Statement of Work

Child, Youth, and Family Crisis Teams

PURPOSE

The purpose of Child, Youth, and Family Crisis Teams (CYFCT) is to recognize and respond to families in crisis in ways that support the developmental needs of children, young adults, parents, and caregivers. CYFCTs are designed to meet the sense of urgency that parents and caregivers experience when their child/youth begins to demonstrate behavioral changes they feel ill equipped to manage on their own. In supporting the caregiver's ability to respond effectively CYFCTs decrease the likelihood that higher intensity interventions will become necessary.

CYFCTs are an upstream intervention that is available to families when their usual coping skills or problem-solving strategies are overwhelmed or ineffective. Services are designed to meet the family's sense of urgency and focused on shifting care pathways away from higher intensity options. Exposure to placement disruptions, hospitalization, law enforcement, child welfare involvement and other higher-intensity services is both costlier and potentially trauma-inducing. CYFCTs promote in-home stabilization through recognizing and honoring natural intervention points of support systems that are available to families in their own communities. CYFCT services are easily accessible, timely, equitable, and culturally humble. The service model both recognizes and nurtures the healing potential within communities and caregivers' innate ability to address future crises in their own families.

CYFCTs are grounded in System of Care philosophy and values and strive to meet best practice standards as outlined in the Mobile Response and Stabilization Services (MRSS) model. In aligning efforts with child serving systems, CYFCTs aim to play a supportive role within a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health and other challenges.

SERVICE POPULATION

Children, youth, and young adults birth to 21 with their parents or caregivers.

SERVICES

Outreach and Engagement

CYFCTs engage in outreach activities to inform families, communities, and system partners about the availability of the program. Key system partners include school districts, law enforcement agencies, and hospitals. CYFCT providers are expected to demonstrate that they have developed strong relationships with these partners through referral data.

Other outreach areas for consideration include but are not limited to pediatric primary care providers, inpatient adolescent units, juvenile justice, child welfare, foster parents, after school programs, substance use and co-occurring disorder providers, and shelters serving both youth and families with children.

Single Access Point

It is considered best practice within the MRSS model to identify and support a single point of access that is operational 24/7/365 and is staffed with a workforce that has been trained in MRSS. While the single point of access may offer response and services across the lifespan, staff need to have specific training and triage protocols for children, youth, and families that allow for the family or youth to define the crisis and receive immediate face-to-face responses. Staff must have immediate access to clinical and psychiatric consultation.

Ultimately, 988 is expected to be the single access point, and provide customized triage in accordance with MRSS principles. Staff must be trained in MRSS principles, be capable of responding to concerns around the clock, and have the capacity to accept phone calls, texts, and chat. The single access point provider must engage in suicide screen protocols for all contacts and put a warm handoff protocol in place to dispatch mobile response teams. Finally, the single access point provider must have the capacity to remain on the line with callers until the mobile team arrives for high risk or high need calls. Requests for services are not screened in or out based on the reported problem set or perceived acuity. Teams are dispatched to every service call.

Crisis Mobile Response (up to 72 hours)

CYFCTs are available to respond in-person to homes and community locations. Time from dispatch to in-person response must fall within 2 hours of the referral from the single point of access for an emergent crisis, and within 24 hours for an urgent crisis. MRSS best practice is to respond in-person within an hour for all dispatches. Teams must have immediate access to clinical and psychiatric consultation. CYFCTs screen for suicide and work with the child, youth, or young adult and their caregivers to develop a written crisis and safety plan. Teams should intentionally include parents, caregivers, natural supports, and relevant treatment providers to help the person in crisis stabilize. This should be in accordance with Washington state law when encountering youth 13-17 years old and within the limits of confidentiality.

After the initial in-person response, mobile services including brief care coordination may last up to 72 hours. This should include the use of a child specific assessment tool to aid the team in identifying needs and possible resources. Since the CYFCT may be the first point of contact a family has with the behavioral health system, the team should build a trusting relationship of mutual respect and provide individualized care including family voice. CYFCTs work with youth and families identify and connect them with existing systems of care and natural supports through warm handoffs, including to the stabilization phase.

- Crisis Response Guidelines:
  - The crisis is defined by the child, youth, young adult, parent, or caregiver.
  - Best practice is an in-person response within 60 minutes, though mobile teams must be on the scene within 2 hours for emergent crises and 24 hours for urgent crises.
  - Respond without law enforcement whenever possible and with the goal of diverting from justice system intervention if officers are present.
  - Work with the child/youth and caregivers to reduce admissions to ERs, inpatient adolescent units, detention centers, residential treatment centers, or foster care placement transitions.
  - Initial response should include developmentally appropriate de-escalation, a children or youth risk assessment, safety planning, peer support, and skill-building.
  - Support and maintain child/youth in their living and community environment, reducing out of home placements.
  - Promote and support safe behavior in the home, schools, and community.
  - Ensure staff are trained in culturally responsive, developmentally appropriate trauma-informed care, de-escalation, and harm reduction strategies.

Stabilization

Stabilization services are provided for up to 2 weeks for youth and families who have received a mobile response, can benefit from continued MRSS support, and are not already receiving care coordination support

(i.e., WISe, targeted case management, etc.). Services focus on helping children and youth to stabilize in their current living arrangement and return to routine functioning. Connections to natural and community supports are emphasized. Direct care staff have immediate access to clinical and psychiatric consultation. It is best practice for the same workers who provided the mobile response to provide the stabilization services.

The stabilization phase can include identifying and addressing ongoing needs, reviewing safety plans, skill building, parent support and care coordination to identify and connect families with community providers through family-facing systems of care, and natural supports. Community connections are linked to inherent strengths and interests of the child/youth and provide opportunity for connection, relationships, skill building, and community-based respite support. This can include, but is not limited to, extracurricular activities, after school programs, sports, arts, community events, church groups, neighbors, and family members. Children, youth, young adults and families enrolled in stabilization services continue to have access to urgent mobile response services at any time, day or night.

- Stabilization Goals:
  - Support and maintain child/youth in their current living situation and community.
  - Services are provided face-to-face in the youth's natural environment, home, school, and community.
  - Support is provided to youth and families that is developmentally appropriate, culturally humble, and trauma-informed.
  - Assist youth and families in identifying, accessing, and linking to community systems of care and refer to additional clinical services if needed.
  - Care coordination to assist youth and families in identifying and linking to ongoing natural and system supports to reduce return to the crisis phase. Include peer support for youth or caregivers as appropriate.

PROGRAM STAFFING

CYFCTs are required to have a licensed or credentialed Mental Health Professional (MHP) as a supervisor. Teams have flexibility in their overall composition. Outreach should occur via a team of at least two staff, preferably with one clinician and one peer (either a youth peer or a parent partner). Teams must have an MHP available during hours of operation for support and clinical consultation. This does not have the MHP supervisor if other MHPs are on staff.

Supervisor MHP

Must meet the requirements as a Mental Health Professional and meet all licensure or credentialing requirements from Department of Health (DOH) to provide services.

MHP Definition:

1. A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapter 71.05 and 71.34 RCW;
2. A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of an MHP;

3. A person who meets the waiver criteria of RCW 71.24.260 which was granted prior to 1986;
4. A person who has an approved waiver to perform the duties of an MHP that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or
5. A person who has been granted a time-limited exception of the minimum requirements of an MHP by the mental health division consistent with WAC 388-865-265. This includes qualified individuals with an agency affiliated credential or associate license who qualify as an MHP.

Clinician

Must have a BA/BS degree or higher in a behavioral health field and be licensed and/or credentialed by DOH to provide services.

Mental Health Care Provider (MHCP) Exemption: For the clinician who qualifies as an MHCP to provide initial services with a peer, the provider agency must obtain an exception from rule from DOGH using the process outlined in WAC 246-341-0302.

MHCP Definition:

1. The individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum requirements are a B.A. level in a related field, A.A. level with two years of experience in the mental health or related fields.

Certified Peer Counselor (CPC)

Certified and credentialed by DOH to provide services, typically as an Agency Affiliated Counselor. Peers will receive additional training on providing crisis peer services in the future to improve service delivery and resilience for the workforce. CPCs can only provide services when accompanied by a licensed or credential staff or their supervisor. All services provided by CPCs must be provided under the oversight of an MHP supervisor.

CPC Definition:

1. Is a self-identified consumer of behavioral health services who:
    a. Has applied for, is eligible for, or has received behavioral health services; or
    b. Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;
2. Is a counselor credentialed under chapter 18.19 RCW;
3. Has completed specialized training provided by or contracted through the Medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in 1, 2, and 4 by January 31, 2005, the person is exempt from completing this specialized training;
4. Has successfully passed an examination administered by the Medicaid agency or an authorized contractor; and
5. Has received a written notification letter from the Medicaid agency stating that the Medicaid agency recognizes the person as a “peer counselor”.

Training Requirements

All peers must complete the HCA sponsored peer crisis training. Additionally, CYFCTs must be offered training opportunities on the following topics:

- Crisis intervention and de-escalation
- Suicide and risk assessment
- MRSS principles and practice
- Safety and crisis planning
- Competence and consideration to race, ethnicity, language, sexual orientation, gender identity and expression, disability, and religion.
- Trauma-responsive care

Response to Death, Serious Injuries, or Other Undesirable Incidents

CYFCTs are expected to develop protocols for effectively addressing and managing workforce stress stemming from exposure to trauma including the death or serious injury of a child, youth, young adult, or caregiver or a co-worker in the field.

COORDINATION

CYFCTs must coordinate with the single point of access and other mobile crisis services providers/teams to educate them about the MRSS model and ensure appropriate referrals to the program. If an adult-focused team responds to a child, youth, or young adult when the CYFCT is unavailable, the provider must follow the process agreed upon between the CYFCT and the provider to facilitate a warm handoff to the CYFCT.

Key partnerships CYFCTs should focus on building with the aim of increasing referrals include hospitals, law enforcement agencies, and schools. Teams are encouraged to creatively engage with these key partners so that they come to see CYFCTs as a reliable and effective resource for children, youth, young adults, and families. Additionally, CYFCTs are encouraged to coordinate with the following system partners to advertise the program and develop strong community ties:

- Behavioral health systems and providers offering long term care coordination services
- Child welfare
- Juvenile justice
- Poison control
- Emergency medical services
- Intellectual and developmental disability systems
- Family/caregiver organizations
- Youth/young adult organizations

The regional Family Youth System Partner Roundtable (FYSPRT) functions as the constituent advisory group for CYFCTs. As such, CYFCTs are responsible to actively participate in outreach and engagement efforts that are intended to recruit youth and families to the organization, train them on issues relevant to the resolution of crises for young people, and engage in youth/adult partnerships that promote positive youth development. Program data must be reported at a regional FYSPRT meeting once per year with the express goal of gathering feedback for the purposes of continuous quality improvement.

DATA/REPORTING

CYFCTs must submit all required service data and transactions in compliance with North Sound BH-ASO Data Guide, SERI reporting requirements and/or North Sound BH-ASO Supplemental Provider Guide for service rendered. Additionally, CYFCTs must work closely with North Sound BH-ASO to identify additional data that must be collected for quality oversight.

The focus of data gathering efforts is subject to change depending on specific goals for re-routing care pathways in service areas. For example, one year a CYFCT may focus on stymying referrals from schools to hospitals, and the next it may shift focus to reducing placement disruptions in foster care. Utilizing feedback from the regional FYSPRT and key community partners, CYFCTs are responsible for developing transparent and accountable community partnerships wherein the teams work closely with the communities they serve to identify program targets.

Data is reviewed quarterly by CYFCT leadership and North Sound BH-ASO. An annual report must be submitted to North Sound BH-ASO that speaks directly to the program's progress towards goals identified for that year, in addition to the standard quality metrics outlined below. This report is presented to both CYFCT staff and the regional FYSPRT for review, celebration, and to gather input toward the development of new goals.

<u>Standard Quality Metrics</u>

- Call Metrics
  - Number of youth-related calls to single access point
  - Split by under/over 18
  - Call answer rate
  - Average answer speed
  - Disposition of call (split by over/under 18)
    - Immediate mobile response
    - Deferred mobile
    - Phone only
    - Telehealth
    - Deemed non-MRSS episode
  - Caller type / primary referral source
    - Youth
    - Family
    - School
    - Emergency Department
    - Police
    - Child welfare
    - Behavioral health provider
    - Primary care provider

- Initial Response – Service Delivery
    - Unique number of youth with mobile episodes
    - Response time – for episodes requiring immediate response
        - Number of responses within 60 minutes
        - Median response time
    - Location of response
        - Home
        - School
        - Emergency department
        - Office
    - Youth history
        - Previous MRSS episode(s) in the last 60 days
        - Previous "service" use and system experiences during the past 6 months and lifetime history
            - Emergency department
            - Inpatient
            - Residential
            - Foster care placement
            - Suspension/expulsion
            - Arrest/detention
        - Current system involvement
            - Child welfare
            - Juvenile justice
            - Intellectual/developmental disabilities
            - Substance use
            - Behavioral/mental health
- Intervention Metrics
    - Primary presenting concern
        - Suicidality
        - Harm/risk of harm to self
        - Harm/risk of harm to others
        - Harm/risk of harm from others
        - Anxiety
        - Disruptive behavior
        - Depression
        - Mood dysregulation
        - Family conflict

        - Trauma
        - Peer difficulties
        - School problems
        - Psychosis
        - Eating disturbance
        - Substance use
        - Intellectual/developmental delays
        - Identify discovery (related to support around gender expression, sexuality, race, ethnicity, etc.)
        - Loneliness
        - Intimate relationship problems
    - Completion of safety plan at end of initial assessment
    - Number of youth receiving stabilization services
- Episode Outcome Metrics
    - Median length of service
    - Living situation at referral and at discharge
        - Home with legal guardian
        - Home: 18+ year olds/emancipated minors
        - Foster/kinship care
        - Group care
        - Unhoused/insecure housing
    - At referral/discharge, was the child experiencing any of the following
        - Voluntary inpatient
        - FIT
        - Detained
        - Emergency department
    - Referrals to community-based supports and/or services
        - Natural supports
        - Care coordination
        - Existing provider
        - Routine outpatient services
        - WISe
        - Other (e.g., parent support groups, individualized school programming, afterschool activities, medical/dental provider, etc.)
    - Family and youth satisfaction
        - Collect family/adult-completed surveys
        - Collect youth-completed surveys
        - Specific family/youth items

        - Families and youth report they felt listened to
        - Families and youth report they had voice and choice over all aspects of their care
        - Families and youth report they felt CYFCT met their needs
        - Families and youth report improved functioning
        - Families and youth report the system functioned as intended
    - Demographics

DELIVERABLES

Quarterly reports that include data not available to North Sound BH-ASO through encounter transactions. This includes data regarding all MCO-funded stabilization services. These are due on the last day of the following months for the previous quarter: April, July, October, January.

Annual report will be required outlining progress made toward yearly goals in addition to all required data metrics not readily available to North Sound BH-ASO via encounter transactions.

Present annual report to North Sound BH-ASO, all CYFCT program staff, and the regional FYSPRT.