Mobile Crisis Intervention: Model Enhancement

Regional Forums
Facilitated by: Kappy Madenwald
April/May 2012
Format for the Day

- Group Coaching/Consultation
- Flexible, interactive, participant-driven format
- We will cover a broad range of topics in a short period of time
- There will be some trips down memory lane
- Collectively think about:
  - What the enhancement means for families?
  - What it means for the team?
  - What it means for me?
  - Getting ready for implementation no later than 5/31/12
Overview of the Session

- Review of MCI model enhancement
- Creating meaningful stabilization capacity
- Developing a service menu (anticipating what families want)
  - Doing more of what you already do well
  - Building new service “tracks”
- Review of select strategies
- Advanced Engagement and Crisis Resolution Strategies
MCI Model Enhancement—What’s Different?
<table>
<thead>
<tr>
<th>Mobile Crisis Intervention IS:</th>
<th>Mobile Crisis Intervention IS NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An active treatment service</td>
<td>• Passive observation/monitoring</td>
</tr>
<tr>
<td>• Based on Medical Necessity Criteria</td>
<td>• Respite</td>
</tr>
<tr>
<td>• Based on individualized plan for intervention/stabilization</td>
<td>• “Specialing”</td>
</tr>
<tr>
<td>• As indicated, the service is varied in intensity and duration</td>
<td>• Staffing augmentation in school or residential settings</td>
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<tr>
<td>• A service that is focused on resolution and decreasing the need</td>
<td>• On-demand (the mutual decision to extend follows an initial crisis</td>
</tr>
<tr>
<td>for out of home treatment</td>
<td>intervention)</td>
</tr>
<tr>
<td>• A service delivered in collaboration with families</td>
<td>• Delivered in the home in the absence of a parent/guardian</td>
</tr>
<tr>
<td>• A service delivered in collaboration with existing care providers</td>
<td>• A substitute for an existing service</td>
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<tr>
<td>• Delivered by a specialized team that can lend expertise by</td>
<td>• A requirement or waiting period before a “next” service can begin</td>
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<tr>
<td>joining with, but not substituting for an existing treatment</td>
<td>• Intended for the purpose of transportation</td>
</tr>
<tr>
<td>provider/team</td>
<td>• Limited to daily ‘follow up’ or ‘re-evaluation’</td>
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</tbody>
</table>

- On-demand (the mutual decision to extend follows an initial crisis intervention)
- Delivered in the home in the absence of a parent/guardian
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- Limited to daily ‘follow up’ or ‘re-evaluation’
MCI Decision Algorithm

- Decision to extend service episode is
  - Mutual
  - Serves the child and parent (Shared, not program-centered, decision-making)
  - Individualized
  - Refined and reframed along the way as clarity is reached and progress is made

- Episode ends
  - When child/parent experience sufficient relief/resolution
  - When linkage is sufficiently made with another provider
  - When an existing provider is able to continue the stabilization work with the family
  - When there is no longer a crisis context for delivering the services
MCI Decision Algorithm

- Routinized follow-up (for example, making a follow-up call to every family as a business rule, rather than as individually determined) is a program-centered habit that...
  - Conflicts with Wraparound Principles of Care
  - Can be experienced as artificial by families
  - Detracts from teams ability to build out meaningful crisis stabilization services for the smaller number of children and families who want it and are still experiencing some aspect of the crisis.
  - Can actually increase risk to children and families

HOW???
MCI Model Enhancement

- There have been modest changes to:
  - Performance Specifications
  - Medical Necessity Criteria
- Remains a bi-disciplinary service over the course of the “up to 7 day” episode
- Service must include Psychiatric consultation and urgent psychopharmacology, when indicated and not otherwise available
- Service remains inclusive of a wide array of assessment, stabilization, intervention, collaborative and resolution-focused activities
- 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 per the Performance Specifications and the Medical Necessity Criteria
MCI Model Enhancement

Most significant change is an emphasis on the crisis stabilization component of the service, and the enhanced opportunity this provides.
MCI Model Enhancement

The enhancement forces new thinking and offers the opportunity for:

- An extended, more specialized assessment when circumstances are complex—there is some luxury of time.
- When, despite the presence of risk factors, the benefits of hospitalization are not perceived by the (family-inclusive) team as outweighing the potential harm. Examples:
  - Would be 1st separation from parent/frightening
  - Prior negative experience
  - Exposure
  - Environmental disruption is destabilizing
  - Stigmatizing—what will my classmates say if they find out?
  - Distance will limit family involvement
- True Diversion—for families who, for a number of reasons, are looking for alternatives to hospitalization and other out-of-home treatment. This is a purposeful alternative that involves the application of Wraparound Principles to the greatest extent possible.
Creating Meaningful Stabilization Capacity
Creating Stabilization Capacity

- The availability of community-based intervention, resolution and stabilization services for up to 7 days certainly sounds like an asset in a crisis system of care.
- It becomes **viable** when it is easily accessible, dependable and tangible as a diversionary option.
- If it is available only by stretching the team’s acute response resources, the viability dissipates—sort of a “robbing Peter to pay Paul”.
Creating Stabilization Capacity

To assure that services on day 2-7 are a viable commodity to families, to MCI teams and to the system of care it is important that:

- That the logistics are sufficient to pull it off (team members in the right places at the right time to do the work)
- That issues of “service continuity” are addressed
- And that the team can deliver the individualized services that families want and need in order to stabilize/resolve a crisis
Developing a Service Menu
Developing a Service Menu

When (by May 31st) the maximum length of an MCI increases from 72 hours to 7 days….

- What do you envision as the potential impact for children and families?
- Standing in the shoes of children in crisis or their parents
- How does the offer of additional days of community-based crisis stabilization make a difference?
Developing a Service Menu

What are families looking for?

A 2012 study by PPAL, *Family Support and Family Involvement: Building Skills, Knowledge and Participation*, asks parents that question.
Developing a Service Menu

- Parents were clear that their children and families need more than home or community based services and treatments.
  - They were eager to gain more knowledge
  - find resources in their communities and
  - take the next step toward participating on committees and in public forums.

Source: 2012 PPAL Study
Developing a Service Menu

Parents said they need 3 things to manage at home:

- Behavioral strategies that go beyond sticker charts, special education advocacy and help finding community resources.
  - Many parents (67%) believe that managing difficult behaviors is possible, but they need sophisticated strategies.

- Second, parents also find that if the school plan doesn’t work, it has a negative impact.
  - They identified a need to advocate for special education services (61%) with expertise in mental health issues.

- Last, parents (56%) said that finding community resources for their child and themselves is very important to them.

Source: 2012 PPAL Study
Developing a Service Menu

- As a seeming contrast to the desire of families to find meaningful resources, we know that a significant number of families that are referred by MCI teams to formal services either
  - Do not make the initial appointment, or
  - Do not return after the first appointment
- The MCI Model Enhancement provides an opportunity to
  - Address linkage barriers and,
  - Become more sophisticated in matching families with services that are wanted and that are likely to bring results/relief/solutions/information/empowerment
  - To feel comfortable NOT automatically linking families to if they are not interested or if the timing is wrong (beware the loaded “yes”)

WHAT THE HECK IS THE LOADED “YES” ???
Developing a Service Menu

From the PPAL report alone, MCI teams have three key starting points in developing a Day 2-7 crisis stabilization menu:

- What are some other potential menu items?
- What menu items might build upon the existing skills/interests of your ESP?
- What menu items might build upon the existing skills/interest of your agency?

The menu doesn’t have to (and won’t) look the same at every agency, but it is useful to think about tangible offerings so that Day 2-7 services are increasingly accessible and usable by both the MCI team and families.
Developing a Service Menu

Enhancing what you already do well:

1. Safety planning/practicing: Expanded use of Crisis Planning Tools
2. Parent Support, advocacy and coaching
3. Psychoeducation: increasing knowledge about a condition, symptoms, treatment options, etc.
4. Orientation to service system: choices, eligibility, access
5. Orientation to parent support network across the state: Groups, on-line resources, opportunities to get engaged
6. Family-centered resource development—cultivating natural, informal and formal supports
7. Brief, pragmatic, and solution-focused interventions
8. Cross service/agency/system collaboration
9. Sophisticated resource matching
Developing a Service Menu

Build Advanced Competency

- substance use-related crises
- School-involved crises or complexities
- Specialized intervention for children in crisis with ID/DD and their parents/caregivers
- Specialized interventions for transition-aged youth or young adults and their parents/caregivers
- Advanced Family Support practices
- Application of evidence-based practice tools within a crisis context
  - Trauma-informed Interventions
  - Dialectical Behavioral Therapy
  - Illness Management and Recovery
Review of Select Strategies
97 Action Steps of Family Partners

- In the Wraparound process, the family partner has three primary roles which are defined in terms of seven functions:
  1. Models effective interactions
  2. Advocates for and supports family’s needs
  3. Sharing your experience
  4. Mentors Families to Improve Self-Efficacy (Confidence they can be successful)
  5. Supports Development, Reconnection and Strengthening of Natural Supports for Families
  6. Supports Implementation of the Phases and Activities of Wraparound
  7. Supports Development of Family to Family Supports
- The functions are further defined in 97 Action Steps (see handout)

Source: Vroon VanDenBerg.
“Parents as Agents of Change” Model

Olin, Hoagwood, Rodriguez, et. al. summarize research findings on gaps that continue to exist in families ACCESSING and USING mental health services. They note...

- Inefficient service delivery
- High “no-show” rates
- Children with the most serious problems or complex social situations are less likely to be retained in treatment
- Service barriers that are about
  - Logistics (transportation, childcare)
  - Attitudes, perceptions, beliefs, experiences with the mental health system
  - Family Contextual factors like parental stress and degree of social supports

“Parents as Agents of Change” Model

- The goal of the Parents as Agents of Change model is to “activate parents as change agents” in meeting their children’s mental health needs.

“Parents as Agents of Change”

Model

The Developers used

- A research-based “Unified Theory of Behavior Change” along with...
- Grassroots-driven/developed “Principles of Parent Support” framework

To create the “Parents as Agents of Change: An Integrated Framework for Action”

Example: Parents as Agents of Change

What do I get out of this?

What do other people think/do?

How do good/bad do I feel about it?

Do I believe I know how to do this?

PARENT ADVISOR STRATEGY

I WILL DO IT

I DID IT

Skills/Knowledge, Habits, Environmental Obstacles, Priorities

“Parents as Agents of Change” Model

- If parents don’t have a clear vision of what they will get out of IT (the service, the action, the safety plan, the behavioral intervention)...
- If parents have concerns about what others think of IT (seeking services, changing parenting styles, using medications)...
- If parents do not feel good about IT (the strategy, the system, the effect, the provider, the label)...
- If parents don’t have the belief that they know how to do IT (advocate, intervene, assure safety, harness natural supports, drive the treatment...

**THE LIKELIHOOD OF CHANGE IS LOW**

Changing the Behavioral Lens

Enhancing Behavioral Strategies

Changing the “lens” through which the behavior is viewed

- If the explanation is NOT that your child is BAD what could it be instead?
- If you believed this new explanation instead, how would it make a difference to you? How would you change your parenting strategy?
- What might be the service implications?
Changing the Behavioral Lens

- Bad
- Bored
- High-Energy
- Curious
- Lonely
- Trauma-Reactive
Changing the Behavioral Lens

Trauma-reactive behaviors

- Recognizing signs and symptoms
  - Behavioral
  - Psychological
  - Cognitive
  - Physical
- Remember that symptoms may mimic and be confused for other mental health conditions
- It isn’t just the big traumas that can impact behavior and functioning

Example
Changing the Lens

non-compliant  unwilling to change
incapable   resistant
poor judgment  decision-making
dysfunctional  oppositional
remorseless    chronic
seeking secondary gain neglectful
chronic   lazy
incorrigible  bad
dumping      gamey

Tell the “strengths-based” side of each of the above stories...
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

Source: [ww.samhsa.gov/prevention/SBIRT](http://ww.samhsa.gov/prevention/SBIRT)
SBIRT

SBIRT CONSISTS OF THREE MAJOR COMPONENTS:

- **Screening** — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.

- **Brief Intervention** — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

- **Referral to Treatment** — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.
SBIRT

- A 2009 article in the journal Drug and Alcohol Dependence, for example, found an almost 68-percent reduction in illicit drug use over a 6-month period among people who had received SBIRT services.

- The researchers reviewed data on 459,599 patients screened at various medical settings in six states. Almost 23 percent had drinking or drug problems or a high risk of developing them. Of those patients, almost 16 percent received a brief intervention; 3 percent received brief treatment; and almost 4 percent received referrals for more specialized treatment.

The Drinker’s Pyramid

Source: World Health Organization
SBIRT Tools

- There are a number of iterations of SBIRT as tools have been developed for a wide range of settings and specific populations.
- One is the *Screening and Brief Intervention Tool Kit for College and University Campuses*.

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Crisis Response for Children with ID/DD

- Specialized assessment skills
- Understanding of and ability to bridge with the ID/DD system
- Unique experiences of parents/caregivers
- Particular sensitivity to pro/con of placement outside of known environment
- Aware of any options for bringing in specialized consultants
- May want to review ID/DD-specific crisis models such as START
Crisis Response for Children with ID/DD

START Model

- Developed in Massachusetts by Joan Beasley for individuals with Intellectual or Developmental Disabilities and behavioral health symptoms
- Systemic, Therapeutic, Assessment, Respite & Treatment.
- Proactive crisis prevention and training of caregivers
- System/provider collaboration is a fundamental component of the model
- Variations of START are being used in other states and communities
Shared Decision-Making

“Shared decision-making is particularly relevant when there is uncertainty about a particular decision. Uncertainty may stem from multiple or competing options each with advantages and disadvantages, incomplete or inconclusive scientific outcome evidence; or individual factors such as personal values and beliefs, a limited knowledge about the options, or lack of support to make a clear choice.”

“Effective shared decision-making requires both informed and involved consumers, and practitioners who are willing to enter into meaningful dialogue with the person about the decision to be made.”

Source: SAMHSA Fact Sheet
Shared Decision-Making

- Includes, but does not stop with, informed consent
- Personal perception of risks and benefits
- The person receiving the service and the service provider both have valuable information to offer
- Recognizes that in most instances, there is more than one reasonable pathway to consider
- Respecting voice, choice and values of recipient
  - Preserves dignity
  - Promotes trust
  - Results in a consensual plan
- If it doesn’t work as intended, then information gained can inform the next decision
Shared Decision-Making

Develop a protocol for its use
This helps to keep us out of “expert mode” and using techniques that are

- Collaborative
- Consultative
- Promotes shared decision making
- Preserves the right to take risk
- Results in mutual responsibility
Shared Decision-Making

Example from another field:
Mayo Clinic Shared Decision-Making tool for persons with diabetes
Advanced Engagement and Crisis Resolution Strategies:
Advanced Engagement and Crisis Resolution Strategies:

- That a child is receiving bed-based services indicates a level of treatment-restrictiveness.
- But, the bed is not the key to resolution.
- The MCI model enhancement offers an interesting opportunity to be nimble and highly individualized in our response.
- And in our use of specialized engagement, resolution and change strategies.
Advanced Engagement and Crisis Resolution Strategies:

Work to understand the nature of the crisis

- As experienced by
  - Child
  - Parent/caregiver
  - Other stakeholder

- See it from their “shoes”

- Consistently practice telling better stories

- Collectively exploring potential antidotes
Advanced Engagement and Crisis Resolution Strategies:

Continue the advancement of cross agency/system collaboration

- Formalizing affiliations with key partners
- Developing point person relationships
- Individualized linkage strategies
- Families benefit from the seamlessness, the efficiency and your cross program/system knowledge
Advanced Engagement and Crisis Resolution Strategies:

Commit to Systems of Care and Wraparound Care Planning principles and model fidelity

- If we adhere to the principles our work will be strengths-based
- The principles are also self-righting if we fall into deficit practices or expert mode
Advanced Engagement and Crisis Resolution Strategies:

If interventions are not producing wanted results it is OUR job to change.

- Help staff to notice the signs
  - Resistance
  - Reluctance
  - Skipping appointments
  - Not following the plan
Advanced Engagement and Crisis Resolution Strategies:

Practice delivering MCI services at a pace that is useful to the child/family

As it is useful to the child/family... slow down

- Offer a period of watchful waiting to see if the crisis stabilizes and if big decisions (like hospitalization) can be avoided
- Defer decision-making until preferences are clear
- Find ways for parents/families to test the treatment waters
- For children/families/young adults that are reluctant to enter formal treatment, MCI team might offer engagement services (perhaps over several crisis episodes)
- Provide brief crisis treatment during MCI episode that may, in fact provide sufficient resolution/relief
Advanced Engagement and Crisis Resolution Strategies:

Feel the value of nimble, nuanced crisis stabilization services

* Help families in harnessing the “right mix” of natural and informal strategies and supports
* Be present at “critical times”
* Get out of the way during periods of “smooth”
Closing Thoughts...