1I - Embedding Crisis Response & Threat Assessment Within Multi-tiered Systems of Support

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- **Topic:** Mental Health/Social-Emotional-Behavioral Well-Being
- **Keywords:** Trauma, Screening, Behavior
When Working In Your Team

Consider 4 Questions

• How does this compare to our priorities?
• What team would oversee this work?
• What should we stop doing to make room for this work?
• How will we assess whether it’s (a) implemented well and (b) working?
Learning Objectives

1. Learn about national current mental health trends
2. Define psychological first aid, threat assessment, and stepped care
3. Learn about how to embed crisis response approaches within MTSS
Embedding Crisis Response & Threat Assessment Within Multi-tiered Systems of Support
PBIS Chicago 2023
Agenda

Part 1: Let's shift our language and terminology

Part 2: The reality and limits of prediction science

Part 3: What we can to that works to reduce risk

Part 4: Summary of best practices
Consider the context of where we are with behavioral health in 2023

“A problem never exists in isolation; it is surrounded by other problems in space and time. The more of the context of a problem that a scientist can comprehend, the greater are their chances of finding a truly adequate solution.”

-Russell Ackoff
### TRAUMA/DISASTER CASCADE POTENTIAL

<table>
<thead>
<tr>
<th>ACE</th>
<th>Previous or systemic adverse experiences or impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY COVID or other crisis impacts</td>
<td>• Losses • Deaths • Isolation</td>
</tr>
<tr>
<td>SECONDARY CRISIS IMPACTS</td>
<td>• Economic • Political • Social • Educational</td>
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What Happened to Kids During COVID

According to a CDC analysis, in 2021, high school students nationally reported they:

- Parent or other adult in the home lost their job
- Experienced physical abuse by a parent or other adult in the home
- Experienced emotional abuse by a parent or another adult in the home
- Persistently felt sad or hopeless during the past year
- Experienced poor mental health during the COVID-19 pandemic
**Reading**

- Score change between 2020 and 2022: **5**
- Largest score drop in reading since 1990

**Mathematics**

- Score change between 2020 and 2022: **7**
- First ever score drop in mathematics
Common Experiences or challenges
We are all crisis managers.

Offering behavioral health support to those in need may (does) fall on all of us regardless of what position we hold or job role we have.

There are simply NOT ENOUGH professional resources to support kids.

Start by identifying your personal “hot button” issues or triggers. If there are things that are too challenging or impossible for you to help others manage through because of your personal experience, it is helpful to have a sense of what those may be.

Having appropriate knowledge and information about how to effectively support those in crisis gives us more “tools in the kit”.

Who can you go to for support and to process emergency incidents or crises when they happen?
Part 1: Let’s shift our language and terminology

Away from “threat assessment” to “risk reduction”.

By focusing on the processes that need to be in place for support, we automatically reduce risk by fostering the growth dynamics that are correlated with successful and positive outcomes for individuals and community.
From “threat assessment” to “risk reduction” in practice
A shift from content to process

Threat Assessment

- Implies “yes” or “no”, categorical thinking that can be (and often is) implicitly biased.
- Issues with implementation fidelity, training, and the statistical reliability and validity of the available instruments.
- Precludes a focus on upstream preventions and interventions.

Risk Reduction

- Provides opportunity to develop tailored, strength & resource-based interventions.
- Reduces likelihood of bias by focusing on whole-person and community resources.
- Allows space for open-ended questions: What and Where are the resources we can leverage, Who is available to support this student, and How can we best meet their individual needs?
PART 2: The reality and limits of prediction science in behavioral health

#1 Correlation is NOT CAUSATION

#2 Risk assessments have significant and sometimes very harmful flaws; Most threat assessments have very outcome little data
Beware of spurious

Divorce rate in Maine correlates with Per capita consumption of margarine

Correlation: 99.26% ($r=0.992558$)

Data sources: National Vital Statistics Reports and U.S. Department of Agriculture

https://www.tylervigen.com/spurious-correlations
“When we don't know how to measure what we want to measure, we often settle for wanting what we can measure.”
Flaws inherent in current risk assessments
What do the data say?

Predictive and other Validity

This study examined the validity and reliability of the Structured Assessment of Violence Risk in Youth (SAVRY), the Youth Level of Service/Case Management Inventory (YLS/CMI), and the Psychopathy Checklist: Youth Version (PCL:YV) in a sample of Spanish adolescents with a community sanction (N = 105). The three measures showed moderate effect sizes in predicting juvenile reoffending. (1)

The objective of the present review was to examine how predictive validity is analyzed and reported in studies of instruments used to assess violence risk. We reviewed 47 predictive validity studies published between 1990 and 2011 of 25 instruments that were included in two recent systematic reviews. Findings suggest a need for standardization of predictive validity reporting to improve comparison across studies and instruments.
“The Structured Assessment of Violence Risk in Youth (SAVRY) total scores were significantly predictive of any type of reoffending with some variability across racial-ethnic groups. Static factors were most strongly predictive of nonviolent rearrest, but dynamic factors (social-contextual) were the most predictive of violent rearrest. Implications for use of risk-needs assessment tools in juvenile justice programs and areas in need of further investigation are discussed.” (4)

“Overall, there is a paucity of evidence to support the use of traditional risk assessment tools to predict future suicidal behavior or prevent future attempts.” (5)

“The VRAG (Violence Risk Appraisal Guide): Results of the study suggest that the VRAG lacks calibration validity.” (6)
By focusing treatment interventions on individual criminogenic needs, a system can more efficiently and effectively reduce the risk of reoffending, through risk management and rehabilitation efforts geared directly to individual risk needs (see the risk-need-responsivity [RNR] model; Andrews & Bonta, 2010). The efficacy of the RNR model has been demonstrated by nearly 20 years of research (Andrews, 2012; Andrews & Bonta, 2010).
References specific to risk assessment

Well-known current threat assessment models include:

- Comprehensive School Threat Assessment Guidelines model (the CSTAG model; Cornell, 2018),
- Virginia’s state model which is known as the Department of Criminal Justice Services model (the DCJS model; VDCJS, 2020),
- United States Secret Service model (the U.S. Secret Service model; NTAC, 2018)
- Student Threat Assessment System model (the STAS model; Van Dreal, 2016), and
- Violence Threat Risk Assessment model (the VTRA model; Cameron, 2018).

Of these, the majority of published research on reliability, validity and impact outcomes are on the CSTAG model. In fact:

“For all models except the CSTAG model, there is little to no research on their impact on school outcomes, such as in reducing school violence and suspensions and expulsions.” (1)
SOME GENERAL FINDINGS:

• Compared to schools not using the CSTAG model, CSTAG schools have also demonstrated lower rates of short- and long-term suspensions and a lower likelihood that students of concern would be transferred to an alternative setting (1).

• CSTAG schools have also shown a decrease in disparities in suspension rates between special and general education students (1).

• Further, students of concern in CSTAG schools relative to comparison schools received more mental health counseling and parent conferences (1).

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Racism and Discrimination in threat assessment

• “Young people of color (YPOC) are disproportionately excluded from school for the federal offense category “violent incident without injury,” which comprises “made terrorist threats,” “harassment or intimidation,” and “caused, attempted, or threatened physical injury”.

• “During the 2016–2017 academic year, 80.4% of the 185,741 total suspensions and expulsions for this offense category were of non-White students (DataQuest, 2018; Table 1).”

• “Using threat assessment procedures may help restore equity after a YPOC is referred, yet the root cause for the disparate number of referrals by school personnel and peers for perceived and real threats remains unexplained.”

CSTAG schools have had smaller racial disparities in long-term suspension rates between Black and White students (JustChildren & Cornell, 2013). Similarly, one study found that Black students were equally as likely as White students, rather than more likely, to receive a long-term suspension in CSTAG schools.

How to roll out a general mental health triage and screening and intervention process that is effective and tiered

PsySTART, TF-CBT, and Health Support Team
Youth Enter Mental Health Care Via “Touchpoints” and Systems of Care: 
Schools are Primary to This, With Broader Capacity to Observe and Identify At Risk Youth

- Schools
- Primary Care
- Hospital Emergency Rooms due to Crisis
Multi-gated triage, assessment, care

**TRIAGE**
- Identify
- High Risk
- Objective
- Features

**SCREENING**
- Distress measures and functional impact

**ASSESSMENT**
- Clinical evaluation

**Clinica l Care**
Pediatric Disaster Systems of Care

Stepped Triage to Care Model

ACUTE DANGER
- EMERGENCY CARE
  - Suicidal risk
- Immediate Crisis Intervention

HIGH RISK
- Prioritized Crisis Intervention
- Secondary Assessment
- Stepped TF CBT Acute-Full

MODERATE RISK
- Secondary Clinical Assessment
- Limited crisis intervention
- PFA

LOW RISK
- Listen Protect Connect PFA
- APC
- Child/Parent PFA LPC
Pediatric Acute Trauma Risk, Resilience and Care

50-90% = Transitory Distress ("symptoms")
(ex: Insomnia, Fears of recurrence)

“Green” Resilience pathway

Prior Trauma SED, SDOH/ (ACES)

Range =20-40% New Incidence Disorder: PTSD, PGD, Depression

“RED” Risk Pathway

Acute Danger

Pediatric Stepped Triage to Care Model
PsySTART Rapid Triage Assumptions
From Distress to Risk

PsySTART not a symptom-based screener: uses QUIET QUESTIONS

Instead, its severe/extreme stressors not initial upset/distress
“Outside your head, not in” – does not require “feelings”

Validation on acutely traumatized children (and adults) and predicts clinical PTSD and Depression (JAMA. 2006 Aug 2;296(5):549-59) in disasters/traumatic injury

Distress or PTSD?

Numb or “chill”?

“I’m fine”
Goal: Getting children to timely continuum of care
Multi-Tiered System of Supports (MTSS)

Tier 3
Intensive
Students at high risk

Tier 2
Targeted
Students with some risk factors

Tier 1
Universal
All students

Increasing intensity of intervention
Continuous parent communication
Decreasing number of students
Collaborative problem solving
Identify trauma exposure

Start Here

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>EXPRESSED THOUGHT OR INTENT TO HARM SELF/OTHERS?</td>
<td></td>
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<tr>
<td>FELT OR EXPRESSED EXTREME PANIC?</td>
<td></td>
</tr>
<tr>
<td>FELT DIRECT THREAT TO LIFE OF SELF OR FAMILY MEMBER?</td>
<td></td>
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<tr>
<td>SAW / HEARD DEATH OR SERIOUS INJURY OF OTHER?</td>
<td></td>
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<tr>
<td>MULTIPLE DEATHS OF FAMILY, FRIENDS OR PEERS?</td>
<td></td>
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<tr>
<td>DEATH OF IMMEDIATE FAMILY MEMBER?</td>
<td></td>
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<tr>
<td>DEATH OF FRIEND OR PEER?</td>
<td></td>
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<tr>
<td>DEATH OF PET?</td>
<td></td>
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<tr>
<td>SIGNIFICANT DISASTER RELATED ILLNESS OR PHYSICAL INJURY OF SELF OR FAMILY MEMBER?</td>
<td></td>
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<tr>
<td>TRAPPED OR DELAYED EVACUATION?</td>
<td></td>
</tr>
<tr>
<td>HOME NOT LIVABLE DUE TO DISASTER?</td>
<td></td>
</tr>
<tr>
<td>CHILD CURRENTLY SEPARATED FROM ALL CAREGIVERS</td>
<td></td>
</tr>
<tr>
<td>FAMILY MEMBERS WHO ARE CURRENTLY SEPARATED OR MISSING</td>
<td></td>
</tr>
<tr>
<td>HEALTH CONCERNS DUE TO EXPOSURE OR CONTAMINATION AND EXPERIENCED MEDICAL TREATMENT OR DECONTAMINATION DUE TO EXPOSURE</td>
<td></td>
</tr>
<tr>
<td>PRIOR HISTORY OF EITHER MENTAL HEALTHCARE, DRUG OR ALCOHOL USE FOR SELF OR FAMILY MEMBER</td>
<td></td>
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<tr>
<td>BELIEF NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS (SUCH AS SOMEONE TO TALK TO).</td>
<td></td>
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<tr>
<td>VERY OFTEN DO NOT HAVE ENOUGH TO EAT, CLEAN CLOTHES TO WEAR OR A SAFE PLACE TO GO</td>
<td></td>
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<tr>
<td>CANNOT GET HELP NEEDED WHEN SICK.</td>
<td></td>
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<tr>
<td>EXPOSURE TO DOMESTIC VIOLENCE, EMOTIONAL, PHYSICAL OR SEXUAL ABUSE</td>
<td></td>
</tr>
<tr>
<td>NO TRIAGE FACTORS IDENTIFIED?</td>
<td></td>
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### PsySTART Aggregated Data Oct 22-July 23

**Site: State**

**Incidents:** COVID TFCBT

**Report Period:** 01-Oct-22 - 16-Jul-23

<table>
<thead>
<tr>
<th>Event Distribution</th>
<th>Records with multiple red and yellow variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Yellow</td>
</tr>
<tr>
<td>chld_0-2_years: 4</td>
<td>chld_13-17_years: 11</td>
</tr>
<tr>
<td>Total Records: 52</td>
<td></td>
</tr>
</tbody>
</table>

### Loss

- **62%**
  - Red: 37%
  - Yellow: 21%
  - No: 6%

### Panic

- **55%**
  - Red: 36%
  - Yellow: 46%
  - No: 0%

### Event

- **55%**
  - Red: 45%
  - Yellow: 27%
  - No: 0%

### Home

- **6%**
  - Red: 6%
  - Yellow: 6%
  - No: 94%

Questions:

- **Expressed thought or intent to harm self/others?**
- **Child currently separated from all caregivers?**
- **Family members who are currently separated or missing?**
- **Health concerns due to exposure or contamination?**
- **Prior history of either physical or alcohol use for self or family member?**
- **Belief not receiving sufficient support from others?**
- **Very often do not have enough to eat, clean clothes to wear or a safe place to go?**
- **Cannot get help needed when sick?**
- **Exposure to domestic violence, emotional, physical or sexual abuse?**
- **No triage factors identified?**

For exclusive use of WA DOM Stepped Triangle to Care Project
Referral Partners “trauma mapping”
Telehealth / Stepped Triage to TF-CBT
Increasing access to care
Reducing Barriers to Behavioral Health Care and Increasing Equitable Access

- Increasing workforce via trained graduate students or increasing efficiency of licensed providers
- Telehealth reduces barriers of time, transportation, childcare
- Treatment at no cost or shortened treatment with good results reduces financial burden
Trauma-Focused CBT Process

- PRAC Modules (typically 4 sessions but may require additional)
- Psychoeducation/Parenting
- Relaxation
- Affective Modulation
- Cognitive coping
- 40%-50% are improved to “graduate” care after PRAC alone

- TICE Modules (Usually an additional 8-12 sessions)
- Trauma Narrative
- In-vivo Trauma Exposure
- Conjoint Parent Child Sessions
- Enhancing Safety and Future Development
Increasing Provider Efficiency

With 50% of kids “graduated” after only 4-6 sessions of PRAC, it allows the provider to take on additional cases. This increases provider efficiency anywhere from 30%-40%. In WA project, clinician efficiency was increased by 67%
Triage to Stepped TF-CBT Model

Figure 1: Stepped Care Model

Initial Triage & Screening

PsySTART
Triage at
Referral Sites

IC Phone
Screen &
CPSS-5

ICs

CPSS-5

TF-CBT

CPSS-5

Step 1: PRAC

Screened Out

Step 2: TICE

Step 2: TICE

Graduated or
Referred Out
Reliable Change Index (RCI) is a psychometric tool that assesses the statistical significance of change in scores over time.
Health Support Team

The HST process includes four steps:

• Listening and Learning
• Offering Support
• Providing Tools
• Emphasizing Hope

LEARN & LISTEN
Learn about the person and Listen to the problem using supportive communication and active listening techniques.

OFFER SUPPORT
Foster resiliency by supporting the person in finding external resources and internal strengths OR Refer them to someone if needed.

PROVIDE A TOOL
Offer them a tool to help them cope, such as a relaxation technique or a thinking strategy.

EMPHASIZE HOPE
Let the person know you are there for them, and that you are an encouraging, supportive resource for them when needed.
The Health Support Team Program

What is the Health Support Team?

• The Health Support Team is a group of individual trainees from local communities who have committed to becoming a resource for others in times of crisis and in the long-term recovery after disasters.
• They are students, parents, teachers, friends, workers, and anyone from the local area who is interested in learning and applying some simple supportive techniques and tools in the assistance of their fellow citizens.
• The Health Support Team is YOU—people who are trained to support.

MODULES & Examples of Content

• Module 1: Introduction to Health Support Team, Disaster Response & Recovery
• Module 2: HST Skills and Techniques: The Supportive Relationship, Communication & Listening
• Module 3: Health Support Team Goals: Engaging with Key Issues, from Listening to Referral
• Module 4: Health Support Team Tools: Relaxation, Stress Reduction, and Thinking Strategies
• Module 5: Health Support Team Member Boundaries and Resilience / Program summary
WHY WE DEVELOPED THIS CURRICULUM:

• To empower trained trainees, to assist their colleagues, students, youth, families, and community members in recovery from trauma and the development of resiliency by: Providing psychosocial and educational information in the form of a disaster behavioral health training program / curriculum and guide; Connecting trained trainees with local resources where and when available.

• To create a sustainable work group of trainers and trainees who can support one another, as well as provide ongoing training to new and additional trainees in the community and surrounding areas.

• To provide the opportunity for the organic growth of a community based mental health support network that could operate independently from foreign aid and resource dependence internationally, and to provide additional community support when resources are in short supply following regional disasters in developed nations.
HST training summary

- Over 500 Haitian community volunteers completed one-day HST training, including students, nurses, translators, community agents, doctors, and security personnel.
- Over 100 Jordanians, Syrians, Iraqis and Palestinians have been trained, about 20 of them as trainers. This includes relief workers and many refugee community leaders.
- In Poland - Over 100 Polish relief workers and Ukrainian refugees were trained, in addition to Polish teachers, principles and superintendents, whose schools were seeing a huge influx of Ukrainian students.
- In the US, we have trained over 1000 community volunteers, educators, medical professionals and responders.
WE KNOW WHAT WORKS TO INCREASE POSITIVE MENTAL HEALTH FACTORS and DECREASE RISK
What we can do that actually works to reduce risk

PART 3:

Focus on process and simple health factors.

Be creative in accessing existing resources and strengths to build resilience and reduce symptoms.

Roll out a mental health triage, screening and support process that is effective and accessible.
What do Children, Youth and Teens NEED?

Safety, Routine and Security
A sense of consistency and predictable patterns

Trust
Honest answers and explanations

Control & Hope
A sense of future and realistic options
Identify internal strengths and external resources

Develop insight, awareness (and self-regulation)

Engage in resilience building

Active coping techniques to reduce symptoms

Listening and other healthy communication tactics

Roadmap for behavioral health: the IDEAL process

How do we get there?
IDENTIFY

INTERNAL STRENGTHS
• Cooperation and communication
• Problem solving
• Self-awareness

EXTERNAL RESOURCES
• What has worked well for you in the past?
• Who can you reach out to?
• What resources are still needed?

• Empathy
• Advocating for yourself
• Goals and aspirations
Develop Insight & Awareness

Being aware of your internal (and external) states; how you express yourself, how you approach others, and how regulated you are, or what to do when you are disregulated.
Resilience Development

Purpose
What motivates you? What is important to you? What are you striving for, or what helps you move forward?

Adaptability
How can you make adjustments that are needed, to time, space, fun, expectations, etc? How can you respond with curiosity?

Hope
How can you shift your thinking from 'threat' to 'challenge' and what are the realistic opportunities you have?

Connection
To whom or what are you connected? Connection can be anything that prevents isolation.
Active Coping

**Anxiety**
- Sensory interventions:
  - Frozen orange, ice
  - Music
  - Shower
  - Fuzzy slippers
- Apps
- Breathing = calming

**Exhaustion**
- Sleep hygiene
  - Same bed and wake times
  - Alcohol and sugar considerations
  - Notepad (not phone or laptop)
- Apps
- Boundaries

**Depression**
- Behavioral activation: Small steps
- Get a “this makes me feel better” list made on a good day
  - 5 minutes to 5 hours
- Movement of any kind
- Connection and support from others
CREATING A (good) COPING PLAN:
General Considerations

• Anticipation of our ‘exposures' to stressful events, as well as creating and working a deterrent plan is one of the most effective ways of reducing symptoms and new incidents of disorder.

• Let's take a note from not making “new years resolutions” and set the right kinds of goals (hint: they have to be achievable).
## Plan ideas/examples

<table>
<thead>
<tr>
<th>Concern</th>
<th>Indicators</th>
<th>People resources</th>
<th>Coping Option(s)</th>
<th>Length of time or resource needed</th>
<th>Other info or resources needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhaustion</td>
<td>Tension headache, snappiness</td>
<td>(names)</td>
<td>Walking the dog</td>
<td>10-30 minutes</td>
<td>After work / at home</td>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Mental confusion, High heart rate, Stomach upset</td>
<td>(names)</td>
<td>Hot shower</td>
<td>30 minutes</td>
<td>Home / none</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Brief Mindfulness exercise</td>
<td>5-10 minutes</td>
<td>No interruptions at work</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Text memes</td>
<td>2-5 minutes</td>
<td>(Names of friends)</td>
</tr>
</tbody>
</table>
Listening & Effective Communication

• Knowing what "temp zone" you are in
• Recognizing what "temp zone" others are in.
• Application of a "challenge" mindset (rather than threat)
• Mindful use of your non-verbal messages.
• ACTIVE LISTENING
## ACTIVE LISTENING

| KIDS 5-12 | ○ Any window is a good window  
○ They don’t communicate on our schedules  
○ Regression in development  
○ Shift expectations |
| KIDS 13-18 | ○ Model careful reactions, slow down  
○ Ask about goals: What do they want or hope for?  
○ Future focus helps with hope  
○ Positive reinforcement for regulated communication |
| ADULTS | ○ Pay attention to signals that the person is ready to talk  
○ Try to start sentences with “I” rather than “you”  
○ If things become too heated, it’s ok to take a break |
Time to change behavioral health intervention and support from “is this student a threat” to “what does this student need to thrive?”
thank you
Please Complete this Session’s Evaluation

10/26/2023
Session ID– 1I - Embedding Crisis Response & Threat Assessment Within Multi-tiered Systems of Support

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