

# Department of Children and Families

## Guide to New and Current MassHealth Behavioral Health Services



# Table of Contents

## Section 1

MassHealth: New and Current Services

Pg 3

## Section 2

Department of Children and Family Protocols

Pg 14

# Section 1

## MassHealth: New and Current Services

# Section 1

## MassHealth: New and Current Services

## I. The Children's Behavioral Health Initiative (CBHI)

The Children's Behavioral Health Initiative is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

The Children's Behavioral Health Initiative is defined by a shared commitment to providing services to families that reflect the following values:

- **Family Driven, Child-Centered and Youth Guided**  
Services are driven by the needs and preferences of the child and family, developed in partnership with families and accountable to families.
- **Strengths-based**  
Services are built on the strengths of the family and their community
- **Culturally Responsive**  
Services are responsive to the family's values, beliefs, norms, and to the socio-economic and cultural context.
- **Collaborative and Integrated**  
Services are integrated across child-serving agencies and programs.
- **Continuously Improving**  
Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence and best practice.

The Initiative places the family and child at the center of our service delivery system, and will build an integrated system of behavioral health services that meets the individual needs of the child and family. The goal is to make it easier for families to find and access appropriate services and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

For more information visit: [www.mass.gov/masshealth/childbehavioralhealth](http://www.mass.gov/masshealth/childbehavioralhealth)

## II. MassHealth: New and Current Services

MassHealth pays for many important health care services for a wide range of people who meet the eligibility rules. In 2009, MassHealth significantly expanded behavioral health services available to its MassHealth Standard and CommonHealth members under the age of 21 by paying for six new home and community-based services. The goal of these services is to help children and youth with significant behavioral, emotional and mental health needs achieve success in home, school and community.

These services have been designed, and are being implemented according to Children's Behavioral Health Initiative Values:

- Family Driven, Child-Centered and Youth Guided
- Strengths-based
- Culturally Responsive
- Collaborative and Integrated
- Continuously Improving

These new services *complement* the behavioral health services currently available to MassHealth Standard and CommonHealth members under the age of 21. Below, you will find brief descriptions of the *new* services, and of the *current community-based* MassHealth Behavioral Health Services.

NOTE: These new services are NOT for the treatment of the behavioral health needs of a youth's parents or caregivers. Behavioral Health services for parents or caregivers should be sought through their health care insurer, or MassHealth, if they are eligible.

### New MassHealth Community-Based Behavioral Health Services<sup>1</sup>

What follows are brief descriptions of the new services, with some suggestions of who might benefit from each of the new services.

This information is intended to provide staff with guidance on how to help families and youth to access appropriate MassHealth behavioral health services. It is important to note that MassHealth members may also self-refer to any behavioral health service they think might be helpful. Families and youth are always welcome to inquire with a provider about a particular service.

This guidance is intended to be informative and to illustrate the potential usefulness of each service. It does NOT replace the Medical Necessity Criteria, attached in Appendix B. Providers of each of the services will use the Medical Necessity Criteria (MNC) to evaluate whether the child or youth has a medical need for the service. Medical Necessity decisions made by providers may be reviewed by the child's or youth's MassHealth Managed Care Plan.

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<sup>1</sup> These new services are expected to become available between June 30 and November 1, 2009. However, MassHealth needs the approval of the federal Medicaid program in order to pay for these services. MassHealth has received approval for Intensive Care Coordination and is awaiting approval for the other services.

## A. Standardized Behavioral Health Screening in Primary Care

As part of well-child visits, the primary care doctor or nurse checks the child's or youth's health, development, need for immunizations, dental health and behavioral health. MassHealth now requires primary care doctors or nurses to offer to use a behavioral health screening tool to check the child's or youth's behavioral health. There are eight approved screening tools. They typically consist of a short list of questions, or a checklist, that the parent, caregiver or youth fills out and then talks about with the primary care doctor or nurse. The screening tool helps to spot concerns early so problems can be found and helped earlier. If there are concerns about a child's or youth's behavioral health, the primary care doctor or nurse will work with the parent/caregiver or youth to decide if a referral to a behavioral health provider for further assessment and treatment is needed, and can help the parent/caregiver/youth get needed services.

## B. Standardized Behavioral Health Assessment, using the Child Adolescent Needs and Strengths tool (CANS)

Beginning November 30, 2008, MassHealth began requiring a uniform behavioral health assessment process for MassHealth members under the age of 21 receiving behavioral health services. The uniform behavioral health assessment process includes a comprehensive needs assessment using the Child and Adolescent Needs and Strengths (CANS) tool.

The CANS is a tool that organizes clinical information collected during a behavioral health assessment in a consistent manner, to improve communication among those involved in planning care for a child or youth. The CANS is also used as a decision-support tool to guide care planning, and to track changing strengths and needs over time. The CANS is used in child and youth serving systems in more than 30 states. There are two forms of the Massachusetts CANS: CANS Birth through Four and CANS Five through Twenty. Both versions include questions that enable the assessor to determine whether a child meets the criteria for Serious Emotional Disturbance (SED), in addition to the CANS assessment questions. (Meeting the definition of SED is a component of the Medical Necessity Criteria for the new service Intensive Care Coordination.)

## C. Intensive Care Coordination (starting June 30, 2009)

ICC is a care coordination service for children and youth with serious emotional disturbance (For definitions of Serious Emotional Disturbance, see ICC Medical Necessity Criteria, Appendix B). ICC will use a model called *Wraparound Care Planning*. In *Wraparound Care Planning*, families and youth work together with professionals, talk about their strengths and needs, and actively guide their own care. In ICC, a team leader, called a Care Coordinator, helps families bring together a team of people to create a child's treatment plan. This Care Planning Team often includes therapists, teachers, social workers and representatives of all child-serving agencies involved with the youth. It also includes "natural supports", such as family members, friends and people from the family's neighborhood or community that the family invites to be part of the team. Together, the team comes up with ways to support the family's goals for the child (or youth's goals, in the case of an older child), creating an Individual Care Plan. This plan, which also focuses on the family's strengths and respects their cultural preferences, lists all the behavioral health, social, therapeutic or other services needed by the child and family including informal and community resources. It will guide the youth's care and involve all providers and state agencies to integrate services.

The Care Planning Team will usually meet monthly and sometimes more often for children and youth with more complex needs. At these meetings the family, youth and other team members can talk about progress, work to solve problems, and make any needed changes to the Individual Care Plan.

Additionally the ICC care planning team seeks to:

- Help the family obtain and coordinate services the youth needs and/or receives from providers, state agencies, special education, or a combination thereof
- Assist with access to medically necessary services and ensure these services are provided in a coordinated manner
- Facilitate a collaborative relationship among a youth with SED, his/her family, natural supports, and involved child-serving systems to support the parent/caregiver in meeting their youth's needs

Who is likely to need ICC?

Children and families who need or receive services from multiple providers or who need or receive services from multiple state agencies, including special education. ICC can help prioritize goals and monitor progress, ensuring that interventions being used are effective and coordinated. ICC can also address needs other than behavioral health needs, such as connecting families with a variety of sustainable supports. Examples of sustainable supports include recreational activities for the child or youth, connection to mentors and opportunities for mutual support and social interaction with other families.

Who may benefit from referral to a different service?

- *A child or youth in acute emotional, behavioral or mental health crisis. Consider referring instead to Mobile Crisis Intervention for immediate stabilization and support.*
- *Family of a child or youth with a single service need who does not need a Care Planning Team to coordinate services: Consider referring instead to the service(s) that may be needed.*
- *A family in too much immediate distress to participate in the team-based sequence of steps of the Wraparound process. Consider referring first to another behavioral health service such as Family Stabilization Teams (until November 1, 2009) or In-home Therapy (available November 1 2009, during which the need for other services including ICC will be assessed).*

How do I make a referral?

See the list of Community Service Agencies in Appendix A.

**Geographically-Based CSAs:** MassHealth's Managed Care Contractors have selected 29 Community Service Agencies (CSAs), one for each of 29 service areas. The service areas correspond to the Areas of the Department of Children and Families.

**Culturally and Linguistically Specialized CSAs:** MassHealth's Managed Care Contractors have also selected 3 culturally and linguistically specialized CSAs. These CSAs were chosen for their demonstrated ability to reach deeply in to specific cultural or linguistic communities and tailor their services to engage and serve their specified populations. Like all CSAs, Specialized

CSAs are expected to serve any family seeking appropriate service without regard to race, ethnicity or language.

- Children's Services of Roxbury specializes in serving the African-American population in Greater Boston.
- The Gandara Center specializes in serving the Latino population in the Springfield/Holyoke area.
- The Learning Center for the Deaf, Walden School specializes in serving the Deaf and Hard of Hearing population, particularly in the eastern/central part of the state.

Families with children or youth enrolled in MassHealth are not required to choose a CSA in their area or a culturally or linguistically specialized CSA, but may choose to work with any CSA.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

#### D. In-Home Therapy (starting November 1, 2009)

In-Home Therapy Services provides intensive family therapy for a child and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. In-Home Therapy Services are provided in the home or other location which is appropriate and convenient to the family. It is provided by a skilled behavioral health provider who may work in a team with a paraprofessional. In-Home Therapy providers work to understand how the family functions together and how these relationships can be strengthened to benefit the child. Together with the child and family, they create and implement a treatment plan. Goals in a treatment plan might include helping the family identify and use community resources, learn to more effectively set limits and establish helpful routines for their child, problem-solve difficult situations or change family behavior patterns that get in the way of their child's success. Note: Parents may also have individual behavioral health needs that may require separate behavioral health treatment.

#### Who is likely to need In-Home Therapy?

- *Families in need of more urgent or intensive help with a youth's emotional and behavioral challenges than could be addressed through outpatient therapy.*
- *Families that have identified their primary need as learning new ways to relate to one another, or new ways to set limits or regulate child behavior, or who have tried outpatient therapy but not found it effective. IHT offers more flexibility than outpatient therapy, not only in intensity but in treatment setting. Therapeutic intervention in a natural environment can offer opportunities for understanding behavior and for rehearsing new strategies which are not available in a clinic environment.*

#### Who may benefit from referral to a different behavioral health service?

- *A child or youth in acute crisis. Consider referral to Mobile Crisis intervention.*
- *Children and families with needs involving multiple providers or state agencies. Consider referral to ICC.*
- *A child with a disorder that can benefit from outpatient individual or family treatment.*

#### How do I make a referral?

Referrals can be made directly to the In-Home provider or the child may access In-Home therapy through ICC or outpatient therapy.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

For a list of the common network of In-Home providers selected by all MassHealth's Managed Care entities, see Appendix A. For additional providers selected for MBHP's "extended network", also see Appendix A. The most up-to-date information on the In-Home Therapy provider network can also be found on the website of the appropriate MassHealth Managed Care entity or by calling the Managed Care entity.

#### E. Mobile Crisis Intervention (starting June 30, 2009)

Mobile Crisis Intervention is the youth (under the age of 21) -serving component of an emergency service program (ESP) provider. Mobile Crisis Intervention will provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

The service includes: A crisis assessment; development of a risk management/safety plan, if the youth/family does not already have one; up to 72 hours of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

#### Who is likely to benefit?

A child with MassHealth who is in a behavioral health crisis and who is likely, without intervention, to escalate in a way that would pose a risk of harm to themselves or others. If in doubt, call the Mobile Crisis Intervention team and consult with the team on whether they should intervene.

#### Who may benefit from a different service?

*If a child is in treatment he or she may have a Risk Management/Safety Plan which may identify other steps prior to calling Mobile Crisis.*

*Note that Mobile Crisis Intervention is only for a child/youth on MassHealth. A person who does not have MassHealth should be triaged through the 800 number on the back of the health insurance card or sent to the local emergency services program or hospital emergency room.*

*If the child/youth is an acute safety risk to self or others and the risk cannot be safely managed in the current setting, call 911.*

How do I make a referral?

Mobile Crisis Intervention is provided by the Emergency Service Provider (ESP) in the region. See the list of ESPs in Appendix A.

F. Additional new MassHealth-covered services can be accessed through outpatient therapy, In-Home therapy or Intensive Care Coordination, as part of the youth's Individual Care Plan (ICP) or treatment plan (for Outpatient or In-Home Therapy).

➤ Family Support and Training (*Starting June 30, 2009*)

Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or In-Home Therapy treatment plan or Individual Care Plan (ICP), for youth enrolled in Intensive Care Coordination (ICC), and to support the youth in the community or to assist the youth in returning to the community.

Services may include education, assistance in navigating the child serving systems (child welfare, education, mental health, juvenile justice, etc.); fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching, and training for the parent/caregiver.

In ICC, the care coordinator and Family Support and Training Partner work together with youth with SED and their families while maintaining their discrete functions. The Family Support and Training Partner works one-on-one and maintains regular frequent contact the parent(s)/caregiver(s) in order to provide education and support throughout the care planning process, attends CPT meetings, and may assist the parent(s)/ caregiver(s) in articulating the youth's strengths, needs, and goals for ICC to the care coordinator and CPT. The Family Support and Training Partner educates parents/ caregivers about how to effectively navigate the child-serving systems for themselves and about the existence of informal/community resources available to them; and facilitates the parent's/caregiver's access to these resources. Family Partners are offered to families as part of Intensive Care Coordination.

➤ *In-Home Behavioral Health Services* – Starting October 1, 2009

In-Home Behavioral Health Services offers valuable support to children and youth with challenging behaviors that get in the way of everyday life. Services are provided by a behavioral health provider, such as a therapist, who is skilled in understanding and treating difficult behaviors in children and youth. The provider works closely with the child and family to create a specific behavior plan to improve the child's functioning. The provider may also work as a team with a skilled paraprofessional called a behavioral management monitor. The monitor works with the child and family to implement the child's behavior plan. In-Home Behavioral Health Services can be provided in places where the child is located, including home, school, childcare centers and other community settings.

➤ *Therapeutic Mentoring Services* – Starting October 1, 2009

A therapeutic mentor works one-on-one with a child or youth who, because of their behavioral health needs, require support and coaching to learn social skills that will allow them to do well in typical, normative environments. These skills may include better ways of communicating with other children and adults, dealing with different opinions and getting along with others. The therapeutic mentor works with the child to achieve goals in a treatment plan written by an outpatient therapist, In-Home Therapy Services provider or Intensive Care Coordination (ICC) team. The mentor is supervised by a behavioral health clinician and can work with a child in his or her home, school, or other social and recreational setting.

For families and youth who may need or benefit from these services, social workers should consider facilitating a referral process with the out-patient provider, in-home therapist, or ICC team.

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly. Contact numbers for the plans are listed at the end of this section.

G. Current MassHealth Community-Based Services (in addition to the New Services)

The following are other community-based (e.g. non-24 hour) behavioral health services that are available to youth enrolled in MassHealth. This is not meant to be an exhaustive list of available benefits but an overview of behavioral health services that are available in addition to the new MassHealth services described earlier in this document.

- **Outpatient Behavioral Health Services:** Outpatient services include individual, family, and group therapies, as well as medication evaluation and monitoring. Outpatient services can be provided in an office, clinic environment, a home, school, or other location. Outpatient services can be used to treat a variety of behavioral health and/or substance abuse issues that significantly interfere with functioning in at least one area of the youth's life (e.g., familial, social, occupational, educational). Outpatient is the least intensive level of care available to youth.
- **Community Support Programs (CSPs):** Provide an array of services delivered by a community-based, mobile, multidisciplinary team of paraprofessionals. CSP services are appropriate for youth who have behavioral health issues challenging their optimal level of functioning in the home/community setting. These services are designed to be maximally flexible in supporting youth who are unable to independently access and sustain involvement with needed services. Services may include: assisting youth in enhancing their daily living skills; case management, skill building, developing a crisis plan; providing prevention and intervention; and fostering empowerment and recovery, including linkages to peer support and self-help groups. NOTE: As of October 1, 2009, CSP for youth under 18 will be replaced by the new community based behavioral health services, described earlier in this document. Youth 18 through 20 will have access to both CSP services as well as the new community based behavioral health services.
- **Structured Outpatient Addiction Program (SOAP):** SOAP is a short-term, clinically intensive, structured day and/or evening substance abuse service. SOAP can be

used by youth, including pregnant youth, who need outpatient services, but who also need more structured treatment for substance abuse. SOAPs provide multidisciplinary treatment to address the sub-acute needs of youth with addiction and/or co-occurring disorders, while allowing them to maintain participation in the community, continue to work or attend school, and be part of family life.

- Partial Hospitalization Program is a nonresidential treatment program that may or may not be hospital-based. The program provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation and medication management, group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance abuse evaluation and counseling, and behavioral plans.

#### How Do I Make a Referral?

For more specific information about how to access these services on behalf of a youth enrolled in a MassHealth managed care plan contact the plan directly.

To locate a provider for youth NOT enrolled in a MassHealth Managed Care Plan, please call: MassHealth Customer Service 1-800-841-2900: TTY: 1-800-497-4648.

For youth who ARE enrolled in a MassHealth Managed Care Plan, please call:

- Boston Medical Center (BMC) HealthNet Plan 1-888-566-0010 (English and other languages) 1-888-566-0012 (Spanish) TTY: 1-800-421-1220
- Fallon Community Health Plan 1-800-341-4848 TTY: 1-877-608-7677
- Health New England (HNE) 1-800-786-9999 (TTY: 1-800-439-2370)
- Neighborhood Health Plan 1-800-462-5449 TTY: 1-800-655-1761
- Network Health 1-888-257-1985 TTY: 617-888-391-5535
- Primary Care Clinician (PCC) Plan 1-800-841-2900 TTY: 1-800-497-4648
- Massachusetts Behavioral Health Partnership 1-800-495-0086 TTY: 617-790-4130
- Beacon Health Strategies 1888-217-3501 TTY:1-866-727-9441

# Section 2

## Department of Children and Family Protocols

# Children's Behavioral Health Protocols

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Process and Procedures for Accessing MassHealth  
Behavioral Health Services on Behalf of DCF Children  
and Families

6/18/09

## I. Strategic Opportunities for DCF to Focus on Children's Behavioral Health:

The Department of Children and Families is one of five Executive Office of Health and Human Services agencies leading the development and implementation of the Children's Behavioral Health Initiative (CBHI). With its commitment to bringing multiple systems together to best meet the needs of children and families, the CBHI is an integral component of the Department's strategic effort to advance effective child welfare practice. The Department is committed to improving the safety, permanence, and well-being of children through family centered, strengths based and community connected practice. This commitment is reflected in the CBHI's focus on engaging families as true partners in the development of a meaningful plan of action that best meets their child's needs for success. When families are actively involved with helping professionals and participate in team decision processes to enhance their strengths and needs children are safer. The shared commitments of the Department and the CBHI are leverage points for improving the child welfare system along three priority objectives:

1. Safely stabilizing and preserving families
2. Safely reunifying families
3. Safely creating new families through adoption, kinship or guardianship.

These priority objectives challenge the Department to align child welfare policy, practices and resources to organize the local delivery of services around the sustained safety of children and families. With an improved systems of care approach, targeted and effective services, and community focused services, the CBHI will play a critical role in the Department's strategy for making our child welfare system among the best in the nation. The overarching expectations that the Department has for the new Children's Behavioral Health system are:

1. To increase timely access to needed and relevant behavioral health services
2. To increase coordination of services to those children who need behavioral health services and whose parents/guardians need support

3. To continue the trend in decreased utilization of Congregate Care and other out of home services
4. To have shorter lengths of stay for children who are in Congregate Care and other out of home settings

### CBHI and the DCF Integrated Casework Practice Model

The Department is currently implementing a new child welfare practice model. The DCF Integrated Casework Practice Model emerged from a four year dialog including a broad range of DCF staff, community providers, family members and national experts. The essential practices of this model are founded on the principles of family centered, safety organized frameworks and are based in the traditions of strength based wraparound approaches. Realizing that child and family safety are a matter of community importance, the Integrated Practice Model relies on collective and community centered approaches to decision making.

The implementation of the CBHI in the context of the Department's Integrated Practice Model will challenge the Department to increase the knowledge and skills of social workers, supervisors and managers related to Children's Protective Services and Children's Behavioral Health in the following practice areas:

1. Strengthen our capacity to assess indicators of safety, risk and parenting capacity
2. Strengthen our capacity to identify children's behavioral health needs as early as possible.

With the new array of behavioral health services now available, families will have access to resources that will complement the community support services that the Department can offer. In some instances the new MassHealth services will be sufficient to support the parent/guardian's care of the child at home and no DCF involvement will be necessary.

The Department has identified four priority populations for referral to CBHI services for fiscal year 2010:

1. Voluntary applications or CHINS referrals received after July 1, 2009 where the primary presenting issue is the child's behavioral health needs. In these cases the differential response will be to refer to a CBHI service for assessment and treatment of those needs.

2. Active Placement Referrals where behavioral health wraparound services may serve to prevent the need for placement, or shorten the duration of that placement.
3. Youth in Congregate Care Placements who are Discharge Ready, where CBHI services can help support the transition to community based care.
4. Open cases where there are significant unmet behavioral health needs of a child or children.

### CBHI and the DCF Family Networks System of Care

For several years the Department has organized access to and management of its purchased service system through a Lead Agency structure called Family Networks. The Community Service Agencies (CSA's) are aligned with the Lead Agency catchment areas. Both systems use systems of care approaches, including intensive service coordination, family team decision making, utilization management procedures that ensure that services are effective in meeting the goals of the service plan, and the development of community based services that create sustainable supports to families following their involvement with the Department. The Department and the families it serves have realized significant benefits as a direct impact of this system. Families have a true voice in the development of their service plan, fewer children are being placed in residential settings and more are receiving services in their community, and the savings that have accrued from efficient management of the service system has led to an increased investment in community based services. The Department is committed to the continued operation and evolution of Family Networks, and will continue to utilize this system to address the protective concerns of families that come to our attention.

Most of the families served by the Department have protective needs, and the majority of those families have children under the age of 11. The focus of DCF's work with these families is to increase the capacity of the parents/guardians to provide a safe and nurturing environment for raising children. Most of these families remain intact while this work is carried out, and the services that have been developed to support them are focused on building parental capacity. In a relatively small percentage of these families children require some period of out of home care

while these capacities are strengthened, as well as to provide a safe and therapeutic environment for children with extraordinary behavioral health needs.

When the family's primary needs are protective, and the service goal is strengthening parental capacities, DCF accesses the Family Networks system to provide services to these families. Through Family Networks, a Family Team is convened by the Area Lead Agency and providers of outpatient or in-home behavioral health services to the family are invited to participate on the team.

Some families have both protective needs and significant behavioral health needs for one or more child. If Intensive Care Coordination is the appropriate behavioral health service and if the family simultaneously needs Family Networks services, a decision will be made with family input to decide whether the Family Team is convened through the Community Service Agency (providing Intensive Care Coordination for CBHI) or through the Family Networks Lead Agency. The following protocols provide guidance to DCF social workers and supervisors on how to make this decision. Regardless of who convenes the Team, it is expected that representatives of each agency will participate as necessary and appropriate.

Other families served come to the attention of the Department through the CHINS process or through a voluntary application for services in order to receive assistance in caring for a child with significant behavioral health needs. A significant proportion of the congregate care population is comprised of CHINS involved adolescents who have behavioral health needs that have not been adequately met through intensive community based services. These youth who are at home, at risk of placement, or already in placement can be a prime beneficiary of the new MassHealth behavioral health services. For eligible youth with significant behavioral health needs, Intensive Care Coordination offered through a Community Service Agency may be an appropriate service. In those cases the Intensive Care Coordinator will convene the Team and coordinate care.

These broad areas of practice represent the conceptual framework for the convergence and integration of the Department's Integrated Practice Model, the Family Networks service management structure, and the Children's Behavioral Health Initiative. What follows are the practice guidance and protocols for the implementation of CBHI within Department casework.

## II. DCF Protocols for the Children's Behavioral Health

### Initiative

#### Primary Care Behavioral Health Screens

- ⇒ DCF social workers are responsible for ensuring that children receive Medical Screening Examinations and Comprehensive Examinations when a child enters a DCF out-of-home placement or enters DCF custody and remains at home.
- ⇒ DCF is required to seek an appointment for a Medical Screening Examination within 7 calendar days and a Comprehensive Medical Examination within 30 calendar days after the child enters DCF out-of-home placement or custody. A comprehensive medical examination is a visit which includes the components required by current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical Protocols and Periodicity Schedule, appropriate to the child's age and focuses on the presence of any acute or chronic medical or behavioral issues that may require treatment, additional evaluation or referral to other medical practitioners.
- ⇒ Every child must have access to primary care. Whenever possible, the comprehensive medical exam should be completed by the child's primary care provider or another medical practitioner in the same practice. MassHealth does not pay for primary care delivered in Emergency Departments. Emergency Departments should not be used for the medical screening examinations for MassHealth Members. When a child under CHINS custody remains at home, the DCF social worker works with the child's parent/guardian to ensure that an EPSDT screen is conducted if needed.
- ⇒ In some cases, the circumstances warranting the transfer of a child's custody to DCF may indicate the need for additional consultation with medical specialists such as child protection teams.

#### DCF Role in Identifying Children With Behavioral Health Needs

Families come to DCF through several paths, including 51A, court custody, CHINS and voluntary requests for services. Regardless of the path to DCF, the process for identifying possible behavioral health needs for children on MassHealth is the same.

⇒ DCF will identify possible behavioral health needs as a structured part of its primary case management decision points:

1. Throughout the DCF Intake, Assessment and Ongoing Casework Process
2. Prior to Referring a Child to Congregate Care
3. Prior to a Child Leaving Congregate Care
4. Prior to Case Closing

⇒ The DCF Social Worker will decide whether a referral for a behavioral health diagnostic assessment (including CANS) and treatment might be appropriate by asking the parent / guardian or other collateral contacts whether any of the following conditions apply to a child or children in the family.

- Does the child appear to be depressed?
- Does the child have outbursts of angry or violent behavior?
- Does the child engage in risky behavior that could result in injury or death?
- Does the child use or abuse substances?
- Does the child have poor interpersonal relationships?
- Does the child have school difficulties that could potentially be related to a possible mental, behavioral or emotional disorder?
- Is anyone concerned that the child may have emotional or psychological problems?
- Is the child currently receiving behavioral health services for any of these conditions?
- If the child is autistic, or developmentally disabled or mentally retarded, does the child also appear to others to have emotional or psychological problems?

⇒ The DCF Social Worker will consult with the Supervisor if there is any reason to be concerned that a child may have behavioral health needs that require services. The supervisor will provide direction to the Social Worker on how to assist the family in determining what services may be most appropriate in accordance with these protocols.

## Identifying The Most Appropriate Behavioral Health Service For a Referral

DCF Referral Goals: DCF's goal in making referrals is to try to ensure that the service meets the child and family's needs and minimizes the number of clinical transitions by helping the family identify what is potentially the most appropriate behavioral health service. DCF will seek to have the behavioral health assessment conducted by the provider most likely to be an appropriate service provider (i.e. Outpatient Therapy, Substance Abuse Treatment, In-Home Therapy, or Intensive Care Coordination through the CSA.) The custodial parent or legal guardian has the right to seek behavioral health treatment including pre treatment assessments from any provider of any service in the child's managed care network.

- Role of DCF Social worker: The DCF social worker, in consultation with his or her supervisor will help the parent/guardian to identify the service most likely to be appropriate, based on the information available. In instances where DCF has care or custody of the child, the DCF will identify the service most likely to be appropriate, consulting with the parents/guardians, in accordance with current practice.
- Role of DCF Supervisor: DCF supervisors will be trained in the differences between the various behavioral health core services offered by MassHealth (i.e. Outpatient Therapy, In-Home Therapy, ICC) and to provide guidance to the social worker regarding the most appropriate service level to refer to for diagnostic assessment and treatment.

## Referring MassHealth Children To A Behavioral Health Assessment

Upon identifying a child in potential need of behavioral health services, the DCF social worker will provide a MassHealth child and family with a referral to an outpatient clinician, in-home therapy or intensive care coordination where they will receive a comprehensive behavioral health diagnostic assessment, followed by behavioral health services as clinically indicated.

- ⇒ If the child already has an outpatient clinician or psychiatrist, the social worker and parent/guardian (depending upon custody) will confer with the child's clinician before making a referral for an assessment.

- ⇒ If a child has a history of significant behavioral health needs or significant trauma, but is not currently seeing an outpatient clinician or psychiatrist, the DCF social worker will share information with the family about the array of MassHealth behavioral health services to help the family determine the most appropriate service and will provide the family with assistance in accessing that service in accordance with these protocols.
- ⇒ If a family is interested in receiving Intensive Care Coordination or In-Home Therapy services, the family may go directly to a local Community Service Agency for Intensive Care Coordination or an In-home Therapy provider to receive a behavioral health assessment and determination of medical need for the service. The Social Worker will assist the family in identifying the service provider in their area.
- ⇒ If a child is in an acute psychiatric crisis, the parent/guardian or caregiver will be directed to immediately call the Emergency Service Provider (ESP) for mobile crisis intervention (described below). The social worker may assist the family in making the call, and will follow up to ensure that emergency services were received.

## Providing Referrals

The referral process for all behavioral health services is as follows:

1. If possible behavioral health needs are identified, the social worker consults with the supervisor as needed to determine which behavioral health service may be most appropriate.
2. Social Worker discusses behavioral health service options and the Department's recommendation with the parent/guardian.
3. DCF social worker obtains the parent/guardian's consent to share and obtain information about themselves and any child under 18 with the service provider. The standard DCF Medical consent form found on the DCF intranet may be used. If the child is in DCF custody, written consent is not required to make the referral for the child.

- Youth over 18 must themselves consent to services and to release information unless the court has appointed a Legally Authorized Representative with the authority to make treatment decisions. Youth over 18 may choose to have their family involved in decisions, but family members or other individuals cannot be involved in any manner without the explicit consent of the youth.
4. The Social Worker makes the referral to the agreed upon behavior health service, or assists the parent in making the referral.
  5. The Social Worker contacts parent/guardian to confirm that the referral has been made and that the intake process is underway.
  6. The Social Worker documents these activities in Family Net

#### For Referrals to Mobile Crisis Intervention Service

##### For Youth Living in the Community

- If the youth is in a behavioral health crisis, the family will be urged to call the ESP/ Mobile Crisis Intervention service in their area. The DCF social worker will have the number of their local Mobile Crisis Intervention service available, and will assist the family in making this call if s/he is requested to do so. The family will be informed that Mobile Crisis Intervention service will come to any location in the community where the youth is located, including home, school or other community setting. The social worker will follow up with the family to make sure that the service was received.

##### For Youth in Placement (Including congregate care and foster care)

- Mobile Crisis should be called by the caregiver or social worker in the event of a behavioral health crisis.

#### Expected Response to Referrals

##### ➤ For Referrals to Intensive Care Coordination

1. Within 24 hours of referral to ICC, the ICC provider will make telephone contact with the parent or guardian to offer a face-to-face interview.

2. A face-to-face interview with the youth and/or family will be offered within three (3) calendar days of the referral to begin a comprehensive home-based assessment.
3. The comprehensive home-based assessment must be completed within 10 calendar days of the date on which consent for ICC was obtained. Eligibility for ICC services is determined as part of the comprehensive home-based assessment.
4. In instances when a youth in DCF custody is referred by someone other than the family or the state agency caseworker, the ICC provider will contact the appropriate DCF office (with proper consent as required by law) to discuss the referral before scheduling the comprehensive home-based assessment inclusive of the CANS. As part of the comprehensive home-based assessment, the ICC care coordinator is expected to secure parent or guardian authorization and to convey it by fax, mail or hand delivery to DCF and the providers with whom they want to speak.
5. The care coordinator will convene the youth's Care Planning Team within 28 calendar days of the parent/guardians consent to treatment.

➤ For Referrals to In-Home Therapy

1. The In-Home Therapy provider responds telephonically to the parent / guardian within one business day of receiving a referral.
2. During daytime operating hours (8 a.m. to 8 p.m.), the In-Home Therapy Services provider responds by offering a face-to-face meeting with the youth or family seeking services within 24 hours.

➤ General

- If the child or youth does not meet the requirements of the service, or if the youth and family do not wish to participate, behavioral health provider is expected to provide a referral to other services, as appropriate.

## Ensuring Continuity of Care During Transitions from Congregate Care

As part of the discharge process from a DCF congregate care to a community setting, the DCF-contracted congregate care provider, DCF social worker, Lead Agency and family will review the youth's needs and options for behavioral health services. In order to ensure a smooth transition to the community and continuity of clinical care, a referral to ICC only will be made no later than three months prior to a planned discharge and no more than 180 days prior to planned discharge. The ICC provider may provide services for eligible youth during this transition period. These services do not supplant services provided through the out of home provider, but rather augment and complement those services. For ICC, the Care Coordinator may convene the first Care Planning Team at the congregate care setting.

Once the family and provider agree on a specific community-based behavioral health service, the DCF Service Plan will be updated. The DCF social worker will note any added behavioral health services in the DCF Service Plan as the treatment plan evolves.

## DCF Participation In ICC Care Planning Team

- DCF Goal for ICC: DCF's goal in the Care Planning Team is to ensure that services support the sustained safety and well-being of children and families. DCF social workers will represent DCF in achieving this goal through collaboration, engagement, partnerships and communication to maximize the formal and informal resources that can help children with behavioral health needs.
  
- DCF Representation on Care Planning Team: For children in the care or custody of the agency, the DCF social worker will participate in the Care Planning Team for the children in their case load. For children not in DCF custody the social worker will participate in the Care Planning Team when requested by the family or youth.
  
- Consent for DCF Social Worker To Share Confidential Family Information within Care Planning Team: In all cases where DCF does not have care or custody, the DCF social worker will receive written consent before sharing confidential family information in the Care Planning Team. The medical release form on the intranet is sufficient.

- DCF Social worker Role: The DCF social worker is an active participant in the Care Planning team and is expected to regularly attend Care Planning meetings. The DCF social worker is expected to function as part of the Care Planning team with the twin objectives of supporting family-driven behavioral health care and child protective services mandates. The DCF social worker is responsible for bringing the concerns of DCF to the Care Planning Team so that a collaborative effort can be made by the Team to adequately address all DCF protective concerns and permanency goals and to try to come to a shared plan of action.
  
- Integrated Care Planning: The ICC Care Planning Team will develop an Individual Care Plan, along with a risk management/safety plan. DCF's Service Plan will be updated.
  - The primary tool for ICC care planning is an Individual Care Plan (ICP). The youth and parent/caregiver (biological, adoptive, foster, guardian, kinship) have the lead role in the development of the ICP supported by the care coordinator and CPT members. Information gathered through the comprehensive home-based assessment and the goals prioritized by the youth and parent/caregiver will guide the plan. The ICP will include both formal services and supports and informal services and supports from the family's natural support system and local community. It is developed by the CPT and specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family and incorporates the strengths and needs of the youth and family.
  
  - The ICC's risk management/safety plan details a response plan for the family to use when crisis situations arise and gives suggestions for how to prevent the need for out-of-home services whenever possible. Each youth must have a risk management/safety plan completed immediately upon gaining consent for participation in ICC. It is expected that this plan will be reviewed at the beginning of each Care Planning Team meeting or more frequently as needed. The risk management/safety plan must be reviewed and updated after a Mobile Crisis

Intervention (MCI), at the time of discharge from a 24-hour facility, or when any circumstances change that impact risk and safety

- DCF Services To Support Community-based Care: As a member of the CPT team the DCF social worker for the referred child will participate in the development of the ICP. Prior to attending the team meeting, the social worker, supervisor and a Lead Agency service coordinator will hold an administrative meeting to discuss what DCF services, if any, may be offered as options to meet goals identified by the CPT. The DCF social worker will then have the authority to approve the inclusion of these services during the team meeting. If community-based services other than those for which prior approval has been given are recommended by the team, the social worker will consult with the supervisor and Lead Agency service coordinator and will inform the Intensive Care Coordinator of services DCF is able to offer in support of the ICP within five business days of the team meeting.
- DCF Placement Providers (including congregate care and foster care) serving a family receiving ICC are expected to participate on the ICC Care Planning Team meetings.

### Coordination Between ICC and the DCF Lead Agency

The DCF Lead Agency provides the utilization management function for all DCF-purchased services (including service identification, referral, and utilization review). In addition, the Lead Agency convenes a Family Team to coordinate services for a DCF-involved family. However, if a child is receiving Intensive Care Coordination services, the ICC will convene the Team and coordinate services. The Lead Agency will not convene a separate Family Team, but will authorize and review utilization of DCF-purchased services for the family. With the family's approval (except when DCF has custody), the DCF supervisor may, at their discretion, ask the lead agency coordinator to attend the ICC Team, if they determine that it might be beneficial.

### How Custodial Issues Impact The Care Planning Process

- In The Decision to Access ICC Services: 1.) When DCF has no custody the custodial parent/guardian will determine whether a referral to Intensive Care Coordination should

be made. 2.) When DCF has non-CHINS custody the social worker will seek the support and participation of the parent(s)/guardians (when appropriate /available) in the care planning teams. Family Partners can be helpful in engaging parents/guardians in these circumstances. 3.) When DCF has CHINS custody or a voluntary placement agreement has been signed, the social worker may defer to the wishes of the parent/guardian regarding a referral to and their participation in the care planning team, or alternatively after consulting with the supervisor, proceed with the referral in the absence of parent/guardian support.

- When DCF has custody and the goal is Permanency through Family Reunification, the ICC Care Coordinator's goal is to facilitate the development of a family driven plan which supports the reunification process while recognizing DCF permanency planning obligations. In this instance, the CPT process should simultaneously respect the department's mandate to ensure the child's safety and welfare and engage the family and build on their strengths and capacity to meet the child's needs. The care planning team process is intended to build common ground and address the concerns of all parties through the Wraparound Team process.
- If DCF has custody and the goal is to achieve Permanency through Adoption, Guardianship, Kin or Alternative Planned Permanent Living Arrangement, the ICC care planning process can enhance permanency if the child has a stable team that will be with the child for the coming year. If the plan is to discharge the child to a kinship placement, pre-adoptive placement or intensive foster care agency it is expected that the receiving parent/guardians will participate in the development of the Care Planning Team and fully support the implementation of the Individual Care Plan.

In the event that DCF places a youth receiving ICC in a temporary foster care setting, it is expected that ICC will schedule a team meeting for care coordination and disposition planning at the earliest possible date. If the placement is outside the CSA service area, the ICC provider will work with DCF and the Care Planning Team to consider whether transfer of ICC services to the closest Community Service Agency (CSA) would be in the child's interest. This transition of care should include the youth and parent/caregiver, the DCF social worker, and the full Care Planning Team.

- ICC can also support youth who are working toward living independently. ICC will work with DCF social worker and the youth to convene a team that will support the youth through the transition to young adulthood. Family members may be included in the team, even if the youth will not return to the family. If DCF has custody, the youth's voice and viewpoint should be an important aspect in determining the composition of the team.

## Partnering With Community Service Agencies (CSAs) Providing Intensive Care Coordination (ICC)

### Establishing a DCF/CSA Collaborative Relationship:

The Area Director and the Lead Agency Program Director of each DCF Area Office will establish a working relationship with the director of the Community Service Agency (CSA) and the ESP/Mobile Crisis Intervention provider in their area to facilitate collaboration for families served by both agencies. If a Specialized CSA also serves their area, the Area Director and Lead Agency Director will also establish a working relationship with the Specialized CSA. Area Directors will confer at least quarterly or more frequently if needed with CSA and ESP directors in order to ensure issues are addressed as they arise in the implementation and ongoing operations of this new system.

### DCF Participation in Local System of Care Committees

- Each DCF Area Director will assign an Area Program Manager to represent the Department at each Local Systems of Care committee.
- When issues arise within the Local System of Care committee meetings that are of concern to the DCF Area Program Manager, these issues will be referred to the DCF Area Director and, as appropriate, to DCF Regional Director and the representative on the CBHI Interagency Team at the State level.
- Each DCF Area Director will invite the CSA Director to sit on Area Board. (During the first year of start-up, this may not be possible for the CSA.)

## Trainings To Ensure Coordination Between DCF and ICC

- DCF Staff Training: All DCF Regional Directors, Regional Clinical Directors, Area Directors, Area Program Managers, Supervisors and Social Workers will receive training in Wraparound, these protocols, and the CBHI service system. The purpose of the Wraparound training is to understand the process of collaborative care planning and the various roles of DCF social workers, supervisors and area directors in the process.
- CSA Staff Training: Care coordinators and family partners will receive training in collaborative approaches to working with DCF, including DCF's protective mandate and how the array of custody arrangements may impact the care planning team process. DCF staff will help deliver this aspect of the CSA training.

## Summary Roles and Responsibilities of DCF Staff

### Role of the DCF Social Worker

1. Obtains information from parent / guardian and collaterals regarding the behavioral health needs of children
2. Consults with supervisor to determine what services may be most appropriate and discusses service options with the parent / guardian
3. Assists in accessing the agreed upon service (s).
4. Participates in ICC Team
5. Documents activities in FamilyNet
6. Updates DCF Service Plan as needed

### Role of the DCF Supervisor

1. Supervisor provides supervision to the Social Worker to assist in determining the most appropriate behavioral health service.
2. Supervisor seeks additional advice, if needed, on the appropriate level of service from the Area Program Manager.
3. Supervisor follows up with Social Worker to learn the outcome of the referral.
4. Supervisor prepares Social Worker for participation on Care Planning Team if Intensive Care Coordination services are to be provided.

### Role of the DCF Area Program Manger

1. Area Program Manager assures referral of MassHealth-eligible children and youth with behavioral health needs to MassHealth Behavioral Health services is covered in supervision with their assigned supervisors.
2. The Area Program Manager provides consultation to the supervisor regarding the most appropriate level of behavioral health service for a child and family.
3. The Area Program Manager monitors/manages the smooth flow of shared cases between DCF, the area lead agencies and the Community Service Agencies.
4. The Area Program Manager represents the Area Director on Local Systems of Care Committee.

### Role of the Area Director

1. The Area Director is the primary liaison to the Community Service Agency. The Area Director and the CSA Director develop a collaborative working relationship in order to ensure the successful integration of Children's Protective Services mandates with the Wraparound care planning process.
2. The AD ensures that all area office staff are knowledgeable about the local behavioral health system, including service definitions, service locations, referral procedures, the

Wraparound Principles of Care, and the process and procedures of Intensive Care Coordination care planning teams.

3. The Area Director convenes monthly meetings with the Director of the CSA to identify and resolve issues related to the integration of the CPS and behavioral health service systems.

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