A Crisis Care Continuum for Children and Adolescents

The Boston Medical Center Model

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KEYWORDS

• Emergency psychiatry • Behavioral health continuum • Community psychiatry child • Adolescent psychiatry

KEY POINTS

- Pediatric Emergency Department (ED) visits for psychiatric crises continue to increase in volume; youth without acute suicidality or psychosis may spend hours in EDs and never see a mental health professional, resulting in limited clinical benefit.
- Coordinated community care models can help a patient move from crisis to stable care in the community, reducing the need for costly and less efficient ED care.
- Short-term clinics can provide meaningful stabilization and act as a bridge to long-term outpatient care.
- Community crisis services may be preferred by patient populations with historical mistrust of police and EDs.

CASE VIGNETTE

Danny is a 6 year old Hispanic, cisgender boy, living with his mother and 3 siblings in Boston. Danny is an energetic and social child who learns new concepts quickly. However, shortly after the transition to first grade, he started exhibiting behavioral challenges. Danny had difficulty staying on task in the classroom and acted out verbally, when teachers attempted to redirect him. Over time, this behavior escalated

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Abbreviations	
BMC	Boston Medical Center
BPD	Boston Police Department
CAHOOTS	Crisis Assistance Helping Out on the Streets
CBHC	Community Behavioral Health Center
CBHI	Children's Behavioral Health Initiative
ED	emergency department
EMS	Emergency Medical Services
MCI	mobile crisis intervention
SEU	School Engagement Unit
YCBHC	Youth Community Behavioral Health Center

and Danny hit and spit on staff. During a particularly difficult day, the school contacted Danny's mother.

Danny's mother was surprised by Danny's behavior at school. Although Danny had difficulty listening at home and had hit his sisters on rare occasions, she had not thought that the behaviors were developmentally inappropriate. She made an appointment with their pediatrician, who referred the family to an in-home therapy program. Danny's mother also worked with the school to begin testing him for special education services.

School staff began offering accommodations to support Danny, including access to breaks throughout the day. Although these had some positive effects, Danny's episodes of dysregulation continued daily. Eventually, school staff felt they could not manage Danny's difficult behaviors and called 911. Emergency Medical Services (EMS) arrived at the school and bring Danny to the Emergency Department (ED) in an ambulance. Danny was nervous to ride in the ambulance but relieved to be leaving school, where he felt his teachers didn't like him.

In the ED, Danny calmly colored with a child life specialist until his mother arrived about an hour later. She felt overwhelmed by having to leave work and dismayed that the school put Danny in an ambulance. She thought that the in-home therapy had been helping Danny to talk about his feelings and practice coping skills he could use in school. Danny's mother initially consented to have a psychiatric evaluation at the ED, but after waiting over 5 hours, she choose to take him home and prepare dinner for him and his siblings. She continued the in-home therapy and scheduled another visit with the pediatrician.

Following another episode, the school suspended Danny for 2 days. Danny's mother was required to attend a re-entry meeting when Danny returned to school, where the school encouraged her to obtain additional behavioral health services for Danny. Less than a week later, the school called 911 again. This time a specialized officer from the School Engagement Unit (SEU) of the Boston Police Department (BPD) responded to the call. After speaking with school staff, the officer requested a mental health clinician (a co-responder who works with BPD) to evaluate Danny at the school.

The co-response clinician talked with the school staff, Danny, and Danny's mother. School staff were frustrated; they were communicating with Danny's mother daily about his behavioral challenges. They felt she had not obtained the additional mental health support that her son needed. The school was advocating for inpatient psychiatric admission. When the co-response clinician talked with Danny, he said that everyone at school was annoying him on purpose. He stated that the ED was boring, the food was terrible, and he didn't want to go back. The co-response clinician then spoke with Danny's mother on the phone. She was concerned about her son and felt she had been actively seeking help through the in-home therapy program, as

advised by the pediatrician. However, she was incredibly frustrated by the school's use of 911 and did not want Danny to be transported to the ED again. The last ED trip resulted in missed educational time for Danny, missed work and earnings for her, and stress during a scramble to find childcare for Danny's siblings. Due to the long wait time in the ED, Danny did not even receive a psychiatric evaluation in the ED.

The co-response clinician provided Danny's mother with information about available urgent mental health services, including mobile crisis intervention (MCI) and the Community Behavioral Health Center (CBHC). She decided to pick up Danny from school and have the MCI team conduct an evaluation in their home. During this evaluation, Danny's mother shared that Danny's grandparent had recently become ill, which may have contributed to Danny's behavior at school. She also shared that Danny's father, who lives outside the home, is not supportive of Danny engaging in behavioral health services. With Danny's mother's permission, the MCI clinician spoke to Danny's school counselor, who reviewed the reasons for the 911 calls, defended Danny's suspension, and reaffirmed the school's belief that inpatient hospitalization was needed.

The MCI clinician discussed treatment options with Danny's mother, who agreed to have Danny referred to the CBHC. They scheduled an intake appointment for Danny the following day to discuss treatment options. The next day, Danny and his mother arrived at the CBHC and met with a behavioral health clinician as well as a family resource navigator. The clinician played with Danny while asking him about his friends at school and his favorite toys. During the conversation, the clinician learned how worried and sad Danny was about his grandmother. Danny's mother shared her worries that Danny had been unable to independently apply the skills he was learning through the in-home therapy to the school setting. The family navigator, who is bilingual, spoke with Danny's mother in Spanish. Feeling more comfortable in her native language, Danny's mother shared how pressured she felt by the school to hospitalize her son or put him on medication. The family navigator reassured Danny's mother that her choices for her son's care would be respected. After thinking over the options, she decided to schedule an individual therapy appointment for Danny and to join the CBHC parent support group. She also scheduled a consult with the psychiatrist. She shared that she was skeptical about medication, but she would like to learn about all the options for Danny.

SYSTEMIC CHALLENGES IN YOUTH BEHAVIORAL HEALTH CRISIS CARE

Danny and his mother are not alone in feeling overwhelmed in navigating behavioral health challenges and health care systems. Mounting evidence indicates that child and adolescent behavioral health has reached a crisis point, marked by sustained increases in behavioral health conditions, unmet treatment needs, and emergency services utilization. Prior to the COVID-19 pandemic, as many as one in 5 youth in United States experienced behavioral health conditions every year.[1] The pandemic then increased youth anxiety and depression.[2,3] Shortages of behavioral health providers make accessing care difficult for youth and families.[4–6] Fewer than half of youth in need receive behavioral health services.[7] As a result, the past 2 decades have seen drastic increases in pediatric hospitalizations and ED visits for behavioral health issues.[8–10]

Over the next few pages, we describe the components of the crisis continuum of services offered at Boston Medical Center (BMC), the largest safety net hospital in New England. We also describe existing research related to different components of crisis care. Research in this space is scarce but growing, with little evidence for

the effectiveness of specific care components or the mechanisms by which they may impact outcomes. Existing research is often criticized as not being sufficiently rigorous; however, it can be challenging to conduct randomized-controlled trials in the context of behavioral health crises, especially when partnering with emergency systems and law enforcement. There is a critical need for high-quality quasi-experimental research to inform the growth and operation of crisis care. At BMC, our programs have been developed in direct response to community behavioral health needs and offer a range of pathways and settings where youth and families can receive care.

EXTERNAL INFLUENCES ON BEHAVIORAL HEALTH PROGRAMMING

In Massachusetts, the payer and behavioral health policy landscape creates access to both crisis intervention services and community-based programming for the majority of youth and families. Massachusetts enacted a reform law in 2006 requiring insurance coverage for individuals of all ages and expanding access to Medicaid coverage—known as Masshealth—for youth. In this context, the state sees near universal insurance coverage for youth under 18 including those who don't meet residency requirements.

Two separate but related initiatives–the Children's Behavioral Health Initiative (CBHI) and the CBHC– support access to crisis intervention services and community-based behavioral healthcare. The CBHI established a range of community-based services, including MCI, guided by the wraparound model emphasizing family voice and choice and providing low barrier access to care. Families are able to self-refer to any services within the initiative and recieve care regardless of insurance status. The CBHC also established a continuum of programming (described throughout this article and summarized in **Table 1**), including urgent ambulatory services, medical management, and brief therapy regardless of insurance status.

Both CBHI and CBHC began with a focus on publicly insured youth and their families but, but the efforst of statewide authorities, have since expanded to include some coverage from most in-state commercial insurers as well, supporting equitable access for all youth in crisis. As a result, all services except for full CBHC core services are insurance blind and limited CBHC core services are available regardless of insurance status.

BMC has been serving at the designated MCI team for much of the city of Boston since 2003, operating in partnership with two local behavioral health care agencies. Over the past 2 decades, BMC has also developed partnerships with BPD and Boston EMS to embed behavioral health professionals within citywide crisis response. BMC's continuum of crisis care for youth now includes a 24/7 call center, MCI services (which include mobile response and a community-based psychiatric urgent care center), a psychiatric ED (PED), a CBHC clinic, and co-response programs with city police and EMS. **Table 1** shows the volume of individuals under age 18 who were served by each component of the BMC crisis care continuum in the year 2025. This continuum of services, shown in **Fig. 1**, provides crisis care options across ED, outpatient and community settings. This acknowledges that families may not know how to seek behavioral health care at the moment of crisis and provides multiple pathways, shown in **Fig. 2**, by which they may be connected to services. For example, when a parent calls 911 about a child in behavioral health crisis, dispatch will conduct initial triage. Depending on the situation, they may route the call to the police, EMS, or the BMC call center.

Table 1
Volume of children and adolescents (under 18) served in the BMC continuum of crisis care in 2025

Program	Encounters	Individuals
Call Center	937	631
Police Co-Response	565	372
EMS Co-Response	198	172
Psychiatric ED	304	234
Psychiatric UCC	111	106
MCI	869	614
CBHC	7395	2800

CALLING FOR HELP. WHO RESPONDS?

For individuals and families experiencing behavioral health crises, calling 911 is often the default response and a primary point of entry into behavioral health care.[11–13] There is a scarcity of research on the use of 911 for children and adolescents experiencing behavioral health crises. Recent studies suggest that the Boston Public School system makes 200 to 300 calls to 911 per year for behavioral health crises, close to 10% of all 911 calls made by the district.[14,15] We know very little about how often parents, youth, or other concerned individuals call 911 for youth behavioral health issues outside of the school setting. The emergency call-takers who answer 911 calls must assess each issue remotely and use caller-provided information to decide whether response should be led by law enforcement, EMS, or another specialized program.[16]

When the information available is insufficient to establish the health and safety for those at the scene and/or the potential responders, law enforcement may be included in the response. Therefore, police may be the first to respond to the scene of a behavioral health crisis.[17,18] Communities, journalists, and scholars have raised concerns about the role of police in crisis response, including increased use of force[19–21] and unnecessary arrests.[22,23] For youth specifically, police involvement during experiences of involuntary psychiatric hospitalization and transport results in largely negative experiences that felt coercive and criminalizing.[24] This reflects the fact that police officers feel unprepared to respond to behavioral health crises, including in youth.[25,26] To address both community and officer concerns, police departments and behavioral health providers are increasingly collaborating to respond jointly to behavioral health crises.[27] One common model for these partnerships is co-

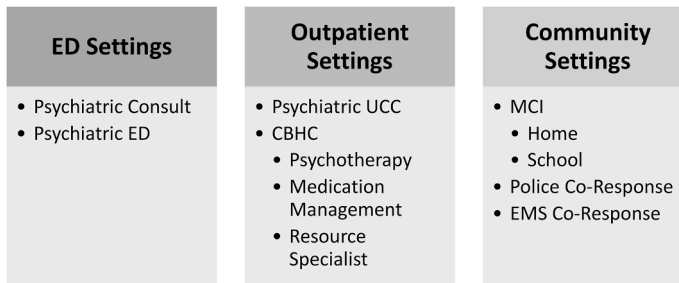

Fig. 1. BMC continuum of child and adolescent crisis care. BMC, Boston Medical Center.

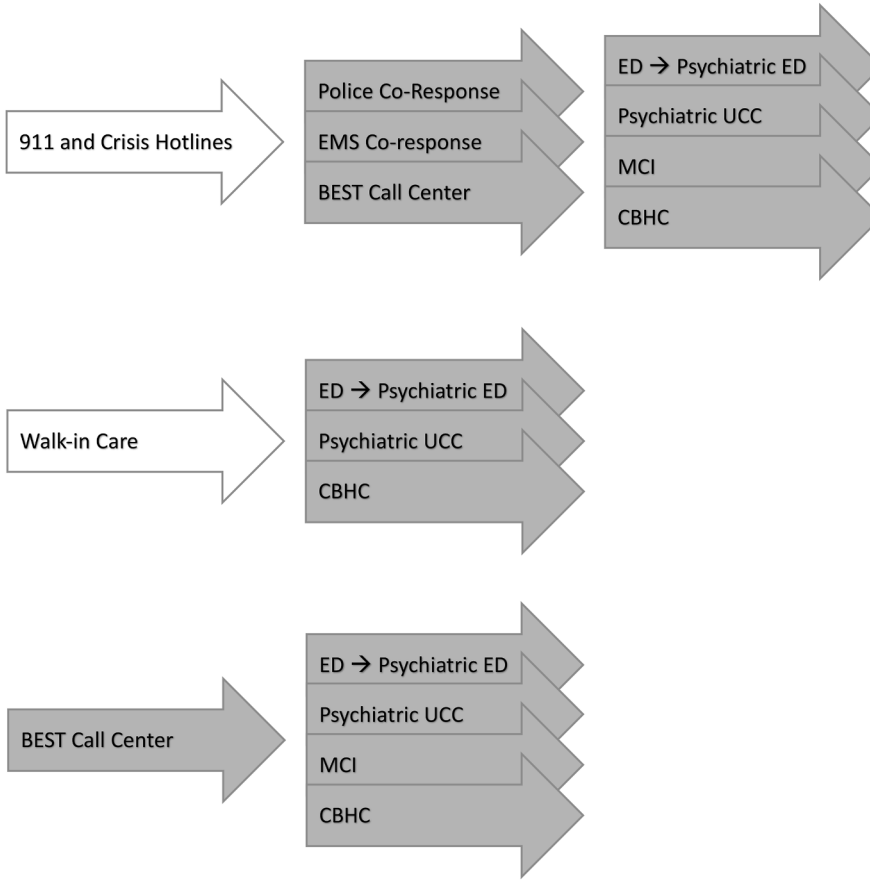

Fig. 2. Pathways into the BMC continuum of crisis care. BMC, Boston Medical Center.

response, where police officers are paired with behavioral health clinicians; this pair "co-responds" to calls involving behavioral health, safely stabilizing individuals in crisis and diverting them from arrest.[28,29]

Evaluating the effects of co-response models is challenging, as the context makes randomized experiments difficult. Quasi-experimental and observational research suggests that co-response may reduce police use of force[18,30–32] and arrest.[33] In a study of youth encounters, co-response was associated with increased de-escalation and lower likelihood of involuntary hospitalization.[34] However, a more robust body of research is necessary to better understand the short- and long-term effects of co-response programs for children and adolescents experiencing behavioral health crises.

BPD, in collaboration with BMC, launched a co-response program in 2011.[29,35] In this program, Master's level clinicians and police officer co-response pairs respond to calls involving confirmed or suspected mental health concerns. In addition, BPD officers can request a consult from a co-response clinician after arriving on a scene where they have identified a behavioral health need. Co-response clinicians assist with de-escalation, triage immediate behavioral health needs, and make disposition recommendations. Outcomes of these interventions include connecting youth and families to available behavioral health resources, transporting youth to a diversionary setting such as the MCI Urgent Care Center or supporting officers in determining the

need for transport to an ED for acute concerns. The program is overseen by a Clinical Director of Criminal Justice Diversion and includes 13 full-time dedicated clinicians, including one dedicated to the BPD SEU. The SEU is a plainclothes team of officers who receive specialized training from the National Association of School Resource Officers. The SEU co-response clinician serves alongside officers in response to school-based 911 calls that involve behavioral health concerns. In addition to providing on-site clinical support and assessment for students in crisis, the co-response clinician shares relevant information with other components of Behavioral Health Crisis Continuum and makes clinically appropriate follow-up referrals.

A 911 operator may also choose to dispatch EMS to a scene, with or without including the police. National data indicate that approximately 10% of pediatric EMS encounters are for behavioral health issues.[36,37] The volume of children and adolescents transported by EMS for behavioral health emergencies has increased over time.[38] Included in these encounters are EMS responses to youth behavioral crises in school settings. National data from 2018 to 2022 indicate that behavioral health issues account for 16.7% of school EMS encounters; 78.3% of those encounters resulted in transportation to an ED.[39]

Collaborations between EMS and mental health professionals have been proposed as an alternative to crisis response that involves police, with the goal of reducing arrests and use of force. A quasi-experimental difference-in-differences design study of the CAHOOTS program (Crisis Assistance Helping Out on the Streets), which is based in Eugene, Oregon, pairs paramedics with behavioral health providers to respond to behavioral health emergencies. A quasi experimental study utilizing a difference-in-differences analysis demonstrated that CAHOOTS replaces 18% of police responses and reduces emergency calls by 23%.[40] As with co-response, these types of programs are becoming more popular; similar models have recently been implemented in Phoenix, Arizona and Denver, Colorado.[41] The novelty of these programs means that we do not yet understand their potential for diverting non-emergent behavioral health crises away from EDs and toward specialty behavioral health care. Research has also not yet examined the effects of these programs specifically for children and adolescents.

BMC and Boston EMS launged a similar program, the Alternative Response Model (ARM) program in 2023. The goal of the ARM is to respond to 911 calls determined to be non-acute behavioral health concerns, with the objective of providing real-time clinical intervention, diverting ambulances to higher acuity calls and avoiding unnecessary ED transports. This specialized unit partners an EMT with a Master's level clinician in an SUV that contains emergency supplies. The ARM unit can be dispatched directly to calls as a first line response or requested on scene by supervisors or EMTs if a behavioral health need is identified during an ongoing response. Similar to the BPD Co-response team ARM clinicians on scene assist with de-escalation, triage immediate behavioral health needs and determine appropriate next steps based on the nature of the clinical concerns. ARM unit vehicles are equipped to provide transportation to a diversionary setting such as the MCI Urgent Care Center; however, incidents can also be resolved on scene when clinicians provide information and referrals to community based behavioral health programs. The ARM program currently supports 4.2 full-time equivalent behavioral health clinicians.

In Boston, a 911 operator can also elect to divert behavioral health calls that are not likely to require immediate police or EMS response to the 24/7 BMC Crisis Call Center through the Hot Handoff program. Individuals or family members who initially call 911 can consent to have their call transferred to the Call Center if the EMS call-taker

determines that the call is more appropriate for a dedicated behavioral health crisis service. A live transfer is completed between the 911 operator and call center clinician in which the initial information shared by the caller is shared as well as the EMS incident number and operator ID. The Call Center clinician then engages directly with the caller to discuss their concerns and engage in shared decision making on potential outcomes. Outcomes may include an MCI evaluation, provision of general information about available behavioral health services or transfer to a specialized support hotline (eg, veteran's support line, peer support warmlines). If at any point during the Call Center interaction the caller requests to be transferred back to 911, or if the clinician determines there is acute risk that requires intervention by police or ambulance the call will be live transferred back to 911 noting the EMS incident number to ensure a seamless transition.

The Call Center also receives calls directly at 1-800-981-BEST from a wide variety of sources including community members (on their own behalf or for loved ones), transfers from 988, behavioral health providers, primary care offices, and schools. Master's level clinicians at our Call Center provide initial triage in response to requests for service from the community and coordinate an appropriate response. The incoming calls fielded by the Call Center fall into multiple categories: requests for MCI, callers looking to be directed to the CBHC clinic, follow up on previous encounters (including MCI and CBHC encounters), and callers with general questions or seeking information about connecting to behavioral health services. In particular, the call center is responsible for dispatching MCI clinicians to the community when that is the most appropriate response.

COMMUNITY RESPONSE

Originally developed in the 1970s, MCI programs provide emergency behavioral health care in the least restrictive setting possible in order to de-escalate behavioral health crises within the community and divert individuals from unnecessary ED visits or inpatient hospitalizations.[42,43] MCI programs may also help reduce the criminalization of behavioral health conditions because they are generally staffed exclusively by behavioral health professionals and minimize law enforcement involvement.[43]

BMC's MCI services can be initiated either through the 24/7 Call Center or by walking into the MCI Urgent Care Center. The Call Center can dispatch the team to a community location (eg, a home or school) or facilitate a telehealth visit with an MCI clinician. The MCI program makes every effort to respond within 1 hour from the time the request is received. The program is staffed by a multidisciplinary team including Master's level clinicians, Bachelor's level Resource Specialists and trained Family Partners who have lived experience raising children who have received care through the behavioral health system. The MCI program has a leadership team of Clinical Supervisors and Program Directors and is supported by the larger BMC leadership team including the Youth Medical Director. One of the particular strengths of the BMC Behavioral Health Crisis Continuum is that the Youth Medical Director not only provides oversight across programs including consultation to the MCI team but also delivers clinical care in the CBHC core clinic. This continuity allows youth and families numerous benefits including full access for the ambulatory team to the clinical information gathered by the MCI clinicians at the time of the crisis, a consistent clinical approach, and a community-based provider who is deeply knowledgeable about the resources available to help manage acute behavioral health concerns.

BRIDGING CARE

The Youth Community Behavioral Health Center (YCBHC) Core Services Clinic is a walk-in behavioral health clinic for youth ages 0 to 20 with public insurance. The CBHC is staffed by the Youth Medical Director, medical providers (MD and NP), a therapist, a clinical supervisor, a medical assistant, a family navigator, a patient care coordinator and a nurse. The Youth Medical Director provides leadership in programming and policies in the YCBHC and coordination across the CBHC continuum of care. The medical providers (including the Youth Medical Director) provide diagnostic and psychopharmacology evaluations, group therapy, and family therapy. The therapist provides individual and group therapy. The clinical supervisor supervises the therapist and family navigator, manages the day-to-day operations of the clinic, and does the majority of brief needs assessments for families who present to the clinic. The Family Navigator works with families to access community resources and referrals, and navigate the mental health system. For example, the Family Navigator can help a parent prepare for their child's psychopharmacology visit, or connect a family to community food resources, or help a teenager apply for a summer job. The Family Navigator also does outreach to schools and other community organizations. The nurse supervises the medical assistants, manages the pharmacy triage line, provides patient health education, administers long-acting injectable medication, and contributes to care coordination for patients and families. The medical assistants take vital signs, administer patient-reported outcome measures, and assist in care-coordination. The Patient Care Coordinator manages the front desk and administrative needs of the clinic.

To access care in the YCBHC, families just walk into the clinic. They are offered a brief assessment within 24 hours of walking in, a therapy intake within a week, and a medication evaluation within 72 hours as appropriate. Different components of the continuum and community partners can contact the YCBHC ahead of time when a walk-in is anticipated. For example, a child might be seen in the school by a co-responder or MCI team and then directed to walk into the CBHC after school.

YOUTH BEHAVIORAL HEALTH CRISIS AND THE EMERGENCY DEPARTMENT

Although MCI and urgent behavioral health services can reduce the volume of behavioral health ED visits, the ED will continue to be a point of entry into services for children experiencing crises and their families. As Danny and his mother experienced, the ED is not the most effective setting for responding to non-emergent behavioral health issues. ED visits for behavioral health often involve long wait times, extended boarding, and a potentially upsetting environment.[44–47] In addition, EDs vary in whether they staff behavioral health professionals or have staff trained in child and adolescent mental health.[10,48] Further, research suggests that children and adolescents who utilize ED services for behavioral health often do not access follow-up outpatient care.[49,50] A recent systematic review examined interventions that integrated behavioral health services for children and adolescents into the ED setting. As compared with usual ED care, behavioral health interventions within the ED were associated with lower inpatient psychiatric hospitalization rates and increased uptake of outpatient specialty behavioral health care.[51–53]

PROGRAM STRENGTH: AN INTEGRATED CONTINUUM

The BMC Behavioral Health Crisis Continuum is supported by a centralized administrative and operational structure that allows for real-time coordination across programs and ongoing efforts to address the challenges that can occur across teams

playing different roles in the community and operating in locations across the city. These central structures include:

- An integrated leadership team that includes Director-level staff from across programs acting as Administrator On Call to support the day-to-day clinical operations of the continuum.
- A 24/7 Call Center staffed by Master's level clinicians that acts as a coordinated information hub and directs requests for service to the appropriate component of care.
- A web-based electronic medical record that is accessible in real time to all program staff whether they are using a desktop computer in an office or a smartphone in the field.

These independent but interconnected teams of providers facilitate interventions at key intercept points where youth with acute behavioral health concerns interact with the larger system of care. As an acute care hospital, the BMC ED acts as both a receiving facility for clinically high-risk patients from the community-based teams as well as a referral source to the diversionary services in the continuum.

PROGRAM STRENGTH: ACCESSIBILITY AND DISPARITY REDUCTION

Our programs provide many doors for access to ongoing behavioral health services, including self-initiated community and office-based evaluations and referral pathways for non-psychiatric providers to connect individuals to behavioral health crisis services. Unlike traditional ED services, follow-up and continued engagement in care are structural components of our programs including 7 days of acute follow-up from the MCI team and up to 3 months of care in the CBHC.

Unlike many specialty behavioral health programs that are available to private pay or privately insured youth only, our programs are accessible to publicly insured youth. Ability to pay is not a barrier to receiving services and an ability to pay does not change the wait times to access services.

There are many paths into our programs for behavioral crisis services that do not involve the police at all or mitigate the risks of police involvement. BMC serves a diverse population, predominantly patients and families of color and patients with significant adverse social determinants of health. While Black patients are overrepresented in crisis care, they are underrepresented in 911 calls.[54] A recent 2023 survey found that Black and Native American individuals were less willing to call police in an emergency.[55] Alternatives to calling 911 and risking police involvement may be more acceptable to our patient population.

PROGRAM CHALLENGES: ENGAGEMENT

During the initial launch of the school engagement clinician position there were challenges with school and police utilization of this new position and the school engagement clinician was often underutilized. Identified challenges in utilization included school thresholds to keep a student in crisis on campus to wait for co-response, rather than calling 911 for the student to be removed, and adapting police workflows to effectively move one clinician between officers potentially responding to 120+ Boston Public School sites. Additionally, schools were trying to reduce police presence, and engaging the SEU co-responder necessitated the presence of police. Discussions between the police, the crisis services, and the schools focused on better partnership and collaboration to meet the behavioral health needs of the student population are ongoing to address these challenges.

General public knowledge of and engagement with prehospital crisis services are another challenge. EDs and 911 services are default services that the general public is very aware of. They are the central subjects of popular television shows. Alternative models that divert away from these systems do not have the same ubiquitous recognition. Increased education of the public and raising awareness about these alternative services is needed to make families knowledgeable about the continuum of behavioral health services before they need them.

PROGRAM CHALLENGES: YOUTH MENTAL HEALTH TREATMENT CAPACITY

The underlying goal of all crisis response is to connect individuals with the ongoing services and care they need to achieve stabilization and ultimately to prevent future crises. Massachusetts, like many states, continues to struggle to maintain sufficient access to ambulatory care, which is necessary to allow clients in urgent care settings to transition to long-term providers. The result of this inhibited throughput can include individuals repeatedly cycling through crisis care without a clear pathway to consistent care, which can be vital for sustained recovery.

PROGRAM CHALLENGES: SOCIAL DETERMINANTS OF HEALTH

Among the most significant challenges in addressing the behavioral health needs of youth and families is the intertwining of social determinants of health in each family's circumstances. Although Massachusetts has largely eliminated insurance coverage as a barrier to care many others exist including available funds to support transportation, child care, missed work to attend appointments, prescriptions, etc. When families need to prioritize retaining unstable housing and gaining sufficient income through multiple jobs, other concerns like engaging behavioral health care are deprioritized contributing to the cycle of engaging in crisis care noted above.

END OF VIGNETTE

Danny had his first individual therapy session, and his mother met with the CBHC psychiatrist. After Danny's mother and teachers completed some screening forms and the psychiatrist conducted a clinical assessment with Danny, he was diagnosed with ADHD, combined type, and Adjustment Disorder with Mixed Disturbance of Conduct and Emotions. Although the current crisis was resolved, diagnosis and connecting with outpatient providers is only the first step in the long-term navigation of Danny's behavioral health needs. CBHC provides short-term care and will help the family connect with any appropriate specialty behavioral health services in the weeks to come. Like many children with behavioral health challenges, Danny may have repeat visits with crisis services. In the meantime, we will continue to grow and adapt our continuum of crisis services to meet the needs of the Boston community.

CLINICS CARE POINTS

- Psychiatric crisis services and other behavioral health care systems can be difficult for families to navigate.
- The BMC Model integrates multiple components of crisis response, including a call center, police co-response, EMS co-response, MCI, a psychiatric ED and UCC, and short-term outpatient care.

- An integrated system of crisis care helps connect families with urgent, stabilizing community-based care even if 911, law enforcement, or EMS is the initial point of contact.

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