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MASSACHUSETTS CBHI:
SUPPORTING YOUTH AND THEIR PARENTS IN CRISIS

TRAINING FOR IHT AND ICC TEAMS

Facilitated by Kappy Madenwald

PART ONE

Madenwald Consulting, LLC

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Introductory Notes

This is not intended to be a passive training—a few requests:

- Please change your profile to include preferred name, title, agency
- Video generally on, understand you may need to briefly turn off at times
  - We will take 1, 15-minute break each day
- Mute generally on, but please interrupt with questions, comments by taking yourself off mute, doing a 'handwave" or notifying the administrator via chat if I miss all of those other signals
- Use the Chat box to comment, amplify, acknowledge other's work in some of the areas we cover
- Participate in Zoom polls

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Note about CE Credits

CE credits are approved for the following licenses: LADC, LMFT, LMHC, Psychology, Social Work

CE credits are available to attendees who meet the following requirements:

- Attend the entire training (both halves)
- Complete the evaluation and CE application in Survey Monkey

Active Participation Code

All attendees must actively participate in the entire training in order to receive CE credit. This is typically done via sign-in and sign-out sheets during in-person trainings. However, since these trainings are virtual, we need to track engagement differently.

We are using a code, given *letter-by-letter* throughout each session, to track engagement.

WRITE DOWN & SAVE THE LETTERS. Then enter the code in the Training Evaluation and CE Application survey you receive following the training. Note that the codes are unique for each 3-hour block. You cannot receive CE credit unless you enter the codes.

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10+ years of CBHI

- Remarkable achievement!
- Implementation is hard, but sustaining change is even harder
- Lots of leadership and line staff changes throughout CBHI
- It has been quite some time since there has been training focused on crisis intervention

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Poll Question #1

- How many years have you worked in CBHI program(s)?
  - Less than 1 year
  - 1-2 years
  - 3-5 years
  - 5-9 years
  - I have worked in CBHI since its launch in 2009!

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Poll Question #2

- What best describes your position?
  - Family Partner
  - Clinical Director
  - Program Manager, IHT
  - Program Manager, ICC
  - Team Supervisor IHT
  - Team Supervisor, ICC
  - Clinician, IHT
  - Therapeutic Training and Support Specialist, IHT
  - Intensive Care Coordinator, ICC

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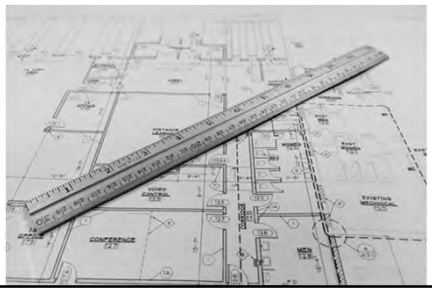
Introductory notes

- This training was developed for IHT and ICC teams.
- It complements the crisis training provided to MCI Teams
- Though the topics we cover today may seem basic, they are not
- Some content may feel personal or provocative
- May unearth deeply held beliefs
- Candor is important
- Psychological safety is important in training and coaching…and is a parallel process



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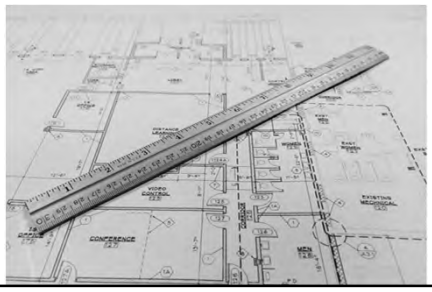
Introductory Notes

- In Massachusetts, there is an emphasis on crisis responses responses that are:
  - Early,
  - Voluntary
  - Local
  - Community-based
- Using approaches that are resolution-focused and that reduce the likelihood of needing:
  - Law enforcement involvement
  - Section 12 initiation
  - Inpatient hospitalization



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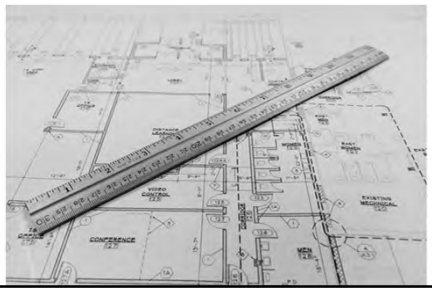
Four primary competencies

To achieve those results, it is essential that the delivery of crisis support and intervention is:

1. Youth and family-centered
2. Strength-based,
3. Resolution-focused, AND that,
4. The services are delivered within the context of the broader crisis system of care—



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Introductory Notes

<u>Today's session</u>

- We are going to start with the 4th competency,
- Then we will spend the bulk of this session building some contextual, and system's level understanding of why these approaches are so important

<u>Part II</u>

- We will turn our attention to the application of the first 3 competencies to crisis support and intervention—the focus is on our individual approach
- We will have an immersive experience—crisis care as experienced from the "shoes" of parents
- We will end with some safety planning strategies

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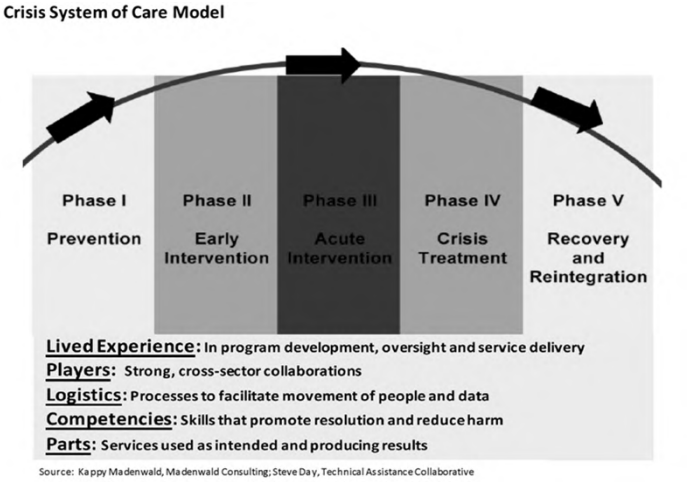
Crisis Systems of Care Framework

- A Crisis System of Care is the *organized whole* of a behavioral health crisis system.
- CSOCs are not naturally present in communities—they must be built
- Crisis work is necessarily systemic—it cannot be effectively addressed by a single person, system or agency.

- Let's look at a familiar analogy…



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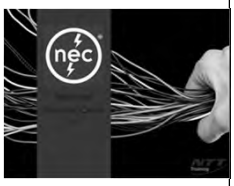
Why are prevention and intervention important?

Fire Prevention	Early Intervention	Acute Intervention	Post-Fire	Fire Recovery
 	 			

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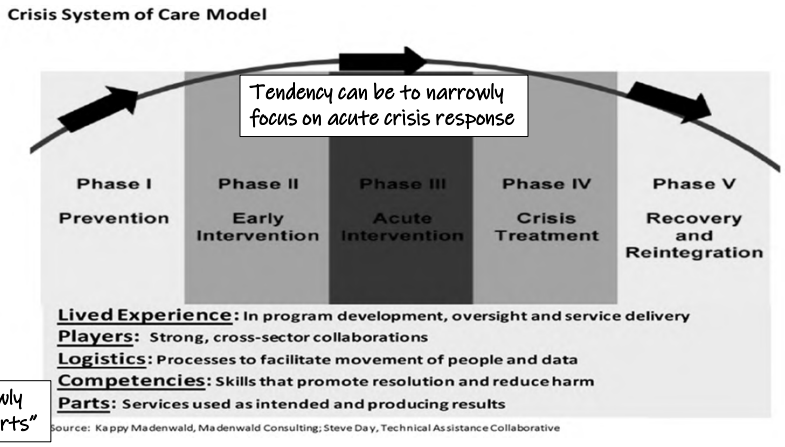
Crisis System of Care Model

This is an organizing and planning framework that offers ten points of opportunity for building depth and breadth into a crisis system: within five "phases" and five "key components"



Tendency can be to narrowly focus on crisis system "parts"

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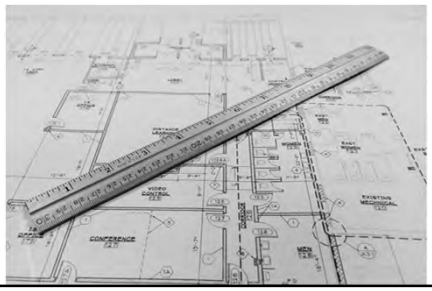
Intervening in crises is complex for individuals and teams

- Because we are working with some youth whose health care crises are life threatening, it is natural to be concerned about personal liability or corporate liability.
- It is important to have a broad understanding of the ways that crises put families at risk,
- But, we also have to understand the ways that a system's response to crises can put families at risk, and
- Individually and as a system, work to minimize iatrogenic harm



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Iatrogenic Harm

- Harm caused by treatment
- Generally unintended
- Often avoidable
- Iatrogenesis: *Brought forth by a healer*

ANY intervention, regardless of provider intention introduces a risk of harm that would not otherwise be present

Use CHAT to share examples of iatrogenic harm in the behavioral health field

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Iatrogenic Harm

When there is iatrogenic harm, it implicates us, as providers of the treatment and it implicates the systems in which we operate

- But, this also gives us power
- We are in the driver's seat to find ways to reduce risk of harm
- It requires continuous improvement of our craft, policies and processes
- Iatrogenic harm is easiest to recognize when we orient ourselves to the care experience of the youth and his/her family—when we view from their shoes

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Poll Question #3

- How familiar are you with the term, and in considering the risk of iatrogenic harm in crisis response?
  - I am familiar, and risk of iatrogenic harm is routinely considered by me/the team in a crisis situation
  - I am somewhat familiar, and risk of iatrogenic harm is occasional considered by me/the team in a crisis situation
  - The term is familiar, but not generally considered by me/the team in a crisis situation
  - This is mostly a new concept for me

Use CHAT to make additional comments

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Diminishing the need for coercive practices

- Though there may be a guise of safety, coercive practices sometimes have less to do with imminent risk and more to do with one or more of the following:
  - Habit
  - Convenience
  - Cost
  - Transportation
  - Concern about personal or corporate liability

"this is how we do it here"

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Diminishing the need for coercive practices

- Watch for patterns that suggest a risk of greater iatrogenic harm
  - Referring entity or admitting facility preference for involuntary hold/admission
  - Routine use of security guards, seclusion or restraints
  - Restrictions by rule rather than exception, such as gowning, 1:1, loss of belongings, visitor restrictions
  - Carrot/stick behavioral systems
  - Unscheduled and/or AMA discharge
  - High volume referrals to youth/adult protective services

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Storytelling

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When responding to crises: what stories are impacting our efficacy?

This may get clearer throughout the training…

- Historic stories of individuals with behavioral health conditions
- Stories about how families use the system/treatment
- Stories about our (intervener/treatment provider) role in a youth's treatment
- Stories about the parents of those individuals— we are going to spend extra time on this--

Stories predispose actions

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Retraining the brain

- Our brains are our number one resource
- Can be trained to aid our work
- Must 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:

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Perceptions of Parents in the Mental Health 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.
- 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".
- 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.

SOURCE: *Child Study Center at New York University (New York, NY)*

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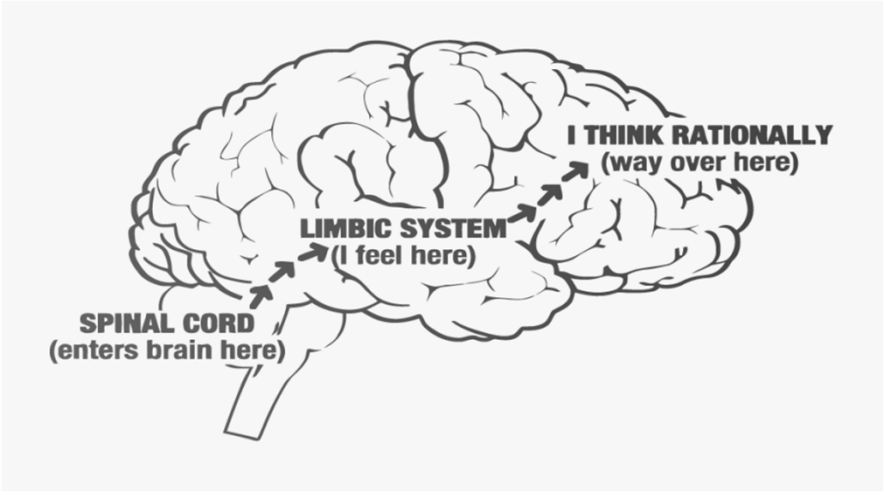
"Credible, Capable, Intuitive and able to Collaborate"



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Parents as collaborators

- 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
- To the degree that it is not already occurring, this gives teams a great opportunity to change the crisis experience for youth and their families.

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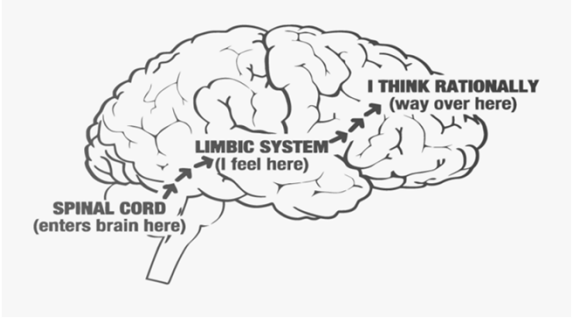
"Parents as collaborators" **even in tough circumstances**

- 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 a 51A is filed

And WHY would we do this?

HOW is this even smart?

Stories predispose actions, and this is a 2-way street!



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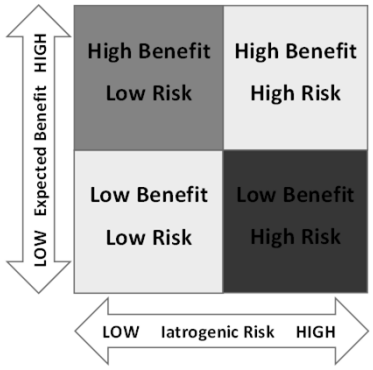

RE-THINKING HOSPITALIZATION

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The Allure of Inpatient Hospitalization

Within a lot of communities, there are deeply held views about hospitalization:

- It is the best and highest quality service (other care is lesser care)
- It is a safer place
- Inpatient treatment is something you do to a person: "*He needs inpatient treatment*"
- Fabulous tests will uncover the answer
- Excellent medication will treat the problem
- Sending to ED and subsequent inpatient treatment is always the best risk management and harm reduction strategy
- Individuals returning from inpatient treatment are now stable and can return to business as usual
- Individuals will be successfully linked to the proper, good and effective treatment services following ED or inpatient treatment stay.

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Efficacy of Inpatient Psychiatric Treatment

Some practice-based evidence…

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Poll Question #4

- Based on your experience and in talking to the families you work with, roughly what percent of time do youth experience a GOOD HEALTH BENEFIT from psychiatric hospitalization?
  - 100%
  - 80%
  - 60%
  - 40%
  - 20%
  - Less than 20%

Use CHAT to make additional comments

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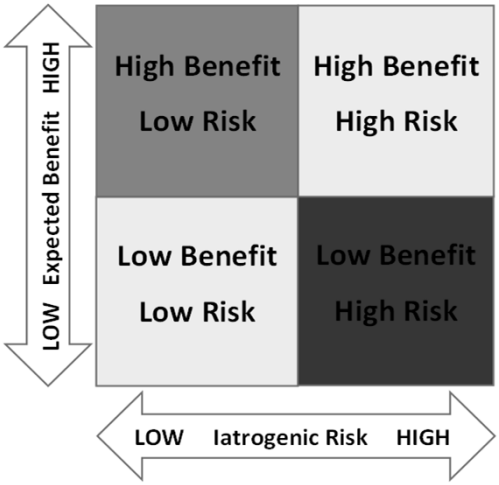
Re-thinking hospitalization



Quadrant Model for Re-Thinking Psychiatric Hospitalization. Source: Madenwald Consulting, LLC

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Poll Question #5

- Based on your experience and in talking to the families you work with, roughly what percent of time do youth experience IATROGENIC HARM from hospitalization?
  - 100%
  - 80%
  - 60%
  - 40%
  - 20%
  - Less than 20%

Use the CHAT feature to make additional comments

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Historic crisis Question	What hasn't always been considered		
Does the individual meet criteria for psychiatric hospitalization?	What is the expected health benefit for THIS individual?	What are the risks of iatrogenic harm to THIS individual?	Are there alternatives that offer THIS individual equal/better potential health benefit, while decreasing risk?

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These are consequential considerations

What changes as you get more information?

- You are eligible for knee replacement surgery
- It is effective___% of the time
- It causes iatrogenic harm ___% of the time
- Here are alternatives that could be considered…

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GETTING TO THE ESSENCE OF THE DISTRESS

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Getting to the Essence of the Distress

- We are collaborating with families who have led extraordinary lives
- For a provider, it can be hard to sort it all out
- Fortunately, we don't have to understand all of the history in order to be of service
- But, we do want to understand the essence of the crisis for the youth AND for the parent(s), and very often, for other players too—this is where a big opportunity for resolution lies
- Essence isn't fundamentally about the diagnosis
- Nor is it fundamentally about the problem

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Getting to the Essence of the Crisis

Fear	Grief/loss
Sadness	Pain
Anger/rage	Exhaustion
Loneliness/isolation	Hunger
Restlessness/boredom	Lack
Hopeless/helpless	Stuck
Uncertainty/ambivalence	Misery
Anxiousness/nervousness	Powerlessness
Guilt	Shame

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Getting to the Essence of the Crisis

- It can be easy for a service provider to hone in…
  - Level of care assessment/disposition (sending them somewhere else as key deliverable)
  - Diagnosis (as if all MSE changes/crises stem from a diagnosable condition)
  - Unwanted behavior (chasing behavior rather than getting to the essence behind it)
  - One's own (service provider) priorities instead of youth/parent priorities

…and miss identifying the essence of the crisis

- This is where person-first and whole-health thinking is so important. People are more than their illness

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Getting to the Essence of the Crisis

IMAGINE IF…

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Getting to the Essence of the Crisis

Question:

If the facts haven't changed, can there be resolution?

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Getting to the essence: SCENARIO

8 yr. old Louie was transported by police officers from his school to the Crisis Response Center where he is waiting to be seen in the ED. You call the school to get more information and are told:

Louie has been continuously disruptive in school. He is restless in his chair, he interrupts other children who are trying to focus on their work and he has repeatedly left the room without permission. Today he threatened another child with a ruler—holding it like a rifle and threatening to kill him. Louie's mother has been very difficult and defiant. She won't answer the phone when the school calls and has missed several meetings. She has gotten verbally abusive with school staff at previous meetings and the adjustment counselor thinks that Louie is subjected to similar verbal abuse at home and suspects that it is why he acts out so much in school. His dad left when Louie was 3 yrs old which probably contributes to the trouble at home. The school has asked repeatedly that she take Louie for an evaluation for medication and warned her that he is at risk of suspension.

You learn that the school has filed a neglect complaint with DCF previously and plans to file another one. The school also tells you that Louie needs a different school placement or partial hospitalization and medication for ADHD. Finally you learn that the school left a message for Louie's mother informing her that Louie is now in the emergency department awaiting your evaluation.

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Standing in The Shoes of a child in crisis…

Stand in Louie's shoes. Using first person language, describe your experience…

- *Describe your experience*
- *What are you feeling and thinking?*
- *How are you acting?*
- *How are you interpreting what is happening?*

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Standing in The Shoes of a Parent…

Stand in the shoes of Louie's parent who got the message from the school and is now in the ED. In first person language…

- *Describe your experience*
- *What are you feeling and thinking?*
- *How are you acting?*
- *How are you interpreting what is happening?*

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Stand in the shoes of a parent…

- Periods of experiencing "parent/parenting" crisis states is an anticipated and normal component of the journey of any parent whose children experience mental health crises.
- Can your "parent/parenting" crisis be resolved even if your child's condition doesn't stabilize or improve?

Why is this important?

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Understanding the Essence of the Crisis (Nature of the Distress)

Fear	Grief/loss
Sadness	Pain
Anger/rage	Exhaustion
Loneliness/isolation	Hunger
Restlessness/boredom	Lack
Hopeless/helpless	Stuck
Uncertainty/ambivalence	Misery
Anxiousness/nervousness	Powerlessness
Guilt	Shame

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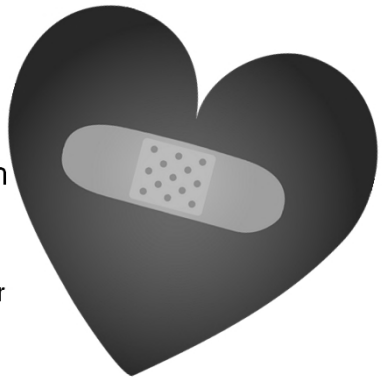
For both child and parent, lead with RELIEF

- Get to the essence of the crisis (understand the nature of the distress)
- Seeing/understanding
  - Not the same as agreeing
- Learn, what is most important right now to the person?
- What is the antidote?
  - Don't forget the basics
  - Take care to not compound the crisis
- Deliberately engage a *credible, capable, intuitive* person
  - Get curious about what matters
  - Get curious about what might help
  - Do not underestimate the value of giving the person in crisis your full attention, unconditional regard, and actively listening



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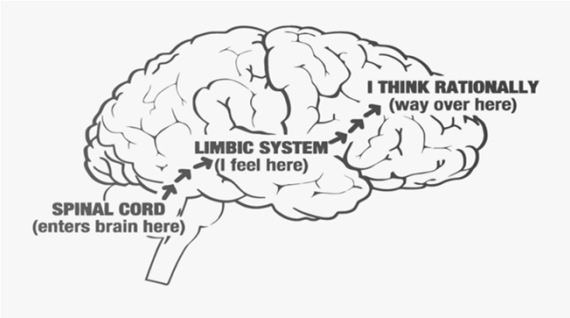
General Rule of Thumb

Think STATE not TRAIT



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PART TWO

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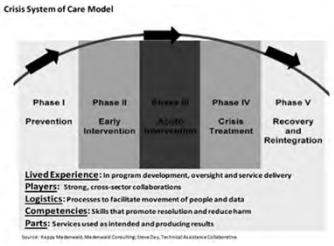
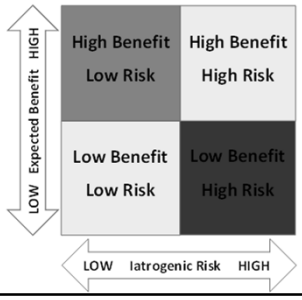
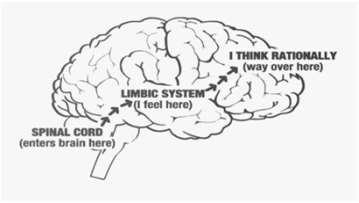
Overnight reflections…let's start some CHAT!

- What stands out to you from yesterday?
- Did anyone have a chance to try any of this out?
- Did anyone use the word "iatrogenic" in a sentence?
- Questions?







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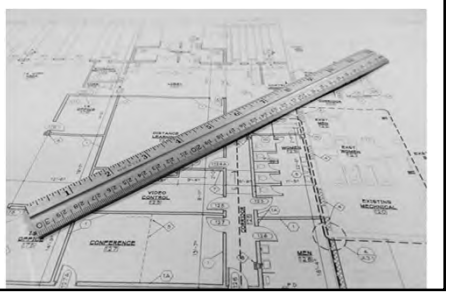
Back to the first three crisis competencies…

Delivery of crisis support and intervention that is…

1. Youth and family-centered
2. Strength-based,
3. Resolution-focused, AND that,



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Youth and Family-Centered

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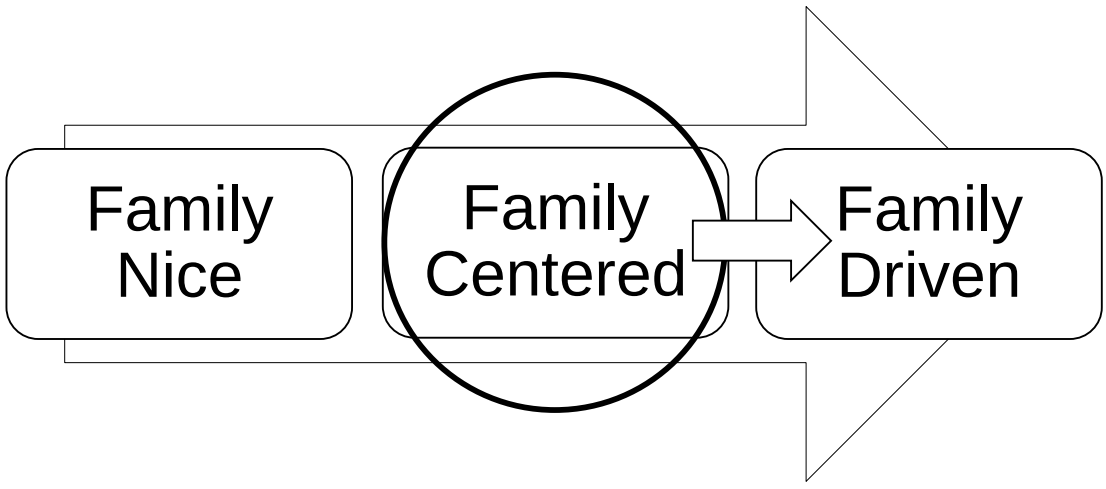
Family-Centered Care



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Aligning with True North

The experience of consumers and families and communities must serve as True North

-Don Berwick

This means that the ordinal point (True North) for system quality is derived from the recipients' reality -- our lived experience, our needs, our beliefs and strengths, as well as our reactions to services extended on our behalf.

-Joyce Burland

Berwick, D. M. (2002). A user's manual for the IOM's "Quality Chasm" report. Health Affairs, 21(3), 80–90. doi:10.1377/hlthaff.21.3.80.

Burland, Joyce, True North: The NAMI Provider Education Program Comes of Age. www.nami.org

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Aligning with True North

"I wish everyone else could see me in the way you see me. I don't even know how you see me, but whatever it is, I want to feel this way forever. I feel like how normal people must feel. But if it doesn't last forever, I'll remember this period in time that I was respected and heard and appreciated for the rest of my life…"

Source: NAMI Advocate. Quote from a participant in a program developed by NAMI Georgia called, "Opening Doors to Recovery"

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Aligning with True North

- The parent (or youth…) and his/her experience is the orientation point for service delivery
- It requires:
  - Seeing youth and parent as credible, capable, intuitive and able to collaborate
    - Honoring the journey
    - Holding a belief in their recovery
  - Joining youth and parent where they are
    - Beliefs
    - Culture
    - Preferences
    - Interpretation of experience

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Aligning with True North

- It is easier said than done because it is such a shift in perspective
- Rather than coming at a problem from my (service provider) lens, perspective and priority, I must re-orient so that I understand his/her (service user's) lens, perspective and priority and start there.

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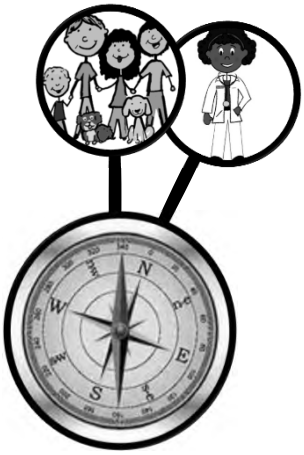

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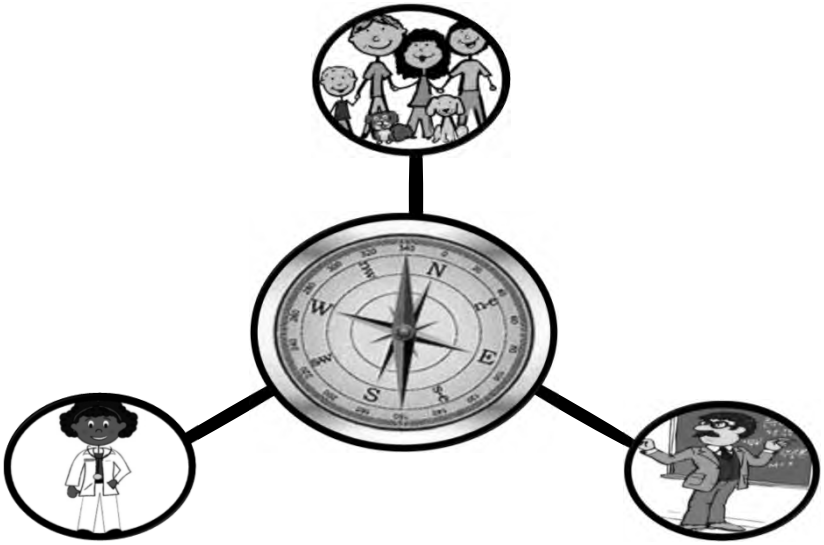

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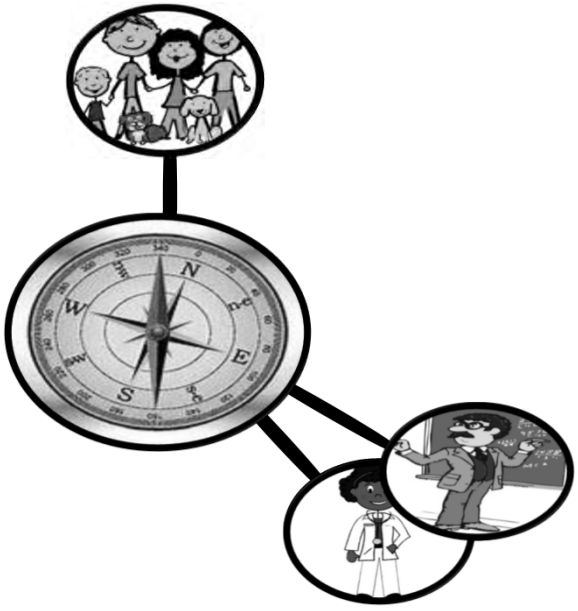

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Poll Question #6

- Within the context of an acute crisis, how often does the team find it difficult or even unsafe to take a youth/family-centered approach?
  - 100%
  - 80%
  - 60%
  - 40%
  - 20%
  - Less than 20%

Use the CHAT feature to make additional comments

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Aligning with True North

- Family-centered care requires a massive shift in the lens through which the service provider delivers treatment. Instead of a service provider viewing a problem, interpreting meaning, and making treatment decisions through his/her lens, the provider intentionally seeks to understand the lens of the youth AND the lens of the parent(s).
- Both the youth and parent(s) are viewed as credible, capable, intuitive collaborators who bring their own expertise that must be jointly considered alongside professional findings and interpretations.
- The difference between provider expert lens and youth/family centered lens can be extraordinary.

LARGE GROUP EXERCISE

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Aligning with True North

EXAMPLE

- A mental health professional evaluates a child and, based on the symptoms, mental status and assessed risk determines that it is imperative that the child be admitted to an inpatient psychiatric unit. But when he meets with the parents and explains the findings and treatment recommendations the child's parents immediately and adamantly refuse to consider hospitalization.
- If the mental health professional is coming from an expert lens and has a deeply held belief that it would be unsafe for the child to be anywhere but the hospital, and the parents are adamantly refusing to consent to the treatment, what must the mental health professional believe about the parents?

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Aligning with True North

- Believing the parent deficit to be true, the mental health professional, through the expert lens has no choice but to act to compel or coerce treatment and that action may include calling security to assure the parents do not take the child; making a referral to child protective services; or initiation of involuntary treatment procedures. Notice that this is a professional conscientiously doing what he thinks is clinically and ethically indicated.

- If however, the mental health professional is aware of the family-centered care approach, the parents' reaction to the recommendation of hospitalization will serve as a prompt for the professional to get curious about the parents' very different belief about what happens next for the child. Instead of interpreting the refusal as a sign of ignorance, denial or neglect, the parents' reaction is viewed as credible and critical to explore

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Aligning with True North

- Through the "expert lens" scenario when parents are in opposition to the mental health professional directed plan, the parental response is viewed as a parenting deficit that puts the child in harm's way. The mental health professional now must proceed in opposition to do what he thinks will assure safety of the child even if that includes coercion.
- Through the "family-centered lens" scenario when parents are in opposition to the plan, the parental response is viewed as credible, protective and important to explore. The mental health professional now must proceed in collaboration with the family considering the credible risks and considerations raised by both mental health professional and parents. The final plan could in fact be hospitalization, or it could be a one-off (youth/family-specific) alternative, considered acceptable to all parties.

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Aligning with True North

- Expertise is important. We want to get better and better at our work.
- Expert lens and expert stance are risky
- We don't, won't and can't know it all
- What we know is ever-evolving
- Approaches believed to be best, are not necessarily "best for me"

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Some notes about aligning with True North

- Perfection isn't possible
- The True North for any individual is continuously shifting.
- Providing services and supports in this fashion means you are operating somewhat in the dark—but at least you know it.

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Strength-Based

70

Poll Question #7

- Within the context of an acute crisis, how often does the team find it difficult or even unsafe to take a strength-based approach?
  - 100%
  - 80%
  - 60%
  - 40%
  - 20%
  - Less than 20%

Use the CHAT feature to make additional comments

71

Strength—Defined

- Capacity for exertion or endurance
- Power to resist force—Solid, Tough
- Power of resisting attack—impregnability
- Strong attribute or inherent asset
- Force as measured in numbers
- Person/thing regarded as embodying or affording force or firmness—(something or someone that gives one strength)
- A concentration, intensity, degree of potency of effect

Source: MERRIAM WEBSTER

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Strength—Defined

- The quality or state of being strong; ability to do or to bear; capacity for exertion or endurance, whether physical, intellectual, or moral; force; vigor; power; as, strength of body or of the arm; strength of mind, of memory, or of judgment
- Power to resist force; solidity or toughness; the quality of bodies by which they endure the application of force without breaking or yielding; -- in this sense opposed to frangibility; as, the strength of a bone, of a beam, of a wall, a rope, and the like
- Power of resisting attacks; impregnability

Source: Brainyquote.com

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Strength—Defined

- That quality which tends to secure results; effective power in an institution or enactment; security; validity; legal or moral force; logical conclusiveness; as, the strength of social or legal obligations; the strength of law; the strength of public opinion; strength of evidence; strength of argument
- One who, or that which, is regarded as embodying or affording force, strength, or firmness; that on which confidence or reliance is based; support; security.
- Vigor or style; force of expression
- Force as measured by amount, numbers, or power of any body
- A strong place; a stronghold

Source: Brainyquote.com

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Strength—Defined

- The state, property, or quality of being strong
- The power to resist attack; impregnability
- The power to resist strain or stress; durability
- The ability to maintain a moral or intellectual position firmly
- Capacity or potential for effective action: a show of strength
- A source of power or force
- One that is regarded as the embodiment of protective or supportive power; a support or mainstay
- An attribute or quality of particular worth or utility; an asset
- Degree of intensity, force, effectiveness, or potency
- Effective or binding force; efficacy: the strength of an argument

Source: Answers.com

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See, understand, get curious about…

- The strength of their perspective
- The strength of their beliefs/culture
- The strength that comes from lived experience (endurance, tenacity, survival, ability to withstand discomfort/pain, scrappiness)
- The strength of where they are on their individual journey (youth, parent)
- The strength of their priorities
- The strength of the lines they have drawn in the sand

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ACHIEVING PRECISION: RESOLUTION-FOCUSED CARE

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"We aren't providing crisis care, we are handing off crisis care.
And then they hand off and then they hand off…"

-Chris Tokarski, Executive Director
Mental Health Resources, Inc.

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Resolution-Focused Care

- Family-centeredness is about a strength-based alignment
- Resolution-focus means using approaches that are resolving/relieving
  - Symptom reduction
  - Empowerment/health activation
  - Clarity
  - Diminished risk/REAL harm reduction
  - Diminished angst
  - Increased hope
  - Return to higher level functioning
- Resolution-focused programs believe in their efficacy and their ability to provide an <u>end-service</u>

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Resolution-focused care

- Provider intention will drive intervention (for better or worse)
- Essential to differentiate:
  - Assessment vs. treatment
  - Disposition vs. resolution
- Medical analogy makes this clearer…

If you are the person with the mangled foot, *<u>are you in this for</u>???*

80

Poll Question #8

Is admission to a psychiatric hospital an example of crisis resolution?

- YES
- NO

Use the CHAT feature to make additional comments

81

Poll Question #9

- Within the context of an acute crisis, how often is the team delivering services that are RESOLUTION and not DISPOSITION focused?
  - 100%
  - 80%
  - 60%
  - 40%
  - 20%
  - Less than 20%

Use the CHAT feature to make additional comments

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COUNTERPRODUCTIVE APPROACHES

83

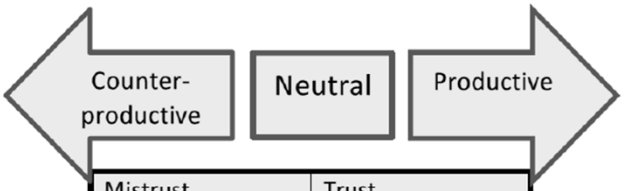
In this exercise, you are the person in receiving services. Pay attention to your "service user" experience as the "service provider" gives you information, asks questions, makes a request or gives you a directive.

Pay attention at a gut level to whether and why the "intervention" is productive or counterproductive.

If it feels **PRODUCTIVE**: Take a step forward

If it feels **COUNTERPRODUCTIVE**: Take a step backward

If it is **NEUTRAL**: Stay where you are



Mistrust	Trust
Disengagement	Engagement
Change Deactivating	Change Activating
Harm Increase	Harm Reduction

Counterproductive/Productive Indicator: An Immersive Learning Experience.™

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Counterproductive Approaches

- In the context of a research project on family-centered care, a number of counterproductive practices were identified.
- Three of the indicators have universal implications
- They are highly relevant in the context of safety planning and the provision of resolution-focused support and intervention

Olin, S.S. Kutash, K., Pollock, M., Burns, B.J., Kuppinger, A., Craig, N., Purdy, F., Armusewicz, K., Wisdom, J., & Hoagwood, K., (2013). Developing quality indicators for family support services in community team-based mental health care. *Administration and Policy in Mental Health.* Published online May 25, 1-14. Doi: 10.1007/s10488-013-0501-9

Olin, S.S., Williams, N., Pollock, M., Armusewicz, K., Kutush, K., Glisson, C. & Hoagwood, K., (2013). Quality indicators for family support services and their relationship to organizational social context. *Administration and Policy in Mental Health.* Published online May 25, 1-12. Doi: 10.1007/s10488-013-0499-z

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Counterproductive Approaches

When a Service provider…

- Uses communication that indicates blame or criticism of the youth or caregiver
- Uses deficit-based language
- Is directive and makes decisions independent of the youth and caregiver about what is good for the family

…it is generally experienced as COUNTER productive

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Counterproductive Approaches

From the provider shoes, consider:

- The absence of bad intentions
- The nuance of the counterproductive intervention—the language doesn't seem so inflammatory when you are the provider that is saying it
- How easy it can be to NOT know you are doing it
- How hard it can be for the provider to recognize the impact—AND understand that he/she is the provocateur

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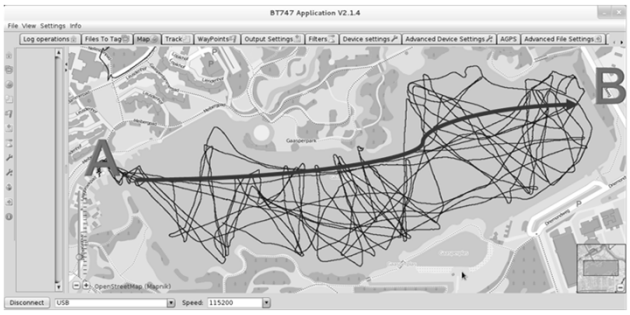
Resolution-focused care

- Care quality and care experience are more about precision than about length, quantity or intensity
- Precision includes choosing approaches that are productive and reducing approaches that are counterproductive



88

Person/family-centeredness in safety planning

89

Iatrogenic risk in safety planning

What are some examples of harms that can come from safety planning and from written safety plans?

90

REAL harm reduction

Think about existing approaches to harm reduction/safety planning

- Why is it being done? To serve what purposes?
- How do you know when a plan is not aimed at REAL harm reduction?
- What are the clues that safety planning will result in REAL harm reduction?

Examples of REAL harm reduction	Examples of approaches not aimed at REAL harm reduction

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REAL Harm Reduction

Risk of harm is reduced when, for example, the child, parent, teacher, and/or other key parties:

- Have an increased empathic understanding of what is happening
- Have reframed from a deficit story to a more strength-based story
- Have a greater understanding of the nature of a child's distress
- Have one or more viable and sustainable strategies (ready, willing, able approaches)
- Feel empowered
- When individuals are activated to change in ways that are health-promoting for the child
- When skills are transferred to/developed by a child or an invested adult

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REAL Harm Reduction

Watch for evidence that the deficit story has changed

- Language used about the child/parent/school has shifted (more empathic, measured)
- Expansion/clarity about the nature of the child's distress
- Shift from ALWAYS/NEVER talk to SOMETIMES talk
  - Example: "He never has good behavior" shifts to "he does well in these situations, has a harder time in those situations
- Expressed insight about child having a normal (even if disruptive) reaction to an uncomfortable situation

Watch for evidence of change activation

- Taking initiative,
- Motivated language,
- Jotting notes,
- Making a call to inquire
- Independently committing to an action (this is stronger than agreeing to)

***DOCUMENT THESE SHIFTS!**

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Safety and Support Plans

- Those are the kinds of results that can come out of effective safety planning
- A specific safety and support plan MAY result out of safety and support planning
- Safety and support plans are best developed as a natural extension of youth and family-centered, resolution-focused intervention:

Resolution-focused interventions
LEAD TO
Safety and support planning, that may
LEAD TO
Development or revision of a plan

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Safety and support plans as a natural extension of a resolution-focused intervention…

Example: Duane

95

Conversation starters

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How to facilitate a productive conversation

- Believe that you are engaging individuals that are CREDIBLE, CAPABLE, INTUITIVE, and ABLE TO COLLABORATE
- These individuals are the ones who are best able to identify sustainable, effective solutions
- Take a facilitative approach
- Use Socratic (open-ended) questions
- Listen attentively
- Use simple techniques to further the brainstorming/problem-solving ("Could you say more about that?")
- Avoid any instinct to interpret or solve for others
- Avoid a rush to a disposition (passing off to someone else to resolve)

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Exploring resources with schools…

- When did he/she first come to your attention?
- What was happening before that?
- What steps do you take when a student comes to your attention?
- Are there particular resources available to you?
- How do any concerns or suggestions that you have get discussed with the teachers and leadership?
- What are the ways that you (school leadership) think about, plan for, discuss, and follow up after crises?
- What options do you have for collaborating with parents whose children are likely to have a crisis?

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Exploration with DCF/Foster Homes

- How is it that he/she got to your home?
- How is he/she experiencing being away from his home/school/siblings/community?
- What part does he struggle the most with?
- In what ways does his behavior make sense to you?
- What parts of his behavior are you trying to sort out/struggling to understand?
- How does it feel, to you to have him/her in your home?
- When you feel (reflecting back, i.e. overwhelmed/uncertain) what are your options for seeking support? From foster care agency? DCF?
- What would make it easier for you to continue to have him/her in your home?
- What are the options for a foster parent who is struggling with a child?
- What strategies do you use so that all parties understand the consent situation for any particular child?

99

Discussing support needs

- Are there things that (you/your child/the student) struggle with or that cause problems for you (or are upsetting to your parents/teachers) either at home, school or in the community?
- What is the nature of the struggle?
- I am curious if there are issues in every period, or just a few?
- Are there certain days of the week/hours of the day that are most difficult?
- I am curious what you think this behavior is about?
- What would you guess is leading to the distress? Disruption?
- As you know, when kids brains are swamped by emotion, they go into fight, flight freeze mode. What are your thoughts about the emotion he is experiencing leading up to these events?

100

Look back at the questions on the last three slides…

What is the intention of asking these questions?

101

How are you experiencing…

Exploration with child

- How are you experiencing…school?
- …the school bus
- …those two hours before you parent gets home
- …this foster home

Exploration with adults about the child:

- How do you (adult) think he/she is experiencing school?
- Are the risks internal to the child?
- Related to how he feels in the environment? How he feels with classmates?
- What is his learning style?
- How do you think he would describe his school experience? What would you say he thinks is the hardest part? The best part?

102

Understanding family preferences and experiences

I am curious?

- Has 911 ever been called because your child was having a mental health/behavioral crisis?
- Has he/she been seen in an emergency department?
- Has your child received crisis services from a mobile crisis team?
- Have you brought in family, friends or other informal supports to help you manage a crisis?

For each of these actions:

- Was it your choice or did someone else make the decision?
- What happened?
- What was the experience like for the family?
- If it were up to you, would you choose to use _____ again?

103

Addressing stances

If the talker (child, parent, teacher, etc) takes a STANCE or POSITION on a topic, probe further, ask:

- "Could you please say more about that?"
- "What are the good reasons to pursue/not pursue…?"
- "What concerns are you trying to address?"
- "What has your experience been with…?"

Listen attentively as the talker has a chance to discuss the reasons behind the stance, listen for the point where they stop to catch their breath, their mood/energy related to the stance shifts, or they begin to make their own counter-argument. Now you can probe a little differently

- "Even given all of the good reasons you mentioned, do you have any reservations?"
- "Do you see any potential risks (in holding onto the stance, i.e. "of not trying the medication?"

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Final thoughts…use CHAT to describe some takeaways!!