Crisis Response Strategies for Children Youth and Families; Including Intellectual and Developmental Disabilities (I/DD)

Presenter

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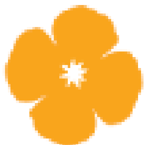

September 29, 2023

M-TAC

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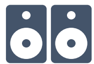

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Dr. Kristin Dempsey has certified that she has no relevant relationships with any commercial or nonprofit organizations that represent a conflict of interest.

Mobile Crisis Services

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to Medi-Cal beneficiaries who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations and law enforcement involvement.

Behavioral Health Information Notice 23-025, p. 3

A New Direction for Mobile Crisis Services

- Change mobile crisis services so that the response is more resolution-focused and works to provide relief to people in crisis in the community.
- Support people in crisis where they are, while using the least restrictive means necessary.

A New Direction for Mobile Crisis Services

Mobile crisis services should be:

- Person-centered
- Trauma-informed
- Equity-driven
- Brief intervention: de-escalation and resolution focused
- Working from a lens of least restrictive interventions
- Culturally responsive, linguistically appropriate, and accessible

Welcome to Today's Session!

Today’s Presenter

Kristin Dempsey, Ed.D., LMFT, LPCC

Therapist, Trainer, and Consultant

Audience Introductions

In the chat box, we invite you to share your:

» Name
» Role
» Organization
» One thing you're hoping to learn today

Today's Agenda

- Identifying Crises
- Trauma-Informed Crisis Resolution and De-Escalation
- Crisis Response for Youth with I/DD
- Behavioral Management in Crisis Settings
- Co-Occurring Disorders and I/DD
- Cultural Considerations for Youth in Crisis
- Children in the Child Welfare System
- Crisis Safety Planning and Follow Up
- California Minor Consent Laws

Learning Objectives

Participants will:

- Explain crisis warning signs and areas of risk for children and youth, including those with I/DD.
- Describe general characteristics of children with I/DD, including intellectual disability and autism spectrum disorder, co-occurrence of I/DD and mental health conditions, and effective crisis intervention strategies.
- Enhance use of assessment strategies for early identification of mental health conditions and engagement into treatment, including youth with I/DD.
- Deliver intervention strategies that will assist families/caregivers with de-escalating the behavior of youth in crisis through resolution while avoiding hospitalization and emergency out-of-home placements.

Learning Objectives

Participants will:

- Identify cultural considerations that mobile crisis teams need to address when working with children, youth, and families in crisis, including children in the child welfare system.
- Offer best practices and strategies to engage caregivers and natural supports, including crisis safety planning and crisis management.
- Provide strategies for care coordination and outreach to other systems of care, i.e., regional centers, schools, and child welfare systems.
- Explain minor consent laws in CA and appropriate protocols for communication with parents/caregivers, and other responsible adults.

Crisis and Intellectual and Developmental Disability

What is a Crisis?

A "behavioral health crisis" refers to any event or situation associated with an actual or potential disruption of stability and safety as a result of behavioral health issues or conditions. A crisis may begin the moment things begin to fall apart (e.g., running out of psychotropic medications or being overwhelmed by the urge to use a substance they are trying to avoid) and may continue until the beneficiary is stabilized and connected or re-connected to ongoing services and supports.

Behavioral Health Information Notice 23-025, p. 2 | National Council for Mental Wellbeing, "Roadmap to the Ideal Crisis System" (2021) p. 14

Mobile Crisis Services and Children and Youth

Mobile crisis teams shall respond to beneficiaries of all ages, including children and youth experiencing behavioral health crises. Through crisis de-escalation and resolution, mobile crisis teams may help children, youth and their families avoid hospitalization and emergency out-of-home placements in many circumstances. For some children and youth, accessing crisis services may be their first introduction to the state's behavioral health system, making it a critical moment for early identification of mental health conditions and engagement into treatment.

Behavioral Health Information Notice 23-025, p. 23

How Do I Know if a Youth is in Crisis?

Warning signs of behavioral health crisis for children and youth may include:

a. Expressing suicidal thoughts, either through explicit statements such as “I want to die” or vague statements such as “I don’t want to be here anymore”

b. Making threats to harm others or themselves

c. Engaging in self-injurious behavior, such as cutting or burning

d. Expressing severe agitation and aggression, including physical aggression, destruction of property, hostility, etc.

e. Experiencing hallucinations or delusions

f. Isolating themselves from friends and family

NAMI: https://nami.org/Your-Journey/Kids-Teens-and-Young-Adults/Kids/What-to-Do-If-Your-Child-Is-in-Crisis

Trauma-Informed Crisis Resolution and De-Escalation

- Basic guidelines for starting a crisis de-escalation conversation:
  - Provide youth and caregivers as much choice as possible during the crisis response
  - Ask who they would like with them when we speak together
  - Inquire with parents about what has worked in the past
  - Reflect – do not question; there is no magic solution that is more important than your being present and engaged (Miller & Rollnick, 2023)
- Consult with caregivers regarding how they would advise approaching the young person. Specifically determine:
  - Language ability and verbal capacity. This is not immediately knowable, but it is helpful to know if the 12-year-old we are speaking to has a 5-year-old vocabulary
  - Nature of what activates the child. If there is an object or resource that comforts the child, provide it for them

Trauma-Informed Crisis Resolution and De-Escalation

- Find a calm, quiet space for the young person to talk. If possible, let them choose the space.
  - Sit at their level. Do not stand above them
  - Avoid power struggles and recognize power imbalances
  - Avoid sudden movements or continuous eye contact, attunement is helpful with children and youth and supports-co-regulation
  - Is there is anything you can do to immediately reduce their suffering? For example, would giving them a blanket or a glass of water help? Ask them what they need. What would help their heart and body slow down?

Trauma-Informed Crisis Resolution and De-Escalation

- Calling for law enforcement response is a last resort.
  - As a mobile crisis team, you are the first responders for the non-immediate danger; the focus of services should revolve around de-escalation, stabilization, and crisis resolution while avoiding hospitalization, unnecessary use of law enforcement, and emergency out-of-home placements

NAMI: https://nami.org/Your-Journey/Kids-Teens-and-Young-Adults/Kids/What-to-Do-If-Your-Child-Is-in-Crisis

Trauma-Informed Crisis Resolution and De-Escalation

- Are you safe? Are they safe?
- To the best of your ability, secure the environment
  - Assess and create safety
  - Have caregiver or others remove any possible weapons
  - Be aware of where you are sitting and standing; be aware of your ability to exit at any time
  - In addition to environmental safety, psychological safety is also critical
  - Behavior is communication, especially for young children and children with I/DD

Trauma-Informed Crisis Resolution and De-Escalation

- Let them choose everything you can: who will join them in the conversation? Do they want to bring a favorite stuffy? Where do they want to sit? Where do they want you to sit?
- Respect pronouns; don’t be afraid to ask- protect confidentiality
- Go slowly and reassure them that you are here to help
- Step away from the “fix it” mentality – move into curiosity about the situation and notice your breath as you start to co-regulate the youth (and their caregiver(s))
- Use a calm, but non-monotone tone of voice when speaking with youth and families

Trauma-Informed Crisis Resolution and De-Escalation

- Minimize questions in favor of reflective listening
  - When we ask questions, we are taking someone's energy. When we listen, we give them support, safety, and attention
- Affirm strengths, where possible. Doing so helps with recovery and seeing oneself as powerful and capable

Trauma-Informed Crisis Resolution and De-Escalation

- Ensure the child/youth is calm before engaging in safety planning
  - Move carefully while supporting voice and choice along the way
  - Assure them that you will work together to help them get started on a plan to help them feel safe
  - Explore what has worked for them before, while validating and acknowledging their experience with what is happening in the moment
    - It is important for children and youth to feel like they are being heard and understood
- Resources available to caregivers provided by the National Alliance on Mental Illness on ways to support a loved one in crisis:
  - Navigating a Mental Health Crisis
    - Available in English and Spanish

https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis

For Discussion

A child says, “No one helps me.
I can’t stand having to hear how everyone hates me and wants me to change. What do they expect me to do about it?”

This is the tip of the iceberg –
what we see on top.

What do you think is under the iceberg,
what is not being said?

Please enter your response in the chat box.

For Discussion

List some of the strengths you see among the young help seekers you serve.

Noticing the strengths, what kinds of affirming statements can you make to support them?

Example: Courageous
"It takes a lot of courage to ask for help."

Please enter your response in the chat box.

Crisis Response Strategies for Children and Youth with Intellectual and Developmental Disability

- Any experience of crisis is subjective, and causes are external and/or internal
- For children/youth in crisis, the cause is often developmental in nature
- Intellectual and developmental disabilities are often a significant part of the presentation of the crisis

Individuals with Intellectual and Developmental Disability

Beneficiaries experiencing behavioral health crises may have co-occurring needs that require additional considerations in the provision of mobile crisis services. People with I/DD and co-occurring mental health conditions may experience sensory or communication challenges that may complicate the de-escalation of a behavioral health crisis. Mobile crisis teams responding to a beneficiary with I/DD shall ensure that natural supports (e.g., familial caregivers, personal attendants) are involved and consulted in the crisis response, if appropriate. To the extent possible, mobile crisis teams are encouraged to include a team member with I/DD expertise or have access to an individual with I/DD expertise (e.g., a Board-Certified Behavioral Analyst) via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions.

[Behavioral Health Information Notice 23-025, p. 24](#)

Mobile Crisis Services and Children and Youth with Intellectual and Developmental Disability

Mobile Crisis Services should always be person-centered and trauma-informed.

Person-centered care aims to shift thinking about children and youth with I/DD from their deficits and needs within a system to focusing on their strengths, capabilities, and potential to contribute to their community. Person-centered care aims to develop collaborative supports with individuals with I/DD focused on community presence and participation, positive relationships, respect, and competence.

National Association of State and Mental Health Program Directors, 2017

Definition of Intellectual and Developmental Disability

An intellectual disability is when limitations in your mental abilities affect intelligence, learning, and everyday life skills. The effects of this can vary widely. Some people may experience minor effects but still live independent lives. Others may have severe effects and need lifelong assistance and support.

Cleveland Clinic, 2023

Prevalence of Intellectual and Developmental Disability

- Affects 1% to 3% of children. It’s slightly more common in males and people assigned male (AMAB) at birth than in females and people assigned female at birth (AFAB)
- In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Text Revision, the formal name is Intellectual Developmental Disorder (Intellectual Disability).
- We do not always know the cause of I/DD
  - Common causes include differences in brain development and brain damage from illness or injury that occurs before 18 years of age

Cleveland Clinic, 2023

Symptoms and Causes of Intellectual and Developmental Disability and How they Relate to Mobile Crisis Services and Teams

Symptoms of Intellectual and Developmental Disability and the Mobile Crisis Teams

- Without understanding I/DD, mobile crisis teams may misunderstand the symptoms of crisis during their response. Understanding the symptoms and causes of I/DD is vital for effective assessment. The symptoms of intellectual disability include deficits in academic skills, social skills, and domestic skills.

- Intelligence related symptoms:
  - Delayed or slowed learning of any kind (such as in school or from real-life experiences)
  - Slowed reading speed
  - Difficulties with reasoning and logic
  - Problems with judgment and critical thinking
  - Trouble using problem-solving and planning abilities
  - Distractibility and difficulty focusing

Cleveland Clinic: https://my.clevelandclinic.org/health/diseases/25015-intellectual-disability-id

Mobile Crisis Services and Children and Youth with Intellectual and Developmental Disability

Recommendation for mobile crisis teams when assessing behavior:

- All behaviors reflect some type of communication. An individual's limited ability to verbally communicate anxiety, mood issues, or a psychotic disorder may manifest in aggression or externalizing behaviors which can often result in higher levels of care and restrictive intervention (i.e., emergency room visits, unnecessary law enforcement involvement, inpatient hospitalization).
- Always ask "what is the communication or behavior trying to achieve?"

The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System 2017

Symptoms of Intellectual and Developmental Disability and the Mobile Crisis Teams

Adaptive behaviors revolve around abilities and learned skills needed to live independently. Symptoms of adaptive behavior-related limitations can be any of the following:

- » Slower learning of toilet training and self-care activities (bathing, dressing, etc.)
- » Slower social development
- » Little or no fear or apprehension of new people (lack of "stranger danger" behaviors)
- » Needing help from parental figures or other caregivers with basic daily activities (bathing, using the bathroom, etc.) past the expected age
- » Difficulty learning how to do chores or other common tasks
- » Trouble understanding concepts like time management or money
- » Needing help managing healthcare appointments or medications
- » Trouble understanding social boundaries
- » Difficulty with or limited understanding of social interactions, including friendships and romantic relationships

Cleveland Clinic: https://my.clevelandclinic.org/health/diseases/25015-intellectual-disability-id

Management of Behavioral Crisis

Behavioral Management of Crisis

Crisis behavior is a **symptom** and not a **disorder**. Behavioral change is often the only way people with I/DD can express that something is wrong and communicate a need.

» Important to engage caregivers and natural supports as appropriate for background and collateral information

» When onsite, greet everyone involved and ask the individual in crisis who they would like to participate (voice and choice)

» For non-verbal children and youth, use alternative communication strategies

» Very frequently, the "something wrong" is not a psychiatric problem. It may signal that child or youth has a physical health problem causing pain or discomfort or that their environment is not meeting their needs

Behavioral Management of Crisis

- Very frequently, the “something wrong” is not a psychiatric problem. It may signal that the person has a physical health problem causing pain or discomfort or that their environment is not meeting their needs.

- During all stages of interacting with individuals in crisis, reflect on their experiences, acknowledge strengths, and provide choice.
  - Active listening often brings calm to individuals; it is often the most effective remedy in a crisis
  - Highlighting strengths helps to build motivation by increasing self-efficacy
  - Praise self-regulation and engagement through soothing techniques ("I like the way you are taking deep breaths; I love how you are hugging your stuffed animal right now")
  - Ask the individual in crisis what they might need in the moment (glass of water, a snack, a comforting and safe object)
  - Modeling is when one person intentionally shows another person what an ideal behavior looks like; modeling can help a child understand the behavior that you are looking for

Behavioral Management of Crisis

Assess and **manage** the behavioral crisis by working with the child/youth, parents/caregivers, and available support resources:

» Engage caregivers in conversations at the scene and bring them into separate spaces to have conversations with caregivers about the history of symptoms, current stressors, and their understanding and/or beliefs regarding the cause of issues

» Avoid being over-directive

» Try to give a menu of options and emphasize autonomy whenever possible; voice and choice are key

» Clarify the cause of the crisis, and assess and manage sequentially any discernible contributing factors, such as medical issues, supports and expectations, emotional issues, and psychiatric disorders

Behavioral Management of a Crisis

Non-Verbal Children and Youth

When someone cannot or will not talk with us, try other non-verbal ways of communication (e.g., experiment with writing, pictures, hand motions, eye contact, and facial expressions) and use best judgment on what seems and feels appropriate in the moment

Guidelines:

- Introduce yourself and be inclusive – do not assume someone cannot hear or understand because they will not speak
- Watch your tone – if you are talking with a teen, speak as if you are talking with a teen and not a child
- Reduce distractions

Adapted from: https://www.vha.ca/blog/communicating-with-someone-who-is-non-verbal

Behavioral Management of a Crisis

Non-Verbal Individuals

Consult with caregivers to determine how the individual typically communicates

Consider:

- Communication boards
- Music and reading
- Using pictures, objects, or writing
- Using close-ended questions to obtain basic information and engage in some aspects of communication

Adapted from: https://www.vha.ca/blog/communicating-with-someone-who-is-non-verbal

Reflection of Non-Verbal Behavior

If a child/youth appears angry and upset, it is ok to reflect on their non-verbal behavior. For example:

It doesn't seem as if you are happy to be here right now…

I can see that you are angry and maybe not too happy about talking with me right now…

You seem upset and hurt right now…

Our nonverbals are important as we are co-regulating everyone in the room.

Co-regulation includes:

- Making sure we breathe – slow and regular
- Maintain eye contact, but notice if direct eye contact increases stress
- Speak slowly and calmly
- We model containment through slow speech and pauses

For Discussion

You receive a request for response from a parent who is concerned their daughter, Jessica, is appearing to regress after making some progress with toilet training and is becoming agitated and aggressive (kicking, screaming, hitting, throwing things, making threats) towards them when instructed to use the restroom. Jessica is currently threatening to harm her parents if they make her go to the restroom. Jessica is six years old and is attending a special needs kindergarten. Jessica speaks very little at school but speaks more at home. She is friendly and eager to make new friends at school. The parents also reported that the day before she started to refuse to use the toilet, she came home from school upset, but unwilling or unable to say what happened. The parents are concerned about potential abuse at school as Jessica's sociability can result in fewer boundaries with adults and children.

1. Given these concerns how might you approach interacting and engaging with Jessica and her parents?
2. What additional information would you want or what questions would you ask?
3. What strategies would you use to support de-escalation?
4. What are some strategies to support communication with Jessica?

Co-Occurring Disorder and Intellectual and Developmental Disability

Co-occurring disorders (COD) occur along with I/DD. COD needs to be considered as the expectation and not the exception. Consider the co-occurring nature, how might the disorders interact with each other?

- Attention Deficit Hyperactivity Disorder (ADHD) might increase distractibility
- Substance Use Disorder (SUD) might increase impulse control disorder
- Autism Spectrum Disorder (ASD) might impact an individual's ability to be flexible and communicate verbally
- Other disorders that often co-occur with I/DD include mood and anxiety disorders and movement disorders

Cultural Considerations for Managing Intellectual and Developmental Disability

Cultural Considerations for Youth in Crisis

- Youth and families are impacted by the larger culture in which they live. How a culture views a behavioral health crisis or developmental disability will greatly impact the internalized messages and external supports that in turn can exacerbate or mitigate crisis situations.
- Culture influences an individual's relationship to disability, including:
  - their understanding of a disability and its etiology
  - whether to seek help
  - treatment options
  - their relationships with health professionals

https://kidsnewtocanada.ca/mental-health/developmental-disability

Cultural Considerations for Youth in Crisis

- In many cultures, social interdependence and an individual's role within the larger family and community are highly valued, while independence and autonomy are valued less than in Western cultures. This perspective can affect how disability is perceived.
- Many cultures seek out spiritual healers and traditional alternative medicines.
- In many cultures, attitudes toward a disability may include religious acceptance. Also, people may believe that a disability is caused by factors such as the influence of past lives, mystical intervention, or the past actions of a parent.
- Health practitioners should acknowledge and consider the culture of the child and family in care.

https://kidsnewtocanada.ca/mental-health/developmental-disability

Cultural Considerations for Youth in Crisis

Providers should work with the cultural and social framework of the family:

- » Observe the family's interaction style – notice who speaks first, whether the family is collaborative or authoritative; when in doubt, defer to elders
- » Honor the space and eye contact practices of the culture; observe carefully and find ways to be humble and deferential to family
- » Listen for common phrases and ways of speaking; notice if you need to bring in a translator
- » Prepare in advance by learning about the cultural practice of families in your community
- » Humility and curiosity should be your guiding attitudes for approaching all families as each system has its individual characteristics and practices

LBGTQI+ Population and Safety and Risk Data

- Suicide is the second leading cause of death among young people aged 10 to 24 (Hedegaard, Curtin, & Warner, 2018) — and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth are at significantly increased risk.
- LGBTQ youth are more than four times as likely to attempt suicide than their peers (Johns et al., 2019; Johns et al., 2020).
- The Trevor Project estimates that more than 1.8 million LGBTQ youth (13-24) seriously consider suicide each year in the U.S. — and at least one attempts suicide every 45 seconds.
- The Trevor Project's 2022 National Survey on LGBTQ youth mental health found that 45% of LGBTQ youth seriously considered attempting suicide in the past year, including more than half of transgender and nonbinary youth.

https://www.thetrevorproject.org/resources/article/facts-about-lgbtq-youth-suicide

LBGTQI+ Population and Safety

- Awareness and acceptance- increasing competencies (continuous learning) around risk for LGBTQI+ children and youth supports positive interactions between behavioral health providers and the youth in crisis
- Normalize adverse impact of stress, validation of unique strengths, and affirm healthy rewarding expressions of sexuality and gender orientations
- Importance of respecting pronouns and impact on risk of suicide and self-harming
- Importance of providing responsive resources to children and youth and caregivers WHEN APPROPRIATE. Always check with youth in crisis first.

Examples of What You Can Say

Notice these are simple reflections:

- *I can understand how being picked on at school can make you feel very angry, like your head is going to explode (validation)*
- *I am hearing that you are so sad that you were left out of the games today (reflection)*
- *You are hurt because it seems like no one ever listens to you*

Examples of What You can Say

Initial questions should be open and allow the young person to tell a story, not provide us with assessment information. We will get to assessment, but we need to make sure the young person is not over-interrogated when we first walk in as too many questions can escalate instead of de-escalate:

» *Help me understand what is making you feel so sad right now.*

» *What would you like me to know about what is making you feel so angry right now?*

Young people can be too reactive for any questions, so if you notice that questions are not going anywhere, stay with reflections, even reflections of nonverbals.

Children in Child Welfare Systems of Care

- Not surprisingly, youth who are in child welfare systems (CWS) have histories of trauma that make them more vulnerable entering crisis
- Assist children in the CWS to access resources that will allow them to learn how to self-regulate and gain support from resources to recover from the current crisis and to prevent the next crisis from happening
- Mobile crisis teams should connect with caregivers on the scene to obtain information and any necessary release of information to contact the youth's CWS care coordinator

Children in Child Welfare Systems of Care

In addition to a care coordinator, children in CWS may have other important professionals who can provide additional current and post-crisis care:

- Therapists (behavioral health)
- Assigned social worker (usually care coordinator)
- Resource specialists (including behavioral coaches)
- Pediatricians and psychiatrist
- Occupational therapists
- Attorney
- Court-Appointed Special Advocate (CASA)
  - It is not uncommon for any one or more of these individuals to be available during or soon after a crisis to help with stabilization

Crisis Safety Planning and Follow-up Strategies

Crisis Safety Planning and Follow-up Strategies for Children, Youth, and Families in Crisis

Medi-Cal behavioral health delivery systems shall ensure that beneficiaries receive a follow-up check-in within 72 hours of the initial mobile crisis response. The purpose of the follow-up check-in is to support continued resolution of the crisis, as appropriate, and should include the creation of or updates to the beneficiary's crisis safety plan, or additional referrals to ongoing supports, as needed. If the beneficiary received a referral to ongoing supports during the initial mobile crisis response, as part of follow-up the mobile crisis team shall check on the status of appointments and continue to support scheduling, arrange for transportation, and provide reminders as needed.

BHIN 23-025, pg. 16

Crisis Safety Planning and Follow-up Strategies

- Important to provide short and long-term prevention strategies and resources the child/youth and parent/caregivers can use to avert or address a future crisis, including harm reduction strategies
- The Stanley Brown safety plan is an evidence-based tool widely used in many settings. Many safety plans are an adaptation of the Stanley Brown safety plan.
- Stanley Brown Safety Plan
- SAMHSA digital download safety plan – modified from Stanley Brown Safety Plan 2021
- Encourage youth and families in crisis to utilize the developed safety plan

Crisis Safety Planning and Follow-up Strategies

- Review crisis strategies, actions taken, and what was effective or ineffective
- Make recommendations for management and prevention of future behavioral crises
- With caregivers and available resources, begin to develop a comprehensive and proactive crisis plan to meet their needs and enhance their quality of life
- Encourage rapid appointments with behavioral health providers if services are already in place and care coordination with other medical behavioral health delivery systems within 48 hours of initial response
- For beneficiaries who frequently visit the Emergency Department, it may be helpful to develop a dialogue with caregivers and local Emergency Department staff
- Encourage parents to attend evidence-based parent education that can help them respond to crisis situations for young children, such as Parent-Child Interaction Therapy

Crisis Follow Up, Review, and Cultural Considerations

- Care coordination with behavioral health providers
- Follow up calls- best practices to engage parents/caregivers and other natural supports
- Coordination and outreach with regional centers, FURS, schools, and other delivery systems
- If a case manager or other needed resources (e.g., a behavior analyst) are not in place, work to access local/regional resources. (Check State and Local Resources.)

Crisis Follow Up, Review, and Cultural Considerations

- If the youth is already receiving mental health treatment, and it makes sense in your given context, contact their psychiatrist or therapist. They can provide guidance on what to do next, incorporating their knowledge of the child and the current situation can support crisis resolution.
- If the youth is not currently receiving treatment, you can help the family by linking them to Mental Health Access lines, or other portals for obtaining behavioral health support.
- Offer warm and hotlines for ongoing support with managing crisis. Options include the California Warm Line or hotline or text line that provides crisis intervention services and resources, such as Crisis Text Line or the 988 Suicide & Crisis Lifeline.
- Family Urgent Response Systems F.U.R.S. and regional centers California Regional Centers Listings

For Discussion

What effective communication strategies have you used with families or children?

Please enter your response in the chat box.

California Minor Consent Laws

Health and Safety Code (HSC) §124260, and Family Code (FC) §6924.

Health & Safety Code § 124260 "[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services. If services are being provided by licensed interns or trainees, there may be obligations to consult with a supervisor regarding provision of minor consent care." See Health & Saf. Code § 124260

http://teenhealthlaw.org/wp-content/uploads/2019/09/CaMCConfMentalHealthChart9-19.pdf

CALIFORNIA MINOR CONSENT LAWS – MENTAL HEALTH SERVICES:
Minor Consent Services and Parents Access Rules*

SERVICE/TREATMENT	CONSENT LAW	INFORMING/CONFIDENTIALITY OBLIGATIONS
ASSESSMENT* *Assessment means the evaluation necessary for an attending professional to assess whether a minor meets criteria of the minor consent statutes, cited in next column. **OUTPATIENT MENTAL HEALTH TREATMENT OR COUNSELING SERVICES*** * This does NOT include inpatient psychiatric care, convulsive therapy, psychosurgery or psychotropic medications. *Treatment and counseling means provision of treatment and counseling on an outpatient basis by • A "professional person" as defined in Health and Safety Code 124260(a), for services provided under that statute. Please see the statute for more information • Certain agencies or a "professional person" as defined in Family Code 6924(a)(1), for services under that statute. Please see the statute for more information.	Two statutes give minors the right to consent to mental health treatment. If a minor meets the criteria under either statute, the minor may consent to treatment. If the minor meets the criteria under both, the provider may decide which statute to apply. There are differences between them. See endnote ** for more on these differences: <u>Family Code § 6924</u> "A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. AND (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse." Fam. Code § 6924. <u>Health & Safety Code § 124260</u> "[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services." Health & Saf. Code § 124260. If services are being provided by licensed interns or trainees, there may be obligations to consult with a supervisor regarding provision of minor consent care. See Health & Saf. Code § 124260	***Parent Access/Confidentiality Obligation*** If the minor consents or could have consented to care, the provider only may share the minor's health information with parents or guardian with the signed authorization of the minor. Health & Saf. Code §§ 123110(a), 123115(a); Civ. Code §§ 56.10(b)(7), 56.11(c); 45 C.F.R §§ 164.502(g)(3); 164.508(a). ***Discretion to Inform/Involve Parents?*** The health care provider is required to involve a parent or guardian in the minor's outpatient treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. When services are being provided under Health and Safety Code § 124260, providers must consult with the minor before making the determination concerning parental involvement. Involving parents in treatment will necessitate sharing certain confidential information; however, having them participate does not mean parents have a right to access confidential records. Providers should attempt to honor the minor's right to confidentiality to the extent possible while still involving parents in treatment. Fam. Code § 6924; 45 C.F.R. § 164.502(g)(3); Health & Saf. Code § 124260(c). This description of applicable law presumes that these are not "Lanterman Petris Short" (LPS) services. See end note *** for more on LPS.

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SERVICE/TREATMENT	CONSENT LAW	INFORMING/CONFIDENTIALITY OBLIGATIONS
PSCYHOTROPIC MEDICATIONS* *"psychotropic medication" means those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses.	Only with parent or guardian consent, except a guardian cannot consent to experimental medications for a minor. Prob. Code § 2356.	***Parent Access/Confidentiality Obligation*** If the minor did not and could not have consented to care, a parent or guardian usually has the right to access the minor's medical information. To share information with others, the provider usually must have a signed authorization from the parent/guardian. Health & Saf. Code §§ 123105(e), 123110(a); Welf. & Inst. Code § 5328(d); Civ. Code §§ 56.10, 56.11. However, there are exceptions. ***Discretion to Refuse Access to Parents?*** The parent/guardian of a minor shall not be entitled to inspect or obtain copies of the minor's patient records where the health care provider determines that access to the patient records requested by the parent/guardian would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith. Health & Saf. Code § 123115(a)(2). *See also* 45 C.F.R. § 164.502(g)(5).
INPATIENT TREATMENT	Only with parent or guardian consent, except a guardian cannot place a minor in a mental health facility against the minor's will. Involuntary placement can only be obtained through a 5150 or 5350 proceeding. This does not preclude a guardian from placing a ward in a state hospital under a WIC 6000 application. Prob. Code § 2356.	
CONVULSIVE THERAPY for MINORS up to 15 years old (see page 5 for rules regarding convulsive therapy for 16 and 17 year old minors) See Welfare and institutions 5325 et al. for more on convulsive therapy and rights	Convulsive treatment shall not be performed on a minor under 12 years of age. Welf. & Inst. Code § 5326.8. Minors 12-15 years of age may be administered convulsive treatment only if it is an emergency situation and is deemed a lifesaving treatment and other criteria are met. If the minor is able to give informed consent, the treatment cannot be performed if the minor refuses. Welf. & Inst. Code §§ 5326.8, 5326.85; see 5326.7 For minors 12-15 years of age, parent consent is also necessary. A guardian cannot consent to convulsive therapy. Prob. Code § 2356.	

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SERVICE/TREATMENT	CONSENT LAW	INFORMING/CONFIDENTIALITY OBLIGATIONS
DRUG or ALCOHOL TREATMENT by federally assisted treatment program* This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. Fam. Code § 6929(f). * Federal confidentiality law applies to any individual, program, or facility that is federally assisted. A program is federally assisted if: 1. The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed, supported or funded in whole or in part by any department of the federal government. Examples include federal, state or local programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds whether used directly for the substance use disorder program or not; or registered with Medicare)(42 C.F.R. §2.12); AND 2. The individual or program is: a. An individual or entity (other than a general medical facility) who holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or b. An identified unit within a general medical facility that holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment; or c. Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers. (42 C.F.R. §2.11; 42 C.F.R. §2.12).	"A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." Fam. Code §6929(b).	Federal law generally prohibits disclosing any information to parents without a minor's written consent. There is an exception, however, permitting the communication of relevant facts to the parents if the program director determines that a minor applicant for services 1) lacks capacity because of extreme youth or mental or physical condition to make a rational decision whether to consent to a disclosure to the parents AND 2) there is a substantial threat to the life or physical well-being of the minor applicant or another individual, and the disclosure of relevant facts to the parents may reduce that threat. 42 C.F.R. §2.14.

DRUG COUNSELING* **By individuals, programs or facilities that are not "federally assisted"** This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. Fam. Code § 6929(f).	"A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." Fam. Code § 6929(b).	***Parent Access/Confidentiality Obligations*** If the minor consents to care, the provider only may share the minor's medical information with the signed consent of the minor. Health & Saf. Code §§ 123110(a), 123115(a); Civ. Code §§ 56.10(b)(7), 56.11(c); 45 C.F.R §§ 164.502(g)(3)(i)(A); 164.508(a). ***Discretion to Inform Parents without Minor's Consent?*** The health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. Involving parents in treatment will necessitate sharing certain confidential information; however, having them participate does not mean parents have a right to access confidential records. Providers should attempt to honor the minor's right to confidentiality to the extent possible while still involving parents in treatment. Fam. Code § 6929(c); 45 C.F.R.§ 164.502(g)(3)(ii).

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<table>
<tr><th>SERVICE/TREATMENT</th><th>CONSENT LAW</th><th>INFORMING/CONFIDENTIALITY OBLIGATIONS</th></tr>
<tr><td>CONVULSIVE THERAPY for 16 and 17-year-old minors</td><td>Minors who are 16 and 17 years old must give voluntary informed consent for convulsive treatment. Many other conditions must be met before therapy can be given. Welf. & Inst. Code §§ 5326.8; 5326.75; 5325(f).</td><td rowspan="2">Parent Access/Confidentiality Obligations
If the minor consents or could have consented to care, the provider only may share the minor's medical information with parents with the signed authorization of the minor. Health & Saf. Code §§ 123110(a), 123115(a); Civ. Code § 56.10(b)(7), 56.11(c); 45 C.F.R §§ 164.502(g)(3);164.508(a).

Discretion to Inform Parents?
The health care provider has no discretion to inform parents without the minor's signed authorization.</td></tr>
<tr><td>GENERAL MEDICAL CARE for Emancipated Minors</td><td>An emancipated minor may consent to medical, dental and psychiatric care.
Fam. Code § 7050(e).

"A person under the age of 18 years is an emancipated minor if any of the following conditions is satisfied: (a) The person has entered into a valid marriage, whether or not the marriage has been dissolved. (b) The person is on active duty with the armed forces of the United States. (c) The person has received a declaration of emancipation" from a court.
Fam. Code § 7002.</td></tr>
</table>

NOTES:

* There are many confidentiality and consent rules. Different rules apply in different contexts. This chart addresses the rules that apply when minors live with their parents or guardians. It does not address the rules that apply when minors are under court jurisdiction or in other special living situations. Further, the confidentiality section focuses on parent and provider access. It does not address when other people or agencies may have a right to access otherwise confidential information. **This chart provides legal information, not advice. Providers are encouraged to speak to their own legal counsel for advice on application of these laws.**

** In addition to having slightly different eligibility criteria, there are other small differences between Health and Safety Code §124260 and Family Code § 6924. For example, the two laws both allow "professional persons" to deliver minor consent services but the two laws define "professional person" differently. Also, there is a funding restriction that applies to Health and Safety Code §124260 but not to Family Code § 6924. (See Fam. Code § 6924, Health & Saf. Code § 124260 and Welf. & Inst. Code § 14029.8 and look for more information on www.teenhealthlaw.org.).

*** Lanterman Petris Short (LPS) services. Many publicly funded mental health services and most inpatient care are LPS services. A complete list of LPS services is found at Health & Safety § 5328. LPS has its own confidentiality protections. For other services, The confidentiality rule in Civil Code § 56 et al may apply.

This chart may be adapted or reprinted providing any adaptation or reprinting be accompanied by an acknowledgement of its source.

Summary

- Trauma-informed crisis resolution and de-escalation strategies prioritize empowering youth voice and choice whenever possible.
- Careful active listening and collaborative care is essential for gaining trust and de-escalating crisis.
- Understanding crisis behavioral as a symptom instead of a cause is vital to effective, trauma-informed management of a behavioral health crisis.
- Each child in crisis is impacted by their family and cultural traditions. Mobile crisis teams need to be mindful of how family beliefs and cultural traditions impact response to a crisis and shape follow-up strategies.

Summary

- Mobile crisis teams should be familiar with the common indicators of I/DD, understand that I/DD regularly co-occurs with other disorders, and have strategies in place to conduct assessments and interventions that are responsive to the needs of youth with I/DD.
- When working with children in the Child Welfare System, it is critical to coordinate supports across their system of care.
- Familiarity with California's minor consent laws is needed to inform development of follow-up actions and safety plans.

Questions

Closing and Thank You

Appreciation!

thank you

Your feedback is important to us!

Post-Survey, attendees must opt into the 90-day survey so we can collect your emails to send out the Certificates of Completion.

The completion of this survey is vital to our quality control and to the future funding of this project, as it allows us to provide you with training and technical assistance at no cost. In addition, it allows us to continually improve our services and provide the information and resources you need in the field.

Please take a few minutes to complete the survey!
Your time and feedback are greatly appreciated and valued!

Contact Us

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