

Mental Health Crisis Planning for Children

Learn to Recognize, Manage, Prevent and
Plan for Your Child's Mental Health Crisis

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YOUTH



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National Alliance on Mental Illness

MINNESOTA

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NAMI Minnesota champions justice, dignity, and respect for all people affected by mental illnesses. Through education, support, and advocacy we strive to eliminate the pervasive stigma of mental illnesses, effect positive changes in the mental health system, and increase the public and professional understanding of mental illnesses.

MENTAL HEALTH CRISIS PLANNING FOR CHILDREN

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for Your Child's Mental Health Crisis*

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INTRODUCTION

Children do develop mental illnesses. We know that 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental health condition at some point during their life; for children aged 8–15 that estimate is 13%. It could be depression, anxiety, obsessive compulsive disorder, or ADHD, to name a few. It's not your child's fault, or your fault. Mental illnesses are like other illnesses that require diagnosis, treatment and supports. Yet, even when there is effective treatment and supports, a child can have a mental health crisis.

A mental health crisis is just as important to address as any other health care crisis. It can be difficult to predict just when a crisis will happen, and it can occur without warning. A crisis can occur even when a family has followed a crisis prevention plan and used techniques taught to them by mental health professionals.

We all do the best we can with the information and resources we have available at the time of a crisis. Some days we can handle more than other days; this is normal and to be expected when raising a child with challenging symptoms. You may need help when you have exhausted all your tools or means of coping with the crisis.

This booklet will help you understand what can cause a crisis, the warning signs of a crisis, the strategies to help de-escalate a crisis, and how to create a crisis plan. Also included in this booklet is information on communication and advocacy skills for families, a sample crisis plan, along with some resources that may be available. The term *child* throughout the booklet refers to both children and adolescents. The term *parent* throughout the booklet refers to any individual that has legal authority to make decisions and plans for the child. ■

RECOGNIZE

What is a Mental Health Crisis?

A crisis is any situation in which the child's behaviors puts them at risk of hurting themselves or others and/or when the parent isn't able to resolve the situation with the skills and resources available.

For the purpose of the use of crisis teams, Minnesota law defines a mental health crisis as a "behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more restrictive setting, including but not limited to, inpatient hospitalization."

What Causes a Mental Health Crisis?

Many things can lead to a mental health crisis. Increased stress, changes in family situations, bullying at school, substance use, and trauma or violence at home or in the community may trigger the sudden appearance of or an increase in behaviors or symptoms that lead to a mental health crisis. Medical illnesses can also affect one's mental health and can lead to a crisis. These issues are difficult for everyone, but they can be more difficult for someone living with a mental illness. This is especially true for a child who probably doesn't understand their illness and its symptoms.

Here are some examples of situations or stressors that can trigger a mental health crisis:

Home or Environmental Triggers

- ▶ Changes to family structure—parents separate, divorce or remarry
- ▶ Loss of any kind—family member or friend due to death or relocation
- ▶ Loss of family pet
- ▶ Transitions between mom's and dad's homes
- ▶ Strained relationships with step-siblings or step-parents
- ▶ Changes in friendships: boyfriend, girlfriend, partners
- ▶ Having a family member with an illness
- ▶ Fights or arguments with siblings or friends
- ▶ Conflict or arguments with parents
- ▶ Family poverty
- ▶ Trauma or exposure to violence

School Triggers

- ▶ Worrying about tests and grades
- ▶ Overwhelmed by homework or projects
- ▶ Feeling singled out by peers or feelings of loneliness
- ▶ Pressures at school, transitions between classes and school activities
- ▶ Bullying at school
- ▶ Pressure from peers
- ▶ Suspensions, detentions or other discipline
- ▶ Use of seclusion or restraints
- ▶ Misunderstood by teachers who may not understand that the child's behavior is a symptom of their mental illness
- ▶ Children's perception that they are being culturally disrespected or are being discounted
- ▶ Perceived or real discrimination

Other Triggers

- ▶ Stops taking medication or misses a few doses
- ▶ Starts new medication or new dosage of current medication

- ▶ Medication stops working
- ▶ Use of drugs or alcohol
- ▶ Pending court dates
- ▶ Being in crowds or large groups of people
- ▶ Community violence or trauma
- ▶ Major crisis in the world such as natural disasters, terrorism
- ▶ Arrest or justice involvement

What are the Warning Signs of the Crisis?

Sometimes families or caregivers observe changes in a child's behavior that may indicate a crisis may be impending; while other times the crisis occurs suddenly and without warning. You may be able to de-escalate or prevent a crisis from happening by identifying early changes in your child's behavior, such as an unusual reaction to daily tasks or an increase in their stress level. Families may want to keep a journal or calendar documenting what preceded the behaviors that are of concern. A sample journal is included in the back of this booklet.

Here are some warning signs of a mental health crisis:

Inability to cope with daily tasks

- ▶ Doesn't bathe, brush teeth, comb or brush hair
- ▶ Refuses to eat or eats too much
- ▶ Sleeps all day, refuses to get out of bed
- ▶ Doesn't sleep or sleeps for very short periods of time

Rapid mood swings

- ▶ Increase in energy
- ▶ Inability to stay still, pacing
- ▶ Suddenly depressed, withdrawn
- ▶ Suddenly happy or calm after period of depression

Increased agitation

- ▶ Makes verbal threats, hostile towards others
- ▶ Violent, out-of-control behavior
- ▶ Destroys/Damages property
- ▶ Cruel to animals
- ▶ Culturally inappropriate language or behavior

Displays abusive behavior

- ▶ Hurts others
- ▶ Cutting, burning or other self-injurious behaviors
- ▶ Uses or abuses alcohol or drugs
- ▶ Promiscuity

Loses touch with reality (psychosis)

- ▶ Unable to recognize family or friends
- ▶ Is confused, has strange ideas
- ▶ Thinks they are someone they are not
- ▶ Does not understand what people are saying
- ▶ Hears voices
- ▶ Sees things that are not there
- ▶ Paranoia

Isolation from school, work, family, friends

- ▶ No or little interest in extracurricular activities
- ▶ Changes in friendships
- ▶ Stops attending school, stops doing homework; declining academic performance
- ▶ Will not leave bedroom, isolates
- ▶ Runs away from home

Unexplained physical symptoms

- ▶ Facial expressions and/or eyes look different
- ▶ Increase in headaches, stomachaches
- ▶ Feels like they are outside of their body
- ▶ Complains they don't feel well

What are the Warning Signs of Suicide?

Any of the following may be warning signs for suicide:

- ▶ Talking about or making plans for suicide
- ▶ Expressing hopelessness about the future
- ▶ Displaying severe/overwhelming emotional pain or distress
- ▶ Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:
 - Withdrawal from or changes in social connections/situations
 - Changes in sleep (increased or decreased)
 - Anger or hostility that seems out of character or out of context
 - Recent increased agitation or irritability

How to respond:

- ▶ Ask if they are ok or if they are having thoughts of suicide, if they have a plan
- ▶ Express your concern about what you are observing in their behavior
- ▶ Listen attentively and non-judgmentally
- ▶ Reflect what they share and let them know they have been heard
- ▶ Tell them they are not alone, offer hope in any form
- ▶ Let them know there are treatments available that can help
- ▶ If you/they are concerned, guide them to additional professional help

If you think your child or another youth may need help right now, call the National Suicide Prevention Lifeline at **1-800-273-TALK(8255) OR TEXT “MN” TO 741741 OR CALL **CRISIS**. Your call is free and confidential. Trained crisis workers in your area can assist you and the child in deciding what they need right now.

Research by: Suicide Awareness Voices of Education (SAVE); American Association for Suicidology (AAS); Substance Abuse and Mental Health Services Administration (SAMSHA) and National Center for the Prevention of Youth Suicide 2015. ■

MANAGE

What to Do in a Mental Health Crisis

When a mental health crisis or severe behaviors occur, parents often don't know what to do. A crisis can occur even when a parent has used de-escalation techniques or other options to address the crisis. It's often nobody's fault. Children's behaviors and crisis situations can be unpredictable and can occur without warning.

If you are worried that your child is in crisis or nearing a crisis, seek help. Assess the situation before deciding whom to call. Is your child in danger of hurting themselves, others or property? Do you need emergency assistance? Do you have time to start with a phone call for guidance and support from a mental health professional or crisis team? **Most importantly—safety first! Ensure the safety of any/all individual(s) in the situation. In a crisis situation, when in doubt, go out.**

De-escalation Techniques

Children cannot always communicate their thoughts, feelings or emotions clearly or understand what others are saying to them during a crisis. As a parent it is important to empathize and connect with your child's feelings, try to de-escalate the crisis, and assess the situation to determine if you need emergency assistance, guidance or support. Seek outside resources listed in the back of this booklet when your actions are not helping.

De-escalation techniques that may help resolve a crisis:

- ▶ Keep your voice calm
- ▶ Avoid overreacting
- ▶ Listen to your child
- ▶ Don't make judgmental comments
- ▶ Don't argue or try to reason with your child

- ▶ Express support and concern
- ▶ Avoid continuous eye contact
- ▶ Ask how you can help
- ▶ Keep stimulation level low
- ▶ Move slowly
- ▶ Offer options instead of trying to take control
- ▶ Avoid touching your child unless you ask permission
- ▶ Be patient
- ▶ Gently announce actions before initiating them
- ▶ Give them space, don't make them feel trapped

If you haven't been able to de-escalate the crisis yourself, you will want to seek additional help from trained mental health professionals who can assess your child to determine the level of crisis intervention required. Often a trained mental health professional can help a family de-escalate the situation or prevent the crisis from ever happening.

If your child is in crisis, remain as calm as possible and continue to seek guidance and support until the crisis is resolved. **Most importantly—safety first! In a crisis situation, when your or anyone else's safety is in doubt, back off or get out.**

Not in immediate danger

If you do not believe you, your child, or others are in immediate danger, call your child's psychiatrist, clinic nurse, therapist, case manager or family physician that is familiar with the child's history. This professional can help assess the situation and offer advice. The professional may be able to schedule an immediate appointment or may be able to admit the child to the hospital. If you don't have a connection to any of these professionals, cannot reach one or if the situation is worsening, do not hesitate to call your county mental health crisis team. If safety is a concern, call 911. However, be sure to tell them this is a mental health crisis. (See "immediate danger" section for additional information.)

Mental Health Crisis Phone Lines and Crisis Response Teams

In Minnesota, each county has a 24-hour mental health crisis phone line for both adults and children. Some 24-hour phone lines serve more than one county. These crisis lines are staffed by trained workers who assist callers with their mental health crises, make referrals and contact emergency services if necessary. If the call is made after normal business hours, the crisis line will connect the caller to a mental health professional within 30 minutes. Right now there are more than 40 crisis num-

bers, but if you call **CRISIS from a cell phone you will be connected to the closest crisis team if you are in the 7-county metro area.

In addition to 24-hour crisis phone lines, most counties also have a mobile crisis response team. Mobile crisis teams are teams of two or more licensed mental health professionals or practitioners that can meet the child at the scene of the crisis or wherever the child will feel most comfortable. Response times for mobile teams may vary depending on your location and the location of the mobile team staff.

Crisis teams are meant to be accessible to anyone in the community at any time. They are available 24 hours a day, seven days a week and 365 days a year to meet face-to-face with a child in a mental health crisis, conduct a mental health crisis assessment and create a crisis treatment plan. A child does not have to have a mental health diagnosis to receive crisis services. Crisis teams will respond and address the situation regardless of whether or not the child has insurance. If the child in crisis does have insurance, the crisis team will bill their insurance company for services they provide. Some crisis teams offer interpreter services for non-English speakers who require assistance, although those who need an interpreter may have to wait longer to receive crisis services depending on the interpreter's availability.

Ways that crisis teams can help:

- ▶ Cope with immediate stressors
- ▶ Develop practical behavioral strategies to address the child's short-term needs
- ▶ Identify what issues led to the crisis
- ▶ Suggest techniques to avoid a crisis in the future
- ▶ Conduct a diagnostic assessment
- ▶ Identify available resources and supports
- ▶ Develop and write a crisis plan
- ▶ Provide phone consultation and support
- ▶ Make a referral to a hospital
- ▶ Consult with outside mental health professionals as needed
- ▶ Respond in non-urgent situations to help prevent a future crisis

Questions the crisis team may ask:

- ▶ Your name and the name of the person in crisis
- ▶ Your relationship to that person
- ▶ The address where the crisis is occurring
- ▶ A phone number to call in case you are disconnected
- ▶ The nature of the problem
- ▶ If safety is a concern
- ▶ If the child has harmed themselves or is threatening harm
- ▶ The possible cause of the crisis

- ▶ Mental health and hospitalization history
- ▶ Health insurance information

The crisis team is required by law to maintain a file on anyone who receives mobile crisis intervention or crisis stabilization services.

The crisis team file will include:

- ▶ The crisis treatment plan for the child receiving services
- ▶ Signed release forms
- ▶ The child's health information and current medications
- ▶ Emergency contacts
- ▶ Case records detailing the intervention
- ▶ Any clinical supervision that may be required
- ▶ Summary of any case reviews
- ▶ Any other information the team would like to have in the file

When you call your mental health crisis team, they will triage the call to determine the level of crisis service needed. If the child experiencing a crisis is in immediate danger to themselves or others, the crisis team will refer the situation to 911, and law enforcement will respond. Sometimes law enforcement and crisis team staff will respond together. If the situation is not as urgent, the crisis team will assess the level of intervention required: information and referral, a phone consultation, an emergency room visit or an immediate site visit.

When the crisis team makes a site visit, they assess the situation to determine if the child is a danger to themselves or others. Crisis staff may decide that law enforcement needs to intervene, that the child should be seen at the nearest emergency room or that the child should be directly admitted to a psychiatric unit at the nearest hospital. Some mobile crisis teams will transport people to emergency rooms; if they don't and transportation is needed, the crisis team may contact paramedics or law enforcement or request that you provide transportation.

A new mode of transportation under Medical Assistance is called *protected transport*, which is for someone who is experiencing a mental health crisis and needs to be driven to the ER or transferred to another hospital. The crisis team or a physician in an Emergency Department can determine that this mode is appropriate. The vehicle cannot be an ambulance or police car, but must have safety locks, a video recorder, a transparent thermoplastic partition and drivers/aides who have specialized training. This is a more dignified way to transport people with mental illnesses in crisis. There are not many in the state.

Stabilization Services

The crisis team may recommend crisis stabilization services. These services may be provided in the child's home, the home of a family member or friend, or in the community. Services are available for up to 14 days after crisis intervention.

Stabilization involves the development of a treatment plan that is driven by the diagnostic assessment and the child's need for services. It must be medically necessary and must identify the child's emotional and behavioral concerns, goals and objectives. The treatment plan will also identify who is responsible for the interventions and services, the frequency or service intensity needed and the desired outcomes. Treatment plans must be completed within 24 hours of beginning services and must be developed by a mental health professional or a mental health practitioner under the supervision of a mental health professional.

At a minimum, a treatment plan will include:

- ▶ A list of problems identified in the assessment
- ▶ A list of the child's strengths and weaknesses
- ▶ Concrete and measurable short-term goals and a timeline for achieving these goals
- ▶ Specific objectives directed at achieving each goal
- ▶ Documentation of participants involved in the service planning
- ▶ What kind of services will be initiated and how frequently they will occur
- ▶ A crisis response action plan in case of a new crisis
- ▶ Clear notes on desired outcomes

Stabilization services may also include brief solution-focused strategies, referrals to long-term care agencies, rapid access to psychiatrists, coordinated crisis plans and a referral to a county's children's mental health services.

In immediate danger

If the situation is life-threatening or if serious property damage is occurring, call 911 and ask for law enforcement assistance. When you call 911, tell them your child is experiencing a mental health crisis and explain the nature of the emergency. Tell the law enforcement agency that it is a crisis involving a child with a mental illness and ask them to send an officer trained to work with people with mental illnesses called CIT, Crisis Intervention Team Training. Be sure to tell them—if you know for certain—whether your child has access to guns, knives or other weapons.

When providing information about a child in a mental health crisis, always be very specific about the behaviors you are observing. Instead of saying “my son is behaving strangely,” for example, you might say, “My son hasn’t slept in three days, he hasn’t eaten anything substantive in over five days, and he believes that someone is talking to him through his iPod.” Report any active psychotic behavior, significant changes in behaviors (such as not leaving the house, not taking showers), threats to other people or increases in manic behaviors or agitation (e.g., pacing, irritability). You need to describe what is going on right now, not what happened a year ago. Be brief and to the point. **Finally, in a crisis situation, remember: when in doubt, back off or go out. Do not put yourself in harm’s way.**

Law Enforcement Response

When the law enforcement officer arrives, provide them with as much relevant and concise information about your child as you can, including the child’s:

- ▶ Diagnosis
- ▶ Medications
- ▶ Hospitalization history
- ▶ Previous history of violence or criminal charges

If the child has no history of violent acts, be sure to point this out. Lay out the facts efficiently and objectively, and let the officer decide the course of action. Remember that once 911 has been called and the officers arrive on the scene, **you do not control the situation**. Depending on the law enforcement officers involved, they may take your child to detention instead of to a hospital emergency room. Law enforcement officers have broad discretion in deciding whom to arrest, whom to hospitalize and whom to ignore. You can encourage and advocate for the law enforcement officers to view the situation as a mental health crisis. **Be clear about what you want to have happen without disrespecting the law enforcement officer’s authority.** But remember, once 911 is called and law enforcement officers arrive on the scene, they determine if a possible crime has occurred, and they have the power to arrest and take into custody a person that they suspect of committing a crime. If you disagree with the officers, don’t argue—later call a friend, mental health professional or advocate for support and information.

Law enforcement can (and often does) call the county mental health crisis teams for assistance in children’s mental health crises. The crisis team may assist law enforcement in deciding what options are available and appropriate for the child and their family. The crisis team may decide to respond with law enforcement. Law enforcement may decide to transport the child to the emergency room.

Some counties have CIT officers. CIT stands for Crisis Intervention Team Training. CIT officers are specially trained to recognize and work with individuals who have a mental illness. CIT officers have a better understanding that a child's behaviors are the result of a mental illness and know how to de-escalate the situation. They recognize that people with mental illnesses sometimes need a specialized response, and they are familiar with the community based mental health resources they can use in a crisis. You can always ask for a CIT officer when you call 911, although there is no guarantee one will be available.

Body cameras are now more commonly being worn by police officers. State law is not clear about the privacy rights of the individual being taped. You may ask if the officer is wearing a body camera and ask about confidentiality.

Emergency Department

If the situation cannot be resolved on site or it is recommended by the crisis team or law enforcement officer, your child may be brought to the emergency department (ED) may be the best option. It is important to know that bringing your child to the emergency department does not guarantee admission. The admission criteria vary and depend on medical necessity as determined by a doctor. Mental health crisis teams can assist with the triage process and refer a child to the hospital for assessment, which may make it easier for them to be admitted. County mobile crisis teams do not typically transport children to emergency rooms; if transportation is needed, the crisis team may contact paramedics or law enforcement or request that you provide transportation.

When you arrive at the ED, **be prepared to wait several hours.** You may want to bring a book, your child's favorite toy, iPod, game or activity if that helps the child in crisis stay calm. Bring any relevant medical information, including the types and doses of all medications. If you have a crisis kit, bring a copy with you to the emergency department or hospital. (See the section on crisis kits in this booklet to learn more.)

If your child is not admitted to the hospital and the situation changes when you return home, don't hesitate to call the crisis team again. The crisis team will re-assess the situation and make recommendations or referrals based on the current situation. Your child may meet the criteria for hospital admission later. If your child is hospitalized and you believe they will need more intensive services and possible residential treatment, be certain to read about your rights and responsibilities under a voluntary foster care agreement (For more information, see NAMI's booklet, *Keeping Families Together*).

Emergency Holds

(a term used under the commitment law)

Sometimes when a person with a mental illness is no longer able to care for themselves or if they pose a threat to self or others, and will not agree to treatment, an emergency hold will be ordered to temporarily confine the person in a secure facility, such as a hospital. Emergency holds last for 72 hours each (not including weekends and holidays). The purpose of the hold is to keep the person safe while awaiting a petition for commitment to be filed or while the pre-petition screening team reviews the matter. An emergency hold doesn't necessarily initiate the commitment process; it's simply a way to assess the individual to determine if commitment is necessary. In order to be committed, the person must have recently: attempted or threatened to physically harm themselves or others, caused significant property damage, failed to obtain food, clothing, shelter or medical care as a result of illness, or be at risk of substantial harm or significant deterioration.

You should know that the commitment law applies to people ages 18 and over. Minnesota laws are confusing about how commitment applies to teenagers ages 16 and 17. Some counties apply the commitment law to teenagers at these ages, providing all the due process requirements. Other counties may allow parents to consent to treatment, use juvenile courts or even use the CHIPS petitions for 16 or 17 year olds that are refusing treatment. Because the practice varies so much, check with your county. (For more information about Minnesota's commitment law, see NAMI's booklet, *Understanding the Minnesota Civil Commitment Process*.)

Runaway Youth

Sometimes children will run away from home in the midst of an impending crisis.

If you think your child has run away:

- ▶ Remain calm
- ▶ Seek help from family members
- ▶ Search the entire house/yard
- ▶ Look inside appliances/vehicles
- ▶ Contact close friends/relatives/neighbors of the child
- ▶ Contact local law enforcement
- ▶ Have a recent picture of your child
- ▶ Describe what your child was wearing
- ▶ Identify any distinguishable scars
- ▶ Share details of what was going on before your child ran away
- ▶ Contact National Center for Missing and Exploited Children at 1-800-THE-LOST® (1-800-843-5678) or www.missingkids.com

- ▶ Contact National Runaway Switchboard at 1-800-RUNAWAY (786-2929) or www.1800runaway.org

When you are reconnected with your child, express your love and concern while putting at bay the anger and fear you are likely experiencing. Discuss with your child what led to running away and come up with a plan your child can use for when he/she feels like running away again. Identify a safe person you both can agree on, that your child may contact in the future, rather than running away. Share the runaway resources with your child. ■

PREVENT

Symptoms can appear seemingly out of the blue. However, It is possible for children who live with a mental illness to experience a crisis even when they are following their treatment plan. The best way to prevent this is to have a treatment plan that works and is followed. It is also important to understand that children change as their brains mature, and medications that were working can suddenly stop working. Behaviors/symptoms change. New behaviors/symptoms occur. Documenting changes in behaviors/symptoms by keeping a journal or making notes on a calendar may help you recognize when a possible crisis is building.

To prevent a crisis, ask yourself:

- ▶ What situations have led to a crisis in the past?
- ▶ What has worked to help reduce my child's stress or to avoid a conflict in the first place?
- ▶ What steps can I take to keep everyone safe and calm?
- ▶ Whom can I call for support in a crisis or to help calm the situation?
- ▶ Should I consider a medic alert tag or bracelet for my child? What should it say?
- ▶ What skills could I or my child learn and practice to reduce the impact of future crises?
- ▶ Have I developed a crisis intervention plan? Does it need to be updated?
- ▶ What can I do to reduce family stressors?
- ▶ Have I utilized all available resources?

LEAP Method

Dr. Xavier Amador, in his book, *I am Not Sick, I Don't Need Help*, outlines a communication skill (L.E.A.P.) that can be used to engage your child and help them stay calm. LEAP stands for Listen, Empathize, Agree and form a Partnership. It is a family-friendly version of a form of therapy called motivational enhancement therapy.

Steps to using the LEAP method:

LISTEN. The goal is to listen to your child’s needs without making judgment, to understand their point of view and to use reflective listening to state back to your child that you understand (not necessarily agree with) what they said or need.

- ▶ Listen and learn; drop your agenda
- ▶ Use questions, not statements
- ▶ State what you heard—all of it (reflecting)
- ▶ Don’t avoid scary topics or thoughts (even delusions)
- ▶ Know your child’s “hot button” fears
- ▶ Take it slowly
- ▶ Remain calm while you are listening, even when hearing shocking things
- ▶ Leave the problem solving for another time

EMPATHIZE. If you want your child to consider your point of view, it is necessary for you to understand theirs. This is not the same as agreeing with your child; it’s about empathizing with them about how they feel.

- ▶ Express empathy for feelings
- ▶ This doesn’t mean you have to agree with beliefs
- ▶ Normalize: “I think I would feel that way too (if I had those beliefs).”
- ▶ Listen + Empathy = “What do you think?” Common feeling and experiences to empathize with:
 - Frustration
 - Fear
 - Discomfort
 - Hopes and dreams (desired)

AGREE. Find common areas on which both you and your child can agree. Acknowledge that your child has personal choices and responsibility for the decisions they make about their behaviors and the consequences of those choices.

- ▶ Stick to perceived problems and symptoms only
- ▶ Review advantages and disadvantages of treatment
- ▶ Agree to disagree when needed. It’s okay to set boundaries
- ▶ You can try to correct misinformation gently
- ▶ Reflect back and highlight the advantages. Use this as the basis for a plan

PARTNER. Form a partnership to achieve shared goals. This involves you and your child developing an action plan to meet agreed-upon goals.

- ▶ Move forward with agreed-upon goals
- ▶ Use phrases that support feelings of control and safety
 - “Would that be all right?”
 - “Do I have that right?”
 - “So, let me see if I got this straight. Are you saying that . . . ?”
 - “Would you mind if I . . . ?”
 - “I can see why you’d feel that way”
 - “I am sure it is upsetting to hear and I know you don’t agree. It’s just how I feel. Can we agree to disagree on this one?”

Remember that using new approaches takes time and practice. Practicing these strategies before a crisis occurs will make them easier to use when needed.

Collaborative Problem Solving

Dr. Ross Greene, in his book, *The Explosive Child*, outlines a collaborative problem solving (CPS) method in which the child and parent engage in finding mutually satisfactory solutions to problems. The emphasis is on preventing problems before they occur by recognizing triggers that occur before the crisis. Dr. Greene believes that children do as well as they can and teaches families to identify their child’s lagging skills. He also believes missing skills can be taught.

All parents need strategies to work with their child’s behavior. We need even more strategies to deal with problem behaviors or symptoms. Fortunately, missing skills can be taught even when they are difficult to learn—but not overnight. The missing skills are what show up as “misbehavior.” Some children don’t know how to do better. We have to teach them the skills in ways that work for them.

In the CPS approach you “lend” your child your frontal lobe by breaking down the problem solving steps in a way that helps them do better in the long run.

Dr. Greene has some innovative ideas about helping children with challenging behaviors and understanding what gets in the way of appropriate behavior. This book may be helpful for parents of children with persistent problem behaviors/symptoms that don’t respond well to typical parenting strategies or “rewards and punishment” behavioral approaches, such as sticker charts, time-outs or “mama’s stern looks.” ■

PLAN

Create a Crisis Plan

A crisis plan is a written plan designed to address symptoms and behaviors and help prepare for a crisis. Preparing for a crisis is an individualized process. However, there are some common elements that can be found in a good crisis prevention plan.

CHILD'S INFORMATION: Name, age, mental health diagnosis, medical history, list of child's strengths and interests.

FAMILY INFORMATION: Name of parents, step-parents, family members who live in the home and family members with close ties.

BEHAVIORS: A list of things that trigger or antecedents (things that are present before the behavior occurs), strategies and treatments that have worked in the past, what may escalate the child's behavior (such as actions or people that are likely to make the situation worse), what helps calm the child or reduces symptoms.

MEDICATION: Name and type of medication(s), dosage, prescriber's name and phone number, pharmacy name and phone number, any medications that have not worked in the past and known allergies.

TREATMENT CHOICES: A list of interventions or treatments that are being used, interventions that have not worked in the past, treatments that should be avoided and treatment preferences.

PROFESSIONAL INVOLVEMENT: Phone numbers of children's crisis team, family doctor, therapist, social worker, psychiatrist and hospitals with psychiatric units.

SUPPORTS: Adults the child has a trusting relationship with such as neighbors, friends, family members, favorite teacher or counselor at school, people at faith communities or work acquaintances.

SAFETY CONCERNS: Limiting access to guns, knives or weapons, medication (both prescription and over-the-counter); safety plan for siblings or other family members; emergency room contact names and phone numbers.

RESOURCES: Advocacy organizations and support groups.

Developing a crisis plan involves active involvement of all team members, including involvement of the child when possible. A crisis plan should be written and distributed to all persons who may be involved in resolving a crisis. It should be updated whenever there is a change in the child's diagnosis, medication, treatment or team members.

Remember:

- ▶ Talk with all family members and discuss what to do, if this were to happen. This is important. There is no reason to be embarrassed. The more you talk about it, the more comfortable your family members will feel and the more education they will get.
- ▶ Contact your local police department and school; provide them with a copy of the crisis plan.
- ▶ Create a safe environment by removing all weapons and sharp objects.
- ▶ Talk to your child's school about what to do in a crisis, including providing permission for them to call the crisis team.
- ▶ Lock up all medications, both over-the-counter and prescription medications. Use a lock with a key lock not a number combination lock.
- ▶ Create a plan that keeps other family members safe, especially younger children in the home.
- ▶ Post the number of your county mental health crisis team.

Create a Crisis Kit

Parents whose children experience frequent crises may benefit from developing a crisis kit that includes their crisis plan, information binder and a small tote bag or backpack with snacks, games, music or books that may help the child when waiting for long periods of time.

This crisis kit should be kept in an easily accessible place in your home or in your car. You may want to consider packing an emergency bag that includes a change of clothes and basic hygiene supplies that can be kept close to your front door or kept in your vehicle in case a crisis occurs.

Reflect

Following a crisis, it is important to reflect back on what has happened to learn what you can do to potentially prevent or minimize future crises.

Some important questions to ask include:

- ▶ What situations or triggers led to the crisis?
- ▶ What worked to reduce tension or avoid a conflict?
- ▶ What steps did we or could we have taken to keep everyone safe and calm?

Write down the results of this reflection and include it in future crisis plans. The more you understand the underlying causes and triggers of a

crisis and what strategies helped, the more prepared you will be in case of future crises.

Including your child in this process may help them recognize their internal warning signs for crisis. If possible, ask your child for a list of things that you can do to help them in a crisis. ■

ADVOCATE

Advocating for a child with a mental illness in the midst of a crisis can be extremely frustrating and difficult. It is not easy to navigate the system or to obtain appropriate services for your child in the best of times. But your child needs you.

Parents are their child's best advocate. They know their child best and most of the time know what they need. You may need help to learn how to advocate appropriately and effectively. Learning to be an advocate and developing these skills takes time.

You will be involved in many meetings concerning your child. These meetings are especially stressful the first few times. The more meetings you participate in, the more comfortable and assertive you will feel because you will feel more on an equal power footing with others in the room. Professionals want to hear from you because you know your child best. At times it may be difficult due to cultural, race or language differences. Presenting your ideas in the following ways will help you gain credibility with professionals and help you effectively advocate for your child's needs.

Be Organized

Over the course of your child's life, you will receive a great deal of information and documents at meetings. It is important to keep all this information together in one place where it is easily accessible. Use a three-ring binder, accordion file or manila folder to organize the paperwork, documents, medical history and progress notes. Organize the binder or accordion folder with divider tabs. It helps to have current information about your child all in one place.

Include the following in your binder:

- ▶ Current diagnostic assessment
- ▶ Copy of the current crisis plan
- ▶ Notes from phone calls and meetings
- ▶ Hospitalization history

- ▶ List of medications and dosages (past & current)
- ▶ Copies of all service plans, evaluations and progress notes including school IEP and 504 plans
- ▶ Names and phone numbers of mental health professionals and mental health agencies working with your child

Take the binder with you to all meetings. It will help you to keep track of discussions, your child's progress, know what questions to ask and what actions have occurred or have not occurred. Getting in the habit of writing things down will benefit your child in the long run. If you have documentation, then it is less "he said, I said" and more "this is what I have in my notes of the conversation/email/text."

When you are at a meeting, prioritize what is important. Putting too many concerns on the table can lead to confusion or a lack of focus. Go to the meeting with a list of the three things you want to accomplish. Having those items written down will help you remain focused. Clearly state your expectations and ideas, provide facts and avoid expressing too much emotion. Listen to what others are saying and take notes. Ask questions if you don't understand what is being said. You may want to bring a friend to help listen and take notes. Bringing cookies or a snack can help break the tension and create a friendly atmosphere.

If you become overwhelmed, ask for a break or excuse yourself to make a phone call or to use the restroom. Give yourself time to gather your thoughts and gain focus. If you feel your objectives cannot be met, try to negotiate and work towards a compromise. Be willing to meet in the middle. Nothing is gained if all parties refuse to listen and work towards a solution.

Speak in terms of what you want achieved for your child, not the service you want. Example: "I want Johnny to increase his reading scores," not "I want one-to-one support."

Be Objective—Stay Calm

When meeting with professionals, remember that you attract more flies with honey than vinegar. Try to keep the conversation focused and in the present. As hard as it can be, try to keep the conversations and questions objective and unemotional. The more you stay objective and unemotional, the more control you have of the situation and the more you stay involved in the conversation and decisions about your child.

Get Support

To be effective advocates, parents need support and need to take care of themselves. You may want to join a support group. Support groups give you a way to help you take care of yourself. At a support group, you meet with other parents with similar experiences, and you benefit from the support they give you. You gain knowledge and learn skills. You also get a chance to support other parents by sharing your experiences and knowledge. By networking with other families, you create more support for yourself and your child, increasing your child's chances to receive appropriate services.

Be Effective

Parents should understand that effective communication can help them receive appropriate services for their child. Effective communication involves verbal and nonverbal language and listening skills. It also involves using the language of the professionals. By communicating in a professional manner, you are ensuring that the professional understands you and you understand them.

Verbal and nonverbal communication work together to convey a message. You can improve your verbal communication by using nonverbal signals and gestures that reinforce and support what you are saying and that will be accepted by the professionals at the table. This can be especially useful when speaking to a large group of people. Be sure to make eye contact with each individual in the meeting.

Non-verbal techniques:

- ▶ Use as much eye contact as is comfortable for you
- ▶ Concentrate on your tone of voice, keep it calm
- ▶ Avoid nonverbal gestures and hand signals which can be misread
- ▶ Sit confidently next to the most important person at the meeting
- ▶ Speak slowly and clearly

You can also develop a number of verbal techniques that will ensure you have understood what has been said and provide feedback to the other person to show that you are listening.

Verbal techniques:

- ▶ **PARAPHRASING.** Put into your own words what the other person has said. Do this by using fewer words and providing facts.
- ▶ **REFLECTIVE LISTENING.** Focus on the feeling or emotion of what has been said. State back what you hear and see, taking note of the nonverbal communication as well and the words that are spoken.
- ▶ **SUMMARIZING.** Sum up what the other person has said. Do this after a person has spoken for a long period of time.

- ▶ **QUESTIONING.** Ask open-ended questions to clarify what has been said.
- ▶ **I-STATEMENTS.** Start sentences with “I.” Take ownership of what has been said and state back what you heard: “I heard you say . . . is that correct?”

Listening is another part of the process that helps you advocate for your child. It requires that you listen to the other person attentively without letting your own thoughts and feelings interfere. Parents can increase their chance of being heard by providing information about their child that is current and in the here and now. Avoid the temptation to tell the whole story. When information is kept to what is needed now and based on facts, not feelings or emotions, you increase the chance of being heard. Remember to keep an open mind and listen to what the other person has said. They may have good ideas that you haven’t thought about.

Support or resource groups are a good place to practice these skills. Visit NAMI Minnesota’s website, www.namimn.org, to find parent resource groups in your area. ■

CONCLUSION

Advocating and caring for a child experiencing a mental health crisis can be extremely stressful. Have a plan in place, know the best techniques to de-escalate a crisis and know where to turn when you need help. Following the steps outlined in this booklet can help you support your child when they experience a crisis and ensure the safety of everyone involved.

NAMI Minnesota has an online video training for families to learn more. The video is available at namimn.org/education-public-awareness/videos/. ■

SAMPLE CRISIS INTERVENTION PLAN

Child and Family Information:

Child's Name:	Birth Date:	Diagnosis(s):	Date of Plan:
Medications:	Dosage:	Prescriber's Name / Number:	Pharmacy Name / Number:
Mother's Name:	Phone(s):	Father's Name:	Phone(s):

Description of child/family strengths (be sure to include all living in the house):

Description of immediate child/family needs:

Safety concerns:

Treatment choices:

Interventions preferred:

Interventions that have been used:

Interventions that should be avoided:

Professional involvement:

Psychiatrist Name/ Phone:	Therapist Name/Phone:	School Contact Phone:	Case Mgr Name/ Phone:
Crisis Team Phone:	Family Doctor Name/ Phone:	Hospital Name/ Phone:	Other:

Supports to use in crisis resolution:

Name/Phone:	Name/Phone:	Name/Phone:	Name/Phone:
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Resources:

Advocacy Group:	Support Group:	MH Agency:	Other:
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Journal Examples

It can be helpful to document behaviors. Here are two examples of how parents can record their child’s behavior.

Written Log

- September 12th Alec refused to get on the school bus, had to take him to school, was late for first period math class
- September 14th Alec threw his school books across the room when I asked him to do his homework at 6 p.m., he ran upstairs screaming and yelling at his sister, slammed the door to his room and kicked the wall several times. He was upset for the next 30 minutes and refused to leave his room.
- September 16th Alec was watching TV when his sister came in the room to ask him a question. He jumped off the couch, pushed her down and threw the TV remote at the wall. He then ran through the house knocking down chairs, lamps and other objects for the next 15 minutes. I was then able to get him to go to his room and remain quiet for the next half hour.

Calendar Log

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Refused to go to school	X	X			X		
Hit sister						At dad’s house	At dad’s house
Meltdown in behavior (screaming)	25 minutes when he got home from school	20 minutes when he got home from school	45 minutes @ 6 p.m. when asked to do homework	20 minutes when he got home from school	35 minutes when he got home from school		
Refused to do chores	X			X		At dad’s house	At dad’s house



COMMON TERMS

Child. Refers to both children and adolescents birth to age 18.

Diagnostic assessment. A diagnostic assessment is a written evaluation conducted by a mental health professional to determine whether a child or youth has a mental health disorder, which one and to develop a treatment plan.

Parent. The birth parent or adoptive parent of a minor. Parent also means the child's legal guardian or any individual who has legal authority to make decisions and plans for the child.

Psychosis. Loss of contact with reality; a psychiatric disorder, such as schizophrenia or bipolar disorder that is marked by delusions, hallucinations, incoherence and distorted perceptions of reality.

Solution focused strategies. Focused therapy concentrating on the present and the future; builds on strengths; focuses on clear, realistic goals; uses tasks; and develops child cooperation and efficacy.

Triage. The process of determining the priority of calls received and the level of care a child needs based on the severity of their symptoms. ■

RESOURCES

Federal and National Resources

Bazon Center for Mental Health Law

www.bazon.org

Child and Adolescent Bipolar Foundation

www.bpkids.org

Children with Attention Deficit Hyperactivity-Disorder

www.chadd.org

National Alliance on Mental Illness

www.nami.org

National Child Traumatic Stress Network

www.nctsn.org

National Federation of Families for Children's Mental Health

www.ffcmh.org

National Institute of Mental Health

www.nimh.nih.gov

NYU Child Study Center

www.nyulangone.org/locations/child-study-center.org

Office of Juvenile Justice and Delinquency Prevention

www.ojjdp.gov

U.S. Department of Education

www.ed.gov

Social Security Administration

www.ssa.gov

Substance Abuse Mental Health Services Administration

www.samhsa.gov

State Resources

Arc of Minnesota

www.arcminnesota.org

ASPIRE Minnesota

aspiremn.org

Juvenile Justice Coalition

www.jjcmn.com

Minnesota Association for Children's Mental Health

www.macmh.org

Minnesota Children's Mental Health Division

www.mn.gov/dhs/childrens-mental-health

Minnesota Autism Society

www.ausm.org

Minnesota Children and Youth with Special Health Needs

www.health.state.mn.us/mcshn

www.health.state.mn.us/suicideprevention

Minnesota Department of Corrections

www.mn.gov/doc/

Minnesota Department of Education

education.mn.gov/mde/index.html

Minnesota Disability Law Center and Legal Aid

www.mylegalaid.org

NAMI Minnesota (National Alliance on Mental Illness)

www.namimn.org

**Office of Ombudsmen for Mental Health
and Developmental Disabilities**

mn.gov/omnndd

Parent Advocacy Coalition for Educational Rights (PACER)

www.pacer.org

If you have comments or suggestions for future printings of this publication, please contact NAMI Minnesota.

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