



Mental Health Crisis Planning for Children

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

INTRODUCTION

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

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

This booklet will help you understand what can cause a crisis, the warning signs of a crisis, the strategies to help de-escalate a crisis, resources that may be available and how to create a crisis plan. Information on communication and advocacy skills for families is included along with a sample crisis plan. The term *child* is used throughout the booklet and refers to both children and adolescents.

RECOGNIZE

What is a mental health crisis?

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

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

What causes a mental health crisis?

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

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

Home or environmental triggers

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

School triggers

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

Other triggers

- Stops taking medication or misses a few doses
- Starts new medication or new dosage of current medication
- Medication stops working
- Use of drugs or alcohol
- Pending court dates
- Being in crowds or large groups of people
- Changes in relationship with boyfriend, girlfriend, partner
- Community violence or trauma

What are the warning signs of a mental health crisis?

Sometimes families or caregivers observe changes in a child's behavior that may indicate a crisis may be impending; while other times the crisis occurs suddenly and without warning. You may be able to de-escalate or prevent a crisis from

happening by identifying the early changes in your child's behavior, such as an unusual reaction to daily tasks or an increase in their stress level. Families may want to keep a journal or calendar documenting what preceded the behaviors that are of concern. A sample journal is included in the back of this booklet.

Here are some warning signs of a mental health crisis:

Inability to cope with daily tasks

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

Rapid mood swings

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

Increased agitation

- Makes verbal threats
- Violent, out-of-control behavior
- Destroys property
- Cruel to animals
- Culturally inappropriate language or behavior

Displays abusive behavior

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

Loses touch with reality (psychosis)

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

Isolation from school, family, friends

- No or little interest in extracurricular activities
- Changes in friendships
- Stops attending school, stops doing homework

Unexplained physical symptoms

- Facial expressions look different
- Increase in headaches, stomach aches
- Complains they don't feel well

MANAGE

What to do in a mental health crisis?

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

If you are worried that your child is in crisis or nearing a crisis, seek help. Assess the situation before deciding whom to call. Is your child in danger of hurting themselves, others or property? Do you need emergency assistance? Do you have time to start with a phone call for guidance and support from a mental health professionals or crisis team? **Most importantly – safety first!**

In a crisis situation, when in doubt, go out.

De-escalation techniques

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

De-escalation techniques that may help resolve a crisis:

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

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

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

Not in immediate danger

If you do not believe your child is in immediate danger, call a psychiatrist, clinic nurse, therapist, case manager or family physician that is familiar with the child's history. This professional can help assess the situation and offer advice. The professional may be able to obtain an appointment or may be able to admit the child to the hospital. If you cannot reach someone and the situation is worsening, do not continue to wait for a return call. Take another action, such as calling your county mental health crisis team. **If safety is a concern, call 911.** However, be sure to tell them this is a mental health crisis. (See "immediate danger" section for additional information.)

Mental health crisis phone lines and crisis response teams

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

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

Crisis teams are meant to be accessible to anyone in the community at any time. They are available 24 hours a day, seven days a week and 365 days a year to meet face-to-face with a child in a mental health crisis, conduct a mental health crisis assessment and create a crisis treatment plan. A child does not have to have a mental health diagnosis to receive crisis services. Crisis teams will respond and address the situation regardless of whether or not the child has insurance. If the individual in crisis does have insurance, the crisis team will bill their insurance company for services they provide. Some crisis teams offer interpreter services

for non-English speakers who require assistance, although those who need an interpreter may have to wait longer to receive crisis services depending on the interpreter's availability.

Crisis teams can help children living with a mental illness and their families:

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

The crisis team will ask questions to determine the best way to address the situation. They may ask you:

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

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

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

When you call your mental health crisis team, they will triage the call to determine the level of crisis service needed. If the person experiencing a crisis is in immediate danger to themselves or others, the crisis team will refer the situation to 911, and

law enforcement will respond. If the situation is not as urgent, the crisis team will assess the level of intervention required: information and referral, a phone consultation, an emergency room visit or an immediate site visit.

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

Stabilization services

The crisis team may recommend crisis stabilization services. These services may be provided in the child's home, the home of a family member or friend, in the community or at a short-term licensed residential program. Services are available for up to 14 days after crisis intervention. Crisis beds are also available to individuals who are experiencing a mental health crisis or have been referred by a crisis team. These beds may be located in a foster care facility or crisis home, and there are specific requirements for staffing in these facilities.

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

At a minimum, a treatment plan will include:

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

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

In immediate danger

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

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

Law enforcement response

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

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

If the child has no history of violent acts, be sure to point this out. Lay out the facts efficiently and objectively, and let the officer decide the course of action.

Remember once 911 has been called and the officers arrive on the scene, **you do not control the situation**. Depending on the law enforcement officers involved, they may take your child to detention instead of to a hospital emergency room. Law enforcement officers have broad discretion in deciding whom to arrest, whom to hospitalize and whom to ignore. You can encourage and advocate for the law enforcement officers to view the situation as a mental health crisis. **Be clear about what you want to have happen without disrespecting the law enforcement officer’s authority**. But remember, once 911 is called and law enforcement officers arrive on the scene, they determine if a possible crime has occurred, and they have the power to arrest and take into custody a person that they suspect of committing a crime. If you disagree with the officers don’t

argue — later call a friend, mental health professional or advocate for support and information.

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

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

Emergency department

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

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

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

Emergency holds (*a term used under the commitment law*)

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

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

PREVENT

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

In order to prevent a crisis, it's also important to ask yourself:

- What situations have led to a crisis in the past?
- What has worked to help reduce my child's stress or to avoid a conflict in the first place?
- What steps can I take to keep everyone safe and calm?
- Whom can I call for support in a crisis or to help calm the situation?
- Should I consider a medic alert tag or bracelet for my child?
- What skills could I or my child learn and practice to reduce the impact of future crisis?

- Have I developed a crisis intervention plan? Does it need to be updated?
- What can I do to reduce family stressors?
- Have I utilized all available resources?

LEAP method

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

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

- Listen and learn; drop your agenda
- Use questions, not statements
- State what you heard - all of it (reflecting)
- Don't avoid scary topics or thoughts (even delusions)
- Know your child's "hot button" fears
- Don't rush it
- Don't have an emotional reaction to what you hear
- Don't try to problem solve

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

- Express empathy for feelings
- This doesn't mean you have to agree with beliefs
- Normalize: "I think I would feel that way too (if I had those beliefs)."
- Listen + Empathy = "What do you think?"

Common feeling and experiences to empathize with:

- Frustration
- Grief
- Discomfort
- Hopes and dreams (desired)

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

- Stick to perceived problems and symptoms only
- Review advantages and disadvantages of treatment

- Agree to disagree when needed. It's okay to set boundaries
- You can try to correct misinformation gently
- Reflect back and highlight the advantages. Use this as the basis for a plan

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

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

Practicing these strategies before a crisis occurs will make them easier to use when needed.

Collaborative problem solving

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

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

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

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

PLAN

Create a crisis plan

Children can experience a mental health crisis even when their families have utilized the best resources offered by mental health professionals, the local school system, advocacy agencies and social service organizations. A crisis plan is a written plan designed to address behaviors and help prepare for a crisis. Preparing for a crisis is an individualized process. However, there are some common elements that can be found in a good crisis prevention plan.

Child's information – name and age of child, mental health diagnosis, medical history, list of child's strengths and interests.

Family information – name of parents, step-parents, list of family members who live in the home and family members with close ties.

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

Medication – name and type of medication, dosage, prescriber's name and phone number, pharmacy name and phone number, list of medications that have not worked in the past and known allergies.

Treatment choices – list of interventions or treatments that are being used, list of interventions that have not worked in the past, treatments that should be avoided, list of treatment preferences.

Professional involvement - phone numbers of children's crisis team, family doctor, therapist, social worker, psychiatrist, and hospitals with psychiatric units.

Supports – adults the child has a trusting relationship with such as neighbors, friends, family members, favorite teacher or counselor at school, people at church or work acquaintances.

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

Resources – advocacy organizations, support groups.

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

Remember:

- Talk with ALL family members and discuss what to do, if this were to happen. This is IMPORTANT. There is no reason to be embarrassed. The more you talk about it, the more comfortable your family members will feel and the more education they will get.

- Contact your local police department; provide them with a copy of the crisis plan.
- Create a safe environment by removing all weapons and sharp objects.
- Lock up all medications, both over-the-counter and prescription medications.
- Create a plan that keeps other family members safe, especially younger children in the home.
- Know the number of your county mental health crisis team.

Create a crisis kit

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

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

Reflect

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

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

Write down the results of this reflection and include it in future crisis plans. The more you understand the underlying causes and triggers of a crisis and what strategies helped, the more prepared you will be in case of future crises.

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

ADVOCACY

Advocating for a child with a mental illness in the midst of a crisis can be extremely frustrating and difficult. It is not easy to navigate the system or to obtain appropriate services for your child. Parents are their child's best advocate. They know their child best and most of the time know what they need but not always how to ask for it. You may need help to learn how to advocate appropriately and effectively. Learning to be an advocate and developing these skills takes time.

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

Be organized

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

In your binder include the following:

- Current diagnostic assessment
- Copy of the current crisis plan
- Notes from phone calls and meetings
- Hospitalization history
- List of medications and dosages
- Copies of all service plans, evaluations and progress notes including school IEP and 504 plans
- Names and phone numbers of mental health professionals and mental health agencies working with your child

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

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

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

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

Be objective – stay calm

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

Get support

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

Be effective

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

Verbal and nonverbal communication work together to convey a message. You can improve your spoken communication by using nonverbal signals and gestures that reinforce and support what you are saying and that will be accepted by the professionals at the table. This can be especially useful when speaking to a large group of people.

Some of these non-verbal techniques are:

- Use as much eye contact as is comfortable for you
- Concentrate on your tone of voice, keep it calm
- Avoid nonverbal gestures and hand signals which can be misread

- Sit next to the most important person at the meeting
- Speak slowly and clearly

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

Paraphrasing – Put into your own words what the other person has said. Do this by using fewer words and providing facts.

Reflective Listening – Focus on the feeling or emotion of what has been said. State back what you hear and see, taking note of the nonverbal communication as well and the words that are spoken.

Summarizing – Sum up what the other person has said. Do this after a person has spoken for a long period of time.

Questioning – Ask open-ended questions to clarify what has been said.

I-Statements – Start sentences with “I.” Take ownership of what has been said and state back what you heard: “I heard you say...is that correct?”

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

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

CONCLUSION

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

CHILD Short-Term Crisis Intervention Plan

Child and Family Information:

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

Description of child/family strengths:

Description of immediate child/family needs:

Safety concerns:

Treatment choices:

Interventions preferred:

Interventions that have been used:

Interventions that should be avoided:

Professional involvement:

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

Supports to use in crisis resolution:

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

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

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

Written Log

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

Calendar Log

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

Common Terms

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

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

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

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

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

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

Federal and National Resources

Bazelon Center for Mental Health law
www.bazelon.org

Child and Adolescent Bipolar Foundation
www.bpkids.org

Children with Attention Deficit Hyperactivity-Disorder
www.chadd.org

National Alliance on Mental Illness
www.nami.org

National Child Traumatic Stress Network
www.nctsn.org

National Federation of Families for Children's Mental Health
www.ffcmh.org

National Institute of Mental Health
www.nimh.nih.gov

NYU Child Study Center
www.aboutourkids.org

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.gov

U.S. Department of Education
www.ed.gov

Social Security Administration
www.ssa.gov

Substance Abuse Mental Health Services Administration
www.samhsa.gov

State Resources

Arc of Minnesota
www.arcmn.org

Juvenile Justice Coalition
www.jjcmn.org

Minnesota Association for Children's Mental Health
www.macmh.org

Minnesota Children's Mental Health Division
www.dhs.state.mn.us/cmh

Minnesota Autism Society
www.ausm.org

Minnesota Children and Youth with Special Health Needs
www.health.state.mn.us/mcshn
www.health.state.mn.us/suicideprevention

Minnesota Council of Child Caring Agencies
www.mccca.org

Minnesota Department of Corrections
www.doc.state.mn.us

Minnesota Department of Education
www.education.state.mn.us

Minnesota Disability Law Center and Legal Aid
www.mndlc.org

Minnesota Parent Leadership Network
www.mpln.org

National Alliance on Mental Illness of Minnesota
www.namihelps.org

Office of Ombudsmen for Mental health and Developmental Disabilities
www.ombudmhm.state.mn.us

Parent Advocacy Coalition for Educational Rights (PACER)
www.pacer.org

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

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