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Child and Adolescent Psychiatric Emergencies: Mobile Crisis Response

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This chapter describes the application of Roberts's (2005) seven-stage crisis intervention model (R-SSCIM) and Myer's (2001) triage assessment model to youth experiencing a psychiatric crisis, defined as a suicidal, homicidal, or actively psychotic episode. Although most children have their first contact with mental health services during a crisis (Burns, Hoagwood, & Mrazek, 1999), there is relatively little research on crisis intervention, and almost nothing written on mobile crisis response for children and adolescents (Singer, 2006). This chapter is an effort to bridge that gap by presenting three case studies of youth experiencing suicidal, homicidal, or psychosis-driven crises. This chapter provides a realistic description of crisis intervention over the phone, in schools, at home, in the hospital, and in a youth homeless shelter. The chapter includes a review diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) for three disorders that are commonly found in youth experiencing psychiatric crises: depression, bipolar, and schizophrenia spectrum disorders. Throughout the chapter, dialogue is used to illustrate crisis assessment and behavioral and solution-focused intervention techniques.

CASE STUDIES

Nikki: Suicidal Youth with Bipolar Disorder

On Tuesday morning, Mr. Anderson, a school counselor at a local elementary school, called the Child and Adolescent Psychiatric Emergency (CAPE)
team to request a suicide assessment. Nikki, an 8-year-old female, had drawn a picture of herself with knives cutting large pieces out of her body; blood was spurting everywhere, and a man was standing to the side, laughing. The counselor reported that Nikki was well known in the principal’s office because of her frequent outbursts and fights with other children. According to Mr. Anderson, there were two previous incidents that caused concern for Nikki’s well-being.

The first crisis occurred 3 months earlier. Mr. Anderson reports that during recess, Nikki was screaming at her classmates and stomping on the ground and refused to comply with the teacher’s requests. Nikki reportedly picked up a rock and threw it at one of her classmates, grazing the student’s shoulder. The school responded as follows: Nikki was restrained by school administrators and removed from the playground. Her classmates were taken back to the classroom, and the wounded student received first aid. The parents of both Nikki and the wounded classmate were called. School administrators had separate conversations with both parents. The school counselor was brought into the classroom to debrief the students. The zero-tolerance policy at Nikki’s school required her to be temporarily expelled to the alternative elementary school. Although by law the school is not allowed to recommend mental health services to the parents, the school counselor mentioned that many children with anger problems benefit from counseling and provided the phone number for some local service providers. After a disruptive first week at the alternative school, Nikki’s behavior improved somewhat due to individualized attention, structured classes, a no-talking policy, and weekly visits with the on-campus psychologist. Upon Nikki’s return to her home school, the counselor again visited the classroom and provided a presentation to the students on what it means to be a friend. Nikki’s behavior was somewhat difficult that first day, but the remainder of the week was without incident.

The second crisis occurred 2 weeks prior to the current crisis. Nikki reportedly refused to come in after recess. Her behavior escalated rapidly, going from arguing, to yelling, to stomping her feet on the ground, to baring her arm. At the first sign of self-injurious behavior, Nikki’s teacher called for backup and restrained Nikki. During the restraint, Nikki smashed the back of her head into her teacher’s face, bruising the teacher’s jaw and enraging Nikki even more. Nikki was in restraints for approximately 10 minutes before her mother arrived. According to Mr. Anderson, Nikki’s mother was “furious” with Nikki and screamed at her to “quit actin’ a fool.” Nikki’s behavior de-escalated rapidly. She was suspended for 2 days and taken home. The school followed a similar protocol for dealing with Nikki’s classmates: The school counselor provided an in-service presentation, the teacher discussed the importance of listening to teachers, and Nikki’s mother was again reminded that some children receive therapy services for this type of behavior.

Today’s crisis appeared to be different from the previous two in that Nikki was not acting inappropriately. After confirming that Nikki’s parent had been contacted and was on the way, a crisis worker drove out to the school to do a crisis and suicide assessment.

Later in the chapter I will describe an application of Roberts’s seven-stage model of crisis intervention, including issues of building rapport, compliance with medication, relapse, and developmental issues.
Brandon: Runaway Youth With Depression

On Sunday afternoon, the 24-hour crisis hotline received a call from staff at the local youth shelter. A 15-year-old male named Brandon had checked in to the shelter that morning after a 4-day, 30-hour bus ride from California. He told the staff that if they called the police, he would run away and did not care if he lived or died. The shelter supervisor stated that homeless youth were allowed to stay 24 hours before the police were called, unless parental consent could be obtained. Based on Brandon's statements, the supervisor requested a suicide assessment.

Although this was the first time Brandon had run away from home, he and his mother were homeless until he was 11 years old. During those years, his mother would find temporary housing with men whom she would befriend. Some of these men physically and/or sexually abused Brandon. Brandon attended 40 schools before dropping out in the eighth grade. He was often popular in school but never sustained friendships as a result of frequent moves.

The CAPE team and the youth shelter had a symbiotic relationship. The CAPE team would provide crisis assessments for youth at the shelter who were suicidal or psychotic. In return, the shelter provided respite for youth who presented at the CAPE team in crisis primarily due to conflict in the home. If the child was between the ages of 14 and 17, a low risk for suicide outside of the home but high risk for suicide in the home, the shelter would agree to provide temporary respite (up to a week) with signed parental consent. The shelter accessed CAPE services approximately twice a month, and CAPE used the shelter three to four times a year. The collaboration between the two agencies created a safety net for adolescents who were not appropriate for hospitalization but whose families lacked the coping skills to prevent an escalation of violence. The respite enabled the CAPE team to provide crisis intervention to the family and adolescent in the shelter.

The case example of Brandon illustrates the complexity of working with a runaway adolescent. According to 1800runaway.org (National Runaway Safeline, 2014), on any given night there are 1.3 million runaway or homeless youth in the United States. Like Brandon, nearly 1 in 6 homeless youth report a history of sexual assault prior to leaving home, and 75% of homeless youth have dropped out or will drop out of school (National Runaway Safeline, 2014). The case application will highlight challenges to building rapport with youth who are in crisis in part because they have poor relationships with adults. This case study will also highlight the role of technology and social media in crisis work.

Although the details of Brandon's crisis differ from Rolando's and Nikki's, all three of these cases illustrate how R-SSCIM (Roberts & Ottens, 2005) can help the crisis worker provide effective and timely crisis intervention. For the youth in the case studies, failure to provide timely crisis intervention could result in death. Spoiler alert: Because this is a textbook, no one dies. But not all youth in crisis are fortunate enough to be case examples in a crisis intervention handbook. Before they were cases in a textbook, Nikki, Rolando, and Brandon were youth on the author's caseload. The interventions and techniques are drawn from the author's experiences. Rationales for what to do and why, as well as illustrative dialogue, are provided.

Roberts (2005) defines crisis as "a period of psychological disequilibrium, experienced as a result of a hazardous event or situation that constitutes a significant problem that cannot be remedied by using familiar coping strategies" (p. 11). The role of a mobile crisis unit is to provide crisis assessment and intervention to people out in the community. The goal of a crisis assessment is to identify the event or situation that precipitated or triggered the crisis. The goal of crisis intervention is to restore clients (either individual or family) to their precrisis state of functioning. Some have argued that effective crisis resolution can have as its goal to leave the client in a better place than prior to the onset of the crisis (see Chapter 3 in this volume). But what if precrisis functioning was barely functioning at all? What if, prior to the precipitating event, the client experienced hallucinations, delusions of grandeur, chronic low-risk suicidal ideation, or homicidal ideation? In these situations, crisis intervention needs to first resolve the immediate crisis and then plan for ongoing treatment of the underlying psychopathology (Singer, 2006). The presence of a serious mental illness can make crisis intervention more complicated. An effective crisis worker should be familiar with the symptoms and typical presentation of psychiatric disorders that can increase vulnerability to crisis, such as depressive, bipolar, and schizophrenia spectrum disorders (American Psychiatric Association, 2013). These diagnoses are briefly reviewed so that the crisis worker can have a superficial understanding of the symptoms and be aware of what factors must be considered when making referrals for postcrisis treatment.
Children, Adolescents, and Young Adults

In this chapter, I look at mobile crisis intervention with the 20% of youth who have a serious mental illness, defined as any emotional, behavioral, or mental disorder that severely disrupts the youth's daily functioning at home, at school, or in the community (Merikangas et al., 2010). The chapter begins with an examination of the existing literature on mobile crisis intervention services for youth. It then proceeds to describe the structure and implementation of mobile crisis intervention services in Austin, Texas, where the author provided mobile crisis response services from 1996 to 2002. The chapter concludes with a discussion of the implications of the findings for the delivery of mobile crisis intervention services to youth with serious mental illnesses.

Agency Considerations

Although various model programs exist (e.g., Eaton & Ertl, 2000), the organization and structure of mobile crisis services will change depending on state and local requirements. In Austin, Texas, mobile crisis services were provided through the local community mental health agency, where the author was employed between 1996 and 2002. From 1996 to 1999, the author provided mobile crisis response services to approximately 250 children and families per year and averaged five crisis assessments per week. Children were eligible for services if they were under the age of 18 and either had no insurance or received Medicaid or coverage under the Children's Health Insurance Plan (CHIP). A child was said to be in crisis if he or she was suicidal, homicidal, or actively psychotic. Children covered under private insurance were triaged over the phone and then referred to their insurance provider or told to call 911 if risk was emergent.

Mobile crisis intervention is one of a number of services that make up the social service safety net. Services range in intensity from least restrictive (outpatient specialty mental health services such as those discussed in this chapter) to most restrictive (inpatient hospitals and residential treatment centers; Schoenwald, Ward, Henggeler, & Rowland, 2000; Wilmshurst, 2002). Table 11.1 provides an example of the continuum of care available to children and families in Austin, Texas, when the youth described in this chapter were receiving services. If the purpose of crisis intervention is to restore functioning, then there must be services beyond crisis intervention to maintain that functioning. For children and families in crisis, a single session or episode of crisis intervention will not result in long-term change. Longer-term services are needed to address the dynamics that produced the crisis. Unfortunately, in 2010, fewer than half (45%) of youth who met criteria for a DSM-IV disorder in the past year used mental health services (Green et al., 2013), and surprisingly, youth with more severe symptoms were no more likely to use services (Kandel et al., 2009). According to the Substance Abuse and Mental Health Services Administration (2010), in 2009, 2.9 million (12.9%) youth aged 12 to 17 received specialty mental health treatment, but only 45% of youth who met criteria for a DSM-IV disorder in the past year used mental health services.

<table>
<thead>
<tr>
<th>Program</th>
<th>Population</th>
<th>Services</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPE Team (Child and Adolescent Psychiatric Emergency)</td>
<td>Children who were suicidal, homicidal, or actively psychotic</td>
<td>Crisis intervention, IT*, FT*, service coordination; office- and community-based</td>
<td>As many hours per day as needed, up to 30 days</td>
</tr>
<tr>
<td>FPP (Family Preservation Program)</td>
<td>Children who were engaged in activities that put them at risk for removal from their home or school</td>
<td>Crisis intervention, IT, FT, service coordination; community-based</td>
<td>6–8 hours per week, up to 120 days</td>
</tr>
<tr>
<td>DPRS Program (Department of Protective and Regu1atory Services)</td>
<td>Children with open cases with the DPRS due to confirmed cases of parental neglect or abuse</td>
<td>Provided traditional office-based therapy and skills training to children, protective parenting classes to parents, made recommendations for or against reunification</td>
<td>1–2 hours per week, up to 2 years</td>
</tr>
<tr>
<td>DayGlow</td>
<td>Children with DSM-IV diagnoses</td>
<td>IT, FT, Gn*, Office-based</td>
<td>1 hour per week, up to 3 years</td>
</tr>
<tr>
<td>Zilker Park Program</td>
<td>Children with DSM-IV diagnoses</td>
<td>Outdoor, experiential therapy program for children aged 7–11</td>
<td>4 hours per week, 6 months to 3 years</td>
</tr>
<tr>
<td>Intake</td>
<td>Children under 18, except for those presenting in crisis</td>
<td>Intake assessment, diagnosis, referral to appropriate program</td>
<td>Up to 2 hours</td>
</tr>
<tr>
<td>Service Coordination</td>
<td>Children and families participating in the DPRS, DayGlow, or Zilker Park program, CAPE and FPP provide service coordination</td>
<td>Coordinate medication checks, psychiatric evaluations, connect with community resources, including rent assistance, utilities, food</td>
<td>1–2 hours per month for the duration of services</td>
</tr>
<tr>
<td>Medication Services</td>
<td>All children with biologically based diagnoses</td>
<td>Medication checks, psychiatric evaluations</td>
<td>As long as needed</td>
</tr>
</tbody>
</table>

treatment or counseling for emotional or behavioral problems. The most likely reason for receiving services in the past year was feeling depressed (46.0%), followed by having problems with home or family (27.8%), breaking rules and “acting out” (26.1%), and thinking about or attempting suicide (20.7%). Additionally, 2.9 million (12%) youth received mental health services in an education setting, as did 603,000 youth (2.5%) in a general medical setting and 109,000 youth (0.4%) in a juvenile justice setting.

Within the author’s agency, the two programs that worked most closely together were the CAPE team and the Family Preservation Program (FPP). After the CAPE team provided intensive crisis stabilization services, FPP would provide slightly less intensive community-based family-centered services. FPP workers would provide services wherever the client and family would most benefit: homes, schools, juvenile detention facilities, or hospitals. Evans et al. (2003) report success using an intensive in-home crisis service similar to the FPP. They report that more than 75% of children enrolled in their programs were maintained in the community. This is significant because, by definition, children entering FPP programs are at risk for removal from the home. Because the purpose of the mobile crisis unit was to provide crisis intervention with the intention of keeping children out of the hospital and in their homes, the availability of a local FPP provided a logical referral along the continuum of care.

The continuum of care extended to programs outside of the agency. Mobile crisis workers for children and adolescents had regular contact with a number of agencies. Some agencies were service recipients, others were services providers, and some were both recipients and providers. Recipient agencies included the local homeless shelter for youth, the school system, and the juvenile detention facility. Provider agencies were law enforcement and emergency medical assistance. Developing a working relationship with law enforcement is mandatory whenever involuntary hospitalizations are part of the job. Both the Austin Police Department and the Travis County Sheriff’s Department had mental health units staffed by officers who were specifically trained in mental health issues. Hospitals both received and provided services: They provided most-restrictive environments for clients who were unable to be safe in the community, and they received services through a special agreement. In the latter, agency workers would provide co-therapy with the hospital staff, attend discharge staffings, and coordinate services between the hospital and the client’s family.

**PSYCHIATRIC DISORDERS**

One of the cornerstones of crisis theory is that crisis is universal; anyone can be in a situation that overwhelms his or her usual coping strategy (Lindemann, 1944). Although the experience of crisis might be universal, the diathesis-stress model suggests that people who start out with fewer coping strategies (because of emotional or behavioral problems, for example) are more likely to have a poorer response to stressful situations and are therefore more vulnerable to going into crisis (Coyne & Downey, 1991). Crisis workers need to evaluate the precrisis mental health of the youth so that appropriate modifications to the crisis intervention can be made. Familiarity with the most common psychiatric disorders will better prepare crisis workers to meet the needs of children and adolescents with a preexisting psychiatric disorder. We briefly review depressive, bipolar, and schizophrenia spectrum disorders, three disorders that play a part in the lives of the children in the case studies. The reader should note that although our review is based on DSM-5 criteria, the youth in this chapter were diagnosed under the previous edition of the DSM (APA, 2000). For a more thorough discussion of these disorders, the reader is encouraged to consult the current version of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) or a current abnormal psychology textbook (e.g. Barlow & Durand, 2014).

**Depressive Disorders**

Mood disorders are present in 80% of adolescents who attempt suicide and in 60% of adolescents who die by suicide (Brent, Poling, & Goldstein, 2011). Approximately 11% of adolescents will experience persistent depressive disorder (dysthymia; [DSM-5 code: 300.4]) or a major depressive episode before adulthood, with girls reporting depressive symptoms nearly three times as often as boys (12.4% vs. 4.3%; Merikangas et al., 2010). Rates of major depressive disorder [DSM-5 code: 296.xx] increase significantly between the ages of 13 and 16, from 4% to 11.6%, respectively (Substance Abuse and Mental Health Services Administration, 2010). Youth with significant depressive symptomology are more likely to engage in self-harming behaviors such as cutting and burning (also called nonsuicidal self-injury), have difficulty developing and maintaining prosocial interpersonal relationships, are more likely to perform poorly in academic and work settings, and are more likely to abuse illicit substances. Approximately 40% of youth meet criteria for more than one class of disorder (i.e., anxiety, behavior, mood, or substance use disorder; Merikangas et al., 2010). Comorbid depression and substance use increase risk for high-lethality suicide attempts among youth both with (Jenkins, Singer, Conner, Calhoun, & Diamond, 2014) and without (O’Brien & Berzin, 2012) a history of nonsuicidal self-injury.

**Bipolar Disorder**

Prior to DSM-5, bipolar disorder was considered a type of depressive disorder. However, bipolar disorder is a stand-alone category in DSM-5...
(American Psychiatric Association, 2013), in part due to research that found that the presence of manic symptoms among people with depression is not always synonymous with bipolar disorder. This is particularly true among children, for whom rapid mood swings and extremely high levels of energy can be attributed to causes other than mania. Bipolar disorder is characterized by episodes of both mania and depression. Bipolar I disorder (DSM-5 code: 296.xx) requires a major depressive episode and a manic episode with elation/euphoric or irritable mood and persistently increased activity or energy levels. Bipolar II disorder (DSM-5 code: 296.89) requires a major depressive episode and a less severe form of mania called hypomania. Although bipolar II was originally thought of as a less severe form of bipolar disorder, people now recognize that the presence of longer-term mild mania with depression causes a similar degree of functional impairment as bipolar I. Furthermore, a recent study suggested that the new DSM-5 criteria will result in rates of diagnosis for bipolar II that are similar to those for bipolar I (Phillips & Kupfer, 2013).

Approximately 3% of youth meet criteria for lifetime prevalence of bipolar I or II disorder (Merikangas et al., 2010). Rates more than double between age 13 (1.9%) and 17 (4.3%). Females are slightly more likely to meet criteria (3.3%) than males (2.6%). Risk for developing bipolar disorder is primarily genetic. Youth with a parent or sibling who has bipolar disorder are up to six times as likely to develop the disorder as are youth with no family history of bipolar disorder (Nurnberger & Foroud, 2000). Half of all cases of bipolar disorder start before age 25 (Kessler et al., 2005).

**Schizophrenia Spectrum Disorder**

Approximately 1% of people worldwide meet criteria for schizophrenia (DSM-5 code: 295.90), but rates for schizophrenia in youth have not been established (McClellan, Stock, & American Academy of Child and Adolescent Psychiatry [AACAP] Committee on Quality Issues [CQI], 2013). The first psychotic episode for most males is in their early- to mid-20s, and for females in their late 20s (APA, 2013). According to the American Academy of Child and Adolescent Psychiatry (McClellan et al., 2013) practice parameters, providers should use DSM-5 adult criteria to diagnose and guide treatment for youth who meet criteria for schizophrenia. Structured diagnostic interviews are recommended. When interviewing children younger than 12, providers should assess for psychotic symptoms within a developmental context. Specifically, providers should clarify that “bizarre thinking” or accounts of seeing or hearing things that others do not see or hear are different from developmentally appropriate fantasy or difficulty distinguishing inner voices from distressing hallucinations. Individuals experiencing true psychosis typically report symptoms as confusing, distressing, and beyond their control. Criterion A symptoms are the same in DSM-IV-TR as in DSM-IV: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms. In DSM-5, however, at least two of the five symptoms must be present for at least 1 month (rather than just one in DSM-IV-TR), and one of the two must be delusions, hallucinations, or disorganized speech (APA, 2013). Youth-specific criteria include a rule out of autism spectrum disorder and the acknowledgment that youth might never have achieved an age-appropriate level of functioning prior to onset of symptoms. Treatment of schizophrenia requires a multimodal approach, including case management, crisis intervention, skills training, antipsychotic medication, educational support, social support, and family therapy (McClellan, Stock, & American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, 2013; Roth & Fonagy, 2005; Schimmelmann, Schmidt, Carbon, & Correll, 2013). In this chapter, the acute psychotic episode is synonymous with a crisis state (although the reverse is not true). The necessity for medication as a primary means of crisis stabilization differentiates an acute psychotic episode from the traditional definition of a crisis state.

The authors of DSM-5 rightly point out that people with schizophrenia are more frequently victimized than individuals in the general population. That said, crisis workers often come into contact with people with schizophrenia when there is risk of violence (toward self or others). The case study of Rolando presented in this chapter is an example of risk for violence. People with schizophrenia disorders are at high risk for suicide, with the suicide rate among people with schizophrenia being approximately 44.5 times the national suicide rate (579 vs. 13 per 100,000; Hor & Taylor, 2010; Drapeau & McIntosh, 2014). To place this number in context, the leading cause of death in the United States is heart disease, with a rate of 191 per 100,000 (Drapeau & McIntosh, 2014). Bennett and colleagues (2011) found that people with schizophrenia “are significantly more likely than those in the general community to commit homicide offences” (p. 226). A recent meta-analysis found that 38.5% of all homicides committed by people with psychosis were committed by people in their first episode, prior to treatment (Nielsen & Large, 2010). Researchers have consistently found that when people with schizophrenia disorders commit homicide offenses, the most likely victim is a family member, specifically a family member who lives in the home (Estroff, Swanson, Lachicotte, Swartz, & Bolduc, 1998; Joyal, Putkonen, Paavola, & Tiitinen, 2004; Nordström & Kullgren, 2003). Family members are at particular risk of violence because they are the primary caregivers of people with serious mental illness, including schizophrenia disorders (Solomon, Cavanaugh, & Gelles, 2005). Furthermore, “A family’s lack of knowledge and ability to manage violent behaviors may exacerbate aggressive incidents, putting the safety of the entire family unit at risk” (Solomon et al., 2005, p. 41). In sum, people with schizophrenia...
spectrum disorders are more likely to be violent during a first episode of psychosis and are more likely to kill a family member than anyone else. Consequently, mobile crisis workers have an ethical and professional obligation to assess for both suicide and homicide risk and to provide family members with safety plans and referrals whenever symptoms of schizophrenia are present, even when that person in crisis does not display enough symptoms to meet criteria for diagnosis.

RESILIENCE AND PROTECTIVE FACTORS

Although it is necessary for crisis workers to be aware of the symptoms and presentation of psychopathology, any successful psychosocial intervention identifies and builds on client strengths and resources. This is particularly true of crisis intervention. Crisis episodes are by definition time limited. The support that a crisis worker provides is temporary, but the strengths and resources that clients bring to the table become the building blocks for regaining precrisis functioning. Although anyone can experience a crisis, people who move out of crisis states quickly can be thought of as resilient. Resilience was originally conceptualized as something internal to the individual. Masten, Best, and Garmezy (1990) give an “individual” definition of resilience as “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (p. 425). They identify three circumstances that can demonstrate resilience: (a) overcoming the odds, (b) sustained competence under adversity, and (c) recovery from trauma. More recently, resilience has been understood as resulting from both internal/individual and environmental factors. Michael Ungar (2012) defines resilience as “a set of behaviors over time that reflect the interactions between individuals and their environments, in particular the opportunities for personal growth that are available and accessible” (p. 14). Behaviors that reduce risk for harm are considered protective factors (King, Foster, & Rogalski, 2013).

Technology, Psychiatric Assessment, and Crisis Intervention

Accurate identification of psychiatric disorders in youth typically requires a clinical interview, observation, and information from family members and collateral contacts such as teachers and probation officers to provide data on symptoms and functional impairment. Self-report measures, and screening and diagnostic tools are helpful but not sufficient to accurately identify psychiatric disorders (Eack, Singer, & Greeno, 2008). Given that noncrisis outpatient mental health providers rarely have the time or

training to assess for and identify the variety of psychiatric disorders that are present in people who access community mental health, it is unreasonable to expect mobile crisis workers to conduct a thorough diagnostic assessment while simultaneously providing crisis response. And yet, knowing if a person has a history of emotional or behavioral disorders can help a crisis worker figure out if temporary deficits in coping skills are due to the current crisis or are a function of prior long-term deficits. There are several technology solutions that can improve data collection for mobile crisis workers.

Web-based applications and mobile devices such as smartphones, tablets, and laptops make it possible for mobile crisis workers to travel with advanced diagnostic tools in a way that was impossible only a few years ago. One example of a web-based self-report screening tool for youth that holds promise for mobile crisis response is the Behavioral Health Screen (BHS; G. Diamond et al., 2010). The BHS identifies current and past-year symptoms of several disorders, including trauma, anxiety, depression, and substance use, as well as behaviors such as suicidal ideation and attempt and nonsuicidal self-injury. The database automatically generates a report for the provider of significant symptoms and areas of concern. There are several versions of the tool, but the one that is most relevant for crisis workers was developed for emergency departments (BHS-ED; Fein et al., 2010). When the feasibility and effects of the BHS-ED were evaluated in a busy urban emergency department, researchers found that youth completed the BHS-ED in approximately 10 minutes and that identification of psychiatric problems increased significantly (Fein et al., 2010).

Technologies such as computerized assessments and mobile applications (apps), widely available secure high-speed Internet connections, and affordable hardware have started to change the delivery and use of healthcare services (Barak & Grohol, 2011; Singer & Sage, 2015). The use of technology can be unintentional, such as texting clients or using online maps to identify local resources (Mishna, Bogo, Root, Sawyer, & Khoury-Kassabri, 2012). There are also intentional telehealth and mHealth initiatives, such as remote supervision and consultation and use of mobile apps to track psychiatric symptoms, and self-guided computerized therapy to reduce depressive and anxiety symptoms and improve mental health at a population level (Elias, Fogger, McGuinness, & D’Alessandro, 2014; Okuboyejo & Eyesan, 2014; Powell et al., 2013).

As the availability and use of mobile technology increase, so will the possibilities for more comprehensive crisis assessment and intervention. For example, although not designed for mobile crisis workers, the BHS, described earlier, could be used in the following way: A crisis worker could travel with a tablet, connect to the BHS online through a secure data connection, have the youth fill out the BHS online, and then read the report. The data could
the recommendations in this chapter derive from the author's experience, Hunt, & Monti, 2011). Outpatient research has focused almost entirely on 2010; Esposito-Smythers, Spirito, Kahler, Sobolewski, Richey, Kowatch, & Grupp-Phelan, 2013) or a clinical lab setting (G. S. Diamond et al., 2012). A study conducted in 2010 found that 62% of homeless youth owned a cell phone, and 41% used their phones to communicate with friends and family weekly (Rice et al., 2012). Mobile crisis workers can use the technology that most youth have in their pockets—the mobile phone—to encourage texting, accessing healthy social networks, and connection with others. Youth who use online social networks to connect with friends and family at home are significantly less depressed and anxious than youth whose primary social connections are with other homeless and runaway youth (Rice et al., 2012). For a more detailed review of technology and social services, see Singer and Sage (2015) and Barak and Grohol (2011).

**CLINICAL PRESENTATION: ISSUES, CONTROVERSES, ROLES, AND SKILLS**

Although mobile crisis intervention provides essential therapeutic services to suicidal, homicidal, or psychotic youth (Evans, Boorhoyd, & Armstrong, 1997; Greenfield, Hechtman, & Tremblay, 1995; Gutstein, Rudd, Graham, & Rayha, 1988; Henggeler et al., 1999) and has demonstrated significant financial savings by diverting youth from in-patient settings (Evans et al., 2001; Evans et al., 2003; Schoenwald et al., 2000), there is surprisingly little research on what works and what does not work in youth psychiatric emergency services. Research on pediatric mental health has increasingly focused on the integration of mental and physical healthcare services and on the influence of parental psychopathology on youth mental health (Hoagwood et al., 2012). Research on how to best work with youth in a suicidal crisis has focused primarily on interventions in an emergency department (Ginnis, White, Ross, & Wharff, 2013; Sobolewski, Richey, Kowatch, & Grupp-Phelan, 2013) or a clinical lab setting (G. S. Diamond et al., 2010; Esposito-Smythers, Spirito, Kahler, Hunt, & Monti, 2011). Outpatient research has focused almost entirely on adults (Salkever, Gibbons, & Ran, 2014) or on youth with substance use problems (Dembo, Gulludge, Robinson, & Winters, 2011). As a result, the recommendations in this chapter derive from the author's experience, unless otherwise cited.

**Stage 1: Assessing Lethality**

When assessing for lethality, a crisis worker gathers data to determine whether the person in crisis is at risk for harm. Failure to assess for lethality...
is both a legal liability and a failure to provide a professional service (Bongar & Sullivan, 2013). Accurate assessment of lethality provides the crisis worker with a solid base from which to move forward with the crisis intervention. A professional assessment instills a sense of confidence in the client. There are three parts of the lethality assessment, although they are not sequential and, depending on the situation, are not equally weighted. The assessment of self-harm is also known as a suicide assessment. The crisis worker must determine if there is ideation (thoughts about killing oneself), intent (desire to kill oneself), and plan (when and how to kill oneself, including access to the means). During the assessment of self-harm, the crisis worker must be careful to avoid mentioning “harm” and “hurt” when assessing for suicide. The difference between “I want to hurt myself” and “I want to kill myself” is important. One suggests the infliction of pain to a sustained life; the other suggests the infliction of pain to end a life. The crisis worker who asks, “Have you had thoughts of hurting yourself?” might elicit the verbalized “no” and the nonverbalized “I have no intention of hurting any more than I already do. I want to end my pain and I plan on ending it by killing myself.” The crisis worker could instead ask, “During all that has happened in the past 24 hours, have you found yourself thinking that you would be better off dead?” In situations where rapport would be lost with the immediate questioning of suicide (e.g., assessment of grief), it is appropriate to ease into the suicide assessment. The following brief example demonstrates one way of moving from “harm” to “kill”:

Crisis Worker: Have you had thoughts of hurting yourself?
Client: No.
Crisis Worker: Have you thought of dying?
Client: Yes.
Crisis Worker: Have you thought of killing yourself?
Client: Yes.
Crisis Worker: When?
Client: This morning.

Precise questions result in accurate data. Determining suicide risk is possible only with accurate data (Shea, 2002).

In many parts of the United States, mobile crisis units provide assessment and intervention services to youth in schools, but most school mental health professionals report feeling ill-equipped to handle youth experiencing psychiatric crises (Allen et al., 2002; Erbacher, Singer, & Poland, 2015; Slovak & Singer, 2011). Because schools are the most important service sites for the identification, referral, and provision of mental health services to school-age youth in the United States (Green et al., 2013), mobile crisis units can ensure that youth get the clinical attention they need, regardless of school personnel training or resources.

Working with children requires the crisis worker to use simple language and concepts, as in this example:

Crisis Worker: Hi, Nikki, my name is Jonathan. You know what I do all day? I talk with kids who say they are thinking of killing themselves. Some kids want to hurt or kill someone else. Others kids hear or see things that nobody else can hear or see.
Nikki: I ain’t crazy like that.
Crisis Worker: Oh. So maybe I’m in the wrong place. How embarrassing (smile). Why do you think I’m here, then?
Nikki: (smiles) Because I drew that picture.
Crisis Worker: You know, Nikki, I think you’re absolutely right about that. Before you tell me about the picture, I want to let you know that you can tell me almost anything and I won’t tell anyone else. They will be just between you and me. There are some things I have to tell your mom, or Mr. Anderson. Can you guess what they are?

The caseworker’s tone is playful, but the content is serious. By turning the review of confidentiality (“There are some things I have to tell your mom”) into a game, the caseworker demonstrates to Nikki that he is speaking her language, the language of play (Gil, 1991). Because play is the main form of treatment for children under the age of 12, a bag of art supplies (large sheets of paper, markers, crayons, colored pencils) is an invaluable tool for the mobile crisis worker. The caseworker takes out some sheets of construction paper and markers. Nikki and the caseworker draw pictures as they talk.

Nikki reported that she had thoughts of killing herself while drawing the picture in the classroom but did not have them at that moment. Her plan was to stab herself to death with a knife from her kitchen, as she had depicted in the drawing. She was unclear when she might kill herself: “Maybe I’ll do it after Shante’s birthday party [next month].” Although suicidal ideation must be taken seriously, Nikki’s time frame (next month) provided an important window of opportunity for intervention. She denied homicidal ideation and stated that she did not hear voices or see things that were not there.

The assessment of lethality in a family requires the assessment of both the parent and the child. Rudd, Joiner, and Rajab (2001) recommend evaluating the parent’s ability to fulfill essential functions (e.g., provision of resources, maintenance of a safe and nonabusive home) and parenting functions (e.g., limit setting, healthy communication, and positive role modeling). The overall suicide risk will go up or down depending on how well the parent can fulfill essential and parenting functions. Based on Nikki’s reports of ideation
without plan or intent, she was at low risk for suicide. Interviewing Nikki’s mom, Mrs. D, would provide important information about her ability to fulfill her essential and parenting functions. The lethality assessment with Mrs. D. is described in Stage 2 in order to reinforce the idea that “it is critically important to establish rapport while assessing lethality and determining the precipitating events/situations” (Roberts & Ottens, 2003, p. 331).

**Stage 2: Establishing Rapport and Communication**

Rapport is a short way of saying that the practitioner and the client are comfortable with each other (Kanel, 2013). Developing rapport might have started during Stage 1, as the client began to feel safer in his or her external environment. Rapport building continues throughout the intervention process as the worker develops a deeper understanding of what will help the client resolve the crisis. During the initial rapport-building stage, the crisis worker assures the client that he or she made the right decision by seeking help and that the crisis worker will provide some assistance to the problem. Kanel (2013, p. 60) identifies five basic attending skills that are used in developing rapport in crisis situations: attending behavior (eye contact, warmth, body posture, vocal style, verbal following, and overall empathy); questioning (open- and closed-ended); paraphrasing (restatement, clarifying); reflection of feelings (painful, positive, ambivalent, nonverbal); and summarization (tying together the precipitating event, the subjective distress, and other cognitive elements). These attending skills can be used throughout the crisis intervention process. The following is the beginning of a 30-minute interview:

**Crisis Worker:** Mrs. D., I’m glad you could come to the school so quickly.

**Mrs. D.:** (frowning) Uh, yeah. That’s all right.

**Crisis Worker:** It sounds like you are not surprised that you were called to the school.

**Mrs. D.:** (angry) Do I look surprised? The office people don’t even have to look up my phone number. It is like I’m on speed dial with a prerecorded message that says, “We’re afraid Nikki might hurt herself.”

**Crisis Worker:** What usually happens once you get up here?

**Mrs. D.:** Do you have kids?

**Crisis Worker:** No, I don’t.

**Mrs. D.:** Well, if you did, you wouldn’t be asking foolish questions.

**Crisis Worker:** Sometimes we have to ask questions that seem foolish, Mrs. D. What usually happens when you get here?

This brief interaction suggested that Mrs. D. did not believe that Nikki’s suicidal statements were legitimate. This reaction is common among parents whose children have repeated or chronic suicidal ideation (Slovak & Singer, 2012). The interview with Mrs. D. suggested a number of things. First, rapport building will be crucial in engaging her in treatment. Second, as per Rudd, Joiner, and Rajab (2001), she was partially fulfilling essential functions of providing basic needs such as shelter and transportation but not parenting functions such as nurturing and emotional validation; specifically, she had been aware of Nikki’s suicidal ideation for a couple of years but had never pursued treatment. She reported that “limit setting doesn’t work.” At the end of the interview, the caseworker had doubts about Mrs. D’s ability to keep Nikki safe or to provide an environment that was relatively free of emotional triggers. In any situation where lethality is an issue, consultation with a supervisor is advised. Because the mother’s evaluation raised the risk of lethality, the caseworker contacted his supervisor, who recommended that the family come in for an emergency evaluation with the psychiatrist. Mrs. D reluctantly agreed to travel with the caseworker back to the offices.

**Stage 3: Identifying Major Problems**

Nikki and her mother met the caseworker in the CAPE team office to complete a more thorough psychosocial assessment in preparation for the appointment with the psychiatrist. A useful technique in family assessment is to speak with each member separately and then together as a family (G. S. Diamond, Diamond, & Levy, 2013). This can be challenging for office-based providers whose agency policies prohibit at-risk youth from being alone in the waiting room (Singer & Greeno, 2013), and in this situation another CAPE team worker stayed with Nikki while the caseworker and Mrs. D. identified the major problems in their family. Mrs. D. reported that she receives psychotherapy and medication for bipolar disorder. According to her, Nikki’s rage and anger were the biggest problem. As a result of her ongoing tantrums, their landlord had served them an eviction notice before they left for school today.

**Mrs. D.:** Right in front of Nikki he says that she has 30 days to stop breaking things and disturbing the neighbors or else she’s going to have to find a new place to sleep.
Youth suicidal behavior can serve a variety of functions within a family. Nikki, for her part, internalized her mother's harsh and critical response. Nikki was bipolar because Nikki's behavior was very different from her feelings and processing the thoughts and feelings that were triggered by the event. To continue identifying problems, the family agreed to speak with the psychiatrist about Nikki's anger and her suicidal ideation. The psychiatrist reviewed the intake assessment and determined that Nikki met criteria for bipolar disorder. She did not believe that Nikki posed a threat to herself at that time and therefore did not meet criteria for hospitalization. Mrs. D also shared information about Nikki's behavior at home, indicating that Nikki would go through rapid cycles of feeling happy and being violent and rageful (like this morning). Mrs. D stated that she did not think Nikki was bipolar because Nikki's behavior was very different from her own experience of bipolar disorder.

The caseworker met with Nikki and determined that the precipitating event was the landlord's signing the eviction notice. When a precipitating event is so specific, it is valuable to spend time in Stage 4: dealing with feelings and processing the thoughts and feelings that were triggered by the event. To continue identifying problems, the family agreed to speak with the psychiatrist about Nikki's anger and her suicidal ideation. The psychiatrist reviewed the intake assessment and determined that Nikki met criteria for bipolar disorder. She did not believe that Nikki posed a threat to herself at that time and therefore did not meet criteria for hospitalization. A safety plan was written down, and a copy was given to Mrs. D. The family was instructed to contact 911 in case of an imminent threat to safety, or the 24-hour hotline if Nikki felt suicidal. The caseworker agreed to call the family that night to check in. The psychiatrist prescribed a mood stabilizer and twice-weekly therapy with a CAPE team caseworker. Because Mrs. D takes the bus to work, the caseworker agreed to meet after school at their house.

Thirty minutes into the interview, it was clear that Mrs. D. was angry at Nikki and felt that her daughter's behavior put an undue burden on her. Nikki, for her part, internalized her mother's harsh and critical response. Youth suicidal behavior can serve a variety of functions within a family. One function is to express behaviorally what cannot be communicated verbally. When Nikki was overwhelmed by her mother's anger, she acted out because it was unsafe to tell her mother how she felt. Another function of a suicidal crisis is to force a parent who is emotionally unstable to "get her act together" and care for the child. More assessment and contact with the family was needed to determine if either dynamic was at play. These dynamics are examples of bidirectional family influence.

Stage 4: Dealing With Feelings and Providing Support

The plan was to discuss Nikki's suicidal ideation, explore feelings, and provide psychoeducation about bipolar disorder. Regular assessment of suicidal ideation is vital during a suicidal crisis. The caseworker is advised to ask the basic questions at every session, such as: "Have you had thoughts of killing yourself today? If so, how and when? How important is it that you succeed?" Proper documentation of this routine assessment will provide excellent continuity of care when the case is transferred, and it will reduce the risk of a lawsuit in the event of a completed suicide (see Bongaz & Sullivan, 2013).

There is a simple yet elegant tool for helping individuals and families better identify emotions. The "How Are You Feeling Today?" chart illustrates dozens of common emotions. A laminated version can be used for circling emotions with a dry-erase marker and for playing checkers. In a game of "Feelings" checkers, checkers are placed on images of faces that represent specific feelings. As players move their checkers to a new feeling, they (a) identify the emotion, (b) talk about a time when they had that emotion, or (c) discuss a situation in which they think they might have that emotion. With children of Nikki's age, a popular variation of the game requires players to imitate the feeling face they land on.

During school visits, Nikki and the caseworker discussed bipolar disorder and explored emotions. For the first 2 weeks of services, however, Mrs. D refused to allow the caseworker to come into the house for the prearranged appointments. She also declined the caseworker's offer to meet at the school.

By the end of the 2nd week, there was no indication that either Mrs. D or Nikki was taking her medication. Mrs. D refused to sign a release of information so that Nikki's caseworker could coordinate services with Mrs. D's caseworker. In a more traditional therapy model, it is standard practice to ultimately refuse to provide services if the client is legally preventing the therapist from adequately doing his or her job. Services to crisis clients preclude the option of refusing services.

Stage 5: Exploring Possible Alternatives

During a typical Stage 5, clients explore alternative solutions to the problem. Because Mrs. D was refusing to participate in services, the caseworker decided to explore possible solutions for engaging the family. There is one reframe that, on occasion, has been successful in developing a therapeutic alliance with nonparticipating parents. The following dialogue illustrates the concept of "It's not you, it's them":

Crisis Worker: I'm wondering if you've noticed a change in Nikki's behavior.
Mrs. D: I wish, but no.
Crisis Worker: I’ve been thinking about this a lot. My job is to help you two develop some new coping skills, and I’m failing you. As far as I can tell, things are as bad now as they were when I first met you.
Mrs. D: (skeptical) Mmm hmm.
Crisis Worker: Tell me if this is true: Your parenting style would work really well with a different kid.
Mrs. D: My 10-year-old nephew listens to me; I don’t see why she don’t.
Crisis Worker: Exactly. So here’s my thought. Your parenting is not the problem. The problem is that Nikki’s behavior requires a different approach to parenting.
Mrs. D: Well, ain’t that the truth.
Crisis Worker: I’m wondering if you can remember a time when you did something different that made a difference in the way you got along?
Mrs. D: One night I was so tired, instead of yellin’ at her to sit down, I just let her run around the apartment. We didn’t fight once that night.

There are a number of components that make this a successful intervention. The first is the caseworker’s taking responsibility for the family’s problems. It is as if he is temporarily holding a heavy bag that the family has lugged around for years. The second component is externalizing the problem: “It’s not you, it’s them.” The third component is the use of the exception question. This helped Mrs. D to step back into the role of successful mother, even if for but a minute.

After this dialogue, Mrs. D opened her door to treatment again. Nikki started taking her meds regularly, and the caseworker brought over the “Feelings” checkerboard. The school reported that Nikki’s behavior became more stable in the classroom. Due to the family’s progress, the caseworker discussed transferring them to FPP for home-based services.

Four weeks after the initial call, the weekend on-call worker was paged to Mrs. D’s house. Nikki had cut herself with a dull knife. She was transported to the emergency room and later was released with the recommendation that she “get some sleep.” After consulting with the agency’s on-call psychiatrist, the recommendation was made that she remain in the city, but that she live temporarily with her grandmother, with whom she has a close and loving relationship.

The caseworker implemented Stages 1 and 2 again. In Stage 3, he and Nikki explored the precipitating event for the recent suicide attempt. According to Nikki, on the day she tried to kill herself, she had seen the landlord put a piece of paper under her mother’s door. She assumed it was the eviction notice they had been threatened with 4 weeks earlier. It is very important to be aware of anniversary or trigger dates. The caseworker missed it, but Nikki remembered.

Because Nikki was temporarily living with her grandmother, the caseworker had an opportunity to gather new information about the family, including confirmation of Mrs. D’s drug addiction and history of prostitution. With the new information, the caseworker invited Mrs. D to join the discussion about family problems, possible solutions, and the formulation of a new action plan.

Stage 6: Formulating an Action Plan
The action plan for the family after the second round of the seven-stage model included the following:
1. Weekly house meetings to discuss family issues and watch a movie together
2. Taking medication regularly as directed
3. Regular appointments for Mrs. D with her psychiatrist
4. Regular attendance at Narcotics Anonymous meetings
5. Transition to the Family Preservation Program

Stage 7: Follow-Up
The traditional term for the end of services with a client is termination (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013). Because of the brief but intense nature of crisis intervention, which almost always results in the client’s moving on to another service, the term transition is a better fit (Singer, 2005). At the end of the 2nd month, the caseworker met the family and their new FPP therapist for a transition session. The family discussed what they had learned during the course of the services. The caseworker shared his impressions of the family’s strengths. Nikki had made no suicidal statements since the second crisis, and she was no longer considered a risk to herself or others. The family was told that they could always contact crisis services in the future if they needed to. The complexities of this case were easier to navigate through the application of Roberts’s framework.

CASE STUDY 2: ROLANDO
Another type of crisis encountered by mobile crisis responders is the psychotic or homicidal client. The following case study presents the use of R-SSCIM with a 16-year-old Latino male, diagnosed with schizophrenia, who is in a homicidal crisis. This case study illustrates phone-based triage,
services in the home and hospital, and the use of pharmacotherapy and family therapy in the resolution of the crisis. The use of Spanish words throughout the case study emphasizes the importance of linguistic competency and culturally relevant services.

**Stage 1: Assessing Lethality**

Assessment of harm to self was illustrated in the first case example. The second area of lethality, addressed in this case example, is the assessment of harm to others: What is the likelihood that the client will hurt someone (including the crisis worker)? Whereas the suicidal client might turn on him- or herself to deal with overwhelming hurt, anger, fear, and frustration, the homicidal client turns on others. As with the suicide assessment, the crisis worker should assess for ideation, intent, and plan to harm others. Except for the rare occasion when the client clearly verbalizes homicidal ideation, the crisis worker needs to do an explicit lethality assessment. Some areas to assess include the following:

1. Does the person have a history of violence against others? (If law enforcement knows the person by name, there is a good chance that there is a history of violence.)
2. Is the person taking responsibility for his or her actions, or is he or she blaming others for the current situation?
3. Is he or she talking about “getting back” at someone for what has happened?
4. Are there lethal weapons in the immediate area? The crisis worker should check the surroundings for weapons (knives or guns) or possible weapons (heavy ashtrays, broken bottles, scraps of wood).

Once the crisis worker has enough information to assess the client’s response, he or she needs to ask specific questions about whether or not the client has thoughts of, an intention of, or a plan for harming others.

According to Roberts (2005), most initial contact in a crisis happens over the phone. As a crisis worker, the author found a number of specific benefits to providing crisis intervention over the phone:

1. Reading from a risk assessment checklist without fear of breaking eye contact
2. Being able to write notes during the assessment
3. Communicating with other crisis team members during the phone call
4. Coordinating services with other agencies, such as supervisors, psychiatrists, and law enforcement.

The assessment of lethality is urgent in Rolando’s situation. Lupe’s stated reason for contacting the CAFE team was that she was fearful that Rolando would harm his brother. His medical records indicate a history of violence. For maximum safety of everyone involved (crisis workers included), we continued our intervention over the phone. In the following dialogue, Kim uses strengths-based language, open- and closed-ended questions to gather descriptions and specific information, and reflection of feeling to maintain rapport.

**Crisis Worker:** Lupe, what are you doing to keep yourself safe right now?

**Lupe:** (voice trembling) I took the phone into the bathroom.

**Crisis Worker:** I’m glad you’re safe. Where are Rolando and his brother right now?

**Lupe:** Yellin’ at each other in the other room.

**Crisis Worker:** Does Rolando have access to any knives or other weapons?

**Lupe:** The knives have been locked up since the last time. I don’t think there is anything else in the house.

**Crisis Worker:** I’m glad you’re safe. Where are Rolando and his brother right now?

**Lupe:** (voice trembling) I took the phone into the bathroom.

**Crisis Worker:** Lupe, what are you doing to keep yourself safe right now?

**Lupe:** Ay no! Kim, it looks like he hasn’t taken his meds in at least a week. ¿Qué vamos a hacer? [What are we going to do? I’m afraid to leave the bathroom.]

**Crisis Worker:** No te preocupas [Don’t worry]. I hear the fear in your voice. You’ve been doing great so far tonight. I see no reason why that will change.

One of the challenges of crisis intervention is that, at any given time, the intervention can go in a number of directions. Without Roberts’s framework to remind us that we have not finished our assessment of lethality, we might focus on Lupe’s escalating anxiety and proceed with exploring emotions and providing support (Stage 4). Rather than ignore Lupe’s experience, we use it to further our assessment of lethality. Lupe’s statements provide us with valuable data about her own assessment of safety and her parental authority in the situation. As noted earlier, crisis workers should assess both the youth’s level of risk and the parent’s capacity and ability to protect (Rudd, Joiner, & Rajab, 2001).

Myer’s (2001) triage assessment model assists in assessing Lupe’s capacity to function. Lower scores on affect, behavior, and cognition suggest higher
functioning. When the crisis worker assessed Lupe, her primary emotion was anxiety or fear, based on her use of the word “fear.” Given the potential for violence in the situation, her affect is appropriate to the situation, with a brief escalation of emotions. On the affective severity scale, she rates a 3 out of 10. Her cognitive domain is future oriented and focused on safety: “What are we going to do?” She believes something terrible will happen because Rolando is not taking his medications. She demonstrates some difficulties with problem solving and making decisions. Her fears about the future are not without basis. On the cognitive severity scale, she rates a 5 out of 10. Behaviorally she is immobile: She is unable to leave the bathroom to address the situation. Her behavior is exacerbating the situation; the longer she stays in the bathroom, the more chance there is that violence could occur. On the behavioral severity scale, she rates an 8 out of 10. Myer’s model helps us to interpret the data. By identifying the most severely impaired domain, we can prioritize our interventions. Based on our assessment, we determine that Lupe cannot be considered a protective factor in the current crisis.

Rapid response is a hallmark of crisis intervention. Like Kim, crisis workers need to be able to think on their feet. Recognizing Lupe’s crisis state, Kim writes a note to me: “Should we call the police?” I write, “Ask Lupe if she’s comfortable with the police coming. If so, tell her I’d like to speak with Rolando.” Involving Lupe in the decision to call the police addressed her cognitive domain: we affirmed her authority as a parent and provided her the opportunity to make a decision. Asking her to leave the bathroom and hand the phone to Rolando addresses her immobility. There are three purposes in talking to Rolando. The first is to remove him from the offending environment (his brother and the living room). The second is to gather more information about his mental state, to involve him in the intervention, and to determine if he can contract for safety. Third, if Rolando is assessed to be a danger to others, he will not be in the living room when the police arrive.

I assessed Rolando’s current functioning and mental status. He confirmed that he had stopped taking his meds, had been sleeping poorly, and had no appetite. He denied use of alcohol or other drugs. He reported that he had no thoughts of killing himself and stated that he would only hurt his brother, not kill him. He refused to contract for safety. The dialogue that follows indicated that the situation was not safe, and it was appropriate for Kim to call the police.

Rolando: Hector won’t stop talking about me. All the time, yo. He and his friends are always saying things about me behind my back. He needs to stop, dawg.

Crisis Worker: How do you know they are talking about you?

Rolando: I know. What, you don’t believe me? (laughs, then becomes angry) I know what you’re thinking. I know what they’re all thinking. Even when they don’t speak out loud, I hear them.

Crisis Worker: I can understand how you’d be angry if you thought your brother and his friends were talking about you. If you’re willing, I’m going to help you so that he doesn’t talk about you anymore. Are we cool?

Rolando presents with delusions of reference, thought broadcasting, and paranoia, all clear indications of psychosis. The extent to which his paranoia is based on actual events or delusional thinking is unclear; medical records note that Hector takes pleasure in teasing Rolando for being “crazy.” Rolando’s presentation of psychosis, his stated intention to harm his brother, and his prior history of violence when not taking medication place him at a high potential for lethality. Using the Community Integration, Inc. Intervention Priority Scale (Roberts, 2002), we rate the call a Priority I because of the threat of imminent violence. Priority I requires the mobilization of emergency services to stabilize the situation. I write a note to Kim to page the on-call psychiatrist for a consultation and call the police. The psychiatrist confirms that children will start to decompensate after a week or two of being off their meds. The psychiatrist recommends hospitalization to stabilize Rolando on his medications, stating that the last time he was hospitalized, it took approximately a week for the antipsychotics to reduce both negative and positive symptoms associated with his psychosis. The police agree to meet us at the house. Police involvement was crucial for three reasons: (a) Police involvement increases the safety for the family and the crisis workers. (b) At age 16, Rolando was old enough to sign himself in and out of treatment in the state of Texas. The only way to comply with the psychiatrist’s recommendations was to have a police officer sign an emergency psychiatric commitment order. If this crisis had occurred in September 2003, rather than 1999, Rolando’s mother would have been able to sign him into the hospital because by that time the age of consent had been raised to 18. (c) The police officer could safely transport Rolando to the hospital.

Rolando stays on the phone with us as we travel to his house. With the police present, he agrees to be transported to the hospital. The psychiatrist on call admits him to the adolescent unit and starts him on his meds. At Rolando’s request and with the permission of the hospital, I agree to return for visits.

**Stage 2: Establishing Rapport and Communication**

The second stage in Roberts’s seven-stage model is establishing rapport and communication. CAPE team workers had established rapport with Rolando...
and his family over the course of their involvement with the team 2 years earlier, after Rolando's first hospitalization. During the first meeting at the hospital since Rolando has been stabilized on his meds, the family shared with the caseworkers some of the elements that facilitated rapport building. The first two comments speak to the value of language and the importance of cultural competence in developing a working relationship (Clark, 2002; Fernandez et al., 2004):

Rolando: Man, you know what's cool? You [addressing the CAPE team caseworker] speak Spanish with my mom. None of the staff at the hospital can do that.

Lupe: Yeah, that's really nice. ¿Sabes que [Do you know what?] I also like that you have personalismo [a warm and familiar way of relating to people].

Rolando: The best thing, dawg, is that you don't mind when I talk about some of the crazy thoughts I have. I know my world ain't like yours, but you cool with that.

Crisis Worker: I appreciate you saying all of those things. What's true is that one of your strengths as individuals and a family is that you have a great capacity to trust others.

Rolando's reference to his "world" is a common way for people with psychotic disorders to identify their experience (Roth & Fonagy, 2005). The caseworker's willingness to discuss Rolando's "crazy thoughts" is more important in developing and maintaining rapport than it is in providing relief from his auditory hallucinations.

The caseworker continued to provide co-therapy with the hospital staff for another week, at which time Rolando was discharged back to the community. He was no longer suffering from hallucinations or delusions. His focus was improved, and he appeared more relaxed. Because his psychotic symptomology was managed, Rolando was able to address the psychodynamic issues that preceded the crisis.

**Stages 3 and 4: Identifying Major Problems and Dealing With Feelings**

The higher the level of family conflict, the more important it is to deal with feelings while identifying major problems. The identification of the precipitating event can bring up feelings as family members try to blame each other for the crisis. The crisis worker can use strengths-based techniques to normalize feelings and reconceptualize individual blame as group responsibility.

The following dialogue illustrates the use of strengths-based language as the crisis worker facilitates a conversation among the three family members:

**Crisis Worker:** Who would like to share their thoughts as to what kicked off this last round of stress?

**Lupe:** If Rolando would just take his medicine, this wouldn't keep happening.

**Rolando:** Mom, you say it like this was all my fault. What about Hector?

**Hector:** What about me? I didn't do anything.

**Crisis Worker:** One of the amazing things about families is that everyone can be in the same room, see and hear the same things, and have completely different memories of it. None of them are wrong, they are just different. Rather than talk about what happened before Lupe called the office last week, perhaps we can talk about what the family has been doing to keep things going well these past 7 months.

Hoff, Hallisey, and Hoff (2009) caution crisis workers to avoid identifying one family member as the problem. She recommends identifying the entire family as the client. In this case, the client is no longer Rolando, and the problem is no longer Rolando's schizophrenia. It is now a systemic issue with the whole family. This does not mean that Rolando's contribution to the family crisis should not be ignored. Indeed, Rolando's psychotic episode (which is synonymous with an acute crisis state), likely precipitated the family crisis (Hoff, Hallisey, & Hoff, 2009). The discussion of major problems allowed each member of the family to take responsibility for his or her role in the crisis. The caseworker's responsibility was to ensure that people felt safe. A safe environment is an environment where family members acknowledge each other's share, take responsibility in front of others, praise each other, and agree to work toward solutions.

Mediating conflict is important in maintaining a safe environment. When working with people with a diagnosis of schizophrenia, maintaining a calm and emotionally safe environment is crucial. People with schizophrenia often have deficits in their ability to understand and manage their own and others' emotions (Eack, 2012). Some treatments, such as cognitive enhancement therapy (Eack, Hogarty, Greenwald, Hogarty, & Keshavan, 2007), explicitly address these deficits, and others, such as art therapy, create low-stimulation environments and encourage nonverbal expressions. Family art therapy is an expressive therapy that is well suited for families with a youth who has schizophrenia (Kwiatkowska, 2001). The components of art therapy (focused kinesthetic work expressing ideas) address the treatment goals of schizophrenia: developing social skills to reduce family conflict and increasing client participation in family activities. For a person with schizophrenia, creative or representational drawing can be a normalizing activity.
The caseworker asked family members to draw a picture of (a) the family, (b) how they are feeling right now, (c) how they were feeling during the event, and (d) how they would like to feel. The caseworker set up ground rules for discussing the activity. According to Lupe, this was the first time in months that the family had laughed together; drawing was one of the few activities where criticism is seen as laughable (e.g., “Dude, you call that a sun? It looks Mom’s barbacoa.”). While Rolando had a much more difficult time creating a recognizable picture of the family, his drawings of feelings were remarkable. His older brother and mother had difficulty representing abstract concepts as well as he did. Rolando’s pride in his accomplishments was a steppingstone to increased self-confidence.

**Stage 5: Exploring Possible Alternatives**

The family identified one precipitating factor and three main problems that they would like to work on. The precipitating factor was Rolando’s yelling at his mom to say that Hector had hidden his medication. When the family processed the precipitating factor, they were able to see the part that each played in the crisis. As an alternative to blaming, arguing, and escalating emotions, the family stated they would like to improve relationships between family members, reduce conflict between the brothers, and decrease the stimulation in the house. Korkeila et al. (2004) report a positive correlation between optimism in adulthood and reports of positive parent-child relationships. The clinical importance of working with families to develop positive parent-child relationships cannot be overemphasized. The development of optimism begins with a strong parent-child relationship. In addition to the family’s suggestions, the caseworker recommended a fourth goal. Although this is not typical in traditional outpatient therapy, taking an active approach is appropriate in crisis intervention. The goal was to eliminate threats to family members. The caseworker explained that there could be no progress on the other goals until the family believed that they would all be safe. The family agreed to the goals.

The caseworker met with Rolando individually. The purpose was not to single him out as a problem but to provide extra support given that he was transitioning from a most restrictive to a least restrictive environment. He discussed his frustration at having no close friends. Rather than having a long discussion about the issue, which can be challenging for people who have difficulty processing information, the caseworker helped Rolando draw a sociogram. The sociogram is a genogram (McGoldrick, Gerson, & Petry, 2008) that represents a person’s social rather than familial world. Through this exercise, Rolando was able to identify friends with whom he could spend more time. Addressing social concerns is significant for people with schizophrenia. Youth with serious mental illness often need concentrated efforts to help them participate in social activities that are crucial for their psychosocial development.

**Stage 6: Formulating an Action Plan**

One challenge to crisis work with families is the programmatic limitation of 30 days per family. One of the goals of this family was to strengthen relationships. The caseworker recognized that to support that goal, the family would benefit most from longer-term services. The solution came in the form of a referral to the FPP. Similar to the crisis unit, FPP is mobile and provides services in people’s homes. The difference is that the FPP services are somewhat less intensive (twice a week instead of daily), but they are more long term. FPP provided individual and family therapy to address the ongoing concerns of the family.

Solution-focused therapy is well suited for Stage 6. One of the classic solution-focused techniques for setting goals is the miracle question (Berg & Miller, 1992):

> Suppose that after our meeting today you... go to bed. While you are sleeping a miracle happens and your problem is solved, like magic. The problem is gone. Because you were sleeping, you don’t know that a miracle happened, but when you wake up tomorrow morning, you will be different. How will you know a miracle has happened? What will be the first small sign that tells you that a miracle has happened and that the problem is resolved? (p. 339)

The responses were as follows:

**Lupe:** I wouldn’t have to yell. “Mijo, get out of bed. You’re going to be late to school.”

**Rolando:** Hector and I wouldn’t yell at each other.

**Crisis Worker:** Instead of yelling, what do imagine doing differently?

**Rolando:** I don’t know. Say nothing?

**Hector:** Rolando would be nice to me like he used to be.

The miracle question proves the crisis worker with some concrete behavioral indicators of what might be different when the current problem is no longer a problem. This idea would be incorporated into longer term treatment, rather than crisis intervention. The final step in the action plan was to have Lupe join the local chapter of the National Alliance on Mental Illness (NAMI), an organization that provides social support and has an educational function that can reduce stress and increase knowledge of disorders.
Stage 7: Follow-Up

The final stage of Roberts's model is follow-up. The final two sessions were very important in bringing closure to the crisis. The penultimate session reviewed the progress made by the family. The following dialogue illustrates termination work with the family:

Crisis Worker: What was one of the most important things you learned about yourself and the family as a result of this experience?
Lupe: My house is much more calm if I am calm. I never knew how important I was. I know that sounds silly, but it is true.
Rolando: I'm the most important person in the family! Nah, just kidding, dawg. For real, my brother is a nice guy.
Hector: When Rolando takes his meds and Mom goes to her meetings, I don't get so mad. I don't know why, but I just don't.
Crisis Worker: It sounds like all of you have learned a great deal in the last 4 weeks. I have one more question for you: Let's say you met a family that was going through the same things as you were going through when you first started CAPE services. What advice would you have for them?
Rolando: I would tell them to take their meds. That's real important.
Lupe: I would tell the mom to do whatever she could to have the family involved with crisis services.
Hector: I'd tell them not to get in this situation in the first place. (everyone laughs)

The family was successful at meeting their goals and the goals of the program. There were no incidents of violence for the duration of the services. Lupe was able to build a new support network. Rolando stabilized on his meds and successfully increased his social circle. Hector demonstrated improved functioning both at school and at home. When we met with the FPP, the goal was to maintain Rolando in the community by engaging the family in communication skills training and cognitive behavioral therapy. Hector's vision of Rolando being nice to him would form the basis of a goal the family could get on board with and work toward. The crisis that had been so powerful and vivid 4 weeks earlier was a foundation on which the family had built a new way of interacting and being together as a family.

CASE STUDY 3: BRANDON

Stages 1 and 2: Assessing Lethality and Establishing Rapport

The third area of lethality is the assessment of whether the client is in danger of being harmed by those around him or her. The crisis worker can think about the connection between Stages 1 and 2 in the following way: In Stage 1, the crisis worker helps clients believe that their external world is safe (safe from harm to self or others or harm by others); in Stage 2, a feeling of safety is established between the crisis worker and the client. Once both external safety and interpersonal safety have been established, the crisis worker and client can work through the remaining stages to re-establish the client's internal safety. As with all of Roberts's stages, the assessment of lethality should be revisited if the crisis worker believes that the client's initial reports have changed or were not accurate to begin with.

Traveling to the shelter, the crisis worker wondered what threats to harm might be present with Brandon. The most recent statistics suggest that between 16% and 50% of homeless youth have attempted suicide (Votta & Manion, 2004; Walls & Bell, 2011). The mortality rate for street-involved youth is estimated at 921 per 100,000, which is approximately 20 times greater than the rate for youth in the general population (50 per 100,000; Murphy, Xu, & Kochanek, 2013; Roy et al., 2004). Rates of sexual and physical abuse range from 35% to 45% (Votta & Manion, 2004), and between 10% and 28% of street youth have reported exchanging sex for shelter, food, drugs, or other subsistence needs (survival sex; Walls & Bell, 2011). Violence toward homeless youth is also greater than for nonhomeless youth (Kidd, 2003). Any psychosocial assessment of street-involved youth should cover these mentioned areas, and a referral for a full medical evaluation should be made (Elliott & Canadian Paediatric Society, Adolescent Health Committee, 2013). A simple way for crisis workers to assess basic information about history of abuse, survival sex, and so forth is to create a checklist that youth can fill out, giving them an opportunity to disclose information without having to talk about it. The tone of the items on the checklist should be respectful and nonblaming. The following is an example of possible wording for the introduction to such a checklist:

Youth who are no longer living at home sometimes find themselves thinking, feeling, or doing things they would never had thought, felt, or done before leaving home. Youth often report a history of abuse, current substance use, survival sex, suicidal and homicidal ideation, etc.
Then the young person completing the checklist would have the option to respond to questions on a scale of 1 to 5, where 1 = none of the time and 5 = nearly all of the time. Examples of questions include: "Have you ever exchanged sex for food, clothing, shelter, or drugs? Have you had thoughts of killing yourself in the past week?" The case worker can review the checklist and follow up with any concerning items.

Assessing these sensitive topics is impossible without establishing rapport. However, because most runaway youth leave home because of a problem with the adult caretaker, there is a built-in distrust of adults and authority. Lambie (2004) suggests that adolescents' distrust of adults is often expressed by displays of defiance and hostility when first meeting counselors. A strengths perspective reframes their defiance as a protective factor: Living on the street requires a healthy skepticism. Rapport building with adolescents is simplified when the crisis worker is familiar with adolescent culture (movies, music, stars, hobbies, etc.). Humor is similarly important. The crisis worker considered all of these factors as he drove to the shelter.

The following are some basic rules for working with adolescents in crisis and traditional counseling:

1. Let them know you are willing to listen, without interruption, to their story.
2. Reflect and restate more than question.
3. Empathize with their situation.
4. Provide them opportunities to take responsibility in the session and in their life.
5. Be honest when you think they are telling you what they think you want to hear. (Peterson, 1995)

In this initial meeting's dialogue, the crisis worker is careful to let the client know he is not going to be biased against him for being a teenager:

Crisis Worker: Hey, Brandon, my name is Jonathan. I work with kids who want to kill themselves, kill other people, or who are actively psychotic. Am I in the right place? (smile)

Brandon: Not smiling! I didn't ask you to come.

Crisis Worker: Yeah, the shelter supervisor called and said you threatened to run if the police were called and that you didn't care if you lived or died.

Brandon: (visibly agitated) Man, I hate it when adults talk for me! Right: Adults think they have to be in charge, so they are always telling teenagers how to live. People like me have to listen to adults talk about how kids don't act right, when the adults were the ones who told the kids how to act in the first place.

Brandon explains that he would "do anything" to make his mom's boyfriend suffer. He reports that he left California because of ongoing abuse and humiliation at the hands of his mother's boyfriend. Even though Brandon's reports suggested risk of harm to others, the fact that he was in Austin and the potential victim was in California meant that the risk was low. If Brandon stated that he had a plan to return to California and hurt the boyfriend, then risk would be moderate to high. In most states, the case worker would have a duty to warn the boyfriend of the potential for harm.
However, at the time of the assessment Brandon was considered at low risk for suicide and violence toward others.

**Stage 3: Identifying Major Problems**

The crisis worker is interested in finding the precipitating event, or the straw that broke the camel’s back. Stage 3 is all about exploring what happened in the past couple of days that precipitated the current crisis. With Brandon, identifying the precipitating event required a careful review of recent events in his life. Because homeless youth experience so many challenges to their basic functioning (physical and sexual abuse, survival sex, substance use, street violence, hunger, etc.), the crisis worker has to be careful not to assume that one of those areas was the precipitating event. Brandon was reluctant to talk about the events leading up to his leaving California. The crisis worker uses the “I don’t know” technique (G. Maddox, personal communication, April 4, 1997) to maintain rapport and encourage Brandon to share:

Crisis Worker: What happened that made you want to leave?
Brandon: Dunno.
Crisis Worker: Is it that you really don’t know, or you just don’t want to tell me? If you don’t know, I can help you figure it out. On the other hand, if you don’t want to tell me, let me know. I respect you and wouldn’t ask you to tell me anything you are not comfortable with. I just ask that you respect me by being honest.
Brandon: Okay. I don’t want to tell you.

This dialogue makes it clear that Brandon knew what happened. It was not necessary that the case worker knew. We explored the severity of the event using negative scaling questions (Selekman, 2002). This variation of the solution-focused technique of scaling questions is useful when discussing something horrible. In the author’s experience, teenagers respond well to these questions.

Crisis Worker: On a scale from -1 to -10, with -1 being bad to -10 being the worst ever, what would you rate the event?
Brandon: -7.
Crisis Worker: Wow. What would be a -10?
Brandon: If he kills my mom.
Crisis Worker: (lengthy silence, looking at Brandon) That would be a -10, wouldn’t it?

When asked, Brandon said he did not think his mother was in danger, nor did he think her safety depended on him being at home. For many homeless youth, returning to their home places them in greater danger than if they remain on the street (Kidd, 2003). One example of Brandon’s resilience is his decision to leave a dangerous situation. Many street kids can be seen as survivors who took their future into their own hands.

Exploration of the precipitating event led to a discussion of current problems. These primarily involved meeting his basic needs: food, shelter, and clothing. Now that problems had been identified and rapport was firmly established, we were in a good position to begin addressing feelings.

**Stage 4: Dealing With Feelings and Providing Support**

People in crisis tend to experience things in extremes: They feel too little or too much; they are overly focused on a single idea, or they are overwhelmed by a constant barrage of ideas; they are incapable of action, or they cannot control their behaviors. Youth in crisis often feel either detached and numb or constantly emotionally overwhelmed. The simple acts of labeling feelings and validating the person’s emotional state help the person feel less overwhelmed and more in control, opening the door to problem-solving. Adolescents, especially those with highly conflictual parent-child relationships, are not used to adults acknowledging and understanding their feelings. Doing so improves rapport and the adolescent’s sense that he or she is with a safe adult.

Roberts’s model does not contain a stage for dealing with cognitive and behavioral elements of a crisis. Myer’s (2001) triage assessment model is a useful framework for assessing cognitive and behavioral domains. The following dialogue provides insight into how the caseworker assessed Brandon’s affective, behavioral, and cognitive functioning, and he validated Brandon’s experience:

Crisis Worker: Brandon, I’ve been asking you a lot of questions for the past 2 hours. Here you are, in a homeless shelter, thousands of miles away from your mother, and uncertain of your future. How are you feeling? Are you happy, scared, angry, sad, or something in between?
Brandon: (clenched fists, tight jaw, furrowed brow) I’ll tell you how I feel. I feel like I can’t go home anymore. My mom is probably disowning me because her boyfriend is convincing her that I’m no good. I don’t have any friends. Not that it matters. I’m outta here soon.
Brandon’s nonverbal cues suggested that he was feeling anger and frustration. The fact that he followed the phrase “I feel like…” with cognitive rather than affective content (the belief that he can no longer go home, rather than expressions of sadness, anger, or frustration) suggested that either he lacked the words to express his emotions or that he was uncomfortable being vulnerable in front of the crisis worker.

Crisis Worker: Brandon, I can totally understand why the thought of your mom’s boyfriend turning her against you would make you so angry.

Brandon: (softer) Damn right.

The crisis worker suggests an emotion (anger) and validates Brandon’s rationale for his feelings. Note that the crisis worker did not say Brandon was right. It is possible that Brandon is completely wrong about his mother and her boyfriend. Validating feelings simply means acknowledging how the person feels and the reason the person might feel that way.

Brandon’s statement “I’m outta here soon” provided insight into his behavioral functioning. Myer (2001) suggested that in crisis situations behaviors can be thought of as either approach (i.e., action—fight or flight) or avoidance (i.e., no action—freeze). Brandon’s behavioral response to the current crisis is best described as approach: He left California, he threatened to leave the shelter if it called the cops, and he just told the crisis worker that he was “outta here.” The crisis worker needs to determine if the approach behaviors will intensify the crisis or if they will help to resolve them. If Brandon stated that he was traveling back to California to resolve issues with his mother and her boyfriend, then those approach behaviors could be seen as crisis resolving. Leaving the shelter with no safe destination and no plan for finding stable housing is an example of crisis perpetuating approach behaviors. In the problem-solving stage, the crisis worker could include an exploration of what might happen if Brandon left and what options exist for crisis resolution.

Brandon’s statements about loss provided a great deal of information about his cognitive state. He believes that he lost his home when he left (past). He believes that he will lose his relationship with his mom (future). He has no friends (present). The goal for the crisis worker would be to help Brandon think more expansively and less rigidly about his present and future. Basic cognitive therapy techniques would be effective here.

In the following dialogue, the caseworker validates and supports Brandon. In doing so, he opens the door to exploring possible alternatives (Roberts’s Stage 5):

Crisis Worker: One of the things I’m really impressed by, Brandon, is your approach to solving problems: You got yourself out of a bad situation in California. You found the shelter in Austin. You agreed to talk with me. All of those things are real strengths.

Brandon: (silent, eyes moving around nervously)

Crisis Worker: (recognizing Brandon’s discomfort with praise, reframes the silence) I also appreciate you letting me say some of these things without interruption. That’s a skill that not many people have.

Brandon: Thanks.

Crisis Worker: I also know that you are concerned about having to leave the shelter. I have the same questions you do: Where will I go? Will I be safe? How will I survive? If you are willing, I’d be happy to talk about some possible solutions to these problems.

Brandon: Okay.

Stage 5: Exploring Possible Alternatives

Most adults know how to problem-solve even if they cannot name the steps. Many youth have not yet learned these steps. People in crisis have difficulty remembering and focusing. I found that writing the problem-solving steps on a piece of paper provided a structured activity during the session and increased the likelihood that the steps would be followed. Additionally, using the solution-focused technique of identifying past successes was very helpful during the brainstorming step.

Crisis Worker: Now that we have identified the problem as “I don’t have a place to live,” we brainstorm solutions. Tell me whatever comes to mind, as strange as they might sound, and we’ll write them down. When we’re done, we’ll go back and evaluate which alternative would be the best solution.

Brandon: You could give me a thousand dollars. My mom could get rid of her boyfriend and come get me. The shelter could let me stay. I could hitchhike to the next town and stay in their shelter until they kick me out.... I can’t think of any others.

Crisis Worker: I’m impressed with how quickly you came up with that list. You mentioned that you and your mom were homeless when you were a kid. Did you ever stay with someone that was safe and protected you?

Brandon: A couple of times Mom and I went and stayed at her cousin’s house.

Crisis Worker: Great! So another alternative is to contact your relatives and see if you could stay with them.
Brandon’s behavioral coping style, approach, is reflected by his choice of possibilities. If a client is sufficiently cognitively impaired, the crisis worker will have to be more active in providing alternatives. Stage 5 can be an exciting and rewarding stage if the previous stages have been adequately addressed. If the crisis worker has difficulty engaging the client in exploring alternatives, it will be necessary to either re-examine the problem or address affect, cognitions, or behaviors that get in the way of looking forward. In addition to housing, Brandon identified problems with his cell phone, feeling disconnected from his friends at home, and dislike of the other kids in the shelter. During the action plan stage, we focused on his housing and cell phone.

Stage 6: Formulating an Action Plan

The creation of an action plan based on the alternatives generated in Stage 5 is a two-part process. First, support the client to develop specific actions based on the alternatives. Second, ensure that the steps are realistic and measurable and have built-in support. The question “How will you know when you have achieved your goal?” is useful in evaluating the action steps. The following is Brandon’s action plan:

1. **Problem:** I have nowhere to live.
   **Solution:** Call Aunt Emerson in North Carolina and ask if I can stay with her.
   **Support:** The caseworker will text tonight to see if I have gotten in touch with my aunt.

2. **Problem:** I don’t know what is going on with my mom. I can’t text her because my phone is out of juice.
   **Solution:** Charge the phone, text mom.
   **Support:** Shelter staff will lend me a charger and agree to keep my phone in the office so that it can charge safely.

3. **Strength:** I am good at solving my problems.
   **Plan:** When I get stuck, I will sit down with a pen and paper and write out all the possible alternatives to my problem.
   **Support:** If I’m on the street, I’ll call the National Runaway Safeline (1800runaway.org) or use their chat line over my phone or at a computer in the library (Singer, 2011).

Stage 7: Follow-Up

The last stage of Roberts’s model is follow-up. In all clinical relationships, closure is important. It is a time when the crisis worker can provide final feedback about progress and the client can provide feedback about what has changed in his or her life. For many clients, closure is one of the few times when a close relationship has had a formal ending. The process of getting closure allows the client to look forward without regret or a sense of loss. The experience is just as valid a therapeutic tool as any implemented in the previous six stages.

Brandon’s text to the crisis worker said that the aunt was happy to have him come to North Carolina. She bought a train ticket for him online. The shelter staff agreed to let Brandon print out the ticket in their office. The next day the crisis worker met Brandon at the train station and gave him a phone charger that had been left at the office. The crisis worker bought Brandon an ice cream cone at McDonald’s, and they talked Brandon’s experiences in services and what his plan was for the next 24 hours. The crisis worker stated that he would check in with Brandon, and Brandon agreed that he would call or text the crisis worker when he arrived in North Carolina or if there were any issues after he arrived.

**SUMMARY AND CONCLUSION**

The information presented in this chapter was intended to provide a practical view of pediatric mobile crisis intervention. The assessment techniques and interventions were based more in practice wisdom than empirical knowledge. This is in part because almost nothing has been written about outpatient crisis intervention for youth. As if to highlight this gap in the knowledge base, crisis intervention as a treatment modality was omitted in a recent comprehensive review of outpatient mental health services for youth (Garland et al., 2013).

The empirical literature is not the only place where information on crisis intervention is missing. Graduate students routinely report having little or no training in working with people experiencing psychiatric emergencies (Debski, Spadafore, Jacob, Poole, & Hixson, 2007; Singer & Slovak, 2011). Even if graduate education were available, it is difficult to acquire the skills and knowledge necessary to be an effective crisis intervention worker without having field experience. If you find yourself overwhelmed by the amount of information presented, I encourage you to take a deep breath. Part of learning how to deal with crises involves increasing your own coping skills as a professional (Singer & Dewane, 2010): Be yourself; stay current with the literature; seek supervision whenever possible; listen to episodes of the Social Work Podcast (www.socialworkpodcast.com); and allow yourself to take in the amazing gift of watching persons in crisis rediscover themselves.
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