MOBILE CRISIS SERVICES FOR CHILDREN AND ADOLESCENTS

TRAINING RESOURCE

BEST PRACTICES
GUIDELINES FOR MOBILE CRISIS WORKERS
GUIDELINES FOR MOBILE CRISIS SERVICES
REFERENCE MATERIALS
ACKNOWLEDGEMENTS

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SECTION I

BEST PRACTICES
INTRODUCTION

OVERVIEW OF THE PROJECT

The Ministry of Community and Social Services (MCSS), together with the Ministry of Health & Long-Term Care (MOHLTC), has embarked on an initiative to strengthen mobile crisis services across Ontario to serve children and adolescents better.

Youthdale Treatment Centres has taken the lead with a team of clinicians, researchers and educators with a special interest in children's mental health to develop a training resource for mobile crisis services based on research into current best practices in North America.

The best practices suggested here derive from:

1. A review of the research literature on mobile crisis services, with an emphasis on models developed for children and adolescents.

2. Interviews with crisis service providers and other key informants to identify best practices and develop effective approaches to staff training.

A search for published materials on mobile crisis services was conducted using the MedLine, PsychLit and Social Work Abstracts databases. Publications on mobile crisis services in North America and unpublished literature provided by professionals in the field were reviewed for best practices.

Semi-structured interviews were conducted with 15 crisis service providers across Canada and the United States using an instrument developed by the principal researchers and the Advisory Committee. In addition, key informants from MCSS and MOHLTC and professional association representatives were interviewed.

It must be emphasized that the best practices and service model outlined in this resource may need to be adapted to respond to the unique characteristics of each region of Ontario. Partnerships and collaborations with local service providers will be critical in the development of mobile crisis services, particularly in regions with larger areas or more limited resources.
DEFINITION OF CRISIS

Most models of crisis intervention are organized around a working definition of “crisis”. The Crisis Worker's Society of Ontario maintains:

“[Crisis is] the onset of an emotional disturbance or situational distress (which may be cumulative), involving a sudden breakdown of an individual's ability to cope. The individual's state of crisis (distress) is not likely to change/improve, and may worsen without immediate intervention. At times, such crisis may result in putting the person at risk of potential harm to themselves or others. It is recognized that a crisis state is subjective … and that it can be precipitated by biological and/or psychosocial factors.”

RATIONALE FOR MOBILE CRISIS SERVICES FOR CHILDREN AND ADOLESCENTS

A mother places an urgent call to a local children’s mental health centre with the hope of obtaining immediate help for her son. The intake worker is only able to offer an appointment in eight weeks time. The mother is upset and frantic because her son's problems have escalated beyond the family's ability to cope. There are other children in the home to care for and everyone is at their wit's end. The boy's school is calling daily with complaints about his oppositional and disruptive behavior and his mother fears for her son's psychological and physical well-being. If the intake worker could direct the mother to a mobile crisis team, the child could be seen in the home or at school within a short period of time. The mother's immediate concerns would be addressed, while the family waited for an appointment for non-urgent services. In the absence of a mobile crisis service, the family is isolated, with an escalating and potentially dangerous situation on their hands. Some parents may opt to take their child to a local hospital emergency room; others may adopt a “wait and see attitude” which could inadvertently worsen the child's condition.

Mobile crisis services in North America are designed and operate primarily for adults. An exception is Younddale's Crisis Support Team that was established in 1981, and provides mobile crisis response for children in Toronto (Armstrong, 1987).

Mobile crisis response for children is identified as a priority need in improving the delivery of children's mental health services in Ontario. This innovative model of intervention has been defined as follows: “Mobile crisis teams (MCT) employ the spectrum of clinical services traditionally provided in an emergency room, clinic, or hospital setting and deliver those services on-site, directly to patients” (Alexander & Zealberg, 1999, p. 93).
Mobile crisis response is based on the assumption that community-based care is more humane, more therapeutic, and less stigmatizing than institutional care. Taking crisis services “to the streets” allows for on-site assessments in family homes, schools, group care and other settings where more accurate evaluations can be made in the child's living environment.

Community-based responses are also believed to reduce out-of-home placements, repeat visits to emergency rooms, revolving-door admissions to hospital, and chronic dependency on intensive psychiatric services or restrictive custodial care.

Although crisis intervention shares some similarities with longer-term treatment approaches, this work is fundamentally different. The potential danger, the urgency of need, the intensity of emotion, and the short-term involvement all go together to make crisis work distinct.

Experts in crisis intervention note that too often professionals are required to respond to crises as part of their day-to-day work without sufficient training or models of intervention to guide them. It is important that professionals dealing with people in crisis be equipped with this specialized knowledge.

**DELIVERING MOBILE CRISIS SERVICES TO CHILDREN AND ADOLESCENTS**

Responding to children and adolescents in crisis requires knowledge of both child development and systemic approaches.

- First, crisis assessment requires a sound grasp of child development and family dynamics in order to provide the basis for an enduring resolution of the crisis.

- Second, crisis intervention warrants a family-based approach, not just a focus on treating the child. Crisis intervention must also take account of systems beyond the family as potential sources of support.

The child's crisis may be symptomatic of external factors, such as disruption in the family or a precipitating event in the child's life. Responding to the child's crisis in isolation from these forces will not effectively address the child's underlying difficulties and may result in recurrence of the crisis.

*An introduction to crisis theory is included as Reference Article I on page 65.*
ELEMENTS OF CRISIS INTERVENTION SERVICES

Continuum of Crisis Services

While the benefits of mobile crisis teams are apparent, mobile crisis services must be viewed as part of a continuum of intensive services for children and families with urgent mental health needs. Following a mobile crisis response, a variety of further interventions may be recommended:

- community-based stabilization
- in-home family-based treatment
- traditional family therapy
- psychiatric consultation for treatment planning
- prescribing of medications
- psychiatric hospital admission

Community Collaboration and Partnerships

The unique needs and characteristics of each community or region must be reflected in the development of any mobile crisis service. Population characteristics, cultural considerations, infrastructure and geography are of primary importance. The return on investment of available resources can be maximized by creative collaborations and sustainable partnerships, while lack of resources needs to be identified and addressed. Positive relations and strong partnerships with hospitals, law enforcement agencies, schools and other social agencies need to be built and nurtured for the effective delivery of crisis services. Service providers consistently report the importance of forging agreements and protocols for working with partners.

Educating the community is also important for the successful functioning of a mobile crisis service. Informing the general public, parents and service providers of the capabilities and limitations of this type of service increases appropriate use and reduces frustration.

Team Structure and Crisis Work Skills

Team composition and structure have been examined for mobile crisis work and certain characteristics are identified as positively contributing to optimal team functioning. A multi-disciplinary team in a flat organization is recommended.
Diversity of disciplines on the crisis team helps ensure a broad knowledge base and promotes creative interventions. Crisis workers may be child and youth workers, social workers, nurses, psychologists, or other clinicians. The availability of dependable psychiatric consultation is strongly recommended. Peer models of supervision and performance evaluation tend to dominate team structure (Alexander & Zealberg, 1999; Redding & Raphaelson, 1995; Seelig, Goldman-Hall & Jerrell, 1992; Shulman & Athey, 1993).

Competent crisis workers are trained professionals who feel comfortable performing their work in a variety of settings in the community and are able to exercise the necessary precautions for safety. They are able to think quickly and make judgment calls to deal with the situation at hand.

Training

Specialized training in crisis theory and intervention, mental health issues, systemic approaches, and child and adolescent development is strongly recommended for the effective functioning of a mobile crisis service for children.

Most mobile crisis services in Canada rely on in-field training that involves the novice worker “shadowing” a senior worker until a sufficient level of skill is acquired in particular areas of competency. This is commonly referred to as “mentoring”. In-field training may be supplemented by formal seminars led by the consultant to the crisis service or other experts in the field. The majority of service providers note that, while training by mentorship is invaluable, other avenues of professional development are under-resourced. Few crisis services possess training manuals and most rely on policies and procedures for administrative and general practice guidelines. The present training resource is meant to help remedy this situation for new mobile crisis services in Ontario.

Figure I illustrates a comprehensive mobile crisis service.

REFERENCES


Mobile Crisis Service for Children and Adolescents

Mobile Crisis Services for Children and Adolescents

FIGURE I Comprehensive Mobile Crisis Service

<table>
<thead>
<tr>
<th>MOBILE CRISIS SERVICE</th>
<th>COMMUNITY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Crisis Intervention</td>
<td>- Hospital emergency</td>
</tr>
<tr>
<td>- support to caller</td>
<td>- 911</td>
</tr>
<tr>
<td>- triage</td>
<td>- Police</td>
</tr>
<tr>
<td>- risk assessment of child</td>
<td>- CAS</td>
</tr>
<tr>
<td>- interview with caller and child</td>
<td>- Refer to CAS</td>
</tr>
<tr>
<td>- interview collateral informants</td>
<td>- Relocate to respite bed</td>
</tr>
<tr>
<td>- formulation</td>
<td>- Admit to hospital psychiatric bed</td>
</tr>
<tr>
<td>- safety plan</td>
<td>- Connect with current service providers</td>
</tr>
<tr>
<td>- treatment plan</td>
<td>- Facilitate referral to children’s mental health services</td>
</tr>
<tr>
<td>- (re) connection to community resources</td>
<td>- Facilitate appointment with community-based psychiatrist</td>
</tr>
</tbody>
</table>

Mobile Response

- support to family
- stabilization of child
- secondary triage
- risk assessment of child
- interview with child and family
- interview collateral informants
- mental status examination
- formulation
- safety plan
- treatment plan
- (re) connection to community resources

Consultation

Disposition

Refer to intensive home support
SUMMARY OF BEST PRACTICES

Our review of the literature and interviews with crisis service providers and other key informants yielded a number of best practice guidelines for mobile crisis services for children.

MOBILE CRISIS SERVICES SHOULD ENDEAVOUR TO CARRY OUT THE FOLLOWING

1. Provide timely, flexible and accessible service 24 hours a day, 7 days a week.
2. Function within a network of related services comprised of viable partnerships with the goal of a fully integrated crisis system.
3. Be engaged in partnerships and work within protocols.
4. Provide systemic approaches for the assessment of children and adolescents in crisis.
5. Maintain sufficient resources and supports for communication and mobile capabilities.
7. Have a working definition of crisis and standard assessment tools.
8. Have ready access to a psychiatrist or other qualified specialist for urgent and on-going consultation.
9. Function as a multi-disciplinary team within a flat organizational structure, with supportive supervision and regular worker evaluation.
11. Educate the community about the capabilities and limitations of a mobile crisis service.
SUMMARY OF BEST PRACTICES

1. Provide timely, flexible and accessible service 24 hours a day, 7 days a week.
   - rapid response (1-24 hours)
   - full coverage for high volume periods
   - alternative coverage for low activity times
   - ability to conduct assessments in the community
   - family systems/systemic orientation for children and adolescents

2. Function within a network of related services comprised of viable partnerships with the goal of a fully integrated crisis system.
   - "seamless" delivery of services in an interdependent network of services
   - access to acute psychiatric beds
   - access to respite beds in community agencies
   - partnerships with child welfare for consultation and back-up
   - law enforcement involvement
   - formal agreements with community agencies for follow-up services

3. Be engaged in partnerships and work within protocols.
   - identify critical partners
   - identify cultural and linguistic diversity in the community being served
   - outreach to engage cultural groups within the community
   - develop mutually beneficial relationships
   - nurture and sustain partnerships

4. Provide systemic approaches for the assessment of children and adolescents in crisis.
   - children in crisis need to be viewed within the context of family and other significant social systems
   - children within the family should be assessed in a cultural context
   - crisis follow-up with intensive in-home family support or on-going out-patient family work
5. **Maintain sufficient resources and supports for communication and mobile capabilities.**

- telephone support by trained professionals to screen calls for mobile response (in-house or with another agency)
- 1-2 "live" telephone lines, not voice mail
- transportation (special accommodations need to be considered for remote regions e.g. water access)
- pagers and/or cell phones
- mobile laptops (with fax modem capabilities) for rapid correspondence
- automated/electronic case recording and timely exchange of information

6. **Ensure client and crisis worker safety.**

- training in how to ensure safety for the client and worker
- 1-2 workers per mobile response, depending on level of risk
- police accompaniment for high-risk calls
- mobile responses to be relocated to neutral settings when risk management is uncertain

7. **Have a working definition of crisis and standard assessment tools.**

- crisis is defined by clients and service providers
- kinds of crises/kinds of response, e.g.
  a. psychiatric emergency (possible hospitalization)
  b. psychiatric crisis (defuse, re-connect or refer; possible hospitalization)
  c. behavioral problem (defuse, re-connect or refer)
  d. family problem or violence in families (diffuse, re-connect or refer)
- risk assessment (usually designed by the crisis service)
- culturally sensitive and responsive assessment

8. **Have ready access to a psychiatrist or other qualified specialist for urgent and on-going consultation.**

- on-call psychiatric consultation to crisis workers
- teledicine communications for remote communities
- mobile psychiatrists or nurse practitioners
9. Function as a multi-disciplinary team within a flat organizational structure, with supportive supervision and regular worker evaluation.

- child and youth workers, social workers, nurses, psychologists and psychiatrists
- minimum 3 years, preferably 5+ years of experience in children's mental health
- knowledge of local resources for children and families, cross-sectoral experience
- collective vs. hierarchical team structure
- regular team meetings with educational component
- daily case reviews


- intensive initial training
- crisis intervention specific to children
- mentorship, preceptorship (shadowing) for skill acquisition
- on-going training, both in-house and through external conferences, workshops, seminars
- knowledge of relevant community resources

11. Educate the community about the capabilities and limitations of a mobile crisis service.

- raising professional awareness of service
- seminars and training for service users
- outreach to marginalized groups
SECTION II

GUIDELINES FOR MOBILE CRISIS WORKERS
KEY CONCEPTS

DEFINITION OF TERMS

Child
For the purpose of this training resource and within the mandate of the MCSS funding, the term “child” refers to any person under the age of 18 years. The term “child” will be used throughout the document to refer to both young children and adolescents.

Crisis Worker
Refers to the clinicians on the mobile crisis response team who will be a mix of child and youth workers, registered nurses, social workers, psychologists or other clinicians with experience in children’s mental health.

Consultant
For the purpose of this training resource and within the mandate of the MCSS funding, the term “consultant” refers to a psychiatrist, physician or other qualified specialist who is part of the mobile crisis team and is available for consultation in person or by telephone around the clock.

Triage
Refers to a process of committing relatively scarce mental health resources to children on the basis of urgency of need.

Provisional Diagnosis
Refers to an interim diagnosis of the child's mental condition, usually offered by the psychiatric consultant to the crisis service on the basis of available information provided by the crisis worker.

Formulation
Refers to a process of gathering and organizing information about the child's current circumstance into a concise structure that is useful for planning the crisis intervention.

Disposition
Refers to the outcome of the crisis worker’s information gathering and crisis response, including the plan for follow-up and long-term support.

FORMAT OF THE MANUAL

Section II is organized into two categories - Telephone Crisis Intervention and Mobile Crisis Response. Each method of delivering the crisis service is equally important and in many cases requires the same intervention steps. The symbols 📞 📞 will appear throughout this section. 📞 Indicates the steps unique to telephone intervention. 📞 Indicates steps unique to the mobile response.
MODEL OF CRISIS INTERVENTION

The Guidelines for Mobile Crisis Workers outlined in this Section are based on a specific model of crisis intervention that has been selected and endorsed by the Ministry of Community and Social Services.

Parents and others concerned about the safety and mental health of a child can access the crisis service, including a mobile response, by speaking with a trained professional on the telephone 24 hours a day, 7 days a week.

As a team, the mobile crisis service is multidisciplinary, with its membership comprised of child and youth workers, social workers, nurses, psychologists and other clinicians with experience in children's mental health. Front-line crisis workers have direct access to a psychiatrist or other qualified specialist for consultation around-the-clock, and all crisis interventions will be coordinated with the consultant.

As a community resource, the mobile crisis service is integrated into a continuum of intensive supports for children and families with urgent mental health needs, including emergency out-patient assessment and counseling, intensive in-home supports, respite and acute care beds, and child protection.

Planning for the crisis service will need to take into account the unique population, geography, existing resource base and other relevant features of the community it is meant to serve. The crisis service will need to develop formal partnerships and protocols with other service providers, including children's mental health centres, Children's Aid Societies, hospitals and the police, in order to remain responsive and accessible in emergency situations.

Figure II illustrates the Model of Crisis Intervention beginning at intake through to disposition of the referral.
FIGURE II  Model of Crisis Intervention

INTAKE

- 911
- Police
- Child protection agency
- Hospital

High Risk

INITIAL TRIAGE
Determining level of imminent risk

Low Risk

FURTHER ASSESSMENT AND/OR MOBILE RESPONSE

PSYCHIATRIC CONSULTATION

MORE INFORMATION REQUIRED

PROVISIONAL DIAGNOSIS AND FORMULATION

SECONDARY TRIAGE

DISPOSITION

- Information on children’s mental health system
- Referrals to community resources
- General education
TELEPHONE CRISIS INTERVENTION
Crisis intervention usually begins with a telephone call (or a series of telephone calls) from people concerned about the safety and mental health of a child. Crisis workers may respond by attending at the child's residence or by accompanying the child to a safe place outside the home. Crisis workers may also be able to complete their assessment and provide their assistance entirely over the telephone.

Telephone crisis intervention is a readily accessible, intensive clinical service with its own goals and requirements.

**THE PRIMARY COMPONENTS OF TELEPHONE CRISIS INTERVENTION**

1. **ASSESSING IMMINENT RISK** (Initial Triage)

2. **UNDERSTANDING THE FACTORS CONTRIBUTING TO THE CHILD'S CURRENT DIFFICULTIES** (Provisional Diagnosis And Formulation)

3. **RECOMMENDING MEASURES TO HELP PROTECT THE CHILD AND OTHERS** (Safety Plan)

4. **CONTRACTING FOR FURTHER CLINICAL SERVICE, INCLUDING MOBILE CRISIS RESPONSE, AS APPROPRIATE** (Secondary Triage)

5. **COMPLETING THE INVOLVEMENT OF THE CRISIS SERVICE ONCE THE CHILD’S SITUATION IS STABLE** (Crisis Resolution And Continuing Availability)
COMPONENT 1
ASSESSING IMMINENT RISK AND CARRYING OUT AN INITIAL TRIAGE

Assessing Imminent Risk On The Telephone

As soon as crisis workers answer the telephone they begin to assess the level of risk in the situation. Frequently a distraught caller will describe a situation where a child has been aggressive to another member of the family, perhaps the caller herself, or where the child may have already inflicted some injury on himself. Of immediate concern for crisis workers is estimating the child's imminent risk.

The risk assessment involves weighing and balancing those factors internal to the child that pose a risk (e.g. major psychiatric illness, state of intoxication) and those situational factors external to the child that might either moderate or increase the risk (e.g. availability of caregivers who are motivated to help, presence of weapons in the home).

Crisis workers should obtain the following information from the caller:

- Information identifying the child and the caller's relationship to the child.
- Is the child settled or agitated, threatening or calm? What is the child's current mood, degree of stability and predictability?
- Is the child's environment safe or are there dangerous objects at hand? Is there a plan in place to ensure everyone's safety? How confident is the caller in the plan?
- What supports are readily available and what supports are in the process of being engaged?
- Is the caller able to use available resources? Has the caller done so in the past?

In conducting the risk assessment crisis workers should remember that one of the most reliable predictors of future suicidal behavior is a history of prior attempts. Similarly, one of the best predictors of future aggressive behavior is past aggression.
The following general questions may be asked of the caller and the child separately:

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>How do you perceive the risk?</td>
</tr>
<tr>
<td>How do you understand the cause of the problem?</td>
</tr>
<tr>
<td>Do you have any plans or solutions to propose?</td>
</tr>
<tr>
<td>What are your short- and long-term goals?</td>
</tr>
</tbody>
</table>

Crisis workers should be mindful of how likely the child and caregivers are to cooperate with each other (and with service providers) and to honor their commitments to ensuring everyone's personal safety.

On the basis of these preliminary enquiries, crisis workers and their consultant measure the child’s needs and risk against the likely impact of resources that are directly or indirectly available through the crisis service and its partners (e.g. on-going telephone support, mobile crisis response, intensive child and family support, admission to respite or acute care bed).

An introduction to risk factors for suicide and self-harm in Canada and a discussion of motivation and self-harming behaviors is included as Reference Article VII on page 88.
INITIAL TRIAGE

Triage is the basic principle that guides the crisis service in committing relatively scarce mental health resources to children on the basis of urgency of need.

Referrals To The Crisis Service May Be Triaged Initially Into Three Groups

| LOW RISK | Children whose concerns are such that crisis intervention is not absolutely or immediately required. |
| MODERATE RISK | Children who do not present an imminent risk, but who might benefit significantly from a focal crisis intervention. |
| HIGH RISK | Children at imminent risk of harming themselves or others, whose immediate need for safe containment exceeds the resources of the crisis service and its community partners. |

- Crisis workers should respond respectfully to any call about a child who presents with little or no risk, and may spend more or less time assisting the caller, depending on other service demands and service philosophy and mandate.

- For a child in the moderate-risk group, crisis workers will need to gather additional information in order to consult with the psychiatrist or other qualified specialist on a provisional diagnosis, formulation and plan for intervention.

- Crisis workers should refer a child in the high-risk group to 911 emergency services and provide the caller with any necessary assistance. Crisis workers should remain in contact with emergency services to provide for appropriate follow-up.

At regular intervals during the day, crisis workers should review the status of all referrals with the consultant, including referrals considered low-risk and those triaged to intensive emergency services.

The crisis service should develop protocols with local police and ambulance services to coordinate and expedite the delivery of intensive emergency services to ensure continuity of care.
### TRIAGING THE LEVEL OF THE CRISIS

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Action Taken</th>
<th>Who Responds</th>
</tr>
</thead>
<tbody>
<tr>
<td>An incident or situation:</td>
<td>• support the caller</td>
<td>• community services</td>
</tr>
<tr>
<td>• that poses little or no threat to the child or anyone else</td>
<td>• redirect to more appropriate service</td>
<td>• children’s mental health agencies</td>
</tr>
<tr>
<td>• that can be managed by a non-crisis response</td>
<td>• provide general information about service system</td>
<td></td>
</tr>
<tr>
<td>• that does not require a mobile response or extensive telephone intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An incident or situation:</td>
<td>• conduct a comprehensive telephone interview</td>
<td>• crisis workers in consultation with psychiatrist or other qualified specialist</td>
</tr>
<tr>
<td>• that involves a more serious incident or behavior that poses a potential threat to life</td>
<td>• assess risk</td>
<td></td>
</tr>
<tr>
<td>• that may require a mobile response</td>
<td>• contact current/recent services</td>
<td></td>
</tr>
<tr>
<td>• that warrants connecting with collateral informants</td>
<td>• consult with psychiatrist or other qualified specialist</td>
<td></td>
</tr>
<tr>
<td>• that may require admission to respite care or psychiatric facility</td>
<td>• identify need for mobile crisis response</td>
<td></td>
</tr>
<tr>
<td>• imminent danger to self or others</td>
<td>• identify need for respite or hospital admission</td>
<td></td>
</tr>
<tr>
<td>• that is beyond capacity of the crisis service to provide safe containment of risk</td>
<td>• link child and family to resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• instruct caller to call 911 and assist as necessary</td>
<td>• police</td>
</tr>
<tr>
<td></td>
<td>• remain in contact with emergency services to provide for continuity of care in the follow-up</td>
<td>• 911</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ambulance</td>
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<tr>
<td></td>
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<td>• hospital</td>
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</table>
COMPONENT 2
UNDERSTANDING THE FACTORS CONTRIBUTING TO THE CHILD’S CURRENT DIFFICULTIES

DEVELOPING A PROVISIONAL DIAGNOSIS

For the consultant to make a provisional diagnosis, crisis workers will need to obtain information on the history of each of the child's presenting problems in turn, according to the following priority:

- Concerns relating to the child's risk of harming self or others.
- Concerns suggestive of the child's inability to care for self (e.g. behaviors that show a lack of judgment or excessive risk-taking).
- Concerns suggesting an impairment of social or interpersonal functioning (e.g. legal involvement, school problems, or the child's response to trauma).
- Concerns that may not be central to the crisis, but may be important for understanding the child's current circumstance.

To gather this information, crisis workers may need to speak with the referring person and others involved with the child (e.g. the child's teacher or therapist). In addition, workers may need to conduct a mobile response to the child's residence to complete a mental status examination. (See “Completing a Mental Status Examination” on page 47)

Crisis workers should enquire about any previous assessments by a psychiatrist, psychologist, neurologist or other specialist and ask for the results of those assessments, as appropriate.

Crisis workers should ensure that a child's legal guardian (and a child who is sixteen years of age or older) is aware of their involvement and is consenting to the exchange of information between the crisis service and other service providers.
SCREENING FOR RISK

The crisis worker may pursue the following topics with the caller and other informants to ensure that significant areas of potential concern are included:

Screen for risk of harm to self.

- History of thoughts, threats, or acts of self-harm, including self-mutilation; time, place and other context; need for medical or other intervention; apparent regret.
- History of risk-taking behavior, including drug or alcohol abuse, unsafe sex, running away, illegal activity.
- Preoccupation with themes of death (e.g. reading, writing, music, film, Internet, peer culture).
- History of significant loss or trauma.
- Family history of self-harm.

Screen for risk of harm to others.

- History of thoughts, threats or acts of aggression; time, place and other context; need for police or other intervention; apparent remorse.
- History of bullying, intimidation or fighting, sexual aggression, gang involvement.
- History of property damage, preoccupation with fire or fire setting.
- Preoccupation with weapons, the military or themes of violence.
- History of cruelty to animals.
- School problems, including behavioral and other difficulties in peer relationships.
- Excessive conflict with authority at home, school or in the community.
- Family history of aggression.

Screen for evidence of an “inability to care for one’s self.”

Refers to a child's lack or loss of judgment or clarity of thought that may inadvertently place the child at risk of harm.

- History of running away, inappropriate involvements with adults or peers, prostitution, criminal activity or substance abuse.
- History of confusion or disorganization of thought, social withdrawal or isolation.
- Obsessive or compulsive behavior or paranoia.
- Unusual preoccupations with food, diet or body image.
Screen for disorders of behavior and relationships.

- History of defiance of authority, legal involvement, school problems, suspensions or expulsions.
- Hyperactivity (diagnosis, treatment and response).
- Learning disability or developmental delay (psychological testing, remediation and response).
- Sensory, motor or tic disorder.

Screen for disorders of mood or anxiety.

- History of depressive episodes (diagnosis, treatment and response).
- History of undiagnosed physical complaints (e.g. headaches, stomachaches, fatigue or malaise).
- History of sleep disorders (e.g. nightmares, insomnia, hypersomnia, night terrors or lack of need for sleep).
- History of eating disorders (e.g. anorexia, increased appetite or weight change).
- History of mania (e.g. pressured speech, racing thoughts, loss of judgment, uncharacteristic impulsivity or grandiosity).
- History of mood instability, irritability or temper outbursts.
- History of obsessions, compulsions or phobias.
- History of social withdrawal, loss of interest or loss of future orientation.
- History of panic or flashbacks of traumatic events.

Screen for disorders of thought.

- Evidence of psychosis (e.g. hallucinations, delusions, magical thinking or ideas of reference).
- Confusion or disorganized thinking, loss of memory or change in personality.
- History of trances or dissociative episodes, complaints of feeling “empty” or “unreal”.

Screen for significant health problems.

- History of cigarette smoking, substance or alcohol abuse, and details regarding the extent and seriousness of the problem, and any impact of drug use (e.g. school difficulties, legal involvements, blackouts or seizures).
- History of medication (prescribing physician, purpose, dosage, duration, apparent effects and side-effects).
- History of environmental and medication allergies.
- History of hospitalization or significant medical illness, history of seizures or head injury.
Screen for evidence of a “family crisis.”

Refers to the impact on the child of forces within the family that are generally perceived as out of the child’s control and that may place the child at risk.

- Recent changes in parental relationship (e.g. spousal abuse, separation, new partners).
- History of physical, sexual or emotional abuse, exposure to violence.
- Multiple or significant losses, placement in care.
- Adjustment to acute or chronic illness.
- History of drug or alcohol abuse in the parent or child.
- Recent change in work or financial status in the family.
- Relevant social issues (e.g. community issues, national disasters, traumatic experiences involving peers, relatives or friends).

Screen for relevant family history.

Refers to difficulties with other family members. This information may provide evidence of psychosocial and biological risk factors (e.g. genetic, intra-uterine exposures).

- Significant psychiatric or other medical problems in parents and near relatives; whether these problems are active, recent or remote.
- History of parents’ relationship.
- Pregnancy, childbirth, early parent-child separation, problems in early development.
- Any noteworthy issues such as problematic school experiences, friendships and socialization, history of trauma or loss, multiple moves or school changes, changes or loss of caregivers.
- History of adoption, placement in care, involvement of Children’s Aid Society.

On the basis of a comprehensive review of the child’s presenting problems and the history of these presenting problems and other significant concerns, crisis workers can consult with a psychiatrist or other qualified specialist on the child’s provisional diagnosis. For the consulting psychiatrist to provide a formulation, crisis workers may need to clarify with others the various components and factors contributing to the child’s current circumstance.

An introduction to the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association and an overview of the diagnostic issues that are most commonly encountered with children in crisis is included as Reference Article VI on page 79.
DEVELOPING A FORMULATION

A formulation organizes the wealth of information and concerns of caregivers and service providers involved with a child into a simple, concise structure which is useful for treatment planning.

A formulation encourages crisis workers and their consultant to consider children in broad terms, taking into account their environment, and their strengths and weaknesses when planning the crisis intervention.

A case example and formulation

Jed is a healthy, attractive 12-year-old boy who was referred to the crisis service after attempting to hang himself with a coat hanger. He had been living at a foster home for several months and he had needed to be restrained by the foster parents in the home. At these times, Jed would attempt to bite, kick and spit in their faces. He would run away when he could, often being brought back to the home by police. He would damage property and, while at times he appeared quite remorseful for his actions, logical consequences appeared to have little impact on his behavior. He would sincerely promise to do better, but subsequent outbursts would come explosively. Foster parents described Jed as “a great kid who loved sports and playing games when things went his way, but a terror when angry.”

Jed’s biological parents had never lived together. He had lived with his mother until he was taken into care by the Children’s Aid Society several months earlier. He was then placed with his father, whom he had seen perhaps only a dozen times before. Jed’s mother was alcoholic and physically abusive. His father, a long haul truck driver, proved unable to care for Jed despite his good intentions. Father’s job and lifestyle, as well as the enormous demands of his son’s needs, made this impossible. Jed was hyperactive and had multiple learning disabilities. A fetal alcohol syndrome was suspected, but mother stated that she did not drink during the pregnancy. Jed’s suicide attempt came after his father failed to visit as he had promised, for the second time in a row.
The basic information of the case may be used to construct the formulation table below. It is not necessary that all boxes be filled in, just those that appear relevant to the child's current situation.

### TABLE I  A Formulation Table Describing Jed's Situation

<table>
<thead>
<tr>
<th></th>
<th>Predisposing Factors</th>
<th>Precipitating Factors</th>
<th>Perpetuating Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Fetal alcohol syndrome?</td>
<td>Hyperactivity.</td>
<td>Physically healthy, attractive child.</td>
<td></td>
</tr>
<tr>
<td>Familial/Social</td>
<td>Single mother, abusive, alcoholic.</td>
<td>Disconnection from family, Placement in care, Father missing visit.</td>
<td>Poor social skills, Family unavailable.</td>
<td>Identified as a high needs child, receiving special education support, very committed foster parents with a lot of experience.</td>
</tr>
</tbody>
</table>

With the formulation table completed, it may be helpful to construct a chart depicting the flow of influences that lead to the current crisis. This can help identify areas where an intervention might have either a short- or long-term impact on the child's course.

While the emphasis in crisis work is on triage, assessment and stabilization, the formulation can be invaluable in guiding follow-up and providing other agencies with a sense of where to invest their resources.

Figure III illustrates an example of a flowchart to assist in a formulation.
FIGURE III  Flowchart Describing Jed's Situation

- Mother alcoholic
- Family Problems
- Parental Rejection
- Possible Fetal Alcohol Syndrome
- Hyperactivity
- Reactive Attachment Disorder
- Low Self Esteem and Depression
- Learning Disabilities
- Placement in Care
- Suicide Attempt
- Father Missing Visit

Numbers:
1. Low Self Esteem and Depression
2. Suicide Attempt
3. Reactive Attachment Disorder
4. Father Missing Visit
5. Possible Fetal Alcohol Syndrome
6. Placement in Care
The flowchart illustrates a number of points of intervention that may be useful in both crisis work and long-term treatment planning. Some possible interventions for the case have been numbered on the flowchart in small circles, indicating where in the system the intervention would have its impact.

Key to interventions:

1. Jed's learning disabilities may be contributing to problems of mood and self-esteem, and vice-versa. Have his learning problems been qualified and quantified? Is there, in fact, a global developmental delay? The presence of learning problems – particularly those that may impact on language, communication and social skills can clearly affect what recommendations might be appropriate regarding short- or long-term psychotherapy. Information from Jed's school or a review of his old report cards may be helpful. Psychological or psycho-educational testing may be helpful if it has never been done or is outdated. Formal assessment may also impact positively on Jed's candidacy for special education support, family benefit support, and so on. Treating an underlying mood disorder may also help Jed's learning, by improving his self-confidence, concentration, frustration tolerance and motivation.

2, 4, 6. Interventions here take on three basic forms. There are those that act to decrease the stressors affecting Jed in order that he will feel less motivation to hurt himself; there are those that attempt to change or modify his internal resources in order to help him cope more appropriately with the existing stressors; and there are those that attempt to provide Jed with greater external structure and support, so that his existing coping resources will not be overwhelmed.

If we consider 2, the role of Jed's low self-esteem and depression, we may think of actively treating a depression through crisis counseling, anti-depressant medications, social skills training or other interventions aimed at improving Jed's inner resources.

Turning to 6, Jed's placement in care, we recognize this stressor is one that is out of his control, that he is likely grieving the loss of his family, that he may be open to supportive therapy around this, but none of this will change the reality of his situation. Jed may be fortunate in his foster family, as they seem concerned and caring. Any efforts to support the external structure provided by his caregivers (i.e. prevent their burn-out, a possible future placement breakdown, and the trauma of additional moves to new placements) will likely be rewarded. One should enquire of the boy's experience of being removed from his family and placed in foster care. The foster parents could be asked about what supports they need to ensure Jed's safety during the crisis, but also what they anticipate needing after the crisis has passed and they move into a long-term professional relationship with a special needs child. Might they, for example, benefit from guidance or instruction regarding specific child management techniques? Are they aware of specific issues relevant to working with a child with hyperactivity or fetal alcohol syndrome?
Looking at ④, the apparent precipitant of Jed's father not showing up for his planned visit, interventions here may focus on attempting to decrease the stress that Jed is exposed to and helping him to better cope. An attempt will have to be made to determine the father's commitment to following through on future visits before they are arranged, given the profound effect Jed's disappointment has on his safety. Does father respect and appreciate this? Does he need additional support to ensure that future visits will occur as planned, or do they need to be done differently in the future (for example, taking Jed to father after confirming his availability rather than relying on father to come himself) or should they be suspended for a time as too stressful or risky? Before planned visits, it might be helpful to prepare Jed, helping him to better anticipate how he might feel, and how he can manage his feelings appropriately, should the visit not go as hoped. One should enquire of mother's availability to the child and the possibility of her supporting others to stabilize his placement in care.

③ The treatment of Jed's hyperactivity might not be optimal. There may be benefit in enquiring how the diagnosis was established and what is being done for treatment. Comprehensive treatment may involve a combination of psycho-social support, educational support and possibly medication.

⑤ It is easy to confuse attention-deficit/hyperactivity disorder with primary learning problems. Complicating the picture here is the possibility that anxiety secondary to a mood disorder may be mimicking an attention deficit/hyperactivity disorder. A careful history, specialty psychiatric evaluation or even a medication trial may be indicated to clarify the issue. Misunderstanding the cause or causes of the problem and the application of "treatment" without ascertaining the cause of the difficulty may do more harm than good.
COMPONENT 3
RECOMMENDING MEASURES TO HELP PROTECT THE CHILD AND OTHERS

DEVELOPING A SAFETY PLAN 🔐 🚗

A key element of crisis intervention is to ensure the safety of the child and people around the child, including siblings and other family members, classmates, co-residents in group care, and the general public.

An additional expected outcome of crisis intervention is that more children can remain in their current place of residence and that fewer children will require the more intrusive or restrictive interventions in an emergency, such as hospitalization or detention.

Safety Plan for a Child to Remain in the Home

In developing a Safety Plan for the child to remain in the family home, crisis workers require information from the child's caregivers and others who are familiar with the child's situation. This includes:

- What steps can be taken to secure the child's physical environment and minimize risk (e.g. remove weapons, medicines)?
- What is the extent and quality of supervision currently available?
- If current resources are viewed as inadequate, are additional non-professional supports available (e.g. can a relative or neighbor spend time in the home)?
- Are additional professional supports available (e.g. family service worker, intensive child and family supports)?
- Have other safety plans been tried in the past in similar circumstances (successfully or unsuccessfully)?
- What are the parents' firm expectations of their child, especially those relating to personal safety in the home? Have they stated these expectations and the consequences for failing to meet these expectations to their child clearly? Is the child in agreement and prepared to work with others to ensure everyone's personal safety?
- Are there sources of conflict that the child and parents can resolve or at least agree “to put on hold” to allow for a general de-escalation of tension in the household?
- Can the parents alleviate any stressors for the child (e.g. intense sibling rivalry, uncertainty about a pending consequence for some misbehavior)?
- Can the parents and child agree on how they will seek and give assurance around issues of personal safety?
Where There Are Child Protection Concerns

Crisis workers must evaluate any parent’s plan for a child to remain in the home against relevant provisions for the protection of children in the Child and Family Services Act:

- Is the child in crisis in need of protection?
- Is another child in need of protection should the child in crisis remain in the home?

Crisis workers have a duty to report any reasonable grounds to believe that any child is in need of protection to the Children’s Aid Society forthwith.

The crisis service should develop protocols with the local Children’s Aid Society to coordinate the development of Safety Plans for high-risk children in the home.

Safety Plan for a Child to Remain in a Group Care Setting

Most of the same kinds of considerations apply in developing a Safety Plan for a child to remain in a group care setting. Other considerations include:

- Has there been recent staff turnover? If so, how is this affecting the team’s ability to respond to the children's needs, and especially the needs of the child in crisis?
- Has the membership of the children’s group changed significantly? If so, how has this impacted the child in crisis?
- Has another child or staff in the residence suffered a significant loss or trauma recently? Has this loss or trauma been processed?
- Is the child’s difficulty part of a group contagion that will need to be addressed to bring stability to the program? What is the genesis and current dynamic of the contagion?
- Is the child’s placement at risk?
- Is the child's legal guardian aware of the crisis? Is the guardian involved in developing a Safety Plan?
Crisis workers should ensure that every Safety Plan includes steps to be taken should the child’s difficulties increase. For example:

1. Additional logical consequences (e.g. closer supervision, loss of privileges).
2. Use of resources held in reserve for this contingency (e.g. Mobile Crisis Response, extra staffing).
3. Immediate referral to police or emergency medical services.

Crisis workers should ask caregivers to advise them of any significant worsening of a child’s condition as soon as practicable.
COMPONENT 4  
CONTRACTING FOR FURTHER CLINICAL SERVICE, INCLUDING A MOBILE CRISIS RESPONSE

CONDUCTING A SECONDARY TRIAGE

Besides developing and supporting a Safety Plan, crisis workers should use the formulation of the child’s current circumstance to plan a time-limited intervention that is focused on reducing risk, reinforcing existing familial and social supports, and helping parents access additional supports in their community.

This step is referred to as “Secondary Triage” since the crisis service is again involved in deciding how to commit relatively scarce mental health resources, including its own, on the basis of urgency of need. The crisis service should ensure that a range of options is readily available through its own resources at this stage.

These options must include mobile crisis response and may also include the following:

Telephone “Alert”

Crisis workers may want to maintain daily telephone contact with a child and caregiver over a period of about 7 – 10 days. During this time, crisis workers can support and monitor the implementation of the Safety Plan, follow the child’s stabilization and recovery, and assist the caregiver in making referrals to other services.

Parents may find that daily telephone contact will help reduce their anxiety and sense of isolation. If parents are unfamiliar with the availability of children’s services in their area, they may also appreciate having this information and the assistance of crisis workers may help alleviate the family’s stress of seeking other professional help.

Service providers may find the continuing support of the crisis service helpful, whether they are working with a known client or responding to a new referral. With the appropriate consents, the crisis service should share its assessment and recommendations with other service providers in a timely manner. Indeed, the crisis service should work closely with other service providers to ensure a smooth transition for the child and family from one support system to the next.
Emergency Out-patient Appointment

A psychiatrist or clinical consultant may be available to meet with children and families in crisis on relatively short notice (within 48 hours). Crisis workers should prepare the consultant for the meeting, providing any relevant background and suggestions for the focus of the consultation. Crisis workers may attend the appointment with the child and caregivers, as other service demands and program philosophy allow. The consultant and crisis workers need to clarify for both themselves and the family their respective roles and responsibilities in any follow-up to the consultation.

Continuum of Crisis Supports

In addition to its own service options, the crisis service will want to partner with other community resources to coordinate the delivery of a continuum of services for children, including intensive child and family supports and respite care.

Intensive Child and Family Supports

Intensive in-home services are multi-faceted and include counselling, skills training and helping families obtain appropriate services. The service offers a time-limited, intensive model of service delivery. Intensive in-home services will ensure follow-up, on-going stabilization and connection with appropriate supports.

Staff persons have small caseloads (4 - 6 cases) that permit them to work actively and intensively with each family.

During the initial intensive phase, a worker may spend 8 - 12 hours per week with one family in the home and in the community. Subsequent to the intensive period, there is a follow-up component where the worker will meet with family members less frequently. This offers an opportunity for the worker and the family to disengage gradually. During this period, the family begins to take a more independent role in implementing the treatment goals and in connecting with other resources that may serve them over the long term. At the same time, it offers a way for the family and worker to build on the work that has been done, and to reinforce the gains that have been made.

MCSS is taking the initiative to provide additional resources for Intensive Child and Family Support Services that will be linked to the mobile crisis service and together will form part of a continuum of services to children.
Respite Care

Respite care provides a child with a safe place to stay away from home for a short time to reduce the chance of the crisis escalating, to provide caregivers with a break from the responsibility of supervising the child, and to promote the child’s recovery outside a more restrictive or intrusive environment.

Respite care should be available 24 hours a day, 7 days a week and may be provided in settings like foster homes and group care facilities. Staff at the facility should have the skills to manage the child in crisis with appropriate guidance and backup from the crisis service.

Respite care is not an appropriate resource for children who are at imminent risk of harming themselves or other people. Protocols between the respite service and the crisis service need to clarify the process for admission and discharge and their respective roles and responsibilities over the course of the child’s stay.

Acute Psychiatric Care

Children who turn out upon further examination to be at imminent risk of harming themselves or others, and whose need for immediate safe containment exceeds the resources of the crisis service, should be referred for admission to hospital under the Mental Health Act. Crisis workers should assist the child's caregivers with making any necessary arrangements for the child's transfer to hospital by police or ambulance and remain involved to ensure continuity of care in the follow-up.

Emergency Admissions to Secure Treatment

Children under the age of sixteen years of age may be admitted in an emergency to secure treatment at Youthdale Treatment Centres in Toronto for up to thirty days under the Child and Family Services Act (see C. F. S. A. Section 124). Referrals to emergency secure treatment are initiated by contacting Youthdale's mobile Crisis Support Team at 416-363-9990.

Special Populations

Introductory essays on crisis intervention with children with special needs are included in Section IV. See “Crisis Intervention with Abused Children” (pp. 70 – 71), “Crisis Intervention with Developmentally Handicapped Children” (pp. 72 – 74), and “Crisis Intervention with Autistic Children” (pp. 75 – 78).
COMPONENT 5
COMPLETING INVOLVEMENT ONCE THE CHILD’S SITUATION IS STABLE

CRISIS RESOLUTION

To remain available to children in acute situations, the crisis service must usually limit its involvement to rapid assessment, stabilization of high-risk behavior, sharing pertinent information and recommendations, and helping caregivers engage with other services, as appropriate.

Research and experience suggest that the crisis service can expect to be involved for about 7 – 10 days in helping a child through these sorts of difficulties. It may be helpful to define the role of the crisis service in these terms for a caller early on so that people are prepared when crisis workers believe it is time for them to complete their involvement. Crisis workers should inform all parties when and on what terms they are completing their involvement.

Continuing Availability and Continuity

When completing their involvement, crisis workers should assure children, parents and other service providers that they can call again for assistance at any time. Records of previous contacts should be kept readily available to crisis workers to support continuity of care over time.

Documentation

All contacts in a telephone crisis intervention should be logged and recorded. Preparing and maintaining concise, accurate documentation of crisis work is a medical-legal responsibility.

The final recording of a telephone crisis intervention should detail the child’s status and any recommendations for the child’s supervision and referrals for on-going treatment.
PRACTICAL TIPS FOR TELEPHONE CRISIS INTERVENTION
PRACTICAL TIPS FOR TELEPHONE CRISIS INTERVENTION

Callers to a crisis service are often fearful, angry and confused. They may be ambivalent about calling, and unsure about what they can expect or even want from the crisis workers. Callers need a sense of reassurance that the crisis service can help. Crisis workers can convey this sense by relating to the caller in a calm, understanding and empathetic manner.

Callers may have contacted the crisis service in the past
- Access any previous documentation.
- Compare the child's previous and current situation.
- Check if previous recommendations have been followed.

Callers may be in the midst of an emergency but refuse to disclose identifying information
- Keep the caller on the line and direct someone else to call 911.
- Use another phone line to call 911 when alone.
- Do not use the phone again if the caller hangs up or is disconnected. The police may be able to trace the call if the phone has not been used.

Callers in crisis may be highly anxious and need assistance in getting composed to provide pertinent information
- Ask the caller to calm down and speak slowly.
- Validate the caller's concerns.

Callers may get right into “story telling”
- Get pertinent information early on in the call.
- Determining a child's risk is paramount.
Callers in crisis need the tools to deal with the situation constructively
• Give the caller a sense of direction and a sense of empowerment.
• Inform the caller of any procedures that will be followed throughout the call.

Callers in crisis may be verbally abusive or critical of other services
• Do not hang up on an abusive caller.
• Be direct and ask the caller to calm down or suggest they call back when they can be more appropriate.
• Be careful not to become defensive.
• Do not over-identify with the caller’s concerns about other services.

Callers in crisis may hear only what they want or need to hear
• Be clear with recommendations and directions.
• Ask the caller to paraphrase.
EXAMPLES OF TELEPHONE CRISIS CALLS

Case One

Shannon calls the crisis service. She is 11 years old and is residing with her mother in her maternal grandmother's one bedroom apartment. Shannon refuses to give her telephone number, but the crisis worker is able to view it on "call display" on the crisis phone. She is crying and, when asked, explains she is alone in the bathroom, mother is out, and grandmother is in the living room. With support, Shannon admits she is thinking of harming herself. Mother and Shannon had an argument about chores and homework, then mother left angry. Shannon believes mother would be better off without her and she worries that she and mother will never find an affordable apartment. The crisis worker asks if Shannon is okay or if she has done anything to harm herself. Shannon denies any self-harm. With gentle probing, Shannon discloses that she is quite close to grandmother and can trust and confide in her. The crisis worker then ascertains that Shannon and mother have just started to see a counsellor at a children's mental health centre and that an appointment is scheduled for the following day after school. Again with support and direction, Shannon finally agrees to let the crisis worker speak to her grandmother and after a brief update Shannon's safety plan is discussed and agreed upon by all:

→ Grandmother to sit with Shannon.
→ Both will speak with mother to address the hurt feelings.
→ Shannon commits to not harming herself, and to tell grandmother if feelings resurface.
→ All to address these issues at the appointment with a counsellor the following day.
→ Shannon is calm and is no longer tearful. She declines the crisis worker's offer to call the treatment centre to follow-up. Grandmother agrees to use hospital or police if the situation escalates to that point.
Case Two

Brian phones the crisis service from a telephone booth. He is crying and explains he has recently moved to the city, has little money and no friends here, and has forgotten to bring his anti-depressant medication. Brian is 18 years old and after several heated arguments with his family chose to pack his belongings and leave. Parents do not know his present whereabouts. The crisis worker gives him the name, number and address of the closest shelter and encourages Brian to go to the nearest hospital to be seen regarding his medication. The crisis worker gives Brian directions to the nearest hospital and he agrees to go there first, then to the shelter. The crisis worker encourages Brian to let his family know of his whereabouts, especially as a missing person’s report may have been filed. Brian agrees to contact his parents the next day. Brian is thankful for the information, sounds more confident and focused and ends the call.

Case Three

A mother calls quite upset and gravely concerned about her 14-year-old daughter. The crisis worker quickly ascertains that there has been previous contact with the case and the file is retrieved. Her daughter, Heather, was raped one and a half months ago while on the run and she has continued to leave the home at late hours without permission. Heather is now at school. The local general hospital became involved when Heather disclosed her rape and is offering out-patient counselling. Mother states Heather’s behavior is deteriorating and in fits of rage she has made statements of wanting to be dead. The crisis worker encourages mother to speak to the counsellor at the hospital and express her concerns. Mother calms quickly and explains she needed just to speak to someone who would listen. Mother agrees to call the counsellor, set an appointment and address her concerns with her daughter. Mother agrees to discuss options of allowing Heather to “take space” when she is angry instead of the situation becoming heated and resulting in poor decision-making.
MOBILE CRISIS RESPONSE
MOBILE CRISIS RESPONSE

A comprehensive crisis service must allow for a mobile response to the site of the child’s difficulties (e.g. family home, treatment residence, hostel, detention facility or hospital). Mobile crisis response can add significantly to the telephone assessment of the child’s circumstance, and is an active intervention that can help stabilize the child and reinforce family and social supports.

THE PRIMARY COMPONENTS OF MOBILE CRISIS RESPONSE

1. ASSESSING THE RISK TO CRISIS WORKERS IN THE CHILD’S ENVIRONMENT.
2. ORIENTING THE CAREGIVER AND CHILD TO THE INTERVENTION.
3. REDUCING CONFLICT BETWEEN THE CHILD AND CAREGIVERS.
4. UNDERSTANDING THE CHILD’S CURRENT DIFFICULTIES BETTER BY DIRECT OBSERVATION, INCLUDING MENTAL STATUS EXAMINATION.
COMPONENT 1
ASSESSING THE RISK TO CRISIS WORKERS

Crisis workers should identify any personal risks they might face in the child’s neighborhood or residence and determine the feasibility of minimizing these risks to an acceptable level:

- Crisis workers must be satisfied that no one in the household poses a substantial risk to harm them.
- Crisis workers should ask parents, other service providers and/or police whether special precautions should be taken in the child’s neighborhood.

Routine consultation around issues of personal safety with other team members, including the psychiatrist or other qualified specialist, is recommended.

Mobile response affords crisis workers the best opportunity to assess the child’s risk on the basis of direct observation in a naturalistic setting. Relevant observations include:

- The child’s level of agitation, degree of stability and predictability
- Any injuries to the child or others
- The general condition of the home and any damage to property
- The availability of weapons or harmful substances
- The interaction of the child and caregivers

*Crisis workers should not proceed with a mobile response unless they feel assured of their personal safety. Crisis workers should remove themselves from any situation where they feel unsafe and call for assistance.*

The crisis service should develop protocols with local police to help minimize any personal risk to crisis workers on a mobile response.

Practical “tips” for minimizing personal risk on a mobile crisis response are located on page 50 and are included as Reference Article II on page 68.
COMPONENT 2
ORIENTING THE CAREGIVER AND CHILD TO THE INTERVENTION

Crisis workers should ensure that the child’s caregivers understand the general purpose of the mobile response:

- To learn more about everyone's perspective.
- To observe the child firsthand.
- To reduce conflict between the child and caregivers.

Crisis workers may ask that other relatives or service providers (e.g. non-custodial parent, Family Services Worker) be invited to attend and should ensure that these participants understand their potential contribution beforehand.

Crisis workers should ensure that the child is aware of the plan and is in general agreement with the mobile response. Crisis workers may rely on a parent or another service provider to speak with the child or they may want to speak with the child directly over the telephone.

Some children may fear that crisis workers are coming to the home to remove them from their families; other children may believe that crisis workers are coming simply “to read them the riot act.” These kinds of worries and misconceptions may, in fact, reflect a caregiver’s prior statements to the child and need to be addressed (by the caregiver preferably) in order to motivate the child to participate in the intervention.

Once crisis workers arrive on-site, they should review the purpose of the intervention with everyone to ensure a common understanding.

*Practical “tips”* for structuring the mobile crisis response are provided starting on page 50.
COMPONENT 3
REDUCING CONFLICT BETWEEN THE CHILD AND CAREGIVERS

Crisis often involves an intense conflict between the needs of the child and the expectations of others. Children in crisis can experience overwhelming emotions and may use a variety of defenses to cope. Some coping strategies are maladaptive and only serve to perpetuate the child’s difficulties. Some strategies may place the child and caregivers at risk. In turn, the caregiver’s reactions to the child may exacerbate the situation.

Crisis workers can try to ease tension and reduce conflict between the child and caregivers through the following interventions:

1. Relieving emotional distress.
2. Alleviating precipitating events.
3. Identifying predisposing conflicts.
5. Planning for safety and continuing care.

1. Relieving Emotional Distress

Children in crisis often experience such intense emotions that their behavior becomes highly unpredictable and their sense of reality may even be impaired. Crisis workers may need to reduce the intensity of the child’s emotions so that the child can use words instead of behavior to express feelings. One approach is Emotional First Aid (Wood & Long, 1991).

Emotional First Aid

- Draining off emotional intensity - crisis workers can help defuse the intensity of a child’s emotions by listening sympathetically, identifying and validating the child’s feelings, and assuring the child that the upsetting feelings will diminish over time.
• Maintaining communication when relationships are breaking down - some children in crisis become uncommunicative and withdraw into a world of hostile fantasy. Crisis workers should try to engage these children in any kind of conversation (e.g. about sports, music, a valued possession) until they feel comfortable discussing their feelings.

• Supporting a child who is acting out intense emotions - with children who have lost internal control of their behavior, crisis workers need to provide firm assurance that rules, adult authority, and external controls ultimately guide the crisis intervention.

On a mobile response, crisis workers may need to provide Emotional First Aid to caregivers as well before they can participate in a helpful way and not provoke the child to further escalation. Early telephone crisis intervention with caregivers partly serves the function of providing them with this support, and allows crisis workers on a mobile response to engage more quickly with the child and family as a whole.

2. **Alleviating Precipitating Events**

It is not uncommon for children and caregivers to be unaware of the emotional and psychological impact of recent changes in their lives. A precipitating event may be public (e.g. death of a parent) or may have been kept private (e.g. sexual assault). Frequently crisis workers are able to identify themes of profound loss or threat of loss for the child and members of the child's support system (e.g. loss of friendship, rejection by a non-custodial parent, birth of a sibling, a parent remarrying). These losses can threaten the child’s sense of well-being, worth and security and may give rise to intense feelings of sadness, anxiety, confusion or anger. Some of the losses for the child may also impact the child’s caregivers directly and may have a similar debilitating effect on them as well.

Crisis workers can help children and caregivers identify recent life events and can help them share with each other the impact of those events on them as individuals and as members of the family.

Besides the therapeutic value of promoting this kind of communication between the child and caregiver, the identification of precipitating factors may open the way to minimizing the child’s exposure to major psychosocial stressors (e.g. eliminating an abusive father’s access to his daughter, addressing a child’s being bullied at school). Crisis workers can help the child and caregivers work together to problem-solve in these cases.

3. **Identifying Predisposing Conflicts**

In other situations, crisis workers are unable to identify a precipitating event that would account for anything like the magnitude of the child’s emotional and behavioral reaction. Here one might suspect that the child’s crisis may be symptomatic of a predisposing developmental conflict.
For example:

- Fear of abandonment -- may be expressed by a child in crisis as an intense drive to satisfy basic needs (e.g. eating, hoarding, stealing, pursuit of sexual gratification, superficial or indiscriminate emotional attachments)
- Sense of inadequacy -- may be expressed as a need to avoid failure at all costs (e.g. blaming others, denying responsibility, lying, avoiding situations with uncertain outcomes)
- Sense of guilt -- may be expressed either as passive-aggression (expressing anger in devious ways in order to avoid blame) or as scapegoating of oneself (blatant acting out in order to be punished)
- Conflict of autonomy-dependency -- may be expressed as an intense need to be in control (e.g. fighting or manipulating the system, aggression, transgression of societal norms)
- Crisis of identity -- may be expressed as uncertainty about self-worth, values, orientation, unstable social affiliations, extreme vacillations in behavior

For these children, there may be a chronic sense of insecurity, unpredictability, alienation or helplessness or failure in their lives. Nonetheless, crisis workers may raise the child's developmental conflicts to the surface for discussion and provide the child with some relief from the underlying anxiety.

4. Selecting A Crisis Treatment Theme

Within the time limits of a mobile response, crisis workers will likely want to settle on a single treatment theme, depending on their understanding of the central issue, the child's motivation to change, and the caregiver's support. A useful approach is provided by Life Space Intervention (Wood & Long, 1991), based on the pioneering work of Fritz Redl and David Wineman with children in residential treatment in the 1950's.

Crisis workers need to support children and caregivers in expressing their views on the current situation. Some children may begin with defensiveness and denial of responsibility; some caregivers may begin with blaming and threats of reprisal. Both are likely to be more open or at least drop hints about their underlying thoughts and feelings as they become more comfortable with the discussion. Crisis workers can help by:

- Questioning – for additional factual information and for the child's and caregiver's perspectives
- Active Listening – for key words, ideas or images
- Active Observing – of non-verbal communication
- Reflecting – the child's and caregiver's communications in order to convey interest and competence
- Interpreting – the connection between feelings and behaviors
Crisis workers can help children and caregivers view the crisis as a sequence of events (and their reactions to these events) along a time continuum. Crisis workers may be able to translate key concepts in the formulation (e.g. predisposing, precipitating, perpetuating and protective factors) into meaningful examples for both the child and caregivers. In many cases, this shared understanding of the genesis of the crisis can help reduce everyone's uncertainty and confusion and can promote a greater openness on everyone's part to search for alternatives.

Most treatment themes for children in crisis can be grouped into the following broad categories:

**Organizing Reality**
- appropriate for children who are unaware of their own behavior or the reactions of others, and who are thus unable to interpret or sequence events
- therapeutic focus is on organizing a mental representation of time and a sequence of events

**Confronting Unacceptable Behavior**
- appropriate for children who are too comfortable with their aggression, passive-aggression or manipulation of others
- therapeutic focus is on using external controls and authority to make the children uncomfortable with their deviant behavior and the inevitability of negative consequences

**Building Values To Strengthen Self-Control**
- appropriate for children who are remorseful after acting out, and for those who have a negative self-image or social role
- therapeutic focus is on expanding self-control and promoting self-confidence by emphasizing positive attributes

**Teaching New Social Skills**
- appropriate for children seeking approval of adults but lacking appropriate social skills
- therapeutic focus is on teaching specific social behaviors that will yield immediate rewards

**Exposing Exploitation**
- appropriate for children who are neglected, abused, scapegoated or who seek out destructive relationships
- therapeutic focus is on providing insight into the behavior of others who are acting against the child's interests
Whenever possible, crisis workers should encourage children to generate alternative solutions in line with the treatment theme and they should guide children in evaluating the pros and cons of each alternative. Crisis workers should also engage the caregivers in this exercise with the child because, in the end, both will need to be committed to the solution.

Crisis workers should help children plan how to resolve their current situation and to avoid relapse in the future:

- Rehearsing new behaviors -- rehearsing specific strategies for handling similar situations in the future, simple role playing for younger children
- Anticipating consequences -- preparing the child to face and accept responsibility for previous behavior, rather than avoiding or shifting responsibility onto others
- Affirming potential benefits -- the crisis workers and caregivers expressing their confidence in the child

5. Planning for Safety and Continuing Care

Crisis workers should always include a plan to ensure the safety of the child and others in their recommendations. On a mobile response, the Safety Plan may include remaining with the child and caregivers until the arrival of additional supports from professional or non-professional helpers, or accompanying the child and caregivers to a respite or acute psychiatric care setting.

Crisis workers should also triage the child for further clinical support through the crisis service or its partners in the community. (See “Secondary Triage” on page 31)

REFERENCES

**COMPONENT 4**  
**COMPLETING A MENTAL STATUS EXAMINATION**

The Mental Status Examination

1. **Appearance and behavior**  
   − dress and grooming  
   − posture and gait  
   − physical characteristics  
   − facial expression  
   − eye contact  
   − motor activity  
   − specific mannerisms  
   − speech

2. **Emotions**  
   − mood  
   − affect (variability, intensity, lability, appropriateness)

3. **Thought**  
   − form (flow of ideas, quality of associations)  
   − content  
   − distortions (delusions, ideas of reference, depersonalization)  
   − preoccupations (obsessions, phobias, somatic concerns)  
   − perceptual disturbances (illusions, hallucinations)

4. **Cognition**  
   − consciousness  
   − orientation (time, place and person)  
   − concentration  
   − memory (immediate, recent and remote)  
   − general knowledge  
   − abstraction  
   − judgment  
   − insight

5. **Attitude toward the interviewer**
The following briefly describes each area of the mental status examination:

1. Appearance and behavior

Crisis workers should observe the child's manner of dress and self-care closely as these may yield evidence of a disorder of emotion or thought process. Observe for evidence of trauma, including child abuse or self-harm (e.g. lacerations, scars, burn marks or bruising). Is there evidence of intoxication or substance withdrawal? Does the child have access to weapons or other dangerous or age-inappropriate objects, such as lighters or drug paraphernalia? Is the child's facial expression animated? Does the child make good eye contact? Is the child's speech slurred? Note any abnormalities of gross movement, including problems with gait, balance or coordination. Are there tics or other abnormalities of fine motor movement, fidgeting or nervous habits?

2. Emotions

"Mood" refers to the subjective report of the child's emotional state. The child may respond to a question or spontaneously report that the child's mood is happy, sad, angry, anxious or suspicious.

"Affect" refers to the objective appraisal of the child's feelings in regard to mood. Crisis workers may observe that the child's affect is congruent or incongruent with mood. For example, a child who is smiling while describing how saddened he is by the death of a pet would be displaying an affect that was incongruent. Affect may also be described as "labile" (rapid changes in expression of feeling), "retarded" (slowed expression of feeling), "blunted" (decreased expression of feeling) or "flat" (no expression of feeling).

In assessing a child's risk for self-harm, crisis workers should observe for evidence of neurovegetative signs of depression (e.g. loss of appetite, loss of energy, sleep disturbance, loss of interest in usually enjoyable activities) as well as the child's orientation to the future (e.g. education or career goals, whether they see themselves with children of their own someday). Crisis workers should ask the child directly about any history of suicidal or homicidal behavior and any current thoughts or plans of self-harm or harming others. The child should be asked about any history of mistreatment.

3. Thought

Thought form can be described as logical or illogical, disorganized or confused. For example, "circumstantial thinking" refers to a long-winded, indirect response to questions. "Loosening of associations" is observed in a child who cannot always make clear or logical connections between topics in a conversation (e.g. "I really had fun with my dad at the baseball game. The Blue Jays are a great team. I like to go bird watching.")

Thought content may reveal unusual preoccupations or obsessions, delusions, magical thinking or ideas of reference. Crisis workers may also observe evidence of perceptual disturbances, such as hallucinations or illusions (e.g. the child may startle and look to the side, as though responding to an unexpected stimulus).
4. Cognition

Cognition generally refers to a child's capacity to integrate experience, to think clearly and to communicate with others. A basic cognitive screen is an important part of the mental status examination, including:

- orientation to person, place and time
- level of alertness
- concentration (this may be appraised by asking the child to state the days of the week or months of the year backwards, perform serial addition by 7's, etc.)
- memory (immediate recall, short- and long-term memory)
- intelligence (verbal and nonverbal) and general knowledge
- insight and self-awareness
- social judgment

5. Attitude toward the interviewer

The interviewer may find the child is friendly and cooperative, or hostile and uncommunicative. The child may appear extremely guarded or overly familiar with the interviewer. The child's attitude may change as the interview progresses (e.g. the child may warm to the interviewer or the child may become sullen after a particular line of enquiry). The child's responses to specific questions (e.g. suicidal or homicidal ideation) may be viewed as reliable or unreliable.

Although crisis workers may become familiar with many technical terms, they need to beware of relying too heavily on psychiatric jargon in their discussions with parents, other service providers or even among themselves and with their consultant. When there are no apparent abnormalities in the mental status examination, remarks can be brief (e.g. “speech was clear and normal in rate”). When there are abnormal findings, crisis workers should refer to specific examples and quotes from the interview (e.g. it is not enough to report “auditory hallucinations” but rather “the child reported hearing his father's voice telling him to hurt himself during the interview”).

PRACTICAL TIPS FOR CONDUCTING MOBILE CRISIS INTERVENTION
PRACTICAL TIPS FOR CONDUCTING THE MOBILE CRISIS RESPONSE

Competent crisis workers are trained professionals who should feel comfortable in performing their work in a variety of settings in the community and are able to exercise the necessary precautions for safety. Crisis workers are able to think quickly and make judgment calls to deal with the situation at hand.

Community-based crisis intervention differs significantly from traditional office- and hospital-based services. One must apply the same assessment, interview and intervention skills but within an unpredictable, unstructured and potentially volatile environment.

Steps and procedures should be in place to ensure safety while on the mobile response

- Prior to leaving for the mobile response, provide a colleague with the address, telephone number and expected time of return.
- Always carry a cell phone for communication and safety. (Where cell phones are operational)
- If there are safety concerns, the assessment should not occur and alternative arrangements should be made (e.g. assess at a different time or location, or in the company of police or other professionals).
- Remember that you can turn around at any time.

Coordination and planning is required where two workers conduct the mobile response

- Clarify the role of each worker.
- Determine who will take the “lead” in coordinating the crisis intervention.
- Agree to exchange roles at the scene, if necessary.
- Develop codes/signals to cue each other non-verbally.
- Select key words that will assist in clarification or when sensing danger.
- Never assume that taking another worker along is going to make it safe.
Before setting out on the mobile response it is important to have a clear sense of what additional information is required and how the intervention is likely to proceed

- Seek clinical input from the rest of the team, including the consultant, to assist in highlighting any issues that need to be clarified.
- Make sure the preliminary assessment is complete, including input from service providers currently or recently involved with the child and family.

Consideration needs to be given to many contextual variables

- Consider the gender of the child.
- Consider specific cultural or religious beliefs and customs of the family.
- Arrange for an interpreter to attend the assessment, if needed.
- Consider the timing of the mobile response, particularly where the child is young.
- Where parents are separated or divorced, determine whether both are agreeable with the intervention and will be present and cooperative.
- Be mindful of others who will be present at the visit (e.g. other professionals or family members).
- Consider whether the parents are aware of and in agreement with the concerns expressed to the crisis service by other professionals.

Parents or guardians need to be present during the assessment and involved in the crisis intervention

- Where parents are separated and there is a joint custody agreement or regular access, have the referring parent contact the other to seek agreement for the mobile response.
- Ensure that the parents or guardians remain in the home while you are meeting with the child, as it not suitable for them to leave the premises.
- When a child resides in either a treatment residence, a detention centre or is in hospital, it is advisable for the parent/guardian to be present.
- Meet with the facility staff person to get the most up-to-date information on the child's functioning and request that this staff person be available during the assessment.
Meeting in the family home can provide useful information and insights but also has its challenges

- The upkeep and condition of the child’s residence can provide useful information.
- Maintain professional boundaries and reinforce your role frequently.
- Maintain control of the environment (e.g. request that unexpected guests leave, address repeated telephone interruptions).
- Set out the “rules of conduct” for participants (e.g. no interrupting each other, no foul or abusive language).
- Determine where interviews will take place.
- Establish and maintain objectivity and promote a sense of trustworthiness for all participants.
- Request a quiet and private area away from the child and family to call for consultation.

It is important to structure the intervention

- Bring all of the participants together initially to clarify issues and answer any questions.
- Introduce yourself, say where you are from, and state the purpose of the visit.
- Let everyone know that they will have an opportunity to speak and that all pertinent information will be shared at the end of the assessment.
- A meeting should be held with the child individually.
- Make it clear that discussions are confidential with the exception of child protection issues.
- Let people know that a consultation will take place with the psychiatrist to review the mental status examination and to develop more formal recommendations.
- A wrap-up includes bringing everyone back together for preliminary feedback, even if the consultation is postponed.

Children usually wish to meet with the worker first, as they may be curious or anxious about the assessment

- Schedule the interview at the convenience of the child and caregivers, if appropriate.
- Meet alone with the child first, if possible.
- Determine the best location to meet with the child (a bedroom is not appropriate).
- Adapt the questions to suit the child’s age and cognitive ability.
- Bring paper and crayons for younger children.
- Do not pressure the child if the child is refusing to be interviewed.
The child may speak about physical, sexual or emotional abuse or neglect by a parent or guardian

- The CFSA clearly defines the duty to report any suspicion of child abuse to the CAS.
- Establish the child’s safety needs before leaving the home.
- Contact the CAS from the family home or immediately after leaving the home.

Before leaving the assessment, information should be provided and ways to assist the child should be discussed

- If possible, contact the consultant from the location of the assessment to review the case.
- Provide information and recommendations to the family.
- If it’s not appropriate to consult while on-site, arrange to contact the family later that day with final recommendations.
- Clarify any safety plan or steps to be taken should the situation escalate.
- Check again for any immediate risk to the child or others.
- Agree to maintain contact with the family until they are linked to appropriate services.

The child may need to be relocated, for example, with a more supportive family member or friend or to a respite facility or hospital

- Parents should transport the child whenever possible.
- If the child is transported by ambulance, meet the child and family at the hospital to assist in the assessment and admission process.
- Contact the police to transport the child where the child is at risk of harming others and meet the police to assist as appropriate.
- Contact the CAS whenever there are child protection concerns.
SECTION III

GUIDELINES FOR MOBILE CRISIS SERVICES
PROTOCOLS AND PARTNERSHIPS

Best practices dictate that mobile crisis services should be developed within a network of related services comprised of viable partnerships to provide a fully integrated crisis system. The goal is to provide "seamless" delivery of service in an interdependent network of services.

COLLABORATION

Collaboration among services in the community is an essential component of a mobile crisis service. Collaboration goes beyond cooperation and good working relationships. It is a formalized commitment by two or more agencies to provide services differently (that may extend beyond mandates), to break down barriers, and find creative ways to reach a mutual goal or vision. Collaborations require comprehensive planning and well-defined processes for communication.

In many communities across the province, funding may not be sufficient to provide all of the components necessary for a comprehensive system of mental health crisis supports for children and families. Partnerships need to be developed or existing ones strengthened. These partnerships may extend beyond traditional children's service providers to include adult services, police, hospitals and other community agencies.

Example One:

A children's mental health centre may establish a partnership with a hospital that provides adult crisis services to share responsibility for ensuring telephone crisis response 24 hours a day, 7 days a week. The children's mental health centre provides the child-focused intervention and the hospital provides 24-hour coverage. With effective partnerships, children and families in crisis can access service any time, day or night, by calling the hospital crisis line. Calls made during regular office hours are routed directly to the crisis worker at the children's mental health centre. After hours and on weekends, calls are handled by the hospital crisis team who then forward the case to the children's crisis worker at the beginning of the next business day.
Example Two:

To ensure that mobile crisis response and follow-up services are accessible, two or more children’s mental health centres may establish a partnership wherein each agency takes the lead role in operating different components, with management and resources being shared among the agencies. The arrangement is mutually beneficial for the agencies and promotes “buy in” on everyone’s part to provide priority access to children in crisis when needed.

Service Agreements

Service agreements are useful tools to set out the process of intake and referral between the mobile crisis service and longer-term supports in the community.

The crisis service should be time-limited, focused on assessment, stabilization, and linking the child and family to follow-up services. Children in crisis require priority access to follow-up services. Timely response in a crisis contributes to the recovery of the child and promotes a seamless service system. Although there are fiscal constraints and long waiting lists for services, it is critical to engage other agencies in service agreements to provide priority access to children in crisis.

Protocols

Protocols With Police

Protocols are particularly important with local and regional police services. Success in establishing and maintaining protocols with police services depends on involving them early in planning the mobile crisis service.

Procedures for calling 911, for seeking police assistance on mobile visits, and the appropriate numbers to call for police assistance in other situations should be clearly established. Meeting with police officers on a regular basis provides an opportunity for building relationships.

Protocols With Ethno-Cultural and Language Services

Families across Ontario represent a rich diversity of cultural and linguistic backgrounds. The mobile crisis service should strive in its membership to reflect the diversity of its community. Protocols with other children’s service providers, whose staff may complement the crisis service, should be developed to reduce any cultural or linguistic barriers to service.
Caution needs to be taken when accessing an interpreter. It is not appropriate for a family member or an untrained member of the community to interpret for the child or parents in a crisis.

Service agreements with local ethno-specific agencies to provide cultural and linguistic interpreters may be useful.

Protocols With Hospitals

Hospitals are a vital support for community-based crisis services. Protocols with hospitals may include:

- how mobile crisis workers can refer children in the community for admission to hospital, based on their assessment and consultation with a psychiatrist or other qualified specialist.
- how the hospital can refer children presenting in the emergency department to the mobile team for assessment.
- how the crisis service can support a child in hospital and contribute to discharge planning and follow-up.

A positive working relationship with local hospitals will provide the crisis service with medical support and perhaps additional psychiatric consultation. This partnership should be perceived and function to the mutual benefit of the hospital and crisis team in serving the best interests of children and families.

Maintaining the Linkages

Maintaining and nurturing linkages needs to be done through open communication with both management and front-line staff. Involving various agency staff and professionals in joint training sessions is a useful way of establishing relationships and nurturing partnerships.
Inter-Agency Advisory Committee

It is important to receive input from community service providers in planning and developing the mobile crisis service. An interagency advisory committee is recommended to consult with the crisis service on planning and developing its program and to assist in establishing credibility with more traditional and established service providers in the community. The advisory committee can also help resolve problems that may arise between the crisis service and other agencies.

Representation should include all key stakeholders and partners (e.g. children’s mental health centres, Children’s Aid Societies, schools, probation services, police, hospitals and relevant adult services).

Parent/Family Support Network

Families in crisis can benefit from connecting with others who have experienced similar difficulties. A parent support network should be developed and available to help broaden and strengthen the safety net available to “catch” a child and family in crisis. The parent support network should be recognized as an essential component of any crisis response system. Where required, the development and on-going operation of this network should be sponsored, supported and facilitated by existing children’s service agencies.
INTERNAL PROCEDURES OR GUIDELINES

The mobile crisis service should develop policies and procedures to cover unique aspects of its service delivery:

1. Criteria for calling 911
2. Criteria for police accompaniment during a mobile response
3. Guidelines for responding to the crisis line with one worker in the office
4. Guidelines for documentation of all interventions
5. Requirements for data collection
6. Guidelines for transporting clients
7. Guidelines for workers in situations where the child may require physical restraint
THE CRISIS WORKER

Crisis workers come from a mix of professional backgrounds, including child and youth work, nursing, social work, psychology and other clinical practices. Diversity of disciplines is a benefit to a crisis team as it provides access to a broad knowledge base and experience and promotes creative interventions. Formal academic training is important; however, crisis work requires special skills, experience and personal characteristics.

A crisis worker's primary role is to:

1) Stabilize and manage crisis situations  
2) Conduct risk assessments and make safety plans  
3) Give support and access support from many sources  
4) Validate client autonomy and control  
5) Develop and negotiate service plans  
6) Educate the community and train other professionals

Certain personal characteristics may be especially suited to crisis work:

- Flexibility  
- Creativity and resourcefulness  
- Emotional maturity  
- Optimism and hopefulness  
- Tenacity  
- Openness to new knowledge  
- Self-directed  
- Respectful of differences and limitations
Selecting New Staff

Best practices suggest that crisis teams function more effectively when operating in a flat, non-hierarchical structure. This type of structure shapes the process of screening and selecting new staff.

Team members should review and screen new job applications and be involved in interviews with prospective candidates together with the manager of the crisis service. Applicants can be short-listed for observation shifts with the team as part of the selection process. The applicant should attend on a mobile response and complete a report of the intervention.

The manager of the crisis service will consult with the team and should normally agree with their impressions of the suitability of applicants.

Training of New Staff

Specialized training is critical in the following areas:

- Crisis theory and intervention
- Normal and abnormal child development
- Children's mental health
- Family and social systems
- Risk assessment and suicide prevention
- Mental status examination
- Psychiatric diagnosis and formulation
- Use of psychotropic medications
- Non-violent crisis intervention
- Cross-cultural awareness and sensitivity
- Legislation governing the delivery of mental health and other children's services

In addition, the crisis worker must develop a sound working knowledge of resources, partnerships and agreements with outside agencies. The worker needs to know the telephone numbers and locations of police stations, hospitals and Justices of the Peace.
Preceptorship Training And Orientation

Preceptorship or “shadowing” is recommended for all new crisis workers and involves in-field training under the supervision of an experienced worker.

To train for telephone crisis intervention, the novice worker should listen on a second telephone as senior staff members respond to crisis calls. The caller should be told whenever two staff members are present on the telephone. This form of shadowing allows the novice to hear telephone interventions with different kinds of callers in different kinds of crisis, and with different styles of crisis response. The novice should make notes of the telephone crisis intervention for review with senior staff.

The novice should progress from listening in and making notes of telephone crisis interventions, to making calls to collateral informants in cases that have already been opened by senior staff members, to being the first person to respond to a caller on the crisis line. The novice should review all case work with the team and the consultant as part of the initial training.

To train for mobile crisis response, the novice should accompany senior staff members on a variety of crises in a variety of settings. The novice should progress from observation of the mobile response, to collecting background information, and finally to the mental status examination. Seniors workers should encourage the novice to make notes of the assessment and consult with the psychiatrist, under supervision.

Senior crisis workers may find that case notes are a good indicator of the novice’s readiness to work more independently. Initial training for telephone crisis intervention and mobile crisis response may be expected to take about six months.

On-going Professional Development

Working in a learning environment is key to the effectiveness of any professional as it rejuvenates and reenergizes staff and ensures that up-to-date knowledge is available. Professional development is particularly important for crisis workers as they rely on their own knowledge and personal resources on the telephone and in the field. It is essential for workers to keep on top of new developments in research and treatment approaches as well as to take part in on-going team building.
Supervision

Manager of the Mobile Crisis Service

Although existing crisis services tend to function as nonhierarchical teams, a manager with a strong clinical and administrative background is important. The manager carries the major responsibilities for administering the service, deals with any conflicts among members of the team and has major responsibilities for managing protocols with the community partners and the crisis service. The manager may also play a role in teaching crisis workers and providing professional development training.

Peer Supervision

*Daily clinical rounds* are necessary for effective communication. The staff on shift should meet periodically to review all outstanding referrals to the crisis service. This affords an opportunity for members of the team to consult with peers and to share ideas for service delivery. These meetings also provide workers with the opportunity to discuss their own emotional response to calls and to “check and balance” any biases they may show in their work with a particular case. Finally, daily meetings promote consistent management of outstanding cases. The consultant should attempt to attend these meetings in person or by telephone.

*Weekly team meetings* are essential for effective crisis intervention services and should be built into the schedule of all workers. Team meetings allow members to receive peer support and supervision, to meet with the manager of the crisis service on administrative or job-related matters, and to discuss complex cases in detail with the consultant. These meetings can include professional development workshops and presentations from community agencies.
THE ROLE OF THE CONSULTANT (PSYCHIATRIST OR OTHER QUALIFIED SPECIALIST)

On the mobile crisis service, the consultant may have one or more primary roles, as well as a number of secondary ones, which will vary in importance in different jurisdictions. These roles may include:

1. **Consultation**
   It is expected that in most circumstances, the crisis workers will collect background information and conduct a risk assessment of the child. The consultant will then review this information with the crisis workers. The consultant may advise the crisis workers regarding possible gaps in information required for a preliminary diagnosis and formulation of the case. If so, the crisis workers will have to return to the sources of information to fill the gaps before the treatment plan can proceed. For a plan to be effective, one must also take into account the availability of outside resources and their likely impact on the child’s situation.

   In consultation around cases, the consultant will be responsible for guiding the triage of referrals to the service, allowing for the most efficient use of the crisis team's limited resources.

2. **Support**
   The consultant will act as a support person to the crisis workers and will provide guidance for the management of limited clinical resources and the handling of unfamiliar or difficult situations.

3. **Supervision of Treatment**
   The consultant will provide both a theoretical and clinical foundation for active cases being managed by the members of the mobile crisis team. The consultant may help create an initial treatment plan and modify it according to circumstances as the situation evolves. The consultant may meet with a child or family when a diagnostic or therapeutic question arises that the crisis workers feel is beyond the scope of their training or experience.

4. **Education**
   The role of the consultant may include providing educational support to the crisis team and other groups or settings in the community. The role of education may be closely tied to that of support and supervision of other members of the mobile crisis service. The consultant may give presentations, lectures or workshops on selected topics, and provide group supervision and discussion of clinical cases or theoretical issues.
Formal training and clinical supervision on a case-by-case basis by the consultant will be required for workers to acquire the skills necessary to conduct a mental status examination in the variety of situations encountered on a mobile crisis service. Over time the consultant will gain confidence in the ability of the crisis workers, and their review of the results of the child’s mental status examination will come to play a crucial role in the diagnosis, formulation and planning for the child.

5. Research
This task may involve the collection, maintenance and organization of statistical information relevant to the service. This may allow for refinement of service provision based on practical information gained on the nature of the needs of the community. Contribution to the clinical literature of emergency service provision may also be possible, allowing the experience gained locally to be of broader benefit.

6. Direct Treatment Provision
In those situations where his or her particular skills could be best employed, it may be appropriate for the consultant to provide direct treatment to individuals or families. The consultant may also, at times, see individual children or families for diagnostic purposes or to consult with regard to medication issues.

7. Liaison
The consultant may act as a linking agent between the crisis service and other community service providers, including hospitals or outpatient treatment and mental health settings, private physicians, schools, church groups, Children’s Aid Societies or Native Child and Family Services or police and probation services. The mobile crisis service, to be of optimal benefit to the community, must be well-known and well-integrated as one component of a continuum of services available in the region. As liaison, the consultant may help establish the name, credibility and role of the crisis service with colleagues in the community. Adequate liaison may help prevent blocks to or lapses in care when the crisis service completes its involvement with the child and family.
SECTION IV

REFERENCE MATERIALS
CRISIS THEORY

“Crisis is a perception of an event or situation as an intolerable difficulty that exceeds the person's resources and coping mechanisms” (Gilliland & James, 1997).

Basic Crisis Theory: Since Lindemann's (1944, 1956) seminal contribution of a basic crisis theory stemming from his work in loss and grief, the development of crisis theory has advanced considerably. Lindemann identified crises as having: (1) a period of disequilibrium; (2) a process of working through the problems; and (3) an eventual restoration of equilibrium. Together with the contributions of Caplan (1964), this work evolved to eventually include crisis intervention for psychological reactions to traumatic experiences and expanded the mental health field's knowledge base in applying basic crisis theory to other types of crises experienced by people.

In addition to recognizing that a crisis is accompanied by temporary disequilibrium, crisis theorists identify the potential for human growth from the crisis experience and the belief that resolution may lead to positive and constructive outcomes such as enhanced coping abilities. Thus, the duality contained in a crisis is the co-existence of danger and opportunity (Gilliland & James, 1997). One part of the crisis state is a person's increased vulnerability and reduced defensiveness. This creates an openness in people for trying different methods of problem-solving and leads to change characterizing life crises (Kendricks, 1985).

Expanded Crisis Theory: While expanded crisis theory, as we understand it today, merges key constructs from systems, adaptational, psychoanalytic and interpersonal theories (Gilliland & James, 1997), the advent of systemic thinking heralded a new way of viewing crisis states. By shifting away from focusing exclusively on the individual in crisis to understanding their state within interpersonal/familial relationships and life events, entry points and avenues for intervention significantly increase. Systems theory promotes the notion that traditional cause and effect formulations have a tendency to overlook the complex and difficult to understand symptomology often observed in people in crisis. Especially with younger populations, crisis assessments should occur only within the familial and social context of the child in crisis.

More recently the ecological perspective is gaining popularity as it evolves and develops into models of crisis intervention. From this perspective, crises are believed to be best viewed in the person's total environmental context, including political and socio-economic contexts. Thus, in the United States, mobile crisis teams primarily responding to adult populations use an ecological model. Issues of poverty, homelessness, chronicity, marginalization and pervasive disenfranchisement characterize the client population served (Cohen, 1990).
Ecocsystem Theory: Most recently an ecosystem theory of crisis is evolving to explain not only the individual in crisis, but to understand those affected by crisis and the ecological impact on communities. For example, the devastating rate of suicide and attempted suicide in Inuit youth reverberates through their communities on multiple levels. Ecosystem theory also deals with larger scale crises from environmental disasters (e.g. oil spills) to human disasters (e.g. Columbine school shootings).

Applied Crisis Theory: Applied crisis theory encompasses the following three domains:

1) Developmental crises which are events in the normal flow of human growth and development whereby a dramatic change produces maladaptive responses (e.g., birth of a child, retirement);

2) Situational crises which emerge with the occurrence of uncommon and extraordinary events which the individual has no way of predicting or controlling (e.g., traumatic event, sudden illness) and;

3) Existential crises which refer to inner conflicts and anxieties that relate to human issues of purpose, responsibility and autonomy (e.g., middle life crisis).

Each person and situation is unique and should be responded to as such. Therefore, it is useful to understand the crisis from one or more of these domains in order to understand the complexities of the individual's situation and to intervene in more effective ways. One would also tend to see a younger population with developmental and/or situational crises (Gilliland & James, 1997).

Stages of a Crisis

In order to articulate the elements of a responsive mobile crisis service a conceptual framework of the stages of crisis is presented. There is agreement in the literature that most crisis interventions should last about one to six weeks (Caplan, 1964; Kendricks, 1985). This suggested time frame is based on identifiable stages of a crisis. Frequently cited in the literature (Gilliland & James, 1997; Smith, 1978) is Caplan's four stages of crisis:

Stage 1: A precipitating event or condition produces tension in the person(s) at which time customary problem-solving strategies are attempted.

Stage 2: Tension increases if problem-solving attempts are met with failure.

Stage 3: Other problem-solving resources are sought but prove ineffective or unavailable and the precipitating condition persists.

Stage 4: If the external threat is not reduced, or if intervention has not occurred, the tension culminates and produces severe emotional disorganization.
While others have proposed slightly varying stages, there are commonalities in understanding that crises are time-limited, have a beginning, middle and end, and that intervention early in a crisis can produce stabilization and a return to the pre-crisis state. No intervention, or inadequate intervention, can result in chronic patterns of behavior that result in transcrisis states (Gilliland & James, 1997).

Transcrisis states contain the appearance of resolution but the recurrence of the crisis usually indicates that the crisis has not been adequately addressed. This manifests in repeated hospital admissions or numerous visits to emergency rooms.

In summary, overall goals specific to mobile crisis services cited by service providers include: providing timely treatment in the least restrictive environment; utilizing community-based treatment alternatives rather than in-patient treatment; hospital diversion when appropriate; hospital admission when necessary; increasing client functioning; providing medication/symptom management; involving supportive family members; and assisting clients in obtaining service from other programs for on-going treatment.

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GENERAL SAFETY TIPS PASSED ON BY EXPERIENCED CRISIS WORKERS

- Crisis workers should be familiar with the area they are going to visit (e.g. whether there is a high crime rate, gang activity, high drug use etc).
- If going to an apartment, check out the building itself (e.g. high density, low income).
- Check out the parking situation. Will the crisis workers have to walk through alleys, especially after dark? This kind of information is available through police community relations officers, until the workers are familiar with the area.
- Scan the environment and identify any potential safety risks.
- Listen to what family members or others say about what could happen or has happened in the neighborhood in the past.
- Establish that there are no weapons on the premises.
- Make sure cell phones are always charged and functioning.
- Have on hand a functioning flashlight (with batteries) in the car for dark streets, stairwells etc.
- Wear identification badges with first name only and the name of the crisis service. Some people will request to see ID before allowing crisis workers to enter their home or apartment building.
- Appropriate clothing is important, avoid high heels, tight skirts, and jewelry. Wear semi-casual clothes in case there is a need to run.
- Travel light; don't carry a big bag or brief case as there may be a need to leave quickly.
- Meet the client in a public place if there is a potential safety risk in the home.
- Develop safety phrases with co-workers or signals when going out as a team.
- On entering the home scan the environment, including general cleanliness, exits, location of rooms, pets, evidence of rodents, or any potentially dangerous objects.
- Check the location of the entrances and exits of buildings/homes making sure exits are visible and unobstructed by furniture or people.
- If drug or alcohol use is suspected, check for harmful objects which are easily accessible (e.g. knives).
- If there are animals, ask people to place them in another room (clients have claimed their animal is “friendly” and it has turned out differently).
- Take health safety precautions if you suspect or are aware a person has a communicable disease.
- It is not necessary or advisable to remove your shoes at the door.
- Keep in contact with your office during the mobile response and when you leave the site.
Getting in to see the child

- At the telephone intervention stage, find out how the team will get in to an apartment building (i.e. will someone be in the lobby?) Is there an entry code or other security measure? Is there a different name used on the buzzer?
- If there is no phone to contact anyone in the household, pre-schedule a meeting place and time with the client/family/other.
- If the crisis worker arrives at the designated location and there is no answer, call the client on your cell phone to verify the address. If the situation was assessed as low risk, try to buzz the apartment again, wait a few minutes more, and then leave.
- If there is a concern that someone might be injured, you may call the superintendent to help you gain access or contact the police.

During the on-site interview

- Be aware of your own body language and that of others.
- Keep a reasonable distance from the client and others.
- Do not sit down if others in the home remain standing.
- Request that radios, TV’s and stereos are turned off.
- Meet in an open, central location, such as the kitchen or living room.

Do not assume that going with two workers will guarantee safety.

If it is unsafe for a female worker it is also unsafe for a male worker.

Remember that your instincts are usually reliable. You can turn around and go back to the office and reschedule an interview if necessary, or if you have arrived at the home and you begin to feel unsafe you can make an excuse to leave, and follow-up from the office.
CRISIS INTERVENTION WITH ABUSED CHILDREN

Physically and emotionally: child abuse hurts. But these are not the only ways that abuse can hurt. Child abuse may impede a child’s physical, social, and intellectual development. Abuse may also provoke a crisis situation in a family, resulting in a call to a mobile crisis service.

It is important to be clear about the roles of the many helping professionals who are charged with the responsibility of responding to allegations of child sexual abuse. If the presenting issue in a call to the mobile crisis service is an allegation of abuse, the required response is legally mandated. An immediate call must be made to the appropriate local child welfare agency. It is the legal responsibility of the child welfare agency to respond to all allegations of abuse.

All calls to a mobile crisis service should be assessed for potential child abuse. If there is any indication that abuse is involved, it is incumbent on the crisis intervention professional to report the concern to the appropriate child welfare agency. Once the report has been made, it is important to plan together for how to most effectively respond to the crisis call in a way that will support the child and family, reduce the potential for additional trauma and meet all legal requirements.

Abuse is not generally experienced in isolation; a child who is being sexually abused may also be physically abused and is certainly experiencing a form of emotional abuse. The impact of the abuse is dependent upon many variables, including the age of the child, the duration of the abuse and the relationship between the child and the abuser. However, there are a number of common experiences.

A child who is being neglected may experience delays in physical or cognitive development. Inadequate nutrition will affect both intellectual and physical development. These children may be tired, lethargic and disengaged from what is happening around them. Situations of neglect are unlikely to prompt a call to a mobile crisis service.

Physical abuse may result in everything from minor injuries to death. Physical abuse also causes emotional trauma for children and can impede intellectual and emotional development. A call to a mobile crisis service because of physical abuse may come from a neighbor and/or the child. It is important to call the local child welfare agency immediately and to report the allegations of abuse. It is the responsibility of the child welfare agency to investigate and respond.
Sexual abuse can result in physical injury as well as having the potential for tremendous emotional trauma. For example, resulting anxiety may lead to an inability to concentrate at school or unresolved anger may lead to “acting out” behavior that results in a suspension from school. If a presenting issue in the call to a mobile crisis service is an allegation of sexual abuse, the local child welfare agency should be called immediately and the allegations of abuse reported. It is the responsibility of the child welfare agency to investigate and respond.

Emotional abuse is perhaps the most insidious form of abuse. If children live in environments in which they are repeatedly denigrated, they may lose faith in their ability to do anything right. This lack of belief can impair children’s development on a number of fronts, as they become reluctant to try anything that might result in failure (or in perceived failure). Emotional abuse may be one of the presenting issues in a call to a mobile crisis service. If the worker believes that emotional abuse is present, at minimum, a consultation call to the local child welfare agency is appropriate.

All forms of abuse are traumatic. Children manifest trauma in different ways. A child’s ability to cope with traumatic events depends upon a number of different factors including:

- Temperament
- Ability to problem solve and reason
- Level of self-confidence and self-esteem
- Age at the onset of abuse
- Gender
- Others’ response to disclosure of abuse

Abuse may be one of the factors that precipitates a call to a mobile crisis service. In any instance where the allegation of abuse has not yet been reported to the appropriate child welfare agency, a report must be made immediately. Working collaboratively, the crisis intervention professional should determine with the child welfare worker who will respond to the crisis situation and what intervention will occur. It is critical to remember that the Child and Family Services Act mandates that the child welfare worker take the lead role in this process.

One of the key objectives of the mobile crisis service is to limit or minimize institutional intervention based on the idea that community-based care is more humane, more therapeutic and less stigmatizing than in-patient care. However, it is critical to recognize that in situations where abuse is suspected or disclosed, institutional intervention will be legally mandated and cannot be avoided. In most instances, the local child welfare agency will work with services and supports within the community to protect the child and support the family. The best interests of the child should always be paramount.

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CRISIS INTERVENTION WITH DEVELOPMENTALLY HANDICAPPED CHILDREN

This essay assumes that the majority of developmentally handicapped (DH) children referred for crisis intervention will have a disability in the mild range of developmental handicap, as this group constitutes 75% to 85% of the DH population. DSM-IV sets these criteria for a diagnosis of mental retardation (or developmental handicap):

- IQ of 70 or below.
- Deficits in adaptive functioning.
- Onset of the disorder before age 18 years.

We also assume that the purpose of crisis intervention is assessment and formulation of the reasons for and nature of the crisis, together with recommendations for interventions.

It should be understood that all of the treatment modalities one would offer to any child should be considered for the DH child. These include: individual psychotherapy, family therapy and group therapy, as well as environmental alterations. Behavior therapy is a treatment modality that is frequently recommended for DH children, and which should be considered in combination with any one or more of the other treatment modalities that are usually made available to children.

Given that DH children are at higher risk for deficits in hearing and communication, an interdisciplinary team that would include a Speech/Language Pathologist is preferred for crisis intervention. If this is not possible, the following information and strategies should be incorporated into the interview.

Children with DH are at increased risk for hearing loss. In fact, approximately 50% of children who come to the Children and Youth Services Division (CYSD) at Surrey Place Centre (SPC) have a previously undetected hearing loss. Hearing problems in early childhood will have an impact on communication and learning, especially learning that relies on language.

Because communication and cognition are highly related, DH by definition involves some degree of communication disorder. Communication disorders vary in presentation. In many cases, children who are able to express themselves fluently may not be able to process the verbal information presented to them orally. In other cases, comprehension of language may be greater than expressive ability. Because they often use language with difficulty in social situations, their verbal communications may be inappropriate. For example, the DH child may introduce himself inappropriately to a stranger.
Assume, therefore, that the DH child who presents for crisis intervention may well have an unidentified hearing or communication deficit. The following strategies should therefore be used in interviewing the client:

- Make sure you have the child's attention before talking to him. Call him by his name or tap his shoulder, if necessary.
- Obtain and maintain eye contact with the child. Some DH children (e.g. Fragile X, autistic spectrum disorder) will have eye gaze aversion; although they will not give you eye contact even with your effort, they may still be listening.
- Use concrete language and short sentences.
- Ask direct, non-leading questions.
- Make sure that you speak clearly and loudly. Avoid touching your face or covering your mouth when you talk to the child.
- Ask the child to repeat what you have said, to ensure that your words have been heard correctly.

One of the features of the DH population in general is the much greater likelihood of exposure to abuse. Therefore, in the assessment and formulation the interviewer should be aware of the higher likelihood that some form of abuse or re-victimization, or a cue eliciting previous abuse, may have precipitated the crisis. In addition, diagnostic issues are blurred in the presence of abuse, given recent findings that DH may be either an antecedent to or a result of abuse.

The usual standards and guidelines for interviewing children should be upheld with DH children. These children are accustomed to being invalidated, having been subjected to experiences of being dismissed and marginalized throughout their lives. Informed consent for all procedures should be obtained from the DH child and family or caregivers. Confidentiality and the limits to it, especially as regards disclosure of abuse, must be explained. This allows for the protection of the child's autonomy and dignity. Client capacity is assumed in the absence of definitive evidence that would disqualify it. These steps will ensure an appropriate framework for the assessment and are a necessary condition for the formulation of a therapeutic alliance.

In identifying the precipitant for the crisis, unidentified medical causes should be considered. Because of the DH child's difficulties in communication, their medical problems causing pain and distress may be overlooked unless carefully screened for. The interviewer should recognize that the aggression and self-injurious behavior frequently seen in DH children when in crisis is an expression of medical, psychiatric and interpersonal or environmental problems. The temptation to explain aggression and self-injurious behavior circularly, that is, in terms of the DH diagnosis as such, should be avoided.
Children are dependent upon their environments (e.g., family, school) and DH children are even more so. Compared to other children, DH children require more environmental supports (e.g., group homes, one-to-one contract workers, respite). When appropriate community supports are not in place, reviewing the child's access to community supports and providing information to guide caretakers to appropriate resources can relieve the stress on an overburdened family. Group home or contract workers can act as collateral informants in the assessment. DH children may have difficulty in providing a detailed description of their everyday activities.

The interviewer must think in both intrapsychic and systemic terms when interviewing, assessing and formulating for DH children. DH children have an internal world of meanings, although it will often be more difficult to gain access to it than with other children. To aid in accessing the internal world of the child, observational and non-verbal techniques should be used in addition to verbal enquiry. Play techniques should be employed; props such as puppets, dolls and animal figures should be made available. Drawings of self, family or objects may be employed as a projective technique.

These children may be cognizant of the consequences of saying “the wrong thing” in front of parents or care providers. Therefore, while it is advisable to obtain input from multiple informants, it is also necessary to interview the DH child alone. Any suspected abuse must be reported to the Children’s Aid Society. Finally, avoid referring the child for formal psychological testing while he is still in crisis.

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CRISIS INTERVENTION WITH AUTISTIC CHILDREN

The following components are vital to developing a responsive crisis intervention plan for children who present with special needs such as autism.

Direct Practice Principles

Principle 1: Sources of Crises

Children with autism presenting to crisis services are often experiencing difficulties evidenced by anxiety or depression. The interaction of developmental disability with the typical maturational stressors associated with adolescence can result in an increased awareness of "differentness". This growing sense of themselves as not measuring up to others, paired with the lack of friendships and struggles to meet increasing academic challenges, can create pressures that hinder their capacity to cope. A lack of recognition by family members and community service providers that developmentally disabled children experience these insights, yet are isolated without peer support, can stimulate a heightened expression of anxiety or depression. Significant withdrawal or aggressive outbursts, either of which may appear unprovoked, can be expressions of this anxiety and depression.

Service providers need to be aware that children who present in this manner are affected by a neurological disorder, and not simply an emotional one. Although both disorders may be evident, these children cannot be treated using only interventions that have proven successful with children with emotional disturbance.

Principle 2: Characteristics of Developmental Disorders to be Considered

Central to the challenges associated with autism are difficulties with communication, behavior and social interactions. As well, many children may experience significant difficulties related to their sensory perceptions, their need for structure and routine, and their reliance on visually presented information.

The communication challenges include both verbal and non-verbal communication. Even if the child has good use of speech, he may struggle with the social use of language. It will be essential to determine that the child has a reliable means of communicating his needs and wishes. The involvement of an experienced Speech-Language Pathologist or communication consultant may be required to assess the communication skills of the child and provide assistance in developing an appropriate response to their communication needs.
For many children with autism, behavior may be their only or most effective communication tool. In order to address behavioral concerns it is critical to analyze the communicative function of presenting behaviors. Strategies to address communication needs must be implemented before long-lasting behavioral change will occur. Positive behavioral intervention approaches have proven to be the most effective in bringing about successful skill development.

The impairments in social interactions can become exacerbated as these children become aware of the challenges they are facing in social and relationship domains. Their inability to make and keep friends can further raise issues of self-esteem. The extreme communication difficulties that are characteristic of this disorder impact on their ability to both discuss their feelings and obtain support in the same way as their typically-developing peers. When in crisis, it will be important for the staff to have an understanding of and sensitivity to these deficits in social skills and to have realistic expectations for the acquisition of these skills. Insight-focused intervention will be unsuccessful. They will need assistance in learning and practicing more appropriate, and specific social skills. The lack of awareness of the effect of their behaviors on others and the methods used to develop this awareness, such as social stories, interferes with their capacity to benefit from more traditional mental health interventions.

Medication reviews and psycho-educational assessments may also be needed to fully address the challenges of autism.

Most often, the family will be best positioned to advise the crisis staff on the interventions that have been most beneficial to the child and that provide accommodation to their particular learning style. Understanding ways to assist with relaxation, introduce structure and routine and use visual tools to the fullest benefit can be essential to developing an effective intervention plan. These strategies can be obtained from family members and other service providers who know the child. There must be recognition of and respect for the knowledge parents possess regarding their child and his or her disorder, strengths and challenges.

Principle 3: Challenges Associated with Transitions and New Experiences

Children with autism experience extraordinary difficulties with change. It must be recognized that the child’s adjustment to change (e.g. placement outside home) may take much longer than anticipated and that the behaviors observed during this time may be unrelated to the crisis or atypical for this child. Structure, routine and predictability are essential components of a plan to stabilize the child. Familiar people, places and objects can provide both structure and a sense of security. Consideration must also be given to the transition back home from any in-patient crisis response.
Systemic Principles

Principle 1: Access to Service

The presence of an autistic disorder should not pose a barrier to access to crisis services. Access to appropriate crisis services can be enhanced through education, training and consultation from specialty service providers. These specialty agencies are part of the larger continuum of services. Formalized arrangements will help to ensure a commitment to access. In addition, such arrangements enhance the knowledge of the entire service system and will provide more support directly to staff, enhancing their confidence and competence in working with difficult children such as those with the challenge of autism.

Principle 2: Integrated Services

The term “integration” means that relationships between services are coordinated and consolidated. Agreements are established through formalized arrangements to ensure smooth access to crisis services and coordinated delivery of the necessary treatment elements to address the crisis. These formalized partnerships help to build the various components of a crisis continuum and help ensure that the services a child requires are available at the right time and place.

For example, a child identified by parents to a community agency might be presenting with acute self-destructive behaviors, or violent behaviors toward caregivers, eventually resulting in the breakdown in the family unit. The crisis response would be based upon the options within the crisis service continuum. This might involve initial admission to a short-term crisis bed for stabilization. While in the crisis bed more complex medical/psychiatric needs could be identified, resulting in the need for hospitalization. While in hospital a number of community services might come together to work with the original crisis staff and the hospital staff to develop a long-term service plan with the family.

Principle 3: Shared Responsibility

It is essential that all community stakeholders are part of both the treatment planning and the larger continuum of crisis supports and services. Stakeholders must include families, a range of service providers and representation from different service sectors. The goal is to work “collaboratively” and not to offload the responsibility to one service or sector to respond to a crisis situation.

For example a child with autism in crisis, or a crisis service provider dealing with a child with autism, might need to have access to a specialized service to provide clarification of the behaviors that are being exhibited or to identify what might be exacerbating the crisis given the diagnosis. This does not necessarily mean that the specialized service needs to provide all the services to manage the crisis. Rather, the specialty service provider's role may be to support other service providers in formulating a crisis plan for the child and family and enhancing the existing resources.
available by adding their specialty expertise to the team. In this type of approach the crisis plan is a shared responsibility.

Principle 4: Flexible Response

When examining the unique challenges of responding to children with autism some of the more traditional crisis interventions may not be suitable. As a result increased flexibility and creative solutions will be required to find appropriate means to address the crisis situation. During the initial crisis period the child might present with behaviors that are not typical for that child and which may not be associated with the identified crisis. This might require staff, programs and agencies serving these children to make accommodations to the unique needs of this individual. For example, staff and program expectations might need to be adjusted. Structure, routine and predictability will need to be enhanced. It will also be important to incorporate the use of visual schedules into the treatment plan. It is critical that staffing is consistent and predictable. This may require different thinking about shift assignments. During this period children might better stabilize if they have access to familiar people and objects.

Principle 5: Planned Transitions

Transitions pose one of the most significant challenges for children with autism. For example, a child moving from hospital to home might require a comprehensive plan that includes structured preparation for the change. The idea of providing in-home staffing support to help the child and family with this transition is critical to avoid possible readmission to hospital or precipitating another crisis. Often mobile crisis services can help avoid the need for hospitalization and may provide a much more effective intervention. The need for a “flexible pool of resources” (e.g. both financial and human) which agencies can access to support these more difficult children in their own environment is an essential component in the continuum of crisis service options.

Principle 6: Developing a Continuum of Crisis Response

The success of responding to children with complex needs is dependent upon community partners working together to provide a range of service options such as respite beds, quick access to hospital, in-home support, and crisis response (e.g. mobile crisis response). Agencies in the community that might not traditionally provide crisis services to this population should be considered as possible supports in building a crisis continuum. For example, an agency might be able to offer a respite bed, but might need additional staffing support or consultation through the network of services that are part of the crisis continuum. The staffing might be provided by an agency that has expertise in autism or the agency might provide some level of direct consultation to the staff that is working with the child. Such an approach provides direct support to the staff and will enhance their knowledge in the area of autism and their understanding of the complexities of these children’s learning styles.

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Article VI

PSYCHIATRIC DISORDERS- GENERAL INFORMATION

In North America the current standard for the diagnosis of mental disorders in children and adults is the DSM-IV (Diagnostic and Statistical Manual, 4th edition, 1994) of the American Psychiatric Association. The DSM-IV classifies conditions in terms of their chief clinical features, using hierarchical inclusionary and exclusionary criteria, and symptom duration and severity, to distinguish among disorders.

The DSM-IV uses five axes to describe the child's condition:

**Axis I:** Clinical disorders.
Other conditions that may be a focus of clinical attention.

**Axis II:** Personality disorders and mental retardation.

**Axis III:** General medical conditions.

**Axis IV:** Psychosocial and environmental problems (e.g. family problems, housing or school difficulties, significant losses or traumatic experiences, etc).

**Axis V:** Global Assessment of Functioning (an overall opinion of how well the child is functioning or coping given the issues and concerns noted in axes I - IV).

This section will focus on a general description of mental health *signs* and *symptoms* in order to provide an overview of the clinical features that may be seen in a child that are useful in making a clinical diagnosis. *Signs* are the observable markers of a condition, such as scars, bruises, dilated pupils or the odor of alcohol, while *symptoms* refer to the subjective sensations of the child, such as sadness, fear or nausea.

Accurate diagnosis relies on clinical judgment and experience based on evaluation of information obtained from a number of sources. Each source must be judged with respect to its reliability, validity and importance. In the context of an emergency assessment, sources of information may include the child, parents or guardians, siblings, other service providers and ancillary sources of information, such as school or medical reports, results of psychological testing, etc.

While many of these sources of information may be accessed without face-to-face contact with the child, this contact may often be required to evaluate the interactions of the child and caregivers as well as to perform a Mental Status Examination.
Despite the utility and general acceptance of the DSM-IV, it has a number of limitations and these will become particularly apparent in crisis work, where invariably the interview occurs with time constraints and with children and caregivers under unusually high stress. Limitations of the DSM-IV include:

1) The fact that a clinical diagnosis is descriptive. It is based not on the results of objective hard data (such as x-rays, pathology reports, laboratory test results or physical examination findings), but rather on the subjective impressions of the psychiatrist or clinician. Different people might interview the same child and strongly disagree on the level of irritability, sadness or social impairment. The clinician’s understanding of the presenting problems is shaped by his or her experience, how the information is conveyed, and other factors that are difficult to evaluate (e.g. whether the child’s mood is being altered by legal or illegal drug use).

2) The circumstances of the assessment may dramatically alter the presentation of the condition. A hyperactive or learning-disabled child who is observed in the classroom may appear much more dysfunctional – and be much more dysfunctional – than the same child seen at a video arcade.

3) The diagnosis of many conditions is based on their course over long periods and so information about the duration of symptoms and how they evolved must be obtained. Sometimes this is not possible in one or two meetings. When working with children, the impact of developmental change on functioning must also be factored into the equation.

4) Reviewing the history of medical and other treatment interventions provides only general evidence of the child’s difficulties. An earlier diagnosis may have been incorrect or a condition might have been treated without the diagnosis being adequately documented (e.g. in order to avoid “labeling” or stigmatizing the child).

5) History of the use of medicines in treatment is likewise an unreliable guide to diagnosis. This is because often medicine will be initiated on a trial basis without a clear diagnosis being made, as well as the fact that the same medication may be used to treat a wide range of disorders in children. For example, antidepressants may be given for anxiety and mood problems, impulsivity, aggression, and so on.

Most clinical disorders in the DSM-IV can be grouped under the headings of “Problems of Feeling,” “Problems of Behaving and Relating,” and “Problems of Thinking.” The listing of conditions below is not all-inclusive, but does encompass the majority of conditions relevant to crisis intervention with children. References to specific diagnosis in the DSM-IV appear in bold face type.
Problems of Feeling

Here the chief complaint involves a disturbance of a child's inner sense of self. Young or immature children may be unable to say much more than that they feel "bad" or "sad" or "mad" and the assessor will need to infer the child's subjective state from others' observations of the child's statements and behaviors. It is not unusual for children to insist they "feel okay," while parents and teachers may report dramatic changes in attitude, social functioning, and physical well-being.

Problems of feeling usually present as one of the following complaints:

- The child is "sad." There may also be a complaint of the child having no energy or feeling "sick" (headaches, stomachaches and so on) without physical cause. In the extreme, the child may feel suicidal.
- The child is "bad." He may be described as "not being himself" or there may be a history of fighting, breaking things, self-harm, verbal abuse of others, or he may be described as "pushing people away." There may be problems with stealing, drug abuse, unsafe sex or moodiness. School attendance or performance may have suffered. The child may refuse involvement in normally pleasurable activities. Appetite may be poor.
- The child may be described as "scared." The child may be worried all the time, panicky or clingy, or talk about others dying or leaving.
- The child may seem "empty." There may be a history of social withdrawal and isolation or complaints of boredom.
- The child is "mad." The child may appear highly irritable or agitated, belligerent, euphoric, grandiose or with disorganized thinking. The child may be disinhibited or show a lack of social judgment or evidence of racing thoughts.

If any of the above descriptions clearly applies to a child's situation, a disorder of mood or anxiety would be high on the clinician's list of possible diagnoses.

Sadness, withdrawal and deterioration in the child's functioning point one in the direction of depression. Specific diagnosis will be determined by the severity and duration of symptoms. It is important to distinguish a dysthymic disorder from a major depressive disorder. Dysthymia refers to a long-standing condition suggesting a "depressive personality" and typically involves a pessimistic attitude towards the future, the world, and the self. A major depressive episode, on the other hand, implies a significant deterioration from a typically brighter mood.

Sometimes clinicians will distinguish between "primary (or endogenous) depression" and "secondary (or exogenous) depression." The former applies when there are no clear stressors or life events to explain why a child feels depressed. Secondary depression seems related to stressful life events, such as a significant loss or trauma. The clinician should note these life events on Axis IV of the DSM-IV.
If there is a history of severe mood instability, involving agitation, disinhibition, euphoria or impaired judgment, the clinician will often consider a bipolar (manic depressive) disorder. Mania refers to the above features often accompanied by motor restlessness and lack of need for sleep (sometimes lasting for days at a time), where the child's thinking has become profoundly disorganized or there are hallucinations or delusions present. A hypomanic individual will experience the excitement of a mania, but without the extreme disorganization of thought or other psychotic features. Bipolar individuals may have repeated episodes of mania, hypomania, depression, or dysthymia over the years. Bipolar disorders affect about 1% of the population and are much less common than depressive disorders.

Attention-deficit/hyperactivity disorder in children may be confused with the early onset of a bipolar disorder. Both conditions may cause impaired social judgment, poor concentration, restlessness and impulsivity. A family history of either condition can help with a differential diagnosis. Changes in sleep patterns may be suggestive of a mood disorder, but the use of psycho-stimulant medicine can also impair sleep in a hyperactive child and mimic the sleep pattern seen in a bipolar disorder. A child's response to a medication trial, or a history of depression, might also support one diagnosis over the other. Lastly, in the case of a hyperactive child, we would expect a history of sustained high energy and activity presenting almost continuously from an early age, while a bipolar child might be expected to present a more intermittent pattern of disturbance.

Problems of anxiety will often emerge secondary to a depression. Clinicians often underestimate the importance of anxiety as a cause of social impairment in the depressed child. This is unfortunate, as fear and worry may be more painful and incapacitating for many children than their feeling of sadness.

Anxiety disorders have nervousness, worry, and a feeling of tension or unease as their prominent features. There may be sleep disturbances or nightmares. The clinician should enquire about panic attacks and their triggers. Flashbacks involve the re-experience of emotions from a prior event of extreme emotional pain or trauma. Flashbacks, situation-specific panic, hypervigilence, and nightmares are suggestive of a post-traumatic stress disorder. With the anxiety disorders, physical complaints (such as headaches, cramps, stomachache, dizziness or even fainting spells) will be common. However, if physical complaints are the most prominent feature of the child's presentation, a diagnosis of a somatization disorder may be more appropriate.

A child experiencing a generalized anxiety disorder will present with “free floating” anxiety. While the child's worry may change, depending on circumstances, the child is usually worried about something. These children may be needy and dependent, clingy and always wanting reassurance.

Simple phobias involve fear of specific objects or situations and are easy to identify. The child can always describe the object of fear. Common childhood phobias include fear of the dark, large animals, heights, insects, and so on. Of course, the child will typically avoid the object of fear.
Social phobias involve fear of humiliation or embarrassment in public or society. Common social phobias include public speaking, using public washrooms, or activities such as eating in public or even having to sign one's name.

Agoraphobia (literally translated from the Greek as “fear of the market place”) involves an avoidance of a range of social situations in public. Most often, an agoraphobic child has a history of panic attacks in public and is now avoiding places where an attack may recur. These children may become reclusive, refusing to go out at all, because of their anxiety.

With separation anxiety disorder, children may refuse to go to school or leave a parent alone. These children may fear an occurrence in the home if they are not there to protect people or they may fear what might happen to them at school. The separation anxiety may follow a traumatic experience (e.g. being teased or bullied at school, a fire or break-in at home, a parent having an accident). Other times, the child's anxiety is out of all proportion to any life event.

With obsessive-compulsive disorder, a child seems unable to resist thinking disturbing thoughts or engaging in compulsive behaviors in his or her attempts to avoid feelings of overwhelming anxiety.

“Déjà vu” experiences are similar conceptually but would be included with derealization and depersonalization as “Dissociative Disorders.” The term “disorder” should only be applied if the experience is severe or frequent enough to cause considerable stress or impairment. Various medical conditions (such as strokes, seizures, hypoglycemia, hypoxia and so on) may contribute to these alterations of consciousness. Of course, substance use may cause this as well. Where these feelings are long standing or there are frequent shifts in one's sense of being, identity or connectedness to the body, this may be evidence of an underlying or developing Borderline Personality Disorder.

Problems of behaving and relating

Here, we consider clinical disorders characterized chiefly by overt manifestations of problematic behavior that impact on a child's social and interpersonal functioning.

With oppositional-defiant disorder, a child manifests a sustained disrespect and defiance of the authority of caregivers, leading to conflict and an impairment of social functioning. There may be minor legal involvements, repeated suspensions from school, and the child may develop a reputation for having a “bad attitude.”

Where the child's problems with authority and disrespect for the law and the rights of others become extreme, a conduct disorder may be diagnosed. Alcohol and substance abuse, sexual acting out and legal entanglements are quite common with these children, as are learning disabilities, attention-deficit/hyperactivity disorder, and mood disorder.
Attention-deficit/hyperactivity disorder is often associated with conduct problems, but must be distinguished from conduct disorder. The chief complaints of a child with attention-deficit disorder are usually excessive restlessness, impulsivity and poor concentration (generally increased by anxiety or stress). These children often have poor social skills and are “stimulus bound” or over-reactive to their environments. These traits are most noticeable in settings where the child has little gratification (e.g. school, church) or where there is the greatest need for quiet and attentiveness.

With multiple tic disorder (Tourette’s syndrome), children may exhibit multiple involuntary motor or vocal tics (e.g. grunts, barks or shouts of profanity). Some children may also describe obsessions or display compulsive behaviors or have difficulty controlling aggressive or destructive impulses. Hyperactivity and attention-deficit will often be observed as well.

Use of psycho-stimulants to treat attention-deficit disorder may cause motor tics as a side effect, sometimes confusing the clinical picture and making effective treatment more difficult. Problems with conduct and attention are found more frequently in boys, while problems with anxiety are seen more frequently in girls.

With adjustment disorder, a child may present with an array of mood, anxiety, thought or behavioral features in response to a stressful life event. These features are less severe and time-limited.

With reactive attachment disorder of infancy or childhood, a child displays markedly abnormal patterns of social relatedness, generally starting before age five, in the context of a grossly disturbed upbringing. As many of these children will have been traumatized, many will present with a post-traumatic stress disorder as well. Reactive attachment disorders may be sub-classified as inhibited or disinhibited. In the former case, the child persistently avoids initiating or responding to others in a socially or age-appropriate fashion. In the latter case, the child seems to interact indiscriminately with strangers and those intimate to him alike.

Problems of Thinking

With problems of thinking, symptoms or complaints may include disturbances of perception, reality testing or cognition. A mental status examination is the formal part of a psychiatric interview where specific screening questions may be asked to assess the child for evidence of a thought disorder. A perceptual disorder may involve hallucinations, illusions, synesthesia (the confusion of one sense with another e.g. “smelling colors”), illusions, or microscopy (observing the world as if it were far away).

A disturbance of reality testing may involve “magical thinking” (e.g. beliefs in ghosts or special powers like telepathy, telekinesis, precognition, etc.), “thought insertion or control” (feeling like people are putting ideas into one’s head or controlling one’s thoughts), or “thought blocking” (losing one’s thoughts or ideas in mid-sentence).
A child may also suffer from a variety of delusions or fixed false beliefs, including:

- persecutory delusion (e.g. of being pursued by the police)
- erotomanic delusion (e.g. of being loved by a celebrity)
- grandiose delusion (e.g. of having great wisdom, wealth or power)
- somatic delusion (e.g. of one’s body changing shape or composition)
- ideas of reference (e.g. of receiving special messages through the media)

A disorder of cognition may involve disorientation or confusion, disturbance of memory, attention or concentration, shifting levels of alertness, and problems with language, reasoning, insight or judgment.

Disorders of perception, thought and cognition most commonly occur in one of four conditions:

1. primary psychotic disorder
2. secondary to a mood disorder
3. secondary to a medical condition or drug or alcohol use
4. secondary to less common causes

(1) Primary psychotic disorder

A brief reactive psychosis describes the relatively abrupt onset (and rapid resolution) of psychotic symptoms, most often in response to an emotionally overwhelming trauma. The total duration of the disorder is a matter of days or weeks, with a full resolution of symptoms being typical.

A schizophreniform psychosis is characterized by a more gradual onset and resolution of psychotic symptoms where the total duration of the disorder, including its prodrome and resolution, is less than six months. If the symptoms endure over six months, the diagnosis of schizophrenia may apply. The onset of schizophrenia is most typically seen in the teen years or young adulthood and is very uncommon in childhood.

The psychotic disorders grade into so-called cluster ‘A’ personality disorders, which are characterized by odd or eccentric attitudes and beliefs, but with no gross impairment of reality testing. The paranoid personality is generally suspicious and feels victimized or scapegoated by others. The schizoid personality is withdrawn, isolated, and shows little interest in people or relationships. The schizotypal personality has very peculiar habits, and odd lifestyle or philosophy.
2) Problems of thinking secondary to a mood disorder

Problems of thinking occur in a significant percentage of individuals with serious mood disorders. Psychotic features are called “mood congruent” if their nature is in keeping with the person’s mood. For example, a manic person might believe she owned the stock market; a depressed person might believe he was infested with parasites. Psychotic features are called “mood incongruent” if their nature is not in keeping with the person’s mood. For example, a depressed person might believe he was incredibly attractive and “has to beat women off with a stick.”

A schizoaffective disorder is a “hybrid” condition where the person experiences mood and psychotic symptoms in equal measure. Because many of these people have chronic disturbances and have had very chaotic upbringings with multiple traumas or losses, their diagnosis may often be hard to distinguish from other conditions associated with severe abuse, including dissociative disorders, borderline personality disorder, and post-traumatic stress disorder.

3) Problems of thinking secondary to a medical condition or drug use

These conditions are among the most important to recognize and address in an emergency. The worry is that misdiagnosis or inappropriate treatment may worsen a patient’s distress or contribute to increased morbidity and mortality.

It is important to distinguish delirium from psychosis. Delirium is characterized by the abrupt onset of a confused and disorganized mental state. The individual is often disoriented and does not know the date, cannot identify himself, or think or speak clearly, and is agitated. The individual will appear to be in significant distress or his state of consciousness may fluctuate rapidly. The individual may not be able to speak clearly or in a logical, organized fashion, or even respond to simple commands.

Hypoglycemia may cause delirium, stupor, or coma in a diabetic. Seizures or post-seizure states may result in confusion, loss of memory, agitation or aggression. Head injury, intra-cranial bleeding or stroke, may cause similar alterations accompanied by sudden onset of headaches, paralysis, loss of vision or inability to speak. Crisis workers should seek immediate medical attention for children presenting with these symptoms.

4) Problems of thinking secondary to other causes

Pervasive developmental disorders are recognized by a lifelong history of significant disturbance in social or interpersonal relatedness and peculiarities of thought. Autism is the most severe and common form of this disorder, and is usually accompanied by grossly deficient or disturbed use of language and developmental delay. Asperger’s syndrome (“high functioning autism”) involves impaired social judgment and relatedness, odd use of language, and multiple non-verbal learning disabilities, without a significant global developmental delay.
With **body dysmorphic disorder**, the child is preoccupied with feelings that her body is abnormal, ugly or repulsive to others. She may believe, for example, that people detect a persistent foul odor from her or that her mouth is deformed. **Anorexia nervosa** is characterized by a misperception of obesity and a drive for weight loss. The false beliefs of the dysmorphophobic or anorexic child may be extreme to the point of being delusional.

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Article VII

RISK ASSESSMENT

Risk assessment has features of both art and science. The art of risk assessment combines the clinician’s experience, intuition and appraisal of an individual child. The science of risk assessment is based on epidemiology, or the study of statistics related to the health of a population of individuals.

It is thought that perhaps as many as 1 in 10 children seriously consider or attempt suicide. It is very difficult to estimate the percentage of suicide attempts by children that result in death because most attempts are never treated or even reported.

In Canada, the following statements about suicide and self-harming behavior in children are true:

- In 1996, the suicide rate for boys 10 - 14 years old was 3 per 100,000; for boys 15 - 19 years old, the rate was 18.51 per 100,000. These rates represent about a 300% increase in 25 years.
- In 1996, the suicide rate for girls 10 - 14 years old was 0.91 per 100,000; for girls 15 - 19, the rate was 4.20 per 100,000. These rates represent about a 170% increase in 25 years.
- Teenage boys and girls have shown the most striking increase in suicide rates of any age group. This is the so-called “epidemic” of suicide among children.
- Girls attempt suicide 3 or 4 times as often as boys.
- Boys complete suicide 2 or 3 times as often as girls.
- A boy’s “typical” suicide attempt is, therefore, more lethal than a girl’s. Boys are more likely to attempt suicide using firearms or by hanging/asphyxiation; girls are more likely to attempt suicide by overdosing or cutting themselves.
- Many suicides involve drugs or alcohol. Substance use may impair a child’s judgment and increase impulsivity, delay reactions in an emergency, and increase the lethality of other chemicals ingested during an attempt.
- Children who attempt suicide are more likely to have a history of physical or sexual abuse, problems with parental relationships (e.g. marital separation, domestic violence, substance abuse, separation from parents), or poor economic circumstances.
- One of the most reliable predictors of suicide is a history of attempts; one of the best predictors of aggressive behavior is past aggression.
- Suicidality may be provoked by feelings of failure or disappointment. The clinician should beware of relationship breakups, school failure, or loss of employment.
- Moves to new neighborhoods (suggesting loss of friends, school change and other stressors) may provoke suicidality in a vulnerable child.
- Family history of suicide is a significant risk factor. The clinician should beware of “anniversaries” of losses or deaths in the family (even of beloved pets).
The limits of epidemiological analysis are obvious in clinical work. A child who is at high risk in a statistical sense may never attempt suicide, even as a child who is at low risk statistically may commit suicide on a first attempt.

A mental status examination can be vital for risk assessment. Without a mental status examination, the clinician may miss an underlying thought or mood disorder that could significantly increase the risk to the child. Auditory hallucinations that command the child to suicide may be impossible to resist. Paranoid delusions – either persecutory or grandiose – may have the child consider suicide as a means of escaping an imminent threat or fulfilling a special destiny. These sorts of considerations bring us to the critical issue of what motivates a child to contemplate or attempt suicide.

**Motivation and Self-Harming Behavior**

While statistics on rates of suicide abound, there is little research on underlying motives for the variety of self-harming behaviors that children can present. While psychiatric diagnosis is suggestive of the general nature of the child's difficulties (e.g. problems of feeling, thinking, or behaving and relating), it does not provide direct evidence of the motivation for the child's self-harming behavior. A psychotic child, for example, might consider suicide for different reasons at different points in his course. At one time, the child might become religiously preoccupied and contemplate suicide in order to fulfill a sense of religious destiny. At another time, despairing over the chronic nature of his illness, the child might contemplate suicide as a means of escaping an unhappy fate.

Understanding the motivation underlying the self-harming behavior might indicate when the child is at highest risk, and might point the crisis worker in the direction of the most appropriate intervention. In the preceding example, medicine might be the most effective treatment for a religious delusion, while a child's despair over the potential impact of an illness would require a psycho-educational or psycho-therapeutic approach. It is only from speaking with and getting to know the child that we can learn to anticipate what may be most provocative at any given time.

It is vitally important that the crisis worker, through an understanding of the child's motivation, be able to address those issues that push the child's destructive behavior forward as well as those that hold it back. Understanding the balance of these forces is at the core of risk assessment. Because we consider the motivation for self-harm so critical to risk assessment, it is useful to distinguish the various forms of worrisome behaviors that crisis workers will encounter in terms of their outward expression as well as their underlying goal or meaning.

**Suicidal behavior**

"Suicidal behavior" refers to an act or purposeful inaction (e.g. not moving out of the path of an oncoming vehicle) taken by a child with the motivation or expectation that death will result. For clinical purposes, we include here the "gambling" behavior we frequently hear described by young people (e.g. "I took the pills. I didn't really know what they were, but I took a handful. I just wanted to sleep ... to get the bad feelings to stop ... I didn't care if I would ever wake-up.").
Parasuicidal behavior

“Parasuicidal behavior” refers to acts that are not overtly suicidal, but appear objectively and subjectively as “suicide equivalents.” These behaviors appear to reflect the child’s “giving up on life” or “giving into helplessness,” or the child’s playing out a suicidal impulse in an indirect fashion. When confronted with their behavior, these children will respond with indifference towards their existence and a lack of orientation toward their future (“whatever happens, happens…”). This attitude is often found in children with serious drug or alcohol abuse problems and is portrayed in popular accounts of such notable figures as Marilyn Monroe, Elvis Presley and Kurt Cobaine, and certainly appears to contribute to the aura of drama and mystery surrounding these celebrities.

Self-mutilating behavior

“Self-mutilating behavior” refers to acts that a child intends to cause physical damage, but not specifically death. If given the chance, children who self-mutilate might argue that their cutting or burning is no more suicidal than cigarette smoking. Self-mutilators may recognized intellectually that their behavior is “bad for them,” but they do not worry so much because it serves its intended purpose (e.g. dealing with stress, calming nerves, or giving pleasure in its own right). It is very important to distinguish self-mutilation from suicidal and risk-taking behavior. Repetitive self-mutilation is more common than suicidal behavior and requires a different treatment approach, but people who engage in self-mutilation are at increased risk of suicide as well.

Risk-taking behavior

“Risk-taking behavior” refers to dangerous or reckless behavior that the child engages in with little or no apparent regard to safety or consequences. While we may speculate as to whether the child is or is not motivated to suicide, the child will deny this. The child who dies on a dare or during a gang initiation rite would not be considered suicidal, since the goal was not to self-destruct.

Many children will simultaneously exhibit suicidal, risk-taking, parasuicidal and self-mutilating behaviors with different, even contradictory, motivations for each. For example, a child may self-mutilate to deal with feelings of anger, loneliness or boredom; she may abuse drugs and engage in unsafe sex to be popular; she may attempt suicide to draw parents’ expressions of concern; and she may then run away when her parents show their concern by setting limits.

The motivation underlying a child’s risk-taking and parasuicidal behavior may be less clear and straightforward than that underlying suicidal or self-mutilating behavior. With risk-takers and parasuicides, motive and meaning may be more fluid and dependant on the sort of behavior involved, and where they are in their course. For example, compulsive gamblers may start out seeking diversion, excitement or easy money, but may end up appearing self-punishing or seeking their own ruin.
Table II outlines some of the distinctions that may be drawn among the potentially dangerous behaviors presented by children in crisis.

### TABLE II  Comparison of Potentially Dangerous Behaviors

<table>
<thead>
<tr>
<th>Behavior Type</th>
<th>Goal/Motivation</th>
<th>Pursuit of Goal</th>
<th>Male/Female Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal</td>
<td>Death</td>
<td>Direct</td>
<td>More male completions More female attempts</td>
</tr>
<tr>
<td>Parasuicidal e.g., alcoholism</td>
<td>Death? Pleasure or coping</td>
<td>Indirect Direct or variable</td>
<td>Variable</td>
</tr>
<tr>
<td>Self-mutilation e.g. cutting, burning</td>
<td>Relief of distress Coping strategy</td>
<td>Direct Direct</td>
<td>More female</td>
</tr>
<tr>
<td>Risk taking e.g. dangerous driving, unsafe sex</td>
<td>Thrill seeking Challenging one’s ability Death-seeking vs. life affirming</td>
<td>Direct or indirect</td>
<td>Variable, more likely male</td>
</tr>
</tbody>
</table>

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