****

**Rosie D. Feature Article September 2015**

***MCI Practice Guidelines – Establishing Quality Standards for
Home-Based Services***

As required by the Court’s Judgment in *Rosie D*. and ongoing disengagement efforts, the parties are working to improve the consistency and quality of remedial services, establish standards for service delivery, and promote best practices within the Children Behavioral Health Initiative (CBHI).   Newly released Practice Guidelines for Mobile Crisis Intervention, In-Home Behavior, Therapeutic Mentoring and In-Home Behavior Services advance all three of these goals, with the intention of supporting providers, educating stakeholders, and improving outcomes for youth and families.

CBHI Practice Guidelines incorporate and build upon the knowledge gained during six years of service delivery and implementation experience.  Informed by subject matter experts and Massachusetts providers, the Guidelines are intended as clinical manual for the provision of home-based services that establishes professional quality standards in areas like youth and family engagement, assessment, treatment planning and intervention, transitions and clinical supervision.  This is the first in a series of features highlighting the new Practice Guidelines and their role in the evolving remedial service system.

In January of 2015, the Commonwealth released the first of its Practice Guidelines, addressing the delivery of Mobile Crisis Intervention (MCI).  Developed with the assistance of consulting expert and program trainer Kappy Maddenwald, the MCI Practice Guidelines cover the full spectrum of crisis services from outreach and individualized risk assessments to safety planning and service linkages – all while stressing the importance of highly individualized, resolution-focused crisis interventions delivered in community-based settings.  Several of these practice standards are highlighted below.

**Community Outreach and Data Analysis**

MCI Practice Guidelines emphasize the MCI providers’ responsibilities to educate their communities and system of care partners about the availability and benefits of community-based crisis intervention.  MCI providers are expected to collect and use data to inform these outreach efforts, analyzing referral sources and trends in their communities, and dedicating resources to further outreach and development of strategic partnerships with local constituencies.

A robust crisis system includes a range of less restrictive alternatives, designed to stabilize and empower youth and families and to avoid unnecessary hospitalization and out-of-home placement.  In their outreach to area behavior health programs, medical providers, schools, law enforcement agencies, and other referral sources, providers are advised to discourage the use of emergency rooms for management of behavioral health crises, since these facilities are often experienced by youth as uncomfortable, embarrassing, isolating or frightening.  Similarly, even short term hospitalization can disrupt school, family, job and social activities, and often lead to out-of-home services that are more restrictive in nature.  By communicating to families and other system stakeholders about the value of community-based supports and interventions, the benefits of developing a safety and crisis management plan, and the availability of other home-based services, MCI teams can achieve service standards for proactive crisis prevention, increased community-based interventions, and effective hospital diversion strategies.

**Risk Assessment and MCI Triage**

Accurately screening requests for mobile crisis intervention and assessing callers’ level of risk is a critical component of MCI service delivery – one which shapes the nature of the crisis encounter and determines the frequency with which teams are dispatched to home and community-based settings.  With this in mind, the Guidelines establish standards for triage screening in the context of MCI Medical Necessity Criteria.

In the absence of imminent risk of harm, and in their exercise of professional judgment, MCI teams are expected to begin with the assumption that a community-based crisis intervention is the 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.  Only 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, is it appropriate for the MCI to call 911 and*to coordinate*with emergency responders to ensure safety. The ESP/MCI team should dispatch to meet emergency responders at the location of the crisis, and work to further de-escalate the situation.

To determine if an exception to mobile response exists, triage staff gathers details 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.  Among the best practices promoted by the Guidelines is the development and submission of a Crisis Planning Tool to the local MCI team***before***a crisis occurs.  Having access to this information allows MCI providers to make a more informed and individualized assessment of risk for the youth in question, while identifying 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.

**Crisis Stabilization Services**

MCI teams can offer youth and families up to 7 days of crisis stabilization services following resolution of the initial crisis event.  This expanded period of intervention provides the flexibility to offer ongoing staff support in the home, to develop a youth/family-specific strategy for crisis resolution, to include de-escalation strategies in the safety plan, to explore treatment options, and to generate referrals for needed care coordination.  The availability of ongoing crisis staff in the home or other community location can be a critical strategy for avoiding out of home placement, hospitalization, or other disruptive transition.

The MCI Practice Guidelines expect teams to discuss potential crisis stabilization goals with all youth and families, including the function and range of ongoing mobile crisis staff and support services which can be offered during this period: continued face-to-face and telephonic crisis counseling; practicing of de-escalation techniques; refinement and dissemination of the Safety Plan; consultation with existing providers, including school staff; and the initiation and support of new service referrals.

Extended MCI services also can benefit youth and families who may be unsure about the need for, or appropriate course of, future treatment interventions, allowing them to defer decision-making until the crisis has abated, providing the opportunity to explore various treatment options, and supporting any transition to/engagement with new service providers.  In this stabilization phase, the Guidelines promote best practices including maintaining a bi-disciplinary approach (clinician and family partner), avoiding routinized or perfunctory intervention strategies, and using shared decision-making to identify and deliver individually tailored, youth and family-centered treatment.

A copy of the complete [**MCI Practice Guidelines**](http://www.rosied.org/resources/Documents/MCI%20Practice%20Guidelines.final.pdf), including the detailed Appendix, is available for download here and in the *Rosie D.* implementation library.