Best Practices in Children's Mental Health

A Series of Reports Summarizing the Empirical Research and other Pertinent Literature

on Selected Topics

Report # 13

Community Mental Health
Crisis Services
for Children and Adolescents

A Review of the National Literature
December, 2004

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TABLE OF CONTENTS

**Best Practices in Community Mental Health Crisis Services
for Children and Adolescents**

EXECUTIVE SUMMARY

Community-based crisis programs set out to offer **short-term, intensive interventions aimed to alleviate current difficulties, avoid unnecessary hospitalization, and restore an individuals' functioning** to previous levels or better if possible. Available 24/7, crisis programs provide an immediate response (at least within 24 hours of the initial call), evaluation, assessment, intervention and stabilization as well as follow up planning, while focusing on problem solving and new coping skills. Usually, immediate and extended family members are involved as much as possible in all phases of treatment. Service types include telephone hotlines, crisis group homes, walk-in services, runaway shelters, mobile crisis teams, therapeutic foster homes, if used for short term crisis placements, as well as crisis stabilization units, hospital emergency rooms, and inpatient services. In the absence of child and family focused crisis programs a significant number of children are likely hospitalized or inappropriately served through adult crisis models. Thus, **community mental health services are well advised to further the availability, quality and integration of crisis services for children and maximize continuity of care for children and families by integrating crisis services into continuum of care.**

Despite a growing body of research about children in crisis and the effects of trauma, research generally does not offer guidelines as to how to engage children in crisis, nor do existing guidelines offer much in terms of evaluations of treatment responses. Only a few experimental studies have been conducted on specific community based crisis intervention models for children and youth, and even fewer provide longer term follow-up data. Nonetheless, **experimental and non-experimental research provide some evidence that crisis intervention programs can successfully divert hospitalization** for many children and adolescents with emotional and behavioral disabilities in favor of less restrictive community-based alternatives. It should also be noted, though, that the need for hospitalization cannot be fully eliminated; **hospitalization usually remains necessary for a number of children.**

At least **for a short-term period, crisis programs can bring about improvements in behavior, diminished suicidal tendencies, and increases in self-concept for some children, or heightened parental self-efficacy.** However, it appears that the gains children with SED initially make on behavioral scores, self concept or other measures will dissipate after the intervention ends and preexisting, chronic difficulties will continue. Therefore, **crisis programs alone may not be sufficient to maintain gains beyond the end of intervention** unless "booster" services or ongoing supports are employed, or crisis services are fully integrated into a continuum of care ensuring the continuity of services with an appropriate intensity.

Research on the **experiences of families** of SED children shows that they first turn to **informal supports** like spouses, friends and extended family. Respite care and parent support groups are useful concrete supports. Moreover, families benefit from services focusing on the prevention of crises and **sustained supports rather than short-term crisis intervention.** Absence or discontinuance of ongoing services can precipitate crises while access to affordable, appropriate ongoing supports are deemed essential to prevent or curtail recurrent crises episodes. **Competent, non-blaming, strengths-focused service providers** who formed long-term alliances were treasured by families. Finally, properly prescribed, administered and monitored **medications** are critical in keeping the child at home.

Effective **crisis teams** usually combine various professions such as social workers, psychologists and psychiatrists. **Quick access to child psychiatric and medical assessment** is a

necessary component. Teams should be guided by **shared visions and values** such as a commitment to avert unnecessary out-of-home placements and involvement of families. They are also well advised to create consensus about their respective responsibilities and sense of safety in their work. Effective crisis response for children requires staff **trained in crisis intervention as well as in the approaches needed to work successfully with children and families**. Specific practitioner skills best include experience in child and family mental health, and experience in crisis theory and intervention. This combination of experiences includes such skills as the ability to apply ecological/ systems approaches and strengths-based approaches in assessment and intervention, as well as the ability to successfully de-escalate clients to preclude more drastic and risky measures like restraint or seclusion.

A crisis for a child is determined by the timing of a child's behaviors and the resources available to adults. **Ecological and strength based approaches** therefore actively assess and involve immediate, and extended family networks as well as formal and informal community supports. **Areas of assessment** should include:

- danger of the child to self or others
- danger to the child from others
- the child's ability to maintain his or her own safety and use environmental supports
- the child's innate vulnerability
- the child's engagement in serious drug or alcohol use or abuse that endangers his or her own life or that of others
- the child's degree of exposure to drugs and alcohol
- the severity of environmental stressors that adversely impact the family and render the child vulnerable to heightened stress
- the extent to which environmental assistance through the family, community, or service providers are available and able to provide critical safety or support for the child, including the family's psychosocial functioning, the adequacy of physical, educational, and financial resources, the resources of the extended family, kinship network or community, and the adequacy of formal community-based services to ameliorate previous factors.

The **ability to successfully de-escalate** clients to preempt seclusion or restraint includes such skills as

- being attuned to own emotional responses and ability to use own responses purposefully;
- having a repertoire of possible responses and the flexibility to choose one;
- being able to elicit client's story;
- observing and verbally connecting with client;
- being able to stay verbally connected;
- being able to stay calm, use calm tone of voice;
- noticing changes in client's behaviors;
- verbally identifying changes and asking the client about those changes;
- empathizing with client's perspective (not arguing it);
- having a clear sense of client's desire and the ability to communicate alternative ways to achieve desires;
- and being able to offer simple and direct choices.

Crisis debriefing and crisis stress management models were developed to **assist providers** of crisis intervention. If implemented according the standards, there is some evidence of the effectiveness of programs such as Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM) on staff. Properly led debriefing should be available to all crisis staff.

There is **much less clarity about the effectiveness of debriefing strategies for primary victims or traumatic events, and young victims in particular**. Given the original purpose of debriefing and contradictory interpretations of research, debriefing strategies should be applied with caution, and only by personnel trained in specific debriefing models.

Recommendations:
Current Best Practices in Crisis Services for Children and Adolescents

Programming
- ➲ Provide 24/7 intensive, in-home crisis interventions, ready to adapt service times and locations to family needs
- ➲ Emphasize the use of an ecological, strengths-based family approach to assessment and intervention
- ➲ Focus on prioritizing most pressing needs
- ➲ Focus on communication and problem-solving skills
- ➲ Include the provision of concrete services, and availability of flex money
- ➲ Provide linkages to other more and less intensive services in the community including access to crisis beds in local crisis stabilization programs, hospitals and respite care
- ➲ Assure easy access to child psychiatric evaluations and medical services

Especially for SED populations, **prevent crises** by providing accessible, affordable, ongoing community-based support services to children and their families, and **maximize the continuity of care beyond crisis services** to prevent or curtail future crises, by
- ➲ involving the same staff in crisis and ongoing services,
- ➲ providing "booster" crisis services and ongoing supports, such as case management and outpatient therapy, beyond the typically short-term scope of crisis intervention
- ➲ integrating crisis services into full continuum of care

Staffing and Caseload
- ➲ Use a multi-professional team approach
- ➲ Recruit staff skilled in child and family services as well as crisis intervention
- ➲ Assure a low caseload of 2-4 families in crisis at a time
- ➲ Have bilingual service providers available

Training and Supervision
- ➲ Further the integration of child mental health and crisis intervention by cross-training staff and providing hands-on training
- ➲ Provide De-escalation training
- ➲ Grant time and opportunities for teams to build consensus regarding their goals, values, responsibilities, and sense of safety.
- ➲ Allow for team feedback and self-assessment.
- ➲ Assure the availability of ongoing, close supervision at all times
- ➲ Assure the availability of trained personnel to provide critical incident stress debriefing to staff

For Research
Finally, given the scarcity of research about the effectiveness of crisis services for children and adolescents with SED
Conduct research to establish the short and long term effectiveness of existing or new models of community crisis services on hospital diversion, out-of-home placement, behavioral scores, family satisfaction and other measures.

Best Practices in
Community Mental Health Crisis Services
for Children and Adolescents
A Review of the National Literature

Community mental health services today are expected to provide an array of crisis services, including crisis interventions for individuals, families, small groups, as well as large numbers of people in the case of disaster response. Because many youth enter mental health services at a point of crisis, the availability of quality crisis services are deemed extremely important. Their purpose is often twofold in that crisis services are to provide immediate sufficient care and may also open the door to longer-term services within the mental health system (Burns et al. 1999, #3). Crisis services for children must be able to meet the needs of children and adolescents who are affected by a single traumatic event, as well as youngsters affected by repeated trauma or with long-term chronic emotional and behavioral problems who experience periodic acute episodes of crisis (Burns et al., 1999, #3).

Historically, crisis intervention dates back to the seminal works of Lindemann (1944) and Caplan (1964) who first formulated crisis theories. Early community crisis responses usually consisted of clinic based, ad hoc-on site, school-oriented services or those coordinated with other community services, as well as disaster services. More recent integrative models actively link mental health services to concrete disaster response activities (Silver & Goldstein, 1992, #21). Despite a growing body of research about children in crisis and the effects of trauma, research generally does not offer guidelines as to how to engage children in crisis, nor do existing guidelines offer much in terms of evaluations of treatment responses (Tyson, 1999).

The following review of national, and some international, literature was conducted to determine the state-of-the-art knowledge about best practices in crisis services for children and adolescents. Specific attention was given to community-based approaches, empirical studies of particular models or approaches, and otherwise innovative conceptual or descriptive publications. The review is based on systematic searches of relevant databases (PubMed, PsycInfo, WilsonWeb, Social Work Abstracts, and Exceptional Children) as well as books and internet sources. After an initial review, 25 published articles and books were selected for further in-depth review. (See Appendix A. for matrix of selected literature.)

DEFINITIONS

A *crisis* occurs when the demands of a serious acute and potentially dangerous situation overwhelm an individual's capacity to effectively resolve the situation (Hodge & Curtis, 2000). While some crises may build up slowly, an *emergency* is defined as an often unforeseen crisis situation that requires an immediate response or intervention to prevent harm or potential harm. Crises and emergencies are typically viewed as time limited although contributing or resulting problems may last beyond the time of crisis (Hodge & Curtis, 2000).

A more recent term in the field of crisis intervention is *"critical incident"* which is defined as a stressful event that *could* lead to a psychiatric crisis response (i.e. trauma response).

During such events persons may face a threat of or actual death, threat of or actual serious injury, other threats to his or her integrity, they may be witnessing such events, or experience a strong contradiction to a deeply held belief (Flannery, 2000, #8).

Disasters are defined as emergency situations that have a broad and devastating effect on a large number of people or entire communities, for instance like natural disasters such as tornados, or floods, as well as accidental or intended events like terrorist attacks.

Crisis Intervention is understood as a short term process of psychological care focused on the resolution of the most immediate and pressing problems by assisting the prioritizing of goals, and accessing or activating the personal, social, and environmental resources. Goals are the stabilization of the victim, mitigation of acute signs and symptoms, and restoration of an adaptive level of functioning. The basic hallmarks of crisis intervention are immediacy of response, proximity of services to victims, expectancy of return to better functioning, and brevity of services (Flannery, 2000, #8; Hodge & Curtis, 2000).

CRISIS SERVICES OVERVIEW

Traditional mental health crisis services tend to function in a standard adult-focused manner irregardless of the specific needs of children and adolescents (Pumariega & Winters, 2003, #19). Operating from crisis intervention offices, or hospital emergency rooms, they attempt to diffuse crises and refer to follow-up services. If the crisis cannot be defused, children are removed and placed out-of-home in shelters, inpatient facilities or even long-term residential placements whereby families often feel "usurped of their primacy in the child's life when 'experts' take over" (Pumariega & Winters, 2003, p. 781). Categorical services like case management are often duplicated, little family oriented in-home services are provided, and even fewer means are devoted to crisis prevention. *Community-based mental health services*, on the other hand, are devoted to separating issues of service intensity from restrictiveness of placement and offer in-home services with the family as the unit of attention (Pumariega & Winters, 2003, #19).

In a review of the literature about community based services for children with serious emotional disorders (SED) and their families, Burns, Hoagwood and Mrazek (1999, #3) identified *three basic components of crisis services*: (1) evaluation and assessment, (2) crisis intervention and stabilization, and (3) follow up planning. Service goals include immediate intervention, brief intensive treatment, involvement of families in treatment, linking individual clients and families with other community support, and averting hospitalization by stabilizing crisis situation in the most normal setting.

Types of services can include telephone hotlines, crisis group homes, walk-in services, runaway shelters, mobile crisis teams, and therapeutic foster homes, if used for short term crisis placements, as well as crisis stabilization units, hospital emergency rooms, and inpatient services (Burns et al., 1999, #3; Kutash & Rivera, 1995, #13; Stroul & Goldman, 1990, #23). Surveying 32 home-based programs for children and youth, Stroul and Goldman (1990, #23) found that this entire array of services is usually not available in all communities. Although they can vary greatly, community based crisis services share *common characteristics* (Stroul & Goldman, 1990, #23):
- They are available 24/7 to provide screening, evaluation, intervention, and support.

- They have the common purpose to avert hospitalization if appropriate, and stabilize the situation in the least restrictive appropriate setting. Community Based Services (CBS) often serve as gatekeepers to acute inpatient services.
- Services are short-term (4-6 weeks) making use of the time limitations and the increased willingness of clients to initiate change. Services focus on identifying and prioritizing precipitating factors, and mobilizing youth and families to develop new ways of coping. Average length of stay in emergency foster care, or respite homes was seven days. Crisis stabilization units and residences reported mean length of stay between 13 and 21 days.
- Because of the needed intensity of care, crisis residential programs tend to be small, ranging from one (in Therapeutic Foster Care) to about 12 children in group residences. Shelters may accommodate as many as 24 children.
- Services include evaluation, assessment, intervention and stabilization as well as follow up planning, focusing on problem solving and new coping skills. Immediate and extended families are involved as much as possible in all phases of treatment.
- Staff share characteristics such as high ability to be adaptable and flexible, high levels of skill and competence, high degree of energy and commitment, ability to establish relationships quickly and then let go, and the ability to work in a team.
- Because they tend to be brief, crisis programs are usually integrated with other service components.

At the same time, programs differ greatly in regard to 1) their reliance on hospitals as backup rather than initiating individualized Community Based Services (CBS), 2) the extent to which services are part of a larger network, and 3) the credentials of staff which often appear to be determined by the service setting. For instance, crisis stabilization programs tend to employ social workers, psychologists, nursing staff, and psychiatric back up whereas shelter style programs rely on staff with fewer formal credentials but extensive experience in working with youth (Stroul & Goldman, 1990, #23).

Pumariega and Winters (2003, #19) point out that **barriers and challenges** to the implementation of quality crisis services frequently include practitioners' lack of crisis intervention skills and their preference for the comfort and safety of their offices. With greater availability of expert consultation, mobile phones, and better training these barriers can likely be overcome. The underuse of <u>necessary</u> hospital services is possible when "anti-hospital" attitudes meet attempts to avoid hospitalization primarily for financial reasons. Lack of adequate resources for emergency medical evaluations or available psychiatric hospital beds may also cause difficulties. Medical and developmental perspectives must be integrated into community-based crisis intervention approaches, and psychiatric leadership and supervision must be available. At times, system pressures may resist the establishment of crisis services or attempt to centralize such services.

The implementation of **managed care** principles, typically designed for adult needs, has been uneven in the development crisis systems for children. Strength-based, family-centered, and ecological models do not easily fit managed care philosophies or regulations about medical necessity (Pumariega & Winters, 2003, #19).

Other overriding issues that impact the funding of CBS crisis services are the lack of data on costs and cost-effectiveness, lack of third party reimbursement, differing requirements of

multiple contractors and difficulties convincing public and private funders to provide adequate resources (Stroul & Goldman, 1990, #23). Agencies cited particular needs for outreach and community based residential options lest the alternative is all too often hospitalization. ***In the absence of an organized system of care, hospitalization and adult style crisis services focused on screening for hospitalization become the default mode,*** even though there is "little evidence that hospitalization lowers the risk for subsequent crises, perhaps related to its emphasis on the child's psychopathology rather than the family and systemic contextual factors implicated in the crisis" (Pumariega & Winters, 2003, p. 780).

Ecological View of Children and Adolescents in Crisis

Arguing for a contextual, ecological view of child mental health emergencies Pumariega and Winters (2003, #19) point out that the occurrence of a *crisis for a child is determined by the timing of a child's behaviors and the resources available to adults*. "Generally, a child's parents or other responsible adults decide when the child's emotional or behavioral problems are beyond their control and require emergency services. The timing of the acute presentation is as likely to result from impairment in the adult's functioning (or capacity to contain the child's behavior) as from a worsening of the child's psychopathology" (Pumariega & Winters, 2003, p. 779). In the words of Susan Adkins, a crisis for children's mental health occurs "when adults no longer know what to do" (personal conversation, 1996).

Pumariega and Winters (2003, #19) distinguish *six types of child mental health crises* (that may occur concurrently):
(1) danger to self or others;
(2) danger to the child from others;
(3) the child is unable to maintain his or her own safety and use environmental supports;
(4) the child engages in serious drug or alcohol use or abuse that endangers own life or that of others;
(5) severe environmental stressors adversely impact the family system and render the child vulnerable to heightened stress;
(6) environmental supports (family, community, services) break down and are unable to provide critical safety or support for the child.
Contributing *contextual factors* include
- the child's innate vulnerability
- the child's degree of exposure to drugs and alcohol
- the family's psychosocial functioning
- the adequacy of physical, educational, and financial resources
- the resources of the extended family, kinship network or community,
- and the adequacy of formal community-based services to ameliorate previous factors.
(Pumariega & Winters, 2003, #19).

While the immediacy of a crisis response often requires the curtailing of typical mental health assessments, assessments of crises situations should include all of the above areas beginning with the most pressing concerns about the safety of the child, family and community.

RESEARCH ON FAMILY PERSPECTIVES AND EXPERIENCES WITH CRISES

An ecological view of contributing and protective factors for crises is supported by a qualitative focus group study that explored the perspective and experiences of families trying to cope with

crisis situations that threatened out-of-home placement for their SED children (Petr, 1994, #18). The author reports results from interviews with ten families whose children were diagnosed with emotional and behavioral disorders and distinguishes four types of crisis precipitating events: (1) system induced, (2) child condition or behavior, (3) parent incapacity, and (4) general stress.

Over the course of 18 months, four interviews in six months intervals were conducted to explore:

(1) the kinds of crisis situations experienced,
(2) if and which kind of assistance parents sought and received,
(3) whether received services helped prevent placement,
(4) whether or not children were placed,
(5) and what helped maintaining a stable family situation if no crises occurred

The author found that all families experienced at least one major crisis threatening out of home placement, and four children were placed out of home. Findings about factors that assisted with coping and preventing crises include:

- Informal supports and support groups are vitally important for families to cope successfully. Spouses, friends and extended family are the first support systems sought out by families; respite care and parent support groups were viewed as useful concrete supports.
- Families benefit from services focusing on the prevention of crises rather than crisis intervention. Families with SED children seem to benefit little from conventional family preservation or short-term crisis intervention models and instead need more sustained supports including medical insurance, counseling, respite, special education, and vocational training, all of which can help prevent crises situations. Absence or discontinuance of such ongoing services can precipitate crises.
- Attitudes and values of professionals make a difference. Competent, non-blaming, strengths-focused service providers who formed long-term alliances were treasured by families. Labeling families as dysfunctional, and other disrespectful attitudes led to the experience of professionals' adding to the stress of families rather than relieving it.
- Medications help. Although, psychotropic medication for children remains a controversial issue, for many families properly prescribed, administered and monitored medications are critical in keeping the child at home.

INITIATIVES TO IMPROVE CRISIS SERVICE IS KANSAS

As part of the Mental Health Initiative 2000, the Health Care Policy Division (Mental Health, Substance Abuse Treatment and Recovery) at the Department of Social and Rehabilitation Services (SRS) in Kansas commissioned an analysis of Kansas crisis services by outside consultants. In their report, the consultants (Hodge & Curtis, 2000) identified the following elements as best practices for mental health crisis response systems:

- Twenty-four hour, seven days per week, 365 days per year central telephone response system staffed by qualified mental health professionals and having immediate capacity for face-to-face assessment plus on-call consultation with a psychiatrist.
- Staff capability to provide immediate relief of distress of reduction of risk through appropriate intervention, emotional support or practical assistance; to access to basic community and emergency resources; and to initiate and follow-through with referrals and linkages to other services or resources when they are needed.

- Clinical capacity and legal authority to approve or deny admission, voluntary or involuntary, to any public psychiatric inpatient facility or any institution whose services are paid by public funds.
- Assured and speedy access to appropriate clinical specialties, such as board-certified or board eligible child psychiatrists, or respite/attendant care services.
- Mobile capacity, in which teams of mental health professionals and peer counselors are available to respond within one hour to psychiatric crises wherever they present, including hospital emergency rooms, individual homes, shelters, and local jails. The mobile unit must also have the capacity to transport or arrange for transport of individuals in crisis to an appropriate evaluation and stabilization facility.
- A variety of short-term (23 hour-14 day) adult and child observation and intensive residential treatment resources for crisis stabilization and hospital diversion.
- Facilitated linkage with other healthcare resources to arrange for medical clearance, toxic screens, lab work related to rapid medication titration, and medical and non-medical detoxification.
- Direct access to cultural and linguistic clinicians and translation services to facilitate assessment and crisis stabilization.
- Facilitated linkage with mental health services to arrange for crisis alerts, to obtain copies of crisis plans, to insure the use of the least intrusive services.
- Preventive, educational and supportive services which notice changes and problems before they become a major crisis.

(Hodge & Curtis, 2000, p. 91-92)

Beginning in 2001 and based on the Hodge and Curtis report, the Mental Health, Substance Abuse Treatment and Recovery Team at SRS, initiated a two phase planning process to improve community based crisis services. Community Mental Health Centers (CMHCs) in Kansas were asked to develop Crisis Service Plans based on seven guiding principles. The guiding principles for crisis services include: (1) early intervention and prevention; (2) use of natural resources; (3) use of a strengths approach; (4) and emphasis on community-based services and outreach; (5) involvement of families and consumers; (6) comprehensive and inclusive planning; and (7) cultural competence. The plan required CMHCs to assess their current system, and outline efforts to involve community stakeholders, resources, and families. The plan also had to describe concrete goals and objectives to improve the local system, training, supervision and quality improvement to address the needs of nine identified special populations including children at risk of out of home placement, children and adolescents in or at risk for involvement with the juvenile justice system. In addition, planners had to delineate their strategies for collecting and utilizing of data, and how they will meet the minimum expectations of providing at least six types of crisis services, namely 24/7 crisis hotlines, pre-admission screening, crisis case management and diversion, mobile crisis response, as well as in-home and out-of-home crisis stabilization (MHSATR, 2001a, 2001b, official memoranda). (See Appendix B for definitions of these types of crisis services, and the continuum of crisis supports).

Consumer satisfaction surveys of 1803 families with children receiving case management services from Community Mental Health Centers in Kansas (Martin & Petr, 2003) indicated relatively low parental satisfaction with crisis response time and with the crisis services they received when they called the crisis line. Parents' satisfaction with complaint resolution was also

relatively low. Surveys of youth (age 12 and older) indicated they were as dissatisfied as their parents with the response time of crisis services but were more satisfied with the help received (Martin & Petr, 2003).

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RESEARCH ON COMMUNITY-BASED CRISIS MODELS AND PROGRAMS
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With the exception of experimental studies about Multisystemic Therapy (MST), and a comparative study about three intensive in-home programs in the Bronx, New York, the current evidence base for the effectiveness of crisis services for children and adolescents consists largely of uncontrolled studies. Most studies demonstrate some potential of crisis intervention to divert youth from institutional placements (Burns, 1999, #3; Kutash, & Rivera, 1995, #13; Pumariega & Winters, 2003, #19). Kutash & Rivera (1995, #13) reviewed individual studies of effectiveness and reviews for eight mental health service areas, including crisis and emergency services. Authors found that the available literature provides some evidence that crisis programs can effectively reduce the rate of hospitalization or other out-of-home placements. Most evaluations focus on prevention of such placements as the principal outcome variable. Authors conclude that existing research, though still developing, appears to support the expansion of crisis services. Still further research is needed to explore differences between crisis-oriented, home-based services and other types of community-based crisis services, their outcomes and their respective cost effectiveness (Kutash & Rivera, 1995, #13).

Multisystemic Therapy (MST)

Experimental studies using randomized control groups have been published about the use of Multisystemic Therapy (MST) for children and youth in crises (Henggeler, Rowland, et al., 1999; Schoenwald et al., 2000; Henggeler et al., 2002, 2003, #10). One hundred sixteen children and adolescents, ages 10 to 17 years, with serious emotional difficulties, approved for emergency psychiatric hospitalization, were randomly assigned to home-based MST or inpatient hospitalization. The experimental treatment condition utilized an adapted MST format that began with crisis assessment and stabilization, and was followed by usual the MST protocol. The control group received usual crisis hospital services. Data were collected on symptomatology through self reports and parent reports using standardized instruments, antisocial behaviors , self-esteem, family relations through the family adaptability and cohesion scale (FACES - III), peer relations, school attendance, days in out of home placement, school attendance, and consumer satisfaction. Follow up data were collected in intervals up to 18 months post referral.

Although earlier reports about results indicated positive developments for participating youth in terms of their behavioral symptoms (Henggeler et al, 1999; Schoenwald et al., 2000), a longer term follow up conducted one year later showed little difference between the MST treatment and the comparison group. Results indicated that gains youth in the MST condition had made at earlier measuring points dissipated over the course of a year resulting in a convergence of both treatment conditions. Both treatments led to overall reduction of psychiatric symptoms but the patterns of change were different, and the patterns of self reported versus parent reported improvements diverged. On self reports, MST youth indicated their improvements were initially more rapid than those of hospitalized youth, then improvement slowed, then improved again more rapidly. Parents on the other hand indicated that hospitalized youth improved more quickly, then deteriorated, then improved again. In terms of out-of-home placements no significant difference could be detected after a year. Initially favorable results for MST on school attendance at regular school settings had dissipated after a year. Parenting and family relations differed in that MST youth noted slightly more family rules, whereas

hospitalized noted fewer rules. Youth adaptability improved for both conditions with no significant differences after a year, and caregivers in both conditions reported increases in control and supervision. Hospitalized youth scored higher on improved self-esteem. The authors conclude that while MST was significantly more effective during the first months, subsequently gaps gradually dissipated making both treatment means approximately equal. After one year, key measures of functioning like school attendance deteriorated over time highlighting how challenging developmental transitions may be for an adolescent population with SED. Thus, home-based MST may not be a sufficient treatment for these youth. More as well as less intensive services are required to meet the ongoing needs of these youngsters and their families (Henggeler et al., 2003, #10)

The same data were reexamined by Huey, Henggeler et al. (2004, #11) focusing on outcomes pertaining to suicide and associated symptoms. In regards to attempted suicides MST was found significantly more effective than hospitalization at the one year follow up. Youth reported a higher frequency of attempted suicides before treatment, and a sharp decrease in the course of treatment. Caregiver reports did not show significant changes. No differential effects were found on suicidal ideation, hopelessness, or depressive affect. Taking other convergent research into account the authors suggest that changes in suicidal ideation, hopelessness or depression may not occur in tandem with reduction of suicidal behaviors.

Home-Based Crisis Intervention, New York

Another experimental study (Evans et al., 1997, 2001, #4, 2003,#5) examined the differential effectiveness of three intensive in-home crisis service programs in the Bronx, New York City. Participants included 279 children ages 5 to18 years (mean of 12 years) from low economic, households. Slightly more boys (52.9%) than girls were in the sample, and mostly minority children (58.8% Hispanic, 33.6% African-American). Evaluated as at-risk for immediate hospitalization children were randomly assigned to one of three treatment conditions. All three treatment programs lasted four to six weeks and were conducted by master's level nurses or social workers in families' homes or other natural settings (e.g. schools):

1) Standard treatment was Home Based Crisis Intervention (HBCI) based on the Homebuilders family preservation model, providing intensive in-home counseling, designed to teach crisis management and communication skills, and concrete services. Each clinician carried a caseload of two families at a time;
2) the enhanced HBCI model ("HBCI+") added to the standard treatment: a) provider training in cultural competence and family violence, b) flex money of ($ 100) and access to respite care, and c) a bilingual family advocate who provided group and individual parent support;
3) Crisis Case Management (CCM) is an adaptation of intensive case management, whereby case managers carry a caseload of eight families, four of which are families in crisis, and four require generic case management. CCM did not render clinical services at home but assessment, provision of concrete services, and linkages to other services needed to keep child in natural environment. Although CCM came close to serving as a control group, the model was adapted for the study providing more rapid assessments.

Outcome data were collected at intake, discharge and six months post discharge and included instruments measuring children's self-concept, family adaptability and cohesion, parent self-efficacy, an inventory of socially supported behaviors, and the Child Behavior Checklist (CBCL).

Child and Family Characteristics. Children exhibited significant emotional and/or behavioral problems. More than half (52.2%) met criteria for SED. Thirty-six percent were

diagnosed with disruptive behaviors, 19.8 % with adjustment disorders, 14.6 % with mood disorders, 11.8 % with psychotic disorders, and 10.4% with anxiety disorders. Eighty-one percent of children were considered somewhat dangerous to themselves and/or others. Almost seventy-one percent had at least one functional impairment (in areas such as cognition, self-care, social skills etc.), 40% had two or more impairments. Most frequently displayed behaviors were suicidal ideation (56.7%), depression (55%), temper tantrums (45%), verbal aggression (41%), anxiety (33.6%), and destruction of property (32.4%). Substance/alcohol related problems were reported less frequently likely reflecting the predominantly younger age group in this study. Almost 72% of children lived in single parent households (mostly headed by single women), and more than 80% of households had at least two children in the home. Caregivers were 22 to 83 years old (with a mean of 38 years). Seventy-six percent were not working, and 78% earned less than $22,000 per year. The high poverty rate raises questions about the role of poverty in children's and families' crises. Unfortunately, the factor remains unaddressed in this study.

Outcomes six months after discharge:

- All three programs were successful in maintaining children in the community (HBCI: 82%; HBCI+: 86%; CCM: 78%). Differences between programs were not statistically significant. The authors point out that in-home services did not completely eliminate the need for inpatient care for children who posed a danger to themselves. Five to ten percent of children did require hospitalization at some point during the intervention.
- Differential effects between programs were found for internalizing CBCL scores. In contrast to HBCI and HBCI+, children in the CCM program showed significant reductions in internalizing scores at time of discharge. All children showed significant effects comparing scores from admission to six months after discharge. While externalizing scores had not changed significantly at discharge, reductions were significant from admission to six months postdischarge for all programs.
- All three interventions also resulted in significant increases in adaptability and parental self-efficacy. All families showed greater cohesion at discharge but HCBI and HCBI+ participants had made greater improvements than CCM. However, gains made on family cohesion lessened over time.
- All families made gains in socially supported behaviors at discharge, but only HBCI+ families showed significant increases. Again, gains appeared fragile and statistical significance had dissipated at six months postdischarge. The HBCI+ enhancement toward more social support seemed to have short-term success.
- The authors suggest that the brief intervention period of four to six weeks may not be sufficient to identify and develop informal supports, perhaps requiring "booster" efforts or transitional services to maintain gains in this area.

The same data were analyzed in an attempt to determine which interventions, irregardless of program assignment, worked for which children (Evans et al., 2001,#4). Certain demographic, clinical, symptom/behavior and functional impairment variables were selected and analyzed to generate profiles for the population in the study, resulting in four general profiles:

1) young boys with disruptive behaviors
2) children with psychotic-related disorders and functional impairments
3) adolescents with mood disorders and comorbid substance abuse problems
4) children with adjustment disorders and suicidal tendencies

In search of differential outcomes, authors found

- that all three short-term interventions did little to promote self-concepts of children with psychotic symptoms (Profile 2). Clinicians targeting this outcome may wish to use a different program or add supplemental, longer-term services;
- that caregivers of adolescents (Profile 3) experienced themselves as challenged in parenting their child. For them, parent efficacy may need to become a stronger focus in crisis intervention programs to ensure longer lasting effects;
- that children with adjustment disorder and suicidal tendencies (Profile 4) showed a decline in social skills scores over time. The authors suggested that further analysis may shed light on why this occurs and which measures may help mitigating these difficulties.

Community-Based Crisis Intervention, Massachusetts

A study by Nicholson et al. (1996, #17) evaluated the impact of community-based crisis interventions on Medicaid covered emergency mental health services for children in Massachusetts. In 1992, Massachusetts contracted with a private insurance company to implement the carve-out and management for Medicaid services. Trying to reduce costs, the company's managed care intervention consisted of *supporting the development of local crisis stabilization teams and community-based alternatives for hospitalization of children and adolescents, such as emergency residential care, as well as requiring pre-admission screenings for all admissions to overnight crisis services*. Unfortunately, no further details are provided about crisis stabilization teams or community-based alternatives. The study compares the volume of emergency screenings and disposition outcomes for all decisions about hospital admissions one year prior to implementation of community-based services in October of 1992 (October 1, 1991 to September 30, 1992) and one year after full implementation (April 1, 1993 to March 31, 1994). The authors analyzed data of 297 pre-implementation episodes, and 393 post-implementation episodes comparing the volume of screenings, system characteristics (payer, referral, disposition), and client attributes (gender, age, presenting problem, diagnosis, hospitalization history).

Findings indicate that the *total number of screenings increased significantly*, and significantly *more screenings were covered by Medicaid* than Non-Medicaid sources after implementation of managed care (60% after managed care compared to 53% before). Beyond this increase in the percentage of Medicaid as the source of payment, the study found no effects of the implementation of Medicaid managed care on screenings covered by Non-Medicaid payers. Neither client attributes nor the number of inpatient dispositions changed for the group of Non-Medicaid clients. For the Medicaid covered episodes, however, a *significant decrease of hospitalizations and dispositions "to home"* was found after implementation of community-based crisis services: While 34.4% of decisions had resulted in hospitalizations prior to 1992, only 16% of screenings led to inpatient care after implementation. And while 40.1% of pre-managed care screenings had resulted in dispositions "to home", only 29.6% of children's screenings resulted in a "to home" disposition after implementation of services. At the same time a significant *increase of dispositions to the newly developed crisis stabilization* services and to "other" services was noted.

There were also statistically significant *changes in client attributes for the Medicaid group*: more children between the ages of 9 and 11 were screened for hospitalization post-managed care, there was a significant decrease in children presenting with threatening behaviors and an increase for those exhibiting problem behaviors such as destructive, unmanageable or substance abuse behaviors. There was also a shift in diagnoses in that fewer children carried

diagnoses of disruptive disorders and more were diagnosed with post-traumatic stress or anxiety disorders in the post-implementation phase.

In their discussion of findings the authors suggest that increases in total screening volume are explained by the newly introduced requirement that all children be screened before hospitalization. Prior to the screening mandate children could be referred to hospitals directly by providers. It is possible that especially younger children tended to be referred directly thus accounting for the increase of screenings in the 9-11 year old age group after managed care.

The significant changes in disposition away from hospitalization toward crisis stabilization are likely the result of the implementation of these diversion services and policies. The decrease of dispositions to home and the increase of referrals to "other" services are not as easily explained. As the authors point out, data on clients' living situation was insufficient to provide clear answers, and increased referrals to "other" services may reflect an increase in cases involving substance abuse.

Overall the required screenings and services offered under Managed Care appear to have effectively diverted children from costly hospitalization at least for the short-term. It stands to reason that similar services, and policies that support community-based alternatives and crisis response can lead to similar results independent of the involvement of a managed care company.

The study's main limitation is its use of a historical, non-equivalent comparison group which makes it difficult to determine whether the implementation of managed care led to changes or other extant changes that occurred during the same time account for the differences. For instance, the authors suggest that the shift in presenting problems may be influenced by changes in the decision making culture during the time of the study. Awareness of policy initiatives to keep children out of hospitals may have resulted in practitioners labeling fewer behaviors as threatening and group them into problem behaviors instead. Similarly, the move away from disruptive disorder toward more PTSD/anxiety diagnoses may also be the result of growing awareness that behavior formerly viewed as disruptive is more accurately understood as the result of trauma. Also, issues of longer-term recidivism, and the quality of follow-up care, remain unaddressed.

Delaware Study

Blumberg (2002, #2) studied the effectiveness of a ***crisis intervention program for children under twelve years*** of age. Taking advantage of changes in Delaware's mental health services in 1996, the authors compared hospital utilization data after implementation of a new crisis intervention program with data for the three years immediately prior to implementation. Prior to 1996, all inpatient treatment was provided at a state-funded psychiatric hospital providing 25 beds for children under the age of 12. The facility was locked with 24 hour nursing care, a "reasonable level of psychiatric coverage" (p. 2) and lengths of stay ranging from two days to over one year. After implementation of the *new treatment program*, the facility changed its services to 13 residential treatment beds for longer (over one month) stays, and three crisis beds designed for stays of up to three days. In addition, a crisis intervention program was funded which utilized a multidisciplinary staff including a psychiatrist, psychologist, nurses, social workers, educators, and paraprofessionals who provided rapid response, meeting face-to-face with clients within 24 hours of a call (50% of responses occurred actually within two hours of the call), and mobile crisis response to schools. The staff conducted risk assessments and family intervention to establish immediate safety plan and treatment goals. Psychiatric evaluations, monitoring, and consultations with other providers were offered throughout the process. Therapeutic interventions applied systemic, intensive short-term family treatment, with an

average of three sessions a week. Daily sessions were available if needed. Sessions were staffed by two therapists whereby families were made aware that therapists may vary. In addition, short-term crisis beds were available for children with symptoms too dangerous to manage in community (44% of participating children were admitted, staying an average 2.8 days).

The treatment group consisted of 726 Medicaid or uninsured children (ages 2-11 years) participated in the new program between 1996 and 1998. Of these children, 64% were judged as at risk for hospitalization. Their mean age was 8.6 years. Forty-six percent were African-American, 44% white, and 14% Hispanic. Sixty-two percent came from single parent families, 18% lived with two parents, 16% lived with relatives other than parents, and 4% in foster care. Twenty-two percent had multiple admissions to crisis intervention services during the 1996-1998 period.

The authors hypothesized that the treatment would result in no children being harmed, a decrease in the use of psychiatric treatment beds and no increase in costs relative to the historical comparison group.

Results:

- The average length of total treatment was 26.5 days followed by more traditional services.
- The program was deemed successful in that no children were being harmed or harmed others in any significant manner. At the conclusion of services 2.4% were referred to psychiatric hospitals, 5.8% to residential care, 49% to day treatment, 78% to outpatient services, and 4.8% to other nonrestrictive services.
- Compared to the time period before the crisis intervention program, hospital bed utilization decreased by 23%.
- The economic effectiveness of the crisis program was calculated in two ways. First authors compared the costs of the crisis program to the costs of hospitalization. With a total annual budget of $500,000 the hospital diversion program cost $3225 per child admitted to the new program. Compared to an average cost of $11,400 per child admitted to the psychiatric hospital ($570 per day for a mean length of 20 days), the average program cost only 28% of hospital treatment. Second, authors assessed the actual reduction in use of hospital beds. Based on the data available for the years prior to 1996 authors estimated how many children would have been admitted to the hospital annually without the new crisis program. Comparing the estimated annual number of 10.8 beds used per day to the number of beds actually used after 1996 (8.3 beds/day), the program was calculated to have effectively diverted 2.5 children per day from hospital treatment, reducing the utilization of hospital beds by 912 each year. Had these beds been used, hospitalization would have cost $519,840. Thus, the crisis program with its $500,000 budget saved $20,000 in annual treatment costs.

The study is limited through the use of a historical comparison group which does not control for other changes occurring during that time period. The adherence to the treatment model was not systematically monitored, and changes in children's individual functioning were not measured. Follow-up data could not be obtained in sufficient numbers to ascertain longer term outcomes.

Studies without Comparison Groups

Gutstein et al. (1988, #9) conducted an outcome study of the ***Systemic Crisis Intervention Program*** (SCIP) in Houston using a non-experimental study (i.e. there were no control or comparison groups). SCIP provides in interesting approach because of its focus on activating family kin networks, and the attention granted to the disempowering effects for

families when relying on institutional solutions. Still, the study is limited by lack of control or comparison groups and the absence of information about the reliability or validity of instruments used to measure outcomes. Participants were 75 children and teens referred for acute crisis too dangerous for regular outpatient treatment, who were recommended for hospitalization, showed clear crisis precipitating behaviors, and had family members who were highly disturbed by the situation. Target outcomes included safety of child and family, an alleviation of sense of crisis, preventive effects on subsequent crises, avoiding future use of institutional solutions (hospitalizations), and economic viability. Measures were taken at intake, three, six months post intake and as a follow up 12-18 months post intake.

Focusing on ***mobilizing the extended family network to resolve crisis***, the SCIP provided evaluation and emergency intervention within 24 hours by two crisis team members. Assessments included danger to self and others, sense of urgency among family, and the family's willingness to consider mobilizing their kin network. One three-hour-session was followed by an average six to ten preparation sessions with individual family members and two four-hour-sessions with extended kin network.

Results indicated that only two participants showed minor suicidal behaviors during treatment. At 3 months post intake, 79% of parents indicated the crisis had for the most part been resolved. At 12 months post intake, 84% of parents described problems as minimal. For 16% the problem remained severe over 12 months. After 24 months only 10% of parents indicated problems were still severe. The total number of problem episodes overall decreased following intervention. Of the 75 children, five moved to more restrictive placements during the follow up period (two to residential, two to correctional, and one to psychiatric hospital settings). Additional analysis indicated that parents reported improved marital/family relations. Economically SCIP compared favorably to hospitalization but was more expensive than traditional outpatient treatment which led to difficulties getting approval from HMOs.

Sawicki (1988, #20) describes an early type of ***mobile crisis outreach*** program. Based on Lindemann's (1944) and Caplan's (1964) basic definitions of crisis, the outreach program served adolescents in a city of 30,000 inhabitants by running a crisis line. The authors postulated four factors essential for a successful program:

- Immediacy of response (within 12 hours, preferably less) to react to short term nature of crisis state.
- Client centered service delivery at the time and place of the client's identification of crisis
- Prior identification of services, because to be known in the community reduces anxieties and barriers in times of crisis
- and flexibility of services, rendering services where and when needed not limited by opening hours, or standard time limits of weekly sessions or 50 minute hours.

Outreach had an average response rate of 20 minutes by phone to arrange for meeting. The initial meeting usually took place at the location of crisis and lasted approximately 3.5 hours to determine precipitating factors and short term goals. The total intervention lasted an average three weeks during which clients were seen for about twelve hours. When short term goals reached completion, long term goals were set which often included other traditional therapeutic services. Authors reported that a majority of their clients over a two year period were referred to further services and keep appointments in the first 30 days of follow-up. Of 231 crisis calls, only 18 persons called again during the following two years. No other longer-term follow-up data, or details on outcomes were reported.

Program Descriptions without Research Data

Silver and Goldstein (1992, #21) provide a brief program report on a collaborative crisis intervention team in Ohio. Beginning in 1985 the *Community Crisis Intervention Team* (CCIT) of Lake County, a community with 225,000 residents, included eleven professionals from five agencies to be on call for crisis services. The CCIT mission is to identify, assess and dissipate emotional trauma associated with community crisis by providing consultation, education, and coordination. Activated by a telephone hotline, the team is available for crisis intervention after suicides or accidents, any other community crisis requiring mental health services, as well as in the wake of disasters. Later a critical incident stress debriefing team was added. No research data were provided.

Stelzer and Elliott (1990, #22) describe a *continuous-care model* of crisis intervention of emergency psychiatric unit in Winnipeg, Manitoba. The program actively reaches beyond traditional limits of clinic based crisis services and provides continuity of care after the patients are discharged from the hospital. Treatment begins at the Children's Hospital unit that has six beds and receives referrals from the emergency ward of the Children's Hospital, schools, community agencies, family physicians and self referrals. A majority of patients are adolescents who attempted suicide or exhibit uncontrollable aggression. An intake meeting is held involving the team (consisting of a nurse, teacher, psychologist, occupational therapist, social worker and psychiatrist) and the child, family, school and other relevant agencies. Questions, goals and diverging views about the crisis are discussed, and team members offer their particular perspectives for the assessment. Recommendations are made upon discharge meeting which is attended by the same people. During first three months after discharge, weekly meetings with family are held by senior social worker and psychiatrist. The program's occupational therapist holds weekly social skills group, and attendance at educational classes is available for children not immediately able to return to regular schools. Nurses keep regular phone contact with patient and family. Authors provide no details on research data but report that only 8.7 percent of yearly population is readmitted, and that satisfaction scales indicate high satisfaction of parents and children. Upholding the beliefs that patients are best treated when they return to their community, family and school as promptly as possible with support of unit staff, the program makes reinstatement into community into a goal that is not dependent or identical with absence of symptoms. Applying systems thinking, therapeutic intervention is understood as a process permitting the exchange of relevant information between child, family, school and other institutions so as to lower the anxieties about the child returning to the community. The focus of interventions therefore is to reorganize information so that the crisis situation becomes more manageable. Traditional understandings of psychotherapy or methods of diagnosis and treatment are not considered essential.

TRAINING MODELS EMPHASIZING CRISIS PREVENTION AND DE-ESCALATION

Internet searches produced a variety of websites offering training in crisis intervention models that emphasize crisis prevention and de-escalation strategies targeting the individual child. These models include Therapeutic Crisis Intervention (TCI) and programs listed on the "Building Effective Strategies for Teaching Students with Emotional and Behavioral Challenges (BEST)" project website of the University of Vermont (www.uvm.edu/~cdci/best/traininginitiatives.html). BEST provides links for training and technical assistance to "Train the Trainers" for Vermont

schools. Among the programs listed are Crisis Prevention and Management (CPM) Training, Life Space Intervention (LSI) also known as Life Space Crisis Intervention (LSCI), and the Crisis Prevention Institute (CPI). With the exception of LSI, no empirical support for these models could be identified in the published literature.

Therapeutic Crisis Intervention (TCI) and TCI for Family Care Providers (TCIF) was developed by the Residential Child Care Project of Cornell University. TCI stresses crisis prevention and crisis de-escalation in ways that help children learn to avoid losing control. The five-day train-the-trainer program gives agency trainers the tools to teach crisis prevention strategies and crisis intervention techniques to foster and adoptive parents. Trainers are prepared to coach learners during skill practice sessions, to use role playing, to facilitate small group discussions, and to handle resistance to training. There are opportunities to practice activities and to gain immediate training experience in the subject matter. (http://www.rccp.cornell.edu/TCIpage1.htm#)

Crisis Prevention and Management (CPM) Training sets out to "increase the capacity of every school community to humanely and effectively prevent and respond to challenging behavior and school crisis. CPM training focuses primarily on preventing and supporting individuals through behavioral crisis. It is based on the view that discipline is an opportunity to help students learn how to be responsible members of their school community rather than an opportunity to do something to someone. Topics covered in the training include but are not limited to:
1. Distinguishing punishment from discipline;
2. Learning the communicative functions of behavior;
3. Applying the above to individual behavior planning (including techniques of anger management and impulse control) and the strengthening of school culture;
4. Developing strategies for creating nurturing school environments for staff and families; and
5. Learning how to deescalate a behavioral crisis and promote self-reflection."
(http://www.uvm.edu/~cdci/best/traininginitiatives.html)

Life Space Intervention (LSI) is "a therapeutic, verbal strategy for intervention with students in crisis" (Wood & Long, 1991, #24, p. 5) utilized in educational settings. First introduced as "Life Space Interview" by Redl and Wineman in the early 1950s, subsequent authors replaced the term 'interview' with the word 'intervention' to more fully express the approach, and the practitioner's role in the model (Wood & Long, 1991, #24). LSI is sometimes also referred to as Life Space *Crisis* Interview (Beck & Dolce-Maule, 1998, #1). LSI emphasizes the ability for students to self regulate when adults assist them to verbally problem solve based on the students' values. LSI involves six-steps the first three of which identify the crisis (focusing on the incident; needing to talk; finding the central issue and selecting a therapeutic goal), and the final three steps move towards a solution (choosing a solution based on values, planning for success, and getting ready to resume the activity). The six steps are:
  (1) The adult allows the student to "emotionally flood" about the crisis.
  (2) The adult encourages the student to talk about the incident, and to recall events in a sequential timeline. The adult assesses the student's motivation to change.
  (3) The adult assists the student with stating the central issue and discovering a therapeutic goal.
  (4) The adult assists the student to choose a solution based upon the student's own values.

> (5) The adult assists the student to rehearse new behaviors, anticipate consequences, and affirm potential benefits.
>
> (6) The adult assists the student to keep control, formulate a future success plan, and demonstrate responsibility. In addition, examples of abbreviated LSI's are utilized for younger and/or developmentally delayed students.

Beck and Dolce-Maule (1998, #1) describe the successful incorporation of LSI for crisis intervention along with Glasser's Control Therapy and Reality Therapy in an education program for severely emotionally disturbed youth ages ten to eighteen years. The authors employed a qualitative approach to chronicle the school's transformation into a "Quality School." Positive outcomes over a three-year period included a decrease in student behavioral problems and a decrease in the staff turnover rate. Notably, the authors also found that students continued to perform better when they entered the public school system. "They may not have been on the Honor Roll, but they all did internalize the concept of doing the best work they were capable of doing" (Beck & Dolce-Maule, 1998, p. 27).

Mordock (1999, #15) describes his efforts to create a three-stage model with children in a day treatment center using Life Space Intervention as a starting point for calming children in crisis. The author found that the actual interviewing techniques of LSI alone were rarely enough to calm children in that "the prevailing techniques place too much emphasis on finding out what caused each child to lose control and not enough emphasis … on finding ways for each child to regain control or, more importantly, for each child to find ways to become calm" (p. 5). Therefore the author added a second stage that allowed children to distance themselves from the immediate crisis including allowing the children to use motor expression (i.e. play). A third stage consisted of having the child in crisis create positive introjects to calm themselves. Children were asked to remember a positive event and recreate it or symbolize the event.

The Crisis Prevention Institute (CPI) provides training in nonviolent crisis intervention. Described as a "safe, non-harmful behavior management system designed to help educators and human service workers provide for the best possible care and welfare of children who become out-of-control or assaultive," (http://www.uvm.edu/~cdci/best/traininginitiatives.html) the training includes nonverbal and verbal strategies to prevent and de-escalate verbal acting out behaviors, personal safety techniques, therapeutic physical intervention techniques, using a team approach for physical control and restraint, and strategies in therapeutic postvention.

RESEARCH ON PRACTITIONER SKILLS AND PERSPECTIVES

De-Escalation Study

Seclusion or restraint practices are potentially harmful to patients as well as practitioners, and have led to concerns by professional organizations and consumer groups alike (Johnson & Hauser, 2001, #12). A study by Johnson and Hauser (2001, #12) moves away from a focus on seclusion and restraint and instead inquires about how to preempt such measures by successfully de-escalating aggressive psychiatric patients. To that end the authors conducted a qualitative phenomenological study interviewing twenty nurses identified as experts in de-escalating psychiatric patients. Sixty percent of participants worked primarily with adults, 40% primarily with children, 80% on inpatient units, and 20% outpatient. Ninety-five percent of participants were Caucasian, ranging in age between 26 and 63 years. Their years of experience varied between four and 35 years. The authors found that expert nurses know to read both the patient and the situation, know where the patient is on his/her personal escalation continuum, understand

the meaning of behaviors, know what the patient needs at the time, can connect with the patient and match their interventions to the patient's needs. Nurses had values regarding the overall good of their work (such as maintaining patients in the least restrictive environment) and a sense for what is right in the situation. They acted with respect for the patient, asked his or her permission, let the patient know what they were doing and why, gave the benefit of the doubt, choices, and time to respond, used calm tone of voice, empathized and showed support, stayed out of power struggles, did not get caught in the details of a given situation and kept in mind whose needs they were meeting. Their knowledge was highly integrated, and consisted of a repertoire of various strategies. While knowing the patient helped in deescalating, it was not considered necessary. Being able to verbally connect and stay connected was critical. Understanding the context of the situation included an attunement to their own emotional responses, an ability to use their emotional responses purposefully, flexibility in choosing a response and an overall sense of confidence. Expert nurses also spoke of intuition as an immediate sense of knowing. Finally nurses considered eliciting the patient's story an important aspect of preventing escalation to begin with, or being able to know what the patient needs when he/she is already escalating.

As implications for practice the authors note:

Early phases of escalation are most amenable to non-restrictive interventions such as verbally connecting and staying connected, staying calm and using calm tone of voice, verbally pointing out noticed changes in behavioral patterns, and asking what is going on, pointing out where things may be heading, asking what may be helpful, and offering suggestions. Throughout, patients need to be given choices and time to make them. Rather than arguing with patients' points of view empathizing with their perspective is helpful, as is moving the patient away from the center of the milieu. In early phases giving patients an ultimatum may be counterproductive and a "show of force" should be used very judiciously.

When the patient is *already moderately escalated* it is important to continue attempts to connect and stay connected, to offer choices but keep them simple and direct. The presence of other staff may be useful but they must be confident, clear, calm and empathic. Staff should communicate verbally and nonverbally that they care about the patient and want the best. If one has a sense of what the patient wants it is useful to acknowledge the desire, point out that the current behavior is not achieving the goal, and suggest alternative actions.

Crisis Team Study

Lazaro et al (2001, #14) conducted a questionnaire survey study about the perspectives of professionals in multi-disciplinary crisis intervention teams in the UK. Seventy-nine psychiatric consultants, junior doctors, nurses and social workers in the Barnet region north of London, working in crisis intervention teams responded to 37 questions on a Likert-type scale. Questions addressed the perceived appropriateness of referrals, work as a team, safety, follow-up by the community mental health team, and work satisfaction. The analysis compared responses by professional group and found that professionals did not differ in their views on most items. All felt a multi-disciplinary team was a good standard of care, that setting up care plans was not a source of disagreement, and that patients are best assessed at home. All experienced their work as valuable and felt supported by senior colleagues. On ten items, however, views diverged significantly, mostly concerning issues of safety and clinical responsibility. Fifty-eight percent of staff reported having been threatened and 21% being assaulted but only 19% reported feeling frequently unsafe while on duty. Still, junior doctors and psychiatric consultants were less likely

to find safety arrangements sufficient. Junior doctors and psychiatric consultants felt that they held the overall responsibility while social worker and nurses thought that responsibility was shared by the team. A majority of psychiatrists felt that multi-disciplinary meetings were not a useful venue to discuss and review cases. These differences in views about team safety and responsibilities may create significant tensions within teams and may have an impact on the attitudes toward crisis work. Thus authors recommend that measures be taken to address these issues and avoid problems with staff morale and work satisfaction.

DISASTER RESPONSE

Yule (2001, #25) offers recommendations for improving disaster response for children. The author emphasizes the need for schools and other agencies to conduct risk analysis and concrete plans and policies for varying disaster scenarios involving children. Plans should include concrete steps to ensure safety, information flow, and culturally sensitive policies about funeral attendance etc. Agency staff is often trained to deal with individuals or families but not with larger groups of traumatized and anxious people. Connecting with other agency staff and training key personnel will alleviate communication during crisis times. Because disaster scenarios vary, as do people's responses to disasters, there cannot be a "one size fits all intervention". Yule also points out that psychological debriefing programs were developed for emergency personnel not for primary victims or for children. Very few studies evaluate effects of debriefing for children and only two showed some evidence that children who participated fared better on short term follow up (Yule & Udwin, 1991; Stallard & Law, 1993). The author recommends:

- Schools and other agencies should undertake risk analysis and planning
- Agencies must invest in training of key staff
- Key staff should be experienced in dealing with bereft children
- Children's safety, medical and other physical needs must be addressed before beginning psychological interventions
- Interventions should not begin while children are still in shock and disbelief but should begin 5-10 days after the event.
- Some indirect contact should be made immediately to alleviate contacts later
- Groups should be led by appropriately trained people with access to supervision
- Interventions should not be confined to one shot occasions
- Children should be screened and monitored so that further assistance can be implemented as needed.

Debriefing and Crisis Stress Management

Crisis Debriefing

Originally developed to help professionals who serve as first responders, crisis debriefing formats are frequently used with professionals as well as with primary victims of traumatic events, especially in cases of disaster. In recent years there has been a controversy about the clinical effectiveness of debriefing and its appropriate implementation (Everly & Mitchell, 2000, #6). Several studies (McFarlane, 1988; Kenardy et al., 1996), including a meta-analysis known as the Cochrane report (Wessley, Rose & Bisson, 1998), came to the conclusion that debriefing was either not helpful or even harmful to some participants. However, Everly and Mitchell (2000, #6) rebut these claims. Reexamining the studies used in the Cochrane report they come to the conclusion that a majority of negative outcome studies investigated single session

"debriefings" with individuals or used practices that violated standard protocols of Critical Incident Stress Debriefing (CISD) models. The authors found that terms like "debriefing" have been used too loosely, that researchers failed to use standardized debriefing procedures, or failed to implement them according to current standard, for instance by using group procedures with individuals. Given this lack of internal validity, conclusions or generalizations about the effectiveness of "debriefings" should not be made. Rather, the authors suggest, other conclusions can be drawn from the studies, namely that clinicians should be cautious to apply group intervention protocols with individuals, that individualized interventions should not be conducted with a minimal temporal distance to the stressors, and that debriefings should not be used as stand-alone interventions with victims.

Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM)

Everly and Mitchell (2000, #6) and Flannery (2000, #8) reviewed individual and meta-analytic studies and found compelling support of the effectiveness of CISD and CISM although these studies usually did not use randomized controls. CISM is a comprehensive crisis intervention system with multiple components including Critical Incident Stress Debriefing. CISM core elements include pre-crisis preparation, large scale demobilization procedures for public safety personnel and large group crisis debriefings for civilian victims, individual acute crisis intervention, brief small group discussions (defusings), longer small group discussions (also known as CIS debriefings), family crisis intervention, organizational development interventions, referrals. The author takes issue with research about single crisis debriefings that found little or no effects. Shortcomings in research methods as well as implementation should not lead to conclusions about CIS management systems.

Flannery (1999, #7) presents the Assaulted Staff Action Program (ASAP) as a prototype of the CISM model. ASAP was designed and implemented to assist employee victims of psychiatric patient assault or violence. Its philosophy includes the convictions that assault does not come with the job, that violence may precipitate crisis in staff members, that employee victims are worthy of the same compassionate care as any other injured person, and that episodes of assault are not the result of deliberate or intended faults by employees. ASAP structures follow the CISM approach to address the psychological sequelae of potentially traumatic critical incidents. Teams include first responders, supervisors and team leaders comprised from all disciplines and interested administrators. First responders are on call and provide immediate on site interventions and then follow up within three days. Supervisors provide back up and co-lead group debriefings with team leaders. Weekly staff meetings and in-services are held. Services include individual crisis interventions, weekly staff victim support groups, group interventions (debriefings), employee family interventions deemed particularly useful for children of employees who fear for their parents' safety, and professional referrals. The author reports ASAP has been implemented at eleven sites since 1998 including hospitals community mental health centers, community residential programs, etc. with good responses. As a side effect, declines in the rates of assault were reported by several programs. Estimating the costs for an ASAP team at a hospital at $40,000 year, the author finds the program cost effective considering the costs of turnover when staff quit over violent episodes, costs of medical leave, medical and legal expenses and sustained productivity.

CISM with Children Using Art

Using qualitative research elements, Morgan and White (2003, #16) describe a treatment model that modifies CISM for children to include art making. Participants included four groups of a total of 29 children and adolescents who were primary or secondary trauma victims. Initial intervention procedures included the availability of juice and snacks as well as "dry" art materials such as paper, markers, crayons, etc. "Wet" materials were judged to increase emotional arousal and thus avoided. Participants were invited to partake of food and art materials, but were not required to. Facilitators suggested they draw or doodle anything they want and the content could be relevant to what they wanted to talk about. There would be an opportunity but no requirement to talk about their art later. A wall chart outlined a seven-step procedure: (1) ground rules, (2) facts, (3) thoughts, (4) reactions, (5) symptoms, (6) teaching, (7) re-entry. The authors concluded that functions of the art making in the process included (1) an increase of comfort and emotional safety by reducing the anxiety about face-to-face communication, adding the sensual nature of some art materials, (2) the promotion of expression of thoughts and feelings including the sheer motor discharge of being active, redirecting psychological energies from dealing with emotions directly to dealing with the matter of emotions symbolically, and opportunity for unconscious emotional material to emerge, (3) enhancing appropriate containment of emotions by offering ways to project, sublimate, etc., and (4) supporting ego strength by offering opportunities for mastery, choice, resiliency and creative thinking. Common errors in the process that are to be avoided are premature attempts to talk about art work, offering interpretations, or allowing comments about other participants' artwork.

CONCLUSIONS AND RECOMMENDATIONS

Community-based crisis programs set out to offer short-term, intensive interventions aimed to alleviate current difficulties, avoid unnecessary hospitalization, and restore an individuals' functioning to previous levels or better if possible. Available 24/7, crisis programs provide an immediate response (at least within 24 hours of the initial call), evaluation, assessment, intervention and stabilization as well as follow up planning, while focusing on problem solving and new coping skills. Usually, immediate and extended family members are involved as much as possible in all phases of treatment. Service types include telephone hotlines, crisis group homes, walk-in services, runaway shelters, mobile crisis teams, therapeutic foster homes, if used for short term crisis placements, as well as crisis stabilization units, hospital emergency rooms, and inpatient services. However, in the absence of child and family focused crisis programs a significant number of children are likely hospitalized or inappropriately served through adult crisis models. Thus, community mental health services are well advised to further the availability, quality and integration of crisis services for children and maximize continuity of care for children and families by integrating crisis services into continuum of care.

Only a few experimental studies have been conducted on community based crisis intervention models for children and youth, and even fewer provide longer term follow-up data. Still, experimental and non-experimental research provide some evidence that crisis intervention programs can successfully divert hospitalization for many children and adolescents with emotional and behavioral disabilities in favor of less restrictive community-based alternatives. It should be noted, though, that the need for hospitalization cannot be fully eliminated. Hospitalization usually remains necessary for a number of children with SED.

There is also evidence that crisis programs can also bring about improvements in behavior, diminished suicidal tendencies, and increases in self-concept for some children, or heightened parental self-efficacy. However, it appears that many of the gains children with SED initially make on behavioral scores, self concept or other measures will dissipate after the intervention ends and that their preexisting, chronic difficulties will continue (Henggeler et al., 2003, #10; Evans et al., 2003, #5). Therefore, for SED children crisis programs alone may not be sufficient to maintain gains beyond the end of intervention unless "booster" services or ongoing supports are employed, or crisis services are fully integrated into a continuum of care ensuring the continuity of services with an appropriate intensity.

Effective crisis teams usually combine various professions such as social workers, psychologists and psychiatrists. Quick access to child psychiatric and medical assessment is a necessary component. Teams should be guided by shared visions and values such as a commitment to avert unnecessary out-of-home placements and involvement of families. In order to prevent dissatisfaction, turnover, and burnout teams should also create consensus about team members' respective responsibilities as well as discuss and monitor their sense of safety.

Effective crisis response for children requires staff who are trained in crisis intervention as well as in the approaches needed to work successfully with children and families. Practitioners should bring experience in child and family mental health, and experience in crisis theory and intervention. This combination of experiences includes such skills as the ability to apply ecological/ systems approaches as well as strengths-based approaches in assessment and intervention withy children and families, as well as the ability to successfully de-escalate clients to preclude more drastic and risky measures like restraint or seclusion. Successful de-escalation requires the integration of values (such as maintaining patients in the least restrictive environment, avoiding seclusion or restraint, respect for the client), a good sense of timing, and a repertoire of various strategies. Specific skills include asking client's permission, letting the client know what is being done and why, allowing for choices and time to respond, using a calm tone of voice, empathy, support, avoiding power struggles, not getting caught up in details, being able to verbally connect and staying connected. Successful de-escalation further requires understanding the context of the situation, attunement to own emotional responses, flexibility in choosing a response, and eliciting the client's story.

Crisis debriefing and crisis stress management models were developed to assist providers of crisis intervention. If implemented according the standards, there is some evidence of the effectiveness of programs such as Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM) on staff. Properly led debriefing should be available to all crisis staff. There is much less clarity about the effectiveness of debriefing strategies for primary victims or traumatic events, and young victims in particular. Given the original purpose of debriefing and contradictory interpretations of research, the use of debriefing strategies with primary victims should be applied cautiously, and only by personnel well trained in specific debriefing models.

Recommendations:
Current Best Practices in Crisis Services for Children and Adolescents
This review of empirical research and other pertinent literature supports the following:

Programming
- Provide 24/7 intensive, in-home crisis interventions, ready to adapt service times and locations to family needs
- Emphasize the use of an ecological, strengths-based family approach to assessment and intervention
- Focus on prioritizing most pressing needs
- Focus on communication and problem-solving skills
- Include the provision of concrete services, and availability of flex money
- Provide linkages to other more and less intensive services in the community including access to crisis beds in local crisis stabilization programs, hospitals and respite care
- Assure easy access to child psychiatric evaluations and medical services

Especially for SED populations, **prevent crises** by providing accessible, affordable, ongoing community-based support services to children and their families, and **maximize the continuity of care beyond crisis services** to prevent or curtail future crises, by
- involving the same staff in crisis and ongoing services,
- providing "booster" crisis services and ongoing supports beyond the typically short-term scope of crisis intervention
- integrating crisis services into full continuum of care

Staffing and Caseload
- Use a multi-professional team approach
- Recruit staff skilled in child and family services as well as crisis intervention
- Assure a low caseload of 2-4 families in crisis at a time
- Have bilingual service providers available

Training and Supervision
- Further the integration of child mental health and crisis intervention by cross-training staff and providing hands-on training
- Provide De-escalation training
- Grant time and opportunities for teams to build consensus regarding their goals, values, responsibilities, and sense of safety.
- Allow for team feedback and self-assessment.
- Assure the availability of ongoing, close supervision at all times
- Assure the availability of trained personnel to provide critical incident stress debriefing to staff

Research
Finally, given the scarcity of research about the effectiveness of crisis services for children and adolescents with SED
- Conduct research to establish the short and long term effectiveness of existing or new models of community crisis services on hospital diversion, out-of-home placement, behavioral scores, family satisfaction and other measures.

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Appendices

Appendix A - Matrix of Selected Literature

Appendix B - Kansas Definitions of Types of Crisis Services,
and continuum of crisis supports