional	☐	Frequent	☐	Persistent
Bullying	☐	None Reported	☐	Occasional	☐	Frequent	☐	Persistent
Elopement	☐	None	☐	Minimal	☐	Moderate	☐	Imminent
High Risk Factors								
Hallucinations	☐	None Reported	☐	Periodic or Non-intrusive	☐	Troubling Hallucinations	☐	Command Hallucinations
Psychosis	☐	None Reported	☐	Periodic or Non-intrusive	☐	Moderately Impaired	☐	Grossly Psychotic
Judgment	☐	Intact and Functional	☐	Predominantly Intact and Functional	☐	Periodically Impaired	☐	Grossly Impaired
Historic Factors								
Hx of Non-suicidal Self-injurious Behavior	☐	None Reported	☐	Minimal	☐	Moderate	☐	Severe or Frequent
Arrest Record	☐	None	☐	None Reported	☐	Single Arrest	☐	Multiple Arrests
Physical Abuse Hx	☐	None Reported	☐	Minimal Abuse	☐	Moderate Abuse	☐	Severe Abuse
Sexual Abuse Hx	☐	None	☐	No Abuse Reported	☐	Abuse Reported	☐	Severe Abuse
Sexualized Behavior	☐	None Reported	☐	Occasional	☐	Frequent	☐	Persistent

Name (First, MI, Last):	**Record #:**	**DOB:**

Environmental Factors							
Stress	☐	None Reported	☐	Minimal	☐	Moderate	☐ Severe
Loss	☐	None Reported	☐	>2 Years	☐	6 Months To 2 Years	☐ Less Than 6 Months
Financial Stress	☐	None Reported	☐	Mild	☐	Moderate	☐ Severe
Living Arrangements	☐	Safe	☐	With Others	☐	Access To Others	☐ Alone/Isolated
Support From Significant Others	☐	Positive/Helpful	☐	Present/Helpful	☐	Accessible/Somewhat Helpful	☐ Unable/Unwilling To Help

Is parent/guardian/caretaker at risk? ☐ No ☐ Yes; explain:

Protective factors:

Risk assessment summary:

Strengths and Service Preferences

Youth's strengths: (skills, talents, interests, aspirations, and resilience that relate to: personal qualities, daily living situation, finances, employment/education, social supports, health, leisure/recreation, spirituality/culture/religion, etc.)

Parent/guardian/caretaker strengths and resources related to youth's needs:

Service preferences:
Youth:

Parent:

Clinical Formulation

This clinical formulation is based upon information provided by (Check all that apply):

☐ Youth served ☐ Parent(s) ☐ Guardian(s) ☐ Family/friend(s) ☐ Physician ☐ Records
☐ Law enforcement ☐ Service provider ☐ School personnel ☐ Other:

Overall clinical formulation narrative (Please comment on reliability of information):

Diagnosis: ☐ DSM Codes ☐ ICD Codes

Check Primary	Axis	Code	
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
☐	Axis III		
☐	Axis IV		
☐	Axis V	Current GAF:	Highest GAF in Past Year (if known):

Name (First, MI, Last):	**Record #:**	**DOB:**

BPRS completed and attached (24-hour LOC admissions only)? ☐ Yes ☐ No ☐ N/A

Intervention and Stabilization
Therapeutic interventions delivered (including solution-focused crisis counseling):
Response to interventions: **Youth:** **Parent/Guardian:**
Stabilization activities:
Medications administered: ☐ No ☐ Yes; describe:
Restraints used: ☐ No ☐ Yes; describe:

Family Prioritized Needs to be Addressed at the Next Level of Care
1.
2.
3.
4.
5.
Identified needs to be addressed at a later date:

Resolution / Disposition
Rationale for disposition (Including parent/guardian's participation and preference):
☐ **No services needed at this time** ☐ **Natural/community supports** ☐ **ICC, IHT, or OP Hub-contacted and recommended referral to:** ☐ **TM** ☐ **IHBS** ☐ **Medical inpatient admission** ☐ **Youth/guardian declines further services at this time** ☐ **Diversionary services utilized:** ☐ MCI team crisis stabilization services/support for up to 7 days ☐ Home-based outreach services – services utilized: ☐ IHT ☐ CSP ☐ Other: ☐ Mental health outpatient referral ☐ Urgent outpatient referral ☐ Community Crisis Stabilization ☐ DMH/DDS respite bed (with approval of DMH/DDS case manager) ☐ Peer support/self-help/consumer-operated program; specify: ☐ Substance abuse program: ☐ Outpatient ☐ SOAP ☐ Rehab/residential ☐ Detox/ATS ☐ E-ATS/DDART ☐ Partial Hospitalization ☐ Day Treatment ☐ ICBAT ☐ CBAT ☐ 24- to 72-hour psychiatric observation admission **Diversionary provider utilized:**

Name (First, MI, Last):	**Record #:**	**DOB:**

☐ **Psychiatric inpatient referral**
☐ Voluntary ☐ Involuntary; **authorized by:**
Facility utilized: **Accepting doctor:** **UR contact:**

☐ **Other:**

☐ **Diversionary alternatives appropriate but not available; explain:**

Check only if applicable:
☐ Medical clearance provided by:
☐ Psychiatric consult with:
☐ Urgent psychopharmacology provided by:
☐ Specialing by:

Insurance Information

Primary insurance: **Policy number:**

Authorization number: **Number of days:** **Next review date:**

Person authorizing: **Phone number:**

Secondary insurance:

For any MassHealth-enrolled youth up to the age of 21 who will remain in the community, has the MCI team developed a plan with the youth/family to provide additional services/crisis stabilization for up to 7 days?
☐ Yes ☐ No; explain:

Brief description of planned intervention (indicate type/frequency of service, if it is face-to-face, anticipated duration):

Purpose of continued intervention:

Was the youth informed and parent/guardian/caretaker of availability of ESP MCI services if needed in the future, including mobile crisis intervention services and the ESP's community-based location? ☐ Yes ☐ No; If no, explain:

Provider - print name/credential/contact #:	**Date:**	**Supervisor - print name/credential/contact number** (if needed):	**Date:**
Provider signature:	**Date:**	**Supervisor signature** (if needed):	**Date:**
Youth's signature (optional, if appropriate):	**Date:**	**Parent/Guardian/Caretaker signature** (if appropriate):	**Date:**
MD signature (if needed):	**Date:**	**Next appointment if applicable:** **Date:** / / - **Time:** ☐ **a.m.** ☐ **p.m.**	

Appendix K: Managed-Care Entities (MCE) Websites

Beacon Health Strategies: www.beaconhealthstrategies.com

BMC HealthNet Plan: www.bmchp.org

Fallon Community Health Plan: www.fchp.org

Neighborhood Health Plan: www.nhp.org

Network Health: www.network-health.org

MBHP: www.masspartnership.com

Health New England: www.healthnewengland.com

Appendix L: Definition of Terms

Bachelor's Level Staff: In the context of delivering an MCI intervention, this person can deliver the service in tandem with a Masters-Level Clinician. His/her primary purpose in delivering an MCI service is attending to the experience of the parent/caregiver as they support and make decisions for their child who is in crisis, while assuring that the intervention is delivered in a family-centered manner consistent with the culture, values, expressed needs, and preferences of the family. NOTE: ONLY a Bachelor's Level staff person who meets the "lived experience" criteria of a Family Partner may use the title Family Partner.

Child and Adolescent Needs and Strengths (CANS): a tool that provides a standardized way to organize information gathered during behavioral health comprehensive assessments. There are two versions of the Massachusetts CANS for two age groups: Birth through Four and Five through Twenty. The Hub service provider is responsible for updating the CANS every 90 days. Hub-dependent service providers are not required to complete the CANS, but should obtain the initial CANS and updates from the referring Hub provider, use information from the CANS to inform its work with the child and family, and provide feedback to the Hub provider to inform on CANS updates.

Care Coordinator: an individual who provides Intensive Care Coordination (ICC) to youth and families, using the high-fidelity Wraparound model. The role of the Care Coordinator includes facilitating the development of a Care Planning Team (CPT), including the youth and caregiver(s); convening CPT meetings; coordinating and communicating with the members of the CPT to ensure the development and implementation of the Individual Care Plan (ICP); working directly with the youth and family to implement elements of the ICP; coordinating the delivery of other services; and monitoring and reviewing progress toward ICP goals, and with the CPT, revising the ICP when necessary.

Care Planning Team (CPT): In Intensive Care Coordination, CPT includes the youth and caregivers, as well as both formal and natural support people, such as extended family, friends of the youth and family, representatives of child-serving state agencies, school personnel, and advocates who assist the family in identifying goals and developing and implementing an Individual Care Plan. A CPT must include more than the youth, caregiver, and care coordinator.

Community-Based Location (CBL): Each Emergency Services Program/MCI operates at least one CBL in the catchment area where its services are available. These locations are open a minimum of 12 hours per day on weekdays and eight hours per day on weekends and holidays. Some are open 24 hours per day. These locations are often used as an alternative to providing ESP/MCI services in a hospital emergency department setting.

Community Crisis Stabilization (CCS): Adult CCS provides staff-secure, safe, and structured crisis stabilization and treatment services in a voluntary, community-based program that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalization. This program serves adults ages 18 and older, including youth ages 18-21, under the Children's Behavioral Health Initiative (CBHI).

Community Service Agency (CSA): provides Intensive Care Coordination using the high-fidelity Wraparound model, and provides the Family Support and Training Service (Family Partners). CSAs also are responsible for convening a local System of Care meeting to strengthen local communication and collaboration. CSAs contract with MassHealth MCEs through a request-for-proposals (RFP) process. There are currently 29 geographically based CSAs, as well as three CSAs dedicated to meeting the needs of underserved populations.

CSA Program Director: individual responsible for the overall supervision of ICC and FS&T program staff, and the clinical director of operations of the CSA.

Comprehensive Assessment: A Comprehensive Assessment is a clinical assessment completed by the hub provider that includes, but is not limited to the youth's presenting concerns, developmental history, psychiatric history, substance use history, medical history, and allergies or adverse reactions, medications, risk assessment, mental status exam, member strengths, DSM-V diagnosis, and clinical formulation. A Comprehensive Assessment includes a review of the child's need for care coordination and the adequacy of current care coordination services to meet this need. This assessment also includes the CANS, which is not a replacement or substitute for the complete Comprehensive Assessment. This information is collected for assessing the youth's treatment needs and strengths, as well as informing on treatment and determining the youth's need for Hub-dependent services and goals. Hub-dependent services providers are expected to obtain a copy of the most recently completed comprehensive assessment for the youth they serve.

Crisis System of Care (CSOC): refers to the organized whole of the behavioral health crisis system and comprises an infrastructure of services, systems, processes, and pathways that promote early, in-community planning for response to and management of behavioral health crises. CSOC framework includes the crisis-related services provided by Primary Care Clinicians, hospitals, law enforcement entities, schools, congregate care facilities, social services systems, and the actions of consumers, family members, and the general public. (Kappy Madenwald, Steve Day, and TAC Inc.)

Designated Forensic Professional (DFP): a licensed psychologist or physician who has completed the certification for DFP conducted by the Department of Mental Health and the University of Massachusetts Medical School. For purposes of conducting the acute evaluations under this

agreement, DFP candidates who have been formally accepted and are in the process of DFP certification may also conduct the acute evaluations.

Emergency Services Program (ESP): provides behavioral health crisis assessment, intervention, and stabilization services, 24 hours per day, seven days per week, and 365 days per year. Each ESP/MCI provides ESP services for adults, MCI services for youth ages 0-20, and CCS services for adults ages 18 and older. Both ESP services for adults and MCI services for youth may be provided on a mobile basis in individual's homes, as well as other locations such as schools. Both ESP and MCI services may also be accessed on a walk-in or call-ahead basis at the ESP's Community-Based Location.

Family Partner: an individual with "lived experience" as the caregiver of a child or youth with behavioral health or special healthcare needs. Family Partners are trained to assist families in either of two MassHealth services: Family Support and Training (FS&T, a hub-dependent service through a Community Service Agency), or Mobile Crisis Intervention (MCI). Most Family Partners provide the FS&T service, and while they often pair with Care Coordinators to implement the Wraparound process with families, they can also work with families in other hubs, either In-home Therapy or outpatient. On MCI teams, Family Partners pair with clinicians to provide support to youth in crisis and their families. This person provides emotional support for the caregiver and fosters empowerment and expression of family voice. Family Partners often share parts of their own stories as an intentional way of helping caregivers develop motivation and actionable insight.

Family Support and Training (FS&T): a hub-dependent service provided by a Family Partner to the caregiver of a youth receiving ICC, IHT, or outpatient services. Building upon family strengths, the Family Partner supports the caregiver in ways that address the behavioral health needs of the youth. The Family Partner provides emotional support for the caregiver and fosters empowerment and expression of family voice. The Family Partner models, trains, and coaches the caregiver in relevant skills. FS&T may also include activities such as sharing information, providing assistance in navigating the child-serving systems, assisting with linkages to parent support and peer support groups, and identifying community resources. Family Partners in FS&T follow a successive process of "do for, do with, and cheer on" as caregivers become progressively able to accomplish more in support of the child.

Hub Service: includes outpatient therapy, In-Home Therapy (IHT) and Intensive Care Coordination. Hubs serve as the primary behavioral healthcare provider for a youth. They assess the youth's clinical need for various supports and services, including hub-dependent services, and refer and link youth to those services. Hubs collaborate with collateral supports and services to integrate interventions.

Hub-Dependent Service: includes Therapeutic Mentoring, In-Home Behavioral Services (except when circumstances warrant a waiver of the Hub referral), and Family Support and Training. They provide a

specialty service that augments the interventions of the Hub provider. Referrals for hub-dependent services are made by one of the Hub services.

Individual Care Plan (ICP): a care plan for youth enrolled in ICC that specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family. Developed by the CPT, the plan incorporates the strengths and needs of the youth and family. The ICP is the primary coordination tool for Wraparound care planning.

Individualized Action Plan: an In-Home Therapy (IHT) Individualized Action Plan (IAP), also known as a treatment plan, is a detailed, individualized plan developed through collaboration between the IHT team and the youth and family. (NOTE: Some providers use the term Individualized Action Plan for a plan developed by a Hub-dependent service only. Here we also use IAP to refer to an IHT treatment plan, as this term is also used by providers). An IAP states the youth's and family's goals and, using understanding gleaned from the Comprehensive Assessment, identifies the "prescription" for therapeutic activities that will help the youth move towards his or her goals. Hub-dependent providers work on one or more IHT IAP goals, except when ICC serves as the Clinical Hub. In this case, the hub-Dependent provider works on goals in the ICC Individualized Care Plan (ICP). The youth, parent/ caregiver, and IHT clinician all influence and concur with the final IHT IAP. The plan is written in non-technical language that is understandable to the youth and family. The IHT IAP indicates who was involved in the development of the plan and who is responsible for carrying out each action on the plan.

In-Home Behavioral Services (IHBS): hub-dependent service for youth under 21, which addresses behaviors that interfere with successful functioning. Services are delivered by a master's level Behavior Management Therapist (BMT), often in partnership with a Behavior Management Monitor (BMM).

In-Home Therapy Services (IHT): a service that provides intensive therapy in the home or community, through a master's level clinician and often includes a bachelor's-level person providing the service of Therapeutic Training and Support (TT&S). If the youth is not enrolled in Intensive Care Coordination but is enrolled in IHT, then IHT is responsible for hub functions including treatment planning, communicating with other providers, and coordinating care. The IHT clinician develops a treatment plan and uses established psychotherapeutic techniques and intensive family therapy, working with the entire family or a subset of the family.

Intensive Care Coordination (ICC): provides care planning and care coordination using the high-fidelity Wraparound model. Collaborating with the family, ICC conducts an initial comprehensive assessment, facilitates the ongoing process for building a team, develops an Individual Care Plan to address the youth's needs and to support the goals identified by the youth and family, and then monitors and

improves the plan until goals are met. The Intensive Care Coordinator works with the youth, caregivers, supports, providers, schools, state agencies, and others who play a key role in the youth's life to facilitate the development of a Care Planning Team for the youth. Care planning is driven by the needs of the youth and developed through a Wraparound planning process consistent with Systems of Care philosophy.

Managed-Care Entity (MCE): an organization that contracts with the Commonwealth to provide MassHealth insurance products to Massachusetts residents. The term MCE is used by EOHHS to refer to a broad category of health plans, including specialized plans that deliver particular benefits, such as Behavioral Health services only.

Mobile Crisis Intervention (MCI): the youth-serving component of an Emergency Services Program provider, the purpose of which is to support youth and their families through psychiatric emergencies in ways that leave the family safe and emotionally stable. MCI provides an immediate, short-term, face-to-face therapeutic response to a youth experiencing a behavioral health crisis. The team is mobile, travels to where the emergency is taking place, and intervenes within one hour of contact. The MCI identifies, assesses, treats, and stabilizes the situation to reduce immediate risk of danger to the youth or others, consistent with the youth's risk management/safety plan, if one exists. The MCI team helps the family develop a risk management/safety plan, if they do not already have one.

The MCI service is available 24 hours a day, 7 days a week. Following a crisis, MCI can provide up to 7 days of crisis stabilization services, which include face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention. The MCI team, as needed, makes referrals and builds linkages to all medically necessary behavioral health services and supports. For youth who are receiving ICC or IHT, MCI staff coordinates with the youth's Care Coordinator or In-Home Therapist throughout the duration of the MCI service. If IHT is acting as the clinical Hub, the IHT clinician must be available to coordinate with the MCI team before, during, and after the crisis event. MCI also coordinates with the youth's primary care physician, any other care management program, or other behavioral health providers involved with the youth.

Natural Supports: individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as extended family members, friends, neighbors, members of faith communities, contacts at daycare, school, camp, or other community contexts that are accessible in a family's daily environments. Participation of Natural Supports in the service planning process can make it friendlier to families. The purpose of joining with Natural Supports is to find sustainable, affirmative resources that will help children and families move forward in their lives long after professional involvement ends. Connecting with Natural Supports helps youth and families connect with their community and reduce isolation.

Parent/Caregiver: refers to any biological, kinship, foster, and/or adoptive family/caregiver responsible for the care of a youth.

Senior Care Coordinator: supervises other Care Coordinators and is a master's-level clinician licensed at the independent practice level.

Shared Decision Making (Informed Medical Decisions Foundation) (SDM): a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences. Visit www.informedmedicaldecisions.org.

System of Care (SOC): a cross-system, coordinated network of services and supports organized to address the complex and changing needs of youth and families in the context of their culture, environment, and family situation. For a full discussion of System of Care, see *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families* (Beth A. Stroul, M.Ed., and Gary M. Blau, Ph.D., Eds.).

Therapeutic Mentoring: a hub-dependent service that offers structured, one-to-one, strength-based support services between a Therapeutic Mentor and a youth, dependent on the referring Hub service, and guided by the Hub's Individual Action Plan for the purpose of addressing daily living, social, and communication needs.

Therapeutic Training & Support (TT&S): a component of the In-Home Therapy service, which is available to families to assist in achieving treatment goals and therapeutic objectives. The TT&S staff may coach, teach, or otherwise support the youth to develop, practice, and generalize skills to understand and manage emotional responses to family situations. He or she may assist the family in understanding the youth's emotional and mental health needs. TT&S staff may engage in skill building activities to strengthen the youth's functioning in the family and support family members in practicing concrete skills for dealing with the youth's episodes of disturbance. TT&S staff also help youth and families connect to Natural Supports and are not required to have clinical credentials.

Wraparound: an intensive, individualized care planning and management process. Driven by the youth and family's goals, the Wraparound process produces a unique set of community services and natural supports individualized for that youth and family to achieve their goals. Intensive Care Coordination is the CBHI Wraparound service, although all CBHI services are designed to align with Wraparound principles. For more information on the National Wraparound Initiative, visit www.nwi.pdx.edu/wraparoundbasics.shtml.

There are no standard operating procedures that fit for all families. Families deserve interventions that are tailored to their unique needs, based on strengths and considerate of their own culture. More importantly, it is only when families are truly the center of all planning...even during times of crisis...that hope can be inspired and progress can be achieved. – Parent/Professional Advocacy League (PPAL)