1.6 CRISIS RESPONSE WITH STREET-INVOLVED YOUTH

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INTRODUCTION

Youth who are under-housed or street involved can experience crises that include injury by violence, aggressive behaviours, and thoughts of suicide. These crises can be challenging and frightening not only for the youth experiencing them, but also for service providers who work with these young people. Using a strength-based approach during a crisis helps youth develop personal agency. Personal agency refers to the sense of having control over one's own outcomes (Jeannerod, 2003). Even in the face of shaming messages telling them they cannot change, most street-involved youth are extremely resilient and resourceful. We support them in developing personal agency when we help them make their own changes rather than make changes for them. For example, guiding youth along the decision path toward finding safe shelter, supporting them in taking the key steps themselves, accompanying them as they make the arrangements, and celebrating their success go a long way in helping youth build the skills and confidence necessary to address future risks and crises. Furthermore, promoting personal agency strengthens self-esteem, which is a buffer against a range of negative outcomes in youth who are homeless (Kidd & Shahar, 2008).

This chapter describes basic strategies service providers can use to keep themselves, their clients, and other clients as safe as possible during a crisis. It also discusses how at the same time service providers can affirm clients in their strength and resilience in surviving, and assure them that they will be supported, not abandoned.

INTERVENTION COMPONENTS

INJURY DUE TO VIOLENCE

Violence is the most common reason youth aged 12–24 visit an emergency department and is the leading cause of hospitalization among males aged 20–24 (Macpherson et al., 2005). The incidence among street youth is even higher: one quarter report having been a victim of violence (Boivin, Roy, Haley, & Galbaud du Fort, 2005). Youth injured by violence are at high risk of a subsequent, potentially more serious injury. Over 20% will be injured again within the next year (Parveen & Snider, 2013). A more recent shift to a victim-based approach frames youth violence as a public health issue, rather than a criminal justice one.

For many youth, an injury due to violence can be a turning point. Johnson et al. (2007) found that youth injured by violence are often in a reflective state of mind and are receptive to making changes in their lives. This often can be achieved with the support of a compassionate helper. To take advantage of this receptive state, intervening as early as possible helps to build a relationship with the youth. Some hospital-based intervention programs for youth injured by violence include support workers who meet the youth in the emergency department or inpatient unit to begin developing a relationship (Purtle et al., 2013; Snider & Lee, 2009). Key to intervention is meeting with the youth as soon after the injury as possible, regardless of the organizational framework or whether this is a new or existing relationship.

Early in the crisis, the helper must work with the youth to develop a safety plan. Key discussions include how safe the youth feels, where the youth will be staying after hospitalization, the safety of other residents and staff if they are living in a shelter, and the potential risk of retaliation or "unfinished business." In some cases, the youth may require relocation. The de-escalation strategies introduced below can be used for discussions about retaliation. In some cases, you and the youth may feel it is appropriate to involve the local police to ensure personal safety and that of others. Youth should make the disclosure, with your support, whenever possible, to ensure the bond between you remains and to replant the seed of personal agency even when the youth has been victimized.

The youth's potentially more receptive state during crisis can be a good opportunity to begin a relationship with the helper, or to deepen an existing one. Within this context, risk factors contributing to the injury can be addressed. The wraparound care framework

used in many programs places at-risk youth at the centre of care, and it is they who define what puts them at risk (National Wraparound Initiative, n.d.). Risk factors include a lack of safe shelter, food insecurity, addiction, mental health problems, lack of schooling or work, gang involvement, and family conflict. The helper and the youth work together to develop a system of support for each identified risk factor. Initially, it is important to concentrate on basic needs such as food and shelter; however, over time, longer-term goals can be addressed. Working with youth to change risk factors within their control reduces the likelihood of future violence (Simun, Slovacek, Batie, & Simun, 1996; Spergel & Grossman, 1997).

AGGRESSION & DE-ESCALATION

Aggression includes threatening behaviour and language, harassment, verbal abuse, and physical attacks. It is not uncommon among youth in general, and street youth may be at elevated risk: as many as 62% report a history of severe aggressive behaviour (Booth & Zhang, 1996). While official counts of aggressive incidents involving care practitioners are difficult to determine, they are likely rare. More often, youth become aggressive with one another, and intimate partners are at particular risk (Petering, Rhoades, Rice, & Yoshioka-Maxwell, 2015). It is important for practitioners to be aware of risk factors for aggression, and to understand the aggression cycle and de-escalation techniques that can be used with street youth.

Street youth have often experienced childhood trauma, including sexual and physical victimization (Tyler, Kort-Butler, & Swendener, 2014). Unfortunately, they may internalize aggression as a way of managing unpleasant emotions and coping with their environments. Risks for violence among street youth include a history of arrest and conviction (Booth & Zhang, 1996), and substance use or intoxication (Martin et al., 2009; Petering et al., 2015). The time of highest risk is in the late hours of the night or early hours of the morning (Canadian Centre for Occupational Health and Safety, 2012).

Prevention is key to decreasing aggression in street-involved youth, and those with mental health challenges must have access to supports before a crisis develops (Paton et al., 2016). Using weighted furniture and minimizing clutter help create a safe environment, thereby reducing incidents of aggression. For your personal safety, notify colleagues of your whereabouts, meet higher-risk clients in pairs, and pay attention to your own sense

of safety (Canadian Centre for Occupational Health and Safety, 2012). Furthermore, consider your attire, avoiding long earrings and necklaces, ties, and ID badge strings that can be pulled. ID badge strings with safety clips that break open with pressure are a good alternative. For youth, anger management skills and specific skills for tolerating distressing situations and emotions can help them better manage aggression.

Aggressive behaviour can arise out of emotions such as anger, shame, frustration, and guilt, and often has an unnamed need attached to it. Violent behaviour can cycle through phases of escalation, explosion, and post-explosion (Walker, 1980). You may recognize that a youth is in the escalation phase by paying attention to verbal cues (e.g., swearing, yelling, threats) and non-verbal cues (e.g., pacing, hand-wringing, door-slamming). De-escalation strategies using a range of psychosocial techniques can stop the aggression cycle. Parker and Baker (2012) have identified common themes among de-escalation programs (see Table 1.6-1).

TABLE 1.6-1: COMMON THEMES OF DE-ESCALATION PROGRAMS

DE-ESCALATION COMPONENT	EXAMPLES
Characteristics of effective de-escalators	Appearing supportive, non-judgemental, non-threatening; expressing genuine concern
Maintaining personal control	Appearing calm can help both the youth and you make more effective decisions
Verbal and non-verbal skills	Using a gentle tone of voice, awareness of body language, active listening, careful use of eye contact, care not to invade personal space
Engaging with the aggressive person	Promoting autonomy to demonstrate trust, encourage positive emotions and self-control; avoiding punitive approaches
When to intervene	Balancing early intervention with unnecessary intervention using knowledge of the street youth, meaning of the behaviour, impact on others
Ensuring safe conditions for de-escalation	Balancing adequate staff support with crowding; assessing the area for potential safety risks; moving to a quiet area away from others who are not involved
Strategies for de-escalation	Assessing the person's emotional state using listening and interpretation of non-verbal cues and formulating appropriate interventions that balance support and control proportionate to current risk

Specific techniques that can be used in de-escalation are discussed in the "Implementation Considerations" section. Staff should receive regular training in an accredited program; for example, the Crisis Prevention Institute offers training (www.crisisprevention.com). Understanding and Managing Aggressive Behaviour training is also available (www.umabcanada.com).

There will be situations in which the youth's behaviour poses a risk of harm to others and cannot be managed with verbal de-escalation. In these cases, know your organization's protocols for obtaining external supports, whether it be from trained security guards, crisis services, emergency medical services, or police. After the incident, debriefings with the following people can be helpful:

- Fellow practitioners: to manage staff reactions and help prevent further such events;
- Other youth who were present: to support those who may have their own experiences of trauma and victimization and feel triggered by the event; and
- The aggressive youth, once calm: to identify antecedents to the behaviour and what the youth and the people around him or her could do differently in future situations.

SUICIDE

Hearing a youth tell you "I just want to die" is scary and the first thing helpers often want to do is make it better or make the thoughts go away. Feeling trapped, scared, desperate, or hopeless is not unusual for the person experiencing suicidality, who also wants it to "just go away" (O'Connor & Nock, 2014; O'Connor, Smyth, Ferguson, Ryan, & Williams, 2013; Taylor, Gooding, Wood, Johnson, & Tarrier, 2011).

For youth who are homeless, various experiences can contribute to thoughts of worthlessness, to a feeling that life as they know it "will never end," and to thoughts of suicidality. These experiences include stigma, adversity, poverty, and victimization arising from maltreatment; being considered "different" in terms of gender identity, sexual orientation, and race; and feeling disconnected from family and friends (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; da Silva Cais, Stefanello, Fabricio Mauro, Vaz Scavacini de Freitas, & Botega, 2009; Dieserud, Gerhardsen, Van den Weghe, & Corbett, 2010; Hadland et al., 2015; Kidd, 2004, 2009; Mereish, O'Cleirigh, & Bradford, 2014; Sinclair, Hawton, & Gray, 2010; Wong et al., 2008). Feelings of rejection, abandonment, helplessness, fear, and exhaustion, and efforts of surviving the streets are not unusual.

Using alcohol and drugs, non-suicidal self-injury, and thinking about suicide or making suicide attempts can be ways to cope with or communicate the deep pain and scary thoughts for which there are no words (Butler & Malone, 2013; Sinclair & Green, 2005). As a result, street-involved youth are at high risk of dying by suicide, substance misuse, and violence (Roy et al., 2004).

Understanding suicidality as arising from a core of emotional pain or "psychache"—the unbearable and unresolved psychological pain a person experiences—helps to contextualize an understanding of suicidality (Shneidman, 1993; Sledge et al., 2014). Taking it a step further, the person experiencing the suicidal crisis often does not have a language or understanding of the experience outside of intense feelings that need to be discharged (Bergmans, Gordon, & Eynan, 2017), often through anger (Kidd & Carroll, 2007), whereby "undifferentiated states of high emotional arousal—unstoried emotions—are almost always experienced as disorganizing, distressing, and frightening" (Angus & Greenberg, 2011, p. 21).

Non-suicidal self-injury involves harming oneself with no intent to die (Posner, Brodsky, Yershova, Buchanan, & Mann, 2014). It is a risk factor for a subsequent suicide attempt; however, not everyone who self-injures will go on to make a suicide attempt (Butler & Malone, 2013). Reasons for non-suicidal self-injury are unique to each person, and understanding the meaning and intent from the person's perspective is critical. The behaviour might offer relief, provide a sense of control when the person feels powerless, regulate emotional intensity, communicate of internal distress, or perhaps serve as punishment for being "bad" or "different" (Centre for Suicide Prevention, 2016). It may also be suicide "prevention" or the early stages of trying to cope with making the thoughts of ending one's life "go away." Helpers can make statements that show concern and validation, and that help youth understand the potential consequences of the behaviour; for example, "It looks like you're really hurting inside and I wonder how self-injury is helpful for you?" or "I worry that this behaviour is going to hurt you in a way you may not intend." Similarly, recognizing substance use as a coping strategy can help remove the judgement, blame, and stigma of being an "addict." Asking youth what substances do for them can identify the role of substances in coping or providing the "chemical courage" needed to make a suicide attempt; risk of an attempt increases when depressive symptoms and alcohol are combined. Asking youth if they think they will make a suicide attempt can gauge risk for future attempts.

Suicide ideation refers to thoughts of ending one's life (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). Having suicidal thoughts does not mean the person will go on to suicide; however, such thoughts need to be discussed and assessed for risk (Klonsky & May, 2014, 2015). For some, thoughts of suicide are about wanting to end the feelings, seeing no purpose or future for themselves, not wanting to live "like this," taking control, or finding some peace (Bergmans, Langley, Links, & Lavery, 2009). Asking youth what they are trying to "end" or "kill," or what dying will do for them, will help to guide intervention. Being understood, listened to, and heard, and having someone "get" how awful they are feeling is often the need. Talking about hope and future during a crisis can be experienced as invalidating and showing you are not "hearing" the person. Holding your hope for the youth should be a silent intervention. In the words of one youth: "Quite frankly, I don't need your hope when I'm in that place. I need you to understand my hopelessness!"

A suicide attempt is an action associated with some intent to die; higher risk includes three key ingredients: intent, plan, and access to means. We cannot predict who will or will not die by suicide, but we do know that a previous attempt is the strongest predictor to another attempt and eventual death by suicide (Christiansen & Jensen, 2007; Haukka, Suominen, Partonen, & Lonnqvist, 2008; Jenkins, Hale, Papanastassiou, Crawford, & Tyrer, 2002; Wong et al., 2008). A youth may have intent and no plan, or intent and a plan with no means to engage in the plan. You do not know unless you ask. Asking about suicide will not "make" a youth suicidal (Gould et al., 2005). Questions to discern intent, plan, means, or previous attempts could include "Are you thinking of ending your life?"; "Have you thought of a way to end your life?"; "Do you have what you need to end your life"; "Have you ever tried to end your life before?" Given that the intensity of feelings comes and goes, education about reducing access to means is important. Access to means includes excess medications (hoarding/saving pills), having a rope or a gun, and fantasizing about a favourite bridge or rooftop. For some, surveying the area or trying to climb to an edge may be ways of "practising" and reducing the fear of making a suicide attempt. Reducing the fear of dying, a perception of not belonging, and isolation are known risk factors for making a suicide attempt. Often the youth may indicate ambivalence, being committed neither to dying nor living. This does not mean the person has no intent, or does not "really want to die." It is a position of truly not knowing if the person wants to die or live while experiencing the agony. Ambivalence is a state that cannot be taken lightly or ignored (Bergmans et al., 2009; Bergmans et al., 2017; Orbach, Jobes, & Tanney, 2008).

Supporting youth around suicidality

The ability to problem solve is often compromised when emotional crises hit (Williams, Barnhofer, Crane, & Beck, 2005).The intensity of the feelings have "flooded" the thinking part of the brain (Izard, 2002). Often, youth will have no words to identify or describe their emotions; their non-verbal language or behaviour will give you the information to begin the conversation about how terrible things are right now. Safety, validation, normalization, and giving words to the experience of suicidality are the beginning stages of intervention. When seeing tears and hearing statements like "I can't take it anymore," responses like "When I see those tears and hear those words, I can't help but think that the pain is so big and so bad that you're thinking it will never end" can be validating. Normalizing the experience might sound like "You're in a really hard place right now. It's only human to be feeling sad, angry, frustrated, helpless . . . ," using actual situations you know they have experienced. Simultaneously noting the strength and courage it takes to ask for help, survive when homeless, and cope with all the feelings and experiences taps into the person's inherent strengths. Reducing the sense of aloneness and instilling the possibility of hope in despair does not mean creating unrealistic expectations about what is to come. We cannot "make" thoughts of suicide go away; however, we can help youth identify that suicidal thoughts are warning signs that they are experiencing many intense emotions, all of which make sense given their current situation. Reminding them that neither feelings nor thoughts have ever killed a person, but that actions could, allows youth to begin to create awareness and skills to keep safer when they experience intense feelings and thoughts of suicide. Pointing out examples of the youth making safer choices and exhibiting moments of control reflects that you are paying attention. Identifying a genuine appreciation for the fact that they called you for help, are telling you this, that you know they are trying their best in difficult circumstances, lets them know that even when they are feeling they have no control and no choices, they have made safer choices by engaging in these actions.

Using the term "safer" when discussing choices takes away the judgements associated with the words "good" and "bad." Feelings too are neither good nor bad; they are part of the human experience and provide information. Understanding feelings as "comfortable" or "uncomfortable" may help neutralize youths' experience of the feeling. Educating them about the role of emotions might be helpful given that some may have learned that anger is bad or that they have no reason to feel sad when those are feelings connected to experiences over which they may have had little control. Equally as important is realizing that we can have several emotions concurrently. We can feel extremely sad or angry while enjoying chocolate ice cream or while feeling soothed by stroking a pet.

Reaching out is not easy for many youth who have been abandoned, rejected, or hurt, and who are reluctant to trust. They may feel shame or consider seeking help as a sign of weakness (Burke, Kerr, & McKeon, 2008; Everall, Bostik, & Paulson, 2006; Gilchrist & Sullivan, 2006; Wisdom, Clarke, & Green, 2006). Often, youth will minimize their symptoms to appear "normal." Being connected, having social support, and being able to process emotions contribute to an increased sense of agency and personal control for suicidal youth (Everall, Altrows, & Paulson, 2006).

Asking for trust from street-involved youth may be unrealistic. Consider starting from a position of "respect" for the knowledge gained from your experience as a helper, and recognize that there will be suspicion, hesitancy, and caution of "adults" and "professionals." It is not personal—it is a coping strategy.

Street-involved youth can be very transient, but knowing that someone listened and cared about what happened to them in the moment they were being listened to is held in the memory of many youth and can be impactful (Kurtz, Jarvis, Lindsey, & Nackerud, 2000). Small interactions, a skill, a language, a better understanding, and caring can be foundational moments. As long as it is safe for everyone, keep the door open to future conversations should the youth choose to return. It is challenging when someone tells you they want to end their life and then disappears. Concern, fear, and worry predominate in those situations. Talking with a supervisor about next steps to take is critical. Giving yourself permission to recognize what you do not know allows you to be curious and learn more. Sometimes we cannot predict when someone will try to end their life, despite all of our best efforts.

Whether suicidal crisis de-escalation occurs on the street, in a drop-in, or in a shelter, the ultimate concern is your safety, the safety of those around you, and the safety of the client. When a youth discloses suicidality, the ultimate preference is for a quiet space away from others. Sometimes this means a stairwell, a hallway, a bathroom, a park bench. If you leave the premises, make sure a colleague knows where you are and you have a safety check-in system. Sometimes a calm, experienced peer who "knows the pain" can be an incredible asset in the discussion as they will carry more credibility than "the worker." Do not be afraid to call for help. Dealing with a suicidal crisis is far easier when done in tandem with someone else.

Working with a youth who is thinking of, or threatening suicide, is to be taken seriously and assessed. It can be challenging and scary, and leave you feeling incompetent and useless. If you are uncertain, contact a medical professional for a formal risk assessment. Ignoring risk will not make it go away. Document your concerns, intervention, and follow-up plans, and discuss them with your supervisor. To do this work, we need to take care of ourselves through naming our feelings, reaching out to team members, obtaining regular supervision, and asking for consultation. Know that we cannot always prevent a suicide attempt; however, we can continue to believe in the worth and potential of youth after they have survived an attempt, and to believe there is a possibility they can engage with life and live more safely.

IMPLEMENTATION CONSIDERATIONS

Recognize that the more prevention and groundwork that can be laid before a crisis emerges, the greater the likelihood that the duration, frequency, and intensity of episodes will decrease over time. The following suggestions have been organized along the lines of the cycle of violence; however, they can be applied to any crisis situation. At any time, strategies may be interchangeable, or they may not be effective in a given situation for a particular youth. For example, the strategy of focusing on breathing can sometimes cause youth greater distress when they are beginning to escalate.

PREVENTION & DE-ESCALATION

- Reduce emotional arousal and build an alliance through validation: convey that the youth's responses make sense and are understandable within the youth's current life context or situation. Contextualizing and normalizing the experience by offering a name to it can let the youth know that the helper is engaged and paying attention (Linehan, 1993).
- Offer safe alternatives: suggest other activities, grounding strategies, and "face-saving" options, including negotiation of a mutually agreed alternative; positively reinforce non-violent behaviour.
- Facilitate expression: encourage youth to communicate feelings and experiences, and recognize the right to express anger provided the youth can do so without harming self or others.

- Teach grounding techniques: grounding keeps the mind and body connected and in the present; techniques can include naming items in the room, squeezing a stress ball, or saying "heel, toe" while walking.
- Anticipate explosion: ensuring safety for the youth and others is key and may involve removing bystanders or youth to a safe, quiet space and engaging with agency protocol for violence, for example, by involving security, police, or extra staff.

PREVENTION & DEBRIEFING

- Conduct a behavioural chain analysis: guide the youth through a step-by-step description of the chain of events leading up to and following the crisis. This can help test hypotheses about events relevant to generating and maintaining the behaviour, and explore its function and consequences (Miller, Rathus, & Linehan, 2007).
- Engage in shared problem solving: together with the youth, identify events leading to the crisis and determine what has worked before.
- Develop a safety plan (Stanley & Brown, 2012).
- Teach coping strategies and new responses to frustrating situations, and help youth develop distress tolerance skills (Rathus & Miller, 2015). Strategies can include:
  - Changing body chemistry to counteract disabling emotional arousal (e.g., practising paced breathing);
  - Distracting (e.g., activities like going for a walk or texting a friend, or intensifying other sensations by holding or chewing ice); and
  - Self-soothing with senses (e.g., watching a sunset, smelling freshly brewed coffee).
- Develop language for feelings and identify the needs that might be associated with those feelings.

Learning and practising these strategies when not in crisis can make them easier to identify and apply when youth recognize that they are beginning to escalate. This allows youth to take ownership of their own safety and that of those around them. Realistic expectations of availability and skill sets of people in a network are important—knowing who is good for what and when. Identifying expectations and possible outcomes to choices is key.

Working with youth in crisis can be stressful. Just as it is important for youth to identify who in their network can help with what, it is also critical for you to know who you can rely on for support, and the respective roles of the people in your agency in a crisis

situation. It can also help to be familiar with external resources in your community. Familiarize yourself with the standards for documentation and follow-up at your agency. Being prepared for a crisis will help you act more effectively.

KEY MESSAGES

- Walk beside youth as they work through their crisis and help them identify their own strength. A crisis is an opportunity to deepen your relationship and establish trust with a street youth.
- De-escalation techniques will help youth both during crisis and in future potential crises. Being knowledgeable of various techniques is important for the helper and the youth.
- Do not hesitate to involve other caregivers and professionals during a crisis. Ignoring the risk of escalation to repeat injury, aggression, and suicide will not make it go away.

RESOURCES

A suicide prevention toolkit: Self-harm and suicide (Centre for Suicide Prevention, 2016)
www.suicideinfo.ca/wp-content/uploads/2016/10/Self-Harm-Toolkit.pdf

Runaway & homeless youth and relationship violence toolkit (National Resource Center on Domestic Violence, 2013)
www.nrcdv.org/rhydvtoolkit/index.html

Why people die by suicide (Harvard University Press, 2005)

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