Mobile Response Stabilization Service Tool Kit and Resource Guide V1.0

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MENTAL HEALTH & ADDICTION SERVICES | Ohio | MHAS
Promoting wellness and recovery

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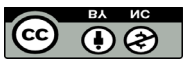
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MRSS Tool Kit

Organization of the Mobile Response Stabilization Service (MRSS) Tool Kit:

The Mobile Response Stabilization Service (MRSS) Tool Kit is organized around the core stages of Ohio's MRSS model:

1. Screening and Triage
2. Mobile Response
3. Stabilization

Each MRSS stage will include the following areas of focus:

- **Tasks:** (Steps: Decision Points; What needs accomplished)
- **Tools and Resources:** (Instruments; assistive materials)
- **Skills/Competencies:** (Knowledge and abilities needed to do the work)
- **Techniques/Interventions/Strategies:** (Methods; Procedures; how it is accomplished)
- **Approach:** Mindset, Service Philosophy; Principles of Care; Perspectives

Hyperlinks:

- Each section listed in the Table of Contents can be accessed directly by clicking the hyperlinks for that section.

- Tools referenced in each section can be accessed directly by clicking on the embedded hyperlinks.

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MRSS Definition

Mobile Response Stabilization Service (MRSS) is a rapid mobile response and stabilization service for young people who are experiencing significant behavioral or emotional distress and their families. MRSS is available 24 hours a day, 365 days a year and is delivered face-to-face at the young person's home, school, local Emergency Department (ED), or another location in the community. The purpose of MRSS is to help youth and families build needed skills to ensure that future distress is less frequent and less intense.

MRSS consists of a series of three stages: triage and screening, mobile response, and stabilization. Interventions are designed to maintain the young person in his/her current living arrangement and to stabilize behavioral health needs to improve functioning in identified life domains.

Major Tenets of MRSS

- The child/family defines the crisis.
- Distress impacts all members of the family system, not just the child
    - MRSS uses a family systems approach to child/family distress because it impacts everyone around them and how their distress is managed has a big influence on the frequency and the intensity of that distress.
- Services are trauma-informed
- Culturally responsive, family driven, youth guided services and supports.
- Activities, services, supports and skill development are offered and are individualized to meet the unique needs and preferences of each family.
- Youth and parent peer support are integral components of the MRSS team and offer lived experience supports to the youth and family.
- Planning and linkage MRSS utilizes a facilitated planning process, in partnership with youth and families, and identified family supports, and involved community service and system providers.
- 24/7 on-call availability

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Ohio MRSS Core Components	
24/7 Response (Hotline and MRSS)	• MRSS staff are available 24/7 for mobile response. • Operates 365 days of the year. • Within 60 minutes of hotline call
Family Defines the Crisis	• The family defines the crisis. The MRSS team's responsibility is to respond to the location of the crisis. If the defined crisis involves a life-threatening emergency, the MRSS team responds to the hospital.
System of Care Principles	• System of Care principles are utilized. • Culturally responsive, family driven, youth guided services and supports.
Mobile Response, De-escalation, and Safety Planning	• MRSS responds to time and place of family choice to help family with what family wants help with. This includes the family's home, school, and other community locations. • Initial de-escalation and safety precautions implemented • Initial MRSS assessment • MRSS plan, including safety plan, co-created with family
Ongoing Stabilization and Support	• Available to provide up to 6 weeks of ongoing stabilization. • MRSS team is on-call to the family 24/7 during the entire MRSS service. • Activities, services, supports and skill development are offered and are individualized to meet the unique needs and preferences of each family.
Youth and Parent Peer Support	• Youth and parent peer support are integral components of the MRSS team and offer lived experience supports to the youth and family.
Facilitated Linkage and Connection	• MRSS utilizes a facilitated planning process in partnership with youth and families, identified family supports, and community service and system providers for the purpose of facilitating linkage and active connection to continuing services and supports.

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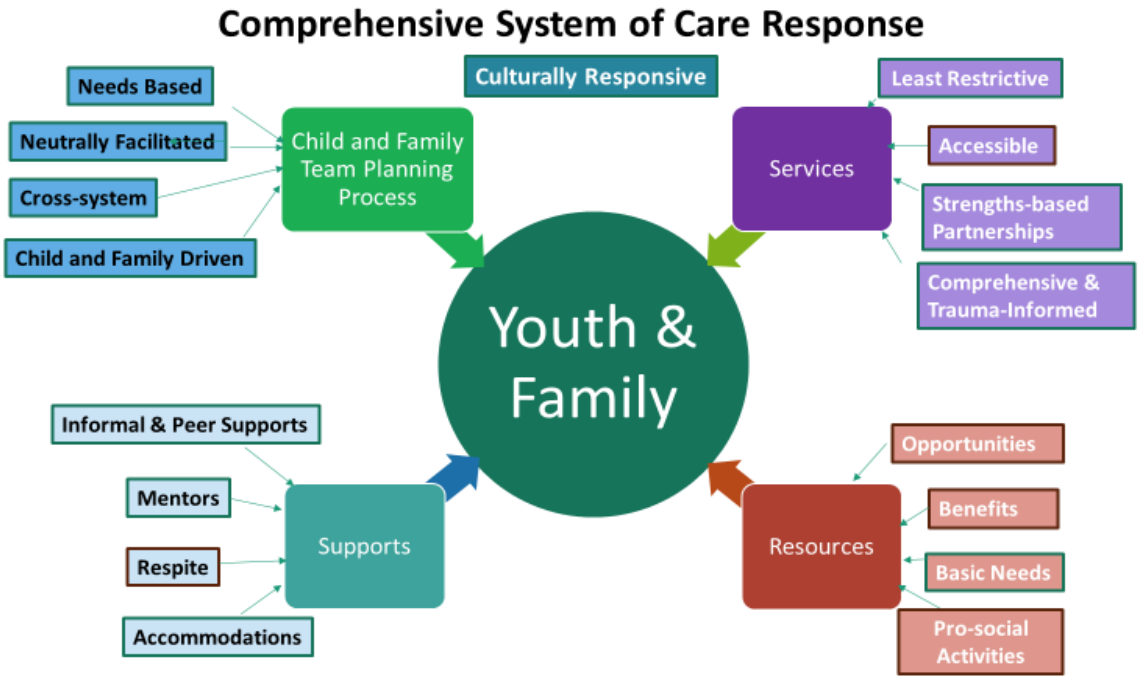
System of Care Principles

Youth (and their families) with complex behavioral health needs experience significant functional challenges in multiple areas of their lives. These youth and families require a comprehensive and coordinated system response. Responsive systems of care are comprised of a wide-ranging set of services and supports guided by strength-based and culturally responsive principles.



MRSS utilizes system of care principles as a foundation for engagement and partnership with youth and families.

System of Care: (Stroul, Blau, Larsen, 2021)

- Incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults.

System of Care is a comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families:

- ORGANIZED INTO A COORDINATED NETWORK OF SERVICES AND SUPPORTS
- BUILDS MEANINGFUL PARTNERSHIPS WITH FAMILIES AND YOUTH
- RESPONSIVE TO FAMILY CULTURAL AND LINGUISTIC NEEDS
- FOCUSES ON RESILIENCE PROMOTION AND TRAUMA-INFORMED CARE

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System of Care Core Values and Guiding Principles (Stroul, Blau, & Larsen, 2021)

Family-Driven and Youth Guided

Community-Based

Culturally and Linguistically Competent

- Comprehensive Array of Services and Supports
- Individualized, Strengths-Based Services and Supports
- Evidence-Based Practices and Practice-Based Evidence
- Trauma-Informed
- Least Restrictive Natural Environment
- Partnerships with Families and Youth
- Interagency Collaboration
- Care Coordination
- Health-Mental Health Integration
- Developmentally Appropriate Services and Supports
- Public Health Approach
- Mental Health Equity
- Data Driven and Accountability
- Rights Protection and Advocacy

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MRSS Stage One: Screening and Triage

Stage One Tasks

1. Screening and Triage

Decision Points

1. Protocols for police notification
2. Hospitalization vs stabilization in natural environment

Techniques/Interventions/Strategies

- Screening and triage

Skills/Competencies

1. Determine response level based on family-defined need (emergency, information and referral, mobile response)
2. Risk and safety concern identification
3. Initial de-escalation

Tools/Instruments

MRSS Phase 1 Tool: Triage Checklist

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Initial Triage Call Task

- Initial triage is completed by the crisis call center staff.
    1. Ask if there is a life-threatening emergency
    2. Ask if the caller and people around them are safe
    3. Obtain the caller's address and phone number
    4. Decide on level of intervention and type of response (information and referral, MRSS mobile response, 911- with MRSS mobile response to emergency stabilization site; see Table 1)
    5. If the call is deemed an emergency, the call center will notify 911 while the family is on the phone
        a. The MRSS team will then be dispatched to the location of emergency stabilization (hospital, home, etc.).
        b. In emergencies, MRSS team is expected to follow-up once the life-threatening situation is addressed.
    6. Conduct initial phone de-escalation
    7. Transfer to MRSS
        a. While caller is on the line, call the MRSS team
        b. Provide caller phone number and address to MRSS
        c. Briefly inform MRSS of the nature of the call
        d. Transfer the caller to MRSS staff
        e. Confirm that the call successfully transferred
    8. If the family explicitly declines an immediate on-site response, they are offered a follow-up appointment the next day, at a meeting place of their choice

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Table 1 Triage Response Levels

Triage Response Levels		
Level of Response	**Description**	**Response & Time**
Information & Referral	• Information, linkage, referral, support • Examples: requests for agency phone numbers; information about benefits or resources; listing of services; • Ask if they have any emergent need that they are calling about.	Over phone by triage staff
Non-immediate	• Family-driven response • Per family or referrer request a scheduled response is requested instead of an immediate response.	Phone stabilization and scheduled response based on family need. Mobile response within 8 – 24 hours
Immediate	• Family-driven response • Response requires a clinician with a license to provide a diagnostic impression. • Response team is a clinician who can provide a diagnostic impression plus one other staff • High degree of distress • Reports of high-risk behaviors: Examples: Unresolvable/escalating conflict; non-life-threatening emergency; ideation with no plan; non-compliance that impacts functioning; aggression	Mobile response within 1 hour
Emergency	• **Substantial risk of self-harm or harm to others**: Actively suicidal; homicidal; active self-harm behaviors; domestic/family violence; active threat of harm to others; overdose; medical emergency • **If the call is deemed an emergency, the hotline will call 911 while the family is on the phone.** • **The MRSS team will then be dispatched to the location of emergency stabilization (hospital, home, etc.).** • **In emergencies, MRSS team is expected to follow-up once the life-threatening situation is stabilized.**	911; Lethality pre-screening; and dispatch MRSS Team to stabilization site.

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MRSS Stage 1 Tool: Triage Checklist

MRSS Triage Checklist
Presenting Acuity
Is there was a life-threatening emergency?
Did you ask if the caller was safe?
Did you ask if people around them are safe? Ex: "*Are the people around you safe*?"
If they are calling about someone else, did you ask if they are concerned about his/her safety? Ex: *"Are you worried about your safety or someone else's safety?"*
If there is an emergency did you call 911 or offer to call 911 for the caller?
Did you get their current location and cell phone number? "Do your parents know where you are right now?"
Did you ask about how you can help?
Did you ask about suicide ideation, threats, plans? Ex: "*Have you thought about suicide as a way of dealing with your current situation*?" "*Are you having thoughts of suicide right now?"; "Have you had thoughts of suicide in the past month?"*
Did you ask about current plan and availability of means? Ex: "Do you have a plan to follow through with suicide?" *"What method are you considering?"; "Is this method available to you now?"*
Did you ask about previous suicide attempts? Ex: "*Have you ever made a suicide attempt*?"
Initial De-escalation
Did you provide initial de-escalation and assess for safety?
Did you offer mobile response within 60 minutes? Did you dispatch the mobile team?
Available Services and Supports
Did you ask about available supports? (Informal and formal) Ex: "Is there anyone else with you right now?"; "Who do you normally talk to when you feel this way?" "Who lives in the home with you? Are they there right now? Can I speak with them?"
Did you ask whether another on-call service is working with the family (MST; IHBT; ICT)?
Did you offer to call the MST/IHBT provider after brief phone stabilization. Ex: "Can I call your IHBT provider and let them know you are currently requesting help?"
Did you ask if the youth and family are currently receiving behavioral health services?
Immediate Linkage and Follow-Up
Did you offer MRSS to every family that calls?
Did you communicate/follow-up with current providers about the call, your response, and the result?
Home and Environmental Safety
Did you ask about current conditions in the home or neighborhood that could pose a threat to staff safety? Ex: *"Are there safety issues in the home or neighborhood we should be aware or prepare for when we come out?"*
Did you ask if anyone in the home is currently under the influence of drugs and/or alcohol?
Did you ask about access to weapons? Did you ask family to secure weapons/lock them in a secure location?
Did you ask about animals that may be aggressive or pose a threat?
Did you ask them to have the animal secured in a separate room during your visit?
Did you ask about history of family violence? Ex: "Have any family arguments escalated to a point of someone being physically hurt or resulted in the police being called out to your home?"

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MRSS Stage Two: Mobile Response

Tasks

- Immediate response call to the youth and family
- Initial engagement with youth and family
- Crisis stabilization
- Mental Status exam/ MRSS Lethality/Risk/Safety assessment
- Initial safety plan including safety precautions
- MRSS assessment and diagnosis
- Ohio Children's Initiative Brief CANS (Ohio Brief CANS) completed within 72 hours
- MRSS Plan in partnership with the youth and family

Decision Points

- Protocols for police notification
- Hospitalization vs stabilization in natural environment

Techniques/Interventions

- De-escalation
- Safety walk through
- Means reduction strategies
- Safety mapping

Skills/Competencies

- Suicide lethality assessment
- Crisis de-escalation and stabilization
- Safety planning
- Engagement
- Identification of crisis escalation and distress patterns

Tools/Instruments

- Safety plan
- Safety and Risk Screen
- Ohio Children's Initiatives CANS
- Engagement Tools
- Crisis Functional Analysis
- Columbia-Suicide Severity Rating Scale

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Mobile Response Task: Immediate Response Call to the Youth and Family

- Call immediately upon receiving the information from the crisis line
  - "I'm on my way to you now"
    - If you are already heading in their direction, they don't need to worry about what is happening next
  - Provide your estimated time of arrival
    - How long is it going to take to reach the family
  - Begin de-escalation of caregiver
    - You can get some of the story of what's going on so you can focus on de-escalation once you are on the scene. Parents/caregivers often do not realize that they are also in distress and this phone contact can give them a chance to start de-escalating.
- Things to keep in mind as clinician receiving a MRSS Call
  - Remain open minded about what is being reported
  - The caller is giving you the information about what is happening based on their perception about what is generating distress for the child/family
    - Often referents are focused on the child's behavior instead of what is driving the behavior
  - Sometimes what is being reported does not sound like a crisis to you, and it is tempting to try to de-escalate the situation by phone or give an alternative response by phone
    - MRSS always responds in person, ALWAYS
    - Reality Check: Mobile response does not always feel like it comes at a convenient time for you

Decision Point: Protocols for Police Notification

- Violence/threats of violence/possession of a weapon, call police to meet you there.
- Make sure that the family knows that you will be bringing law enforcement with you to ensure everyone's safety.
- Request a CIT trained law enforcement officer.
- Each police officer/sheriff deputy has different levels of experience and understanding of mental health needs, so it is important to meet them outside of the community setting (usually in front of the home) to educate them about MRSS protocols before you enter to meet the family
- It's important that they know exactly what your role is and what you are hoping that they can assist you with during the call

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- Ensure that law enforcement understand that they have a mental health professional on scene because many of them believe you are a case worker or a family member unless you clarify your role
- Make sure you let law enforcement know that you intend to do a mental health assessment before any decisions are made about next steps
- Allow the officer to ensure that the home/area is safe to approach before you enter
- If the child cannot be deescalated, you can collaborate with the officer about how transport can be arranged for a hospital evaluation
- Environment scan for immediate safety (animals, weapons, people in the home, etc.)

Mobile Response Task: Arriving on Scene

Mobile Response Technique/Strategy

- Often when we arrive on scene of an MRSS call, emotions could be running high and the first thing that the family/referent wants to do is tell you what started the current situation.
- Rehashing what just occurred often leads to further escalation of emotions which is the opposite of our goal for MRSS.
- In addition, the child is often right there on scene and can be negatively affected by how the story is told by others. It can be invalidating to have your thoughts and emotions explained by someone else.

Mobile Response Task: Introduction to MRSS

Mobile Response Technique/Intervention

- **Opening Question: Have you ever had Mobile Response Stabilization Services before?**
- Opens the door to telling the family about your role and about the MRSS service.
- Helps therapist to keep focus on family systems and away from the immediate telling of the distress story (*"storytelling")*
- May also ask about current service involvement.
- Answering this may get them out of the emotional part of their brain and into the information processing part

SCRIPT: *"MRSS is a family systems intervention in which the family defines what the crisis is. We respond as many times as the family has need for de-escalation. We provide short-term support through a therapist, skill builder and parent or youth peer support specialist. I can be most helpful in focusing on helping you and your family better manage distress. Today, I will focus on three areas of intervention: How to calm down after you are already upset, understanding early warning signs of escalation of distress, and understanding what kinds of things or situations tend to lead to distress. We will help your family to identify ways in which you manage distress as a family."*

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Mobile Response Task On-Site Triage: Determine Immediate Risk of Harm to Self or Others

- **Immediate Risk Factors for Suicide**
  - Talking about wanting to die or to kill oneself
  - Looking for a way to kill oneself, such as searching online or obtaining a gun
  - Talking about feeling hopeless or having no reason to live

- **Serious Risk Factors for Suicide**
  - Talking about feeling trapped or in unbearable pain
  - Talking about being a burden to others
  - Local epidemics of suicide
  - Increasing the use of alcohol or drugs
  - Acting anxious or agitated; behaving recklessly or impulsively
  - Sleeping too little or too much
  - Withdrawing or feeling isolated
  - Showing rage or talking about seeking revenge
  - Displaying extreme mood swings

Components of a Suicide Lethality Assessment (Beck; Jacobs; ASQ; CAMS)

- **Intent:** Subjective desire for a self-destructive act to end in death.
- **Lethality:** Objective danger to life associated with a suicide method or action.
  - Lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous.
- **Degree of ambivalence:** wish to live, wish to die, hopelessness;
- **Degree of agitation and urgency**
- **Psychological pain:** depression; substance use; impulsivity, etc.
- **Past Behavior**: previous attempts
- **Recent Stressors:** Relationship break-up; suicide contagion; trauma; bullying; overwhelming stress, etc.
- **Supports: availability:** responsiveness; consistency

Mobile Response Tool: Columbia-Suicide Severity Rating Scale

Decision Point: Hospitalization

- Based on the results of the completed lethality assessment and the Columbia Suicide-Severity Rating Scale determine if the youth can be safely stabilized in the home or if the youth needs a more secure setting, such as a crisis bed or hospital setting, for stabilization.

Mobile Response Tool: Risk and Safety Screen

Mobile Response Tool: Environmental Safety Screen (Appendix)

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Mobile Response Task: Initial Stabilization and De-Escalation

- **Goal:** Decreasing and regulating strong emotions in real time, returning the neurological system to a different state of arousal, way of controlling level of distress
    - After a person's neurological system has already been escalated, the child/caregiver must be deescalated to a relatively calm stated before verbal interventions will be successful. Most MRSS mobile response interventions start with de-escalation. Your previous discussion about distress patterns should give you some idea of what de-escalation strategy might be the most successful.
    - Often what started the distress happened away from the caregiver and by the time they can intervene they may not understand what is going on.
    - It bears mentioning again that distress looks different for each child and while one may be visibly tearful and upset, another might be angry and acting out.

Approach

- Model calm, non-threatening approach
- Short and simple directions
- Take leadership of the situation
    - Especially in community settings (school, JDC, police, hospital), it is important for everyone to know what you are going to do and how they can help you be successful in the de-escalation of the child

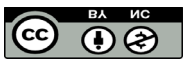
De-Escalation Techniques/Interventions/Strategies for Caretakers

- If other system providers or caretakers want to tell you what has happened, direct the staff to having this conversation away from the child. Sometimes family members find it difficult to move forward without telling you *their* version of events which led to MRSS involvement. Problem solve with them how they can share that info in a way that does not cause further distress to their child/family.

- Begin redirecting the focus on de-escalating the child.
    - *How have you helped your child be successful in calming down in the past when they are in distress*
    - *What has been successful in the past to help your child calm down?*

- Reframe situation from behavior focused to what is generating distress.
    - *Where do you think these strong emotions are coming from?*

- Often children need to be close to their attachment figure(s) when they are in distress and they calm down better when they are near them.
    - *Does your child tend to calm down with you near them or far away? (emotional engagement interventions)*

 2021, CIP, CWRU and OhioMHAS

- Paperwork can be helpful
    - Sometimes it can be helpful to the family/referent to start with paperwork, which is pretty boring but can give them a few minutes to calm down.

- Help the caregiver understand their own emotional state before they start helping the child de-escalate
    - *everyone has less frustration tolerance when they are upset as well
        - Caregiver may need to take a few minutes if possible to chill before attempting an intervention. If the first attempt does not work, they tend to quickly throw all strategies out the window and start to mirror child's emotional state.

De-Escalation Techniques/Interventions/Strategies for Youth

De-escalation: The process of assisting a person (or persons) in decreasing the level and duration of emotional and/or behavioral distress while increasing personal and situational safety. The goal is to help the person return to functional stability where they can use self-regulation skills to initiate adaptive coping responses.

De-escalation Methods:

1. **Establish Safety:**
    - Secure the environment;
    - Facilitating personal and situational safety;
    - Facilitate therapeutic separation;
    - Gain commitment to safety

2. **Calming approach:**
    - Modeling calm behavior and non-threatening approach;
    - Therapeutic connection; emotional engagement; attunement
    - Active listening and empathic responses to help relieve emotional distress;

3. **Contextual interventions:**
    - **Change the situational dynamics/alter the environment**: (escalation cycle; persons involved, demands, etc.)
    - **Facilitate safe space/sanctuary to regulate;**
    - **Decrease stressors:**
        - Ease demands and requirements;
    - **Increase support:**
        - Mobilization of natural supports

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4. **Diversion activities:**
    - Internal diversion or distraction activity: Most common thing that you think about to change your emotional state because it distracts your brain and your thought process
        - listening to music; video game; etc.
    - Take a break and come back
    - Behavioral redirection; Implement diversionary activity;

5. **Increase regulation and coping:**
    - Co-regulation activities;
    - Assisting person in practicing coping skills in the moment;
    - Assistance to, and involvement/participation of the individual in active problem-solving planning;

    - **Emotional regulation:** Deep breathing, relaxation, self-calming strategies

    - **Movement/repetitive motion:**
        - Physical regulation activity: going for a walk; working out; etc.
        - Repetitive motion: assist person in finding a rhythm close to a resting heartbeat (bouncing ball; knitting; etc.)

    - **Expressive:** Visual/physical/verbal representation of what they are experiencing
        - Journaling
        - Drawing/art

    - **Sensory:** The emotional regulation area in your brain is directly influenced by sensory input, which impacts your emotional state.
        - Tactile: Weighted blankets
        - Warm water/bath
        - Soothing smells

Mobile Response Task: Complete Initial Safety Plan

- Establish safety and complete initial safety plan before leaving initial mobile response
- Gain commitment to safety

Approach

The initial safety plan is completed in **partnership** with the young person and family

- Provider **perspective:** Family members are experts on their families
- Calm demeanor
- Creating a sense of hope that the youth and family can make it through their current distress.

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Skills and Competencies

MRSS staff should be able to:

- Identify and implement pre-crisis strategies and supports for crisis prevention
- Create secure and monitored environments (safety measures employed)
- Identify safety net of supports for youth and family (informal and formal)
- Identify coping strategies that youth and family can utilize
- Plan for what to do if the crisis does occur (De-escalation and coping strategies; crisis stabilization supports)
- Delineate roles and responsibilities; assign lead crisis responder role
- Active monitoring of safety plan

Tool: MRSS Safety Plan

Mobile Response Task: Means Reduction

Items to Secure:

- Knives; Guns; Martial arts weapons
- Medicines: all
- Items to hang self with: Ropes; belts
- Harmful ingestible: Poisons; Cleaning products: bleach, etc.

Safety Strategies

- Lock boxes for medicines or knives
- Ask for gun to be kept at another house
- Keep gun locked in case, with safety lock, and ammunition locked separately
- Door alarms
- Baby monitors

Tool: Safety Precautions and Means Reduction Plan

Mobile Response Stage Task: Engagement

Goal: Establish positive working relationship with the youth and family.

- "Our program has been successful with other families that have similar challenges that you are experiencing. While I can't make any promises, I will do my best to help you and your family."

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Approach/Perspective: Respectful, Honoring, and Hopeful

- Think about "being with" rather than "doing"….to promote relationship building
- Enter the home and life of family in such a way that the family feels in control of the environment
- Be credible and build expectancy for change
- Develop partnership: "I am successful if you are successful."
- **Honor family's expertise**
- **Appreciative perspective**: Families are doing the best they can do, given their current abilities and life circumstances.
- **Validation:** The youth and family are validated for their expertise, courage, efforts, and persistence
- **Valuing:** Understand and respect the family's unique beliefs, values, customs, languages, abilities, traditions, and life experiences
- **Provide Hope:** Foster the possibility of hope and a positive future
- **Culturally mindful:** Respectful humility
- **Resilience-perspective:** Children, youth, and families have unique strengths, abilities, and talents that when supported can develop into foundational competencies

Engagement Tool: Resiliency-Oriented Engagement Questions that Elicit Youth and Family Strengths, Culture, and Values

Engagement Tool: Appreciative Communication

Mobile Response Stage Task: Assessment

- Complete the Ohio Children's Initiative CANS (Ohio CANS) with the youth and family
- Utilize the Ohio CANS to inform the diagnostic assessment
- Establish diagnosis
- Determine skill sets/coping strategies needed for functional success
- Assess for youth and family support needs
- Assess for youth and family strengths, interests
- Comprehensive assessment of risk and safety concerns
- Assess contextual functioning (school, home, community, peers)

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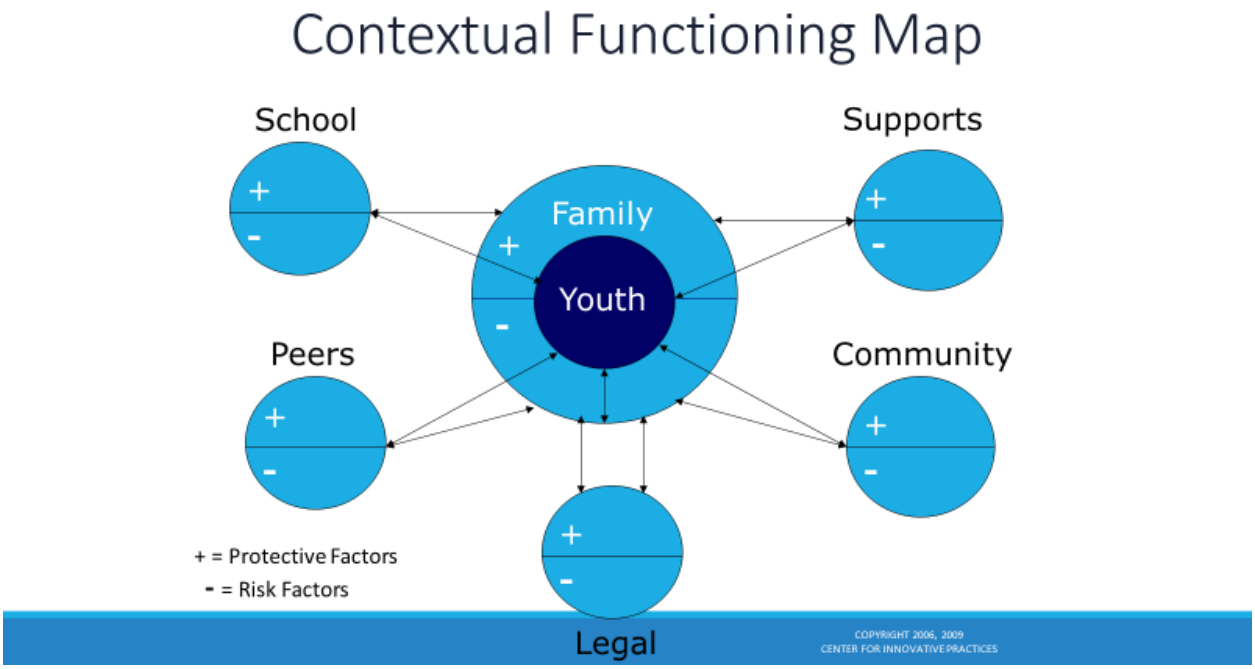
Assessment Tool: Contextual Functioning Map

Assessment Tool: Contextual Functioning Map



Assessment Tool: Safety Tour of the House

- Safety tour of the house
- Completed with parent or caretaking adult (and not the youth)
- Walk through each room of the house prompting the parent/adult with safety questions:
    - Tell me what is in this room that could pose a danger to someone?
    - Think about your son or daughter and what they may have done before– what is in this room that we need to secure?
- Have parents secure items of concern and confirm actions were taken

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Mobile Response Stage Task: Assess Crisis Escalation and Distress Patterns

- Family crises create an opportunity for family members to better understand their escalation and distress patterns, and to develop more effective ways of handling crises in the future.

Assessing escalation and distress patterns

- Warning Signs
- Crisis Functional Analysis
- Frequency
- Intensity
- Related safety concerns
- Who, When, Where
- Systemic dynamics of the crisis

MRSS Assessment Tool: Identification of Early Warning Signs

- **Goals:**
  - To Identify when a child is starting to show signs of distress so that the caregiver can intervene before escalation occurs and help the crisis be less intense.
  - To be able to notice and read the clues of your child's early warning signs of escalation.

Questions and Prompts for Early Warning Sign Identification

- *What is your child telling you with his behaviors in this moment about what is going on emotionally for him?*
- *What do you see as early warning signs for the client?*
- *Who would notice first if the client was escalating? Then who, etc.?*
- *What are the signs that your child is beginning to be upset? Caregiver?*
- *What are the "tells" that things are starting to escalate?*
- *What does your child look like when they are "emotionally sick" and not feeling well?*
- *How well are you able to read your child's body language or non-verbal cues that they are becoming upset? Pacing, change in tone, red face*
- *Who can "read" you better than others? (proximity).* Helps to gauge if caregivers are attuned to child when they start to get upset.

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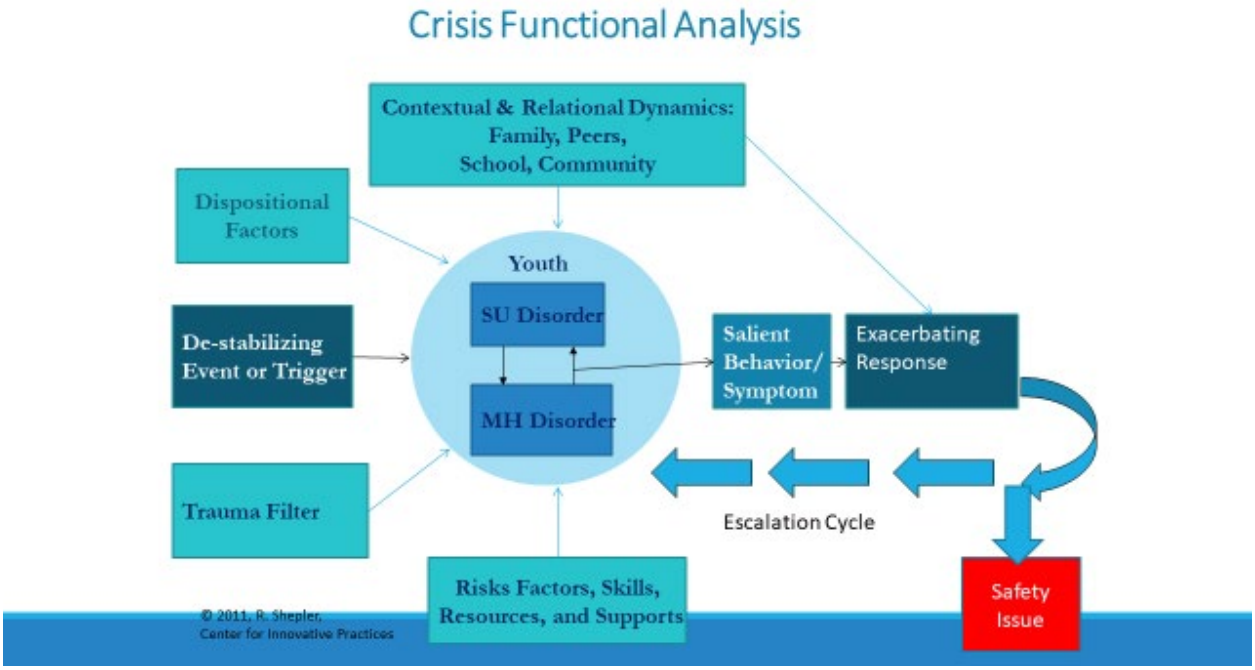
Assessment Tool: Crisis Functional Analysis



Crisis Functional Analysis: A crisis functional analysis is an assessment of the youth and family's escalation pattern and is completed when family is not in a crisis. The crisis functional analysis identifies key areas for intervention including:

- **What: the triggering stimuli (internal and external)**
  - *What interactions tend to lead to your child being more upset?*
    - Introduction of the concept that how the family reacts to a child's distress can impact how intense and how long the distress lasts
  - *What generally happens before the crisis? What are the contributing factors?*
  - *Which of these describe what might trigger your child?*

Typical stressors that can trigger a distress response	
School stressors	Physical health issues
Family stressors	Negative influences
Peer stressors	Social media
Relational conflict: Arguments/Fights	Bullying/Intimidation
Lack of sleep	Trauma event
Medication Compliance	Emotional dysregulation
Other:	Other:

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- **Who is involved: identification of roles in sustaining or escalating the crisis.**
  - *Whom are you usually with when you experience a crisis?*
  - *Who can calm the youth the quickest? Then who?*
  - *Who avoids crisis situations?*
  - *Who escalates situations?*
  - *Who extends the crisis?*
  - *What interactions tend to lead to your child being more upset?*
    - Introduction of the concept that how the family reacts to a child's distress can impact how intense and how long the distress lasts
  - How does caregiver respond/react to the youth's early warning signs?
    Are you a light switch or a dimmer?
    - Light switches usually are "on" or "off" with regard to distress. They tend to escalate quickly with some intensity. Dimmers tend to get upset gradually or over time where small things build up. Often they are seen as overreacting when they do show distress.

- **When: Timeframes and periods**
  - *What time of day; day of the week do these crises generally occur?*
  - *How long do these crises normally last?*
  - *How long do you feel unsettled?*
    - This helps determine how long it takes for the person to return to baseline. It can take minutes, and sometimes even hours. People with an emotionally vulnerable temperament can easily be re-escalated easily, which can happen if we try to discuss what happened to cause distress.

- **Where: Locations and contexts**
  - *Where do these crises usually occur?*
  - *Are there contexts where the crises don't happen?*

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- **Function of the behavior: What is the purpose of the behavior? What are the underlying needs?**

Underlying Needs	
Feeling unsafe	Suspected Favoritism/Attachment
Feeling of not being heard or listened to	Lack of Motivation
Feeling of not being understood	Lack of control/Helplessness
Unconditional acceptance	Poor time management skills
Anxiety/Overwhelmed	Low frustration tolerance
Abandonment/Loss	Lack of Energy

- **Process: Sequence of interactions and escalation patterns**
  - Utilize backwards processing to sequence the events that preceded the crisis.
    - Work backwards from the crisis event. *What happened right before the crisis event, and before that and the event before that*, etc.

- **Barriers to de-escalation:**
  - *What keeps the crisis going?*
    - Examples: Dysregulation; Rigid/unyielding stances; inflexible interaction styles, etc.
  - *What doesn't help?*

Assessment Tool: Distress Escalation Cycle

The distress escalation curve tool can be used in conjunction with the crisis functional analysis to map the rise and fall of the distress escalation pattern. This tool can help caregivers develop a greater understanding of the development and context of crisis-oriented behavior so that they can intervene in a stage-consistent and effective manner. Caregiver(s) often benefit from the visual layout of the distress escalation curve. This tool can be used to map out behaviors, identify triggers causing escalation of behavior and develop strategies to reduce crisis situations.

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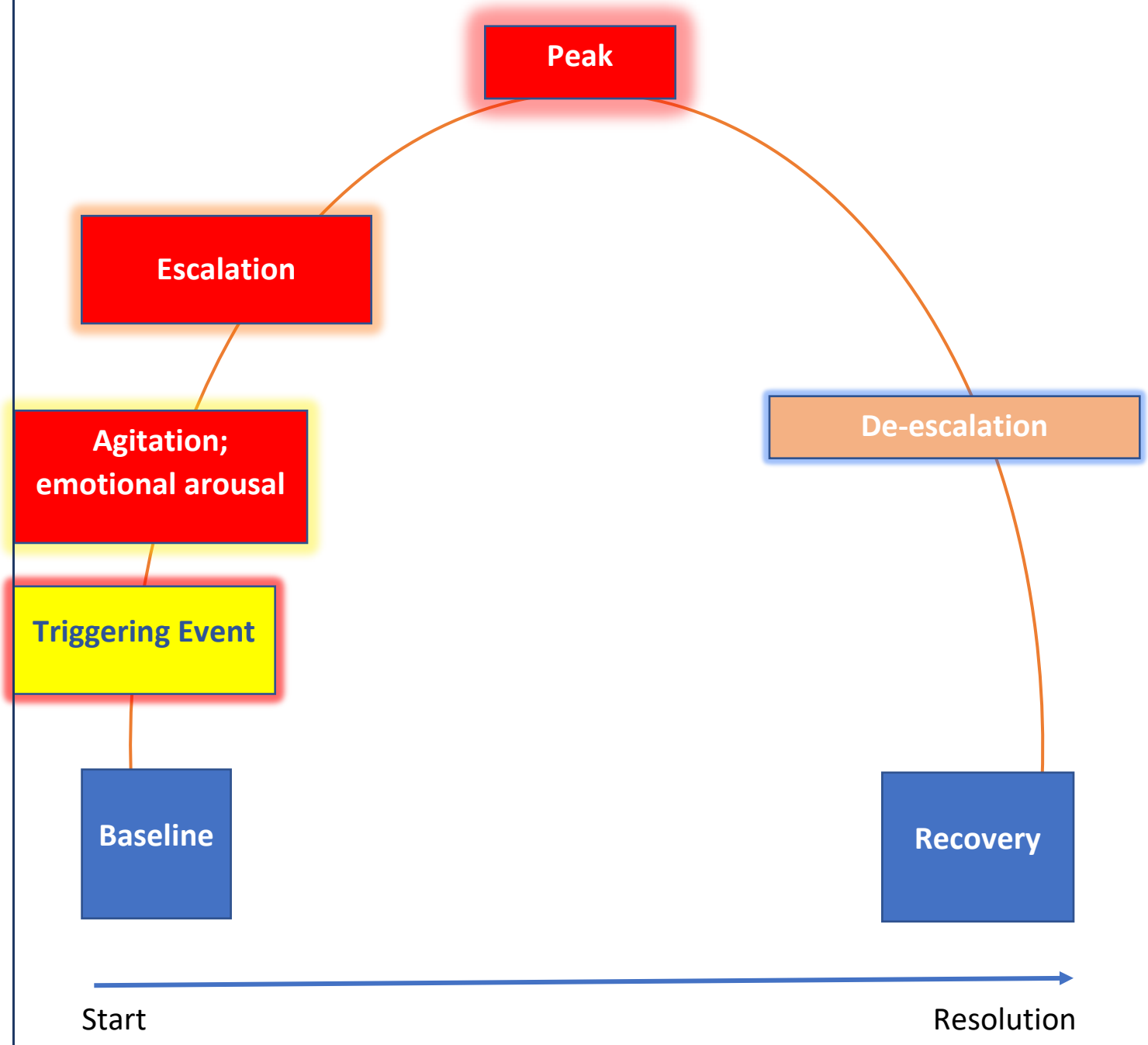
Distress Escalation Curve



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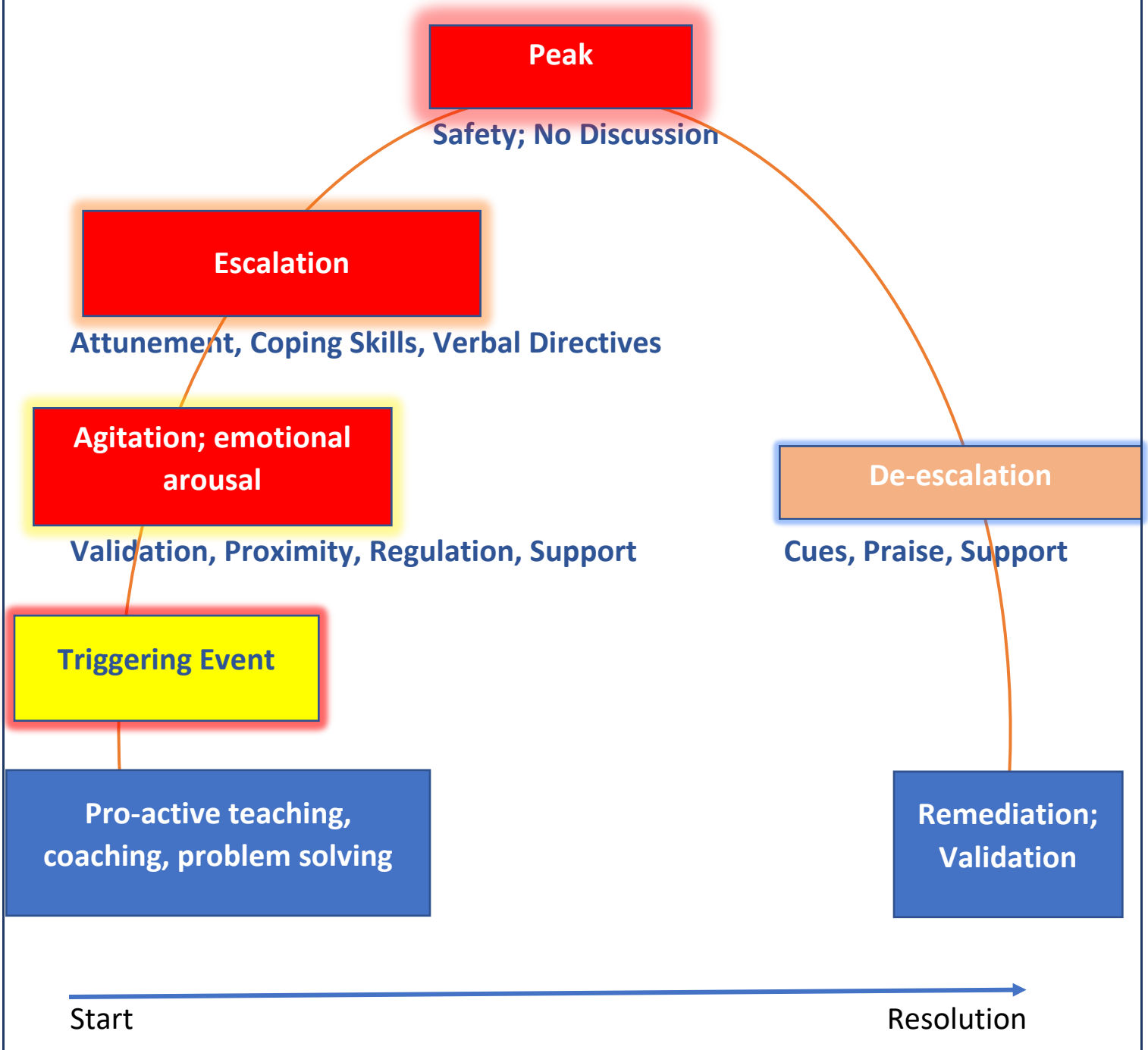
Trauma-Informed Prevention and De-escalation Interventions



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Mobile Response Stage Task: MRSS Plan

- MRSS plans focus on time-limited, achievable skills, supports, and ongoing safety planning and risk reduction. MRSS plans typically address the following areas:
  - Behavioral health symptom reduction;
  - Risk reduction and safety planning;
  - Behaviors management strategies that reduce crisis frequency and intensity;
  - Family relationships and dynamics that contribute to crisis situations;
  - Resource and support building interventions
  - Identification and teaching of alternative coping skills,

Examples of MRSS Treatment Goals:

- Increase family's ability and skill to use calming strategies when under distress.
- Build client's repertoire of appropriate de-escalation strategies to use when feeling distressed or upset.
- Increase caregiver's awareness youth's warning signs that they are escalating.
- Caregiver will learn skills to divert the youth's escalating behaviors.
- Youth will learn and utilize two new distress tolerance skills.
- Build communication skills and team approach to solving family problems
- Increase caregiver's ability to anticipate future crisis and develop plan with client to decrease potential outbursts.
- Caretaker will develop and implement accommodations that facilitate youth's success
- Identify distress patterns for each member of the family system

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MRSS Stage Three: Stabilization Stage

Tasks

- **Ongoing stabilization and safety monitoring**
- **Skill building (Individual and Caretaker)**:
  - De-escalation skills and strategies;
  - Emotional regulation/coping/distress tolerance skills strategies;
  - Problem solving skills and strategies;
  - Communication skills and strategies;
  - Identification of emotional escalation cues and family distress patterns,
  - Prevention skills and strategies; strategic accommodations and supports
- **Support building interventions:**
  - Resilience identification and promotion;
  - Identification and expansion of natural supports
  - **Youth and family peer support:** lived experience support
  - Strategic accommodations
- **Collaboration, coordination, and linkage with key stakeholders**: (i.e., informal supports, School, Clinician/Case Manager, Systems-Juvenile Justice, Children's Services, Probation, Psychiatry, etc.)
  - Short-term care coordination and linkage utilizing child and family team meeting
- **Transition:**
  - Linkage to ongoing supports and services
  - Assisted hand-off
  - Update safety plan
  - Review new skills
  - Predict future challenges
  - Review resources and supports
  - Complete maintenance plan with the family

Tools

- **Skill Building**
  - Emotional regulation
  - Collaborative Problem solving
  - Communication
  - Parenting and family
- **Support Building:**
  - Social Network Map
- **Facilitated Planning Meeting Format**
- **Maintenance Plan**

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MRSS Stage Three: Stabilization Stage (Con.)

Skills/Competencies

- De-escalation Skills
- Meeting facilitation skills
- Resilience identification and linkage

MRSS Stabilization Stage Approach/Perspective: Short-Term Stabilization Service

- Short-term brief intervention
- Clear communication of the brief nature of the service

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MRSS Stabilization Stage Task: Skill Building

Skill Building Tools: Individual

1. **Problem Solving/Conflict Management skills:** (e.g. negotiation, compromise, problem solving; conflict resolution; mediation)
    - ABCDE Problem Solving
    - Collaborative Problem Solving

2. **Emotional Regulation and Distress Tolerance Skills**: managing strong emotions due to frustration.
    - **Coping Skills:**
        - SIFTing Your Mind - Mindsight Practice
        - 4-6-7 Breathing
        - Mindful breathing
        - Body scan meditation

3. **Communication and Language Skills:** (e.g. affective communication; trouble processing and/or difficulty communicating clearly)
    - **Family Communication Skills**
        - Guidelines for Helpful & Effective Family Communication
        - Dyadic Communication Coaching
        - Developing a Pattern of Respect
        - Acknowledging and honoring different perspectives

4. **Personal Safety Skills; Social Problem Solving and Decision-Making:** Personal choice and accountability: pre and post coaching on decisions and consequences. Safe decision-making to prevent re-traumatization; alternative coping options to self-harm behaviors)

5. **Self-Awareness; Self-Knowledge skills**: learning behavioral and emotional triggers; symptom management; relapse/lapse prevention; ability to identify and express emotions
    - **Resiliency: Self-Knowledge Tools**
        - Self-knowledge functional analysis
        - Resiliency is knowing when you are falling and knowing how to catch yourself

Skills Generalization

- Once families understand a few strategies that work and why they work, they can start to apply them to multiple contexts
- Once families are starting to tell you about how they have applied strategies in other areas, they are almost ready to move to next step

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MRSS Stabilization Phase Approach/Perspective: Parenting Youth with Mental Health Disabilities

- Parenting can only be taught through the lens of the family's values, culture, and history.
- Take a disability perspective (Greene) "Such a conceptualization helps adults respond to oppositional behavior in a less personalized, less reactive, and more empathic manner." Collaborative and Proactive Solutions: (Ross Greene): http://www.livesinthebalance.org/

Parenting Youth with Mental Health Disorders

- Requires flexibility, adaptability, and creativity
- Typically need to be weighted with greater amounts of support and resiliency factors
- Aligning expectations to what is achievable
- Ability to avoid or disengage from power struggles
- Increased supervision and monitoring
- Less predictable results: Managing parenting frustrations
- Parent/caregiver coping skills; supports and breaks

Skill Building Tools: Caretaker

Parenting Executive Management Skills

- Supervision and monitoring
- Organization and planning
- Basic structure and routines
- Control and predictability
- Clear expectations and rules
- Clear communication
- Consistency

Co-Regulation Skills: (Kiser, 2015)

- Crises occur in context of family dynamics and other family members ability to self-regulate.
- Family coping through collective regulation experiences
- Learning to read each other's escalation cues
- Introduce predictability and safe interactions
- Co-regulation of affect and emotional expression
- Down-regulation: soothing, calming techniques
- Up-regulating: activating; energizing
- Supportive silence and invitation to reflective problem-solving
- Recognition and self-restraint of reactive impulse/anger response

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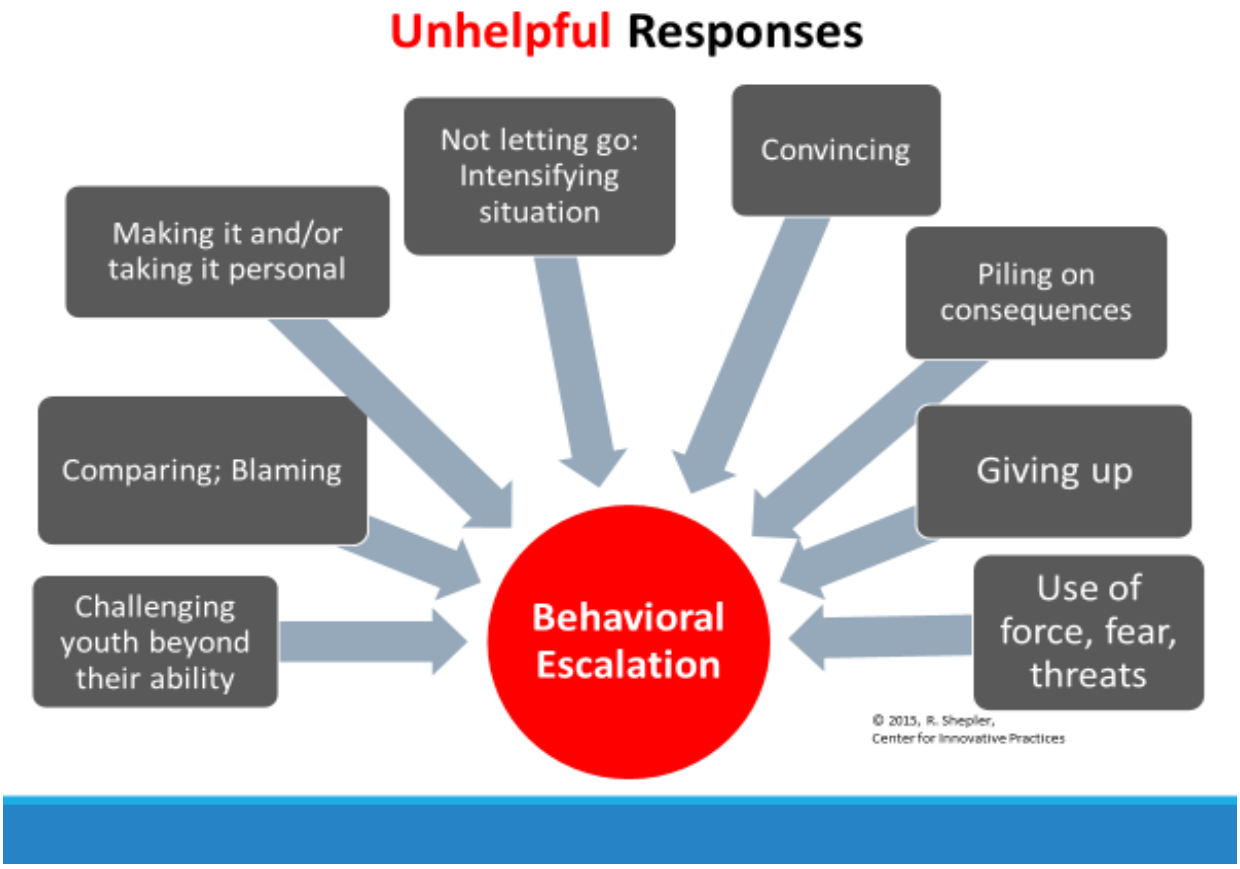
MRSS Stabilization Tool: Coaching Helpful Parenting Responses (Shepler)



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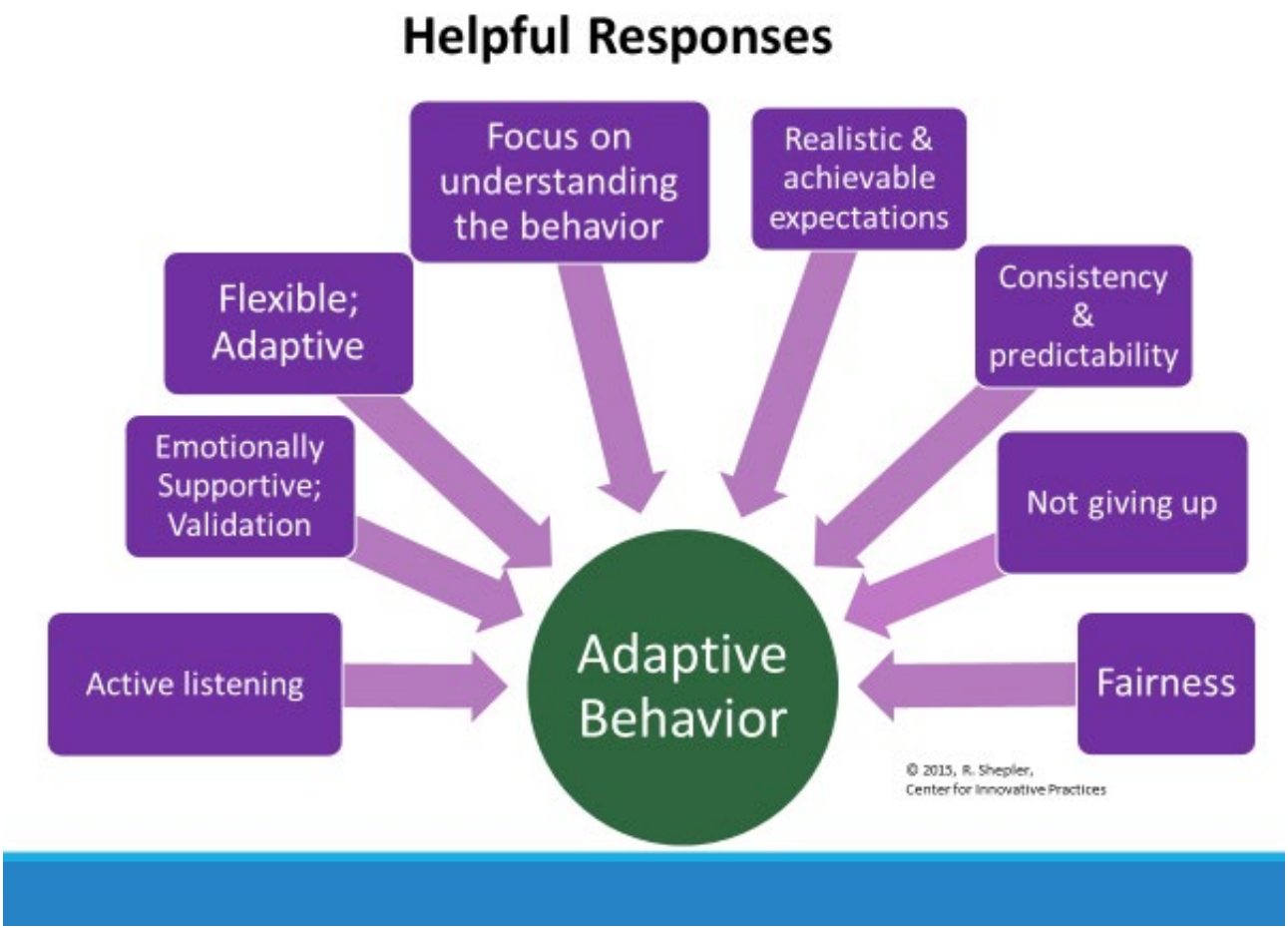

MRSS Stabilization Tool: Psychoeducation with Caretakers: Family Systems Distress Patterns (Taylor & Tuck)

- Each member in a family reacts to difficult situations differently based on several factors, including how their neurological system is "wired" and their life experiences with trauma and attachment.
    - Some individuals are more emotionally vulnerable to distress based on these factors and they tend to get upset faster, with more intensity, and they tend to have a hard time calming down.
    - Anyone in a family system could have an emotionally vulnerable distress pattern, including the child or caregiver(s), or both.
    - Some children react externally with strong emotions and escalated behaviors, while others react with tears and frustration.
    - Families also react differently to distress based on its presentation. They tend to be more tolerant of tears "upset" than they are of anger "outbursts", but they are both representative of children in DISTRESS.

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MRSS Stabilization Tool: Psychoeducation with Caretakers: Family Systems Distress Patterns Taylor & Tuck (Con.)

- ***Does your child express their distress externally or internally?***
  - **External expression** usually is loud and everyone can easily identify when the child is upset by their "outbursts".
  - **Internal expression** is much harder for caregivers to read and often children with this expression shut down and isolate themselves when they are upset.

- ***Sharing Lessons Learned with Caretaker:***
  - There is a real trick to noticing that your child is becoming upset and not jumping in to minimize what they are feeling.
  - Telling a child that they are fine or that what is happening is not a big deal never goes over well, but it is really parental instinct to head off possible disaster
  - What a child is experiencing may not feel like a big deal to the caregiver which leads them to focus on the behavior

- ***Lessons Learned: The perils of focusing on behavior***
  - Focusing on the behavior often leads to giving consequences for the behavior instead of exploring the cause or thinking that the cause does not justify the behavior
  - Consequences often escalate already challenging situations, which is not helpful in deescalating the crisis/distress.
  - During times of distress our job as parents is to focus on how to help their child successfully calm down
  - Give parents permission to not have to always give consequences for behaviors that children express while they are in distress

MRSS Skill/Competency: Anticipation/Preparation (Taylor & Tuck)

- Act together as allies to problem solve and set up the situation for success. This includes preparing for possibilities of things getting escalated and knowing how what is needed to prevent these events from happening as often and as intensely.
- Prevention of future distress is part of the ***stabilization*** phase of MRSS.
- Identifying how to prevent and anticipate a distressful situation before it happens is key to minimizing the frequency of distress in a family system
- One of the benefits of identifying a child and family's distress patterns at the beginning of services is that you can draw on the knowledge that you have gathered to help the family find ways of setting their child up for success by identifying thing that could be problematic for them as situations arise

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MRSS Stabilization Tool: Prevention Questions/Prompts (Taylor & Tuck)

- *What can you do to prevent a crisis from occurring?*
    - Identifying how to prevent and anticipate a distressful situation before it happens is key to minimizing the frequency of distress in a family system
- *Knowing this about your child, how will you help your child be successful?*
- *What's OUR plan?*
- *What do we need to do to get through this event/situation successfully?*
- *What code word can we use to signal when we're feeling overwhelmed in public?*
- *What can child have control of?*
- *How can we do this differently together?*
- *Can you anticipate what might happen next with your kid in a particular scenario?*

Prevention Example

Distress Pattern:

- Your child tends to get wound up and overwhelmed when they are in groups and they struggle with transitions

Example: Upcoming Event

- You have grandmother's 60th birthday party this weekend and these events typically do not go well because your child starts to get overexcited and their voice gets loud, they have low frustration tolerance with cousins, and they often end up having an outburst when it is time to leave

Prevention Strategies for "Upcoming Event" Example

- Discuss with the child what how this event may get overwhelming
- Have them brainstorm things that they may bring to distract themselves when they start getting overexcited
- These can include snacks, games on your phone, comics, whatever they pick
- It's important for the caregiver to closely monitor those *in the moment* signs that the child could be starting to escalate so they can proactively cue the child and implement a prevention strategy.
- Caregivers could identify reward for the child for allowing themselves to be redirected throughout party
    - Not for perfection, but for making a choice or two that demonstrates that they are *trying* to successfully head off distress or to calm down if already upset
    - Jump in with all of the praise and positive reinforcement

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Stabilization Phase Technique/Intervention: Anticipate What is Next

- Help caretaker become more self-aware of feelings and situations so that they can begin to anticipate what is coming next.
    - For example: Structure time at the store so that they will be successful. We're going to the toy store to buy a gift for someone else, we don't have money to buy you something, what's our plan…..Take a kid from the bank to the playground vs. take a kid to the playground and they try to get them to go to the bank
    - Avoid telling the family what to do, as this does not empower the family to problem solve together.

Stabilization Phase Technique/Intervention: Normalizing Managing Difficult Situations

- Set the expectation that stressful things are going to happen, the goal is not to fix the kid or to not have family conflict.
    - **The goal is to have more skills for when challenging situations/behaviors occur.**

MRSS Stabilization Stage Task: Family Remediation

Stabilization Phase Technique/Intervention: Family Remediation

- Process with youth and family what happened (family session): Sequence of events; Triggers;
- Process the effects and consequences of the behaviors;
- Process lessons learned and what could be done differently next time;
- Use crisis as motivation for family to:
    - develop new skill sets,
    - change unhealthy family dynamics and behaviors,
    - build new supports
- Revisit and review safety plan;
- Stepped up monitoring and supervision

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MRSS Stabilization Stage Task: Identification and Expansion of Youth and Family Support

Natural supports are individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as friends, extended family members, ministers, neighbors, and others within the family's community.

Types of Family Support:

- **Emotional support:** Provision of validation, hope, empathy, listening ear
- **Companionship/social support:** mentor, friend, sharing mutual interests
- **Material/instrumental support:** Tangible support such as transportation, child care, basic needs, etc.
- **Informational support:** Provision of knowledge, information, guidance
- **Lived experience support:** Bonding through shared experience and message of hope; offer real life example and road map

Directionality of Support: Family members support each other in a variety of ways, and that support can flow in different directions. In some families, older generations may provide more support to younger generations, while in others the support may go in the opposite direction. And in different stages of life the dynamic may change, as resources shift and new needs emerge. Working within a peer support framework that recognizes the power of mutuality and experiential understanding, parent support providers deliver education, information, and peer support. (Baumeister, Vohs, Aaker, & Garbinsky, 2013; Hoagwood et al., 2010; Obrochta et al., 2011).

Stabilization Phase Tool: The Social Network Map (Tracy, E.M. & Whittaker, J.K. (1990). The Social Network Map: Assessing social support in clinical social work practice. Families in Society, 71(8), 461-470.

The social network map collects information on the total size and composition of the network, the extent to which network members provide various types of support, and the nature of relationships within the network as perceived by the person.

MRSS Stabilization Stage Task: Youth and Parent Peer Support

Youth and Parent Peer Support play a vital support role to families receiving MRSS including the following functions:

- Validation
- Shared experience
- Emotional support
- Identification and linkage to resources, needs, supports
- System navigation
- Advocacy
- Providing hope

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MRSS Stabilization Stage Task: Strategic Accommodations

Strategic Accommodations

When situations or circumstances exceed a person's abilities or capacities to cope or compensate, strategic accommodations and/or adaptations may be necessary for the youth to be successful. The goal is to create success experiences through supportive functional environments.

Stabilization Phase Technique/Intervention/Strategy: Strategic Accommodations

- **Realistic and Achievable Goals:** "Make a goal so that I can reach it. Once I reach it then you can raise it." P. Mattson
  - Based on the youth's ability, development, and interests create a baseline for what they can achieve on a specific behavioral task or milestone.
  - Mutually create goals with the youth and family and get their feedback about "doability" for each goal created. Each goal should be small enough to be achievable.
  - Expand the goal once it is achieved.

- **Complete a functional analysis of the behavior(s) of concern:** with a focus on reducing contextual triggers that lead to escalation cycles.

- **Sanctuary Intervention**

  Youth and families need safe and calming people and places for refuge, respite, recovery, and rejuvenation. Both youth and parents need their own protected space where they can feel and be calm. Youth need multiple safe options for sanctuary in different contexts, including home, school, and the community. Designated and predictable breaks are important for coping with the ongoing challenges of mental illness.

  1. Agree upon a pre-identified safe place, person, activity, or thing that the **youth identifies** and can access when they feel themselves escalating or about to lose control.
     a. quiet space or room;
     b. alternative activity (listen to music);
     c. person (guidance counselor); and/or
     d. thing (stress ball).
  2. Goal: self-de-escalation; return to functional activity when calm (e.g. classroom);
  3. Pro-active and planned;
  4. Non-negotiable:
     a. Cannot be taken away as a consequence or for not making level;
     b. Cannot be taken away because adult believes youth is being manipulative

- **Designated and Predictable Space:** One pro-active strategy is to plan for designated and predictable breaks on a regular basis. This can be in the form of respite (e.g., having the youth spend a weekend with a trusted family member), planned activities, or time with a mentor.

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- **Cueing, Advance Notice, Predictability:** For youth who have difficulty with transitions/deviations from schedule or rules (cognitive flexibility skill deficits): build accommodations that facilitate predictability, cueing, advanced notice, etc.

MRSS Stabilization Stage Task: Service and Support Collaboration, Coordination and Linkage

MRSS Tool: Facilitated Planning Meeting

- During the Stabilization phase, MRSS staff are responsible for convening one or more planning meetings with the youth, family, and cross-system partners for the purpose of developing a plan for ongoing services and supports. This meeting should include the local Family and Children's First Council Service Coordinator. Minimally, FCFC is contacted, consulted with, input is sought and shared during the meeting.

1. **Ultimate planning goal:** facilitated hand-off to youth and family identified service and/or supports
2. **Facilitated planning and linkage steps:**
    a. Facilitated planning meeting convened with the youth, family, their supports, and cross-system partners
    b. Youth and families identify ongoing support/service needs
    c. Linkage and support plan developed with the youth, family, and identified family support system as available
    d. Referral/linkage facilitated

Stabilization Phase Skills/Competencies: Meeting Facilitation Tasks

- **Engage all participants**

- **Establish shared understanding of youth and family needs**
    - Paraphrase/summarize what you understood the person to mean
    - Ask for what you missed
    - Check for meaning and perception
    - Seek additional input and clarification

- **Broaden the possibilities**:
    - Diversify and expand the forms of help beyond formal services
    - Expand the options: "What if we were to …..?"

- **Facilitate shared decision-making**
    - Summarize brainstorms
    - Here are the options we have on the table so far…

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  - Have we thought of all the possible solutions or options that could potentially meet the need? Have we missed anything?
  - Do these options address the youth/family's need?
  - Are they doable?

- **Exploring the Barriers**
  - What might get in the way?
  - What are you anticipating that makes you reluctant to move forward with this plan?
  - What challenges do you anticipate with this plan?

- Actively lead and manage the team by keeping participants on track, assuring strength-based discussion and encouraging equal participation among team member

Stabilization Phase Skills/Competencies: Facilitation

Basic Facilitation Skills

- Ability to encourage participation
  - Ensure all family members have the opportunity to express opinions and share in the decision-making process
- Ability to build consensus
  - Maintain a strengths-based, solution focus
- Ability to validate and support youth and family voice
- Reframing - ability to restate comments in a positive perspective/redirect negative conversations
- Paraphrasing - ability to summarize, review key comments
- Clarifying as needed or requested

Strategies for Family Engagement during the Planning Meeting

- Check-in with the family throughout the meeting:
  - Validates and elevates family opinion
  - Promotes shared-decision making
  - Keeps family fully involved in their meeting
  - Restate the option on the table followed by checking in with the family for their thoughts, concerns, agreement
- Examples:
  - I want to make sure I'm hearing you correctly
  - Is that OK with you Mrs. Smith?
  - We're asking Mrs. Smith to do a lot – I just want to check in with you to make sure it's not overwhelming. Please tell us if it's too much.
- If family is not in agreement, request clarification about what part doesn't work for them, ask what might work better for them, brainstorm with the team as needed

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MRSS Stabilization Stage Task: Transition

Goal for Transition: The goal is to facilitate the successful transition of the young person and family to identified supports, resources and services, which are consistent with their unique needs.

MRSS Tasks: Transition

- Update safety plan
- Review new skills
- Predict future challenges
- Review resources and supports
- Complete maintenance plan with the family
- Active linkage to ongoing supports and services
    - Referrals for additional services and supports at discharge are considered from the beginning of treatment in order to avoid gaps in care.

MRSS Stabilization Stage Approach/Perspective: Short-Term Stabilization Service

- MRSS is intended to be a short-term, ***focused*** intervention for families in distress
- Our treatment targets should focus on helping families identify their distress patterns and build skills based on this base knowledge and to assist families in linking to any needed service that we have identified
- If we do not communicate a clear idea of what we do and how long we will be working with them, families can struggle to transition to a longer-term service

Gifts That Keep Giving: What we want to leave with the family

1. Hope
2. One new skill- youth; One new skill- parent
3. Improve one family relationship; Change one negative family interaction pattern
4. Develop one strategic accommodation
5. Provide the community of helpers with a better understanding of the youth and family
6. Increase safety
7. Identify and build one strength/asset
8. Identify and link to one new support
9. Create one new opportunity
10. Teach parents advocacy and system navigation
11. Assist one system in developing a better working relationship with youth and family

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Transition Phase Tool: MRSS Aftercare/Maintenance Plan

- The Maintenance Plan should identify the newly formed coping skills and strategies, and how the youth and family will maintain them.
- The MRSS Maintenance Plan identifies future challenges and potential Plan B solutions if Plan A (new coping skills and strategies) is not successful.
- Review; Predict; Adapt

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Applied Example #1

Mother called hotline due to client, 14-year-old white male, opening second floor window and walking out onto roof. Mother reports that they convinced client not to jump and called father and youth pastor to come to home. Client reported no SI. Client reported he was angry with his brother due to him picking on him and calling him names. Client reports that he would either hurt brother or runaway. Client reports that on impulse he wanted to jump out the window to run out of home. Mother reports that client is often angry. Client reported that he feels like when he is angry he "gets bigger" and does not "feel pain". Client reports difficulties with sleeping and fatigue. Client reports that he gets angry easily and feels "empty" all the time. Client had a flat affect through-out conversation with therapist.

Applied Examples (Taylor & Tuck)

Applied Example #1

Identifying Distress Patterns (Applied Example 1)

- Due to homeschooling, client and brother often had conflict due to close proximity—being near each other but needing breaks from one another. Escalation started when mother had to repeat directives multiple times and client and brothers began blaming each other.

- Often conflict happened about 1-2 hours before father returned home from work. During this time of the day, mother and children began focusing on chores, dinner and cleaning up the house.

Intervention Point (Applied Example 1)

- "In the Moment" Understanding. We started here instead of De-Escalation Strategies because they already had some calming strategies that they used, the family just needed to know when to use them and the client and brother needed permission to do them sooner. Mother needed assistance in reading the situation and intervening before escalation got out of control.

Treatment Plan (Applied Example #1)

- Decrease the frequency and intensity of emotional outbursts in family system.

- Increase family's awareness of distress and ability to implement calming strategies.

- Increase parent's use of Conscious Discipline strategies.

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Linkage Needs (Applied Example #1)

- Referral for outpatient therapy for client to address depressive symptoms.

- Explored available homeschool and moms' groups mother and family could use to increase ability for breaks from one another.

- Explored options for outside the home activities that supported client and brother's interests and allowed for movement as well as time to take a break from each other.

Skill Building Interventions Implemented (Applied Example #1)

- Therapist initiated a safety management plan and monitored in follow up sessions to monitor client's depressive symptoms and screen for possible suicidal ideation.

- Therapist coached mother and children on "the art of noticing" and checking in. Skill Builder addressed skill of communicating need for a calming strategy when feeling distressed and then allowing time and space to use the strategy. Practiced asking for help and then seeking out a calming strategy.

- Mother had not made transition from treating sons more as teens versus younger elementary age. Therapist provided developmental education and Skill Builder addressed how to give directives and then give time for client to complete instead of giving directives multiple times and assuming client was not complying right away.

- PPSS met with mother to share lived experience and encourage self-care strategies. Last session the intervention moved to Prevention. Since the 1-2 hours before father came home were the most stressful for family system, coached family on how to anticipate this stress and come up with different ideas for doing it differently.

Outcome of Intervention (Applied Example #1)

- Mother reported decrease in overall family conflict and that client and brother were asking for breaks and using calming strategies effectively. First appointment for client to receive outpatient therapy to address depressive symptoms had been scheduled.

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Applied Example #2

Client is a 12-year-old female, Caucasian, who had previous experience of foster care system due to exposure to domestic violence, being locked in a closet for periods of time and physical abuse. At the time of call, client had been triggered by (adopted) siblings/father and had a severe emotional outburst. Client had been yelling, screaming, and swearing. Client was attending Partial Hospitalization Program and transitioning back into regular school soon. Client was also involved in Juvenile Court due to unruly charge. Client reports that to handle stress she needs to be alone, and able to color, listen to music, exercise, or to watch YouTube.

Distress Patterns (Example #2)

- Client, due to hx of trauma and broken attachments, vacillated between needing emotional engagement from caregivers and needing space/alone time. Too much of either seemed to be a trigger for client. Caregivers and siblings were reactive due to not reading cues, exhausted from daily conflict and outbursts.

Intervention Points (Example #2)

- De-Escalation Strategies due to hx of trauma for client intensity of emotional outbursts. De-Escalation Strategies needed for siblings as well.

- Caregivers' intervention point started with "In the Moment" Understanding and ability to read client's cues for re-direction and emotional engagement. Caregivers' intervention then moved to Prevention/Anticipation due to the need for structure and routine so that client knew what to expect and received routine and consistent emotional engagement.

Treatment Plan (Example #2)

- Therapist: in follow-up session identified needed skills in de-escalation strategies for client, mother needed skills in daily structure/routines so that client knew what to daily expect.

- Skill Building: focused on building skills on calming strategies for client. Skill Building w/parent focused on in the moment understanding of when client is beginning to be upset and how to re-direct and reinforce calming strategies.

- Parent Peer Support: focused on helping mother to feel confident in reinforcing skills and boundaries, increasing mother's ability for self-care, mother was very critical of self, PPSS helped her to be positive and confident in the skills she was developing.

Linkage Needs Identified (Example #2)

- Client already had mental health and psychiatric support in place due to history of trauma so this was not needed. However, referral to Wraparound was needed due to multi-systemic engagement of client and family for on-going long term supports.

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- Linkage with Probation Officer was needed to advocate for client and reframe behavior as reaction to trauma rather than "being a bad kid".

- School Liaison contacted to assist client in transition back to school environment and to come up with plan for supporting client in using calming strategies in school setting. Communication was provided to school liaison about identified calming strategies that were working in home environment so that possible duplication of some of these strategies could take place in school setting as needed.

- Client expressed interest in art. Provided family with information about a community art club that allowed client to attend weekly, giving client opportunity to be creative and build confidence in artistic expression as well as caregivers break.

- Linked caregivers with foster/adoption caregiver support group.

Skill Building Interventions Implemented (Example #2)

- Skill Builder used artistic and creative interventions, such as Gingerbread Feeling Man, to help client identify what her body feels like when she is starting to feel distressed and then explored ways in which she could use calming strategies. Skill Builder practiced many calming skills in client's natural environment—including doing short exercise videos on You Tube, drawing in art journal, and dancing to music.

- Emotional Engagement was significant trigger for client and client needed to feel safe with caregivers. Therapist educated caregivers on intimacy barriers and how to build trust in casual and routine interactions with client. Skill Builder took time to coach mother on implementing routine calming strategy of emotional engagement with client—such as hugs, sitting next to each other while watching You Tube videos, coloring side by side together—that would help client to feel safe and calmer.

- Parent Peer Support specialist focused on helping mother to feel confident in reinforcing skills and boundaries. Mother was very critical of herself and PPSS helped her to be positive and confident in the skills she was developing.

Outcome (Example #2)

- Referral to Wraparound was complete and first session was scheduled. Client had made transition back into school setting from PHP program and school liaison reported client was managing distressful situations with some success. Caregivers had engaged in foster/adoption support group and reported increased ability to engage with client positively, allowing for client to be alone when needed as well as when client seemed to need close proximity with caregiver.

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Mobile Response Stabilization Service Supervision

Meyer, K., & Shepler, R., Becker, S. (2020)

Supervision of MRSS providers and teams require an integration of home and community-based service expertise and skills to effectively meet the complex needs of youth with significant behavioral health challenges and their families. On a daily basis, counselors, social workers, case managers and peer supports encounter a variety of crisis, disaster and trauma- based situations when hearing their client's accounts. Situations the worker may encounter include, but are not limited to client lethality (harm to self or others), post-traumatic stress disorder (PTSD), sexual assault, other intimate partner violence, workplace and school violence, financial setbacks, homelessness and, at times, natural disasters.

Good clinical and administrative supervision enhances the quality of client care. It improves the efficiency of counselors in direct and indirect services. It increases workforce satisfaction, professionalism, and employee retention. It ensures that services provided to the public follow legal mandates and ethical standards for the profession. The MRSS supervisor plays a fundamental role in providing the education, resources and support to workers providing these essential crisis services.

The purpose of this chapter is to provide an overview on the key issues that apply to MRSS supervision including:

1. Characteristics of effective MRSS supervisors
2. Unique supervision issues of home and community-based work.
3. Unique ethical challenges of home and community-based work.
4. A description of the knowledge and skills that are critical to supervision.
5. The clinical and administrative role of MRSS supervision.
6. Characteristics of effective MRSS supervisors.
7. Trauma-informed supervision.

Characteristics of Effective MRSS Supervisors

- The supervisor is comfortable in high-risk situations and able to respond in a calm manner to a variety of crisis presentations.
- The supervisor is available 24/7 and able to provide on-site support if necessary.
- Strengths-based and respectful relationships are encouraged by the supervisor.
- The supervisor is able to spot ethical and boundary issues.
- The supervisor demonstrates strong case-conceptualization skills.
- Knowledge of community resources along with strong collaborative community relationships are demonstrated by the supervisor.
- The supervisor is knowledgeable of youth and family rights.
- The supervisor conveys a philosophy to providers of extreme persistence in helping families.
- System of Care development and integration
- Data-Informed quality assurance and improvement
- Staff education, development and supervision
- Ensuring timely linkage to ongoing services and supports

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MRSS Supervisory Knowledge Base

- Knowledge of youth and family rights, laws and entitlements including:
  - IDEA (Individuals with Disabilities Education Act).
  - Juvenile justice system.
  - Youth and family rights.
  - Mental Health and substance-use disability law.
  - Medicaid and (Social Security Disability Insurance) SSDI.
  - Working knowledge of other related systems.
- Monitoring ethical and legal issues
  - Requires knowledge about MRSS legal and ethical issues.
  - Is available for consultation as needed.
  - Engages in pro-active monitoring of ethical and legal issues including maintenance of appropriate provider boundaries in multiple community settings, acceptance of gifts and money.
- Provision of regular training
  - Provides strength-based and developmentally matched professional growth. experiences for supervisees.
  - Provides booster trainings based on populations served.
- Community Resources
  - Is aware of community services and supports.
  - Ensures that continuing care options are offered.

Supervision Issues Unique to Home and Community-based Work

The MRSS supervisor must have adequate training and supervisory expertise to address the unique challenges, which are faced in community settings.

- Supervisors need to be prepared to manage the clinical complexity of cases that present under crisis conditions.
- The supervisor will need to monitor and manage high-risk and safety issues.
- Ongoing training of staff with the least experience to do complex work will be required by the supervisor.
- Staff working independently in unstructured, unpredictable and clinically complex situations will require close supervision and support.
- The supervisor will need to be aware of, and more involved in interaction with outside systems.
- The supervisor will need to attending closely to ethical issues that are more complex and frequent.

MRSS Clinical Supervisory Role

- Intensive Supervision
  - 24/7 supervisory and consultative availability and support is provided.
  - Is available as needed for field supervision and support.
- Clinical Oversight
  - Facilitates case conceptualization.
  - Structures weekly time to be set aside for supervision.

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  - Has the reflective capacity to monitor and address self and provider secondary traumatic stress.
  - Structures the case review process to addresses progress and needs.
- Monitors engagement and strength-based perspective
  - Monitors the quality and effectiveness of partnerships with youth, family and key stakeholders.
- Maintains positive Community professional relationships – System level collaboration
  - Maintains positive and productive working relationships with courts, schools, child welfare, neighborhood-based initiatives, other mental health and substance abuse service providers and vocational services.
- Quality assurance and improvement
  - Reviews Documentation to ensure all Medicaid medical necessity standards are met.
  - Develops a tracking system to monitor program fidelity.
  - Tracks and monitors program outcomes.
  - Develops performance improvement plans based on results of QI tasks

Program Operational Oversight (Becker)

- Triage, Air traffic control;
- Day to Day
- Air Traffic Controller
- Tracking caseloads and assignments: Balancing influx new kids with needs of kids enrolled in service.
- Communication throughout day and week

Daily Team Staffing (Becker)

- Review emergent issues and safety concerns
- Coverage
- Review and update goals and goal achievement for each family
- Goal ratings
- What are you working on this week? i.e. Skill building focus
- Current safety concerns?
- Resource/Linkage needs/recommendations
- Review program coverage and youth and family assignments

Tool: MRSS Real-Time Tracking Board

Collaborative and promotional role (Becker)

- Educate, promote and look to integrate service in agency and system of care
- Partnerships and Memorandums of Understandings
- Resource broker: knowing what is available in the community (formal and informal supports): respite, mentors, FCFC, etc.
- Supervisory role in promoting the value of MRSS in each community.
- Take ownership for the fidelity, outcomes, and establishing collaborative community and system relationships

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Supervision Management of Youth and Family Risk and Safety Issues in MRSS

Active Supervisory Role in Monitoring and Managing Safety, Risk, and Liability

- The supervisor's role is to predict, monitor and manage situations of risk and liability including:
  - Risk to both the youth and family.
  - Risk to the community.
  - Worker safety.
  - Consider professional and agency liability.

- The overarching goals are to:
  - Increase safety.
  - Minimize risk.
  - Minimize liability.

- Managing Worker Safety
  - The supervisor will share safety protocols that are in place.
  - Discuss with the provider safety strategies that have been utilized
  - Review concerns that still exist.

Broadening the Safety Context

- Broad vision of risk and crisis issues
- Assist the MRSS staff thinking globally about risk and safety issues
- Safety planning does not just occur in the child's home
- Expand outward: Wherever the child may go. Is the child safe in that environment?
- Use family and community supports in safety planning
- Monitoring ongoing assessment and adaptation of safety plans

Supervisor Safety Planning Checklist

- Did the MRSS team assess for safety issues using a safety and risk screen and by doing a walkthrough of the home?
- Did the provider consult with the supervisor on salient concerns?
- Did the provider take reasonable actions to plan for safety by completing the MRSS safety plan with the family?
- Did the MRSS team distribute the safety plan to the child and family team?
- Did the family/youth receive a copy of the safety plan?
- Is the safety plan in the client's chart?
- Are the safety goals and objectives incorporated in the MRSS plan?
- Has the MRSS team actively monitored the plan and followed-up with the family?
- Did the supervisor monitor the safety plan during weekly team meetings and during 1:1 supervision to assess status and have the MRSS team make changes if needed?
- Are all changes documented in the client record and on the safety plan?
- Has the supervisor documented supervisory recommendations and directives?

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Supervisory Quality Assurance Tools

- MRSS Standards
- Outcome tools
  - CANS; Global outcomes (psychiatric hospitalization, etc.)
- Process tools
  - Tracking response time for first call, etc.
- Programmatic tools:
  - Real-time Tracking Board: Organizes current youth served; time in program, staffing; goals, etc.
- Clinical tools:
  - Daily staff meeting; Utilize Zoom
  - Scaling tools to measure weekly progress

Supervisor Role: Monitoring and Mitigating Worker Safety

Worker Safety and Comfort Level

- Getting comfortable so you can do the work
- What are your biggest concerns or challenges in doing this work?
- What are some standard safety precautions your team uses?
- Pre-Visit Safety Screening Questions and Safety Pre-Structuring tool (handout)

MRSS: Common Concerns, Challenges, Precautions, and Worker Safety

Common Concerns about Home-based Service Delivery	
Bugs	What assistance does family need to eradicate their current problem (education; resources)
Contagion	Establish rule that family calls to cancel if they are sick and that you will do the same
Threatening animals (dogs)	Request that the family lock up the animal during your sessions until you are more comfortable
Weapons (Guns; martial arts weapons; knives)	Ask the family to have weapons removed from the home or locked up during your time with the family
Substance use or selling behaviors	Pre-structure that you will reschedule sessions if someone in the home is under the influence
Neighborhood safety (Gangs; violence; drug activity)	Ask family when is safest time to come to home for sessions, or where is another location that they could meet.

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Handling Challenging Situations in MRSS

Challenging Situations: Distractions and interruptions	
Issue	**Solution**
• **Television**: Distraction for all	Relate that it is hard for you to focus on what the family is saying with the television on and request if they could turn it down or off to help you
• **Music**: Ability to hear and follow conversation	Relate that it is hard for you to hear with the music this loud and request for it to be turned down or off during the session
• **Telephone**: flow of session	Request that cell phones sound be turned off and put away during the session so you can give and get their full attention
• **Visitors**	Explain your concern for the family's confidentiality and your inability to continue session when visitors are allowed into the session room
• **Extended family**	Explain the need to protect the family's information and confidentiality; balancing who is helpful versus who is not; helping the family develop boundaries
• **Cigarette smoke**: health concerns; balancing sanctity of family home versus your needs as a professional working in their home	Discuss how cigarette smoke affects you and request if they can smoke before and/or after the session.

Managing Challenges in the Environment **Typical Challenges:** Television; Music; Cell Phones; Visitors; Cigarette smoke; others
• Remember you are a guest in their home
• Be respectful of the family's values and culture
• You are in control of the home visiting service and its delivery. The family is in control of their home. • Do not demand or challenge
• Be polite.
• Make simple requests
• The main challenge is to resolve your concerns in such a way that you can be comfortable enough to conduct your services
• Relate to the family how the challenging situation affects you and what would be helpful

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Ethical Considerations in MRSS

(Meyer, K. & Shepler, R., 2020)

Supervisory Management of Ethical Concerns working in Home and Community Settings

Ethical decision making is systemic, and decisions are complex and are embedded in multiple contexts. This includes the system in which you are helping the youth and his/her family. This can also include system partner mandates from school, court, and children's services and the system providing support to the supervisor, team and agency. Embedded in all of these is the personal perspective, experience and relationship of the supervisor as well as the provider.

The MRSS supervisor encourages the MRSS staff to consult with the MRSS team and supervisor; therefore, the MRSS supervisor must maintain availability for consultation. Additionally, the supervisor will need to be pro-active and attentive to policies and procedures, while supporting providers who are experiencing difficult situations. The purpose of this chapter is to provide an overview of the special ethical concerns in providing services in the home and community.

Increasing Complexity of Ethical Challenges

Behavioral Health Trends	Ethical Implication
• Increased collaboration/communication between systems serving children • Multiple systems and providers working with same youth and family • Co-location of services	• Confidentiality • Roles; Relationships; Boundaries • Increased ambiguity • Ethical decision making around the client's needs and care
• Keeping more youth with higher risk and safety issues in the community • Treating youth with greater complexity (co-occurring disorders, etc.)	• Duty to protect and duty to warn • Safety and risk liability • Increased decisions about risk and safety • Competency • Confidentiality
• Services delivered where the youth lives and functions (school, home, and community)	• Boundaries; Relationships • Confidentiality
• Technology	• Confidentiality
• Work pressures: Increased productivity and paperwork	• Primacy of client's interest • Burnout and Impaired professionals
• Complex family dynamics and relationships • Understanding diversity of populations served	• Custodial rights and access to information • Confidentiality • Multicultural competence

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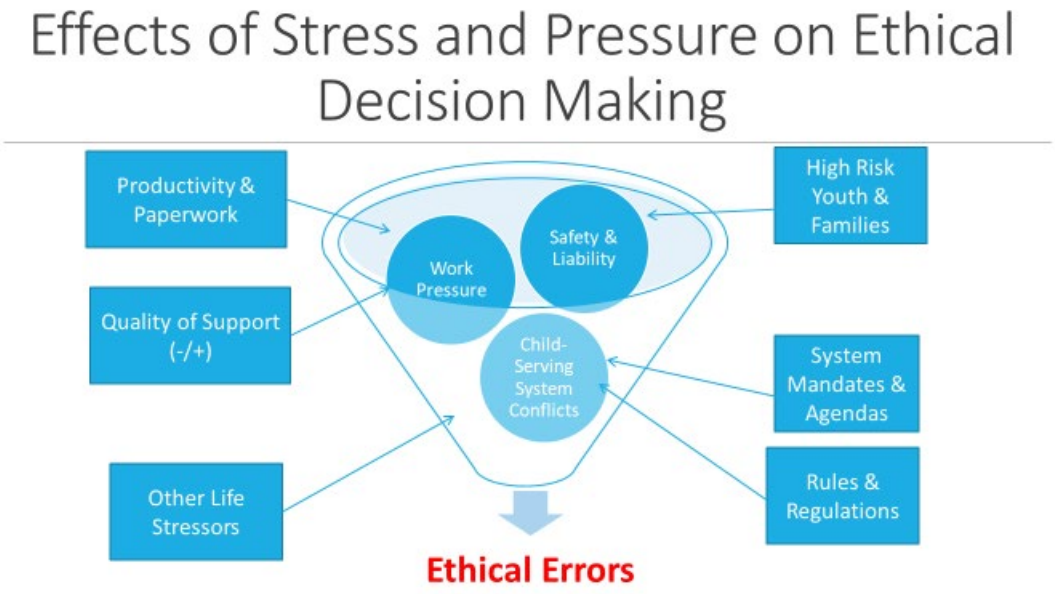
Unique Ethical Challenges of Home and Community Based Work

- The providers will be involved in more and closer relationships in the community.
- Providers will face making more decisions, often rapidly, in pressure situations.
- Ambiguity will be increased, and the ability to think on one's feet is necessary.
- Providers will be challenged with managing confidentiality in the natural environment.
- Providers will have less immediate access to other clinical staff for consultation.

Agency factors that impact ethical decision making

- The work environment including work conflicts.
- The provider receives quality support through individual and group supervision, as well as team meetings.
- Supervisor availability: Dependable, reliable, designated supervisors for high-risk programing.
- Agency supports protection of clinical supervision time.



Youth and Family Perspective

- Always consider the youth and family perspective when making ethical decisions
- Does decision clinically benefit the youth and family?
- Did you consider and respect the family's culture in your decision-making?
- We need to understand the unique experiences and coping styles of clients whose cultural assumptions and experiences are different from our own and the effects of these differences on their lives (NCFBSA)

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Protecting Forward

- What control do you have over confidential information once it is shared?
- Don't share any information you don't want repeated
- Anticipatory confidentiality

Considerations for Managing Confidentiality in Schools

Managing confidentiality in schools is challenging. Even entering the school and identifying yourself has to be considered in light of client confidentiality. MRSS programs may enter into MOUs (Memorandums of Understanding) with school systems that detail the protocols to be followed by the MRSS team in the event of a crisis in the school. The MRSS team should call ahead and establish who their contact person is when arriving at the school, as well as, how they will gain confidential access to the youth.

For planned follow up sessions, the MRSS worker and supervisor will have pre-structured confidentiality expectations including where the meeting space is and the level of confidentiality that exists. Are there windows where other people can see in? It is important to consider that the provider's presence in the school is identifiable by staff and other youth.

It is important to consider how much information you share with whom, including getting releases signed for specific people in the school. Special circumstances such as IEP meetings will also need consideration. When information is shared, very little control, if any, exists on whether that information will be shared or repeated to others. Therefore, it is necessary to think through the confidentiality issues before client or family or school are contacted. This pre-contact planning will guide the MRSS team and supervisor about what information should be shared; whether one-on-one or, in meetings.

Sharing Information with Other Systems

It is important for MRSS providers and supervisors to remember their role as mental health interventionists and, when indicated, mandated reporters. MRSS providers are not extensions of the schools, juvenile court or children's services.

- Releases of Information are needed when sharing information about family members to other systems.
- Informed consent: discuss with the family what they are comfortable sharing.
- Share only the specific information requested and allowed by your release.
- Honor your relationship with the family, and avoid gratuitous, judgmental or critical language in describing the youth or family to another system.
- Think through how the information, judgements or conclusions you are sharing could affect your relationship with the youth and family.
- Do not re-release someone else's information.

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Confidentiality and Consent in Working with Families

At the beginning of MRSS, confidentiality and consent for treatment language and documents should be pre-structured for family members about rules of intervention. This includes expectations about sharing within the family. Decision points in sharing information with parents includes: youth safety, keeping secrets, age of youth, family culture as well as multi-generational confidentiality. The MRSS staff must balance the legal right of the parent with the clinical need to protect the professional relationship with the youth.

Parental Consent in Ohio

Generally, minors must have the consent of a parent or guardian before receiving medical care. The MRSS worker will make every effort to contact the child's parent or legal guardian during the time of crisis. Emancipated minors and 'mature minors can give consent. A 'mature minor' is 14 years or older. If the MRSS provider determines the minor has enough maturity and understanding to make medical and treatment decisions without parental consent, then the provider would treat the minor as an adult. This means providing him/her with the same informed consent as would be provided to an adult. Nevertheless, according to the Ohio statute, minors can consent information and documents to the following services without parental consent:

a) Physical examination of a minor who is a victim of sexual offense at a hospital with written notification to the parent or guardian that such an examination has taken place. (ORC 2907.29)
b) HIV testing (ORC 3701.242)
c) Diagnosis/treatment of any venereal disease by a licensed physician. (ORC 3709.241)
d) Outpatient mental health services (excluding use of medication) at the request of the minor 14 years of age or older. (ORC 5122.4). The mental health provider may provide up to 6 sessions or 30 days of treatment (whichever comes first) without parental consent. However, if it is determined there is compelling need for disclosure based on substantial probability of harm to the minor or to other persons, the provider after letting the minor know, will inform the minor's parent or guardian. After the six sessions or 30 days of service, the provider will terminate services, or with consent of the minor notify the parent or guardian to obtain consent to provide further services. The minor's parent or guardian shall not be liable for the costs of services which are received by a minor under division A. (5122.04, (A) (B) (C).
e) Diagnose/treatment for substance abuse of any condition which is reasonable to believe is caused by a drug of abuse. (ORC 3791.012). Federal law and Ohio law provides that any 'minor' can request Substance Use Disorder (SUD) services. The only exceptions are minors who are applying for alcohol and other drug services and lack the capacity to make a rational decision about whether to sign a consent form. (CFR 42 Part 2)

A minor may receive emergency medical treatment to preserve life and prevent serious impairment without the consent of a parent or guardian. However, every effort is required to reach the parent or guardians during the health crisis. Once the initial crisis has stabilized, a minor fourteen years of age and older, or an emancipated minor may receive additional services in accordance with the above statutes. Otherwise, additional treatment post stabilization will require parental consent.

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Consent to Treat and Confidentiality: School Crisis – MRSS Scenario #1

The local middle school in a rural district faced a situation involving a 13-year-old seventh grader: He had come to school very depressed and agitated. After taking the student aside to inquire what was disturbing him, he admitted to his teacher that he wanted to hurt himself and had attempted to do so by threading a large paper clip under the skin of his upper thigh. The teacher involved the school nurse, who examined him. She found the paper clip imbedded deeply with the end out of sight and blood beginning to pool under the skin. The teacher immediately attempted to reach the student's parents. She was unable to reach them but left messages with both his mother and father who were at work. The school attempted to reach the mental health provider assigned to the middle and high schools, but she was involved in a situation she could not leave at the high school. The school had a memorandum of understanding in place with the county community mental health agency that provided a coordinated policy for crisis situations at school and steps outlined that would be taken to address a crisis. Because the mental health professional was not immediately available and the student's medical and mental health issues required immediate medical assessment and intervention, the MRSS team was called for assistance.

The MRSS provider came directly to the school to assist the school personal in assessing the situation and determining the best course of action. The MRSS provider learned from the student that he was distraught over his parent's impending divorce. He reported they are both still together at home fighting often and at times hitting one another. Although he stated he did not "really want to hurt himself," he was poking a paper clip into his leg until he experienced pain to get his mind off his home problems. However, he reported to the MRSS worker, he was really anxious and sad and could not assure her he would not try something else. The MRSS provider recommended that the school call 911 for an ambulance to take the student to the hospital due the uncertain position the paper clip may have migrated within the student's leg. The MRSS worker would accompany the student to the hospital while all effort was made to locate and inform the parents.

At the hospital, the student was medically assessed, the paperclip removed and the wound treated. A psychiatric assessment followed. It was determined by the hospital staff, that the client was not a continuing danger to himself and would be released with a plan for crisis follow up by the MRSS team. The MRSS provider stayed with the student until his mother arrived three hours later. The mother was able to provide post-crisis consent and agreed to a plan for follow up utilizing MRSS four to six-week community stabilization service. The MRSS provider agreed to meet with the student's mother and her husband the next day and create a safety plan that would involve stabilization at home, in the school and community, as well as further recommendations.

Parent/Guardian/Family Consent Points to Consider:

- The minor is under 14 years of age, therefore it is noted that the law requires that parents/guardians be reached as soon as possible since the minor is only 13 years old.
- Treatment (mental health assessment and medical treatment) was provided on an emergency basis both at school and the hospital while providers continued to try to locate and inform the parents.
- Due to the need for immediate psychiatric and medical attention, providing emergency treatment without the immediate consent of the parent/guardian was well within the law.

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Consent to treat and Confidentiality - Community Crisis: MRSS Scenario #2

Will is a 16-year-old sophomore who was visiting his girlfriend at her house where both her mother and father were home at the time. Will had been staying with his grandmother at the time because his mother was out of the country on a business trip. His grandmother dropped Will off at his girlfriend's house on her way to play bingo. But she realized she forgot her phone at home. She said she would be pick Will up in three hours, when bingo was over. Both Will and his girlfriend whose name is Jane, went to the basement recreation room of the house to work on homework and listen to music while Jane's mother and father remained upstairs.

After about 20 minutes Jane's mother came down to the basement to get a load of laundry and to check on her daughter and Will. She discovered her daughter sobbing and questioned what was wrong. She blurted out that Will said he wanted to "kill himself". Jane's mom sat down beside Will and began to talk to him. He disclosed how depressed he had been feeling and said he had been thinking about harming himself for several days, using a knife or a gun, both of which he had access to. Alarmed, Jane's mother tried to call his grandmother but was unable to reach her. Because she was so concerned about Will and it would be about 2 more hours before Will's grandmother would pick him up, Jane's mother decided to call the county emergency hotline. She was connected with MRSS. The MRSS provider came to the home within thirty minutes. Upon arrival, Will consented to allow the MRSS provider to assess him and make recommendations. The MRSS provider determined that Will needed to go the local hospital due to his inability to promise to keep himself safe. He consented to allow the worker to take him to the hospital while his girlfriend's parents would wait for his grandmother and then let her know when she arrived to pick him up where he was.

At the hospital, Will was assessed and released with a plan for the MRSS worker to follow up the next day either at school or at his grandmother's house. The MRSS worker followed up over the next 2 weeks, helping Will with coping skills and creating a safety plan he and his grandmother would follow until his mother returned the next week. The provider also got him a psychiatric appointment within the second week that coincided with his mother's return.

Parent/Guardian/Family Consent Points to Consider

- Will is over 14, therefore able to consent to Outpatient Mental Health services.
- He consented to allow the MRSS worker to complete an assessment. It determined he needed to be taken to the hospital for further assessment due to his suicidal ideation. A safety plan was needed because he was unable to promise to keep himself safe at home.
- Will's mother was unavailable to authorize treatment at the hospital due to being outside of the country and his grandmother did not have temporary custody or power of attorney to authorize medical care at the hospital.
- However, it was determined at the hospital that Will's risk was low enough that the MRSS provider's intensive follow-up the next day, was an appropriate level of care and that Will could be released back to his grandmother's care.
- Had the hospital determined that Will was an immediate danger to himself, the hospital by law, could have provided emergency inpatient care.
- Will consented to be seen by the MRSS provider the next day and over the next 2 weeks (5 more sessions without his mother's consent) to address his depression until his mother would be home and could authorize further treatment.

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Consent and Confidentiality - School Crisis: MRSS Scenario #3

Doug is a 16-year-old boy living with his biological parents. He is a sophomore and is struggling to maintain his grades. He is at risk for not having enough credits to complete the school year successfully. Doug is smoking marijuana on a regular basis, up to a blunt or blunt and a half each day.

His teachers, especially his physical-education teacher, has questioned him about his red eyes, lack of energy and whether Doug is high in his class. Doug acknowledged his use but said he did not want to talk about it. The teacher expressed concern to the guidance counselor. The counselor called Doug in to talk about what was going on with him. After a lengthy heart-to-heart discussion, Doug said he realized that he needed help because he couldn't concentrate on school work or maintain focus on anything for very long. The guidance counselor, concerned about the amount of marijuana Doug was using and Doug being at risk for additional cannabis-abuse side effects, contacted the MRSS team to come to the school to assess Doug and determine his immediate needs.

The MRSS provider arrived promptly and provided an initial assessment. At first, understanding he did not need to include his parents for either consent or information sharing, Doug was hesitant to go along with further assessment and treatment. After he learned that his parents could be a primary support, Doug reluctantly agreed to share his drug problem and assessment information with them. So, he signed a release of information to include them in his treatment. The MRSS provider referred Doug to a substance use recovery agency for treatment and provided follow-up care until Doug was connected to treatment.

Parent/Guardian/Family Points to Consider

1. Doug is 16 years old and can consent to SU treatment without his parent's consent.
2. Federal confidentiality rules for minors (any age) allow the minor to consent for treatment as well as hold the confidentiality following the 'mature' minor principal.
3. Doug would need to sign a release of information to allow his confidential SU information be shared with his family or any other systems associated with Doug's care.

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Clinical Strategies for Resolving Ethical Dilemmas

- Sometimes the most effective strategy in resolving an ethical dilemma is a clinical intervention.
- "What would need to happen for you to feel safe sharing this information with your mother? "What kind of support would you need?"
- "It sounds like you need a couple of days to figure out how best to talk with your Mom about this."
- "What is your biggest fear in telling your mother?"
- "How do you think your mother could help you if she knew what was going on?"

Protected Information and HIPAA

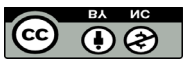
Community-based providers are legally mandated to protecting the confidentiality of client identified information. This is a real challenge that office-based providers don't face to the same degree. Problem areas for the out-and-about provider include the storing and transporting of case files or parts of case files in cars. Considerations include:

- Service provision often requires pieces of the client record be available to the provider at all times.
- It is necessary to take reasonable steps to ensure the record is secure by making sure this information is not visible to others such on car seats, (NCFBSA, 2001).
- Protected information should be kept in a locked compartment and hidden in the vehicle ie. glove compartment, trunk, (NCFBSA, 2001).
- Laptops connections need to be password protected; agency policies need to cover home use. (4757-5-13 CSWMFT)
- Encryption methods are to be used for electronic service delivery (4754-5-13 CSWMFT)

Protected Health Information threats (Greene, 2012)

- Every text exists in three places: the sender phone, the receiver phone and the telecom server involved in the transmission (HHS, Office of Civil Rights).
- The mobile device could become lost or be improperly disposed of.
- Persons other than the owner could get access to the mobile device; it is not known who is receiving the text.
- This could lead to interception of transmission of ePHI by an authorized person.
- Eavesdropping is always a potential risk.

Tool: Supervisory Management of Ethical Issues Checklist

 2021, CIP, CWRU and OhioMHAS

MRSS Tool Kit
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MRSS Tool Kit
Appendix A. Tools

Triage Tool: MRSS Triage Checklist

MRSS Triage Checklist
Presenting Acuity
Is there was a life-threatening emergency?
Did you ask if the caller was safe?
Did you ask if people around them are safe? Ex: "*Are the people around you safe*?"
If they are calling about someone else, did you ask if they are concerned about his/her safety? Ex: *"Are you worried about your safety or someone else's safety?"*
If there is an emergency did you call 911 or offer to call 911 for the caller?
Did you get their current location and cell phone number? "Do your parents know where you are right now?"
Did you ask about how you can help?
Did you ask about suicide ideation, threats, plans? Ex: "*Have you thought about suicide as a way of dealing with your current situation*?" "*Are you having thoughts of suicide right now?"; "Have you had thoughts of suicide in the past month?"*
Did you ask about current plan and availability of means? Ex: "Do you have a plan to follow through with suicide?" *"What method are you considering?"; "Is this method available to you now?"*
Did you ask about previous suicide attempts? Ex: "*Have you ever made a suicide attempt*?"
Initial De-Escalation
Did you provide initial de-escalation and assess for safety?
Did you offer mobile response within 60 minutes? Did you dispatch the mobile team?
Available Services and Supports
Did you ask about available supports? (Informal and formal) Ex: "Is there anyone else with you right now?"; "Who do you normally talk to when you feel this way?" "Who lives in the home with you? Are they there right now? Can I speak with them?"
Did you ask whether another on-call service is working with the family (MST; IHBT; ICT)?
Did you offer to call the MST/IHBT provider after brief phone stabilization. Ex: "Can I call your IHBT provider and let them know you are currently requesting help?"
Did you ask if the youth and family are currently receiving behavioral health services?
Immediate Linkage and Follow-Up
Did you offer MRSS to every family that calls?
Did you actively monitor and follow-up with family?
Did you communicate/follow-up with current providers about the call, your response, and the result?
Home and Environmental Safety
Did you ask about current conditions in the home or neighborhood that could pose a threat to staff safety? Ex: *"Are there safety issues in the home or neighborhood we should be aware or prepare for when we come out?"*
Did you ask if anyone in the home is currently under the influence of drugs and/or alcohol?
Did you ask about access to weapons? Did you ask family to secure weapons/lock them in a secure location?
Did you ask about animals that may be aggressive or pose a threat?
Did you ask them to have the animal secured in a separate room during your visit?
Did you ask about history of family violence? Ex: "Have any family arguments escalated to a point of someone being physically hurt or resulted in the police being called out to your home?"

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Worker Safety Tools

MRSS Pre-Visit Safety Screening Questions and Safety Pre-Structuring

Prior to entering the home for the first time it is common protocol to call the family and pre-structure for worker safety.

Concern	Pre-Visit Safety Screening Questions and Safety Pre-Structuring
Bugs/Pests	• Has your home or apartment complex had any problems with bugs that you had trouble getting rid of? • What have you tried so far? Who have you called for help? • What additional information or resources do you need?
Contagion	• Please let us know if someone in your home is sick or contagious. Our staff will do the same for your family
Animals	• Are there any animals that our staff should be aware of or concerned about when we come to your home or neighborhood? • Until your dog/pet gets to know us is it possible to keep the dog in a separate closed area during our sessions until we get more comfortable with him/her?
Weapons (Guns; martial arts weapons; knives)	• If your son or daughter had access to weapons what would you be most concerned about? • Family safety is our highest priority. What weapons does your family own that could pose a danger to you or your children? • What steps can you take to increase family safety? • Request that the family remove weapons from the home; or keep guns locked in gun safe during your time with the family, with ammunition locked separately, safety locks on guns, and with only caretaker access to key/combination.
Substance use	• Pre-structure that you will reschedule sessions if someone in the home is under the influence.
Neighborhood safety (Gangs; violence; drug activity)	• When is the safest time of day to schedule sessions? • What should our staff be aware of or pay extra attention to in your neighborhood? • When was the last time there was a shooting in your neighborhood? • What gangs operate in your neighborhood? • Do you have any concerns about your son/daughter being in a gang or being targeted by a gang member?
Family Safety	• How does your family deal with/ resolve family conflicts? • When people in your family get angry what are you most concerned about happening? • Who has the biggest temper? • The last time your family got into a fight how bad did it get? • Did any of the fights escalate to point where the police were called?

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Standard Precautions in MRSS	
Pre-Home Visit Safety Assessment	Assess for weapons, animals, family violence, substance use, neighborhood gangs, etc.
Develop clear safety protocols	Train staff on protocols
Cell phones	Always carry cell phones during any outreach activity
Sign-Out/In Sheet	Always let someone know where you are
Where you park	Park on the street, where you cannot be blocked in.
Where you do sessions	Public visibility areas of the house, such as living or family rooms and kitchens; not bedrooms, or secluded areas of the house
Do intakes as a team	Builds in additional safety; family gets to meet another team member (who may be on-call for them); sounding board for case conceptualization; can be the MRSS supervisor (encouraged)
Family member under the influence of substances	Politely reschedule indicating that you want the family to fully benefit from your clinical services
Use your common sense	Trust your intuition; if a situation does not feel safe politely reschedule

Managing Safety Concerns in MRSS
• Positive relationships with families
• Engaging families to help in managing safety
• Conduct safety home check (safety walk through)
• Securing unsafe items (Weapons, dogs)
• Ask for courtesy call if someone in the house is sick
• Utilize universal medical precautions with every family: TIP (Purell)
• Consultation with team members and supervisor

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Youth and Family Safety Assessment Tools

Columbia-Suicide Severity Rating Scale Screen Version-Recent (Posner, 2008, The Research Foundation for Mental Hygiene, Inc.)

Columbia-Suicide Severity Rating Scale Screen Version- Recent	Past month	
Ask questions that are bolded and underlined.	YES	NO
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: *Was this within the past three months?*	YES	NO

- Low Risk
- Moderate Risk
- High Risk

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Risk and Safety Screen

The risk and safety screen can be used as a teaching tool or supervision tool to promote the comprehensiveness of risk and safety screening and assessment.

Instructions: Mark yes or no for each risk or safety item for each category.

- Determine whether there is an immediate safety issue and mark yes if immediate action is required.
- If immediate action is required, document in the case record what action was taken and the result.
- Determine whether item needs to be added to the youth's safety plan. Add item to safety plan.

Type of Risk	Specific Behavioral Concern	Present (Yes/No)	Need for Immediate Intervention	Safety Plan Completed (Date)
Harm to Self	Suicide ideation, gestures, or attempts			
	Self-Injurious Behaviors			
	Eating Disorders			
	Impulsive/dangerous behaviors that put the youth at-risk			
	Other:			
Harm to Others	Aggression; violence to persons, places, animals			
	Fire setting behaviors			
	Problem sexual behaviors			
	Verbal/written threats			
	Other:			
Risk Behaviors	Runaway; unknown whereabouts			
	Unprotected sexual activity			
	Sexual activity for drugs or while intoxicated			
	Suspected illegal activity			
	Gang Involvement			
	Involvement with older negative peers			
	Active substance use			
	Inappropriate internet usage			
	Sexting			
	Cyberbullying			
	Other:			
Environmental Risk	Availability of guns			
	Family violence			
	Active drug use in home			
	Active abuse and/or neglect			
	Homelessness			
	Poverty			
	Human trafficking risk			
	Neighborhood violence			
	Victim of cyberbullying			
	Other			

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MRSS Safety Plan: Crisis Stabilization and Support Plan

Phone Number(s):	Address:
Date Initial Document Completed:	Revision Dates: _____ _____

Emergency Responders & Supports			
Community Resources	**Contact Number**	**Child & Family System Resources**	**Contact Number**
Police		Lead Responder:	
Paramedics		MRSS	
Poison Control		IHBT	
Crisis Helpline		Wraparound	
		Peer	
Friends, Family & Connections			
Name	**Number**	**Role & Commitment**	

Safety Concerns	
1.	
2.	
3.	
Crisis Prediction: What typically leads to a crisis or feeling out of control?	**Proactive Crisis Prevention What can you or your family do to keep it from happening?**
1.	1.
2.	2.
3.	3.
Signs of Distress: How It Looks to Others	**Coping Strategies (What Can I Do?)**
1.	1.
2.	2.
3.	3.
Stabilization and Support Strategies: What can others can do to help?	
1.	
2.	
3.	

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Safety Precautions/Means Reduction Planning

Identify proactive steps to reduce physical risk elements that may present a specific danger to the young person and/or their family. This could involve securing weapons, medicines, or other items as well as setting up protocols for supervision and monitoring.
Safety Concern:
Safety Promotion Action Step:
Person Responsible:
Date Initiated:
Date Reviewed: ☐ Continued ☐ Discontinued Initials_____
Safety Concern:
Safety Promotion Action Step:
Person Responsible:
Date Initiated:
Date Reviewed: ☐ Continued ☐ Discontinued Initials_____

Youth Signature:	Date:	Parent/Guardian Signature:	Date:
Provider Signature/Credentials:	Date:	Supervisor Signature (If Applicable):	Date:

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MRSS Safety Tool: Safety Maintenance Plan

The safety maintenance plan is utilized during the Transition Phase of MRSS and is designed to:

1) REVIEW safety skills, supports, and safety plan measures developed during MRSS and discuss steps the youth/family need to take to keep the progress continuing;

2) PREDICT Identify/predict potential barriers to implementing the Safety Maintenance Plan; and,

3) ADAPT and develop a Plan B if obstacles arise.

Safety Maintenance Plan (Completed at prior to transition from MRSS)	
Coping Skill	
REVIEW Skill(s): Steps to keep it going	
PREDICT: What could go wrong? (IF…)	**ADAPT: Plan "B" (THEN…)**
Means Reduction; Supervision and Monitoring Plan	
REVIEW Plan: Steps to keep it going	
PREDICT: What could go wrong? (IF…)	**ADAPT: Plan "B" (THEN…)**
Supports	
REVIEW Supports: Steps to keep it going	
PREDICT: What could go wrong? (IF…)	**ADAPT: Plan "B" (THEN…)**

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Safety Mapping (Kiser, 2015)

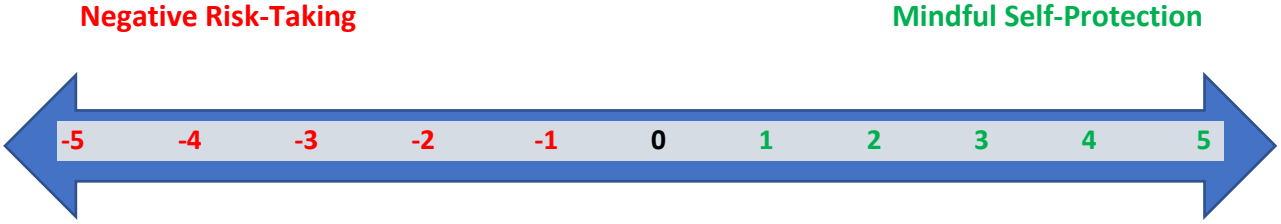
Laurel Kiser Strengthening Family Coping and Resources: Interventions for Families Impacted by Trauma (2015). Routledge, NY.

1. Utilizing easel paper, have youth draw a map of their neighborhood starting with their house. This map should include key places they go like school, church, and the roads taken to get there.
2. Ask the youth to label places that they feel safe or threatened.
3. Ask them to pick a place they do not feel safe and develop a new routine that increases their sense of safety/feeling safer.

MRSS Safety Tool: Personal Safety Skills (Shepler & Cohen)

Instruction: Explore with youth using the Personal Safety Continuum Scale where they rate themselves in a typical week, of taking negative risks that could pose a safety problem for them.

Personal Safety Continuum



Purpose: Self-empowerment and safety.

Directions: Explain to youth that risk taking falls along a continuum from positive to negative. An example of a negative risk would be to use drugs or to engage in illegal behaviors. These types of risks are harmful and can result in long term negative effects on the youth's development.

Explore with youth where they see themselves on the Personal Safety Continuum: "On a scale from -5 (Negative risk-taking) to +5 (Mindful self-protection) in the last month, where would you rate yourself in keeping yourself safe?" mindful alert aware

Utilize scaling questions to help youth think about change.

- Quantitative measure of where they are and where they want to be (de Shazer).
- Specify a time limit (today, last week, during the past month; de Shazer).
- Goal is to use scaling to help the youth make positive movement.
- "What would it take to move you one step to the right?"

For youth and young adults who rate themselves as not taking steps to protect their personal safety, the goal is for them to have less negative risk-taking behaviors each week. This progress can be measured by the Personal Safety Continuum.

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MRSS Safety Tool: Personal Safety Skills (CON.)

Process questions for youth who engage in negative risk-taking behaviors:

- Think about the last time you got into trouble, who were you hanging with at that time?
- Identify situations or circumstances that you are more likely to take a negative risk.
    - What was going on that day/night? (location, time of day, etc.)
- Identify mindsets (anger, depression) or conditions (substance use) that contribute to your taking negative risks.
    - Share with me what you were feeling like that day. How were you getting along with your (significant other, family members, friends, etc.)?
    - Were you or your friends using any drugs or alcohol?
- How often are you engaging in risk situations that could get you or others in trouble?
- What are some steps you could take to minimize these situations?
- What are some steps you could take to increase your personal safety?
- What skills do you need to work on to increase your safety (i.e. assertiveness skills, abstinence from drug use, emotional regulations, etc.)
- What help do you need from others to maintain your safety?
- What would need to happen for you to move from a "-5" to a zero?
- Are there times when these behaviors don't occur?
- Are there certain people that you don't take negative risks around?
    - How could you increase your time with those persons?

For youth who are mindfully aware of risk and safety environments and utilize pro-active safety precautions, the goal is to have them maintain their positive behaviors.

- What support do you need in maintaining your safety?
- What is one barrier that could get in your way of keeping yourself safe?
    - What could you do to plan for and manage this barrier?

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MRSS Assessment Tools

Distress Escalation Curve Tool

Purpose: To help caregivers develop a greater understanding of the development and context of crisis-oriented behavior so that they can intervene in a stage-consistent and effective manner.

Rationale: Youth with multiple needs and challenges frequently experience situations that exceed their ability to cope, which results in crisis-oriented behavior. These behaviors can cause increased stress to the family system and may place the youth at-risk for out-of-home placement. Understandably, caregivers often struggle to recognize or make sense of the many factors that contribute to or maintain a child's crisis-oriented behavior. By helping caregivers understand their child's unique crisis escalation patterns, future crises can be better managed and, in many cases, avoided altogether.

Caregiver(s) often benefit from the visual layout of the distress escalation curve. This tool can be used to map out behaviors, identify triggers causing escalation of behavior and develop strategies to reduce crisis situations.

Instructions:

- Introduce the concept of a distress escalation curve to the parent/caretaker and provide copies of the crisis escalation curve handouts.
- Share your perspective of the parent's role as expert consultant on their child's behaviors.
- Proceed by explaining each phase and providing a behavioral description for each to more clearly illustrate the concept.
- Review the "strategies" handout and discuss the importance for developing more effective responses and skills to avoid further escalation.
    - Highlight the value of effective responses and the unintended consequences of ineffective responses.
    - Note tendency for caregivers to focus on intervening during 'peak' phase and this being the least effective or least teachable phase.
    - Emphasis is made on the use of proactive strategies particularly related to the first two phases.
- Assist the caregiver in identifying the most salient crisis-oriented behaviors in the home. Have the caregiver focus on one behavior/context at a time. Additional behaviors can be addressed during subsequent sessions.
- Depending on the situation, the clinician may opt to encourage focusing on a behavior that would be more responsive to intervention to strengthen caregiver engagement/self-efficacy or a behavior that places the youth at the greatest risk for an out of home placement.

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Distress Escalation Curve Tool (Con.)

- Use the fillable forms and assist the caregiver in completing the escalation cycle and strategies for prevention and de-escalation.
    - **Escalation Cycle:** Use backward or forward mapping to determine the sequence of the escalation pattern. For example: "Prior to the crisis event what signs did you notice that his/her/your behaviors were escalating? Who was interacting with you/your son/daughter at that time? Describe this interaction. What time of day or situations do you most often experience this escalation?"

    - **Prevention and De-escalation Strategies:** Explore strategies and solutions to escalation patterns. For example: "What was most helpful in assisting your son/daughter in de-escalating?" What do you think might have helped prevent this escalation pattern? At what point in the cycle would it be best to implement these strategies?" Utilize a solution-focused approach that focuses on what works, family strengths, and supports that can be utilized.

    - Next, invite the youth to provide their perspective on the phases and strategies and elicit what would most helpful to them and at what points in the cycle.

- **Implement change strategies: Prioritize, Practice, Implement, Evaluate, Revise**
    - Involve all family members in the implementation of change strategies.
    - Identify strategies and skills to **prioritize** and set goals around these. **Rehearse** these strategies and skills with the family.
    - **Implement:** Emphasize a 'trial' approach to these strategies, i.e., there being a likelihood of having to adjust strategies based on youth responsivity.
    - **Review effectiveness** of new strategies and **revise** as needed.

- Provide caregiver(s) and youth copies of these forms.

Information from these handouts can also be used to complete the youth's safety plan.

Case note example:
Engaged the caregiver(s) in an activity to reduce the occurrence and improve the management of crisis-oriented behavior in the home. Educated the caregiver on the 7 phases of crisis escalation. Elicited feedback from the caregiver on how this relates to their child and the importance for effectively responding to their child. Prompted caregiver to identify one high risk behavior and assisted her in identifying the individual components of the curve as it relates to her child. Provided information on effective responses based upon each phase of the crisis. Again, elicited feedback from the caregiver on how to effectively respond in accordance to the youth's corresponding crisis phase. Engaged youth in process by eliciting feedback from him or her about their crisis experience and responsivity to intervention. Assisted caregiver with incorporating youth feedback into crisis plan. Explored potential barriers to implementation and addressed these. Identified and practiced those skills where applicable and set goals for other areas of skill development.

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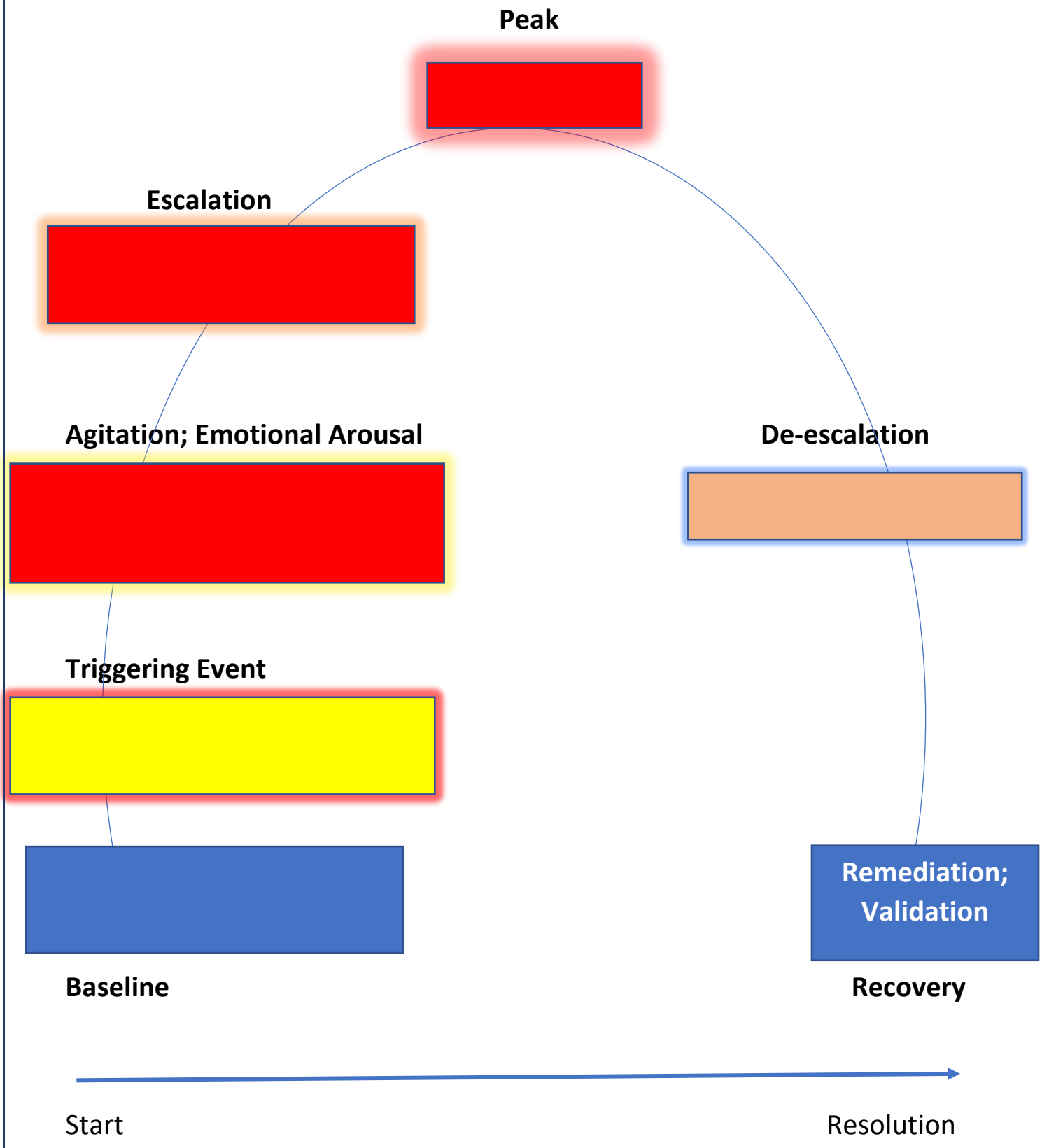
Distress Escalation Curve (Describe what it looks like)



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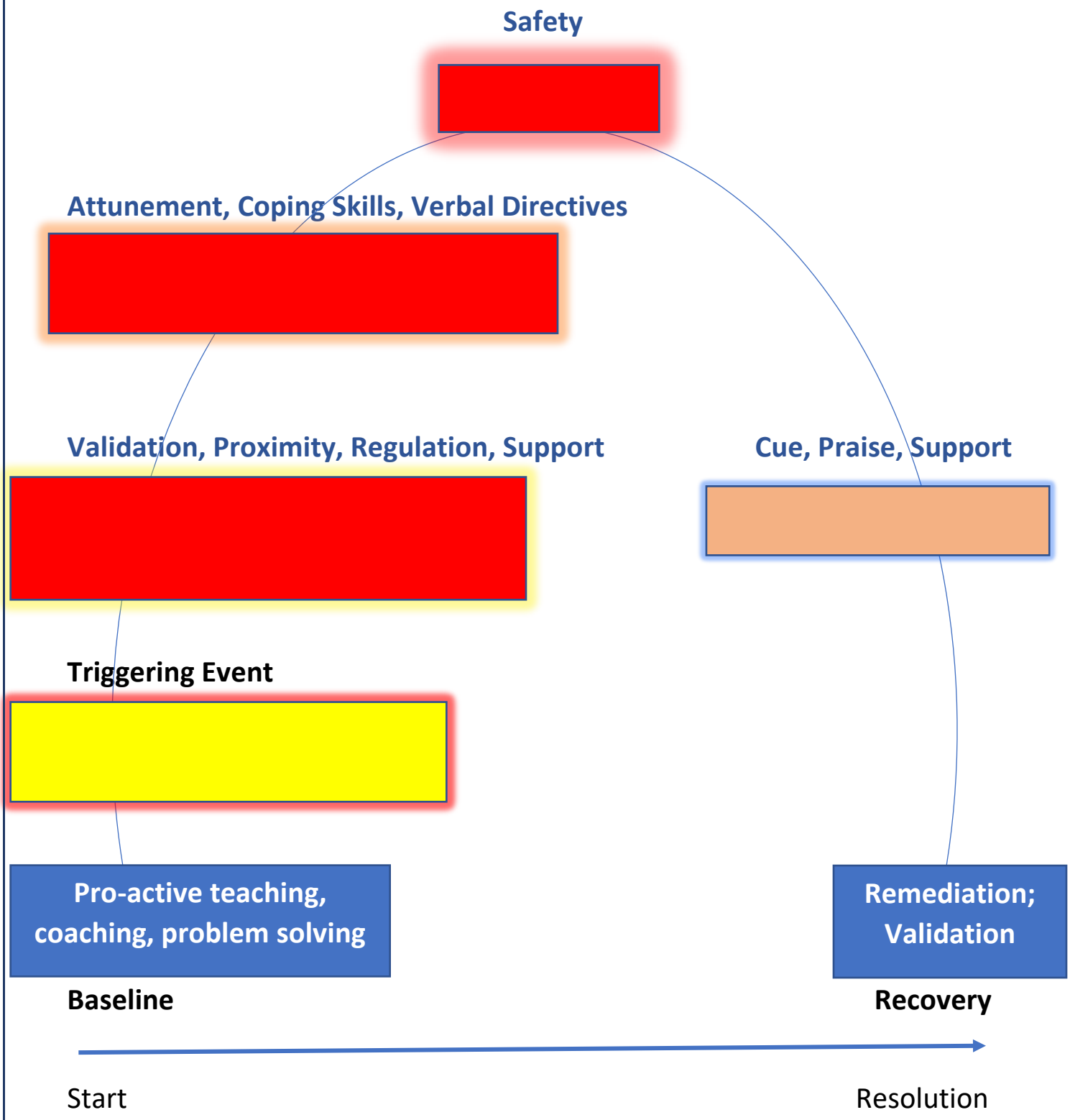
Trauma-Informed Prevention and De-escalation Interventions



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MRSS Tool Kit

Resiliency and Development Timeline

Utilize the **Resiliency and Development Timeline** to help identify developmental resiliency over time, as well as significant traumatic life events that impact functioning.

Age	Developmental Assets, Milestones, and Resources	Significant Life Events (i.e., Trauma)	Mental Health Functioning
0-1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
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Risk and Promotional Factors Checklist V.4

	Risk Factors		Promotional Factors
Individual	☐ Trauma history		☐ Gives back to the community
	☐ Difficulty learning and understanding		☐ Futures orientation
	☐ Cognitive and/or situational inflexibility		☐ Hopefulness
	☐ High impulsivity		☐ Motivation to Succeed
	☐ Low harm avoidance; risk & sensation seeking		☐ Effective communication skills
	☐ Limited frustration tolerance		☐ Conflict resolution; problem solving skills
	☐ Poor ability to problem solve		☐ Emotional regulation skills
	☐ Poor self-regulation skills (Behavior; emotions)		☐ Organization and planning skills
	☐ Previous self-harm ideation or behaviors		☐ Appropriate decision-making skills
	☐ Lacks futures orientation		☐ Tolerance in frustrating situations
	☐ Drug Use: Favorable attitudes/Early use		☐ Knowledge of triggers & relapse prevention skills
	☐ Physical health concerns		☐ Physically healthy and active
	☐ Developmental concerns (ASD; LD, etc.)		☐ Abilities & Talents_____
	☐ Medication: (non-compliance; no psychiatric)		☐ Medication compliant _____
	☐ **Individual Risk Factors Total**		☐ **Individual Protective Factors Total**
Family	☐ Low monitoring and supervision		☐ High monitoring; supervision; structure
	☐ Family substance use challenges		☐ Supportive relationships & strong bonds
	☐ Family mental health challenges		☐ Positive communication
	☐ Family violence		☐ Realistic expectations & accountability
	☐ High family conflict		☐ Clear rules and consistent consequences
	☐ Low family bonding		☐ Available and accessible family supports
	☐ Lack of rules, structure, accountability		☐ Adequate resources
	☐ Inconsistent or harsh discipline		☐ Regular family activities
	☐ Basic needs unmet (Housing; food; utilities)		☐ Stable housing
	☐ Physical or emotional safety not ensured		☐ Physical and emotional safety ensured
	☐ **Family Risk Factors Total**		☐ **Family Protective Factors Total**
Peers & Activities	☐ Negative peer influences		☐ Pro-social peers
	☐ Weak conventional ties (school/community)		☐ Peers attend school/community events
	☐ Unsupervised, unstructured time and activities		☐ Organized activities with adult supervision
	☐ No positive activities		☐ Asset-enhancing activities
	☐ **Peers Risk Factors Total**		☐ **Peers Protective Factors Total**
School	☐ Poor attendance/truancy		☐ Positive youth and parental involvement
	☐ Failure in school/poor school performance		☐ Accommodations matched to need
	☐ Unrealistic/unachievable expectations (from school)		☐ Positive & caring school climate
	☐ Lack of positive connections (in school)		☐ Realistic & achievable expectations (school)
	☐ Behavioral problems at school		☐ Clear rules and consequences
	☐ Lack of school credits (falling behind)		☐ On schedule to graduate
	☐ Low commitment to school		☐ Good fit with school placement
	☐ School placement does not meet educational needs		☐ Positive relationships with school
	☐ **School Risk Factors Total**		☐ **School Protective Factors Total**
Community	☐ Poverty		☐ Positive adult role models (mentors, etc)
	☐ Restricted opportunity for positive involvement		☐ Faith connections
	☐ Density of delinquent peers		☐ Opportunities to give back
	☐ Violence in neighborhood		☐ Neighborhood monitoring and supports
	☐ Drug use/selling in neighborhood		☐ Structured & monitored activities available
	☐ **Community Risk Factors Total**		☐ **Community Protective Factors Total**
Totals	☐ **Risk Factors Total**		☐ **Protective Factors Total**

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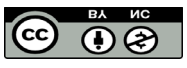
Risk and Promotional Factors Checklist Directions:

Utilize the Risk and Promotional Factor Checklist to identify the youth's risk and protective factors per life domain.

Complete the tool to establish a baseline score and then again at time of discharge. For each life domain under the Risk Factor column, place a checkmark next to all the items that apply to the youth and family you are rating. Follow the same procedure for the Promotional Factor column.

Utilize the information to develop treatment plan goals to address main areas of concern. The overall treatment goal is to reduce risk factors and increase promotional factors or assets in the youth's life. Remember to include positive treatment goals that reflect promotional factors and asset building.

Complete the tool again at discharge and compare the number of risk and protective factors to the baseline measure. You can use the tool in this way to create an outcome for the percentage of change over time for risk and protective factors.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MRSS Tool Kit

Basic Needs, Resources, and Supports Map

Complete a Basic Needs and Resources Map/Checklist with the family.
The basic needs and resource map is a diagrammatic representation of the family's most basic needs and resources. This can be utilized to assess the family's basic needs and resources, and the family and community supports available to meet them.

1. The following are key areas where families may need support or assistance. Identify what basic needs, resources, and supports the family need for basic emotional and physical safety.
    a. Food
    b. Housing: affordable and safe housing
    c. Employment/Education: supported employment; job coaching; job skills
    d. Benefits/Income: Insurance/Medicaid; SSDI; Food Stamps; etc.
    e. Physical and Behavioral Health: Medical doctors; safe behaviors
    f. Transportation: learning how to use public transportation; living near a bus line
    g. Communication technology: phone, computer, etc.

2. Note the resources present (+) or needed (-) for the family in each area.

3. For each area identify if support is needed and what kind?
    a. Tangible Support (Financial support; benefits; food; transportation; etc.)
    b. Emotional Support
    c. Informational Support ("How to" information)

4. Identify the source of the support?
    a. Informal support: (Friend, family, faith community, neighbor, etc.)
    b. Formal support: (Treatment providers, caseworkers, teachers, etc.…)

5. Indicate the availability of the support needed
    a. Is the support available and accessible when the youth and family needs it? Is the service available in your county?
    b. Is the youth/family eligible for the support/benefit? Do they need assistance in obtaining it?

6. Identify barriers and potential solutions
    a. Resources and funding
    b. Lack of relationship between organization and community supports
    c. Resources being used for others, other purposes, or not efficiently
    d. Burned bridges: What type of advocacy is needed to reinstate a previous support? Can the youth/family achieve this advocacy task by themselves? What kind of coaching or rehearsal is needed for them to achieve this task on their own?

7. Identify/prioritize which resources are needed most to prevent further negative functional impacts.

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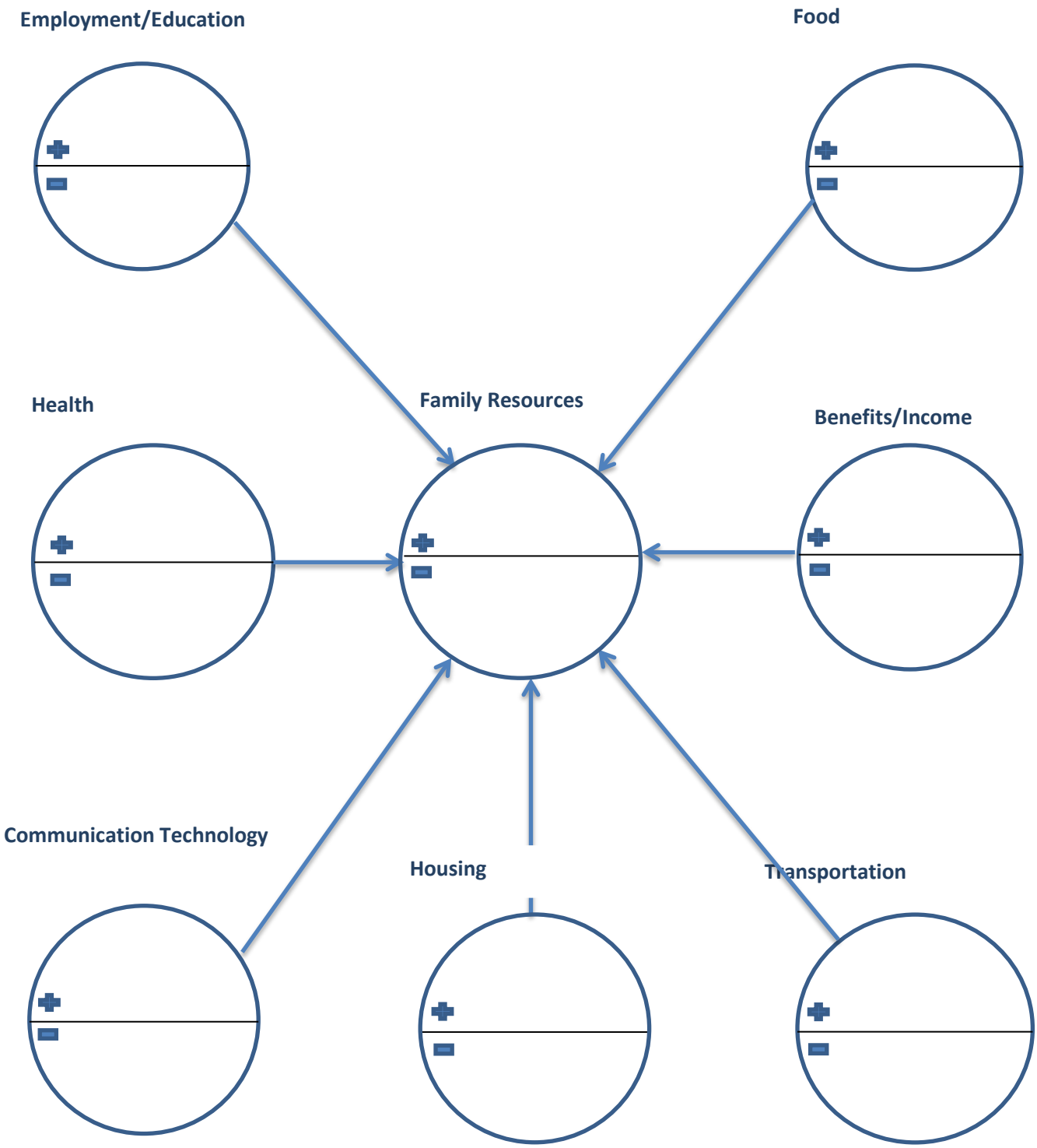
Basic Needs, Resources, and Supports Map

Name: **Date:**



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Engagement Tools

Resiliency-Oriented Engagement Questions that Elicit Youth and Family Strengths, Culture, and Values (Shepler)

Strengths Eliciting Questions (Youth):

- What do you like to do when you are not in school?
- What are some special qualities about you that people don't always see?
- What are you good at?
- What do people say you are good at?
- What is your best sport?
- What music do you like?
- What subjects do you do best in?
- Tell me about the last time you and your family did something fun together.

Questions that Elicit Youth and Family Culture and Experience

Youth:

- Tell me about what it's like growing up in your city/town?
- What are some of the day-to-day challenges you face?
- What do you have to do to survive?
- In what ways do you feel the same/different than other youth at your school?
- What makes you feel different? Do you feel accepted for this difference by your peers?
- What do you want your parents to know about your generation?
- What are the challenges growing up _____ in your town?

Family:

- What do you want your child to understand about your culture?
- What family value was passed on to you that you want to pass on to your child?
- What are the challenges raising a family in your town?

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Appreciative Communication

"It is not how smart you are- it is how are you smart?" Mark Katz

Appreciative perspective: Facilitated discussion between family members.

- **Valuing and Understanding:** MRSS staff facilitate a discussion about understanding and respecting each family member's unique needs and perspectives- beliefs, values, abilities, and life experiences
- **Honor:** Have each person identify one way in which the other family member is an important part of your family.
- **Discover**: Strengths discovery: Have family members identify what they most appreciate about the other person (support, strengths, etc.)
- **No one is perfect:** we are all on a journey. We all have things to learn. Have each person self-identify an area of growth in their journey

Appreciative Inquiry: Understanding the Family's Journey

- What would you want someone on the outside to know so they could better understand how hard it is for you right now?
- What are some special qualities about you that people don't always see?
- You are an expert on your family. What can you tell me that will help us develop solutions to the current problem?
- Tell me about your journey. Tell me about your family's journey.
- If there was one question that I did not ask that would help me understand you or your situation better what would it be?
- What would others say they appreciate most about you, and what you have been through?
- Think about the time your family did the best together- what was going right?

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Skill Building and Competency Enhancement Tools

Many developmental competencies are associated with resilient outcomes in future life stages. Key tasks as each stage build on tasks from previous stages. It is critical that treatment go beyond symptom reduction to target achievement of key developmental tasks as a primary goal. Given the impact of trauma on development, targeting developmental competencies should be considered an integral component of, rather than an adjunct to, "trauma-focused" treatment. The following activities focus on 2 key domains particularly relevant to resilient outcome among stress-impacted youth. Remember to consider *developmental stage* rather than *chronological age* when selecting interventions.

Coping and Regulation Skills

Self-Regulation Interventions (B. Beale, adapted from Blaustein, M.E. & Kinniburgh, K.M. (2010) *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self-Regulation, and Competency.* New York: Guilford)

Self-regulation involves the capacity to effectively manage experience on many levels: cognitive, emotional, physiological, and behavioral. Self-regulation involves many things, including an awareness of internal states, the ability to tolerate a range of arousal/emotions, the ability to take action or think to modulate arousal, an understanding of the connections between feelings, thoughts and behaviors, and the capacity to effectively communicate with others.

- **Affect Identification** – Trauma overwhelms the limited emotional management skills of children, forcing them to either disconnect from their feelings or use unhealthy coping skills. Working on affect identification can help these children to increase internal awareness, name emotional states, and understand why these states originate.

  - **Feelings Flashcards** – Create flashcards using drawings, magazines, photos, etc., that show a range of emotional expressions. While you could purchase flashcards, creating a set with the child/family is another strategy to work on affect identification together. To use the cards, progress from basic to subtle, only moving to the next level when the child is competent on the current level.
    - Start with only a few basic emotions portrayed in obvious pictures and simply ask the child to identify the emotion. Once this skill is strengthened…
    - Ask the child to identify what might have happened to elicit that emotion. Once this skill is strengthened…
    - Ask the child what might make them feel that emotion. Once this skill is strengthened…
    - Expand to subtler emotions and/or variations on a single emotion.

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- **Emotion scales** – Have children identify the strength of current emotions on a scale from 0-5. Older children can do this verbally, but younger children will benefit from a visual scale that they can point to (on a sheet of paper) or move to (markers on the floor or wall). This will help them understand degrees of feeling and the concept that stronger emotions may elicit behaviors that are tougher to modulate.

- **Anger Thermometer** – Since anger is one of the tougher emotions to manage appropriately, it's good to spend some extra time on this one. Draw a thermometer on a piece of thick paper or thin cardboard. Label it with angry feeling words, with milder ones at the bottom and the strongest at the top (annoyed, irritated, angry, furious, and enraged). Make slits in the cardboard at the top and the bottom of the thermometer, wide enough for a piece of ribbon to be threaded through it. Give the child a length of white ribbon that fits into the slits, but is twice as long as the thermometer. Have the child use a marker to color half of the ribbon red, and allow it to dry. Thread the ribbon into the thermometer with the red at the bottom and the white at the top. Discuss what a thermometer does as the air gets hotter. Explain that as people get angry, it is as if they get hotter too. Review each term on the thermometer and discuss their meanings. Give the child a situation that might make them more or less angry and have them adjust the ribbon by pulling up or down to indicate exactly how they would feel. Include a discussion about how to cool off or modulate that anger.

- **Feeling Pie** – This is a useful strategy to demonstrate how we can have many different feelings about something. Make a large circle on a piece of paper, and then draw lines indicating slices of pie. Identify a situation, like going to an amusement park, which might inspire a variety of emotions and write them down, 3-5 would be plenty. Now have the child assign each emotion a color. Explain that the circle is the child and have them decide how many pieces of the pie are needed to represent each emotion/color. For example, you might feel very excited, a little brave and curious, and a tiny bit nervous about the amusement park. If the pie had 8 pieces, perhaps 3 would be colored for excited, 2 each for brave and curious, and only 1 nervous color piece.

- **Feelings Toolbox** – This is an ongoing activity that you can add to as you work, identifying and modulating a wide variety of feelings over time. Introduce this activity by saying, "Since feelings are so important, we're going to build a toolbox of different things you can do when you're having different feelings." Use a shoebox or other container and have the child decorate it. Together, pick a feeling on which the child would like to work; then pick a "tool". Be creative and involve the child in identifying helpful cues or tools to include in their box. Here are a few examples:
  - Excitement – small container of bubbles with wand; a picture/drawing of child doing jumping jacks; small objects/toys to manipulate.
  - Anger - a picture/drawing of a child pushing against a doorway or wall; stress ball to squeeze; small container of play-dough to flatten.
  - Worry – small tablet of paper to write worries down and then throw them away; index card with a stop sign on one side and a positive statement (I can handle this!) on the other; list of distracting activities to try (belly breathing, ride bike).

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- **Affect Modulation** - Alternating States Regulation involves helping children learn how to flow through and tolerate increasing and decreasing levels of arousal. These techniques use fun activities to teach children how to tune in to and change arousal level on cue.

  - **Slo-Mo** – Use slow-motion movement to teach children how to slow themselves down. Once they gain skill in moving in slow motion, they can be cued to shift into it when in a hyper aroused state. Model a typical movement in slow motion, like running. Invite the child to join you, then invite them to show you a different activity in slow motion. Practice shifting to slow motion in response to cues; walk around the room normally, then randomly call out "slo-mo" or "freeze". Once the child is practiced in this technique, the cue can be incorporated into daily routine by caregivers, teachers, etc.

  - **Stop/Start Games** – Explain that you are going to play a game that helps you practice being in control of your body. Discuss times and places that it's ok to move a lot and be silly (recess) and when it's not (class time). Play Red Light Green Light, Musical Chairs, or Freeze Dance. Reinforce the child's ability to stop or freeze on cue.

- **Affect Expression** – Sharing emotional experience is a key aspect of human relationships. These exercises should help children build the skills and tolerance for effectively sharing emotional experience with others.

  - **Circles of Trust** – Draw a set of circles on a blank piece of paper; it should look like a bullseye with a small circle in the center and 3 or 4 larger circles around the center. Put the child's name or picture in the middle and discuss how we all have many different people in our lives. Some of them we are really close to and we can tell them anything. Some of them are nice and we can say most things, but not everything. Some are just acquaintances and we just say "hi" or talk about little things like the weather. Have the child name different people in their life and help them to put them in the correct circle, with close, trusted people in the closest circle and casual relationships in the outer circles. Discuss comfort levels for each circle as well as differences in type of information shared or communication styles for each circle.

  - **Feelings Detective** – Start with a blank sheet of paper; draw a large triangle on it, labeling each corner with a letter, A, B & C. (These stand for Affect, Behavior & Cognition.) Brainstorm a list of emotions with the child and choose one to work on at a time; write that emotion in the A corner of the triangle. Talk or write about ways that feeling might show up in their behavior; write those behaviors in the B corner. Talk or write about thoughts that might have triggered that feeling; write those thoughts in the C corner. Finally, put the child's name in the middle of the triangle and talk or write about how this all makes his/her body feel. Discuss how our thoughts, feelings and behaviors are all connected inside our bodies. Also discuss how we can change how we express ourselves by understanding these connections and making adjustments in any part of the triangle.

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- **Personal Bubble** – Teach the child about personal space or comfort zone, which is an invisible circle around our body that others should not enter without our permission. Have the child create their own bubble by stretching their arms out and turning in a circle or using yarn to actually create a circle around them on the floor. Practice and model asking permission to enter their space. Then discuss that other people have personal bubbles too and that the child should not enter another person's space without permission either.

- **"I" Statements** – Teach the child that "I" statements are ways to let other people know how we feel. Use this technique in the moment and connect it with affect identification skills. When a child describes an emotional experience, prompt him/her to use "I" statements. Make a card with the following sentence stems to help:
  - I feel _____.
  - I felt _____.
  - I want _____.
  - I would like _____.
  - I need _____.
  - It makes me feel _____ when you _____.

Coping Skills Box/Sanctuary Box: http://childhoodinterventions.blogspot.com/2012/08/coping-skills-box.html

A Coping Skills Box is a box in which the client can keep items that can help him or her cope with difficult emotions (anger, disappointment, frustration, sadness). You can use a shoe box or purchase a plain box and allow the youth to decorate and personalize his/her box, using items such as construction paper, scissors, glue, stickers, photos, magazines to cut pictures out of, glitter, etc. While the youth decorates the box, you may want to discuss what a coping skill is, if the client does not already know. You will need to get to know your client and what works for him or her as a coping skill before you can begin filling the box. What you put in the box depends upon the age of the youth. Suggestions for items to put in the coping skills box:

- *Coping skills:* self-soothing; deep breathing, cognitive behavioral skills
- *Journal*
- *Coloring book/sketch pad*
- *Positive affirmations/readings*
- *Photos/pictures that are calming to the client*
- Stress relief: *Squishy ball or other object to squeeze*
- *Music*
- *List of phone numbers for family members/friends who can offer support*

Important instruction: The box can't be taken away from the youth as a discipline or restriction. Youth is allowed to access his or her coping box and the contents in it anytime they need it.

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MRSS Tool Kit

SIFTing Your Mind - Mindsight Practice (Mauri Lung)

Description: SIFT is a guided mindfulness practice. This is the basic way we can SIFT our sea inside to see what is going on. When we SIFT through our minds, we check inwardly on the sensations, images, feelings, and thoughts going on inside ourselves at any
given moment. "Sift" is an apt term to describe the process, or course, because all of the many sensations, images, feelings, and thoughts that may come up in awareness are often connected to one another in a free-flowing process.
Time: 5-10 minutes
Props: None
Preparation: Space to sit as a group, a semi-circle is best to make sure everyone can be seen and heard by others but not required.
Procedure:

1. **Give these instructions:** *"Right now, get comfortable, try closing your eyes, but you don't have to close your eyes, relax, and ask yourself the following questions…"* Allow 30-60 seconds after each prompt.

   S — What am I sensing right now in my body? You may feel tension in your muscles or you may sense your heart beating, your lungs breathing, or simply a wash of sensations from the body as a whole.

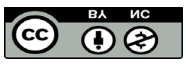
   I — What images come up in my mind's eye? Images may take many forms, including the familiar visual ones. But you can also have images of sounds and touch, an image of a time of your life or some hope for the future.

   F — What feelings are inside me? Emotions can involve bodily sensations, yes, but they also link our bodies to our thoughts, to our memories, and to our perceptions.

   T — What thoughts are streaming through my consciousness? Some experience an inner voice that they can hear, others just a sense that has no words. It is fine however thoughts emerge; you just need to let yourself be aware of whatever comes up for you right now.

2. Don't worry about putting words to these inner experiences; simply becoming aware of our internal world is the essential component for this SIFTing practice.

Activity Source: Siegel, D. J. (2013). *Brainstorm: The power and purpose of the teenage brain*. Penguin Group.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4-7-8 Breathing

(Andrew Weil; Sarah Vaynerman: https://www.huffpost.com/entry/three-easy-mindfulness-me_b_9674614)

- Begin by emptying your lungs.
- Breathe in through your nose for 4 seconds.
- Hold your breath for 7 seconds.
- Exhale firmly through your mouth, pursing the lips, for 8 seconds
- You may repeat this breathing cycle up to 4 times.
- This type of simple technique is rejuvenating for the nervous system. This kind of breathing acts as a natural tranquilizer.

A simple exercise to activate the parasympathetic nervous system - ie, the relaxation response - involves regulating the breath to lower the heart right and blood pressure quickly and effectively.

When our exhales are longer than our inhales, our body signals its "rest & digest" mode (vs. "fight or flight" mode) and we are able to relax from the inside out. Relaxation breathing tackles physical responses to sudden, acute stress while buying us time to respond thoughtfully rather than react impulsively.

As you inhale, visualize the movement of oxygen through your respiratory system. As you inhale, imagine any stress you've been holding float away. Repeat five times.

Mindful Breathing Meditation - 7 Minutes

Use this meditation twice daily to develop better focus, attention and a greater overall sense of clarity and calm over time.

Mindfulness is the practice of awareness of the present moment, enabling us to disassociate with notions of past and future that trigger rumination and stress. With mindful breathing meditation, we use the breath as an object of meditation, concentrating deeply on the rhythm and sensation of our most basic life force. Think of it as an exercise for your brain that strengthens your "attention muscle" by forcing your awareness inward and challenging you to stay focused.

In perhaps the most significant mindfulness study to date, a team of Harvard researchers found that after 8 weeks of daily practice, mindful meditators reported a sense of increased peace and clarity while non-meditators did not. Not only that, but their MRIs showed an increase in gray matter in parts of the brain associated with focus and attention and a decrease in gray matter associated with stress and anxiety (non-meditators remained unchanged).

The practice: Sit comfortably with a long, straight spine and find a slow, oceanic breath. Begin counting your inhales and exhales from one to ten (inhale one, exhale one; inhale two, exhale two; etc.). When you reach ten, start again but count backwards to one. Repeat this cycle five times. When you've completed five cycles of breath-counting, simply continue to breathe at this calm, steady pace,

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for two-to-three minutes, visualizing the breath moving through the respiratory system and appreciating its physical relationship with the body.

Body Scan Meditation - 5 Minutes

Use this meditation to build body awareness and ease tension after a long day or before falling asleep at night.

A body scan meditation allows us to identify where unconscious holding patterns reside and helps to release them with our own awareness, enabling us to relax more completely.

Research suggests that including body scan meditation in a mindfulness practice significantly reduces sleep problems and improves symptoms and severity of fatigue and depression.

The practice: Sit or lay down in a comfortable position and take a few moments to find a calm, steady breath. Now, bring your awareness to sensations in the body, where you will spend several slow breaths on each focal point beginning with the left toes and checking in with left foot, left ankle, calf, knee, thigh - all the way through the left hip. When you notice an area of tension or discomfort, breathe into it, relaxing on the out-breath. Repeat through the right side. Follow with the pelvic region, abdomen and lower back, moving up through the torso and heart region. From there, follow and breathe through the sensations in the fingers, hands, wrists, up the arms, through the shoulders, neck, jaw, temples, ears, eyes, forehead, crown of the head and skull.

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MRSS Tool Kit

MRSS Tools: Problems Solving Skills

ABCDE Problem Solving (Kreidler, 1984):

Use and Rationale: This tool is designed to assist family members to utilize higher-order cognitive processes to solve problems and make choices in the service of reaching identified goals. For many people, problem solving steps are an unconscious, rapid process. For children exposed to trauma, however, these steps are skipped as they move straight to reaction. The goal is to make this unconscious process conscious. A less formal way to do this is to "think out loud" when a problem arises and allow the child to hear your problem-solving steps and see them in action. More formally, you should teach and rehearse these ABCDE steps, which are easily memorized by children, but will need prompting to enact.

Ask: What's the problem? Assess the issue. Give people a chance to talk about the problem and how it affects them. Make sure everyone understands and agrees.

Brainstorm: Encourage the family to share lots of ideas. Support that there are no bad ideas. Sometimes a "silly" idea has just that seed of wisdom that can lead to a solution?

Choose: Let people select and promote an idea. Discuss the ideas and talk about the potential consequences of trying out ideas. Consider which idea might best solve the problem. Agree to TRY one idea that everyone can live with. They don't have to love the idea, just be willing to give it a good try.

Do: The only way you'll know for sure if it's a good idea is to try it. Set a time limit. It should be long enough to give the idea a good trial, short enough to limit the damage if the idea doesn't work. Commit to making a good effort.

Evaluate: What was the result? Discuss what happened. Could we do better? In some cases, you may need to explore the idea and change it a little to make it fully effective. In other cases, you may decide to go back to the list of possible solutions and try another one. Kreidler, W. 1984. *Creative Conflict Resolution.* Glenview, IL: Good Year Books.

Parenting Problem Solving (Beale & Lung)

Rationale: Parenting Problem Solving Process: All families, no matter how positive parents/guardians have been, will still have conflict. There will still be arguments, children will still misbehave, and people will still get frustrated. The demands of our daily lives will inevitably create conflict and misunderstanding. That being said, problems that occur within the family are best solved proactively. (Barish, K., 2013)

Step Back: Whenever there is a recurring problem, we first want to take a step back so that we can look for the root causes. Try to identify the sources of feelings. These may be frustration in learning, or criticism, or bullying, or exclusion, or...

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Place the problem: Generally speaking, children, just as the adults, want to solve problems and they want to do well. Similarly, they may become frustrated or feel hopeless about possible solutions. Placing the problem before your child, it presenting an observation of the shared problem. For example, "We often have a problem in the morning, when it's time to get ready, and I end up yelling at you. I imagine that you might be frustrated, too, and we need to solve this problem."

Elicit ideas: Although some problems may require consequences, generally, we want to first engage our children in solving the problem. After the brainstorming, it might be helpful to let this simmer a bit before taking the next step and select an idea to try.

Develop a plan: Even presenting the idea of, "we have a plan," helps to instill hope and change. With the idea selected, talk about what that would look like, a time frame to experiment, and support that might be needed.

Reward and evaluate progress: By noticing increments of change, and efforts of compliance, it is more likely to support the change.

Collaborative Problem Solving/Collaborative and Pro-active Solutions (Greene & Ablon)

- **Understand (Empathy)**: Change our perspective
  - Understand behavioral health challenges in a different way: "Help me understand"
- **Identify the problem to be solved**:
  - Identify the unsolved problem that precipitates the challenging behavior: with whom; over what; where does it occur; when does it happen
  - Parent concern about the behavior is shared
- **Negotiate solution**
  - Do something different that is acceptable to both parties
  - Accommodations
  - New skill
  - New approach

Collaborative and Proactive Solutions: https://www.livesinthebalance.org/

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MRSS Tool Kit

Steps for Effective Problem Solving (Adapted from 7 Steps for Effective Problem Solving in the Workplace; Tim Hicks) https://www.mediate.com/articles/thicks.cfm

1. Identify the issues.

- Be clear about what the problem is.
- Remember that different people might have different views of what the issues are.

2. Understand everyone's needs.

- Needs are what drives the underlying concerns.
- The best solution is the one that satisfies everyone's needs and interests.
- This is the time for active listening. Put down your differences and listen to each other with the intention to understand.

3. List the possible solutions (options)

- This is the time to do some brainstorming. There may be lots of room for creativity.

4. Evaluate the options.

- What are the pluses and minuses?

5. Select an option or options.

- What's the best option, in the balance?
- Is there a way to "bundle" a number of options together for a more satisfactory solution?

6. Agree on contingencies and evaluation.

- Conditions may change. Make contingency agreements about foreseeable future circumstances (If-then!).
- Create opportunities to evaluate the agreements and their implementation. ("Let's try it this way for three months and then look at it.")

Effective problem solving does take some time and attention. Working through this process is not always a strictly linear exercise. You may have to cycle back to an earlier step.

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Communication Skills Tools

Guidelines for Helpful & Effective Family Communication (CIP, Steve Case)

In order to promote a healthy and safe living environment, each family member agrees to communicate in the following ways:

1. We agree to respect each other's personal space.
2. We agree to respect each other's physical body by not hitting, punching, kicking, biting, slapping, etc.
3. We will ask the person that we would like to speak with whether they are willing and ready to listen, e.g., 'Can you listen to me now?"
4. When expressing our thoughts or feelings, we will use 'I-Statements' rather than starting our sentences with "You…" For example, "I feel *(feeling word)*, when you *(unhelpful behavior)*, I would prefer you to *(helpful behavior).*
5. We agree to speak to each other in a respectful manner, e.g., no cursing, yelling, name-calling, threatening, etc.
6. We will remain present-focused, i.e., speak only on current problem and not bring up 'old problems.'
7. We will only discuss one issue at a time.
8. We agree to avoid using any language that deliberately elicits conflict (e.g., blaming, provoking, taunting, teasing, etc.) or is at the expense of another's feelings.
9. We will make requests, rather than demands or threats when wanting something.
10. We will be patient and not interrupt or rush the individual who is speaking.
11. We will be mindful of our body language, e.g. facial expressions, body posture, gestures, mannerisms, etc. This is where most of our communication happens!
12. We will not involve ourselves in other peoples' arguments.
13. We will focus on what is required of ourselves and not worry about what is required of others in the household.

*** Remember, the key to communication is understanding— not to determine who is right or wrong!

Name of the tool	Guidelines for Helpful & Effective Family Communication
Purpose and Applications	• To encourage healthy patterns of communication within the family both in- and outside of session. • To assess effective and ineffective family patterns of communication • To structure family sessions to promote productive communications. • Used as an on-going skill-building intervention for the purposes of identifying and practicing helpful and effective communications.
When: phases of MRSS	• This tool should be used in the Stabilization Phase of MRSS. • It is not advised to use this when the family is in crisis or is simply unable to be in a room together without it leading to significant, unresolvable conflict.

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Description of the Steps	• Family members are invited to talk about their experiences of communication within their family: what is helpful and what is not helpful. • The therapist should discourage blaming and may need to use prompting or redirection to keep the conversation productive. • Family members are then asked to envision how things would be different if everyone were to feel heard and were able to successfully communicate their thoughts and feelings. It's important for the therapist to attend to each family member's response and intervene only if the conversation becomes unproductive. • With family permission, the therapist provides feedback on the usefulness of identifying some "guidelines" on how family members communicate with one another, noting several of the helpful or unhelpful strategies previously identified. • With family permission, the therapist writes these strategies down and provides additional recommendations. • Help family prioritize communication rules and guidelines and then skill-build around each one in successive sessions. • The therapist should make copies for the family and utilize these during sessions. • Follow-up with the family on their use of communication strategies and affirm the family's strengths and successes in the use of these.
Example of documentation using this tool	Explored family's perception of communication in the family. Invited family to identify those aspects of their communication that are helpful/unhelpful. Reflected these for the family while highlighting those strengths and areas of success. Enhanced family's motivation for change by eliciting the benefits of improved family communication. Reflected how these align with their values and goals. With family permission, provided feedback on guidelines to improve their interpersonal interactions and elicited their receptivity to these. Assisted the family in prioritizing which communication patterns they would like to improve upon and how they could utilize these guidelines to do so. Tasked the family to practice these throughout the session as well as between sessions. Provided family with a copy to serve as a reminder to guide their family communications.
Desired outcome	Family would be able to identify and prioritize those skills which they would like to work on and demonstrate some behavioral follow through. As a result, family would practice these both in and outside of session and demonstrate improvement in those desired skills.

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MRSS Tool Kit

Dyadic Communication Coaching Exercise (Shepler)

Pre-work: (done separately with parent and youth)

- Teach new communication skill that you are focusing on to both members of the family you are working with.
- Practice new skill utilizing role plays and reverse role plays.
- Check readiness to use these new skills with the parent or youth
- Do your homework (therapist): identify underlying needs for each person; craft effective communication examples for them to use;

Set the stage:

- Set ground rules for discussion
- Respectful participation
- Strengths-based and problem-solving focus
- I will redirect session if it becomes negative
- If you need to leave to get some space, take the time you need, but please return prior to the end of the session
- Create a signal for a break from hot topic (e.g. raising hand)
- No cussing; no use of threats; no name calling; no attacks, etc.
- Emphasize that it takes time to learn and perfect new skills
- Predict initial challenges

Implementation:

- Pick non-hot topic for implementing new skill
- Pick person to start (one who can most positively initiate conversation)
- Start positive: strengths comments (pre-identified)
- Proceed to simple requests and then more complex requests
- Goal is to complete a negotiation which both parties can live with and feel respected in the process

Active Coaching:

- Dyadic communication training requires active monitoring and coaching.
- Coach on understanding the underlying need of the request
- "Call a friend" technique: when someone struggles in the exercise they can ask for help from the therapist. Therapist then provides alternative phrasing utilizing communication tool being taught ("I" statements; feeling statements; reflective listening, negotiation, requesting, etc.)
- Offer sentence starters: I get concerned about you when….; When you are out late I worry about….;
- Don't start something you can't finish/can't control
- Don't have them try something beyond their current skill set

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Evaluate and Refine

- Process exercise: What was their experience in trying this new way of communicating?
- What needs refined/tweaked/fine-tuned?
- Evaluate effectiveness: Was goal achieved?
- Identify next steps

Developing a Pattern of Respect: (M. Lung)

Respect is the core of family relationships and harmony. Respect means that we treat others in a thoughtful and courteous way. A family is constantly changing and growing. Sometimes the family guidelines for respect are clear; they have been spoken out loud, shared, and demonstrated. Other times, these guidelines are silently in place to follow. As family members grow, they learn to relate to each other differently. Each family member is unique and has their own style and personality. Family members may give each other permission to make mistakes or even to fail when trying to show respect. To develop a pattern of respect in the family, open communication should be present. (Floyd & Morman, 2014; Williams & Nussbaum, 2013).

Effective Communication: Research identifies communication as an essential building block of strong family relationships. Feeling heard and understood also develops trust and caring between people. Communication can be both instrumental and affective. Instrumental communication is the exchange of factual information (e.g., telling a child to come sit at the table for dinner). Affective communication is the way individual family members share their emotions with one another (e.g., sadness, anger, joy). Communication is also verbal and non-verbal information. Communication within the family is extremely important because it enables members to express their needs, wants, and concerns to each other. It is through communication that family members are able to resolve the unavoidable problems that arise in all families (Epstein et al.,1993).

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Self-Awareness/ Self-Knowledge Skills

- **Self-development & Identity** – Like all children, traumatized children internalize and incorporate their experiences into their sense of self. Unfortunately, they internalize many more negative experiences than their peers. We want to support children in exploring and building an understanding of self and personal identity, including unique and positive qualities, coherent across time and experience, with the capacity to imagine and work toward a range of positive future possibilities.

    - **All About Me book** – Help children identify personal attributes including likes & dislikes, values, talents, preferences, opinions, family & cultural influences, spiritual beliefs, etc. You will need materials to build a book together. This is an ongoing project, often adding a single page per session. Provide structure for young children; create a page of favorites (holidays, colors, pets, foods), a page of skills and abilities, a page of potential future jobs, etc. Drawings, pictures or words can be used. For older youth, consider more abstract concepts and incorporate affect. For example, list or draw exciting or frightening experiences, document previous events, include personal values.

    - **Pride Wall** – This focuses on the positive self, building internal resources and positive self-identification. Note both absolute strengths (skills at math or athletics) and relative successes (efforts at a difficult task or bravely facing a challenge). Pride walls can be set up at home, school or therapy office. You will need a bulletin board or a blank wall, index cards, markers, and tape or thumbtacks. Invite the child (and family) to add things of which they are proud to the wall. Pride walls are an excellent way to help caregivers "catch their children being good", which is also great for attachment.

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MRSS Tool Kit

Overcoming Life's Challenges Worksheet (Adapted from Resiliency Leadership Ohio, 2006)

This activity is designed to help youth identify challenges in their life and how they can get through them.

Introduction: All people have situations, or personal challenges that they struggle with in life. It could be as small as getting through a project at school or as large as managing anger. Persons living with mental health diagnoses can have additional barriers to work through, in order to address their challenges. But when we overcome them, we grow in wisdom and personal strength.

What are your top three challenges right now?

Everyone is challenged by something different. It is up to you to decide what you are struggling with most. For example, telling people when you need help, getting overwhelmed by school projects, making friends at your new school. Fill in your challenges into the mountains.

Pick and describe one challenge that you are currently struggling and need help with:

What I am doing to overcome the challenge right now? **Exploratory Question:** What gives you the strength to get through every day?
A couple of things that I have tried in the past that worked are… Which of these things might work best for this situation? **Exploratory Questions:** What do you tell yourself that helps you get through tough times? Where do you draw your courage, confidence from? In handling difficult situations in the past, what did you learn about yourself?
One thing that I could do differently is….
Who I need help from in order to overcome the challenge is… (Family, teachers, friends, etc.) **Exploratory Question:** Who has helped you through difficult times in the past?
One way that people in my life can show that they support me during this challenging time is… **Exploratory Question:** What supports do you need to be strong?

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Future's Orientation: Use solution-focused questions to explore a positive vision of their future.

- If things go as planned, where do you see yourself in five years?
- What will you have done to accomplish this?
- What barriers would you have encountered?
- How would you have overcome these challenges?
- Who supported you along your journey?
- What would you be most proud of accomplishing?
- Who would be most surprised? What would you want to tell them?

Resiliency Functional Analysis (Shepler)

Directions: Conduct a functional analysis with the youth. Explore with the young adult the people, places, things, and personal health conditions (sleeping, eating, exercise, health, etc.) that promote positive well-being.

- How well do you know yourself?
- Let's talk about what supports your wellness.
- What have you learned about yourself that you know you need to do every day to be well?
- What things – when you don't do them—increase your ____ symptom(s)?
- What supports do you need – from who?
- Give me an example of the last time things escalated out of control.
    - Can you tell me who you were with? In what context it happened? How were you feeling that day? Were you sleeping well, eating well, taking your medications?
    - Can you describe the interactions that happened that made you feel the way that you did?
    - Is this situation similar to others that you have experienced?
    - What could you do differently next time?
    - What part of that situation do you have control?
- Opportunity to explore who we are as people and are own stuff
- Using Functional analysis—knowing your triggers and positive triggers and environments
- What triggers positive behaviors?

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MRSS Tools: Parenting Skills

Explore the "No"; Expand the "Yes" (Shepler)

- **Explore the "No":**
  - **Parent:** "We tried that and it didn't work."
  - **MRSS Provider:**
    - That must have been frustrating.
    - Can you describe what happened?
    - Where do you think things went wrong? What do you think would have made it work better?
    - Sequencing: So when you did ____ what happened next? And then what happened….
    - What would need to happen for you to feel comfortable with saying "Yes" to your daughter's request?

- **Expand the "Yes":**
  - **Provider:**
    - It sounds like Johnny was helpful at Grandma's this weekend- and you finally got a break. What was most helpful to you, your mom, your son?
    - If your mom was open to it, how beneficial do you think it would be to schedule regular visits? (Scale: 1 not helpful to 10 very helpful)
      - Reciprocity: What could you do for your mom to show your appreciation?

The "Nuts & Bolts" of Parenting Effectively (Mitterling)

A. Clear Expectations for Behavior (Written Behavior Contract)

1. Clarifies expectations for everyone; reduces confusion.
2. Reduces conflict in the moment, which in turn can zap caregiver energy and persistence.
3. Establishes contingencies for behavior in advance, which reduces need for caregiver to make quick decisions.
4. Promotes stability.
5. Necessary for appropriate development.
6. Messages to child from parent are reliable & consistent.

B. Consistency—predictability is key.

1. It helps them to develop stability.
2. Consistent (100%) follow-through = decreased resistance on the child's part with time and persistence.

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C. Close Monitoring

1. Consistency and follow-through can't happen unless the caregiver is monitoring closely and is aware of behaviors.
2. Unmonitored time is risky; caregiver(s) should be aware of the location, activities, peers, and behaviors of the child(ren) in all settings (e.g., school, peers' homes, etc.) and take measures to ensure adequate supervision.
3. Parents also need to "catch" appropriate behavior and reinforce it.

D. Ability to Avoid or Disengage from Power Struggles

1. Arguments and conflicts zap parents of energy, hope, confidence, and ability to remain firm.
2. Child(ren) "win" and gain control as soon as a parent engages in an argument with them.
3. The child's goal of engaging a parent in a power struggle is usually to distract the focus and wear down the parent to get the parent to give in (which is often very effective).
4. Parents choosing their battles is important because it limits their vulnerability to being pulled into a power struggle and helps parents to prioritize.
5. Non-emotional limit-setting is vital to conflict avoidance; also the ability to "walk away" when necessary.

E. Adequate Caregiver Support

1. Parents need breaks. Parenting is a tough job which requires abundant energy, persistence, patience, and hope. A burned-out parent with no support is likely to be less effective.
2. Parents need instrumental, appraisal, and informational support.
3. Single parents, in particular, are trying to meet the many needs of their families and are often overwhelmed and over-stretched.

F. Caregiver Collaboration

1. Team parenting is essential to effective parenting. When caregivers are making decisions together, problem-solving together, and communicating regularly, fewer opportunities exist for splitting by the youth.
2. It is important for one parent's decision not to be undermined by another. This circumstance is frustrating and may lead to a parent feeling, "What's the use?"
3. Consistency across caregivers (and households) is paramount. Without it, the youth will "slip through the cracks" and be able to avoid consequences.

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My Exit-and-Wait Strategy Plan (Mitterling)

1. Unacceptable Behaviors to me are: (What pushes me over the edge?)

2. My Exit and Wait Statement is:

Example: ***What you are saying and/or doing is disrespectful to me. I am going to leave right now and talk to you later when we are both calm.***

3. My cooling off spot is:

My cooling off activity is:

I know I can return when:

4. Consequences or Reward:

- What is my planned consequence if my teen follows me to my cooling off spot?
- What is my planned consequence if my teen continues the unacceptable behavior after I exit from the conflict?
- What is my planned reward if my teen shows restraint and does not follow me?
- What is my planned reward if my teen stops the misbehavior after one warning?
- What is my planned reward if I allow my teen to exit and wait?

5. My Backup Supporters are:

I will call them when:

6. My plan to get back with my teen and problem solve is:

Natural and Logical Consequences: See PDFs in Tool Kit folder

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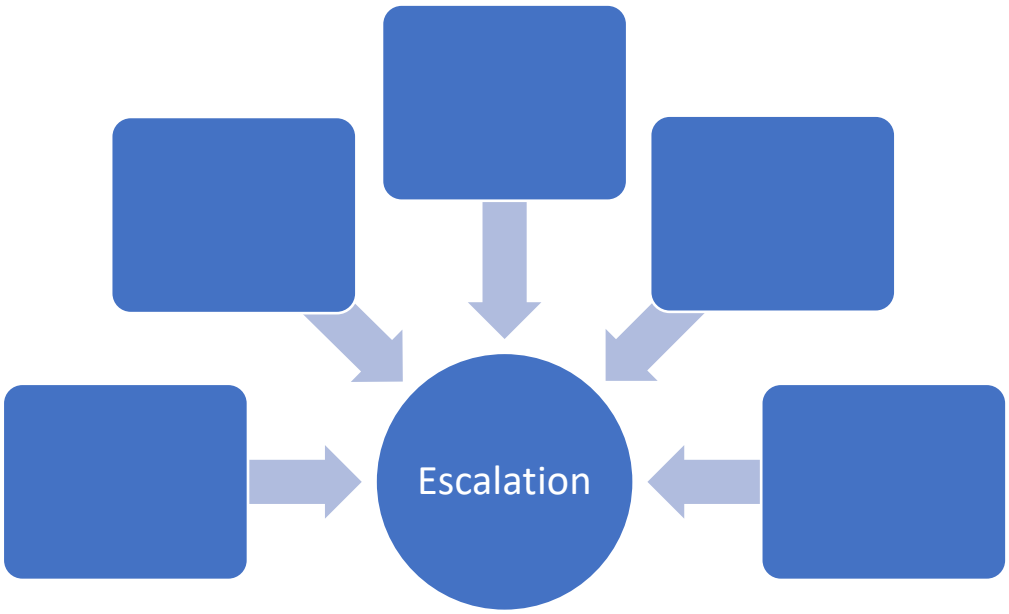
MRSS Tool Kit

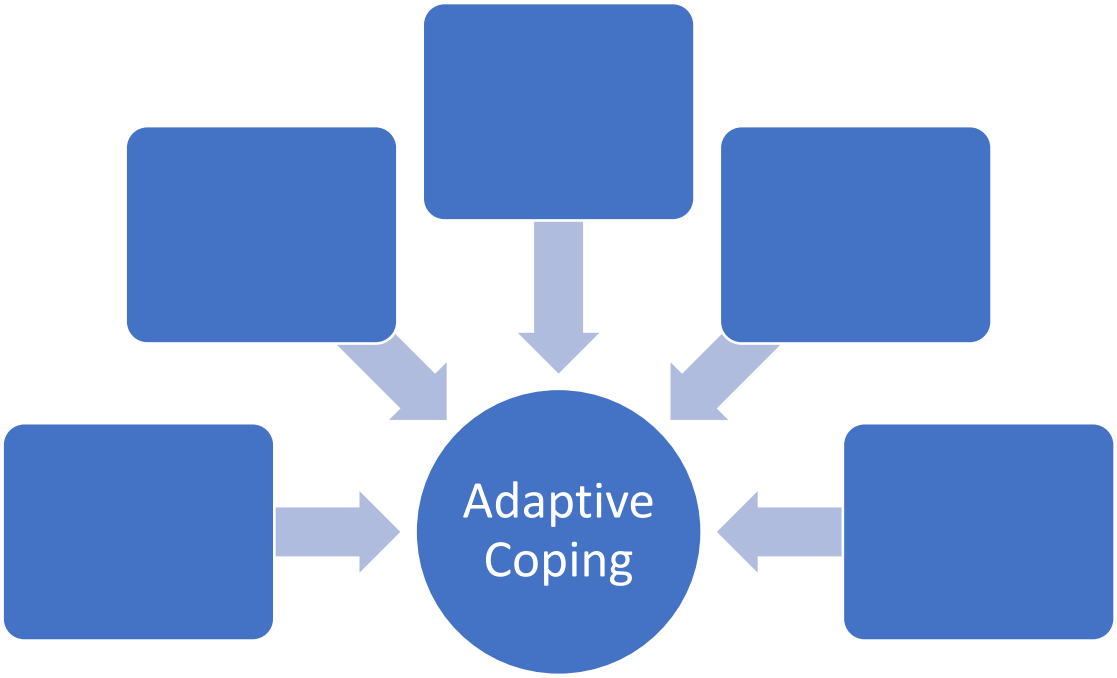
Interactional Responses That Lead to Escalation Behaviors (Shepler)

Instructions: Explore with youth and family members comments, demands, stressors, etc. that lead to youth distress and/or escalation.



Interactional Responses That Lead to Adaptive Coping Responses

Instructions: Explore with youth and family member positive interactions that led to adaptive youth coping such as, supports/accommodations, validation, focus on understanding the youth's behavior, etc.



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MRSS Tool Kit

MRSS Support Network Tools

The Social Network Map (Tracy, E.M. & Whittaker, J.K. (1990). The Social Network Map: Assessing social support in clinical social work practice. Families in Society, 71(8), 461-470.)

The Social Network Map is best utilized during the stabilization phase of MRSS. *The social network map collects information on the total size and composition of the network, the extent to which network members provide various types of support, and the nature of relationships within the network as perceived by the person (Tracey & Whittaker, 1990).*

Social Network Composition: (Size and Composition)

1. Household
2. Family/relatives
3. Friends
4. School
5. Clubs, organizations, church
6. Neighbors
7. Agencies/formal service providers

Social Network Functioning

Name	Type of Support	Availability	Critical	Closeness	Direction of help	How often	Stability

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The Social Network Map (Con.) (Tracy, E.M. & Whittaker, J.K. (1990).

Social Network Functioning:

1. **Network Size:** total number of people identified in the network; **Domain Size:** total number of people in each domain
2. **Type of Support:** a) Emotional, b) Instrumental/practical, c) Informational, d) Companionship/social;
3. **Perceived availability of the support:** 1= Hardly ever; 2= Sometimes; 3= Always
4. **Criticalness:** is person critical of you? 1 = Hardly ever; 2= Sometimes; 3= Almost always
5. **Closeness:** 1= not very close; 2= Somewhat close; 3= Very close
6. **Reciprocity/ Directionality:** Does support flow to the network from your consumer? Does support flow from the network to your consumer? 1= Goes both ways; 2= You to them; 3= Them to you
7. **Stability:** Length of relationships: 1 = less than 1 year; 2= 1 to 5 years; 3= more than 5 years
8. **Frequency**: frequency of contact: 0 = Does not see; 1 = A few times a year; 2 = Monthly; 3= Weekly; 4= Daily

Capacity to Handle Multiple Stressors (Tennis Ball Exercise: Garbarino, 1999; Katz)

- **Goal of exercise:**
  - Demonstrate limits of a person's ability to handle multiple stressors at any given time.
  - Demonstrates how other's support can help us better cope and handle multiple stressors.

- Take a number of tennis balls and write a risk factor on each ball. Such factors include divorce, drug addiction, poverty, loss of a loved one, rejection, learning difficulty, mental illness, alcohol problems, poor self-esteem, racism, etc. Have the kids practice juggling, starting with one or two balls, and then adding more. The point of the exercise is to demonstrate how difficult it is for young people to deal with multiple issues.

- Next, have a friend come alongside the young person, so that each one of them are juggling only two balls. This demonstrates the importance of having a good friend or family member who will share the journey and help the young person deal with his or her problems.

- "Give me one tennis ball, and I can toss it up and down with ease. Give me two, and I can still manage easily. Add a third, and it takes special skill to juggle them. Make it four and I will drop them all." (from James Garbarino in *Lost Boys*)

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Relational Support and Attachment

ATTACHMENT INTERVENTIONS (**B. Beale**, adapted from Blaustein, M.E. & Kinniburgh, K.M. (2010) *Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self-Regulation, and Competency*. New York: Guilford)

One of the most basic human needs is connection to others. The earliest relationship, built between the child and his/her caregiver becomes a model for all other relationships in life. This relationship should provide a safe environment for healthy development where the child learns to cope with and express emotions. The following interventions can help stabilize the caregiver/child relationship with healthy attachment strategies.

- **Caregiver Affect Management** - Teach and rehearse self-awareness techniques with caretakers. It is virtually impossible to be anxious and uptight while intentionally calming and relaxing. Actually practice these techniques with the caregiver. This will provide good modeling for them, ensure that they can do the skill when you aren't around, and as an added bonus, improve your own self-care.
  - **Deep Breathing** – Teach diaphragmatic, or belly breathing, techniques. Have the caregiver lie down or recline, place their hands on their belly, and take long, slow breaths. They should see and feel their hands rise as the air fills their torso. It doesn't take long, 5-10 breaths are usually sufficient to calm yourself. Once they have this skill, they can do it anytime they get anxious, upset or frustrated. Plus they can do it anywhere, anytime; they no longer have to lie down to do it. This is a great skill for the caregiver to then share with the child.
  - **Muscle Relaxation** – Teach either guided or self-directed progressive muscle relaxation. Again, have the caregiver find a relaxed position and start with 2-4 deep breaths. You can find a variety of progressive muscle relaxation scripts online. You can read it to the caregiver as you teach them this skill and follow up by making an audio tape for them to listen to when you are not around.
  - **Breaks** – Sometimes caregivers need their own "time out", especially when there are intense emotions and/or conflict. Encourage them to take 5-10 minutes to calm down and check in with themselves. It can help them to be more focused, effective, and supportive. Help caregivers understand safe versus unsafe situations, for example taking a break in your home while your child is in his or her room is usually safe, but taking a break and leaving your child in a public area is not. Also, recognizing unsafe situations for the child and modeling how to separate from those situations is helpful. Help caregivers communicate this to their child (e.g., "I'm upset and need a few minutes to calm down. I'm going to my room, but I'll be back in 5 minutes and we'll talk about this.").

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- **Attunement** – Attunement is the capacity of caregivers to accurately read children's cues and respond appropriately. Attunement is an ongoing process that occurs in day to day interactions, not just during intensive experiences. Teach caregivers to respond to children's cues across situations. Encourage and model reflective listening skills; actively hear, validate, and communicate support.
  - **Feeling Charades** – Caregiver (or provider) acts out a feeling state; child must guess the emotion. Then switch roles. There are infinite variations of this game: act out what the other person looks like during a specific feeling and have them guess the feeling; pick a feeling together, then act out a situation that might elicit that feeling and have them guess the situation or trigger; act like another person in the family in an emotional state and guess who it is. In all variations, take turns being the actor and the guesser.
  - **Child-directed Play** – Encourage the caregiver to offer 15 minutes of individual time to the child each day. Have the caregiver invite the child to play, "It's our time to play together. You can play with any of these things and I'll play with you. You have to play gently and stay in this area." The caregiver must avoid commands, questions and critical statements; simply follow the child's lead, imitate their play, offer praise of appropriate behavior, and be enthusiastic.
- **Consistent Caregiver Response** – An important part of building a safe environment is building predictability in caregiver response, which should be safe, supportive, and appropriate at all times.
  - **Behavior Skills Training** – there are many good programs to teach these skills to caregivers: Incredible Years, Parent-Child Interaction Therapy, etc. They all follow a simple format, first improve your relationship with your child, and then consistently apply behavior management techniques. Key concepts include consistency, praise and reinforcement, appropriate ignoring, limit setting, use of time-out.
  - **Homework** – Don't just talk about skills and hope they get adopted. Teach a skill and have caregivers use skills with you present. Then assign one skill for them to focus on, practice, and track it each week.
- **Routines and rituals** – Consistent routines and predictability are helpful in decreasing insecurity and feelings of vulnerability. Increased sense of safety allows children to shift their energy from survival to healthy development.
  - **ID Trouble Spots** – Review these common routine targets: morning transition, mealtimes, playtime, chores, homework, and bedtime. Make sure you get everyone's opinion; different family members may struggle at different times of the day. Help the caregiver prioritize and target only one area to work on at a time.
  - **Create Routines** – Start by building routines into your therapy or intervention sessions. This is an ideal place to model safe, supportive routines for your families. Always begin with a check-in, include a structured activity and some free time, use a check-out, and always finish with joint clean up. Work with the caregiver to develop routines around identified trouble spots. You may need to develop a plan and then rehearse how to deal with distractions that derail new routines, as well as when it's ok to vary from established routines.

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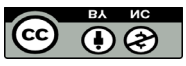
Accommodations that Increase Functional Success

When situations or circumstances exceed a person's abilities or capacities to cope or compensate, strategic accommodations and/or adaptations may be necessary for the youth to be successful. The goal is to create success experiences through supportive functional environments.

- **Realistic and achievable goals.** Based on the youth's ability, development, and interests create a baseline for what they can achieve on a specific behavioral task or milestone.
  - Mutually create goals with the youth and family and get their feedback about "doability" for each goal created. Each goal should be small enough to be achievable.
  - Expand on the goal once it is achieved. "Make a goal so that I can reach it. Once I reach it then you can raise it." P. Mattson

- **Sanctuary Intervention:** Youth and families need safe and calming people and places for refuge, respite, recovery, and rejuvenation. Both youth and parents need their own protected space where they can feel and be calm. Youth need multiple safe options for sanctuary in different contexts, including home, school, and the community. Designated and predictable breaks are important for coping with the ongoing challenges of mental illness.
  1. Agree upon a pre-identified safe place, person, activity, or thing that the **youth identifies** and can access when they feel themselves escalating or about to lose control.
     a. quiet space or room;
     b. alternative activity (listen to music);
     c. person (guidance counselor); and/or
     d. thing (stress ball).
  2. Goal: self-de-escalation; return to functional activity when calm (e.g. classroom);
  3. Pro-active and planned;
  4. Non-negotiable:
     a. Cannot be taken away as a consequence or for not making level;
     b. Cannot be taken away because adult believes youth is being manipulative

- **Designated and Predictable Space:** One pro-active strategy is to plan for designated and predictable breaks on a regular basis. This can be in the form of respite (e.g., having the youth spend a weekend with a trusted family member), planned activities, or time with a mentor.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Facilitation Skills for Child and Family Team Planning

Validation Prompts

- The youth and family are validated for their expertise, courage, efforts, and persistence
- Facilitate communication that encourages family members to validate each other's pain and perspective
- "It sounds like things are so hard for you and your family right now."
- What do you want your mom or daughter to know so that they can understand how hard it is for you right now?
- Can you share some of the biggest challenges for you and your family most recently? In raising your son/daughter?

Simple Reflections

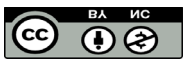
- What I heard you saying is . . .
- Let me see if I'm understanding you correctly……
- Reflect the meaning rather than simply parroting the words
- Verify accuracy of your understanding: Is that correct?

Reframing/Translational listening/Identification of Underlying Needs

- Assist family members in considering alternate meanings or motivation behind a negatively perceived behavior or event
- Assist the family members in developing effective language around unmet needs - Translational listening
- Listen for the underlying need/positive intent behind the interaction or behavior
- Restate/translate the original statement into a needs statement or a positive intent statement
- Check in with family/team about the accuracy of the needs statements
- Make sure it's plausible and believable

Establishing a Shared Understanding

- Team members may see the same facts in different ways
- Facts and perceptions are different
- Facts can be agreed to, i.e. we all agree this happened
- Perceptions are important to know because they guide the response to the facts
- Perceptions may or may not change, but when they are public, it's easier to work with each other

 2021, CIP, CWRU and OhioMHAS

Facilitation Skills for Child and Family Team Planning (Con.)

Strategies for Establishing a Shared Understanding

- Check to see if people heard the same thing
- Paraphrase/summarize what you understood the person to mean
- Ask for what you missed
- Check for meaning and perception
- Explore what people think the information implies
- Seek additional input and clarification
- Round out the picture of fact, perception or both
- Remember, what you ask about influences what you hear about
- Summarize from a new place
- Goal is consensus vs. agreement

Broadening the Possibilities

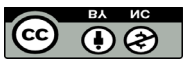
- Creates conditions for hope: Having looked at many options it's possible to experience a sense of choice where there was none before
- Encourage exchange of ideas
- Draw out all team members
- Create the expectation that we will consider more than one option: "The more choices, the more likely we are to make an effective decision. Let's come up with a couple more choices"
- Use the "What if this were not true" approach
- What if we didn't have this service?
- What if this is not the only reason . . . ?
- What's the consequence if we don't . . . ?
- Use what you know to push people out of their "habit" roles: "I know you . . . Would you . . . ?

Exploring the Barriers

- What's getting in the way?
- What are you anticipating that makes you reluctant to move forward with this plan?
- What challenges do you anticipate with this plan?

Exploring Solutions

- Past:
    - What worked in the past?
    - Think about the last time your son/daughter/family was doing better. What was different then? Of the things that were going "right" which could be done now?
- Future:
    - "Tell me what's different for you when you're not fighting with your parents?"
    - What needs to change for things to get better?
    - If you had a magic wand and could grant one thing that would solve the problem/meet your need, what would you wish for?

 2021, CIP, CWRU and OhioMHAS

Facilitation Skills for Child and Family Team Planning (Con.)

Techniques for Connecting to the Big Picture

Statements and summarizations by the facilitator

- It looks to me like we . . .

Questions about impact

- Does this . . . ?
- Have we . . . ?

Seeking the perceptions of others by comparing the current situation to prior or foreseen reality

- What do you think . . . ?
- Has anyone had experience with . . .?

Partnering Request

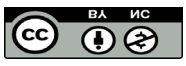
- As we work together on this, what supports/help are needed from us to make this plan successful?
- If we are successful together, what supports will need to be in place for this to work for you?

Facilitative Techniques: Supports and Resources Inquiry

- Is there something the team can do now (mentors, activities, respite) while a more comprehensive plan is developed?
- What's needed to make this work?
- Who's there for your family? Who provides support?
    - Family, faith, friends, neighbors, etc.
    - For what purpose? (Emotional, informational, resource, practical support)
    - Under what circumstances? In what time frame?
- Who could give you a break on regular basis? Now and then?
- Who was available in the past but isn't available now?
- Explore the "no" and define the "yes." Is there another way that your Mother can be supportive to you?

Basic Therapeutic Facilitation Skills

- Ability to encourage participation
    - Ensure all family members have the opportunity to express opinions and share in the decision-making process
- Ability to build consensus
    - Maintain a strengths-based, solution focus
- Ability to intervene in a way that adds to the family's creativity
- Ability to validate and support youth and family voice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Facilitation Skills for Child and Family Team Planning (Con.)

Strategies for In-Meeting Family Engagement

- Check-in with the family throughout the meeting:
  - Validates and elevates family opinion
  - Promotes shared-decision making
  - Keeps family fully involved in their meeting
- Examples:
  - I want to make sure I'm hearing you correctly
  - Is that OK with you Mrs. Smith?
  - We're asking Mrs. Smith to do a lot – I just want to check in with you to make sure it's not overwhelming. Please tell us if it's too much.
- Restate the option on the table followed by checking in with the family for their thoughts, concerns, agreement
- If family is not in agreement, request clarification about what part doesn't work for them, ask what might work better for them, brainstorm with the team as needed

Pathways to Shared Action

- Establish more than one option
- Review options against the goal or target
  - Explore for connection between the option and what it is meant to do
- Check for additional opportunities
  - Ask for other ways and other people to join in an action

Listening Skills:

- Reframing - ability to restate comments in a positive perspective/redirect negative conversations
- Paraphrasing - ability to summarize, review key comments
- Clarifying as needed or requested

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MRSS Tool Kit

MRSS Supervision Tools

Scaling Worksheet for Supervision (Hillary Gruss, LISW-S)

Name of the tool/strategy	**MRSS Case Scaling Worksheet for Supervision**
Purpose/rationale of the tool/strategy	To provide supervisor with a quick "snap shot" of each MRSS case to maximize individual supervision time with MRSS clinicians.
For whom: population/ symptom of focus	MRSS clinician
When: phases of MRSS; timing	Ongoing; during weekly supervision.
What: contexts: circumstances	This MRSS Case Scaling Worksheet should be turned into MRSS supervisor before each individual supervision in order to share a "snap shot" assessment of each case on clinician's MRSS caseload. Worksheet can then be used by supervisor to structure supervision time so that themes can be reviewed, high risk/low engagement families discussed, and barriers problem solved in a collaborative manner. Also, allows supervisor to be aware of case progression (or lack of) through the Family Need Hierarchy so that transition plans (referral to lower level of care, for example) or additional resources/supports can be discussed in a timely manner. • Can be a provider/staff tool to be used in the field e.g. emotional regulation activity or strategy for a particular population of youth • Or Supervisor/administrative tools--- safety plan tracking tool etc. • Tool must be applied to use in the home and community
Description of the Steps	Refer to attached worksheet and scaling breakdown with suggested prompts/work-flow.
Vignette/example of tool in use; case note describing use	n/a
Desired outcome	To decrease risk related to supervising MRSS cases, while maximizing individual supervision time; to increase ongoing knowledge/conceptualization about each case specifically related to risk, family engagement, MRSS Family Need Hierarchy, and top clinical concerns; to allow supervisor to identify trends or themes across entire MRSS team or individual clinicians to inform development, programmatic training needs, and so forth.
Citations; references; related readings/resources/websites	Cunningham, P.B., & Henggeler, S.W. (1999). Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. Family Process. 38, 265-286.

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MRSS Tool Kit

MRSS Case Scaling Worksheet (for supervision)

Client initials:

Engagement/Level of Buy-In: **0 1 2 3 4 5**

Risk Level: **0 1 2 3 4 5**

Family need hierarchy: **(I) basic needs/safety (II) skills (III) ecosystemic fx (IV) resiliency**

Top Concern:

Barriers related to top concern: **Y N**

Client initials:

Engagement/Level of Buy-In: **0 1 2 3 4 5**

Risk Level: **0 1 2 3 4 5**

Family need hierarchy: **(I) basic needs/safety (II) skills (III) ecosystemic fx (IV) resiliency**

Top Concern:

Barriers related to top concern: **Y N**

Client initials:

Engagement/Level of Buy-In: **0 1 2 3 4 5**

Risk Level: **0 1 2 3 4 5**

Family need hierarchy: **(I) basic needs/safety (II) skills (III) ecosystemic fx (IV) resiliency**

Top Concern:

Barriers related to top concern: **Y N**

From an MRSS perspective, treatment cannot progress unless key family members are engaged and actively participating in the treatment process- helping to define problems, setting goals, and implementing interventions to meet those goals. The clinician may have developed a "brilliant" set of intervention strategies, but such strategies will have little value in the absence of a strong therapeutic alliance. (Cunningham & Henggeler, 1999)

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Engagement/Level of Buy-In:

0- Family not involved in treatment, no contact, not keeping appts, not returning calls, family may be avoiding clinician.

1- Little or no contact, but no clear evidence of avoidance.

2- Family schedules appts but may not keep them, very inconsistent with communication and follow through of tasks due to not having shared goals.

3- Family communicating with clinician, schedules and keeps most appts, will talk about intervention implementation but follow through may be hit/miss, family and clinician are on the same page regarding treatment goals.

4- Family participates in sessions, openly communicates in session and outside of session, keeps appts, and completes tasks with some clinician oversight/guidance.

5- Family is active in treatment, keeps appts, shares ideas, implements interventions consistently, communicates openly with clinician, completes between-session-tasks, and independently works towards treatment goals.

Risk Level:

0- No risk for out of home placement, team and family engaged and working towards shared goals, stakeholders in full support of MRSS, no safety risks (SI, HI, SIB, aggression, etc), family consistently implementing safety plan.

1- MRSS being delivered as expected with anticipated challenges/triggers/barriers related to client safety; however, safety plan implemented in the home/school/community with no access to lethal means.

2- Recent situation or crisis with appropriate response from family and team, safety plan adjusted and in place, evidence of plans being followed.

3- Recent situation or crisis in which interventions and engagement are disrupted, family begins to show signs of feeling tired and hopeless, safety plan in place but followed inconsistently.

4- Recent crisis in which hospitalization or higher level of care was needed or discussed, stakeholders questioning sustainability of MRSS interventions, family feeling hopeless, safety plan ineffective or not being implemented by family.

5- High risk! Stakeholders are considering out of home placement, family and/or client in an "active" crisis; could be "stuck" in *Basic Needs and Safety* on the Family Needs Hierarchy due to overall instability.

Family Need Hierarchy: Circle where you are on the Family Need Hierarchy with each particular case.

Top Concern: **What is the top clinical concern for the youth and/or family, at this time?** For example: self-injury, engagement concerns, behavioral issues such as leaving without permission, school attendance or performance concerns, upcoming court hearing, family conflict, and so forth.

Barriers related to top concern:

Y **N** **Are there barriers that are preventing or making it hard to address or stabilize the top clinical concern?** Circle Yes or No, and reflect on a few of those here!

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MRSS Tool Kit

MRSS Real-Time Tracking Board

	Family 1	Family 2	Family 3
Staffing	RS/WT	BB/HW	
Admit date: Week # Discharge:	6-6- 2020; Week One	5-5- 2020 Week 4	6 -10- 2020 to 6-12-2020 Initial stabilization only
Reason for call			
Stabilization phase goals			
Safety plan completed			June 10, 2020
FTM			
Peer support			
Linkage (service, support)			

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Supervisor Safety Planning Checklist		
Action Step		**Follow-Up Needed**
Did your staff assess for safety issues?	☐ Yes ☐ No	
• Safety walk through of the home	☐ Yes ☐ No	
• Safety and Risk Screen	☐ Yes ☐ No	
Did staff consult with you about salient concerns?	☐ Yes ☐ No	
Did staff take reasonable actions to plan for safety?	☐ Yes ☐ No	
• IHBT Safety Plan completed with youth and family	☐ Yes ☐ No	
Did staff distribute safety plan to team?	☐ Yes ☐ No	
Is the safety plan in the client's chart?	☐ Yes ☐ No	
Did staff incorporate safety goals and objectives into treatment plan?	☐ Yes ☐ No	
Did staff actively monitor and follow-up with family?	☐ Yes ☐ No	
Did you monitor plan weekly during supervision to assess status and make changes as needed?	☐ Yes ☐ No	
Did staff update the safety plan as needed?	☐ Yes ☐ No	
Did staff document all the above?	☐ Yes ☐ No	
Did you document supervisory recommendations and directives?	☐ Yes ☐ No	

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Supervisory Management of Ethical Issues Checklist

☐ Does your program have policies and procedures that address CBI ethical issues in the field (e.g., sessions with minor in the home alone, etc.)?

- ☐ Are they updated as needed to address current issues and trends?

☐ Do you conduct regular staff trainings on ethical and legal issues that occur in CBI?

☐ Do you pro-actively monitor ethical & legal issues?

☐ Are you available, approachable, and supportive to your staff for consultation?

☐ Steps in managing an ethical dilemma in supervision:

- ☐ Clarify information
- ☐ Process worker's decision(s) in the field
- ☐ Validate/challenge decision(s)
- ☐ Develop follow-up action steps (including supervisory)
  - ☐ Additional consultation as needed (Clinical director, etc.)
- ☐ Check out worker's comfort level with the action steps
- ☐ Follow up with worker on action steps taken
- ☐ Review staff documentation
- ☐ Supervisory documentation of the steps taken

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MRSS Tool Kit

Appendix B: Special Education (Marjorie Cook)

Challenges for Parents

- Not trained in education or mental health
- Don't know rights
- Love their children (Mama Bear)
- Deal with child all the time (no respite)
- Own personal challenges with physical or mental health
- Lack of support from family and friends
- Fear and frustration with child, systems, family, providers
- Unrealistic expectations
- Stigma

Challenges for Students

- Don't understand/don't want to understand mental health
- Recognizing or afraid to admit they are different
- Inconsistent energy for school/often do not feel like themselves
- Reputation from past behavior/discipline issues
- Their unrealistic expectations of themselves and others
- Unrealistic expectations of them
- Unclear expectations
- Processing issues
- No one understands!
- Stigma
- Lack of social skills/no friends
- Want desperately to fit in

Free and Appropriate Public Education – FAPE

- ALL children are guaranteed a *Free and Appropriate Public Education* – FAPE
- Schools exist to serve each individual as well as the community in a structured environment.
- ALL children are expected to make progress, including children with disabilities.

Three laws give this guarantee

1. Right to Education Act.
2. Individuals with Disabilities Education Act (IDEA).
3. Section 504 of the Rehabilitation Act of 1973.

Supporting Documents* for Special Education in Ohio

1. Operating Standards for Ohio's Schools
2. Operating Standards for Ohio Schools Serving Children with Disabilities
3. Academic Content Standards
4. A Guide to Parent Rights in Special Education

*Available on the Ohio Department of Education website: www.ode.state.oh.us or www.edresourcesohio.org

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Free and Appropriate Public Education – FAPE (Con.)

- In order to receive federal assistance, states must demonstrate that they have policies and procedures to fulfill the requirements.
- There is a "gap" between law and implementation.
- The federal language is vague and allows significant under-identification of children with special needs.
- Children with special needs often behave in ways that disrupt the school and make them unpopular with peers and staff. Schools may wish them to study elsewhere for safety reasons.
- Schools assume that mental health treatment will resolve the problem.
- Schools are concerned about labeling students.

Children whose disability impacts learning, must receive access, when needed, to special education or related services.

- Special education programs and services must be designed to meet a child's educational needs through:
  a. **Intervention Assistance Teams – IAT**
  b. **Response to Intervention – RTI**
  c. **504 Plan**
  d. **Individualized Education Plan – IEP**

Who is a child with a disability?

Any person under the age of 22 with one or more of the following disabilities that adversely affects that child's educational performance:

Qualifying Disabilities for Special Education	
Autism	*Orthopedic Impairment*
Deaf – Blindness	*Other Health Impairment*
Deafness	*Specific Learning Disability*
Emotional Disturbance	*Speech/Language Impairment*
Hearing Impairment	*Traumatic Brain Injury (TBI)*
Intellectual Disability	*Visual Impairment*
Multiple Disabilities	

The Process to Special Education Services

Step 1 – A concern from the parent, the teacher, the counselor or even the child.

Step 2 – A Response to Intervention Team – RTI or an Intervention Assistance Team – IAT is convened.

Step 3 – RTI or IAT is made up of parent, teacher, special education teacher, administrator and others. They are to collect data, establish baselines and goals and develop interventions.

Step 4 – If interventions are successful they continue.

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The Process to Special Education Services (Con.)

Step 5 – If not they may request an **Evaluation Team Report or ETR**. The parent may initiate the request prior to the team -not guaranteed that the child will receive testing.

If an ETR is to be done the school psychologist will oversee the process. There are many sources to learn about the in-depth process of the MFE (multifactored evaluation)/ETR. The evaluation should address all areas related to the disability, along with health, vision, hearing, general intelligence, achievement, motor ability and aptitudes, collected from multiple perspectives including, parents, student, teachers, and others in educational placement.

The school must have signed parental consent. If the parent will not sign the consent they can take to due process. The school must give a parent prior written notice within 30 days from the date of the referral.

The school should complete the ETR within 60 days of referral but…if the school can prove it is making sufficient progress that date can be extended. You can ask for an extension as well

The school may want documentation from mental health providers. A letter with a diagnosis is all that is required, although more information may be shared with the parent's permission. ***Be careful – this information follows a child through the school!***

Individualized Education Plan (IEP)

If the team determines the student is eligible under one of the categories an **Individualized Education Plan (IEP)** is developed.

- The IEP must have goals and objectives addressing the issues raised in the ETR (behavior, speech, occupational therapy, counseling, etc.)
- The parent is an equal member of the team.
- Only a draft should be provided to the parent to sign not a final document.
- At age 14, address transition issues for after graduation – how to prepare students for life after high school. Often need help that other students do not – could be counting money, scheduling appointments, telling time, filling out applications, attending technical/trade schools or colleges, finding way around campus or new city, and the list goes on.
- The needs/goals determine services. Special Education is a service not a place – It is specially designed instruction!
- Services should be in the least restrictive environment. Mainstreaming means a child is in a regular classroom with no special education assistance. Inclusion means the services/supports follow the child.
- The IEP meeting is convened at a time convenient for parent as well as school. Parents should always receive a written invitation that allows them to accept the proposed time or to request a different day or time.

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Individualized Education Plan (Con.)

- Parents may bring someone with them. Parents do not need to get the school's permission. The school is required to provide a written invitation listing those who are invited prior to the meeting.
- Be sure the child's strengths are addressed – this is how we build success!

*The ETR must be reevaluated no fewer than 1 time every 3 years (not more than 1 time a year) unless you or the school requests it.

504 Plans

"504"s are disability accommodation programs. It is section 504 of the rehabilitation Act of 1973.

1. A 504 is not an education program.
2. A child who is not eligible for an IEP may have a 504 plan.
3. Examples: child leaving the room several times a day because of anxiety, a child entering school early because he cannot ride a bus because of sensory issues, a child being allowed to take tests in the library to reduce stimulation.
4. 504s are not specially designed instruction/special education.
5. There are no legal protections for behavior.
6. 504s do not need to be evaluated yearly.
7. If this is what your child needs it may be discovered during the RTI / IAT.

Disagreements and Disputes

If there are major disagreements over conducting testing

- Start with a Case Conference, go to Administrative Review, then to Mediation and lastly to Due Process.
- All communication must be in writing. If it is not written, it did not happen. Parents MUST respond in writing.
- All dispute resolution venues require one to state the issue, state how it violates the law and state what one wants done.
- If one cannot state the above clearly, the dispute will not be handled or resolved.

If the ETR Team determines the child is eligible under one of the categories, an IEP is written

- The IEP must have goals and objectives addressing the issues raised in the ETR (behavior, speech, occupational therapy, counseling, etc.)
- The parent is an equal member of the team. They should be as informed as other team members.

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IEP Plan (Con.)

- Only a draft should be provided to the parent -not a final document to sign. Parent input is a requirement for the IEP.
- At age 14 address transition issues – goals to help student transition to post-secondary education or to be career ready.
- The needs/goals determine services not the category. All needs should be addressed. Special Education is a service not a place – It is specially designed instruction!
- Services should be in the least restrictive environment. Mainstreaming means a child is in a regular classroom with no special education assistance. Inclusion means the services/supports follow the child.
- The IEP is developed at a time convenient for parent as well as school.
- The ETR must be reevaluated no fewer than 1 time every 3 years and not more than 1 time a year unless you or the school requests it.
- Parents may bring someone with them. They do not need to get permission from the school. The school is required to provide a written invitation listing those who are invited prior to the meeting.
- Be sure the child's strengths are addressed – this is how we build success!
- Transportation can be provided on the IEP if needed (with or without supports). Transportation can be a contract with parents to provide for a fee, a special vehicle, a special bus or the regular bus with supports.

School Discipline/Suspensions

- A child on an IEP may be suspended for up to 10 days total per year – like any other child.
- The school cannot suspend if the behavior is the direct result of the disability or the direct result of the school districts failure to implement the IEP after 10 days. This would constitute a change of placement.
- After 10 days the school is required to conduct a functional behavior assessment.
- If there is a disagreement it goes to a Manifestation Determination Hearing. The child must prove that the behavior is the direct manifestation of the symptoms of the disability.
- If a manifestation of the disability, the school will owe the child compensatory time. The school is not allowed to change placement without parental consent. Some schools move children to alternative schools and have parents sign the change of placement on the IEP – parents are not informed of their child's rights!

School Discipline/Expulsions

- A child on an IEP may be moved to an alternative educational placement for up to 45 days for the following:
- Carries a weapon to or possesses a weapon at school, on school premises or to or at a school function under the jurisdiction of a school district or the Ohio Dept. of Ed.; Knowingly possesses or uses illegal drugs, or sells or tries to buy or sell a controlled substance while at school, on school premises or at a school function under the authority of a school district or the Ohio Dept. of Ed.; or Has done SERIOUS bodily harm to another person while at school, on school premises or at a school function under the authority of a school district or the Ohio Dept. of Ed.

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Least Restrictive Environment

The school must have a continuum of placement options available to students ranging from home instruction, instruction in hospitals to regular education and everything in between. Children should be educated with their peers/other non-disabled students whenever possible.

- Least restrictive environment is the goal. Services and supports can take place anywhere.
- Placement must depend on the nature of the disability and the ability of the child to function in a regular classroom.
- Sometime least restrictive for our kids may be a small, quiet classroom with few students or a separate school
- A child can be integrated for certain classes or events.
- Supports and accommodations follow a child if necessary.
- Children are allowed to attend extracurricular activities – with supports if necessary (aide, behavior plan, safety plan, all accommodations, etc.).

Special Education Placements

Least Restrictive Environment is decided by the IEP team AFTER goals and services are determined.

- School Programs can be a special classroom, special school, special services, aids and assistance in regular classrooms or both.
- Areas may have alternative structured learning environments for students with academic or behavioral difficulties in the regular classroom.
- Reasons can include; chronic disciplinary actions, truancies and suspensions/expulsions.
- These environments may be housed in a regular school, an alternative school with its own building, or it may be a hospital or residential setting
- There may be services such as therapeutic case management, crisis management, counseling or other therapeutic services, transition services, vocational assistance, transportation.

Information, Support & Guidance

1. Ohio Legal Rights Services – www.olrs.org
2. Wrights Law – www.wrightslaw.com
3. Ohio Coalition for the Education of Children with Disabilities – **www.ocecd.org**
4. The Ohio Federation for Children's Mental Health – **www.OhioFederation.org**
5. Parent Advocacy Connection - (PAC) is a grassroots organization of trained advocates overseen by NAMI Ohio and funded by the Ohio Departments of Mental Health, Job and Family Services, Drug and Alcohol Services, Education, and Youth Services – **www.namiohio.org**
6. The *No Child Left Behind* Act is no longer in effect – governance has been given back to states.
7. Ohio Department of Education - **www.ode.state.oh.us** or **www.edresourcesohio.org**

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Transitioning to Adulthood

Examples of areas to address with goals on the IEP:

- Educational opportunities may be available until 22 - student becomes an adult at 18.
- Vocational school, colleges, training programs paperwork & interviews
- Become familiar with and enroll in the ADULT community mental health agencies
- Explore social security options
- Self-advocacy
- Awareness of adult legal issues and confidentiality.
- Independent living skills / navigate systems

Examples of Accommodations on IEP or 504

- Photocopied notes to avoid copying from the board
- Graphic Organizers / chart paper
- Provide time management tips/sticky note reminders on desk
- Words of encouragement
- Tracking sheets/planner of expected assignments for the week/day
- Music
- Keep instructions/directions 'chunked'. Provide one step at a time
- Structure unstructured time or help plan activity for recess or break
- Limited verbal interaction from Adults when escalated
- Provide extra time for the processing of information
- Larger size font is sometimes helpful
- Auditory supports to avoid having too much text to read
- Give repetition and clarification regularly
- Frequent breaks – pass for breaks
- Fidgets for hands or feet
- Standing, kneeling, walking around room
- Physical exercise or movement
- Writing to student instead of speaking
- Provide close proximity to the teacher
- Seat away from distractions – not always at front of room
- Visual Reminders - charts, number lines, vocabulary, math facts
- Provide a study carrel or alternate place to work for specific tasks
- Provide scribe or utilize the speech to text software applications
- Plan for sleep needs/snack needs
- Provide a quiet area to 'chill out, relax or de-escalate'
- Provide headphones to remove extraneous noises
- Oral response to demonstrate understanding of concept
- Provide time extensions as necessary – extra day, double time
- Sensory breaks
- Calculator
- Provide on-task/focusing prompts
- Gum / water
- Odd/Even numbered questions only – Percent of each section

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Examples of Accommodations on IEP or 504 (Con.)

- No homework – or homework for set period of time each night (30 min)
- Small group for tests / one on one for tests
- Manipulative for math – other strategies
- Advance notice of changes in routine or fire alarms

Strategies

Strategies refer to skills or techniques used to assist in learning that are individualized to suit learning style and developmental level.

- highlighting
- rehearsal
- color coding
- memory joggers
- visual cues
- number lines
- alphabet strips
- Key ring sight words
- flip chart
- organization/transition cards
- Jello - play dough - window paint – shaving cream – sand tray
- stencils
- ink stamps
- Using liked characters in work – such as Spiderman
- Planned ignoring of low-level behaviors by students and teachers

Modifications for IEP

Modifications are when what is taught/what is expected to be learned is different from what the other children are learning. The curriculum is modified.

- Instructional level taught varies from other children or grade level.
- All students are learning about the solar system – a modified curriculum states that the student only has to learn the names and locations of the planets.
- All students are learning algebra the student is learning how to make change or working on other math skills and concepts.
- Grades tell how well the student is learning what is being taught. They do not tell what grade level is being taught.
- If a child is more than 1 grade level behind, modifications should be discussed – a fifth grader reading at second grade level might need to have second grade spelling words in addition to second grade level reading materials.

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Areas of IEP

- **Future Planning** – what does the team want to see in the future (next year, 5 years, etc.) Include statement from parent and from student.
- **Special Instructional Factors** – checklist for team to respond to
- **Profile** – synopsis of educational placements, services and supports
- **Extended School Year (ESY)** – if a child loses skills and is not able to recover them in the first 4-6 weeks of school, ESY would be appropriate to work on those skills.
- **Post-Secondary Transition** – goals for after graduation and how to meet those goals. May include daily living skills if needed.
- **Goals** – academic, behavioral, speech, OT, etc.
- **Specially Designed Instruction** – how many minutes of service to work on a goal.
- **Assistive Technology** – communication devices, technology for blind or hard of hearing
- **Related Services** – counseling, OT, PT, SLP, etc.
- **Accommodations and Modifications** – know the difference!
- **Behavior Plans/Safety Plans** – needed to address behaviors interfering with access to education.
- **Transportation** – need for special transportation services or supports
- **Non-Academic and Extracurricular Activities** – Students are entitled to any needed supports or services (behavior plan, monitoring, aide services, etc.) they receive in school if determined they are needed for sports, clubs, field trips, etc.
- **General Factors** – Checklist for team to consider
- **Least Restrictive Environment (LRE)** – Where on the continuum of placements a child receives their education.
- **Statewide and Districtwide Assessments** – lists accommodations needed – no read aloud for reading goals.
- **Exemptions** – third grade reading guarantee, graduation requirements, etc.
- **Meeting Participants** – Be sure that only those in attendance are listed and sign. Empower parents to put lines through blank spaces or through spaces of those not in attendance.
- **Signature Page** – Parents sign agreement or disagreement and agree that they have received a copy and their procedural safeguards. Not signing does not show disagreement. It shows that you did not engage. Sign that you agree or sign that you disagree.
- List of paperwork and forms may be included such as Prior Written Notice (PR01) requires schools to send written explanations of any proposed changes in the educational plan – even if agreed on at meeting and also requires the school to send a written notice and explanation if it denies a parent's request. These are great ways to document a request. Parents should always respond in writing if they disagree with what the school is saying happened in a PR01 to document their understanding.

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Extended School Year Services (ESY)

- ESY is specialized instruction or related services that are part of a student's IEP. ESY services are provided through the school district at no cost to parents/caregivers.
- ESY is provided when school is not in session usually over the summer. The services are individualized to each student to help maintain skills and not lose progress (regression) made toward goals. It may be one or two goals or all goals.
- What ESY looks like for the student is a decision made by the IEP team.

The main issues the team addresses are ***regression*** **(losing skills) and** ***recoupment*** **(the time needed to relearn skills).**
The questions the team considers are:

- **Will the student lose critical skills without continued support and teaching?**

- **Will it take a long time for the student to regain those skills—longer than it would take a student without a learning difference?**

Considerations for ESY

- Has the student had difficulty retaining skills over shorter breaks?
- Does the student have known issues with working memory?
- Does the student need continual reinforcement to keep his skills during the regular school year (maintain skills already mastered)?
- Does the student have behavior issues that get in the way of learning? Will behavior be a problem next year without continued support over the summer?
- Is the student making steady progress toward meeting the IEP goals? And will a break in services threaten that progress?
- Is the student just beginning to master a critical skill, such as learning to read, count, write, communicate, control behavior, etc. (prevent or avoid loss of emerging skill)?

It's all about the data: How do you know if the student is having any of these challenges? What if the school says no and you think yes? Students on IEPs get report cards and progress notes – is the student making progress? Did the student regress over the last summer break or over the winter holiday? Make sure you understand the baseline data so that you can measure progress.

- Even though not all students are eligible for ESY, every IEP team should discuss the option annually.
- Teachers should assess for any regression or recoupment issues a student has after other breaks during the year.
- Collect data before summer break and again in the fall to help plan for the following summer.
- Transportation is included to and from ESY services

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ESY Criteria per Ohio Disability Rights

No single criterion should be used when determining ESY. The school must consider all relevant information and individual student circumstances in determining eligibility, such as:

- Regression/recoupment
- Nature and severity of disability
- Educational progress (goal achievement)
- Behavioral considerations
- Age and skill (emerging/breakthrough opportunities)
- Attainment of self-sufficiency. Ohio rules require the IEP team to consider the regression/recoupment standard and also require the team to consider if ESY is necessary to provide **free appropriate public education (FAPE).**

Formal Learning Opportunities

- ESY – Extended School Year
- Home Instruction
- Summer School
- Tutoring
- Social Groups
- Counseling
- Overnight/Day Camp
- Respite
- Gym/exercise routine
- Field trips
- PT, OT, SLP services
- Reading Groups at Library

Additional Information

- Document needed training for Parents and/or Staff
- Special needs for Transportation – behavior plan, safety, other children
- Parents receive copies of: ETR, IEP, Whose IDEA Is It?` - Including the signature pages, Prior Written Notices (PR01) and any other forms included in the document.
- Develop and Document transition services/supports during change of placement/change to LRE
- Student entitled to participate in extra-curricular activities – document supports if needed
- One Regular Education Teacher and one Special Education Teacher/Intervention Specialist is required to be at IEP meetings unless excused in writing by parent
- **ETR Timeline** – 60 days to complete ETR/every 3 years thereafter
- **IEP Timeline** 30 days to develop initial IEP/yearly review
    - Summer and breaks count in the timelines listed above!
- School year and day consistent in length with those of non-disabled students. Don't let the school send student home early unless that it what you want.
- Behavior plan/crisis plan/safety plan should be added to IEP as accommodation/service

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Appendix C: Working with Youth in Foster Care, Homeless Youth, Transition-Age Youth (A. Lariviere)

Youth requiring MRSS services are already in a state of crisis. In this section we will address issues and concerns for youth facing additional barriers and special needs. This will include exploring three case scenarios that involve youth in kinship care, circumstantially independent youth, and homeless youth. In each of these situations, we will provide resources to create a better understanding of their unique needs and recommend strategies to better engage and serve them.

We will also make highlight things to consider when developing a treatment plan for these populations. We will identify visible and invisible factors that should be acknowledged in order to create a safety and success foundation when working on a limited timeline.

To create a foundation of knowledge and clear understanding of these populations youth we will start by defining the circumstances and needs.

Homeless Youth: The basic definition of homeless youth, according to the McKinney-Vento Homeless Education Act, are youth who lack a fixed and regular nighttime residence. Youth who may reside in a shelter, couch surf, or live in a car or on the street. If available these youth may utilize community centers, libraries or drop in center services to have a safe space or to attempt to get their daily needs met.

It is extremely hard to get an accurate count on homeless youth due to their transition and creative living conditions. Many homeless youth don't self-disclose causing more confusion among how we can count homeless youth however, in recent years we have gotten better at documenting homeless youth and there have been many new research studies that give us a clearer picture. There are an estimated 4.2 million homeless Youth in the United States according to the National Conference of State Legislators. In Ohio that number can be as high as or higher than 40,000 considering School and shelter data up to age 25.

Out of 88 counties in Ohio, less than half have access to homeless youth services, drop in, shelter, or housing programs. Youth in need of these services often are either remaining street homeless, or couch surfing/doubling up with others. Some youth are able to access the adult system, but they are often not a prioritized population and do not receive the resources nor the culturally competent services to help them succeed.

Know the Facts: 1 in 10 youth age 18 – 25 and 1 in 30 youth 13- 17 experience independent homelessness without a parent each year.

- 29% report having a SUD
- 69% report having a mental health issue
- 33% have been part of the foster care system (913 youth aged out in Ohio in 2019)
- 50% reported having been in the Juvenile Justice System, Jail, or Detention

** The study found that the number 1 correlation for elevated risk of youth homelessness is a lack of High School Diploma or a GED

Source: Voices of Youth Count study by Chapin Hall, University of Chicago

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Youth in Kinship Care: Youth who are in the custody or temporary guardianship of a relative. According to the Ohio Department of Jobs and Family Services, Kinship Care refers to a temporary or permanent arrangement in which a relative or any non-relative adult who has a long-standing relationship or bond with the child and/or family, has taken over the full-time, substitute care of a child whose parents are unable or unwilling to do so. Kinship Care includes those relationships established through an informal arrangement, legal custody or guardianship order, a relative foster care placement or kinship adoption.

In most cases Kinship placement represents the most optimal situation for all involved, It offers the greatest level of stability by allowing children to maintain their sense of belonging and enhances their ability to identify with their family's culture and traditions.
While Kinship Care can be beneficial for many reasons, it can also create a complex and sometimes stressful situation for the family and the youth. This is especially true for informal placement as the caregiver may be limited on resources and the right to consent to services may be unclear.

Know the Facts:

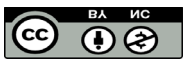
- **97,811 Grandparents in Ohio are raising grandchildren**
- **26,737 children were placed out of home**
- **26% were placed in a Kinship home**
- **33% were ages 12=18+**

Source: 2019 Data compiled by the Public Children Services Association of Ohio
Independent Minors: Youth who live independently from their parents or whose parents are disengaged or unwilling to participate in services. These youth can be any school age, however, in order to receive mental health treatment, under Ohio Revised Code 5122.04, a minor must be at least 14 years old and may only receive services for a limited number of outpatient sessions. Also, this does not allow consent for medication.

This population is very similar, but different from homeless youth or informal kinship care in that the parents may be present on paper or even reside in the same household, but are not active participants in the life or daily needs of the youth. In Ohio we have seen a dramatic increase in this population as our opiate use increased and more parents became addicted and unwilling or unable to engage in their child's school or community services. In many cases the mental health or addiction issues facing the family may be held in secrete causing more anxiety and stress on the child, thus increasing their need for possible MRSS interventions.

Know the Facts: Unaccompanied Youth / Situationally Independent Minors
Unaccompanied Youth who are not attached to their parents, may be unidentified and flying under the radar trying to avoid child welfare or other system involvement. Many may be living with friends attending school and working.

- Studies have found that 20-40% of unaccompanied youth were abused sexually in their homes
- 40-60% were abused physically.
- Over two-thirds of unaccompanied youth report that at least one of their parents abuses drugs or alcohol.
- 20-40% of unaccompanied youth have been thrown out of their homes because they are gay, lesbian, bisexual, transgender, or pregnant.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ORC 5122.04 Outpatient services for minors without knowledge or consent of parent or guardian.
(A) Upon the request of a minor fourteen years of age or older, a mental health professional may provide outpatient mental health services, excluding the use of medication, without the consent or knowledge of the minor's parent or guardian. Except as otherwise provided in this section, the minor's parent or guardian shall not be informed of the services without the minor's consent unless the mental health professional treating the minor determines that there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of the mental health professional's intent to inform the minor's parent, or guardian.

(B) Services provided to a minor pursuant to this section shall be limited to not more than six sessions or thirty days of services whichever occurs sooner. After the sixth session or thirty days of services the mental health professional shall terminate the services or, with the consent of the minor, notify the parent, or guardian, to obtain consent to provide further outpatient services.

Scenario: Kinship Care, 12-year-old Ben.

Incident: At dinner, Ben appeared to become angry at sibling and quickly lost control, yelling and cussing. When approached by adults in the room the youth ran off and locked themselves in his room. Adult could hear banging and yelling. They could not convince the youth to open the door and were only able to get him to begin to calm down after a lot of coaxing. He was crying and eventually unlocked the door. He said he felt he was losing control and needed it to stop. The crisis line was called.

Crisis Team: After a brief phone interview with the kinship provider a mobile crisis team including a therapist and a parent peer supporter is dispatched to the home.

On Site: The siblings of the youth and other family members are gathered in the living room. The youth has settled to his room and the kinship provider, mother's cousin, is sitting in a chair across the room monitoring the youth.

Things you are told by the cousin: Ben has been living in the household for many years but only recently became under the custody of the Child Welfare System. He has received some services in the past but not since the change in circumstance. Ben now seems to be becoming angrier and more disconnected in the past few weeks. The cousin is concerned about his decline and now his safety. They tried to get services but are on a waiting list. They have informed the school of the situation as Ben has been more defiant to his teachers and is disengaging in school work.

What we see:

- A youth visibly shaken up and emotionally exhausted and is open for skeptical of services.
- A family who cares and is very concerned including a supportive kinship provider.
- Four siblings, in two separate placements, who are only a few years apart and seem to be close.
- Everyone is frustrated about the waiting list for mental health services.

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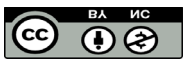
What we do not see:

- A youth who has witnessed and experienced years of abuse at the hands of a now absent father.
- A mother who is living with a new boyfriend and does not have the mental or financial stability to care for her minor children at this point.
- Two older young adult siblings who live in another state with Dad.
- No one in his immediate family have graduated or even attended High school.
- Ben's life goals are to attend college and own a home.
- In the immediate family higher education is not valued and considered a threat.
- There have been multiple cases opened over the years but no real intervention until this time.
- Ben has unofficially not lived with his mother in over 3 years and is now terrified of going back.
- Ben has been doing well and focused on his self but now has to be involved in a case involving his siblings who are at a very different place emotionally than Ben.
- Ben use to have nightmares three years ago that went away but have returned since the placement of his siblings.
- Bens siblings were at the dinner. While Ben has had very little contact with Mom, the siblings have been communicating through social media at unscheduled times.
- Mom has been updating the siblings on the case from her perspective and using them to leverage support from the other children, including Ben.
- At dinner, one sibling talks about an upcoming court date and that they are excited to get to go back home. Ben was both unaware of the court date and the possibility of returning home.

Things to Consider:

- Be extremely honest and realistic about your role and what is likely to happen.
- DO NOT promise or set an expectation that certain things may happen if you are not sure they will.
- It is important to determine a realistic timeline based on the situation. Is this a long-term or short-term placement? Does the Kinship provider have any insight on when or if custody is scheduled to return to the parent?
- You should contact your county child welfare agency in advance to establish a working agreement as to how to manage calls from Kinship or Foster placements.
- Who is the advocate for the needs of the child in crisis?
- Be careful that treatment does not become the Trigger or be perceived as the Trigger.
- A youth may not be open to one more professional or system to deal with. STRONGLY consider every non-traditional support you can to help this intervention look and feel different.
- A youth-in-care often is asked to repeat and relive their trauma to multiple case managers, doctors, court personnel, school or other professional. This can cause a youth not to be able to process or move forward or they can lose trust and not understand why they have to repeat and may start leaving out critical details of their situation because they are just done with talking about it.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Things to Consider (Con.)

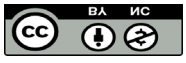
- Try to engage the youth through other conversations that do not include dredging up past trauma. Gain as much information as you can from supportive adults or case files.
- It is important, even though they have a supportive family, to ensure the youth, regardless of age, are fully including in knowing their rights and receive a copy of all documents and contact information in case of placement disruption or return home.
- Assess if the siblings are playing a role in the trauma triggers. A key factor influencing youth could be the sibling's relationship with the parent or having differing opinions about long term outcomes regarding their situation.
- All children and youth have some level of hope, love, loyalty to their parent. In a lot of cases this can cause a very unrealistic view about reality of their parents' situation. Be careful to not trigger situation to become about picking sides or defending parental behaviors.
- If youth is returned to a parent, can services continue? Will the parent be required to follow the mental health or treatment plan after regaining custodial rights?
- How will you follow up or evaluate if the youth is returned home?
- How are the needs of this individual youth being addressed verses the entire family?
- A similar call could come where the family does not have formal system inclusion.
- Be prepared on how to deal with relatives who do not have court guardianship or formal custody. Do they have a medical power of attorney? In Ohio, parents may only grant grandparents legal power of attorney rights to their children, which excludes a large number of other kinship arrangements, however, the parent maybe available to sign a medical consent or release depending on your agency policies. Bring a form with you in case you would need a medical release form or consent.

Scenario: School Based Crisis, 14-year-old Carla

Incident: 14-year-old girl. Carla. Carla is a middle school student who has attended this school for the past 2 years. She has been a generally good student until this school year. She has become increasingly disruptive often shutting down and not doing her work. On this day after a morning school award assembly Carla refused to go back to her class. When the teacher asked her to come into the classroom she started yelling and calling the teacher names stating that she did not have to listen. A school administrator was walking down the hall and heard the incident. As he approached Carla, she ran into a nearby stairwell and began punching the wall and cursing at the adults. In fear of her safety the administrator and the teacher blocked her exit from the stair way and was able to contain her until she calmed down and was willing to go sit in the office. The school called her mother but there was no answer, as is usually the case. The school administrator decided to call the crisis line for guidance in this situation as the youth was clearly escalating and needed immediate help.

What we see:

- A youth who is very angry and upset
- Teachers who are caring and supportive but who are frustrated and need to keep other students safe.
- A school full of Administrators and staff who what to provide the best supports to the youth.
- A school file full of failed attempts to engage with Mom.
- A log of reports sent to the county child welfare agency.
- A student failing classes and struggling in ways she never did in the past.

 2021, CIP, CWRU and OhioMHAS

What we don't see:

- This youth loves singing and basketball
- Born to Teen parents with multiple ACE indicators for Childhood Trauma
- Family of Generational poverty
- Parents had some family
- Parents both addicted
- Father very abusive
- Children taken to live drug houses, doubled up, transitional
- Left unattended and unfed for hours and
- One or more parent may be gone for days
- Court and Child Services involvement, but no placement or interventions
- Spent most time with extended family
- Lived in unofficial relative placement
- Stably housed for the past 8 years, except one-year relative placement
- Was involved in an afterschool program in elementary school, but nothing recently
- No one in the household is receiving any type of services Key factor\

Things to Consider:

- The biggest concern here is if the parent does not engage or refuses services. How do we support the youth?
- In Ohio youth ages 14 and up can receive mental health treatment without a parent for up to 6 sessions and not over 30 days. Work with your agencies to set a policy for this situation.
- Youth will defend their parent and may be afraid of the foster system. There is a very HIGH likely hood that they will not disclose drug or alcohol use or other abuse at home.
- Youth will not want other adults to have a negative view of their parent. Try not to point out the obvious. The youth knows the parent is absent. If they are disengaged with the school, they are probably disengaged at home.
- Create a support structure using the resources available at school so if you are not able to continue services there is a strong safety and support plan. Have the youth identify any staff or peers they trust and designate a safe space in the school (office, nurse, gym..) where the youth can take a temporary time out if they are getting angry or triggered.
- Make sure you leave them a care card that includes community agencies that are open during out of school hours. Highlight ones that do not require parent participation.. i.e. Library, Community Center.
- Bring list of rights and any other resources the youth may need
- Connect them with a peer mentor if school offers it or a Peer support
- Check with your agency to see if the youth can receive text or participate in peer support services without a parent's consent. If your agency can't do it, leave a list of virtual positive peer groups or activities.

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Scenario: Homeless Youth Drop-In Center, 19-year-old Christy.

While using the services at a homeless youth drop in center, Christy was sitting in a common area when a small argument broke out between a couple of youth who were dating. During the argument a liter of cola was knocked over and spilled all over Christies backpack. Christy immediately jumped up and ran to the staff who were trying to address the argument. She grabbed her back pack and began crying hysterically. She was angry at the staff for not preventing the argument and demanded that the other youth be punished. She continued to cry and the staff could not console her. She took her backpack and sat in a corner refusing to talk to anyone. Whenever a staff would try to come talk to her she would just yell at them to go away and leave her alone. The center was about to close and they could not get her to communicate between sobs about ruining her life and making vague threats to the other youth. They were concerned because she had been a regular youth at the center and was usually very quiet and respectful. They decided to call the crisis line.

What we see:

- A homeless youth who seems scared
- A situation you can't imagine
- Stress of not knowing where you will sleep or what is going to happen to you
- A center that is safe but with limited hours
- A front-line staff that is young but caring and well trained
- The 50 or so youth who are all in this same situation

What we don't see:

- Has a score of 8 on the ACES indicators for Childhood Trauma
- Has extensive family network, but very working poor and cannot keep her all the time
- Moved frequently, doubled up with relatives out of care
- Parents have been long divorced but both are incarcerated
- Filled role of primary caretaker of 5 younger siblings most of her life
- Never taken into custody, but siblings have recently been in care for over a year.
- Held back in school, quite school, but had returned to graduate as an adult
- Lives mostly as a couch surfer with friends and relatives
- Trying to attend college
- Motivated to be a role model for younger siblings
- Attends weekly visits with siblings in care, mother rarely attends
- Siblings have received a lot help and support in foster care, but she is not eligible because she had just turned 18 at time of placement.
- Suffers depression, anxiety, and PTSD

Things to consider:

- Various agencies have a hard time identifying homeless youth and engaging them in tailored across-agency services and case management, in some cases due to the fact that their systems and referral sources are designed for families or youth involved with the child welfare system.[1]

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Things to Consider (Con.)

- If basic needs are not met is it nearly impossible to engage a youth. At least acknowledge and inquire about basic physical needs, even if it obvious. Don't promise anything you don't have immediate access to.
- Understand your supports and housing options for 18-24-year old in your community
- Build a relationship with adult shelters and housing program so you can make direct referral or get updates on what actual waiting list are.
- Know what are eligibility requirements for every program identified. Some programs have hidden eligibility requirements so do not assume all youth are eligible based solely on age.
- Do you have a street card in your area – get one or make one.
- Work with partners to ID legal resources for homeless youth. Your local legal aid may be willing to help create a list of legal rights for homeless youth.
- Empowerment is key for independent and homeless youth. Make sure they are given the lead in directing services.
- Respect and do not judge the situation.
- If the youth turns out to be 17 or younger make sure you assess if this is a mandatory reporting situation. BE TOTALLY HONEST and Up front about your mandatory reporting status and what that means

Be Prepared: What to Bring on Crisis Calls

In each case scenario it is not certain that you would be able to continue services beyond one day. Be totally honest and set realistic expectations about services and supports you offer. These youth have been let down by adults too often and is likely a key source of anxiety and anger. Do not promise things that cannot happen or may take a long time. Be prepared to leave the youth with as many tools as possible without overwhelming them. DO NOT ASSUME all youth are eligible for services and make this clear to the youth. Make sure to follow through on any promise or perceived promise made. Also, it is critical to remember that youth in these types of special populations often use manipulation and lying as a survival tool. This is not meant to be mean or vindictive in most cases. Be aware and try to understand that this is coming from a place of trauma.

Items to bring:

- A Resource/Contact Card. This should include all available contact information on one side, including how to contact a peer support person and any crisis text or phone information. On the flip side include rights of foster youth and any other services this youth may utilize.
- For homeless youth or youth you identify as at risk of homelessness: print out a list of agencies that include eligibility and what you need to access services. This should include emergency shelters, housing programs, education programs, food sites and resources, including scheduled of times, community centers and hours of operation, libraries, mental health agencies.
- BE as creative and thorough as possible and make sure contact information and eligibility are updated.
- A support mapping worksheet to help youth identify alliances and other positive alternatives or non-traditional supports such as online support programs, community agencies, school contact, peer they trust, a family member, a church, a youth center.

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Be Prepared: What to Bring on Crisis Calls (Con.)

- These should be printed and given to the youth so they will have a "cheat sheet" and be empowered to understand their rights and access supports.
- A care package or bag. Include a "gift" and a card. This could be a journal, coloring book, Art supply, book, puzzle book, fidget toy, puzzle, an exercise or yoga log. Think of things that will promote mental wellness or distract from stress or trauma. Leave with the youth incase this is a one-time intervention they will have at least one tool to calm or refocus and they will remember that you cared about their needs.

Example Crisis Card

Side 1: Tips for Eligibility, What you need, ID, Expectations.

Side 2: Job, Education, Shelter, Housing, Food, Transportation, 800 numbers if available and 211

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