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RESEARCH ARTICLE

Practical Crisis Management for Parents and Clinicians: Adolescent Suicidal, Aggressive, Elopement Behaviours: Intensive Treatment Settings

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Abstract

Objective: In the many guidelines, recommendations and strategies for crisis management of suicide-related behaviours, aggression/vandalism and elopement in adolescents, immediately usable and specifically detailed descriptions and rationales of the strategies, especially for parents, are noticeably absent. This paper describes a feasibility project to develop one overall detailed strategy with specific adaptations for each of the three crises for adolescents in intensive services. It is a contribution to the discussion and joint service/parent management of these crises. **Method:** The factors to consider and the development of the strategy and PARENT GUIDE are described. Examples are provided. While the main work was done by the psychiatrist and staff of a day treatment service many other colleagues and families contributed over the seven years. The accompanying PARENT GUIDE is a necessary, separate and available document. **Results:** Since the purpose was to develop and evolve the strategy, it did not lend itself to a clear research outcome. However, careful estimates using the approximately 30 adolescents (of about 350 adolescents) for whom the strategy was used showed: no deaths, assault and vandalism stopped and elopement was managed. Parents regained skills, hope and improved relationships with their adolescents. They developed the confidence, specific knowledge and skills to manage for the future. **Conclusions:** The successful development and evolution of the strategy demonstrated feasibility of the concept. The hope is that such strategies contribute to the advancement of patient care, the discussion in the literature and provide the basis for future research.

Key Words: *adolescent, suicide, management, crisis, intervention*

Résumé

Objectif: Dans de nombreuses lignes directrices, les recommandations et stratégies de gestion de crise pour des comportements liés au suicide, à l'agressivité/vandalisme et à la fugue chez les adolescents, les descriptions immédiatement utilisables et spécifiquement détaillées et les justifications des stratégies, surtout pour les parents, sont nettement absentes. Cet article décrit un projet de faisabilité afin d'élaborer une stratégie générale détaillée comportant des adaptations spécifiques à chacune des trois crises pour les adolescents dans des services intensifs. C'est une contribution à la discussion et à la gestion conjointe service/parent de ces crises. **Méthode:** Les facteurs à prendre en compte et l'élaboration de la stratégie et du GUIDE DES PARENTS sont décrits. Des exemples sont fournis. Bien que la majeure partie du travail ait été effectuée par le psychiatre et le personnel d'un service de traitement de jour, nombre d'autres collègues et familles ont contribué au fil des sept années. Le GUIDE DES PARENTS annexe est un document nécessaire, distinct et disponible. **Résultats:** Puisque le but était d'élaborer et de faire évoluer la stratégie, il ne se prêtait pas à un résultat de recherche défini. Toutefois, des estimations prudentes obtenues à l'aide des quelque 30 adolescents (sur environ 350 adolescents) chez qui la stratégie a été utilisée ont démontré : aucun décès, arrêt des agressions et du vandalisme, et gestion des fugues. Les parents ont retrouvé leurs compétences, l'espoir et ont amélioré leurs relations avec leurs adolescents. Ils ont acquis la confiance, les connaissances et les compétences spécifiques pour la gestion

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future. **Conclusions:** L'élaboration et l'évolution réussies de la stratégie ont démontré la faisabilité du concept. L'espoir est que ces stratégies contribuent au progrès des soins des patients et à la discussion de la littérature, et qu'elles constituent une base pour la future recherche.

Mots clés: *adolescent, suicide, gestion, crise, intervention*

Introduction

Adolescents in intensive treatment services (inpatient—IP, day treatment services/partial hospitalization—DTS, and some Intensive Community Services) frequently use maladaptive coping strategies (MCS) (Piquet, & Wagner, 2003) which can become the three crises: strong and immediate suicidal intention or suicide-related behaviours (combined and abbreviated as SRB), aggression/vandalism and elopement as attempts to manage unwanted emotions, stress, supervision and treatment. Responding to and managing these crises can become immediate and preempt all other aspects of treatment in a DTS. The parents are usually in distress, frustrated and uncertain what to do.

This paper is about a project to test the feasibility of developing an overall conceptual strategy to help the adolescents in these crises, their parents, clinicians, and services that coordinate plans and implementation.

Suicidal ideation and SRB are found in all diagnostic categories (Khan, 1987) but with a higher frequency in mood, disruptive behavior and substance use disorders (Shaffer et al., 1996). Aggression is also found in a wide variety of diagnoses, states and traits (American Academy of Child and Adolescent Psychiatry, 2002). The publications in **Table 1** provide a guideline both to the background knowledge and skills and to those of more direct relevance to this publication.

Table 1. Management of the Crises, Treatment Settings and Individual Programs

FIRST AUTHOR and TITLE (abbreviated from references)
FOCUS of the publication
This Publication (Item 1): Practical crisis management for parents and clinicians
Narrow and specific focus; unless specifically stated (e.g. Kiser et al., 1991), the reference papers below are not as directly focused on these five features: 1. Adolescent already a patient in an intensive service: Day Treatment Service (DTS), In Patient (IP), Intensive Community Service (ICS) 2. Specific crises: Suicide-Related Behavior (SRB), aggression (AGG), and elopement (ELO) 3. Key issues outlined in SRB decision to admit to IP, or not, with written specific implications and actions for clinicians, parents, services and adolescents 4. Written strategy (called PARENT GUIDE) coordinates interdependent roles and actions of parents, services, clinicians and adolescents 5. Strategy and PARENT GUIDE pre adapted to address SRB, AGG and ELO
American Acad. Of Child and Adolescent Psychiatry, 2001. *Practice Parameter…children and adolescents with suicidal behavior* ***SRB – Practice Parameter:*** General Guidelines and Policies (GGP—includes: review, assessment, role of family, risk factors, diagnoses, prevention, treatment, crisis management and follow-up), excellent prerequisite information in all the areas but without the specific features of item 1 (above).
American Acad. Of Child and Adolescent Psychiatry, 1997. *Practice Parameters…children and adolescents with Conduct Disorder* ***AGG – Practice Parameter:*** GGP for aggression, notes use of institutions but no management directly related to features in item 1.
American Acad. Of Child and Adolescent Psychiatry, 2002. *Practice Parameter for the prevention and management of aggressive behavior in child…* ***AGG – Practice Parameter:*** GGP for aggression, excellent coverage of prevention, crisis management, levels of intervention, seclusion and restraint and more.
American Psychiatric Assoc., 2003, reissue 2010. *Practice Guideline for the Assessment and treatment of patients with suicidal behaviors* ***SRB – Practice Parameter:*** GGP, excellent prerequisite information for adults and older adolescent but without the specific features in item 1.
Stewart, Manion, & Davison, 2002. *Emergency management of the adolescent suicide attempter…a review* ***SRB – Emergency Management for Mental Health Clinicians:*** Comprehensive review and a prerequisite for emergency crisis work with adolescents, includes IP as short term admissions, need for a critical pathway to discharge and follow up; provides conceptual basis but not specifics as in item 1.

continued

Table 1 continued
Gordon & Melvin, 2014. Risk assessment and initial management of suicidal adolescents ***SRB– Emergency Management for Family Practice:*** Practical and detailed for family practitioners proceeding through assessing risk, safety plans and involvement of parents and other professionals. Ten practical steps for initial management and protocol; does not include features in item 1
Press & Khan, 1997. *Management of the suicidal child or adolescent in the emergency department* ***SRB – Emergency Management for Pediatricians:*** Practical and detailed for pediatricians who must often do this work. Includes assessing risk, safety plans and involvement of parents and other professionals. Includes guidelines leading to disposition. No specifics as in item 1.
Garrison & Daigler, 2006. *Treatment settings for adolescent psychiatric conditions* ***SRB, AGG – Mental Health Intensive Treatment Settings:*** Describes main features and purpose of IP, DTS and residential care crossed referenced with suitability for SRB, disruptive behaviours (AGG), psychosis, eating disorders and polysubstance abuse. Provides the conceptual bases for best match of treatment settings and disorders/behaviors; emphasizes close working relationships with families. No specific details of features noted item 1.
Lamb, 2009. Alternatives to admission for children and adolescents: Providing intensive MHS at home and in communities: what works? ***ICS Alternative:*** Reviewed evidence for alternatives to IP care. Day hospital (DTS) had no randomized controlled studies (DTS vs IP) but has demonstrated effectiveness with transfer out of IP admissions. It supported immediate and intensive follow up as reducing IP stays with no reduction in benefits for patients.
Mazza, Capitani, Barbarino, De Risio, & Bria, 2006. A treatment protocol for suicidal patients in a day hospital setting: Preliminary results. ***SRB – DTS Management:*** Patients admitted from emergency assessment to a DTS which developed a biological, psychological and sociological therapeutic management program. One year follow up demonstrated reduction in SRB and no completed suicides. Demonstrated the usefulness of DTS to address SRB. No specifics as in item 1.
Miller, Esposito-Smythers, & Leichtweis, 2014. *Role of social support in adolescent suicidal ideation and suicide attempts. (Study done in DTS).* ***SRB – DTS Management:*** Suicidal ideation studied in 143 adolescents in a DTS found increased ideation if adolescent perceived lower school and parental support. Confirmed the importance for DTSs to coordinate with school staff and parents to increase perceived social support. No item 1 features.
Dean, Duke, George, & Scott, 2007. Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. ***AGG – IP Management:*** Children and adolescents showing aggression managed with individual plans. The multidisciplinary staff worked with parents, consumer consultants and state government to evolve a preventive, early identification, unit wide behavioral intervention strategy. There were statistically significant pre and post differences with decreased incidents, injuries, sick leave, need for security/seclusion/restraint, and reduced duration of incidents. This study demonstrated the importance of program wide policies to address IP aggression, which constitute crises with each occurrence. Although parental involvement was important, minimal mention was made about managing aggression within the home. Supports programmatic approach to item 1 features.
Greenfield, Larson, Hechtman, Rousseau, & Platt, 2002. A rapid-response outpatient model for reducing hospitalization rates among suicidal adolescents ***SRB – ICS Alternative:*** Adolescents not admitted to the IP unit were assigned to a rapid response team or control group (treatment as usual, more variation in treatment personnel and longer time to initiate treatment). At 6 months, ICS group required less hospitalizations than control for SRB with no difference in outcomes. Demonstrates that minimizing numbers and frequency of IP admissions with no change in outcomes is beneficial for patients and services. An ICS contributes to these benefits. No mention of DTS or item 1 but, see Lamb above for DTS and IP.
Assan et al., 2008. The Adolescent Intensive Management team: an intensive outreach Mental Health Service for high-risk adolescents. ***SRB, AGG – ICS Alternative:*** A 5 member multidisciplinary community outreach team with 2 sessions/week psychiatry support, 8-10 clients/team member. All high risk (suicide, poly substance abuse, aggression, multiple diagnoses and similarly high risk families). Purpose: reduce the over 35% drop out rate. Result: 12 months with 0% drop out with 70 clients, increased school attendance and some (unmeasured) improvement in functioning. Demonstrated that high at-risk inpatients can be discharged to an AIM team, shorten hospital stays, and help in the management of SRB, AGG and high risk families.
Kiser, Heston, Millsap, & Pruitt, 1991. Testing the limits: Special treatment procedures for child and adolescent partial hospitalization ***SRB, AGG, ELO – BEST and only direct DTS Comparison:*** This paper addresses all three crises more from the perspective of DTS clinicians and program managers and complements the focus on parents in item 1. The GGP have significant similarities to the DTS in item 1 including safety planning specific to the crises within DTS. They adapt to parental abilities and their role in processing with the adolescent. Management of aggression within the DTS fits into similar, but less detailed, instructions to parents for AGG in the home (including police involvement). Management of SRB is in DTS with only the most high-risk patients transferred to IP. Where possible, they have written guidelines for clinicians and parents. Management of elopement and substance use also involve standard program responses (e.g. may limit some program privileges and require processing the crises with a staff member). The written materials are closer to good GGP but lack the comprehensiveness, detail and specifics of the work outlined in Item 1.

In summary, a variety of search combinations revealed many publications addressing general background knowledge and skills important to work with the crises but only one publication (Kiser et al., 1991) directly addressed all three crises in intensive treatment settings. While many of its guidelines and policies overlapped with the DTS in this publication, it did not directly address the specifics of parental involvement or coordination of clinicians and services. With this in mind, this paper addresses the gradual development, creation and use of a strategy with adaptations useful in intensive treatment settings.

The use of MCS stymied progress in a three month four days per week DTS that focused on empathic support, relationships, family involvement, therapeutic classroom, longer term group and individual treatment and healthy coping skills. The DTS was administratively programmatically linked to a wide range of the health centre's mental health services, in particular in-home support and other intensive services such as IP (five km away). Given the seriousness and frequency of these behaviors, the DTS staff developed overall strategy with adaptations for the three crises, coordinating the intensive services. It evolved constantly and was needed for about 30 of the 350 adolescents over the seven years of development. The conceptual basis of the strategy and adaptations are presented as a contribution to the ongoing literature on managing these crises.

The strategies clarify the roles of the parents, staff, services, and adolescents. They address the risks and challenges. Its basic principles can be found in the guidelines and protocol references noted in Table 1 and Rice et al. (2014) and Khawaja et al. (2010):

- The adolescent's choices and behavior are voluntary and purposeful
- Enlist motivation for personal hopes, goals and values for living
- Enlist family support
- Work directly and empathically with the crisis
- Focus on safety in all settings
- Use the crisis as a learning opportunity
- Teach healthy coping skills
- Do not reinforce maladaptive coping skills

Methods

The following components and steps received input from adolescents, parents, front line staff and clinicians. As a result of the constant evolution of the strategy during these several years, use of it as an outcomes based research project was not possible.

Risks and challenges

The risks in these crises are the possibility of death, injury, criminal charges, supervision failure by adults and financial and emotional distress.

The challenges include assessing the intent, the effect of diagnoses, the role of families, clinicians, services and agencies and the decision about IP admission vs. non-admission. The end goal is to build healthy coping strategies that support personal goal achievement, healthy relationships and shift the growth and developmental trajectory in a healthier direction.

Characteristics of the strategy

The strategy addresses the risks and challenges of all three crises and incorporates additional guidelines. It meets ethical and professional responsibilities with logical reasoning for decisions. The choices made by the adolescent are respected, regardless of the judgments of others. It requires the parents and clinicians to co-develop a formulation that includes the MCS. The MCS are not reinforced. Indications and contra-indications are outlined. Families are able to manage the most severe crises with confidence and clarity.

A detailed written PARENT GUIDE is absolutely necessary for both the parents and staff.

Initial Steps

Indications and contra-indications: Key indications are an adolescent presenting with one of the three crises and a co-developed formulation that clarifies the current, or habitual pattern, as MCS. Absolute contra-indications are suicidal ideation and SRB directly arising as symptoms of a psychotic disorder, major mood disorder or bipolar disorder. Relative contra-indications (very low level of intellectual functioning, severe anxiety, non-suicidal self-injury, Borderline Personality Disorder [Paris, 2002]) are evaluated by staff after careful formulation.

Separate crisis management and treatment (Mazza et al., 2006)*:* The crisis pre-empts treatment that focuses on long term goals. Therefore, treatment goals are set aside and all participants, including the adolescent, focus directly on the crisis.

Parental expectations: In order to support the parents, the usual expectations of adolescents are clarified as are the unconditional and conditional roles of parents (see PARENT GUIDE). This makes it easier for them to carry on through the crisis and set boundaries that guide them. Their most important contribution is a caring healthy parenting role. Equally important, they are not expected to be mental health professionals, police officers or security guards. For each crisis, they are to call upon the appropriate service: SRB (health care), aggression/vandalism (police), elopement (any of the preceding and child welfare).

Training: While it is important for the leadership within the intensive services to understand the basics of the strategy and while group teaching helps staff when there are questions, frequently just reviewing the PARENT GUIDE enables everyone to maximize their role in crisis resolution.

Typical Presentation of the Adolescents

The adolescents show behaviours of one of the three crisis which staff and family agree is a current or longstanding MCS. There are no contra-indications to using the strategy and the crisis takes precedence over work on treatment goals. Frequently their behavior is very distressing to the family, peers and often to themselves. (Note that elopement, a shorter term behavior, usually from potentially functional families, was chosen to differentiate 'runaways', which usually refers to the homeless literature (Holliday, Edelen, & Tucker, 2017)).

Typical Presentation of the Family

Most prominently, families feel helpless, frustrated, scared, and confused and often regard the situation as out of control. Despite some basic capacity for parenting they desire a better relationship with the adolescent; the mix of crisis behaviors and emotions add to the fears and frustration. They want help, want to know what to do, are willing to learn, and want to take back an appropriate parenting role in their household.

Planning Ahead vs In the Crisis

With some adolescents the appearance and type of the crisis is predictable in advance. In these circumstances, a meeting is held first with the parents. When the crisis appears before meeting with the parents, the first meeting is with the adolescent. In either case, the same features are reviewed.

Meeting with Parents

The staff assesses their abilities, motivation and readiness to do the work. Next, they establish a shared formulation that includes the MCS. Staff clarify the typical adolescent/parenting guidelines and clarify that they are not to take on roles of mental health professionals, police or security guards.

Staff then review the PARENT GUIDE in detail with particular emphasis on their child's crisis (e.g. SRB). Parents are taught the indications to take action, the specific actions to take and how to use community resources. 'Adolescents are in charge of choices; adults are in charge of responses' is a daily mantra in these situations. They are taught how to establish a 24 hour calm down routine for the whole family in the house, a common response. They are given a copy of the PARENT GUIDE and throughout the meeting specific reinforcement is given to the CONNECT© Training (Moretti, Obsuth, Craig, & Bartolo, 2015) attachment based relationship principles in use throughout the DTS (see PARENT GUIDE).

The Strategy

Using Suicide Crisis as the Paradigm

Rule and action for parents: All acts or threats of acts of suicide-related behavior are to be assessed by mental health professionals.

(The parents alone, or with the police, contact any of the earlier noted mental health services. Since the key decision is IP admission or no admission, this assumes eventual involvement of an admitting psychiatrist or physician in the Emergency Department.)

Meeting with the Adolescent: The essence of the suicide risk assessment during the often lengthy meetings lay in establishing the answer to two key questions (Q).

> Q1. "Are you planning to end your life and kill yourself right now?"
>
> Anything other than a clear 'NO' is deemed ambiguous requiring careful dissection. Any 'Non-No' carries a higher risk of SRB. Clarification must be made and question two always follows.
>
> Q2. "Are you able and willing to look after your safety?"
>
> Anything other than a clear 'YES' requires clarification; any 'Non-Yes' means leaving space for SRB and others must look after the adolescent's safety.

Even with a YES, a communication safety plan is created in the event that the 'YES' commitment is jeopardized. Hence, the plan includes a duration established with the 'YES' (e.g. 24 hours, next therapy appointment, etc.) and naming a trusted person with whom to share their safety concerns.

All ambiguous answers are followed by clarification of the meaning of the 'Non-No' and the 'Non-Yes'. The word 'can't' is only allowed for the contra-indications (psychosis, mood, bipolar); other uses are substituted with 'won't' with a message of acceptance and respect for the adolescent's answers.

For paradigm purposes, the adolescent has given these answers: Q1 = YES, Q2 = NO. Work with the adolescent is guided by self-determination and learning about the implications of their answers. The situation now combines teaching and safety into one package.

Implications of the Adolescent's Words: The adolescent's plans for suicide and not looking after their safety immediately places their life as the professional responsibility of the physician. The physician then explains how such a serious responsibility is implemented.

Admission Route

The clinician explains the professional and ethical responsibility to take charge of safety. Since nothing is more important than being alive or dead, accepting the adolescent's decision is guided by and focuses solely on the safety crisis and the tasks of the clinician and the adolescent. Treatment is already in place in the intensive community service (usually DTS).

Clinician Tasks: The clinician explains that all components of the routine are necessary steps to ensure the life of the adolescent is not jeopardized. Within the IP service, this is known as the 'Holding Bed Routine' and included:

- Admit to psychiatric IP (voluntarily or involuntarily) solely for crisis/safety purposes (not for longer term treatment purposes).
- Maintain close contact in a supportive, empathic and educational role throughout the admission.
- Focus solely on the task of the adolescent and supply material relevant to the task.
- Use a single room (reduces distraction from the task or factors that could increase the risk).
- Use hospital clothing (reduces chances of eloping and not being identified).
- Reduce all stimuli that could contribute to supporting the plans for suicide or distract from the task of the adolescent (e.g. electronics, magazines, books) (exception: materials relevant to the crisis and task of the adolescent).
- No visitors allowed (they may accidently worsen the situation; parents may have limited supervised and supportive visits).
- No privileges of freedom of movement outside their room (contact with other patients, telephone calls); these may mislead the adolescent or distract from the task.
- Reduce available objects and furnishing with which to harm oneself.

Adolescent Two Part Task: The adolescent, with staff support, needs to find thoughtful answers:

1. What do you need to do to take back personal responsibility for your safety?
2. What three additional options could you use instead of suicide?

The very serious and logical response to the adolescent's decision is understood by the adolescent but often perceived as sensory deprivation, loss of control over their life and even as punishment. This may lead to anger but it is important to emphasize that nothing is more important in life than the decision to die by suicide, including the anger that may be expressed to those who care enough to take the responsibility for that life.

Discharge: Discharge from the IP and all accompanying restrictions along with a return to treatment occurs when:

The adolescent decides to take back control of their safety.

Three healthy coping strategies are developed for future suicidal crises

Sufficient time has passed to trust the adolescent's decision (usually a minimum of 12-24 hours but may extend through a weekend).

Treatment continues in the community or DTS (the adolescent usually maintains attendance at DTS while still an inpatient and Holding Bed Routine).

Non Admission Route

This follows parents taking the adolescent for an assessment (sometimes with police help) with a Community Mobile Crisis Team, the Emergency Department, or their individual clinician. If the crisis developed at the DTS the clinicians address it and bring in the parents as soon as appropriate. After much work (and usually many hours of waiting and stress), the adolescent's new decision is to take charge of personal safety. The commitment to Q1=YES and Q2=NO was weaker and the adolescent makes the shift back to Q1=NO; Q2=YES.

The parents now state to the adolescent (in the presence of the clinicians) their response plans:

- 24 hour calm down time for the whole family because the crisis has been emotionally difficult for everyone
- Adolescent to develop three healthy coping strategies for safety as alternatives to the choice of suicide
- Parents to use CONNECT© practices and to evaluate additional parenting options
- If the adolescent has school or intensive treatment (e.g. DTS) the next day, they are encouraged to attend (getting life back to normal)
- Adolescent could use the calm down time to practice the new skills as taught in therapy
- No privileges to be out of the home, with friends, and there should be no family outings, special dinners etc.
- No privileges for electronics but the family are free to interact, support, discuss, and play board games etc. (further details, e.g. cell phones etc. are covered in the PARENT GUIDE). **Supplemental**

Next Steps: The crisis is resolved and new options are developed for similar crises in the future. The parents keep the normal parenting role throughout the crisis and any admission or return to home. Life returns to normal. Therapy continues with the DTS or community treatment service.

Endangering the Safety of Others or Property

Rule for parents: All acts or threats of acts of harm or property destruction to others should be managed by immediate calls to the police with a request for help.

The Police: The police decide to remove the adolescent or, most commonly, leave them in the home, since the adolescent usually settles before or during their visit. In front of the police officer, the parent institutes the same 24 hour calm down routine and search for options as with the suicide crisis. The parents are instructed not to allow the police to talk them out of the calm down routine. They are to note that they had already received professional advice. They thank the police for their response. In consideration of possible future recurrences and for record keeping, the parents also:

- Take police officer's name and number.
- Ensure that the officer will make a report.
- Track all visits and circumstances (e.g. on a calendar). (Police do not like to return to homes several times with an adolescent continually making threats or producing damage or danger. They need past reports to understand the current context and consider other options.)

Late, Avoidance, and Elopement

Rule for parents: Institute the curfew rule. Ensure the adolescent has knowledge of community resources. Home is not to be a drop-in centre for coming and going as they please.

All adolescents have to learn to conclude their activities within the normal allotted hours in or out of the home. For most families and adolescents, the use of the curfew rule, setting when the adolescent is allowed out, is adequate on its own.

Allowed Out: The Curfew Rule: A curfew time is set, defining when the adolescent is late, usually in cooperation with the adolescent, and usually in two sets: Sunday to Thursday and Friday + Saturday. Once set, each evening's privileges are dependent upon the previous evening, and therefore under the control of the adolescent. Every late minute is doubled and subtracted from the next night. If return on the second night is past the new time, there is no outing on night three. Successful returns after penalty times lead to return to normal curfew times. Thursday is subtracted from Sunday and Saturday from the coming Friday. More variations needed to account for duration of lateness, locking doors, loss of privileges etc. are in the PARENT GUIDE.

Allowed In: Some adolescents gradually escalate lateness to the point of avoidance of home and elopement. Graduated responses and further definitions are needed. For instance, excessive lateness, two hours past curfew becomes 'Overnight' and may become, by 06:00H 'No Return' (NR). Excessive NR can become a Habitual Pattern (HP). At the same time, parents have a responsibility to ensure the safety of other family members and the safety of their house, usually done by locking the doors.

No Returns and Habitual Pattern: A definition needs to be constructed for NR (e.g. after 06:00H) and HP, (e.g. NR ≥2/week, for ≥2 weeks/month, for ≥2 months). Frequently these adolescents are out much more than the preceding definition and this is best monitored by keeping a record.

Under these circumstances, the adolescent clearly has places to go and attempts to restrain freedom by confining them to the house by force is inappropriate. Regaining control of the house is established by the conditions under which the adolescent is allowed back in. The doors need to be kept locked, the adolescent is given a clear understanding of the consequences in advance and safety information (police, shelters, youth services, child welfare etc.). The police may be notified. Again, there are fuller details in the PARENT GUIDE.

Case Examples (Chosen to illustrate a use in DTS and a use in IP)

Case 1: Suicide Crisis during Day Treatment Service Admission

Background: This 16 year old (YO) female living with both parents was a high functioning academic and athletic student. Her family moved from her more emotionally distant out of province paternal relatives to the local more open maternal relatives. She had been anxious since preschool and showed chronic suicidal ideation since age 12. She had been reviewed for Bipolar Disorder and Eating Disorder and possible diagnoses regarding her emotional dysregulation during two admissions for serious SRB in one month. She was placed on quetiapine 25mg QHS and transferred on an urgent basis to DTS. There was a maternal history of depression and paternal history of anxiety.

Patient Goals: She was a vague historian, had a vague sense of self and identity, and very vague goals yet engaged in seriously maladaptive behaviours.

Presentation to DTS: She was very fearful of growing up and facing adult expectations. She presented a bland to absent sense of identity with accompanying low self-esteem and coped with this state with poor emotional regulation, SRB and disordered eating. Progress remained very slow. Quetiapine was stopped with a switch to sertraline 100 mg. Gradually, she described her stressors as 20% peer relations, 40% disordered eating and 40% a new unrevealed situation. She was being blackmailed regarding online photos. This led to police involvement which, along with little official time left in the three month admission and return to school

looming, became too overwhelming and she returned to SRB. Despite working to progress within the DTS, crisis admission to IP was necessary.

Course and Results: Holding bed routine was used along with excellent healthy coping skills training by IP staff. The admission allowed her to take her mind off blackmail and safety. She began a focus on herself and her future, bringing her sense of identity from the external attributions to internal goals. Within a few days she began building a fragile but positive confidence to return to school within three weeks. The CONNECT© Training also helped her mother withdraw from an intrusive parenting style (related to years of fear that her daughter would die by suicide), support growing internal identity and adopt guided family support for eating. The patient benefited immensely from the crisis intervention and showed this with better emotional regulation allowing return to school and family by discharge from DTS.

Case 2: Repetitive Suicide Crises in Inpatient Facility

Background: An intelligent and athletic 18 YO old female was in the IP facility for about one year with continuing frequent unpredictable serious SRB, often drug overdoses. She was becoming institutionalized with close attachments shifting to staff, away from family. Her past and recent history included eating disorder, binge drinking, theft of drugs, risky behaviors with other adolescents (lengthy periods in unsafe areas at night while under the influence of street drugs), untreated Attention-Deficit/ Hyperactivity Disorder (ADHD), sexual assaults by a neighbour but no conviction and symptoms of Post-Traumatic Stress Disorder. The family was very supportive but also felt helpless, had role confusion, and were caught between love facilitated helplessness and frustrating uncertain boundaries.

Patient goals: She wanted to finish her education, manage the ADHD, develop and use non safety threatening coping skills and to return to living with her family.

Presentation to DTS: While living in the IP facility, a very slow transition was made to the DTS during which the main task of the primary care staff was to build a personal relationship and attachment to DTS. While in DTS she showed a variable presentation - from helpless, insecure frightened 18 month old to angry oppositional ten YO (sexual abuse at age ten) to rational capable 18 YO. During much of this time, she made slow additional transitions to parents who rented a nearby apartment for this purpose. She still ran and engaged in serious SRB.

Course and Results: Very detailed plans were developed. These included 12 typed pages signed by patient, family and staff; two pages of staff protocol addressed clear consistent boundaries to account for splitting, attachment, transference, counter transference, outside hospital contact and crisis role of validating emotions, healthy coping but avoiding therapy.

Once she was attached to the DTS, she accepted that all further crises would be managed appropriately, including necessary admissions but all admissions would be Holding Bed Routine, and therapy would be at DTS.

Privileges in the apartment, DTS and IP depended upon her performance. Her time and privileges were described in detail along with the actions parents would take in the event of SRB or elopement.

Suicide crises continued, but were gradually reduced in frequency and she proudly noted her first one month free of SRB. No longer living in hospital but with her parents, was a major step, and the usual three months of DTS took eight months but she left happily with her family. The PARENT GUIDE provided the basics and extensive details of protocols etc. enabled transition to a healthier 18 YO functioning and developmental trajectory.

Results

1. Six to twelve months follow up of the 30 adolescents noted no deaths, parents felt safe in their homes and the use of elopement changed in a manner to allow families to return to adult management and control.
2. Over the years, there were two or three older adolescents who chose to leave home yet these families spoke of and even wrote letters attesting to the comfort and support gained from the staff and use of the strategy.
3. By far, the most common crisis was SRB (estimate 60%); threats to the safety of others and curfew problems were about similar in number (estimate 20% each).
4. After experiencing the results of leaving their life in the hands of others, no matter how positive and empathic the staff were, by far the majority of adolescents chose to use strategies that no longer included SRB, expressing a desire not to return to the inpatient facility. Fewer than five cases required a second admission.
5. Although threats to the safety of others and chronic lateness or short periods of elopement were about equal, most lateness problems were resolved with an understanding and use of the curfew rule.
6. Most adolescents chose to continue treatment and even those that did not either did not, or rarely, used these maladaptive strategies again (no strategy acted as a total prevention even if extreme outcomes were avoided).
7. The challenges and risks were believed to be met, as well as the guidelines set out.
8. The written PARENT GUIDE and time with the parents to teach and review it, was essential.

Conclusion

The intent of this paper is to share the results of a feasibility project to develop a very practical strategy for managing three common and serious crises in work with adolescents. The strategy proved to be both helpful and effective. The hope is that this may prove helpful to others who work with such crises in adolescents and provide a basis for research. The PARENT GUIDE is available at the online site for this edition of this journal.

Acknowledgements / Conflicts of Interest

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