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Assessment #9

Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm

August 2020

Alexandria, Virginia

Ninth in a Series of Ten Briefs Addressing—Beyond Beds: Crisis Services

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Improving the Child and Adolescent Crisis System:
Shifting from a 9-1-1 to a 9-8-8 Paradigm

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Recommended Citation
Hoover, S., Bostic, J. (2020). *Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm.* Alexandria, VA: National Association of State Mental Health Program Directors.

Perhaps the most potent element of all, in an effective crisis service system, is relationships.
To be human. To be compassionate.
We know from experience that immediate access to help, hope and healing saves lives.

- SAMHSA 2020,
National Guidelines for Behavioral Health Crisis Care
Best Practice Toolkit

Background

The lack of a comprehensive coordinated crisis response system for children and youth has resulted in inconsistent care, repeated emergency department (ED) visits and hospitalization, and arrests and detention for youth whose crises are responded to by law enforcement rather than behavioral health providers [1] [2] [3]. SAMSHA has recently emphasized the importance of crisis services that are available to **anyone, anywhere, and any time**, and which do not lead to delays, detainment, or denial of services, or create undue burdens on those afflicted, or on EDs, law enforcement, or the justice system [4]. This vision is perhaps most critical for our youngest citizens, whose behavioral health challenges can often be prevented or identified early, yet are often neglected, at a high cost to society and to the quality of life of many children and families.

Behavioral health disorders are described as serious changes in the way children typically learn, behave, or handle their emotions, leading to distress and problems getting through the day.[5] The prevalence of chronic behavioral health disorders continues to grow among youth, doubling in the past decade, and impacting 20–25 percent of school-aged youth [6] [7]. In children aged 3-17, the most commonly diagnosed behavioral health conditions in children are anxiety (7.1%), ADHD (9.4%), disruptive behavior disorders (7.4%), and depression (3.2%); these conditions often are comorbid, and are more common among children impacted by poverty and other social determinants of health [8] [9]. Suicide is currently the second most common cause of death in young people (ages 10-24) in the United States, and suicide rates in youth have increased 56% over the past decade, with the greatest increases occurring since 2014.[10] People younger than 25 years of age account for 45% of the global burden of disease from behavioral health conditions.[11]

With the rise in behavioral health disorders, we have seen a parallel increase in behavioral health crises among children and adolescents in the United States [1]. These crises are typically addressed by engagement with EDs, law enforcement, or psychiatric inpatient care [2] [3]. Children in crisis are frequently boarded for long periods in EDs or receive short inpatient stays, often resulting in readmission. Many concerns that result in hospitalization may have been prevented or better served via community-based care models with appropriate wraparound supports.

Challenges with the Current Child and Adolescent Crisis System

Limited prevention, early identification and intervention

Emotional and behavioral health challenges in children can often be prevented or diminished with early, immediate identification and action, yet our care systems often do not reflect this reality. The benefits of prevention and early intervention for physical health are now well-recognized. Routine screenings and checkups, and awareness of signs and symptoms that allow early detection and intervention, are increasingly implemented in pediatrics. Such routine screening and behavioral health checkups have lagged in child behavioral health,[12] with those under age 25 experiencing the greatest delay to initial treatment after initial symptom onset.[13] Currently, less than half of children with a behavioral health condition receive any behavioral health treatment,[14] resulting in estimated costs of approximately $247 billion annually from this lack of behavioral health treatment.[15] A number of factors, including persisting stigma and lack of providers, have slowed the emphasis of behavioral health early intervention, leading to much more costly downstream or late intervention, when behavioral health crises necessitate urgent, dense, and often lengthy interventions.[16] The World Health Organization recognized that addressing childhood adversities, particularly those associated with maladaptive family functioning, such as parental mental illness, child abuse and neglect, would lead to a 30% reduction of any lifetime mental disorder, and a 39% reduction in child mental disorders.[17] Moreover, these childhood risk factors and adversities contribute to children having further recurrence of mental disorders later in life.[18] Promoting early detection of behavioral health symptoms and implementing prevention and early intervention strategies that enhance children's emotional and behavioral regulation slows and alters the progression and impacts of child mental illness.

Misuse of Emergency Departments (EDs)

Pediatric behavioral health ED visits nationwide have increased dramatically across the United States in recent years. EDs are typically the first point of contact for children having any type of crisis. Despite its frequency of use, the ED has become an unattractive option to manage behavioral health crises for multiple reasons.[19] First, EDs have become overburdened with non-emergent, inappropriate behavioral health referrals. The ED has become a prime route for patients after hours, once clinics close, and at least one-third of these referrals are not truly urgent. Similarly, about half of the students sent by schools to the ED for behavioral health conditions are inappropriate (i.e., low severity of presenting complaint, low harm potential, absent suicidality or psychosis, and/or no recommended behavioral health follow-up).[20] Second, children with limited resources are routed to the ED amidst an escalation or conflict, yet rarely does ongoing behavioral health care result; children with public health insurance or no health insurance are four times more likely to seek mental health treatment at the ED than children with private insurance.[21] Third, ED staff are poorly prepared to respond to behavioral health crises beyond suicidality and psychosis, despite most behavioral health crises arising from aggressive

outbursts or escalations.[22] Fourth, despite efforts to route families to community providers after an initial ED visit, the ED often becomes the ongoing site for recurrent behavioral health crises.[23] [24] So behavioral health crises routed to the ED more often result in subsequent ED visits, more testing, longer stays, and boarding for hours to days until transfer from the ED to a suitable placement can occur.[25]

Law Enforcement Involvement in Child Behavioral health Crises

As first responders, police are frequently accessed for behavioral health crises in children and families. Police are usually poorly prepared for managing behavioral health crises, and feel time pressured to deescalate situations quickly or to then employ more familiar policing strategies, which too often lead to arrest and detention. An adult with a behavioral health condition is six times more likely to get arrested than someone without a serious mental illness,[26] and 16 times more likely to get injured or die during encounters with the police.[27] Nearly 70 percent of children in the juvenile justice system have a diagnosable behavioral health disorder,[28] 60% of children with an emotional disturbance will be arrested at least once within 4 years after leaving high school, and 39% report being on probation or parole.[29] Most police academies devote less than 1% of training to interactions with adolescents,[30] yet 20% to 40% of juvenile arrests are for "contempt of cop" offenses, such as questioning or "disrespecting" an officer.[31] Incarceration of adolescents fails to decrease recidivism and compounds the negative impacts on the 60-70% of youth in correctional facilities who have significant untreated behavioral health problems.[32] [33]

Racism and Inequity

Despite many emotional and behavioral crises in children and youth resulting from unmet behavioral health needs, crisis events are often responded to with disciplinary or legal action, disproportionately affecting Black and Latinx/Hispanic students compared to White youth[34]. System challenges contribute to a preference for disciplinary versus behavioral health response, including implicit bias and racism among educators and health providers, and fewer behavioral health resources and instead greater law enforcement presence in communities of color [35]. In schools, where most ED referrals for child and adolescent crises arise, educators are usually inadequately trained to identify and address behavioral health concerns [36]. Further, "zero tolerance" policies remain common, despite evidence that they are counterproductive and disproportionately negatively impact youth of color [37]. Ultimately, when youth of color experience emotional and behavioral health crises, they are often met with education and health systems that favor a discipline response over a behavioral health response. In addition, inequities in behavioral health care access, utilization, and quality persist for children and adolescents [38]. Disparities are often attributed to challenges such as stigma, cost, and transportation, but also result from the systemic racism within our behavioral healthcare institutions that lead to limited access and poor quality of care for youth and families of color [38].

A paradigm shift

The challenges outlined above illuminate the need to reconfigure the behavioral health crisis system to better provide coordinated, specialized and equitable crisis prevention and intervention for all children and youth. In 2020, SAMHSA introduced national guidelines for behavioral health crisis care, calling for system transformation toward a more proactive, compassionate, efficient and effective system for those experiencing crises [4]. Core principles of the guidelines include addressing recovery needs, engaging peers, utilizing a trauma-informed and zero suicide

approach, and collaborative partnerships with law enforcement, dispatch and emergency medical services (EMS). While many of the principles and practices apply across the lifespan, some additions and adjustments must be considered for application with children and adolescents and their families. Fortunately, the core principles of the new national guidelines align well with System of Care principles that have been adopted and adapted by many state and local systems for children and adolescents, including family- and youth-driven care, cultural and linguistic competence, preference for community-based services, and interagency collaboration [39].

Multiple current conditions uniquely position us to establish a comprehensive, high-quality child and adolescent crisis system: (1) the 2020 introduction of SAMHSA behavioral health crisis practice guidelines; (2) the recent Federal Communications Commission (FCC) approval of the 9-8-8 behavioral health crisis hotline (to expand our existing 9-1-1 emergency response); and (3) a multitude of lessons and innovations from the global COVID-19 pandemic to inform crisis system transformation. In this brief, we offer best practice considerations for achieving a paradigm shift in our child and adolescent crisis system, away from a reactive and fragmented approach toward a full continuum of supports and services, built on the collaboration of child-serving systems and leveraging current technology. We will first highlight opportunities to "work upstream"; that is, to prevent crises before they occur and diminish them when they do arise by leveraging the natural support systems already available to children and families, including schools, pediatric primary care and community partners. We then outline child-specific considerations to augment the SAMHSA Crisis Best Practice Toolkit, with an emphasis on developmental attunement, youth and family engagement, and cultural responsiveness and equity. Finally, we derive policies from lessons learned in the context of COVID-19, including ways to harness and expand technology to augment care quality and access.

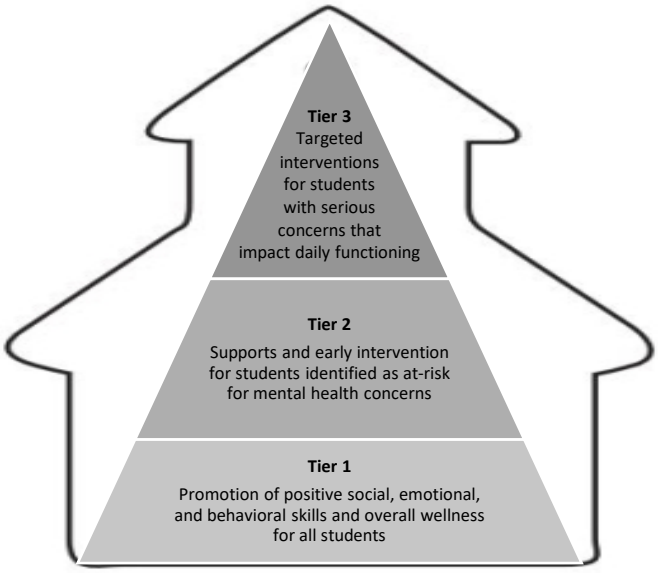
Working Upstream: Prevention and Early Intervention in Child and Adolescent Crisis

In a 2018 brief to the National Association of State Mental Health Program Directors (NASMHPD), states and communities were described as increasingly shifting delivery systems for children's behavioral health to an upstream approach that minimized unnecessary use of acute care settings, such as emergency departments, psychiatric hospitals, and residential treatment facilities.[40] The brief described the value of Mobile Crisis Response and Stabilization Services (MRSS) as an approach that identified problems early, before intensive psychiatric care (e.g., inpatient or residential treatment) were needed. Moving further upstream than the MRSS, other resources and interventions exist that may both prevent and intervene early to diminish children's emotional and behavioral health crises. Many mental illnesses that lead to behavioral health crises could have been identified and treated earlier in their trajectory, likely lessening the negative outcomes for children and families, including the experience of crises. Further, many of our youngest citizens, especially youth of color, experience disciplinary responses, such as juvenile services and incarceration, for behaviors that could have been prevented or best addressed with a behavioral health response [34 38]. This is a fundamental tenet in building a comprehensive behavioral health care system which cannot be overstated and should be a focus of every conversation regarding crisis response systems. Although we must address current failings in our current crisis response system for children, we should only do so while simultaneously building universal behavioral health promotion and early identification and intervention systems to minimize crises from occurring in the first place.

Schools

Increasingly, schools are installing *comprehensive school mental health systems (CSMHS)*, reflecting partnerships between education and behavioral health sectors to support a full continuum of behavioral health supports and services, from promotion to treatment [41]. CSMHS provide a full array of tiered services, often referred to as multi-tiered systems of support (MTSS; see Figure 1), including universal behavioral health promotion activities for all students, selective prevention activities for those most at risk to develop behavioral health conditions, and indicated early intervention services such as clinical assessment and treatment for those students who screen positive for behavioral health conditions. CSMHSs rely on meaningful partnerships between school systems and community programs so that children are supported by collaborative school-employed behavioral health professionals and community behavioral health providers.

Figure 1. Multi-Tiered Systems of Support (MTSS) in Schools

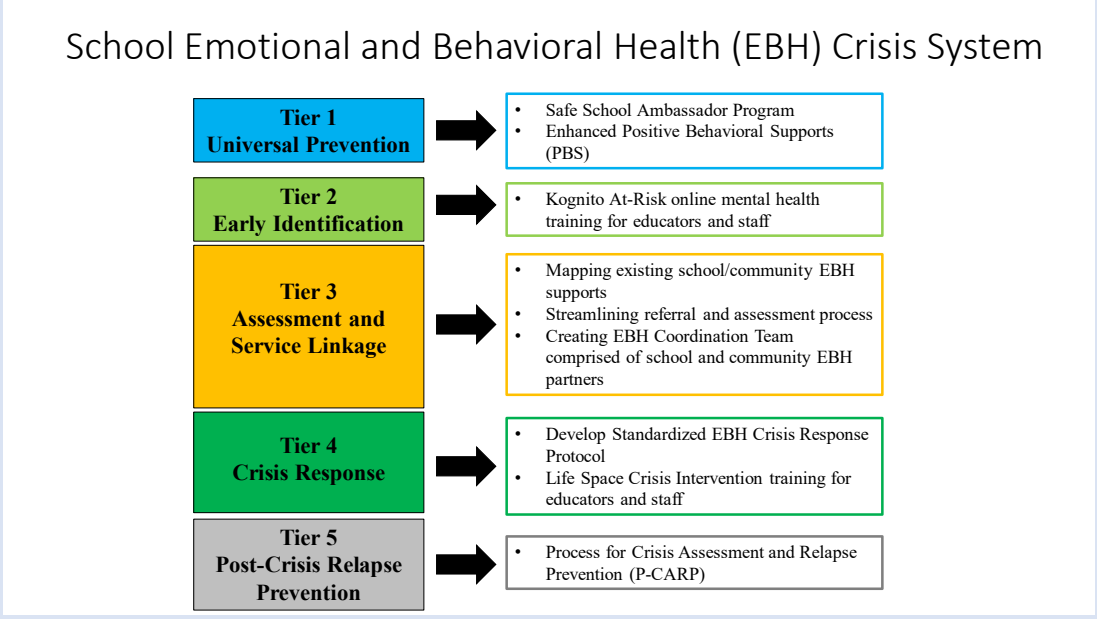


When treatment is delivered in the school setting, youth are far more likely to be identified early, and to initiate and complete care [42 43 44]. Further, interventions delivered in schools have demonstrated positive impact on multiple of children's psychosocial outcomes. Schools across the nation are increasingly delivering universal programming, with students participating in social emotional learning (SEL) programs demonstrating significantly greater social-emotional skills (e.g., emotion regulation), prosocial behavior and positive self-image, and significantly fewer conduct problems, emotional distress and substance use problems than their peers who do not receive such programming [45 46 47 48]. Behavioral health treatments delivered in schools have demonstrated success at reducing mental illness, including anxiety and depression [49 50], post-traumatic stress [51 52 53], behavior disorders [54 55], and substance use problems [56 57].

An essential component of CSMHS is crisis prevention and response. The installation of a comprehensive MTSS has been demonstrated to reduce emotional and behavioral health crises [58]. Despite many emotional and behavioral crises in schools resulting from unmet behavioral health needs, crisis events too often lead to unnecessary disciplinary or legal action by schools, [59] which disproportionately affects Black and Latinx/Hispanic students compared to White students [60]. System challenges also contribute to disciplinary over behavioral health

responses in schools, such as inadequate training of school staff to identify and address behavioral health concerns [61] [62], overburdened educators and inadequate student instructional support staffing, and limited response mechanisms to support behavioral health interventions relative to typically well-specified disciplinary procedures [63]. Successful school crisis prevention and response involves a comprehensive approach that installs a continuum of behavioral health supports and services, including universal focus on positive school climate and social emotional learning, behavioral health literacy for teachers and students, crisis preparedness for all school personnel, a focus on educator and school staff well-being, and availability of on-site school behavioral health providers, including both school- and community-employed professionals. Box

Box 1. The School Emotional and Behavioral Health (EBH) Crisis System was installed and studied as part of a randomized controlled trial (RCT) funded by the National Institute for Justice. As illustrated, at the universal level (Tier 1), the Safe Schools Ambassadors program offered peer training for students from various social groups in conflict management and bullying prevention. At Tier 2, an online virtual simulation technology trained teachers in how to support students experience psychological distress. In addition to creating clear referral, assessment and coordination of school and community behavioral health supports (Tier 3), all education staff received crisis response training using the Life Space Crisis Intervention program (Tier 4). Finally, a structured process was implemented for post-crisis response relapse prevention (Tier 5).



The system is now established as a "Promising Program," with the initial RCT demonstrating increases in school staff knowledge and preparedness to address emotional and behavioral health issues and increases in student actions and behaviors to prevent mistreatment and improve school climate. Intervention schools also had 56% fewer suspensions, 75% fewer office referrals, and more on-site crisis response and threat assessments as opposed to off-site referrals to EDs or law enforcement. For more information: https://www.crimesolutions.gov/ProgramDetails.aspx?ID=677&utm_source=govdelivery&utm_medium=email&utm_campaign=csreleases

1 illustrates a comprehensive school-based crisis prevention and intervention initiative recently studied as part of the National Institute of Justice Comprehensive School Safety Program.

Pediatric Primary Care

Pediatricians remain a trusted and frequently accessed avenue for children and families to obtain behavioral health support. Over 70% of children and adolescents under age 18 see a primary care provider annually,[64] and parents and youth report feeling comfortable discussing behavioral health issues with their primary care providers.[65] [66] Pediatricians may be particularly helpful in apprising families of a 9-8-8 system as that emerges, and in providing families de-escalation approaches and behavioral health checkups during routine physical checkups. For more complex issues, collaboration and behavioral health support for pediatricians by behavioral health providers has emerged as an effective approach, with improved behavioral health outcomes for youth compared to usual care.[67] The elements most effective for collaborative care include population-based care (systematic efforts to screen or track all patients for a condition and track outcomes), measurement-based care (using validated tools to identify and monitor responses to treatment of particular behavioral health conditions), and evidence-based behavioral health services (specific psychological interventions such as motivational interviewing, problem-solving, psychotropic prescribing, psychoeducation).[68] A guide for initiating collaborative behavioral health care within pediatric primary care has been devised by the American Academy of Child and Adolescent Psychiatry and is freely available on their website (https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf).

Multiple approaches have improved infusion of behavioral health promotion and early intervention into contemporary pediatric care. First, *child psychiatry access programs* (CPAPs) are a "facilitated referral model," (coordinated care model) where pediatricians have rapid (within an hour) access to behavioral health providers located off-site, and who consult to pediatricians about mental conditions, including crises, but do not absorb the direct care of these patients. CPAPs have now been implemented in over 30 states in the past decade. The initial Massachusetts Child Psychiatry Access Program (MCPAP) has remained the model most states now emulate. Initial calls from the pediatrician are immediately triaged by a MCPAP care coordinator who either (a) provides the pediatrician viable behavioral health resources (e.g., a counselor appropriate for the child's condition, who is geographically feasible, and who takes the family's insurance), or (b) connects the pediatrician, within 60 minutes, to a MCPAP child psychiatrist, psychologist, or social worker to discuss the case and plan treatment. While the MCPAP behavioral health provider does not assume care of the child/family, they remain a consultation support for the pediatrician to manage the case, or until care is transitioned, if necessary, to a local behavioral health provider for ongoing treatment. Over 95% of Massachusetts pediatricians participate in the program, and satisfaction with services has remained high since creation of the program.[69] [70] There is now an existing national infrastructure, the National Network of Child Psychiatry Access Programs (NNCPAP) of now 30+ state programs, to support pediatric primary care physicians as they manage psychiatric issues of their patients.[71] These programs initially relied on remote calling centers, but now many include face to face evaluations patients with unclear diagnoses, and also telepsychiatry meetings with patients. In addition, most of these CPAP programs maintain active websites (e.g., www.mcpap.org, www.dcmap.org) with efforts to provide pediatricians effective screening tools for both general and specific behavioral health monitoring, and provide ongoing guides and

recommendations to address common behavioral health concerns. These CPAP programs provide an alternative rapid route for children and families experiencing urgent behavioral health needs, and also an opportunity for mass distribution of relevant mental information (e.g., 9-8-8 information, de-escalation approaches for families) through the NNCPAP network that allows relevant information to be applied to specific regions or States.

Second, co-located models, in which behavioral health clinicians are housed in primary care settings to provide direct care and consultation provide another model where families can be more easily seen by a behavioral health clinician on-site (or virtually by telehealth) familiar and more easily accessible to the pediatrician. Data are promising for on-site co-located behavioral health providers, with reports that 85% of patients follow through to attend their first appointment, and 84% of patients report showing improvement over a 6-month interval.[72] Co-located providers appear effective in diverting patients from visits to the ED; over a six month period, embedded predoctoral psychology interns in one pediatric clinic were able to provide 184 "warm handoffs," 250 same-day behavioral health consultations, 223 follow-up appointments, and to manage onsite 21/23 (91%) patients who reported suicidal/homicidal ideation (and who otherwise would have been referred to the ED for further evaluation).[73]

Community Partners

Schools and primary care providers are parts of most communities and can serve a critical role in crisis prevention and response. Additional important partners for addressing behavioral health care are local community organizations, sometimes unique to the area. Identifying those community organizations that have aligned goals and interests is important for configuring a collaborative behavioral health system, including crisis prevention and response. Multiple types of organizations may enhance the collaborative care system for a community, such as:

- Mentorship programs (e.g., Big Brother/Big Sister)
- After school programs
- Recreation and parks programs
- Youth sports leagues
- Youth and family advocacy organizations
- Faith organizations, youth groups

To create a behavioral health crisis management system for children and adolescents, mapping the local resources to identify important partners can significantly expand local, familiar, trusted supports for both children and families who have experienced behavioral health crises.

Best Practice Considerations for Child and Adolescent Crisis Systems

Consistent with the premise described by SAMHSA that crisis services must be available to **anyone, anywhere, and anytime**, best practices indicate that a child and adolescent crisis continuum should be available 24/7 to all children, regardless of payer[74]. A comprehensive crisis continuum includes screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination. These components, articulated in the 2018 NASMHPD *Making the Case for a Comprehensive Children's Continuum of Care*, align with the 2020 SAMHSA practice guidelines for crisis behavioral health. The guidelines specify

three organizing categories of support that must be embedded in any comprehensive crisis system:

1) Regional Crisis Call Hub Services (*Someone to Talk To*)
2) Mobile Crisis Team Services (*Someone to Respond*)
3) Crisis Receiving and Stabilization Services (*A Place to Go*)

We will describe each component briefly, followed by considerations for how to best fit these to the child and adolescent system context.

Regional Crisis Call Hub Services (*Someone to Talk To*)
Regional crisis call services allow for real-time access to a live person 24/7/365 to support those experiencing behavioral health crises. As of July 2020, the FCC approved a national 9-8-8 behavioral health crisis number, to be fully installed by July 2022, that will increase access to immediate crisis support via this one easily recognized and remembered number. Minimally, regional crisis lines are staffed by clinicians with expertise in behavioral health crises and suicide risk assessment, and who are equipped to triage callers to appropriate mobile teams or facility-based care, as warranted. Best practices call for regional crisis services to have Caller ID functionality, utilize GPS-enabled technology to dispatch mobile care when needed, utilize real-time bed registry data to connect to facility-based care, and schedule community-based follow-up care akin to a warm handoff following the crisis episode.

To meet the needs of children and families in crisis, regional crisis call hub services should consider the following:

- **Expand technology options for callers**, including the use of texting, telephone and telehealth. Children and adolescents may prefer to seek crisis support via texting or videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing.
- Akin to how we begin teaching children about 9-1-1 in preschool, **educate children in preschool and throughout K-12 schooling about how to access regional crisis call services** (e.g., OK2SAY program, https://www.michigan.gov/ok2say/), preferably as part of behavioral health literacy education in the curriculum. Education should emphasize help-seeking efficacy and destigmatizing of mental illness and seeking support.
- All regional center calls pertaining to child and adolescent concerns should be staffed by individuals with **specialized training in child and adolescent development and behavioral health and illness**. This would include an understanding of typical developmental milestones, how to promote positive behavioral health, and how to distinguish typical challenging behaviors of childhood and adolescents from behaviors that reflect a more serious concern. They should be familiar with child behavioral health and developmental disorders and behaviors or symptoms that differ from those experienced by adults, including autism, sensory processing disorders, developmental delays, separation anxiety, and Attention Deficit Hyperactivity Disorder. See Table 1 for examples of common behavioral health concerns among children and adolescents and how they might be presented during a crisis call.

- Call center staff should have **skills to navigate family systems** during crisis call, including how to diminish conflict and increase safety, engage additional support people, and determine whether speaking with the child or adolescent in crisis will be useful for information gathering and de-escalation. These skills would include how to best engage families as co-supporters and experts about their child, when possible, and addressing any parent/guardian concerns about child safety, including family concerns about being reported to protective services or law enforcement if they seek help.
- Call centers should have **developmentally attuned guidance for de-escalating children and adolescents** and their family members, as needed. This may include how to support family and school personnel in managing conflict and behavior dysregulation, and how to separate, support, and/or distract a child experiencing a crisis.
- All calls should be delivered in a **culturally responsive manner**, with call center staff receiving ongoing training on racism and bias, and the unique strengths and needs of Black, Indigenous and People of Color (BIPOC) youth and families, and how those intersect with behavioral health crises. Interpretation services should be made available to the extent possible (see Pinals, Edwards, 2020)[75].
- Call center staff should have training in **adolescent reactivity to peer rejection or romantic breakups**, both predictors of suicidality and risk behavior.
- Given the high risk for suicide, bullying, substance use and other behavioral health concerns among **LGBTQ+ children and adolescents**, call center staff need to be versed in supports responsive to this population.
- Call center staff need to be **familiar with school-specific concerns** such as chronic absenteeism or school refusal, aggression and bullying (including cyberbullying) in schools, and emotional and behavior dysregulation that disrupts the school environment, and how these may best be managed in the school setting.
- Call center staff should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Developmental Differences Manifest Differently in Youth

Approximately 75% of behavioral health conditions begin before adulthood. Crisis responders need to be aware of how youth may describe symptoms compared to adults. For example, young children rarely describe being "anxious" or "depressed," but may instead complain of physical ailments, often week after week, as they may only notice that they feel badly rather than understand why. Youth with depression are often more likely to report feeling angry or irritable than to report feeling depressed or sad, and may stop doing previously enjoyable activities (e.g., riding a bike, playing a sport, etc.) when they become depressed.

In addition, some behavioral health symptoms more commonly occur in youth, and result in crises, such that crisis responders require specific child behavioral health training to be prepared to recognize underlying conditions that may result in a behavioral health crisis. Table 1 describes how parents/guardians may describe a current crisis to a 9-8-8 phone responder.

Table 1: Behavioral health Symptoms Presenting as a Crisis in Youth

Behavioral health Category	**How This May Present as a Crisis Call to a 9-8-8 Phone Responder "My Child:"**
Autism	"doesn't speak or look at me or seem to want to engage." "won't listen or respond to me." "freaks out if we don't do our usual schedule or change our plans" "doesn't play or show any interest in other children." "freaks out over normal noises." "does weird stuff with toys instead of playing with them." "just wants to swing or rock for hours and won't stop."
Anxiety	"won't go outside, worries about everything." "won't be apart from me, wants to know where I am." "describes having bad dreams every night and comes to my room."
Attention Deficit Hyperactivity	"doesn't think before doing dangerous, foolish things." "refuses to listen to me and do what I ask." "runs into the street or jumps off high places."
Communication Disorders	"is making stuttering sounds." "got into another fight with a peer today because of misunderstanding."
Conduct	"is stealing/shoplifting/vandalizing, assaulting others." "is lying and I can't take it anymore." "is staying out late, disobeying my rules." "is hiding guns/knives/bullets in room." "hurt our family pet/set a fire for no reason."
Disruptive Mood Dysregulation	"is having horrible meltdowns over nothing every other day." "is in a bad mood all the time and can't calm down for hours."
Elimination Disorders	"is peeing all over the place; keeps wetting the bed after told not to." "is leaving poop under the couch; won't clean self after pooping."
Feeding and Eating Disorders	"will only eat a few things." "eats weird stuff—like dirt or hair" "refuses to eat because they'll get too fat." "will eat but then do things so they'll throw up."
Intellectual Disability	"isn't doing or keeping up with schoolwork." "isn't doing what other kids their age."
Learning Disorder	"hates school and refuses to do math/reading/writing assignments."
Movement Disorder	"is making weird movements with arms/legs/mouth/head." "is suddenly now blinking all the time/making weird noises uncontrollably."
Obsessive-Compulsive Disorders	"does this long ritual before they will leave home and freaks out if interrupted." "has pulled all their hair out over the weekend." "has hoarded all kinds of food into a closet, and it's all rotting now."
Somatic Disorder	"keeps saying they have a stomach/headache, refuses to walk." "is very sick, eyes rolling back in their head, and no one believes me."
Traumatic Disorder	"won't stay with a sibling alone at night in a room." "keeps avoiding my relative, who they used to like." "has bad dreams often and will scream or come to my room."

Mobile Crisis Team Services (*Someone to Respond*)
To respond to crises as they occur, mobile crisis teams that offer community-based interventions must be available to support individuals in crisis wherever they are, including home, school, or any other community location. Two-person teams are preferred, with diversion from emergency department or the justice system preferred. Minimally, mobile crisis team services must include a licensed and/or credentialed clinician who can respond wherever and whenever a crisis occurs. This can include home, stores, schools, offices, streets, and even juvenile courts outside of a locked facility in some states. The team will conduct warm hand-offs to facility-based care as needed and coordinate transportation if the situation warrants location transition. Best practices call for peer support (i.e., those with direct experience with the behavioral health system and who are trained to support individuals in crisis) as part of the mobile crisis team to decrease engagement of law enforcement. As above, mobile crisis teams should partner with the regional crisis call center to utilize GPS-enabled technology.

To meet the needs of children and families in crisis, mobile crisis team services should consider the following:

- **Expand technology options for crisis response teams, including the use of telehealth**. Children and adolescents may prefer to engage in crisis support via videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing. In addition, telehealth may allow for broader access and improved response time and efficiency.
- For all crises pertaining to child and adolescent concerns, mobile crisis team members should be staffed by individuals with **specialized training** (as outlined above for call responders) including training in:
    - child and adolescent development and behavioral health and illness, including manifestations of child traumatic stress (e.g., difficulties at school, withdrawal);
    - skills to navigate family systems, including how to diminish conflict and increase safety, engage additional support people, and how to best engage child and family in a developmentally appropriate manner to gather information and de-escalate crisis;
    - the escalation cycle across the developmental spectrum, and developmentally attuned de-escalation skills, including approaches like collaborative problem solving and specific strategies (e.g., validate feelings but not actions; see Box 2 for specific child-specific de-escalation strategies from The Crisis Prevention Institute, https://www.crisisprevention.com/).
    - culturally responsive crisis management, including skills in supporting the unique strengths and needs of BIPOC and LGBTQ+ youth and families;
    - assessing for child abuse, neglect and family violence and supporting families if a report to child protective services is warranted;
    - assessing parent readiness and ability to implement recommendations and interventions, with consideration for parental behavioral health, cognitive ability, social supports and stressors and economic resources.
- Mobile crisis team members responding to child and adolescent crises should be **familiar with school-specific concerns and school procedures to support students with emotional and behavioral needs.** Team members should be versed in the special

education process, including how families can access and advocate for special education programming (e.g., 504 Plans and Individualized Education Programs).

- Mobile crisis team members should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Box 2. 18 De-escalation Strategies for Children and Adolescents

1. Don't yell to be heard over a screaming child
2. Avoid making demands
3. Validate their feelings, not actions
4. Don't try to reason
5. Be aware of your body language
6. Respect personal space
7. Get on child's level
8. Use a distraction
9. Acknowledge child's right for refusal
10. Reflective listening
11. Silence
12. Be non-judgmental
13. Answer questions and ignore verbal aggression
14. Movement break
15. Avoid the word "no"
16. Decrease stimulation
17. Deep breathing exercises
18. Calming visuals

Crisis Receiving and Stabilization Services (*A Place to Go*)

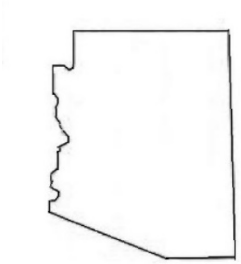
During a crisis, it is essential that individuals have a place to go that will accept, support and stabilize them regardless of age or clinical condition. Crisis receiving and stabilization services act as a "no wrong door" mechanism for those in crisis to receive immediate behavioral health support and offer our de-facto crisis responders (i.e., law enforcement, emergency departments) a more appropriate alternative to address crisis. Minimally, crisis receiving and stabilization services accept all referrals (including walk-in and first responder drop-offs), do not require medical clearance prior to admission (but offer medical support, as needed), design services to address mental health and substance use needs, offer 24/7/265 multidisciplinary staffing capable of meeting all levels of crisis and screening for suicide and violence risk, when clinically indicated. Best practices dictate functioning for a 24 hour or less facility with a dedicated first responder drop-off area, incorporation of intensive support beds (including those within the real-time bed registry system), and coordinate connection to ongoing care.

To meet the needs of children and families in crisis, crisis receiving and stabilization services should consider the following:

- Children and adolescents should have **a separate area from adults** to be received and supported during crisis. It can be distressing and frightening to young people to witness adults in crisis, increasing the likelihood that the child's crisis will escalate rather than diminish. The climate of receiving and stabilization needs to be calming, positive, welcoming and compassionate.
- **Receiving spaces should be developmentally attuned**, with places to play and move safely, especially for younger children. For adolescents, who may be particularly concerned about the stigma of seeking help, spaces that allow privacy are optimal. The environment should be calming aesthetically and include art and signage that is appealing and friendly to youth, and not overstimulating.
- **Telehealth should be available for care provision and engagement of supportive others.** Children and adolescents in crisis may prefer to see providers via videoconferencing, also expanding the capacity for access to limited child behavioral health specialists. Telehealth technologies can be used to integrate other support important in the care process, including school personnel, family members, peers, or primary care providers.
- For all crises pertaining to child and adolescent concerns, crisis receiving and stabilization services should be staffed by individuals with **specialized training** in child and adolescent development and behavioral health (as outlined above for call responders and mobile crisis teams).
- **Medical staff must have training in child and adolescent health** to ensure developmentally appropriate, high-quality medical care, as needed. If pediatric or child psychiatric providers cannot be available on-site, telehealth may be utilized as a mechanism to ensure 24/7/265 pediatrician and child psychiatry consultation.
- Crisis receiving and stabilization services must have **spaces for family support and gathering**, both to immediately support the child in crisis and to provide a space for separation and parental/guardian support, as needed. Families should be offered comfortable places to stay with children, including places for rest for young children, access to snacks and developmentally attuned activities.

Three vignettes are provided in **Appendix A** that describe example circumstances with varied system responses during child and adolescent crisis situations. These represent a small sampling of the crisis situations that present during childhood and adolescence but are illustrative of the unique considerations that arise during each stage of crisis response, from call to stabilization.

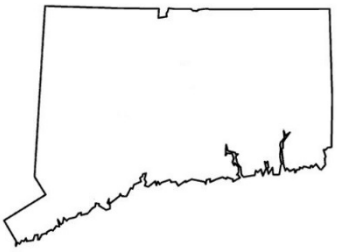
Examples and Outcomes of Child and Adolescent Crisis Response Systems



Arizona: Crisis Response Center (CRC)

In 2006, county bond funds supported the development of the Banner-University Medicine Crisis Response Center (CRC), serving adults and children in Pima County, Arizona. The CRC was initiated to provide support to those in need of urgent psychiatric care and to reduce the number of individuals with behavioral health needs in emergency departments or the criminal justice system. In addition to a 24/7 Behavioral Health Crisis Line that can dispatch GPS-tracked mobile crisis teams and manages an electronic bed placement board, the CRC offers a peer-operated warm-line staffed by trained peers who, as described on their website, "provide a friendly voice, support and help to alleviate loneliness and isolation."[76] They also offer a Tribal warm line, supported by the American Indian Support Service. The CRC serves approximately 12,000 adults and 2,200 children annually, with 45% brought directly by law enforcement via a secure gated sally-port and 10% are transported from emergency departments. Adults and children are served in distinct, separately licensed areas of the facility. The CRC is connected to a Level II trauma emergency room, a 66-bed Behavioral Health Pavilion, and the mental health court. Between 2015-2019, the CRC had an 8% increase in adult visits and a 24% increase in youth visits. Increasing numbers may reflect growing awareness of the service, including among law enforcement who now have a more sophisticated option than waiting hours in an emergency department, and may also reflect the limited options to prevent crises before they occur.

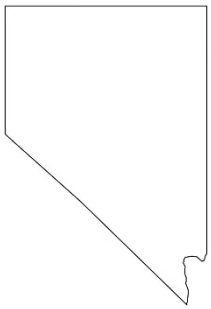
Connecticut: Mobile Crisis Intervention Services



Connecticut's Mobile Crisis Intervention Services (formerly called EMPS) is available at no cost to all youth in the state under age 18. A single statewide call center, currently accessed by dialing 2-1-1, deploys providers to the crisis location. The providers are comprised of 160 trained behavioral health professionals from 14 different sites, allowing for on-site response within 45 minutes of when a child experiencing a behavioral health need or crisis. Mobile Crisis provides ongoing care to youth and families for up to 45 days to offer stabilization and linkages to ongoing behavioral health support.

Since data collection began in 2011, the number of Mobile Crisis response episodes of care increased by 54%, with 14,585 episodes in 2018 alone. For two consecutive years, schools have provided the greatest proportion of referrals to Mobile Crisis (44.3% in 2018). Schools often use Mobile Crisis as an alternative to transporting a child to the Emergency Department or contacting law enforcement. A recent study demonstrated that over a period of 18 months, youth using Mobile Crisis had 25% lower emergency department use than a comparable group[77]. Most (88%) of parents or guardians report satisfaction with Mobile Crisis and 2018 data demonstrate significant decrease in problem severity and increase in functioning among youth who received Mobile Crisis[78]. Evaluation of Mobile Crisis has demonstrated significant cost savings, with the

average cost of an inpatient stay for Medicaid-enrolled children and youth being $13,320, while the cost of Mobile Crisis was $1,000, saving $12,320 per youth[79].



Nevada: Children's Mobile Crisis Response System Rural Team
In November 2016, the Rural Mobile Crisis Response (RMCRT) team of Nevada began taking calls. By September 2017, the RMCRT had served 243 youth and families across Rural Nevada; 86 percent of youth were successfully diverted from the hospital. Initially funded for three years through the State's Division of Child and Family Services, the Department of Public and Behavioral Health Rural Clinics received a budget enhancement during the 2019 legislative session to grant continued funding through Fund for a Healthy Nevada (allocated from tobacco settlement monies to help with services that address the health and well-being of all Nevadans). Call volume has increased in recent years, and in 2017, the RMCRT reported a Hospital Diversion Rate of 86%. The rural team intends to expand coverage using telehealth and has already equipped many of its rural schools, hospitals and Juvenile Detention Centers with the telehealth program the RMCRT uses for interventions, allowing for more efficient crisis response.

Crisis Lessons and Innovations from COVID-19

COVID-19 has disrupted the delivery of behavioral health care across the globe. Data also points to an anticipated surge in behavioral health care needs related to the pandemic, including for children and adolescents who are suffering the burdens of family financial insecurity, caregiving load, and social isolation during a time of limited access to supports [80] [81]. Past pandemics, such as the Influenza of 1918, 2009 H1N1 flu, and the 2014 Ebola virus all were associated with increases in depression, anxiety, stigma, and shaming.[82] Longitudinal negative impacts of other large-scale community crises (e.g., natural disasters) on children's behavioral health and academic functioning have also been well documented [83] [84]. These tragic events, though, also led to significant transformations in behavioral health care.[85] There are many lessons and innovations from the global response to COVID-19 that can guide us as we reconstruct our children's crisis system.

1. **COVID-19 has further illuminated disparate inequities in our health, education and economic systems and the resulting toll on youth behavioral health.** COVID-19 has disproportionately impacted non-White racial and ethnic groups [86] [87] [88]. Social determinants of health, including systemic racism, poverty, and inequitable access and quality of healthcare and education, have historically prevented BIPOC individuals from having equal economic, physical and behavioral health. Children suffer the same disparities, which during and following crises are compounded by their limited ability to independently mobilize resources and supports to buffer the negative impacts [89]. COVID-19 is expected to worsen the inequities in health outcomes for those living in poverty and in resource-poor rural communities across the United States [90].The disparate increases in unemployment and economic burden from COVID-19 in poor regions and in communities of color alone will be detrimental to children's mental health. Golberstein and colleagues found a striking 35% to 50% increase in "clinically meaningful childhood mental-health problems" during a 5-percent-age-point increase in national unemployment

during the Great Recession (2007 to 2009) [91]. Given unemployment rates of over 11% in August 2020 compared to less than 4% in January 2020, and that the increase is in the context of a health crisis and school closures, the mental health impact on children is likely to be even more severe than past trends, particularly in communities that are harder hit. In addition to greater density of family and community members inflicted with COVID-19 in communities of color, resulting in greater behavioral health consequences, youth of color are much less likely to have access to behavioral health support and at greater odds of receiving poor quality behavioral health care [92]. Children living in rural areas are also more likely to have more negative COVID-19-related health outcomes and limited accessibility, availability and acceptability of behavioral health services [90 93].

The profound inequities highlighted during COVID-19 have implications for how we build crisis response systems for children. Namely, children's behavioral health crises must be viewed within the context of the child's family and neighborhood/community and influenced by social and environmental factors. As such, these factors must be both assessed and addressed during crisis response, rather than simply focusing on the individual child or attributing crisis behaviors to individual psychopathology that can be treated at the child level [94]. In addition to assessing for and addressing social determinants of health during crisis response with children and families, our systems must act as "health strategists," addressing the social determinants that contribute to the development of behavioral health crises in the first place [95]. Recognizing the anticipated long-lasting impacts of COVID-19 on marginalized communities, Shah and colleagues (2020) called for our public health departments to think beyond individual interventions and to foster cross-system partnerships, with public health departments in the lead, to develop broad social supports (e.g., financial assistance, microloan programs) to assist those most vulnerable [90]. So too must our children's behavioral health systems consider the broader interventions that may prevent and address crises by integrating supports for accessible and culturally responsive healthcare, food, housing and educational support.

2. **EDs are not suited for youth mental health or substance use crises, and broad community awareness campaigns and education can route children and families to more appropriate avenues for support .** Many families with children experiencing significant psychological deterioration in the context of COVID fear increased exposure risk by going to the ED. This has further highlighted the need for creating more appropriate places for children in crisis to go and has resulted in public awareness efforts to triage families to other community-based settings, including telehealth options. This type of re-routing of families from the default of the ED as the first point of entry during a crisis can be facilitated by the establishment of the 9-8-8 crisis line. However, the 9-8-8 system alone will not be sufficient to alter families' patterns of service utilization. Awareness campaigns can direct youth and families to trusted internet and social media sites as escalating events and crises do arise, providing de-escalation and help-seeking information and encouraging more appropriate pathways to support and care. During COVID-19, the Centers for Disease Control, the World Health Organization, and other health organizations regularly provide updates and guidance across multiple social media platforms, and these platforms similarly reciprocate by routing those seeking new, more specific information to the CDC and WHO sites,[96] and this similarly should be

envisioned and configured with appropriate behavioral health crises sites. In addition, public health information to address behavioral health crises (e.g, the 9-8-8 number, noticing if others are struggling, de-escalation techniques) can be added to existing user platforms, including through banners, pop-ups, and other such tools to directly message users about preferred approaches for managing behavioral health difficulties. This may include chatbots for basic psychological first aid and geotargeted sites for crisis services based on one's location.[97]

3. **The rise in risk coupled by a decrease in reporting of child abuse and neglect during COVID-19 highlighted the need for accessible mechanisms for youth and families to directly access crisis support.** Many children during COVID-19 are at increased risk of abuse, neglect and exposure to family violence.[98] Calls to protective services have decreased during stay-at-home orders, likely due to schools being closed and traditional monitoring systems not being intact [99]. By providing children and families with an accessible way to get help when they are in distress (e.g., by educating them about 9-8-8 and supports that are youth- and family-centered), exposure to adverse childhood experiences may be reduced or prevented. Further, youth and families will benefit from behavioral health literacy efforts that educate them about how to obtain and sustain positive mental health, recognize and seek help for mental health problems, and identify and support others experiencing mental distress. Recognizing the tremendous burden on families during COVID and the increased risk of child abuse and neglect, many organizations have mobilized to provide education and support to families to reduce risk. For example, the Child Mind Institute (https://childmind.org/coping-during-covid-19-resources-for-parents/), a national nonprofit, offers online learning, outreach, and resource support to families including tips for parent self-care, strategies for remote learning and discipline, skills for responding to children's mental health needs. Even prior to COVID-19, behavioral health literacy efforts for children and adolescents were increasingly implemented via school curricula, with several states (e.g., Florida, New York, Virginia) recently mandating the inclusion of mental health literacy in schools. For example, New York schools are required to integrate four key mental health literacy components into students' education [100]: 1) Understanding how to obtain and maintain good mental health; 2) Decreasing stigma related to mental health; 3) Enhancing help-seeking efficacy (knowing when, where, and how to obtain good health with skills to promote self-care); and 4) Understanding mental disorders (*i.e.,* anxiety and depression) and treatments.

4. **Telehealth services are needed, feasible, and often preferred by youth and families.** The paradigm shift in children's behavioral health crisis systems calls for significant expansion of telehealth technology. During COVID-19, behavioral health systems witnessed a dramatic increase in the utilization of telehealth to support the behavioral health needs of children and families. This occurred with federal, state and local infrastructure support, policy adjustments to ease use, and technical assistance and training to providers and consumers [101] [102]. A transformation of our children's crisis system toward robust telehealth capacity will require continued infrastructure improvements (e.g., enhanced broadband systems, up-to-date telehealth delivery equipment, internet connectivity services for providers and consumers); policy expansion

(e.g., reimbursement parity for telehealth, expanded access of Medicaid and Children's Health Insurance telehealth programs); and ongoing guidance and support to providers and families to increase adoption and facility of telehealth services [80] [103]. Policy must move toward parity such that state parity laws guarantee comparable payment for telehealth at the same rate as in-person services (i.e., reimbursement parity). Prior to COVID-19, only five states had implemented telehealth parity laws, and while 21 states expanded telehealth services during COVID-19, only 13 required parity. We must continue to evolve in this area and consider how to best integrate telehealth at all levels of the crisis system. As demonstrated during rapid adoption of telemental health during COVID-19, funding must be dedicated to both clinician and user training and to improving the infrastructure (e.g., hardware, software, internet access) necessary for successful telemental health practices [103].

During COVID-19 and beyond, child and adolescent mental health services traditionally provided in-person, including crisis services, may be shifted to telehealth, allowing youth and families to access support while minimizing health risks and other burdens of in-person care. As illustrated in Box 3, telehealth has already improved crisis response efficiency and outcomes for children and youth [104]. It is important to recognize that rapid shifts to telehealth may inadvertently increase health disparities, as people with less income may not have consistent access to the internet or devices. Increasing access to the internet, ensuring that resources are accessible to individuals with disabilities, and providing free or low-cost devices may help to address this problem. Further, given that so many children and families access behavioral health services through schools, it will be essential for school-based behavioral health providers to become facile with and be supported to use telehealth services

Box 3. To address the absence of child and adolescent behavioral health specialists in EDs, the Children's Hospital of Colorado used telepsychiatry to link the specialists at its central academic medical center to pediatric EDs and urgent care centers in the Denver area. The goal was to improve care and decrease patient transfers to the main campus. Children and youth who received the telehealth consultations, when compared with those receiving usual care, had ED lengths of stay that were 2.8 hours shorter, patient charges for care that were more than 40% lower, and higher satisfaction with services among ED providers and the patients' caregivers.

5. **COVID-19 has illuminated the need for flexibility and innovation to provide effective care amidst different public health parameters.** Across all tiers of support, from universal mental health promotion to treatment for mental illness, behavioral health supports have been adapted to meeting the changing landscape of mental health needs resulting from the pandemic and its sequalae and to conform to the necessary adjustments in service delivery. The innovations in behavioral healthcare during COVID-19 point to the importance of a nimble system during community crises, and to the importance of crisis systems being similarly equipped to adjust as needed to changing public health parameters. For example, at the universal (Tier 1) level, addressing prolonged loneliness

experienced during COVID-19, a risk factor for multiple behavioral health conditions, requires that not only everyone retain some contact virtually with others (e.g., school, peer activity networks), but also that teachers, coaches, mentors, and other supportive adults directly reach out to young people weekly, as employers are now being encouraged to do with each worker. [105] Video and voice interactions will be needed, particularly for children often too young to shift to a more written or texting type intervention. At the selective intervention (Tier 2) level, the lack of direct contact and access will require modifications in screening and responding to early signs of distress. Nontraditional groups (e.g., parenting groups, teachers/school staff, community organization members) may be provided familiarity with a simplified version of psychological first aid and specific questions or approaches to check in with children, which historically may have been done with a more standardized program designed for more highly trained clinicians (but now insufficient or inaccessible) At the intensive intervention (Tier 3) level, different counseling models will be better suited to evolving public health circumstances; for example, written counseling has been described as effective to address needs for those who may not have access to telehealth equipment or resources[106]. Novel approaches mindful of new public health constraints (e.g., changes in shaking hands/greetings, going to an office) should be monitored for applicability to crisis management as well.

6. Finally, even with brick and mortar schools closed, **schools remain a hub for a full continuum of behavioral health supports for students and their families**. Of children in the United States who receive any behavioral health care, over half receive care at school, and this is even greater for youth of color or living in poverty. [107] During COVID-19, schools mobilized to continue supporting students' nutritional, educational and behavioral health needs. While rates of community behavioral health access dipped during COVID-19, school support personnel and school-based mental health clinicians continued to provide needed behavioral health support, often via telemental health. Our children's behavioral health system should leverage schools as a place to support social emotional health, and to practice early identification and intervention, including crisis response. Parallels from Hurricane Katrina to COVID-19 also illuminate the need to ensure that beyond the supports for students and families, our behavioral health and education systems must attend to the ongoing needs of educators and other school staff as they work to support students' behavioral health.[108] Guidance from the Centers for Medicare and Medicaid Services and SAMHSA offers states ideas and examples for how state Medicaid programs can increase and improve school mental health service delivery and several states and local communities have leveraged school-community partnerships to improve children's behavioral health systems. [109] [41]

Conclusion

The stage is set to reimagine the child and youth crisis prevention and response system given the limitations of the existing system, burgeoning innovations in youth mental health, and lessons learned amidst the current global pandemic and increased attention to longstanding social injustices. As community behavioral health crisis policies and practices are established, the unique needs of children and families must be considered across the developmental spectrum and across communities and cultures, always addressing issues of equity and racism. The vision must include promotion, prevention, early identification and intervention available through natural

supports like schools, primary care, and other community partners (e.g., afterschool programming, faith organizations) and through expanded technologies, including telehealth. The opportunity to shift the paradigm for how we build and implement children's crisis response systems is within our reach and will require thoughtful leadership and advocacy, significant policy and financing support, and active engagement of youth and families to shape the supports they will receive.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

Appendix A: Vignettes

The roles of the (a) Call Responder, (b) Mobile Crisis Team, and (c) Receiving and Stabilization Services are described below, and then applied to each vignette:

Call Responder: (1) **clarify safety**: is this new/unusual (possible poison ingestion), or abuse/trauma reaction; (2) **identify impacts** across multiple spheres of life: does the child do this everywhere, or only at home, around certain people (3) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; and (4) **offer parent support/appropriate de-escalation strategies** (see Box 2); clarify if parent receptive to speaking with a behavioral health provider, if telehealth visit acceptable.

Mobile Crisis Team: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, both (a conflict between them), and/or other (e.g., school staff, peers); (2) **observe/speak** with the child to clarify potential behavioral health conditions that best explain behaviors; (3) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; and (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance, further evaluation (medical or behavioral health))

Receiving and Stabilization Services: (1) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; (2) Clarify if **ongoing parent/child/family support services** are needed (e.g., speech therapy for social pragmatics, autism program at school); and (3) **identify where these services might best be provided** (considering feasibility and accessibility for family).

Angel is a 4yo, whose parent calls 9-8-8 reporting "my child refused to eat dinner tonight and started screaming uncontrollably. My child isn't like other kids and I'm scared; doesn't talk to anyone, just sits in a corner, no facial expression, and freaks out if touched or asked to eat anything other than uncooked macaroni. I think something is really wrong and I don't know what to do."

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by distinguishing whether this circumstance is a new-onset, sudden deterioration (suggestive of poison intoxication, traumatic events, or an underlying medical condition) vs. an ongoing, worsening pattern (suggestive of autism spectrum or chronic trauma). The **CR** might further (2) **clarify impacts**, such as if these behaviors occur everywhere, all the time, with peers, family, and at preschool (suggestive of autism spectrum or general developmental or social skill delays) vs. only in certain settings and times, such as when visiting particular relatives (suggestive of trauma). The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, which might be that the child is being treated differently than other children, that relatives have expressed concerns, or that the parent may be doing something to contribute to these behaviors; inquiry about the child may reveal whether the child is distressed by any of these behaviors, or instead preferring to be apart from others to do preferred activities. The **CR** may (4) **provide some immediate de-escalation** to this event by reviewing the history of these behaviors ("these are not new, but are now more concerning, so it seems you want someone more familiar with this to

partner with as you decide your next steps") and inquiring whether the family would like to speak with someone immediately about the behaviors Angel is displaying, including offering videoconferencing as an option for communication.

In Angel's crisis, the **Mobile Crisis Team (MCT)** uses telehealth technology to connect via videoconference (which the family preferred over an in-person visit) to (1) **elicit descriptions** from the parent about the evolution of these behaviors, who in the family seems most distressed or impacted by them; (2) **observe/speak** with the child to clarify potential behavioral health conditions (e.g., trauma, autism spectrum, anxiety and selective mutism) that best explain this child's unique constellation of behaviors; (3) **understand this unique family's perspectives and their goals** (parents might ask " Is this because we did something wrong?" "We don't know who can evaluate these symptoms to help us figure out what to do at home," or "Does Angel need a special school?" "What should we do right now about Angel only eating macaroni?") and (4) **clarify interventions needed now** to improve/resolve this crisis (e.g., parent support and guidance about trying some different types of food, engaging around activities/play to see if that increases interaction and communication, and partnering around the process to obtain further evaluation, medical or behavioral health, including potential fears (parents might ask "Will I get turned in to Child Protective Services or will Angel be taken away if we talk with someone?") or perceived obstacles ("I don't know what to do, or if I can do it; I don't have insurance to do any further evaluations, and they'll just blame me for all this…like they did before")). In this case, the **MCT** used videoconferencing to engage a pediatric specialist who could discuss some of the family's concerns and better assess Angel's behaviors. Angel and her family were routed by the **MCT** to a community-based assessment and intervention program with a pediatrician to clarify the diagnosis, to partner with the school to provide evaluation for additional needs (such as speech, occupational therapy, etc.) and to create a plan to be delivered through the preschool to address behaviors.

If Angel's behaviors continued to escalate or the family requested respite and immediate in-person support, the **MCT** may have referred them to **Crisis Receiving and Stabilization Services (CRSS)**. In this case, **CRSS** providers, including specialists in child development, might (1) **seek to understand this unique family and youth's perspectives and their goals** (parents might describe fears that Angel will escalate to doing harm to self or others, or that others in the family are frustrated and likely to lash out aggressively toward Angel, such that safety becomes an issue; e.g., "My other children, and I, are freaking out—we're afraid Angel may try to hurt herself while we're sleeping"); (2) clarify if **ongoing parent/child/family support services** are needed (e.g., family education and respite, parent peer support, child diagnosis and intervention), and (3) **identify where these services might best be provided** (e.g., other family members to stay with if the family is currently overwhelmed or concerns of traumatic conditions are present, local family support chapter for autism, pediatrician specializing in autism and developmental disorders).

Lin is a 7yo, whose parent texts 9-8-8, distraught that the child would not get out of the car to go into the school since the beginning of this school year; usually the child will scream and cry when approaching the school; when brought to the school other times, the child will describe physical symptoms so that the parent will be called and come get the child; today the child was cursing and biting at the teacher who was trying to walk the child into the school; the school

threatened to report the child as habitually truant if the parent cannot get the child to come and stay at school.

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by addressing whether Lin is actually trying to harm others (e.g., the teacher(s)), describes plans or obtains "weapons" to harm anyone, has specific people at home, at school, or elsewhere that frighten Lin such that Lin seeks the protection of family and to avoid a perhaps past traumatic situation (suggestive of posttraumatic stress), or if there are consistent physical symptoms that may suggest an underlying, perhaps new, medical condition, or if Lin has consistently each year avoided separating from family to attend school or other seemingly safe, desirable places (suggestive of separation anxiety), The **CR** might further (2) **identify impacts** across multiple spheres of life, such as how often these events occur, whether parents are able to transition Lin to school most days or to separate to be with others, and which people (e.g., parents, caregivers, certain school staff) are most engaged in this situation, and how long these episodes involve these other people, and how Lin is progressing academically and socially at school. The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as threats that the police or child services may be called if Lin does not transition into school, that the parent doesn't know what else to do and thus seeks help and support, the family fears school reporting may result in all children being removed and thus want Lin out of the home now, etc. The **CR** might (4) **offer parent support/appropriate de-escalation strategies** by helping the family preview separations to go to school, provide distracting options for Lin such as listening to music while driving to school, etc.), and to offer consultation or teleconferencing with a **Mobile Crisis Team (MCT)** to help devise alternative strategies (e.g., helping Lin transition to familiar others (staff and possibly peers) when Lin arrives at school to make these transitions less stressful) as well support the family as they address their fears about school reporting them.

In Lin's crisis, the **MCT** might initially have a phone call to demonstrate support for parent and address fears of reporting to the police/child services, and then as trust is created engage in a videoconference to (1) **elicit descriptions** from the parent about what Lin seems to "gain" by these episodes (e.g., get to go back home to be with a parent, avoid some person or activity disliked at school), how these episodes impact the parent(s) (Parent may say "yes, I have to stay home now to care for Lin, which isn't so bad since I hated my job anyway," or "I've had many problems with the school staff there---they have reported me multiple times with multiple of my children over the years, so this is just another way they try to get us to move."): (2) **observe/speak** with the child to discern if this sounds new and acute to suggest a traumatic origin, or if this seems more like ongoing separation anxiety (even if a repetition of what has occurred at the beginning of new school years), or some other behavioral circumstance (Lin might say "I need to be home with my Mother as she's sick" ("or needs my help taking care of my Grampa," etc.): (3) **understand this unique family's perspectives and their goals** (parents), which might include parental fears of being turned in, the police arriving and scaring other family members, fears of betrayal and distrust given past experiences with the school, and parental aspirations to get the school to be more understanding and partnered with the parents around these events or alternatively to compel the school to place Lin in a different school); and (4) **clarify interventions now needed** to improve/resolve this crisis, such as collaboration with the school to understand the school's experiences or concerns so that a different, more collaborative plan between home and school can be initiated to ease transitions, school options

for gradually getting Lin to transition fully (all day) into school (which might include some interval of virtual school so that Lin becomes more comfortable with new teachers and peers)..

If Lin continues to be threatening to others at school or at home, or the parents fear that others in the family may get angry or aggressive toward Lin, then **Crisis Receiving and Stabilization Services (CRSS)** may be needed to (1) **better understand this unique family and youth's perspectives and their goals** to manage Lin's behaviors and eliminate aggression during school transitions, which might include family interviewing and then supportive or focused counseling (e.g., parent previewing, calm management of Lin's escalations, problem-solving techniques and practice with family to prepare for transitions, and anxiety reduction techniques for Lin) at the CRSS site; (2) clarify if **ongoing parent/child/family support services** are needed (e.g., school-based behavioral health services to target the source of transition behaviors via skill development and/or trauma treatment); and (3) **identify where these services might best be provided** (e.g., feasible practices for the family to do differently, the possibility of implementing promptly a school program with preferred school staff or peers to improve the magnetism of school for Lin and to simultaneously make home more "boring," so that Lin is more motivated to transition to school).

Devon is a 14yo, whose parent contacts 9-8-8 after finding a bag of "weed" in Devon's room and confronting Devon; Devon became livid, asked why the parent was "in my stuff," and ran out the door, breaking a lamp on the way out, saying "I don't want to live like this anymore."

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by asking family if this is a new/unusual explosive event, or recurrent ("has Devon had other episodes or signs of substance use, has Devon made threats, tried to harm self/others before" and directly address Devon's comment by exploring "what did "I don't want to live like this anymore" seems to suggest today?" to parents, or others present or who may have heard similar comments from Devon before, and which may have included descriptions of self-harm plans/acts, or preparations to gather weapons, write suicide notes, etc.). The **CR** might (2) **identify impacts** across multiple spheres of life: the CR might inquire about whether Devon explodes or "takes off" everywhere, or only today at home? and how Devon's functioning with school, peers, and parents has changed in recent months). The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as parental fears that Devon's substance abuse is now problematic, fears that others involved with substances may come to their home, and fears that any discussion of this with others may lead to police searching their home. The **CR** may (4) **offer parent support/appropriate de-escalation strategies**, such as ensuring that Devon is now in a safe place with trusted others, and plans by parents for addressing this situation (parents may say "we want him to return but he has to get rid of the weed and not bring it into our home again," or "we want Devon to go away now for treatment---this has been going on for too long—he cannot come back right now"), and clarify if parents are receptive to speaking with a behavioral health provider, including by teleconference, to identify next steps to locate/find Devon, and determine appropriate next steps.

In Devon's crisis, the **Mobile Crisis Team (MCT)** might speak with family to: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, or both (a

conflict between them), The **MCT** might then text or phone Devon to (2) **observe/speak** with Devon to clarify potential behavioral health conditions that best explain the episode at home (from depression to substance use ("I don't want to live like this anymore" could refer to some ongoing situation or stressor, from bullying to gender or sexual identity concerns, to ongoing substance or legal problems, etc.). From both family/others and Devon, the **MCT** may be able to (3) **understand this unique family's perspectives and their goals**, which might include parental fears of Devon harming/stealing from parents, police involvement and fear of arrests, family fears of Devon being unable to control substance use and significant deteriorations observed, as well as Devon's fears of being misunderstood, overreactions to rare marijuana use that has not been associated with deteriorations in functioning, etc. Based on information from both family and Devon, the **MCT** would speak with parents and/or Devon to (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance to reach and deescalate conflict with Devon, steps to address Devon's substance use vs. Devon's underlying distress recently leading to substance use).

If this crisis results in Devon or parents unable to work out this situation so that he can return home safely, then **Crisis Receiving and Stabilization Services (CRSS)** may be required to: (1) **better understand this unique family and youth's perspectives and their goals**, which might include discussing options with parents and Devon together to navigate an acceptable resolution, identifying underlying fears family members have regarding Devon, as well as stressors that may be influencing Devon's recent behaviors, and both the family and Devon's perceptions of law enforcement as well as social support agencies in partnering with families like them; (2) **clarify if ongoing parent/child/family support services are needed** (e.g., crisis team members clarify whether Devon will be able to safely return home by the next day or whether other options for Devon may need to be explored now, are Devon and family able to work with a provider to agree to terms of returning, is the home environment likely to work or does it remain too volatile between child and parent such that immediate return may put Devon or family members at jeopardy for harm, etc.); and (3) **identify where these services might best be provided** (e.g., does Devon require further evaluation to clarify underlying substance use disorders/withdrawal/intoxication symptoms, specialized referral for other issues, substance abuse treatment, depression, etc.).

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