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North Sound Behavioral Health Administrative Services Organization, LLC

Section 1700: Child, Youth, and Family Crisis Teams

Authorizing Source: HCA Contract
Approved by: Executive Director Date: 5/13/2025 Signature:

POLICY # 1735.00

SUBJECT: CHILD, YOUTH, AND FAMILY CRISIS TEAMS

PURPOSE

Child, Youth, and Family Crisis Teams (CYFCT) closely adhere to the Mobile Response and Stabilization Services (MRSS) model to provide a rapid response, home- and community-based crisis intervention customized to meet the developmental needs of children, youth, young adults (ages 0-21), and their families. The inclusion of CYFCTs within a comprehensive System of Care (SOC) and care crisis continuum is a core component of a state-of-the-art children's behavioral health system as outlined in the Washington Mobile Rapid Response Crisis Teams Best Practice Guidelines. CYFCT is embedded within a full spectrum of effective services and supports for youth with or at-risk for behavioral health and emotional challenges. CYFCTs are intended to:

1. Reduce dependence on law enforcement, fire, emergency medical services, and emergency departments for behavioral health crisis situations.
2. Develop a robust crisis workforce that is well-trained and able to address urgent and emergent needs.
3. Include peers in crisis work to build rapport and give children, youth, young adults, and caregivers someone to connect with who has similar experience(s).
4. Expand the definition of crisis to whatever the person experiencing the situation defines it as to reduce barriers to potential solutions.
5. Address systemic barriers by attending to the needs of underserved populations.

DEFINITIONS

Certified Peer Counselor (CPC)

Certified and credentialed by the Washington Department of Health (DOH) to provide services, typically as an Agency Affiliated Counselor. CPCs can only provide services when accompanied by a licensed or credentialed staff or their supervisor. All services provided by CPCs must be provided under the oversight of a Mental Health Professional (MHP) supervisor.

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, the Washington State Health Care Authority (HCA). If the person was trained by trainers approved by the Department of Social and Health Services (DSHS) 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 HCA or an authorized contractor; and
5. Has received a written notification letter from HCA stating that HCArecognizes the person as a "peer counselor".

More information on peer counselor credentials can be found at the HCA's website: Peer counselors | Washington State Health Care Authority

Clinician
Must have a BA/BS degree or higher in a behavioral health field, an A.A. level with two years of experience in a mental health or related 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 DOH using the process outlined in Washington Admirative Code (WAC) 246-341-0302. MHPs do not need to obtain this exemption.

Mental Health Professional (MHP)

1. A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, as defined in chapter 71.05 and chapter 71.34 RCW.
2. A mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate, as defined in chapter 18.225 RCW.
3. A certified or licensed agency affiliated counselor, as defined in chapter 18.19 RCW.

Mobile Rapid Response Crisis Team (MRRCT)
A team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for Individuals who are experiencing a Behavioral Health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response items established by the HCA. MRRCTs that are endorsed must follow standards outlined in WAC 182-140.

Mobile Response and Stabilization Services (MRSS)
Mobile Response and Stabilization Services (MRSS) is a crisis intervention model that emphasizes the need to respond to crises with urgency to the immediate needs of children, youth, young adults, and their caregivers. MRSS is part of larger state health reform initiatives and a necessary component of a robust and comprehensive system design. It is comprised of three service components:

- Someone to Contact—the access points for those experiencing a crisis and their caregivers.
- Someone to Respond—mobile units that respond to crises in homes and community settings.
- System to Support—stabilization services for those who need them.

System of Care (SOC)
A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, to help them to function better at home, in school, in the community, and throughout life.

POLICY

CYFCTs are MRRCTs that respond in-person to calls regarding children, youth, and young adults ages 0-21 and their families and/or caregivers. CYFCTs may or may not be endorsed per WAC 182-140. CYFCT services are developmentally appropriate, trauma-informed, and delivered in-person whenever possible. Full performance standards for all MRRCTs can be found in North Sound BH-ASO Policy 1733.00 *Crisis Services General Requirements* and North Sound BH-ASO Policy 1734.00 *Mobile Rapid Response Crisis Teams and Involuntary Treatment Investigation Services*.

CYFCTs must:

1. Serve children, youth, young adults and families or caregivers in their natural environments including, but not limited to, home, school, and community settings to include hospital inpatient units and emergency departments.
    a. While ideally CYFCT will provide a diversion from emergency departments, there will be times when a family will seek help for a child, youth, or young adult at the hospital prior to learning that mobile services are available.
    b. CYFCT can support discharge planning when necessary and appropriate and provide a service bridge between inpatient and outpatient services.
    c. CYFCT will not act in lieu of a hospital MHP.
2. Provide face-to-face services within two hours of contact for emergent crises and within 24 hours for urgent crises. Best practice is a response within 60 minutes for all call types.
3. Employ a "just go" protocol, rather than seeking to resolve the crisis over the phone or set appointments for in-person meetings.
4. Provide developmentally appropriate services and operate in a fashion that is intentionally inclusive of family/caregivers and natural supports throughout the crisis and stabilization periods.
5. Create partnerships with children, youth, young adults, and family/caregivers to identify, restore, and increase family and community connections and create linkages to necessary resources within a connected behavioral health System of Care.

For each family served, the CYFCT should strive to:

1. Support and maintain Individuals in their current living situation and community environment, reducing the need for any type of out-of-home placement, including inpatient admissions.
2. Support Individuals, Youth, and families by providing trauma-informed care and smooth transitions between the acute and stabilization phases of the service.
3. Promote and support safe behavior in home, school, and community settings.
4. Reduce the use of emergency departments, hospital boarding, and detention centers due to a behavioral health crisis.
5. Assist Individuals, Youth, and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.

PROCEDURES

Single Access Point

The contractor responsible for operating the Regional Crisis Line (RCL) and 988 shall act as the Single Access Point for CYFCT services. All marketing materials shall clearly direct youth, families, and community partners

to the Single Access Point. While the Single Access Point may offer services to individuals across the lifespan, staff must have specific training and triage protocols for children, youth, young adults, and families that:

1. Allow the family or youth to define the crisis, and
2. Ensure youth and families receive immediate face-to-face responses.

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 have a warm handoff protocol in place to dispatch CYFCTs. 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 for children, youth, young adults, and their caregivers. Staff at the Single Access Point and with the CYFCTs must have immediate access to clinical and psychiatric consultation.

CYFCTs may not operate round the clock as they are in the process of being developed. Thus, CYFCTs must have agreements with MRRCTs that may respond to calls regarding children, youth, young adults, and families while the CYFCT is not available. CYFCTs are expected to provide guidance and support to adult teams regarding MRSS and developmentally appropriate interventions to deescalate crises when working with children, youth, young adults, and families, and to ensure that the Single Access Point is appraised of any changes in the agreed upon protocols for dispatch and referral between mobile teams.

Staffing

CYFCTs must have an MHP supervisor and adhere to the HCA crisis team model. Teams will respond in two-person dyads consisting of a Clinician and a Certified Peer Counselor. Teams may include other professionals or paraprofessionals with expertise in developmentally appropriate behavioral health crisis intervention. Respondents must have received training as required in RCW 49.19.030. No retaliation is permitted against any crisis worker who declines to respond in-person without a second appropriately trained crisis staff. MHCPs with WAC 246-341-0302 exemption, can respond jointly with a peer in place of an MHP, as long as at least one MHP is available 24/7 for any MHCP or peer to contact for consultation. This MHP does not have to be the supervisor. All peers must complete the HCA sponsored peer crisis training. All individuals providing mobile crisis services, whether they are new or previously existing staff, must complete the HCA training in Trauma Informed Care, De-escalation Techniques, and Harm Reduction. The goal for each CYFCT is to have the capacity to provide services in the community 24 hours per day, seven days per week, 365 days per year with a two-person dyad (peer and clinician) within available funding.

Outreach and Marketing

CYFCTs engage in outreach activities to inform families, communities, and system partners about 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.

Acute Phase

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 Access Point 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 safety and risk, and work with the child, youth, or young adult and their caregivers to develop a written crisis 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. Since CYFCT is intended as a diversion from more intensive interventions, law enforcement may only be called for assistance where there are extenuating circumstances, and the decision must be justified in the case notes.

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 to identify and connect them with existing systems of care and natural supports through warm handoffs, including to the stabilization phase. If the CYFCT discovers that the child, youth, or young adult is enrolled in either Wraparound with Intensive Services (WISe) or Program for Assertive Community Treatment (PACT), that team must be informed and the case transferred to the outpatient team as soon as possible.

Stabilization Phase

Stabilization services may be provided for up to eight weeks for children, youth, and families that are expected to benefit from continued MRSS support and are not already receiving care coordination support through an intensive services program (i.e., WISe, PACT, targeted case management, etc.). Stabilization services focus on helping children, youth, and families make changes to their living arrangements such that they can return to routine functioning. Connections to natural and community supports must be emphasized during this phase.

It is best practice for the same workers who provided the mobile response to provide the stabilization services. Where this is not possible, CYFCTs are expected to ease transitions between providers to the greatest possible extent. The Stabilization Phase must include a standard assessment using a tool that has been approved by North Sound BH-ASO. Services and case planning may 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 the inherent strengths and interests of the child/youth and provide opportunities 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.

Reporting Requirements

CYFCTs must submit all required service data and transactions in compliance with the North Sound BH-ASO Data Guide, SERI reporting requirements and/or the North Sound BH-ASO Supplemental Provider Guide for services rendered. Additionally, CYFCTs shall 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.

Utilizing feedback from the regional Family Youth System Partner Roundtable (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.

Quarterly reports must include data not available to North Sound BH-ASO through encounter transactions. These are due on the last day of the following months for the previous quarter: April, July, October, January.

Annual reports will be required to outline progress made toward yearly goals in addition to all required data metrics not readily available to North Sound BH-ASO via encounter transactions. North Sound BH-ASO reserves the right to audit case files in order to verify accuracy and gather any additional data needed. The annual report must be presented to North Sound BH-ASO, all CYFCT program staff, and the regional FYSPRT in collaboration with North Sound BH-ASO.

ATTACHMENTS
None