BUILDING COMPETENCY IN EFFECTIVE CRISIS PLANNING, PREVENTION, SUPPORT AND EARLY INTERVENTION

PART I

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Sponsored by the CBHI Knowledge Center
Overview of Training and Coaching Series

- There is no “ask”
- And there is no “tell”
- Interactive and introspective
- Some content may feel personal or provocative
- Psychological safety is important…
- Take a fresh look at the ART and ACT of family-centered care in the context of crisis prevention and support
- If a provider STARTS (or gets better at) doing family-centered care, what does he/she STOP doing?
- Identify deeply held beliefs that promote or stymie change
- Practice approaches that promote FCC
Overview of Training and Coaching Series

• Continuum is a non-traditional service
• It is a service for youth not well-served by traditional/historic methodologies
  ➢ Including traditional/historic beliefs and mental models of care providers
• Person/Family-centeredness is fundamental to many EBPs
  ➢ It requires care providers adopt new beliefs and mental models—and set aside some old ones
• Person/Family-centeredness is fundamental to effective crisis prevention, planning, support and intervention
Overview of Training and Coaching Series

Within the context of delivering family-centered crisis support, we will talk a lot about parents, but this is a parallel process. This approach works with youth and adults (as well as colleagues, spouses, in-laws, etc)

Why mostly about parents?

…And by this, I mean “parents as parents”
…And I also mean, “parents as collaborators”
Overview of Training and Coaching Series

And if we make a clear and intentional decision to view parents as collaborators it means we make a clear and intentional decision to not view them as...??
Overview of Training and Coaching Series

• Provider engagement and activation of parents as informed and intuitive drivers of their children’s health care is an under-developed skill set
• This is particularly true in the mental health field because of concern about the ability of parents whose children have mental health and other behavioral conditions to make competent decisions
• Providers are often not trained in collaborative and shared decision-making models
• Parents are not experienced participants
• This is a huge, largely untapped, opportunity
• For a multitude of reasons, it is easier said than done
GETTING TO THE ESSENCE OF THE CRISIS
Getting to the Essence of the Crisis

- You are collaborating with families who have led extraordinary lives
- Hard to sort it all out
- Fortunately, you don’t have to understand all of the history in order to be of service
- But, you do want to understand the essence of the crisis for the youth AND for the parent(s), and sometimes other players too—this is where a big opportunity for resolution lies
- Essence isn’t fundamentally about the diagnosis
- Nor is it fundamentally about the problem
Getting to the Essence of the Crisis

Think back to a time when you experienced a personal crisis…

Without detailing the facts, describe the essence of the crisis?

- What were the thoughts you had?
- What were the accompanying emotions?
- What were the accompanying behaviors?
- What would others have noticed about you at that time?
Getting to the Essence of the Crisis

Now think forward from them the crisis to the point where you felt relief…

- What changed that resulted in relief?
- What were the thoughts you had?
- What were the accompanying emotions?
- What were the accompanying behaviors?
- What would others have noticed about you at the point of relief?
Getting to the Essence of the Crisis

Question:
If the facts haven’t changed, can there be resolution?
Stand in the shoes of a parent whose child is receiving continuum services…

Think about the hours, days, months and years that led to the Continuum referral…

• As a parent, what has been the essence of the crisis for you, from your parent shoes? From your parenting shoes?
• Is your experience impacting your functioning? If so, how?
• How do suspect you are “coming across” to providers?
• Is your experience the same or different from the experience your child is having?
Stand in the shoes of a parent...

• Periods of experiencing “parent/parenting” crisis states is an anticipated and normal component of the journey of any parent whose children experience mental health crises.
• Can your “parent/parenting” crisis be resolved even if your child’s condition doesn’t stabilize or improve?
• Why is this important?
## Getting to the Essence of the Crisis

<table>
<thead>
<tr>
<th>Fear</th>
<th>Grief/loss</th>
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<tr>
<td>Sadness</td>
<td>Pain</td>
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<tr>
<td>Anger/rage</td>
<td>Exhaustion</td>
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<tr>
<td>Loneliness/isolation</td>
<td>Hunger</td>
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<tr>
<td>Restlessness/boredom</td>
<td>Lack</td>
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<tr>
<td>Hopeless/helpless</td>
<td>Stuck</td>
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<tr>
<td>Uncertainty/ambivalence</td>
<td>Misery</td>
</tr>
<tr>
<td>Anxiousness/nervousness</td>
<td>Powerlessness</td>
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</table>
General Rule of Thumb

Think STATE not TRAIT
Where are the opportunities for resolution in the crisis definitions below?

• A personal difficulty or situation that disables a person. It is also a hardship that can prevent one from controlling his or her life (Belkin, 1984, p. 424).
• An event as that is viewed as unbearable; it is also one that exceeds a person’s usual resources and coping mechanisms (Gilliland & James, 1997, p.3).
• “A state of disorganization in which people face frustration of important life goals or profound disruption of their life cycles and methods of coping with stressors” (Brammer, 1985, p.94)
Where are the opportunities for resolution in the crisis definitions below?

• Perceiving a precipitating event as being meaningful and threatening...
• Appearing unable to modify or lessen the impact of stressful events with traditional coping methods (previously successful coping strategies are ineffective)
• Experiencing increased fear, tension, and/or discomfort
• Exhibiting a high level of subjective discomfort
• Proceeding rapidly to an active state of crisis—a state of disequilibrium.
• (A. Roberts, 2000)
Resolution-focused Care

QUESTION:
Is admission to a psychiatric hospital an example of crisis resolution?
The Allure of Inpatient Hospitalization

Within a lot of communities, there are **deeply held** views about hospitalization:

- It is the best and highest quality service (other care is lesser care)
- It is a safer place
- Inpatient treatment is something you “do to” a person
- Those fabulous tests will uncover the answer
- That excellent medication will offer the relief
- Sending to ED and subsequent inpatient treatment is always the best risk management and harm reduction strategy
- Individuals returning from inpatient treatment are now stable and can return to business as usual
- Individuals are successfully linked to the proper, good and effective treatment services following ED or inpatient treatment stay.
Efficacy of Inpatient Psychiatric Treatment

Some practice-based evidence…
Re-thinking hospitalization

Quadrant Model for Re-Thinking Psychiatric Hospitalization. Source: Madenwald Consulting, LLC
Iatrogenic Effect

• Harm caused by treatment
• Generally unintended
• Often avoidable
• Iatrogenesis: *Brought forth by a healer*
Offering Crisis Support in Vivo

Why do it?
- Why particularly for the youth receiving continuum services?
- It seems so much easier to rely on 911 / crisis teams / EDs?
- What is the business reason for doing this?
Offering Crisis Support in Vivo

We know what we want for individuals in crisis:

• Safety (for everyone)
• Resolution
• As comfortably as possible.
• As soon as possible.
• Preserving as much choice as possible.
• All while minimizing harm.
“True-North” Concept of Family-Centered Care
Aligning with True North

The experience of consumers and families and communities must serve as True North

-Don Berwick

This means that the ordinal point (True North) for system quality is derived from the recipients’ reality -- our lived experience, our needs, our beliefs and strengths, as well as our reactions to services extended on our behalf.

-Joyce Burland


Burland, Joyce, True North: The NAMI Provider Education Program Comes of Age. www.nami.org
Aligning with True North

“I wish everyone else could see me in the way you see me. I don’t even know how you see me, but whatever it is, I want to feel this way forever. I feel like how normal people must feel. But if it doesn’t last forever, I’ll remember this period in time that I was respected and heard and appreciated for the rest of my life…”

Source: NAMI Advocate. Quote from a participant in a program developed by NAMI Georgia called, “Opening Doors to Recovery”
Aligning with True North

• The parent (or youth…) and his/her experience is the orientation point for service delivery

• It requires:
  ➢ Seeing youth and parent as whole and capable
    ▪ Seeing strengths and not pathology
    ▪ Honoring the journey
    ▪ Holding a belief in their recovery
  ➢ Joining youth and parent where they are
    ▪ Beliefs
    ▪ Culture
    ▪ Preferences
Aligning with True North

• It is easier said than done because it is such a shift in perspective.
• Rather than coming at a problem from my (service provider) lens, perspective and priority, I must re-orient so that I understand his/her (service user’s) lens, perspective and priority and start there.
Aligning with True North

• Family-centered care requires a massive shift in the lens through which the service provider delivers treatment. Instead of a service provider viewing a problem, interpreting meaning, and making treatment decisions through his/her lens, the provider intentionally seeks to understand the lens of the youth AND the lens of the parent(s).

• Both the youth and parent(s) are viewed as credible, capable collaborators bringing with them expertise of their own that must be jointly considered alongside professional findings and interpretations.

• The difference between provider expert lens and youth/family centered lens can be extraordinary.
Aligning with True North

EXAMPLE

• A mental health professional evaluates a child and, based on the symptoms, mental status and assessed risk determines that it is imperative that the child be admitted to an inpatient psychiatric unit. But when he meets with the parents and explains the findings and treatment recommendations the child’s parents immediately and adamantly refuse to consider hospitalization.

• If the mental health professional is coming from an expert lens and has a deeply held belief that it would be unsafe for the child to be anywhere but the hospital, and the parents are adamantly refusing to consent to the treatment, what must the mental health professional believe about the parents?
Aligning with True North

• Believing the parent deficit to be true, the mental health professional, through the expert lens has no choice but to act to compel or coerce treatment and that action may include calling security to assure the parents do not take the child; making a referral to child protective services; or initiation of involuntary treatment procedures. Notice that this is a professional conscientiously doing what he thinks is clinically and ethically indicated.

• If however, the mental health professional is aware of the family-centered care approach, the parents’ reaction to the recommendation of hospitalization will serve as a prompt for the professional to get curious about the parents’ very different belief about what happens next for the child. Instead of interpreting the refusal as a sign of ignorance, denial or neglect, the parents’ reaction is viewed as credible and critical to explore
Aligning with True North

• Through the “expert lens” scenario when parents are in opposition to the mental health professional directed plan, the parental response is viewed as a parenting deficit that puts the child in harm’s way. The mental health professional now must proceed in opposition to do what he thinks will assure safety of the child even if that includes coercion.

• Through the “family-centered lens” scenario when parents are in opposition to the plan, the parental response is viewed as credible, protective and important to explore. The mental health professional now must proceed in collaboration with the family considering the credible risks and considerations raised by both mental health professional and parents. The final plan could in fact be hospitalization, or it could be a one-off (youth/family-specific) alternative, considered acceptable to all parties.
COUNTERPRODUCTIVE APPROACHES
In this exercise, you are the person in receiving services. Pay attention to your “service user” experience as the “service provider” gives you information, asks questions, makes a request or gives you a directive.

Pay attention at a gut level to whether and why the “intervention” is productive or counterproductive.

If it feels **PRODUCTIVE**: Take a step forward

If it feels **COUNTERPRODUCTIVE**: Take a step backward

If it is **NEUTRAL**: Stay where you are

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**Counterproductive/Productive Indicator: An Immersive Learning Experience.**

Source: Madenwald Consulting, LLC and the New York University Child Study Center, 2013. All Rights Reserved.
Counterproductive Approaches

- In the context of a research project on family-centered care, a number of counterproductive practices were identified.
- Three of the indicators have universal implications
- They are highly relevant in the context of safety planning and the provision of resolution-focused support and intervention


Counterproductive Approaches

When a Service provider…

- Uses communication that indicates blame or criticism of the youth or caregiver
- Uses deficit-based language
- Is directive and makes decisions independent of the youth and caregiver about what is good for the family

…it is generally experienced as COUNTER productive
Counterproductive Approaches

From the provider shoes, consider:

- The absence of bad intentions
- The nuance of the counterproductive intervention—the language doesn’t seem so inflammatory when you are the provider that is saying it
- How easy it can be to NOT know you are doing it
- How hard it can be for the provider to recognize the impact—AND understand that he/she is the provocateur
The Parent Journey

In the exercise you were immersed in “parent shoes.”

• What did you learn about the parent experience when his/her child is in crisis?
SUPPORTING YOUTH AND FAMILIES IN THE DEVELOPMENT OF EFFECTIVE SAFETY PLANS
Families deserve interventions that are tailored to their unique needs, based on their strengths and considerate of their own culture. More importantly, it is only when families are truly the center of all planning...even during times of crisis...that hope can be inspired and progress can be achieved.

—Parent Professional Advocacy League (PPAL)
Supporting the Development of Effective Safety Plans

• How are youth experiencing safety planning now?
• Parents?
• Teams?

Who are you doing it for?
The WHY of Family-Centered Crisis Planning

Overarching goal is health activation at youth and family level

• REAL harm reduction

• Youth and/or parent shifting from:
  ➢ From powerlessness to empowered
  ➢ From reactive (primal) to experienced, informed and thoughtful (health-activated)
  ➢ From less healthy responses to healthier

• Increased insight in planning/debriefing and increasing self-aware and intuitive response when in crisis
The Why of Family-Centered Crisis Planning

- Like any aspect of development, the actual mastery (change, growth, improved coping) is internal.
- It cannot be “done to”, or “done for”.
- Sometimes the mastery comes in a eureka moment—AHA!
- Other times, it is developmental, with incremental learning, plateaus, setbacks, new approaches.
- It does not happen on “our clock” but we certainly can influence someone else’s learning clock for better or worse.
Comparing Counterproductive vs Productive Plans

“Expert-driven” Plans
• Plans that make providers feel better
• Provider interpretation/goal
• Plans that list what providers/others think a youth/family should do
• Cookie cutter components like, “Call 911 in an emergency”
• Elements that are handy for providers like to see: risk factors, diagnoses, and demographics
• Formatted in provider-fashion

Family-Centered Plans
• Plans that promote the capabilities of youth and families
• Youth/Family interpretation/goal
• Plans that list what youth/families actually intend to do
• One-off plans
• Elements that are youth and family feel are handy to see: phone numbers for key supports and pragmatic, doable strategies
• Formatted in family fashion (including non-traditional ways)
Supporting the Development of Effective Safety Plans

It is the youth’s/family's Safety Plan developed through their eyes, for their benefit, and in accordance with their own strengths, resources, and perceptions of what they reasonably think might work now.
Traditional Crisis Plan

• A plan developed for use in the home or community.
• The focus could be crisis prevention, crisis resolution, harm reduction, consolidating resources, or just managing the crisis in the best possible way.
• Developed BY or WITH youth and family
<table>
<thead>
<tr>
<th>Some areas to think about when identifying the goal(s) of your safety planning</th>
<th>How important is this to you right now?</th>
<th>How controllable does this seem right now?</th>
<th>Where do you want to start and what is the goal? (You don’t have to do it all at once)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong>—Things we (child, parent, other) can try to keep the crisis from occurring</td>
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<tr>
<td><strong>Resolution</strong>—Things we (child, parent, other) can do once the crisis starts to try and resolve the crisis</td>
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<tr>
<td><strong>Safety/supervision</strong>—This is about safety for the person in crisis, but also for everyone else that is around.</td>
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<tr>
<td><strong>Communication</strong>—Knowing who to ask, what to ask for and how to ask for it, so we get what we need</td>
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<tr>
<td><strong>Logistics</strong>—Knowing where to go, what to take with us and how we are going to get there</td>
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<tr>
<td><strong>Time efficiency</strong>—Finding ways to simplify the process and reduce waiting time and redundancy</td>
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<tr>
<td><strong>Multi-tasking</strong>—Figuring out and managing the rest of our responsibilities (work, school, siblings, pets, etc) while at the same time working on the crisis.</td>
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<tr>
<td><strong>Information</strong>—This might include giving or getting information ahead of time or knowing how to give/get information once a crisis happens. Or, it might be about knowing what will happen, what choices there will be, how will decisions be made, who might talk to us, or understanding our rights.</td>
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<tr>
<td><strong>Other</strong></td>
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Advance Communication to Provider
(Wellness Recovery Action Plan—WRAP, Advance Directive)

• This type of plan is used to inform/instruct providers and other support providers.

• In essence, it communicates the following: "If you see me/my child in crisis, here is how I/we would like to be treated, here are the types of interventions I/we prefer, and here is what is important to me/our family."

• This is a tool that promotes the consideration of personal/family voice and choice and the practice of “Shared Decision-Making“

• The Advance Communication is not a legal document, the treatment provider is not bound by the requests made on the form, but its use can simplify communication and allow those requests to be considered and honored if possible
Advance Communication to Provider

This type of crisis planning gives youth and families a chance to think through priorities, preferences and deeply held beliefs on big deal issues, like use of:

- 911
- Emergency Department
- MCI Teams
- Hospitalization
- Emergency medication
How my/our child looks and acts when in crisis
Lara does not want to be a burden so she often tells the crisis team that she is fine even when she is really upset inside and is having thoughts of hurting herself.

My/our priorities when my/our child is in crisis
She is very embarrassed that she has to get help—privacy and discretion are very important to her and to us.

What helps my/our child during crisis support/intervention
1. It is usually difficult for her to open up to men—if a woman is available, it would probably go better.
2. She may want one of us to stay with her while she is being interviewed. Please respect her wishes.
3. She carries a sketchpad and pen and uses it when she is upset. Please let her keep it with her.

What helps my/our family during crisis support/intervention
1. We want to be a part of decisions rather than being told what the plan is—we have a lot of experience in knowing what works. 2. Our other children feel overlooked by the crisis team. They are scared for their sister. If you can take a few minutes to ask them how they are doing or if they have questions they really appreciate it.

Treatment I/we prefer for my/our child
1. We have a lot of family members and friends who will help out at home and if we can keep her safely in the home, that is our choice. 2. We only want referrals to providers that are experts in trauma and will tell us about their trauma training and experience.

Treatment I/we prefer my/our child NOT receive
Anything that is overwhelming—we do not think she could bear it and she has been very upset when crisis staff have talked to her about it before. Unless it is a life or death situation, we will keep her at home.

If I/we cannot be immediately reached if child is in crisis, please:
If the crisis is at school, talk to Mrs. Washington, the guidance counselor. Also, any time you cannot reach us call Aunt Martha at ### to see if she can come to be with Lara

Additional information, needs or requests
If you come to our home, please pull in to the back of the driveway and use the side door
Advance Communication to Treatment Provider

What I experience when I am in crisis

The problem is usually that I have been angry or feeling sorry for myself and I start drinking. Then I start thinking about killing myself. When people try to help me, I shut down at first—it isn’t personal. I just need time to get my words together.

My priorities in a crisis

STAYING OUT OF THE HOSPITAL! I can pull it back together pretty quickly and I know the point when I need to call crisis. Also, I just started a new job that I really like and I cannot miss any shifts for the first three months or I will be fired.

What helps me in a crisis

Give me some space and then I will be ready to talk. Don’t just come in asking all of your questions all at once. I want to keep my cell phone with me so I can call a friend or my aunt at some point. I am not going to go into details about the abuse—look at the old flies if you want to know, but don’t ask me. It is in the past and I am done talking about it.

Treatment I prefer (specific programs, medications, types of intervention, alternatives to hospitalization, involvement of friends and family)

I am done going to treatment. Maybe someday, but not now. I am trying it on my own and am doing ok so far. My focus is my career and my friends and enjoying the GOOD instead of talking about the BAD. I can use crisis if I slip.

Treatment I prefer NOT to receive

NO MEDICATIONS.

If I am admitted to a facility, I need to plan for the following (pet, child, housing, car, job, school, etc) I SHOULDN’T be admitted anywhere, but IF I EVER AM, call my aunt Jasmine at ###. She has a key and will pick up my dog and watch my place.

Additional information, needs or requests

Do not call my mother—she is not in my life anymore and I do not want her to have any information.

Developed by: Jasmine Sample
Date Completed: 07/07/11

Filed With: MCI Team

This Advance Communication is for (person who will be receiving the crisis service):

01/01/1992
Jasmine Sample
N/A

Date of Birth
First Name

Last Name

I have diabetes and will have to check my levels every 4 hours (other information, needs, requests, accommodations)
Supporting the Development of Effective Safety Plans

• We all know from personal experience that having a “problem” and knowing how/being ready to address it are very different things.
• As providers, it is easy for us to be in ACTION mode—we are ready for families to solve the problem, and for children to stop the behavior NOW.
• But, families may be ambivalent, have questions about their ability to change, not have an acceptable alternative or have different priorities.
• We will feel the RESISTANCE if we are pushing someone into something they are not ready for or interested in—THIS MEANS WE need to adjust.
• Plans that are filled with things that "we" (the providers/funders) would do give "us" (providers/funders) a false sense of confidence that the risk of harm is reduced.
Supporting the Development of Effective Safety Plans

Keep it **authentic**—having no answer is better than a pat answer, having no safety plan is better than a bad or forced safety plan

• It isn’t necessary to have “everyone” on board
• Dragging someone kicking and screaming to the safety planning table is counterproductive
  ➢ Take a “Stages of Change” approach
  ➢ See if you can figure out and address “why not?” “What isn’t helpful about this?”
  ➢ But, voice and choice prevail
Michel was not interested in completing a written safety plan—he says he would not keep it around where other people might see it. He has not told very many people that he has had suicidal thoughts.

He did choose, however, to add a new contact to his cell phone called “Information.” He listed names and numbers of three people he could call if he is “feeling stressed” and wants to talk to somebody.

He also listed the number for the Kids Help Phone and the Crisis Response team, but says he is not sure if he would use them.
Supporting the Development of Effective Safety Plans

• It diminishes the authority of the parent, voice of the family, and the credibility of the plan to have it filled with actions that a child (or anyone else) is unlikely to take.

• Attempts to implement this kind of plan may actually escalate the household rather than reduce risk or unwanted behaviors.
  - If a family is not ready for much, the plan should not be much.
  - The choice is theirs to make.
  - Build an authentic relationship that respects where they are now.
  - When they are ready for more, we are ready too.
Supporting the Development of Effective Safety Plans

• Guard against a deficit approach in safety planning—gain momentum by focusing on what works
• Build plans and strategies around what is natural
• Build on the “basic goodness” or wellness of the person/family
• Help them discover: What are our core talents?
• Help them discover: What do we do best?
• Help them discover: Strategies that are sustainable
Supporting the Development of Effective Safety Plans

• There are a wide range of ways…
  ➢ to decrease unwanted behaviors,
  ➢ to improve management of a crisis, and
  ➢ to reduce risk of harm
• The “right” solutions, actions, strategies are unique to an individual/family
• Culture, beliefs, preferences, readiness for change, strengths, barriers, and prior experience will all come into play in the event of a crisis and must be taken into account when creating a usable Safety Plan.
• What I think is “good” for you and what you think is “good” are often very different
Keep it Simple

Suggest a focus on:
• Do-able
• Controllable
• Consensus
• Areas of low/no-resistance
• Normal, natural, enjoyable
Supporting the Development of Effective Safety Plans

• If the Safety Plan achieves its promise of being person/family-centered, the content will be a good reflection of where the person/family is right now and where they want and are ready to be heading

• And it will be consistent with:
  ➢ Stage of interest in and readiness for change
  ➢ Family's self-defined priorities
  ➢ Natural ecology and culture
  ➢ Degree of comfort and success that has been achieved in managing crisis situations
  ➢ Family's interest in use of formal systems
  ➢ Family's interest in use of natural supports
Assessing Plan Authenticity

• The “validity” of a plan can be very difficult to judge from the outside (i.e. quality review)
  ➢ Authentic plans may be very basic
  ➢ They may have a narrow focus
  ➢ Sections may be left blank
  ➢ Plans may not directly reference known risks (document these conversations elsewhere)

• Signs the plan may not be authentic:
  ➢ 100% of youth on a team/in a program have a plan
  ➢ Plans have little variation/contain canned/pat strategies
  ➢ Comprehensive plans
  ➢ “Clinical language” rather than layperson language
  ➢ Plans are filled with formal solutions
Four Examples of Family Styles

- Preference for FORMAL services
- Preference for a mix of FORMAL Services and INFORMAL supports
- Preference for a mix of INFORMAL supports and Self-Management
- Preference for Self-Management
Voices from Peel Region’s Diverse Youth. October 2013 Report

96 diverse youth in the Peel Region of Ontario, Canada participated in a forum and completed a survey to help the community understand:

Who do youth feel most comfortable talking to about their mental health?
Who would you hypothetically talk to if you were feeling anxiety and stress that you could not cope with on your own?

SOURCE: Voices from Peel Region's Diverse Youth. October 2013 Report
Who would you hypothetically talk to if you had the urge to hurt yourself?

SOURCE: Voices from Peel Region’s Diverse Youth. October 2013 Report
What would help youth feel comfortable accessing mental health and addiction services?

- Easy to access by public transportation
- Located somewhere I already go (i.e. school)
- Specializing in mental health and addiction services for youth
- Interpretation services available
- Culturally specific services available
- Drop-in services (no appointment needed)
- Your parents not knowing
- Your friends not knowing
- A service not in my community so no one knows me
What are the most common reasons youth wait until a crisis before accessing mental health services?

- They are not sure where to go
- They feel ashamed
- They are doubtful that service will help
- Seeking service for mental health would be unacceptable to their parents
- Seeking service for mental health would be unacceptable to their community
- Services may not respect their cultural or religious beliefs
- Other (please specify)

SOURCE: Voices from Peel Region’s Diverse Youth. October 2013 Report
Crisis System of Care Model

This is an organizing and planning framework that offers nine points of opportunity for building depth and breadth into a crisis system: within five “phases” and four “key components”.

Players: Strong, cross-sector collaborations
Logistics: Processes to facilitate movement of people and data
Competencies: Building skills that promote resolution & reduce harm
Parts: Services used as intended and producing results

Madenwald & Day, Technical Assistance Collaborative, Inc.
Crisis System of Care Model

• A Crisis System of Care is defined as the organized whole of a behavioral health crisis system.

• This is quite different from how the system “works” in many communities where you might find:
 ➢ Systems and services operating in silo from each other
 ➢ Default, and often early use, of safety net providers such as law enforcement, hospital emergency departments and crisis teams
 ➢ Under-defined mission, standards and measures
 ➢ Under-assigned roles and responsibilities and systemic expectations
 ➢ Underdeveloped crisis competency within the system.
 ➢ Narrow focus on assessment, not enough focus on intervention/treatment
 ➢ Narrow focus on disposition, not enough focus on resolution
Crisis System of Care Model

Phase I: Prevention
Phase II: Early Intervention
Phase III: Acute Intervention
Phase IV: Crisis Treatment
Phase V: Recovery and Reintegration

Tendency can be to narrowly focus on acute crisis response

Players: Strong, cross-sector collaborations
Logistics: Processes to facilitate movement of people and data
Competencies: Building skills that promote resolution & reduce harm
Parts: Services used as intended and producing results

Madenwald & Day, Technical Assistance Collaborative, Inc.
Crisis System of Care Model

• Unlike other traditional mental health treatment services, the delivery and effectiveness of crisis services is heavily influenced by longstanding beliefs, decisions, practices and actions within the broader behavioral health system, other community sectors and the general public.

• Developing effective collaborations across sectors is essential to maximizing health outcomes and getting the most out of a community’s investment in acute crisis services.

• This is work that is necessarily systemic.

• It permeates the work of every youth-serving system and public safety, health and business sector and crosses socio-economic and payer categories.
Crisis System of Care Model

- There can be considerable variation in how crisis episodes are managed based on the comfort level of the particular system/provider and it can have a significant impact on the care experience

Example: cutting behavior

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>I haven’t seen this before and it scares me</td>
<td>Any self-injury is unacceptable behavior</td>
<td>What will the community think if something happens and we failed to act?</td>
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<tr>
<td>I think his life is in danger</td>
<td>Policy: If a person self-harms, he will be sent to the ER no matter what</td>
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<tr>
<td>I can’t be responsible for sorting this out</td>
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</table>

- I haven’t seen this before and it scares me
- I think his life is in danger
- I can’t be responsible for sorting this out
“We aren’t providing crisis care, we are handing off crisis care. And then they hand off and then they hand off…”

-Chris Tokarski, Executive Director
Mental Health Resources, Inc.
The Mangled Foot
The Mangled Foot

Assessment vs. Treatment

- What is the difference?
- Implications for Continuum crisis planning and support
The Mangled Foot

Resolution vs. Disposition

- What is the difference?
- Implications for Continuum crisis planning and support
The Mangled Foot

- If you are the person with the mangled foot, **what are you in this for**
ROUND TABLE