CRISIS CARE MOBILE UNITS PROGRAM

Learning Collaborative: Mobile crisis response for children, youth, and adolescents

May 10, 2023

Webinar Policies

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Chat

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Engaging parents as partners in crisis resolution

Facilitated by: Kappy Madenwald, MSW, LISW-S

Introductory notes

One of the complexities of providing crisis intervention for children is that they generally come with parents or other parenting guardians who are essential partners in our interventions.

Effective engagement of parents is an essential competency in the delivery of family-centered, strength-based and resolution-focused crisis intervention with children.

Introductory notes

More often than not parents are also impacted by crises that effect their children.

- This could be an acute response to their child's situation.
- This could be related to concerns about broader impacts on the family.
- And/or this could be the cumulative impact of months and even years of parenting a child with complex needs.

Narrowly focusing on evaluating/treating the child, without effectively engaging the parents lessens the likelihood of a successful intervention.

- It can even make things worse.

Introductory notes

In order to deliver an effective intervention, the mobile crisis team successfully engages both child AND their parent(s) in person-centered fashion.

- Seeking to understanding the nature of the crisis/distress as they are individually experiencing it.
- Seeing it they way they see it—from their individual points of view.

We do all of this without "taking sides".

Instead we want to "SEE" the sides.

- We start with each person "where they are".
- Assist each person in experiencing relief/resolution, and
- Collectively move towards a consensus plan.

This is a collaborative approach that evolves using the narratives of child and parent.

Activating parents as participants in resolution

These approaches lead to <u>engagement and activation</u> of both children and parents-signs of an effective intervention.

(These approaches also work when engaging partners in other systems including school leadership and child protective services teams...).

But, for this training segment I am going to focus specifically on parental activation.

Activating parents as participants in resolution

Provider engagement and activation of parents as informed and intuitive drivers of their children's health care is an under-developed skill set.

This is particularly true in the mental health field because of concern about the ability of parents whose children have mental health and other behavioral conditions to make competent decisions.

- Providers are often not trained in collaborative and shared decision-making models.
- Parents are generally not experienced participants in the same.

Activating parents as participants in resolution

To the degree that it is not already occurring, you have an opportunity to improve the crisis experience and treatment outcome for youth and their families.

It is easier said than done.

One of the barriers to this work is related to long-standing and deeply held beliefs.

What deeply held beliefs (stories) about parents of kids with behavioral health conditions dominate the conversation?

In your own mind

Within the team/agency

In conversations with other child-serving systems

More broadly within your community

Storytelling: perceptions of parents in the MH field

Since the 1970's there are four major categories that these perceptions fall into:

The Cause

Parents are seen as the primary cause of the child's issue and are therefore seen as the primary target for change. This is the most common view. Family dysfunction is viewed as the cause of the child's problems.

Lacking Education

Parents are seen an incompetent to appropriately address the needs of their child because of deficits in their knowledge and they need to be "taught" how to express themselves.

Collaborator

Parents are viewed as collaborators in the education and treatment of their child. This approach develops a relationship with parents aimed at finding workable solutions to the child's problems. However, one of the difficulties with the collaborative approaches is that neither academic training nor clinical training prepares professionals for this perspective.

The Client

Parents are in need of support services themselves. This approach is a shift from the first 2 categories and seeks to support families without blaming them. However, it is problem-focused and dismisses their strengths, abilities and keeps them at the mercy of the "expert".

SOURCE: *Child Study Center at New York University (New York, NY). Used with Permission*

Actively changing the story

- Deficit stories impede our effectiveness
- But we can overcome this by working hard to discard old deeply held beliefs
- It is essential to be vigilant to any deficit stories we tell, and actively work to change them
- For example, we can train our brains to believe this story:

A Parent is NEVER a barrier

The Power of Storytelling

…a lesson from Pediatric Oncology

Strength-based engagement of parents

An adolescent inpatient psychiatry team was struggling with effectively engaging parents. Relationships were combative. Staff views of parents were quite derogatory.

The charge nurse used to work on a pediatric oncology unit and I asked her to describe how that program worked with parents. This is a summary of what she said…

The oncology team knows that when parents bring their children to our unit that they are devastated. They are terrified. They are angry. They wonder if it is something they did or whether they missed something.

They are understandably self-absorbed with and overwhelmed by all of these thoughts and emotions.

The oncology team knows that as long as parents are self absorbed with and overwhelmed by these thoughts and emotions…

They will not be able to meet with the medical team, take in all of the information, and make the tough decisions that they will have to make.

The oncology team knows that as long as parents are self absorbed with and overwhelmed by these thoughts and emotions…

The parents will not readily learn how to use the medical equipment, deliver the treatment, watch for side effects/symptoms

> *And most importantly, the team knows that if the parents are self-absorbed with and overwhelmed by all of these thoughts and emotions:*
>
> *They will not be able to be there for their child the way they want to be there for their child. It doesn't work for them to be sobbing at the bedside.*

So, from the very first day the oncology team purposely engages the parents, talking through their journey, thoughts, and feelings so that they are mentally equipped to

- Actively engage in their child's treatment,
- Absorb new knowledge, and
- Support their child through their experience

Consider the deeply held belief

The oncology team looks at the overwhelmed parent and assumes CRISIS STATE and acts accordingly.

With childhood cancer…

Common public story:
Brave children and their heroic parents

Response from those around them:
Lemonade stands, rotating casserole delivery from friends, cards from classmates

Consider the deeply held belief

The behavioral health team is more likely to assume CHARACTER TRAIT and act accordingly.

And there are other differences. With a behavioral health condition…

Story:
Problem children and the parents who are to blame for it.

Response from those around them:
Distance, hushed whispers, loss of friendships (for parent/child) leery school personnel upon return.

Families are families

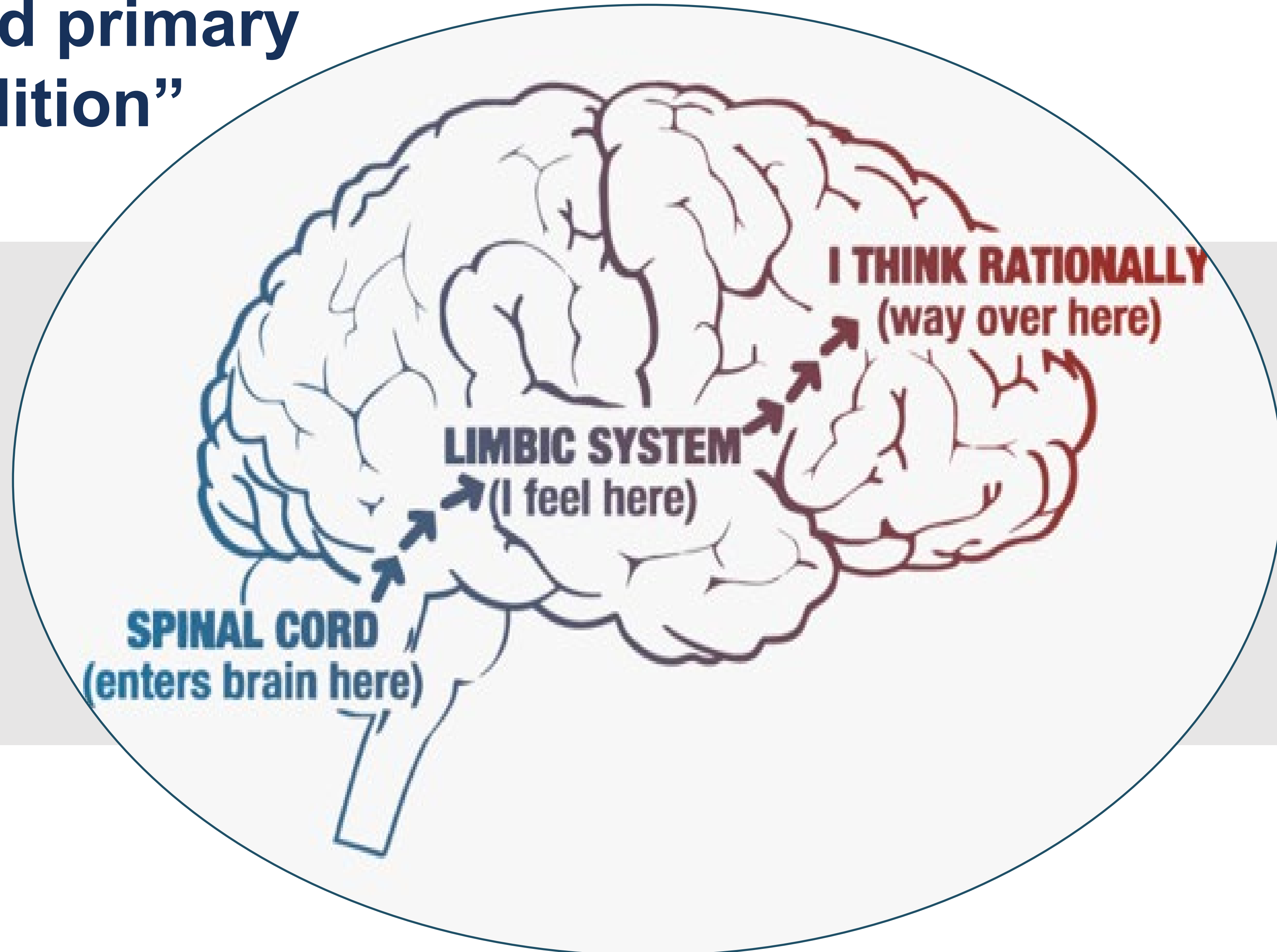
Important to note that oncology units ALSO work with families where children experience abuse, have parents that are divorced, have chaos in the home, have parents with mental illnesses, etc.

And, some of the parents also have limits in their abilities to care for their child

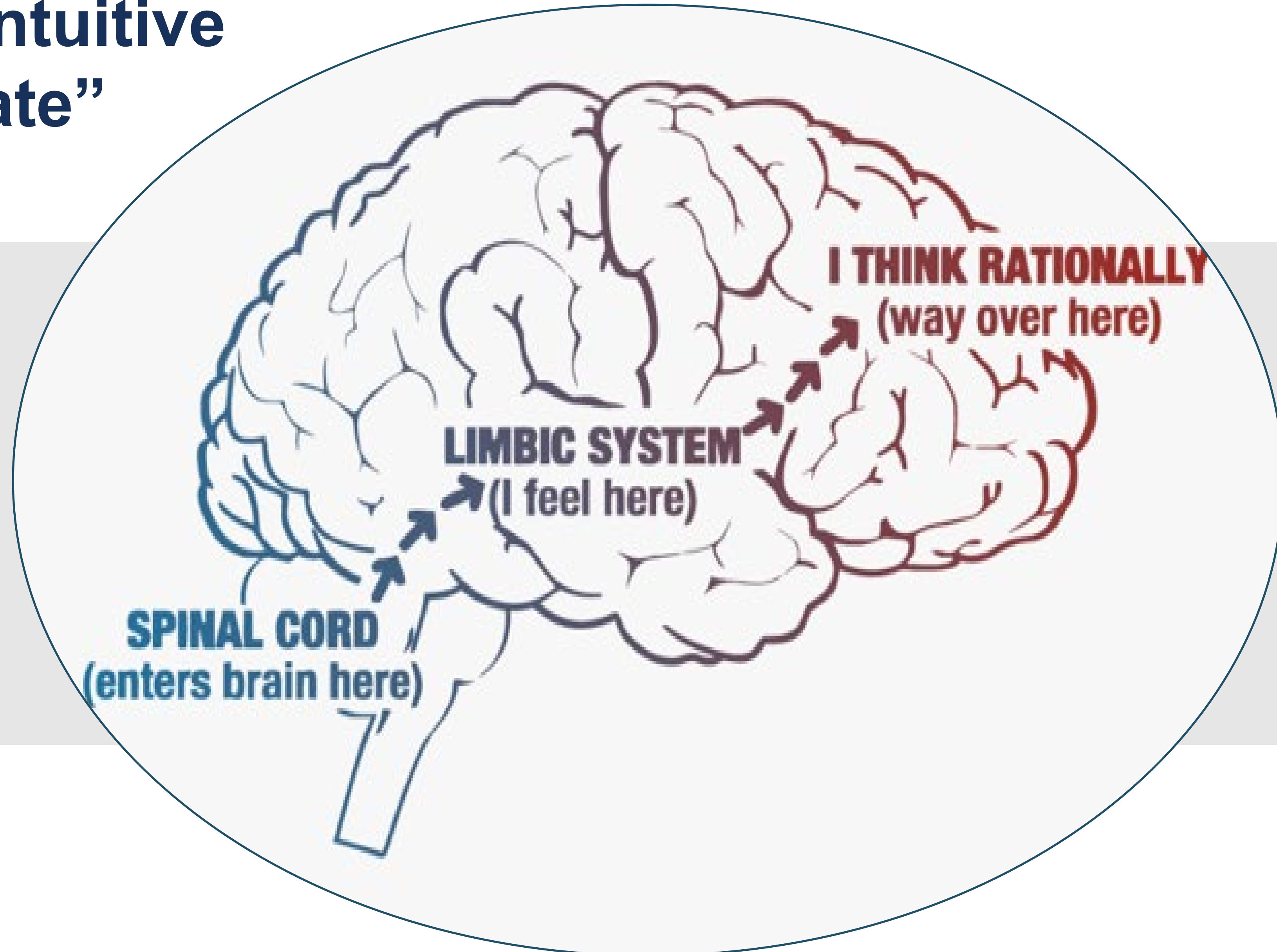
But, this is an approach that maximizes their ability to do so and makes it safer for them to ask for the needed help

And it does so without artificial limit-setting by the treaters

“Parent as barrier and primary cause of child’s condition”

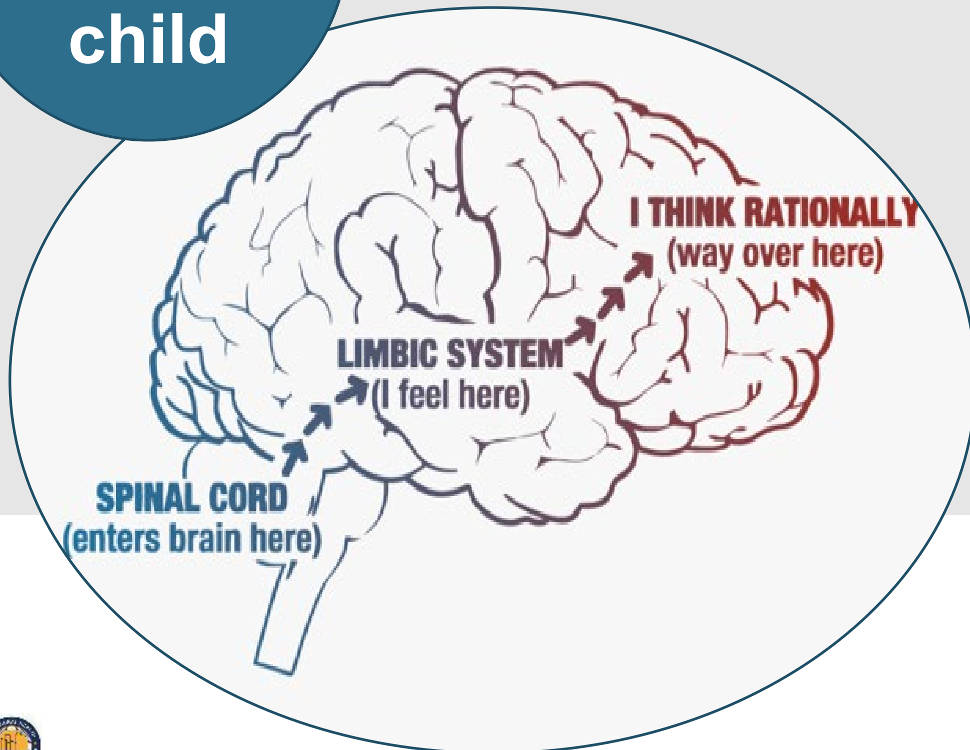


“Credible, Capable, Intuitive and able to Collaborate”

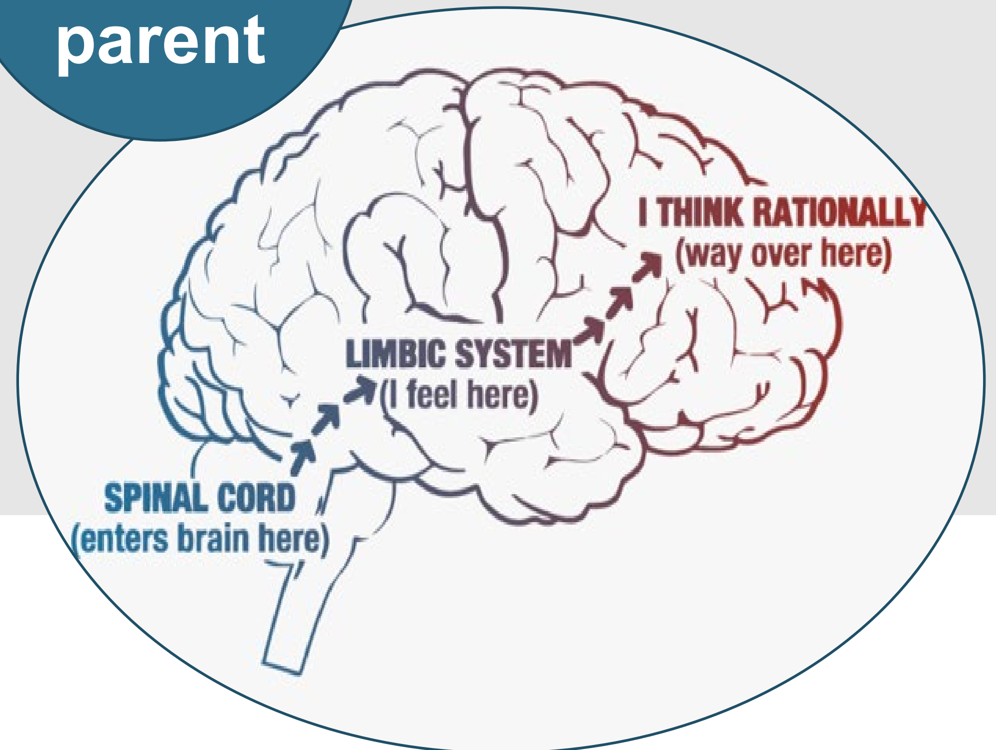


It gets pretty complicated!

story about child

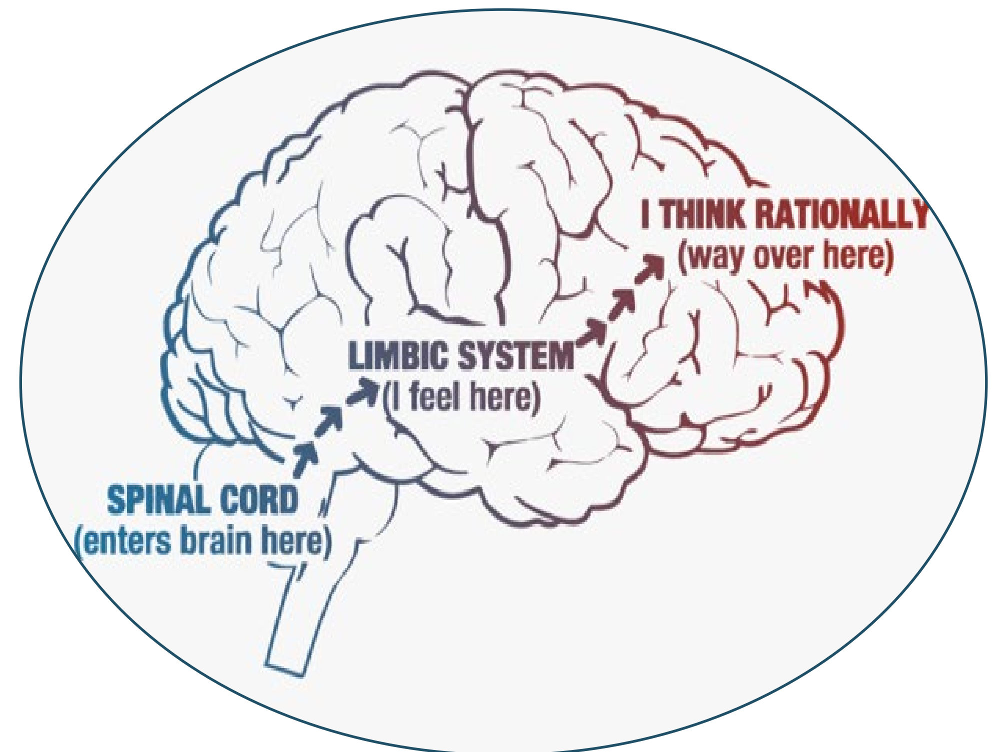


story about parent



“Parents as collaborators” even in tough circumstances

- When parents oppose treatment recommendations
- When we are turned off by how a parent is treating a child
- Parents with trauma history
- When the parent appears “impaired”
- When making a mandated report



Putting it into practice

- As we effectively engage parents as credible, capable, intuitive and able to collaborate we are no longer distracted by any “deficit story” about them (and our reactions that would follow).
- (Note: this does not mean ignoring risks, or failing to report as required).
- Instead, we SEE them in an empathic light, are ready to LISTEN and be PRESENT with them.
- If this approach is new for you, it may feel counterintuitive until you have practiced it and begun to see the results.

Actively employ the story throughout the service:

When the request for Mobile Crisis Response (MCR) is received:

- A credible capable intuitive parent thinks their child needs hospitalization.

Before you knock on the door:

- I am about to engage a credible, capable, intuitive parent, who is able to collaborate.

If you find yourself shifting into deficit think, employ the story ahead of the observation: A credible, capable, intuitive parent who is able to collaborate is:

- Overwhelmed
- Angry
- Opposed to our recommendations
- Threatening to give up child
- Kicking us out of the home

Change is an “inside job”

- As we practice these person-centered, strength-based skills, we are reminded that we cannot do the work for parents or their children and that meaningful, sustainable change cannot be imposed on someone.
- Instead, we connect with and ACTIVATE parents’ expertise, their cultural/familial knowledge, their powers of observation, their powers of insight and intuition and their ability to take action.
- Our sweet spot is facilitating the process—creating the circumstances that make it easier for families to reflect, explore, choose, practice and shift.

Mobile Crisis Units and Youth

Policies to Protect Patients Rights and Promote Resilient Communities

Facilitated by: Anny Bishop, LMFT, OC CAT Team

Patient's Rights and Parent's Rights

SAMHSA National Guidelines for Child and Youth Behavioral Health Crisis Care:

> *"The first priority is keeping youth in their own homes and keeping families intact whenever possible."*

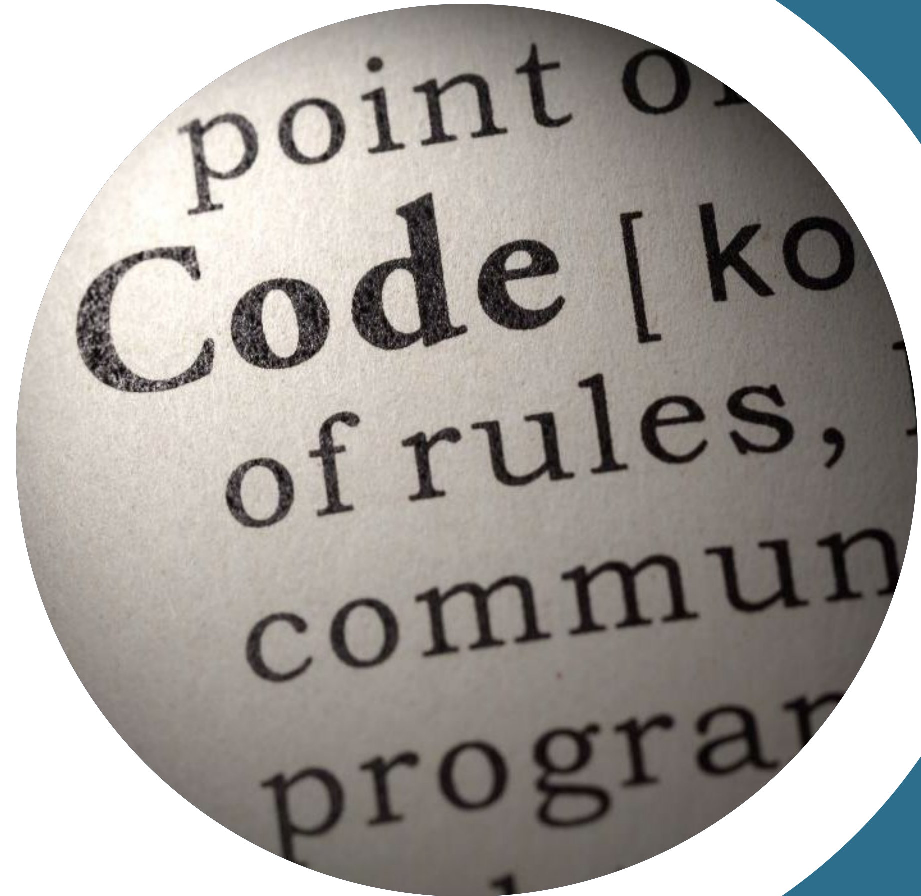
Goal of mobile crisis services is to evaluate for safety during a crisis and link youth to the most effective, least restrictive services that will meet their safety needs.

Policies should emphasize preserving client's rights and keeping children in their homes and communities whenever possible.

5585 versus 6000

Welfare and Institutions Code 5585 (Involuntary Hold)

- If the child is not able to remain safe in the community.
- If the child or parents are not in agreement with going to the hospital voluntarily.
- If parents are not present or are unable to sign the child in voluntarily (e.g., due to logistical issues, such as not being able to leave work, or not having access to transportation).
- If minor is a Juvenile Dependent or Ward (e.g., in foster care, group home placement, or juvenile hall).



5585 versus 6000

Welfare and Institutions Code 6000

- Parents have the right to voluntarily sign their child into treatment.

Mobile crisis response programs must be designed to offer a pathway for parents to choose voluntary placement

- Make every effort to contact parents before evaluation begins, and emphasize their presence is needed.
- Advise at the outset of the evaluation that the outcome may include voluntary or involuntary placement.
- If hospitalization is required, advise again at the conclusion of evaluation that parents have the option to sign the child in voluntarily.
- Consider implementing written materials advising parent of this option, and obtaining a signature if parents chose to waive their right to sign child in voluntarily.

POLLING QUESTION

What are some rights that patients keep, even when they are on a 5150/5585 involuntary hold?

Patients Rights

To be provided by the inpatient facility

Examples (not exhaustive):

- Be free from discrimination based on age, sex, race/ethnicity, religion
- Be free from harassment and bullying
- Wear your own clothes
- Keep personal possessions, or store them in a locker
- Keep a small amount of money for daily purchases
- Make phone calls
- Send/receive mail
- See visitors
- Be involved in treatment decisions
- Refuse medications
- File a grievance or appeal

Independent Clinical Review (ICR)

Patients and parents have the right to an Independent Clinical Review to appeal any treatment decision while minor is inpatient.

- E.g., Attending doctor thinks client needs more time, but child wants to go home.
- Child or parent are not satisfied with the quality of care at the facility and would like child to be discharged so they make seek alternative treatment options.
- Treatment team plans to discharge child, but parent thinks they need more time.

Initiating an ICR

- Patient or parent requests (ideally in writing) an ICR.
- Facility must respond within 24 hours by scheduling a meeting with all parties within 5 days.
- Client will be assigned an Advocate who mediates the meeting.

Patients Rights Advocacy Services

- Facilities must provide access to a Patients Rights Advocate.
- Mobile crisis programs should be familiar with this resource.
- Consider providing written materials (e.g., fliers or business cards) to families outlining their rights, how to contact Patients Rights Advocacy services.

POLLING QUESTION

Do you know your local County or State Patients Rights phone number?

California Patients Rights Advocacy

California Office of Patients' Rights

1831 K Street

Sacramento, CA 95811

(916) 504-5810

Or

California Department of Health Care Services

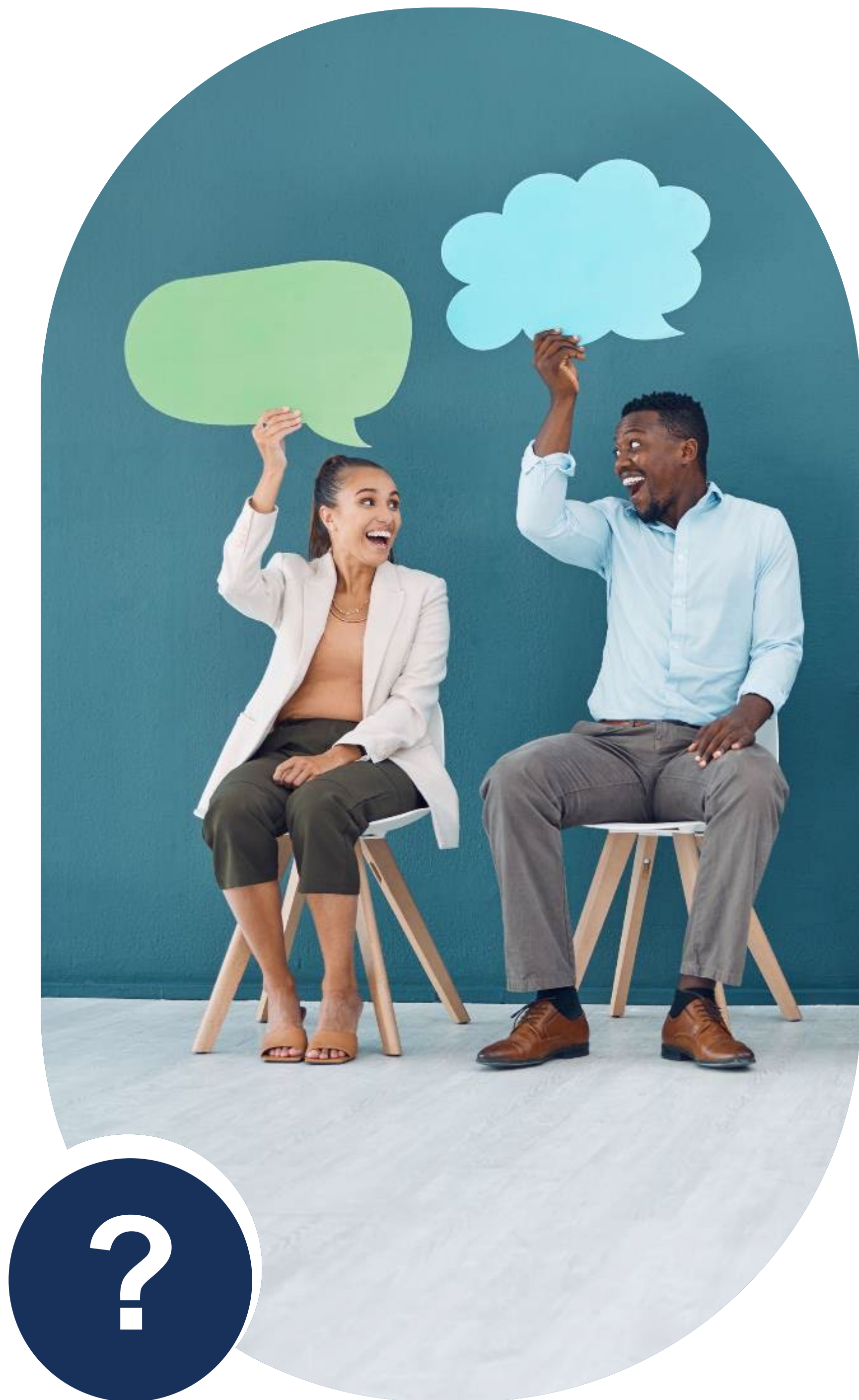
Mental Health Services Division Ombudsman

(800) 896-4042

Mental Health Ombudsman Email

Resilience

- Community resilience includes youth, families, and all stakeholders that encounter youth in crisis (e.g., schools, treatment providers, and Mobile Crisis Response staff)
- Important for programs to foster a workplace culture that promotes staff resilience and reduces staff burnout
- Trainings that can promote staff resilience
    - Psychological First Aid, Vicarious Trauma



POLLING QUESTION

What are some examples of policies that could promote staff resilience in your program?

Building Resilient Systems

Programs should build trust with communities through outreach and engagement with stakeholders.

- Trainings at local sheriffs/police departments.
- Q&A at city council meetings.
- Presence at county board of supervisors meetings.
- Helping schools develop policies for when to utilize Mobile Crisis services.
- Contracting with medical clinics, urgent cares, or emergency rooms.
- Informational booths at community parks, fairs, or other public events.

Resources

SAMHSA National Guidelines for Child and Youth Behavioral Health Crisis Care

California Office of Patients' Rights

Example brochure/pamphlet: Rights for Minors in Mental Health Facilities

Time for a Break

Mobile Crisis Services
ASOC/CSOC Collaboration

Facilitated by:
Kristen Love, LCSW
Client Services Program Supervisor
Kristen Siles, LCSW
Program Supervisor

Placer County CCMU history

Crisis Care Mobile Units (CCMU) or Mobile Crisis Triage (MCT) began in 2014 as age 16 + with first round of SB82 funding provided by Adult Crisis Services and second round of SB82 funding in 2019 included Children's System of Care, which added a children's and family team embedded with local Law Enforcement (Roseville Police Department).

Evolution of Integration between Adult and Childrens Mobile Crisis Services occurred in 2022 with CCMU funding, which increased the amount and availability of teams, expanded geography of response possibilities, and the variety of staff availability to respond (clinicians, peers, family advocates, RNs)

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Placer County 24/7 Access Line Hours of Operation and CCMU Access

Monday – Friday
8:00 a.m. – 10:00 p.m.
Saturday
10:00 a.m. – 7:00 p.m.

***January 1, 2024**
CCMU coverage to increase to 24/7

- One-stop shop phone number (As opposed to calling two different access lines for children versus adults)
- Referring party and case will be triaged to the appropriate crisis service and team.
- Easy access for all referral sources, law enforcement and community members

Decision to Collaborate and Expand

New Grant opportunity (CCMU): Adult Crisis Services interested in expanding MCT throughout county and new opportunities to improve/add additional types of services/support; Children's Crisis Services interested in expanding beyond having a team in 1 city and embedded with LE.

Brainstormed and combined efforts to provide a necessary service to the community as a whole, independent of age, location or payor

Some previous experience with partnership and/or parallel services for crisis in past (in the local ER's, CPS referrals, complex family cases)

Initial Challenges, Staff Apprehension for Collaboration and Expansion

Planning

Preliminary planning with leadership on staffing, work station locations, schedules, procedures, documentation, addressing differences between P&P of Adult and Childrens' services

Services

Staff apprehension about differences between adult and children crisis intervention services

Discussion

Multiple discussions with staff in preparation of the upcoming changes, eliciting their interests/concerns/questions/feedback

Staffing

Staffing shortages

Staff Preparation and Response

- Cross training/shadowing of current teams
- Eliciting staff feedback
- Daily combined “huddles”
- Combined staff meetings every other month
- Shared office spaces
- Leadership huddles

MCT Team Schedule, Coordination, and Dispatching

- Shared supervisor duties for all MCT consultations; 1 CSP/CSC coordinating/dispatching all teams; teams throughout the county and staggered throughout the day; staggered lunches; group texts and frequent communication on status updates
- Decision Tree: Where is crisis located? Age of client in crisis? Who is available? Imminent situation for immediate response, or appropriate to dispatch later when different team/more appropriate team available? Can be done partially or fully over the phone first?

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date	4/17/2023	4/18/2023	4/19/2023	4/20/2023	4/21/2023	4/22/2023
MCT Supervisor	KRISTEN	JENNIFER	KRISTIN SILES	KRISTEN SILES	JENNIFER	AH Supervisors Mon-Sun
MCT Coordnator	Colleen &Plcmtns	Krista & Plcmnts	JENNIFER & Plcmnts	Ben &Plcmnts	Susan & Plcmnts	ASOC Sup NATE C
ASOC Abrn 8-5	Stevie & Sandra	Jess & Deb	Krista & Stevie	Colleen & Jess	Colleen & Ben	ASOC Mngr CURTIS
ASOC Rsvl 8-5	Susan & Deb	Stevie & Mailla	Susan & Mailla	Krista & Deb	Jess & Deb	CSOC Sup KRISTIN S
CSOC Rkln 8-5	Andrew & Jina	Andrew & Athena	Athena & Jina	Missy & Bob	Andrew & Jina	Saturday MCT 10-7:
CSOC Abrn 10-7	Bob & Star	Star & Jina	Bob & Amber	Athena & Jina	Bob & Amber	Michele & Mailla
ASOC Rsvl 10-7						Sat MCT BU: KRISTA
ASOC Rsvl 1-10pm	Ben & Naomi	Ben & Naomi	Michele & Colleen	Michele & Naomi	Michele & Julie	Sat MCT BU: SUSAN
FMT Rslv PD 930-8			Andrey	Andrey (Sierra College @9)	Andrey	FMT: Sat-Andrey;

Continued Learning, Improvements, and Recommendations

- Continuing to seek opportunities for growth, trainings, and learnings.
- Learning each staff's way of assessing/evaluating/consulting as well as staff learning each supervisor's way of consulting, listening, and providing feedback .
- Continuing to assess and modify decision making tree for dispatching.
- Continuing to want to increase/expand more teams/seeking staff.
- Working on continued expansion to 24/7 MCT services and how this collaboration will address that.

Breakout Room Discussion

1. What is your experience engaging parents?
    1. What part of this goes well?
    2. What part of this is difficult?
2. As you think about your mobile teams, would you say they find it easiest to work with child or parent?
3. What practices do you use to ensure parents are well informed about their rights/children's rights?
4. What training supports/strategies does your county have in place to provide children specific crisis services?
5. Has there been resistance or expressed areas of concern/needs by your mobile crisis teams for responding to children in crisis?
6. How does your team strategize when there is a high acuity case (child)? What do practices do you have in place for continuity of care for high utilizers?

Q&A

Contact us

Thank You