APA Resource Document

Approaches to Youth in Mental Health Crisis

Approved by the Joint Reference Committee, June 2021

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." -- *APA Operations Manual*.

Prepared by the APA Council on Children, Adolescents, and Their Families

This document provides an overview of contemporary approaches to youth in mental health crises with practical, solution-oriented recommendations. It provides developmental considerations when dealing with youth in crisis, the continuum of existing response models and encourages readers to understand their role in advocacy through clinical vignettes. The resource document emphasizes de-escalation and rapid linkage to clinical evaluation services and supports the APA's goal of ensuring young people in mental health crises and their families receive support by first responders who are appropriately trained to address their needs.

In February 2021, the American Psychiatric Association (APA) condemned a police officer's use of pepper-spray to subdue a seated, handcuffed, 9-year-old child in Rochester, New York whose parents had called for mental health support when the child was having a mental health crisis.[1] Video footage of the incident drew national attention and condemnation. Apparent problems in the officers' interaction with the 9-year-old child included the lack of effective de-escalation techniques, ineffective use of commands and threats to gain compliance, denial of the child's request for a parent/guardian, and the rapid escalation to aversive pepper spray use even while child was seated and restrained in a police vehicle. While some may argue that the officers followed their established protocol, this situation highlights some of the challenges when police interact with youth in mental health crisis. Some states prohibit the use of handcuffs for young people under the age of 12 unless they are at risk of harm to themselves or others,[2] underscoring the need for developmentally appropriate responses to young people in crisis. We, as experts in children's mental health, support the use of non-violent, developmentally appropriate and trauma informed interventions for young people in crisis.

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1. Definitions

Term	Definition
Mental health	An individual's psychological, emotional, and social health. Mental health affects how we think, feel, and act. It also affects how we handle stress, relate to others, and make choices.

Crisis intervention	Immediate, short-term help to reduce damage to individuals affected by crisis. The crisis is often an event that produces emotional, mental, physical, and behavioral distress or problems.
De-escalation	Helping the individual calm him/herself by using communication strategies in order to resolve conflict and encourage self-regulation. Other terms include conflict resolution, talk down, and defusing. De-escalation is the recommended first-line step in assisting someone in a mental health crisis.[3]
Dysregulation	Excessive reactivity to perceived negative stimuli, it can be manifested by changes in mood or behaviors that appear out of control.
Aggression	Behavior (emotional or psychological) that can result in harm to self or others. It is a response to perceived threats and is typically linked to strong emotions such as anger, injustice, fear, and so on[4]
Motivational approach	Empowers a person to make a needed behavioral change by encouraging self-motivation[5]
ACE	Adverse Childhood Experiences. Potentially traumatic experiences that occur in childhood. For example, violence, abuse, and growing up in a family with substance abuse or mental illness. ACEs can have negative impacts on a person's health later in life.[6,7]

2. Developmental Considerations: The Science of a Brain in Crisis

The brain of a child in a behavioral or emotional crisis is like a "brain on fire." The fear center (amygdala) is overactive, while the rational decision-making area (prefrontal cortex) is significantly under-developed. The brain is flooded with glutamate, an excitatory neurochemical, while the body releases large amounts of adrenaline and cortisol, the flight-or-fright-or-freeze hormones. In this state, a child's brain in crisis is after its most basic need: safety. Some children are likely to have more difficulty managing their emotions if they carry one or more psychiatric diagnoses. However, once safety is established, the brain can turn down the alarm signal.

Safety may be established by a familiar person, place, animal, or toy. Softer voice and tone, physical distance, asking questions rather than giving commands and physically lowering oneself to a child's height when talking can reduce fear. It is also important to encourage helpful behaviors instead of giving attention to problematic behaviors. Forcing children to follow commands before safety has been established risks creating fear and anxiety. Violence should not be used against children.

A child's traumatic encounters with authority figures are informed by the history of such interactions and can have lasting detrimental effects. Children from poor, minority and other marginalized communities are overpoliced, unfairly stereotyped, and over-punished by the education, law enforcement, and criminal justice systems alike.[8-11] Black and Brown-skinned children are often branded as problematic at an earlier age, treated as adults rather than as children, and face lower expectations of achievement.[9,11,12] Repeated antagonistic interactions with authority figures can worsen emotional and behavioral dysregulation for these children, and can lead down a pathway from school disciplinary action to juvenile hall, jail, and prison.[8,13-,17]

Law enforcement has an opportunity to intervene positively in this cycle.[18] Their firsthand experience may help them appreciate how a child in crisis can perceive them as threatening. Establishing safety and finding less threatening allies as surrogates can build rapport with a child and is an effective way for a law enforcement official to avoid perpetuating childhood trauma. Using these measures when encountering a child in crisis is also an opportunity to dispel expectations of police brutality and distrust in the community.

First responders of all types must be critically self-reflective. If they feel themselves becoming emotionally charged by a child's behavior, first responders can take a time-out, "tag out" with a colleague, or remove themselves from the situation to allow time to self-regulate charged emotions.

Developing children are still learning how to identify and express their emotions. Labeling children with judgmental terms, such as manipulative, disrespectful, or malicious, is misplaced and harmful. We should use our understanding of children and our positions of authority to protect and nurture them as they grow.

Developmental Considerations Section Takeaways

- *Recognize the young person's age, developmental level, and vulnerabilities during crises.*
- *Promote safety through de-escalating nonverbal and verbal strategies as well as involving allies to decrease the fear response.*
- *Avoid using violent physical force or restraints on a young person to ensure compliance with directions as this may cause lasting trauma.*

3. The Continuum of Crisis Response Models

In most localities, crisis situations are usually accessed through a central 911 dispatch service with the goal of providing rapid intervention. Such dispatch services field calls about a wide range of crisis situations including, but not limited to, medical concerns, violent crimes, non-violent crimes, domestic complaints, mental health crises, and even children's misbehavior in school. When youth are in crisis in their homes, schools, or communities, the 911 dispatch service is often called to the most critical first responders - paramedics, police officers, and increasingly, crisis response teams.

The role of first responders dealing with a child or youth requiring mental health crisis intervention due to dysregulation, aggression, suicidal behaviors, or other signs of emotional distress, in their home, school, or community, is de-escalation, stabilization, and linkage to mental health evaluation services. This is the guidance by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care that recommend crisis teams respond without law enforcement except in special circumstances.[19]

The SAMHSA guidelines emphasize the need for a comprehensive, integrated crisis response that incorporates structural and programmatic core components, such as a regional crisis call center, mobile crisis teams, and crisis stabilization facilities. Understanding that each community has different access to these resources, we present the Continuum of Response available to local communities interested in improving their current response framework (refer to Table 1). This document focuses on two ends of

the continuum, specifically, Mental Health Professionals Respond to Crisis and the Police Officers with CIT training respond to crisis.

While each response model has strengths and weaknesses, data suggests that models of trained mental health professionals as first responders have particular advantages and should be considered by all localities.

Table 1. Proposed Continuum of Community Crisis Response Models
Mental Health Professionals Respond to Crisis via Mobile Crisis Teams
Mental Health Professionals and Paramedics Co- Respond to Crisis
Plain Clothed Police with CIT Training and Mental Health Professionals Co-Respond to Crisis
Police Officers with CIT Training and Mental Health Professionals Co-Respond to Crisis
Plain Clothed Officers with CIT Training Respond to Crisis
Police Officers with CIT Training Respond to Crisis

a. On the Continuum, Mental Health Professionals Respond to Mental Health Crisis:

The use of mental health professionals to respond via mobile crisis teams may have multiple positive social impacts.

Benefits and features include:

- Involvement of multiple stakeholders, such as departments of public health and behavioral health services, police departments, and paramedics without direct police involvement
- Involvement of multidisciplinary teams of mental health professionals, other healthcare workers such as paramedics and nurses, and trained peer support counselors
- Use of trauma-informed conflict de-escalation techniques
- Diversion of individuals who are suffering from non-violent behavioral health crises, including substance use and/or homelessness, from the criminal justice system or emergency departments into much needed mental health treatment, and provision of services such as shelter, food aid, and medication
- Freeing of law enforcement to focus on higher acuity issues requiring their expertise
- Cost savings of as much as $8.5 million a year.[20] Identification of 'high utilizers' of the justice system, emergency room, and other high cost systems within the community through the use of electronic media and early screening at arrest may obviate the need for law enforcement, and can instead connect the individual to mental health services

This model may present shortcomings for some localities, as it:

- Requires an investment in community based mental health resources, especially in rural and under-resourced urban communities.

- Involves the availability of teams that can intervene in emergencies in the community while staying attuned to the needs of populations that may require more nuanced approaches, such as children and adolescents and individuals with developmental disabilities or substance use disorders.

Model Programs:

- Crisis Assistance Helping Out on the Streets (CAHOOTS) program in Eugene, Oregon[20] (very established)
  - CAHOOTS is run by White Bird, a community health clinic, and has been funded by the police department for more than 30 years. There is currently interest in replicating the model nationally.[21]
- Denver Support Team Assisted Response (STAR) program (more recently established)[22]
- San Francisco Street Crisis Response Team (SCRT) pilot program (more recently established)[22-24]

Mental Health Professionals Respond Sub-Section Takeaways

- *Involving Mobile crisis teams is potentially cost saving for localities, avoids the school to prison pipeline, and frees law enforcement to focus on other emergencies*
- *Localities would need a supportive local mental health infrastructure to facilitate teams and rapid access to treatment.*

b. On the Continuum, Police Officers with Crisis Response Training respond to crisis

Crisis Intervention Teams training or "CIT" training, trains police officers to peacefully de-escalate crisis situations in which there may be underlying mental health issues contributing to the crisis. CIT acknowledges that police officers frequently respond to mental health crises due to a large gap in mental health crisis services. Mental health crises can be frightening and can compromise the safety of individuals involved. With appropriate training, police officers can effectively de-escalate crisis situations. Officers trained in CIT are educated in the role that mental health crises frequently play in behaviors leading to 911 calls.[25]

Basic tenets of CIT include:

- Respond to a mental health crisis with a warm, non-threatening demeanor and non-confrontational posture
- Prioritize verbal de-escalation of crisis over force
  - Engage individual in conversation
  - Maintain steady tone of voice
  - Respect personal boundaries of individual in crisis

Benefits and Features include:

- Directs youth experiencing mental health crises to treatment, rather than incarceration
- Maintains the safety of youth and responding officers
- Optimizes allocation of officers towards addressing criminal offenses
  - Reduce the overall time officers spend on mental health crises, thereby increasing availability of officers to the community

- Save long-term costs, for example, towards incarceration

Shortcoming of CIT:

- Requires more evidence on efficacy to support widespread adoption, despite officers' self-reported positive outcomes when engaged in CIT training voluntarily versus mandated.[26, 27]
- Concern that CIT perpetuates needless injury and death by continuing to engage in law-enforcement-led responses.[28-35]

Model Programs:

Please refer to the following links for more information on CIT programming:

- www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs
- www.citinternational.org/Learn-About-CIT

Crisis Intervention Training Sub-Section Takeaways

- *Crisis Intervention Training (CIT) empowers police officers to recognize clinical signs and symptoms of emotional or behavioral disturbances and provides training in crisis de-escalation strategies.*
- *However, we must advocate to reduce hostile interactions between law enforcement and individuals with mental illness.*

The Continuum of Crisis Response Model Section Takeaways

- *Mental Health professionals are a crucial resource for communities to ensure a compassionate, empathic, and effective response to mental health crises in the community.*
- *Police officers responding to mental health crises should be trained to work with local mental health organizations, recognize mental illness, use de-escalation skills, and prevent use of violent physical force or restraint.*
- *Development of partnerships between key emergency response services is needed to create the crisis response model that works for your community.*

4. Case Vignettes and Discussion

Each of the cases below describes a scenario involving a child or adolescent at school, home or community demonstrating behavioral symptoms. Readers are asked to reflect on their local protocol to manage these types of situations. The vignette goes on to describe one negative outcome of the scenario and an alternate scenario that reinforces some of the principles described in this document. In the points to consider section, readers are left to consider role of individual players as they seek to achieve improved outcomes.

Anna | Enrique | Robert | Chris | Juan

Anna

Anna is a 9-year-old diagnosed with Autism Spectrum Disorder. She loves her bunny. She became angry when her classmate, John, called the classroom bunny "ugly." When John picked up the bunny and slammed it hard on the floor, Anna hit and kicked John, attempted to bite him, and threw chairs. When the school principal attempted to intervene, Anna bit the principal.

Reflection:

What is your school or community's current response protocol to this type of situation?

What happened to Anna? Due to Anna's aggressive behavior, the school called her parents and the local police per its protocol. When police arrived, Anna remained aggressive. She was handcuffed and placed in a police car for transport to the nearest emergency room. Anna remained enraged and her mother was inconsolable and felt powerless watching her daughter being arrested.

What could have happened? When a student or youth acts out in response to negative emotions, we should allow them space. In this particular case, the teacher could have cleared the classroom to allow Anna the space and time to calm down. After removing students from the classroom, the teacher could start an open, non-judgmental conversation to solicit the feelings and thoughts underlying her aggressive behavior. Allowing Anna to share her feelings and express her frustration, may have helped calm her down. Once Anna was calmer, the teacher could escort her to the principal's office to explain the situation and seek further support. This could have prevented Anna's outburst towards the principal, and subsequent police involvement. The teacher and principal could call Anna's mother to discuss the situation and brainstorm how to restore classroom safety and determine the appropriate consequences for Anna's actions.

Points to Consider:

School Role: Create and use an Individual Educational Plan to target physical aggression if this is identified as a problem for Anna.

First Responder Role: A crisis intervention team is a good option instead of law enforcement and would be staffed with personnel that could take a developmentally informed approach to Anna. This would involve verbal de-escalation, collaboration with the school personnel and Anna's family to assist in stabilization and connection to a mental health service if indicated. If law enforcement officers are the first responders, CIT trained police officers would emphasize de-escalation techniques and avoid traumatizing Anna through use of force. Children with developmental and intellectual limitations may be mistrustful of authority figures and first responders will need a gentle, non-forceful, and non-threatening approach in order to stabilize the situation.

Enrique

Enrique is a 14-year-old refugee who struggles with Post Traumatic Stress Disorder. He became irritable and depressed when his girlfriend broke up with him. When his mother told him it was his turn to do the dishes, he became angry, threw his plate across the kitchen, and swung around a metal trivet in a grocery store bag. His mother felt threatened, and his father tried to take the trivet from him. The situation escalated and the older brother called the police.

Reflection:

What is your community's current response protocol to this type of situation?

What happened to Enrique? The police arrived, and due to a language barrier, Enrique's parents could not fully explain the situation to the police officer. The police officer apprehended the boy, who then became aggressive with the police. Enrique was handcuffed, causing injuries to his hands and wrist. He could not stop crying on his way to the juvenile detention center.

What could have happened? When youth act out at home in aggressive ways, it can be very scary for the family and they reach out to local emergency services for help when the situation feels out of their control. However, most families want support but may worry that a police officer's presence may further de-stabilize a situation. While Enrique was aggressive with his family, his age, irritable demeanor and his depressed mood, could have been better handled by the crisis intervention team or CIT trained police officers. Interpreter services could have clarified the details of the situation with the parents. Youth in crisis need space to calm down and time to ventilate their feelings. Once calmer, Enrique should be escorted to the local emergency room for a psychiatric evaluation and connection to outpatient mental health supports instead of the juvenile detention center.

Points to Consider*:*

Community Role: Mental illness in youth may lead to behavior problems, which may result in police interventions. For refugees, their cultural background, language barriers, and acculturation issues may affect their presentation and their response to interventions. Recognizing their vulnerability and obtaining assistance from their assigned caseworker may support their mental health needs and protect them from involvement in the legal system.

Robert

Robert is an 8-year-old boy who lives with his grandmother in Queens, NY, after his parents were imprisoned on drug charges. One day, he was roaming the streets and "hanging with the wrong crowd." He stole a friend's skateboard, and the police were called. The local police were familiar with Robert and his family. Robert was arrested.

Reflection:

What does your community currently do in this type of situation?

What happened next? The police officer became frustrated with Robert since the boy's hands were slim and the handcuffs kept slipping off. The officer informed him he was going to jail, which led Robert to cry and call for his grandmother.

What could have happened next? The police officer commented, "Robert, I wonder why you're not at home right now." Robert said his grandmother "didn't have time" to play with him, so that's why Robert took off. The police escorted Robert back to his grandmother's home and informed her of what happened with Robert. grandmother said she would take him to apologize to the friend whose skateboard he took and discuss the incident at the next counseling session with case worker.

Points to Consider*:*

Family Role: Robert could benefit from his grandmother's support during this time. His parents' incarceration may cause others to preemptively judge him guilty and justify his arrest. Naive to the circumstances, he may think he will never return to his elderly grandmother.

Police Role: Police officer may have avoided use of restrictive handcuffs which, in children, should be avoided.

Chris

Chris is a 16-year-old student who was resting his head on his arms during math class when his teacher called on him. The teacher told him to come to the blackboard to complete a math problem in front of the class. Chris has a specific learning disorder that impairs his ability to write, and he felt embarrassed. He responded in the moment by shouting from his desk "No thank you, Miss." She again asked that he participate by coming to the board. He shoved his math textbook off his desk and asked the teacher "Why don't you do the f***ing problem?" He grabbed his backpack, left the classroom, and ran out of school.

Reflection:

What is your school or community's current response protocol to this type of situation?

What happened next? His teacher then called the on-site police officer at the high school. When the police approached him, he appeared to shake them off and say that he wasn't bothering anyone. The police arrested him for disorderly conduct.

What could have happened? The police officer said, "Seems like something set you off in class, is that right?" Chris said, "I told my teacher I didn't want to write on the board, and I was nice about it, and she still made me do it!" The officer said, "Ah, you don't like to write on the board, huh?" Chris said, "No, and in fact I'm not supposed to have to do that because of my education plan." The officer calmly escorted Chris to the school counselor's office to discuss what happened.

Points to Consider*:*

School Role: Chris' history of a specific learning disorder should be taken into account. While all students need to engage in group work, the teacher needs to consider the impact of asking him to perform in front of his classmates. When Chris shouted from his desk, "No thank you, Miss," the teacher could have moved on to another student. Later, the teacher could have approached Chris to check in with him. This would have given Chris the opportunity to share his thoughts and feelings. The teacher could then better understand how to support Chris and encourage his development instead of shaming or embarrassing him.

Juan

Juan is a 14-year-old gender questioning teen (preferred pronouns: he/him) who lives with his religiously devout parents. He has been struggling with 'coming out' for the past few years and recently began experimenting with socially transitioning to female. Tonight, his father found him dressed as a girl and began screaming and his mother began crying. His younger siblings also were scared and frightened by the chaos in the house. Juan hid in the bathroom and took a razor and cut his wrist superficially. Neighbors who heard the commotion called 911.

Reflection:

What is your school or community's current response protocol to this type of situation?

What happened next?

The police arrived and Juan flew into a hysterical rage, crying, thrashing around, holding the razor… the police, feeling threatened, knowing nothing about the situation, took out their guns and the situation escalated.

What could have been done differently?

What could have happened?

CIT trained police come onto the scene with EMS with the information they have about Juan's self harm behavior. They first attempt to give him space and de-escalate the situation verbally, recognizing that he may be scared and feel threatened seeing the police at his home. EMS staff may ask about the cutting and the need to examine the injury. If needed they would then take him to the nearest hospital for further evaluation.

Points to Consider*:*

EMS or Police or family or neighbor's Role.

5. Closing Statements

We understand that each community may be at a different place along the continuum. Training and consultation with experts in mental health like the members of the American Psychiatric Association (APA) may create pathways for collaboration and connection to much needed treatment. For example, the APA Foundation's *Notice. Talk. Act.™ at School* program is a recommended framework that promotes an interpersonal strategy for engaging young people that includes:[36]

- Emphasis on person-centered, supportive, non-confrontational aspects of motivational interviewing
- Training for education staff members and law enforcement officials to identify behaviors that are evidence of a mental health concern that would benefit from a compassionate and empathic response.
- Engagement with schools and systems in teaching how to respond to disruptive or withdrawn behaviors in young people in order to build relationship and connect them to additional support services
- Identification of strategies that might decrease more punitive measures such as suspensions, expulsions, and that minimize interactions with law enforcement which may result in trauma, disruptions in education, and funneling into the school-to-prison pipeline.

The APA Foundation's *Notice. Talk. Act*. ™ key frame work can be adapted to fit the training needs, available support services, and mental health knowledge of local law enforcement agencies to better respond to youth in the community and to other community members who need support services.

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