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PARENT GUIDE

A Crisis Management Strategy For the Safety of Self and Others and For Adolescents with Serious Maladaptive Behaviors

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CAUTION

This PARENT GUIDE is intended to be used under the guidance of a trained child and adolescent mental health care professional, in particular: psychiatrists, psychologists and social workers. It is only a guide and only a description of one method to help adolescents and families. It is most appropriate for adolescents already receiving active treatment in a therapeutic setting such as a day treatment service or intensive community based service.

It is up to the professionals using it to ensure they understand it and work carefully with selected appropriate parents and adolescents. The strategy is not appropriate for all patients and clinicians need to use their best evidence and skills in making their decisions. The professionals must review it with the parents prior to providing them with a copy.

It can be rewritten to adapt to particular circumstances.

The original author makes no claims that it is the only method to manage the crises, that it is the best method or that it will prevent serious adverse effects in its use.

Introduction

This PARENT GUIDE is primarily for parents (including guardians) responsible for adolescents who are *currently, here and now*, saying they are unable or unwilling to look after their personal safety or to refrain from endangering the safety or property of others. These are maladaptive coping strategies (MCS) and this is crisis work. As long as these statements, intentions and behaviors dominate, it is not possible to do therapy to address all other aspects of the life of the adolescent or family predisposing to the crisis.

The GUIDE assumes that your adolescent-in-crisis is involved in an active therapeutic setting, such as a day treatment service (partial hospitalization and a variety of intensive community treatment services). Also, since therapy cannot take place if the adolescent is not present, the guide includes strategies to manage those adolescents who use avoidance or elopement and for whom home is used as a drop-in centre.

If you are a parent reading this GUIDE, then it is assumed that you have an adolescent in your family currently in one of these crises. It assumes that you have already had meetings with your clinician(s) who have reviewed the overall plans with you, your family, and perhaps your adolescent (note Appendix I on reviewing the plans with the adolescent), and reviewed the reasons to use this safety management PARENT GUIDE for this crisis.

Day treatment services and outpatient services are treatment and therapy oriented. Safety management is a crisis and takes precedence over the more encompassing work of therapy. The strategy in this GUIDE clarifies how to manage the crisis and then return to therapy.

You will learn how to set boundaries around these MCS. Even if the adolescent refuses further treatment, you will

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have the means to manage these behaviors and, as parents have said, 'we can take back control of our lives'. You are freer to function just as parents, the only role you should have and want to have.

To use this guide, you are assumed to be functioning well enough that appropriate care, support, love and accountability training could take place. Even if you find it difficult to learn or use the skills in this guide, trained staff, clinicians and professionals can help you develop the skills. This PARENT GUIDE is a way of learning these skills and keeping them handy for reference.

It is also important to place this crisis planning within the larger context of the adolescent and your family. This means that the basic principles of CONNECT© attachment based parent training (see Appendix II) are important to maintain. For instance, as part of the work it is always important to remain empathically supportive and to consider the meaning and value to the adolescent of making safety endangering choices within the context of their life and past history, including attachment and trauma. It assumes that the work that has been done with the adolescent has consistently taken place in a collaborative relationship, building on the strengths of the adolescent and consistently placed the adolescent in charge of the choices about their life. Choice making is a vital skill in life, requires practice and is fundamental to the safety strategy.

The Adolescent

All people go through the normal growth and developmental tasks of learning and using increasingly sophisticated skills to cope with the many changes and stresses we meet in life. Some children and adolescents have had difficulty developing coping skills that contribute to healthy growth. They may have fallen into learning MCS that endanger their own lives or the lives and property of others. These skills may well make sense to the adolescent in the context of their life, past and trauma. They require immediate crisis management that usually inhibits the ability to do the planning and treatment of therapy. This document helps to ensure the safety of everyone so the adolescent remains alive and therapy can take place. This PARENT GUIDE is designed to put a boundary around the use of MCS and to open the way for adding healthy adaptive coping skills for life.

Emergency crisis management prevents the ability to do therapy that focuses on all the problems underlying or predisposing to the crisis.

Even though in a treatment setting, the characteristics of the crises can develop:

1. Safety of the self

- Communicates imminent suicidal intentions or shows suicide-related behavior
- Not willing or not agreeable to keep themselves safe for a specified period of time and not agreeable to communicate with a responsible adult, call 911 or call a Mental Health Mobile Crisis Team (Tel:) when feeling unsafe

2. Safety of others and their property

- Threatens, intimidates or uses actions of aggression or destruction to gain personal control over the decisions/behaviours of others

3. Not present in the family

- Has established a pattern with more than a few incidents
- The adolescent leaves from and returns to the family home at their desire any time of the day or night and may stay out all night or even several days and nights
- Usually shows no desire or willingness to participate in any therapy or change since they are already getting what they want for their life
- Usually avoiding normal household expectations and accountability for their behaviour
- Families are not able to provide accountability, supervision or appropriate modelling as a result of the absence of the adolescent

Other commonly found features that may or may not accompany the above:

- Families
  - Often describe the situation as "Out of control"
  - Frequently feel helpless, scared and frustrated
- The adolescent
  - May refuse all structured routines such as school, work, employment, community programs, therapeutic programs
  - May be highly disrespectful and disruptive to family members
  - May use harm to self or others or avoidance/eloping as their first choice MCS for stress

Contra-indications

This GUIDE is not about adolescents who have a psychotic illness or a mood disorder for whom safety issues and eloping are symptoms of the illness.

Some adolescents, who may or may not benefit, require additional careful assessment and understanding in devising the therapeutic plan and treatment strategy (which may or may not involve components of this guide). Adolescents

who have extremely low intellectual functioning, who are using non suicidal self-injury (e.g. frequent cutting behaviors) but are not intending or hoping to die, or who show other characteristics familiar to your clinician need a careful pre assessment before using this guide.

Goals

While varying with developmental level and abilities, the healthy adolescent will accept the unconditional love of the family and be able to:

- *Regulate* their emotions and behaviours appropriate to their development.
- *Relate* with family members in a positive loving manner.
- *Reason* with themselves and others.
- Look after their own safety and not endanger the physical safety or property of others.
- Participate in household routines and responsibilities without avoiding or eloping from home to engage in total fulfillment of their own desires.
- Carry out the normal tasks of adolescence that include structured routines of the *Daily Task* such as school, work, community programs or therapy programs and services.
- Manage *In-Home* behaviour in a manner demonstrating respect for others in the home and community.
- Manage and enjoy healthy peer relationships, socializing and interactions.
- Earn the privileges that come with living in a structured, loving and respectful home and family.

In a simple summary, the goal is an adolescent functioning closer to healthy adaptation with normal developmental stages, tasks, responsibilities, challenges and rewards.

THE FOUR BASIC RULES – A SINGLE PAGE SUMMARY:

Earning the privileges of home

1. Normal developmental tasks of adolescent years earn the normal home privileges.

Growth, development, learning and skills are constantly building and evolving in the lives of children from birth on. While love is unconditional, the goal of creating a young adult with an independent identity and mind fully capable of healthy choices is a progressive task. The task balances the development of increasing abilities with increasing responsibilities and privileges. While the task is universal, the details will vary with every child, family and culture.

During adolescence, the gradual transition to personal identity and choice making often brings developmentally normal stresses: What is expected of the adolescent? Is the adolescent showing developmental readiness for another step? What privileges are earned now? Some privileges are mandated by law: driving, alcohol, voting etc. These challenges do not need to involve danger to self or others or avoidance/eloping.

When the normal rules are not enough:

Personal Safety

2. All acts or threats of acts of imminent suicidal intentions or suicide-related behaviors are to be assessed by mental health professionals.

Assessments may be made in professional offices, crisis services, emergency departments etc. Parents are not mental health professionals, security guards or police. Once a plan is made for safety, whether at home or in the hospital, the adolescent is given the opportunity to devise new strategies to manage stress that do not involve self-harm.

The Safety of Others

3. 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.

Once safety of others has been regained, the adolescent is given the opportunity to devise new safer strategies for managing stressful situations.

Late, Avoidance, and Elopement

4. 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.

Home is not a drop-in centre. Curfew rules establish when the adolescent has run and the adolescent is given the information for personal safety and contacts outside the home. No teaching or learning of pro-social behaviour can occur when an adolescent is not present in the family life, the home or the therapeutic setting.

Adolescents are in charge of Choices. Adults are in charge of Consequences.

THE RULES – WITH COMMENTS:

The four rules govern the major areas noted on the summary page. The rules for the appropriately functioning adolescent are given first. These guidelines are compatible with the concept of natural consequences and the use of CONNECT© attachment based principles (see Appendix). **Once you, as parents, understand them; it is important to review the rules with the adolescent. In general, this PARENT GUIDE should not be provided to the adolescent. At all times, be empathically supportive to your adolescent.**

On first reading, it is easy to consider that the remainder of this document is preoccupied with limit setting. It is important to state that by far the majority of families will function with unconditional love, praise, respect, structure and routine. Monitoring leads to conditional privileges that are a natural component of daily family life. This document is relevant when the adolescent is seriously and repetitively not fulfilling the typical daily expectations and is moving into the stage of endangering the safety of self or others.

Earning the privileges of home

1. The typical developmental tasks of adolescent years earn the typical home privileges.

Normal life for families and adolescents* includes unconditional love and acceptance.

The adolescent at home has typical tasks:

- **Daily Task:** Go to school, work, or community agency (e.g. day treatment).
- Finish the day at the above without leaving early or getting suspended.
- Complete additional tasks at home (e.g. homework).
- **In Home**: Treating people with respect.
- In return for the above, the adolescent should be given:
- Praise
- Respect
- Privileges (there are a wide variety of normal privileges in most families)

*In all families the tasks and consequences (both wanted and unwanted) vary widely and are best worked out in a collaborative manner between the parents and the adolescent. The above basics are noted simply because of their fundamental role in this document and their fundamental role in all families.

Privileges in this PARENT GUIDE and adolescents with maladaptive behaviours:

Each family knows the privileges that the adolescent most wants. One of the simplest and most powerful privileges can usually be summarized in one word, 'electricity'. All electricity is a privilege (with the exception of a light bulb). If the Daily Task is not accomplished, there is no access to anything that has electricity, wires, batteries or other means of operating requiring the use of electricity. In general this means no access to: cell phones, home telephone, computer, internet, video games, CDs and DVDs, wireless devices, windup electrical sources (some radios), hand held battery games, digital devices and games, iPods, iPads, radios, stereos, and any other electronic device. If the adolescent has a cell phone and refuses to give it (or other devices) up for 24 hours (see calm down time), they can be offered a choice: "Give us the cell phone for 24 hours or I will call the company and cancel it for one week—your choice." The 'argument' that 'it is mine, I paid for it' is not accepted. All energy use in the house has been paid for by parents and all privileges and use of the house are under the guidance of parents.

Note that while 'electricity' is used as the basic example in this document, you and your clinician should have a review of whether this, or some other privilege(s), maybe the most appropriate in your particular situation.

Not completing the Daily Task means not earning the privilege of electricity that day (yes, even for illness when the focus must be on return to health; some consultation may be helpful).

In Home: If the adolescent is disrespectful during the evening, the privileges can be removed for the rest of the evening. (Use with caution and with guidance about anger management strategies with your clinician.)

In general, each new day should start afresh with no holdover of privilege loss to the next day.

The two main exceptions would be disrespect so late in the evening that the consequence would need to happen the next day, and privilege loss on a previous day for non-completion of the Daily Task means the privilege is only returned after completing the task on the next day (i.e. no privileges in the morning after the loss the previous day).

The main consequences used by parents, even if privileges are removed, should be the provision of support, approval and respect for the adolescent and a concentration on noticing, reinforcing and teaching the many positive behaviors shown by the growing adolescent. Love is unconditional.

Weekends can be managed in various ways. For some, it is best to treat it as a holiday from the Daily Task; for others, they may need to complete the Daily Task at a minimum of

3 or 4 times during the week to earn weekend privileges. Discuss options with your team.

Overall Goal:

The overall goal is for the adolescent to do the typical tasks of adolescence and to earn praise, respect and privileges. In the *Relationship*, love is always available and is not contingent. Behaviours may be met with disapproval but acceptance and love of the child themselves is always shown.

Additional benefits come to care givers who now have a plan in the event of emergencies. The plan is aimed at helping the adolescent acquire skills to manage life more successfully.

Parents should always remember that they are the models. Their ability to use thoughtful appropriate consequences in a consistent and respectful manner is the best model. Their ability to *Regulate* their own emotions and behavior and to *Relate* to others is a powerful model and reinforces positive lessons for their children. Having a plan makes it much easier to do the *Reasoning*, modeling and take appropriate action. Parents are now free to be ‘parents’, the role only they can do best.

Personal Safety

2. All acts or threats of acts of imminent suicidal intentions or suicide-related behaviours are to be assessed by mental health professionals.

(This may take place, in their offices, by a Mental Health Mobile Crisis Team (Tel:) or at an Emergency Department. (Call 911 or police if help is needed to get a suicidal adolescent to Emergency.)

Comment:

The main point is that all steps need to be in place to preserve the life of the adolescent. In this crisis, there is no goal that is more important than keeping the adolescent alive. Their use of a MCS to manage their situation should not be reinforced and the occasion needs to become an opportunity to help the adolescent learn and develop healthier adaptive skills.

Parents are not mental health professionals, security guards or police officers for their child. The decision about what to do about danger to personal safety should be left for mental health professionals.

When actions or threats of actions of self-harm are being used, the mental health professionals will determine the next steps. When the adolescent is taking this step as a MCS for stressful situations, to avoid accountability, responsibility or even to see the effects of the behaviour on others, it means the adolescent lacks the knowledge of or will to use more appropriate skills.

When the parents have a concern about self-harm, they can review two questions:

1. “Are you planning to end your life and kill yourself right now?”

a. The intent is to determine if the adolescent is considering suicide.

b. If the answer is “No”, family and teen may proceed with life as usual.

c. If the answer is anything but a clear “No”, then the adolescent is ambivalent and question 2 is next (and is often best used regardless of the answer to 1).

2. “Are you able and willing to look after your safety?”

a. If “Yes”, then the adolescent does appropriate actions to look after their safety.

b. Generally this should be accompanied by a communication safety plan to a trusted adult if the ability to look after their safety is jeopardized.

c. Often a duration can be specified (e.g. until my next appointment in therapy)

d. If the answer is other than a clear “Yes”; if the adolescent is ambivalent; or if the parent is in doubt, do any of the following steps:

   i. Obtain a professional assessment.

   ii. Call a Mobile Crisis Service (Tel:) or

   iii. Take the adolescent to the Emergency Department.

   iv. If the adolescent is a suicidal risk, unable or unwilling to look after their safety and refuses assessment, call the police (911). Police are empowered to find and take the adolescent to the Emergency Department.

Inevitably, after an assessment there will be one of two outcomes: admission to a hospital (determined by a physician) or discharge home.

The Admission Route

Admission comes only if the adolescent firmly holds to the decision to continue with suicidal planning and not to look after their personal safety, or if a physician deems it necessary. This leaves the physician responsible for the safety of the adolescent until the adolescent is ready to take back the responsibility themselves. Without safety, there is death. Physicians act ethically, professionally and legally by ensuring the safety of the adolescent. They may admit the adolescent on a voluntary basis or on a certificate of involuntary admission (the latter is used if the adolescent refuses admission yet remains insistent on their decision to die by suicide and not to look after their safety).

Nothing is more important or more fundamental than that the adolescent is alive. No other factor, stressor, goal,

problem or concern is more important than life itself. The sole purpose of this admission is to protect the life of the adolescent, aid the adolescent in taking back responsibility for their safety and develop (and use) alternative strategies that do not endanger safety the next time a similar situation or stressor arises in the life of the adolescent. The admission is to save the life in this crisis, not to do the therapy which is already in place outside the psychiatric unit of the hospital.

The task of the Adolescent:

- The adolescent has two tasks: decide what they will do to take back control of their safety and what they would do in future stressful situations instead of endangering their safety.
- They should have available any pamphlets, books, or reading material focused on their particular situation, problems, life experience, coping skills, problem solving skills (e.g. Chain Analysis).
- They should have staff who work with them in a supportive, empathic manner to help them consider their immediate situation, analyze their situation and help develop additional and healthier options.
- Staff are present to help with the crisis and support the use of the outside resources that provide the therapy.
- The adolescent needs to develop at least three options they could use in the future, to show that they have now re regulated their emotional state and to remain and interact long enough with empathic staff to have built adequate trust that they are ready to be discharged and returned to therapy. Usually this would be 24 hours, and, on rare occasions, up to 72 hours (long weekends, particularly determined adolescent).
- Sample tasks or actions to take the next time they are tempted to use actions or threats of self-harm can include: talk with an adult, write about their present state, call a friend, go for a walk, listen to music, and spend time with their pet or friends.

Adolescents also need to know that promises to keep secret suicidal ideas or plans of harm by anyone, including themselves or best friends, are not to be kept. All concerns about the safety of anyone's life must be shared with responsible adults.

The focus of the staff:

In order for the professional, now responsible for ensuring the safety and life of the adolescent, to carry out this responsibility, the following guidelines are useful:

- Admit to a single room. A roommate usually causes distraction from the main task, adds to the stress or inadvertently supports or accentuates the problems that led the adolescent to give up responsibility for their safety.
- Change to hospital gown. The adolescent could choose to run out of the unit to jump in front of a vehicle or other dangerous activity. Therefore, removal of shoes and street clothing enables them to be identified quickly. A locked unit can be helpful but should not be relied upon as a substitute for the change to hospital clothing.
- Keep the adolescent focused on their two tasks: decide what they have to do to take back control of their safety and what they would do in future stressful situations instead of endangering their safety. This task is of life importance. Nothing is more important than being alive for all other aspects of life are foreclosed if the adolescent is dead. Staff contacts and interactions will be focused solely on this task. Therefore, there should be no distractions from this task. That means:
    - No electronic distractions (TV, telephone, radio, music players, etc.)
    - No visitors (who may both distract from or even endanger the adolescent in this task. With staff supervision, parental visits can be therapeutic, supportive and focused on the adolescent's tasks.)
    - No freedom of the ward privileges as this distracts from the task at hand
    - No reading material unless directly relevant to the task of taking back personal safety and developing other skills
    - No objects of any sort that might be, in any way, used for self-harm or distraction
    - Minimal contacts with family who could distract from the task at hand of the adolescent

Perception of Adolescents:

Once the adolescent is in the above state, some will regard it as a punishment and may become distressed at the perceived isolation. As noted above, nothing is more important than being alive, including being angry that someone else cares enough to ensure that the adolescent remains alive. The task remains the same, develop new skills and be ready to resume looking after their own personal safety. Staff are always available for help.

Easing of restrictions:

Some adolescents will do this within one hour and decide that they are now ready for discharge. Discharge in this situation is usually premature. A new mental health professional does not have the knowledge in a few hours to know that the adolescent has made a careful and thoughtful decision that will last into and be used in the future. Once the adolescent has made the decision, whether within one hour or several hours, it is important to assess their ability to remain calm, remain in control and remain able to stick to this decision for several hours. Thus, it is usual for at least 12 to

24 hours (very rarely more than 36 hours, sometimes weekends last longer) to take place under the same conditions as noted above, before trusting that the adolescent is truly capable of sticking to this decision, establishes that they want to and are willing to take control of their own safety (and frequently they do not want ever to give up control of their safety to others again in the future, a successful outcome).

Discharge:

Once the adolescent seems secure in this decision, they will be discharged back to the care of the family or self, not kept in hospital. **Treatment interventions of many sorts may be needed or desired by the adolescent and family but these will continue to take place out of hospital.** Longer hospital admission should be reserved for adolescents with psychotic and major affective or anxiety disorders. They, even if suicidal, usually do not need the above protocol.

Non-Admission Route

The adolescent may change their mind upon assessment by a physician in the Emergency Department after understanding the actions that others must take to ensure their safety. They then choose very clearly that they will not endanger their safety and are willing and able to look after it. They then wish to return home. Both adolescents and parents will have experienced much time and stress by now. There still needs to be follow-up consequences by the adults both to reduce reinforcement of self-harm behaviours as MCS and to begin the substitution of more adaptive methods.

As parents, and in front of the physician, use the following guidelines:

- For the next 24 hours, a calm-down routine will be in place. The adolescent will lose 3 major privileges within the home (e.g. electricity, be out of the home, and have friends over). Other in home privileges and enjoyment or talks with others remain.
- The adolescent needs to create 3 healthier strategies to use the next time the stress level reaches consideration of the use of suicide-related behaviours.

By losing privileges (e.g. electricity), the adolescent again has the opportunity to reflect upon the importance of life itself, and not be distracted by other activities or attractions in a home that may distract from tackling the task at hand. The task at hand is similar to that in a psychiatric unit in hospital: create three alternative methods to manage stress whenever there is a temptation to use the maladaptive suicide-related behaviour. The need for 24 hours for the task is to emphasize the importance of the issue and ensure that the adolescent has adequate time to consider the implications of the loss of life and the threats of loss on others.

The parents also benefit from an equally long time to consider their own approaches to managing the adolescent, to model calm self-regulation and to support the adolescent. This information and plan is best presented by the parents to the adolescent in front of the mental health team or physician. Some adolescents will disapprove, become angry or threatening and illustrate the very problem that brought them into contact with mental health professionals again, necessitating resolution on the spot.

The combination of the above actions works to help adolescents appreciate the importance of life itself and the need to create healthier coping skills. These recommended responses are directed at saving a life and, as an additional effect, do not reinforce or provide gain to an adolescent for the use of threats or actions of suicidal related behavior.

When the above is implemented consistently, the adolescent soon stops the maladaptive strategy and the safety of the adolescent is much more likely. Even the use of threats to their safety stop once the adolescent has to face the consequences and implications of their threats and actions.

The Safety of Others

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

Comment

No progress can be made if the members of a household do not feel safe within their own home or live with the fear that at any moment they or their house and property will be subject to damage. This is intimidation, vandalism and assault. The police should be called as the agents of protection for the safety of the public. This can be very hard for parents; however, not stopping the danger gives the adolescent permission to perpetuate it for their own purposes.

The police will assess the degree of risk and determine if removal is warranted.

If the adolescent settles, their usual choice, and it appears that they will not be removed, while the police are present the parent can present their consequences for the major distress for all involved:

- Announce the removal of the 3 major privileges for a 24 hour calm-down as a consequence and require that the adolescent develop three additional adaptive coping skills they could use instead of the destructive strategies employed that resulted in the police visit. On some occasions, the adolescent then shows the threats or actions endangering the safety of others, illustrating the very problem that brought in the police. This is why this step needs to be taken in front of the police officer.
- Note that this was professional advice and do not allow the police to talk you out of it.

- Be sure to take the name, date and time of the visit of the police officer(s).
- Request that the police officers file a report for future reference in the event that there are other calls.
- For repeated events of this sort, keeping a journal diary or calendar recording is helpful for police and courts. The police do not like to make repeated visits to a destructive, assaultive or threatening person and will take appropriate actions if earlier messages of guidance and consequences have not helped.
- As with other 24 hour calm down routines, parents can reassess their own behavior and maintain use of Connect© Principles.

Late, Avoidance, and Elopement

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

Comment:

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

ALLOWED OUT

Curfew Rule

The management of curfews is much more complicated than the previous 2 crises since there are many variations on what can happen. The following is only one version of management and families may wish to simplify some options or make their own modifications.

The first step is to define 'late'. 'Late' starts when the curfew rule is violated. The curfew rule is as follows:

- A curfew time is agreed upon between the parents and the adolescent. Usually this has two sections, Sunday to Thursday night at one time and Friday and Saturday night at a later time since there is no school the next day.
- If an adolescent is late, the late time is doubled and subtracted from the next night (13 minutes late means 26 minutes earlier tomorrow).
- Doubling and subtracting is used for any late time up to and including one hour only.
- Thursday night is subtracted from Sunday. Saturday night is subtracted from the following Friday.
- Doors are locked one hour after curfew (requiring the use of a door bell or a knock).
- If the adolescent does not come in at the required time on the second day with reduced free time, they have no privileges to be out the following day (note that this is not accompanied by loss of any other normal household privileges).
- Returning home within one hour of 'doors-locked-time' (which now means between one to two hours late) results in no outing the next day and loss of one predetermined privilege, e.g. just loss of telephone or internet etc.
- Coming home more than 1 hour after doors-locked time (more than 2 hours after normal curfew time, now labelled 'Overnight') results in being let in but followed by no out-of-home privileges and the loss of the 3 major privileges the next day. Other household privileges such as friendly interactions with others, sorting out problems and solutions and use of their time are not affected.

Beyond Curfews

There are adolescents who repeatedly test and extend the hours out of the house, to the point of not returning at all. This is more than just 'late'. Consequences need to recognize the gradual shifts from repetitive non-compliance to the curfew rule to the extreme of not returning at all as a habitual pattern. The home becomes a drop-in centre and the adolescent has little incentive to change anything since they are now avoiding all consequences and doing what they want, when they want. This prevents the ability to provide supervision, parenting, accountability training and modelling. Managing this is done in three steps.

Stage One - 'Overnight' and 'No Return' Definitions

Each family needs to make its own definitions when late return shifts from exceedingly late—'Overnight', to 'No Return'. One simple way is a specified time (e.g. 06:00H). Anytime later is called 'No Return'. The consequence is always:

- no outings for 2 days and
- 48 hours loss of the 3 major privileges.

Repeats of this within 7 days should shift it to 96 hours loss of privileges for all overnights thereafter. A return to 48 hours loss of privileges follows after 7 days of no post-door-lock 'lates' (i.e. the time at which the door is locked to the home). The essence of all the above is that the main task is setting the rules about when the adolescent is ALLOWED OUT. In some situations, this is not enough.

ALLOWED IN

Stage Two – No Returns and Habitual Pattern

This is for those adolescents who have developed a major difficulty of repetitive **No Return (NR)** at all during the night. Usually this is more than just the example 06:00H, and may include the full next day or even more. It is clear they already know places to go for the night, 'couch surf' etc. These adolescents may continue to escalate this behavior and have now established a **Habitual Pattern (HP)**. An example of HP could be NR $\geq$2/week, for $\geq$2 weeks/month, for $\geq$2 months). (These definitions are arbitrary and should be assessed individually with your clinician.) Parents have a responsibility to ensure the safety of other family members, the safety of their house and the use of appropriate guidelines and consequences for adolescents. Records should be kept of dates, duration and coming home time. The key to stage 2 is Habitual Pattern of No Returns.

It is not appropriate to use force to hold an adolescent in their home. In these circumstances the door should stay locked all night. The adolescent should be informed of this in advance since they will not be ALLOWED IN and have to find their own shelter for the night.

When these adolescents decide to return, they also incur 48 hour loss of the 3 major privileges. Repeated events within 7 days extends the loss of privileges to 96 hours. These adolescents should be given the telephone numbers for the police, child welfare and drop-in shelters (which may also be posted on the door). The parents may choose to report them to the police as missing. The parents should go over the above consequences and safety contacts with the adolescent as a safety plan for the decision the adolescent has repeatedly made not to come home on time. The adolescent may choose not to listen or not to follow the plan, but that is their choice.

Stage Three – Adolescent under 16 years of age

When the adolescent is under 16 years of age, additional considerations are advised for the Overnight late and the No Return plus Habitual Pattern noted in Stage Two. These additional actions can be done.

The police can be notified that the adolescent is missing (consider this at 30 minutes after the 'overnight' definition (e.g. one half hour after 'Overnight' time has started). A 'locate and detain' request can be made but if this is too repetitive, police attention may also be delayed. Sometimes it may be enough to stop future eloping. On other occasions, police should be notified as the episodes of eloping need to be recorded (both in the home and with the police).

Child welfare should be notified. The parents should note that they have appropriate plans for the adolescent but even these have not stopped the adolescent from eloping. The adolescent clearly has places they go because the behaviour is now a pattern. The parents are unable to exercise appropriate supervision and parenting with an adolescent who is not present, uses the home as a drop-in centre, and disrupts normal family safety and functioning. Therefore, the parents will be looking after their own safety and that of others in the home (e.g. younger children) and locking the door permanently 2 hours after curfew time, locking the adolescent out for the rest of the night. They will have reviewed a safety plan for the adolescent, even if the adolescent chooses to ignore it. The usual loss of privileges (24, 48 or 96 hours as noted above, and regaining of privileges) will continue to be used. The use of the ALLOWED IN suggestions is rarely needed but included for the few times it matters.

Again, when they are home, in addition to the loss of privileges for 24 or 48 hours they must develop a plan to find methods to accomplish their tasks within the normal hours of freedom in a family home.

Concluding Comments:

This guide is only to set strategies to manage the most challenging emergency concerns of parents. It is only a beginning. The real work of long term change for the adolescent and family can now take place. Even if the adolescent refuses any further participation, the family now has the home life closer to normal expectations, and in some cases, that may be all that is required.

Most adolescents are only engaged in one of the three major maladaptive strategies to manage personal stress. It is important to review that component carefully and have the GUIDE available for review, even if the other components are not used. Many parents find the curfew rule helpful regardless of other suggestions.

Usually, for the behavior of the adolescent to reach the extremes noted here, there is much more to the story. This work will be to understand that story and begin the changes to free the adolescent and family to move on with a healthier growth and development for the future. That is the work of therapy which can now begin.

Last Note:

For parents who have reviewed these strategies with their clinician, along with any family specific changes, and have then been given this document as an aid to memory, keep in mind that there can be important variations and all questions should be brought back to your clinician and other members of your support team. Modifications may be used for adolescents abusing alcohol and other drugs or substances. The lives of the adolescents using the high risk maladaptive coping skills in this document are too important to have unanswered questions. Always ask if you have a question or are unclear about a situation.

APPENDIX I
INFORMING THE ADOLESCENT

It is important to review the contents of this GUIDE first with the parents until the parents understand it well and have made the adaptations to allow it to fit their family's situation best.

Some families choose to understand the situation well with the clinician and to review the situation and planning with the adolescent themselves. Sometimes that may be all that is required. The family now knows how to manage the difficult situation and the presence of a plan is enough for them to carry on with the normal parenting needed in the family and for the adolescents. Both parties need to keep in mind the mantra: Adolescents are in charge of choices; adults are in charge of consequences.

More commonly there will be one or two tests by the adolescent to determine whether the parents will truly follow through on their plan.

In other families, after the family understands the options with the clinician, the family prefers to explain the situation to the adolescent in the presence of the clinicians. It is important that the parents explain the plan and not the clinician. The plan must be owned and understood by the parents and the adolescent must experience that to believe it. The clinician may help the parents by coaching answers to unexpected questions from the adolescent yet ensure that it is the parents that make the final statements and own the plan.

In many ways, the summary of the rules on page 4 are the key messages for the adolescent. The rest of the GUIDE is needed for parents to understand the rationale, to solve unexpected questions and to review the plan with the adolescent with empathy, caring, concern, clarity and firmness.

As always, showing an ability to Regulate your own emotions and behavior and continuing to build and maintain an empathic caring Relationship is the foundation for Reasoning. Without this, simply attempting to implement rules is far less effective.

SAMPLE RESOURCES FOR PARENTS AND ADOLESCENTS

Kids Helpline	Tel:
Police	911 or Tel:
Emergency Department	Tel:
Clinician contact	Tel:
Mobile crises team	Tel:
Shelters and drop-centres	Tel:
	Address(es)
Adult shelters (older teens)	Tel:
	Address(es)
Child welfare	Tel:

Teenmentalhealth.org

Add your own, appropriate to your local community.

APPENDIX II
CONNECT© PRINCIPLES

All behavior has meaning Attachment needs often underlie behavior, even though these needs may sometimes be difficult to identify.

Attachment is for life Attachment remains important across development, but attachment needs are expressed differently in infants, children, and adolescents.

Attachment underlies our thoughts, feelings and behaviors Attachment is expressed in how we think about others and ourselves; in our feelings; and in our behaviors.

Conflict is part of attachment Conflict is a normative part of relationships and while it often feels threatening it can be an opportunity for healthy change.

Secure attachment contains a balance between connection and independence. Autonomy does not mean disconnection and separation. Healthy autonomy develops through support, structure and respect for differentiation.

Understanding growth and change begins with empathy. It's difficult to express empathy for your adolescent when you're upset, but doing so helps both of you to build a secure attachment and move on.

Relationships thrive when we recognize and balance our needs with the needs of others. Understand that working toward balance in recognizing your own and your children's needs is an ongoing process in healthy relationships.

Growth involves moving forward while understanding the past Growth takes place step by step. Understanding the impact of our own personal narratives on our experiences in attachment relationships helps us develop capacity to be open to new experiences.

Attachment brings joy and pain. Attachment brings joy through celebration of connection with adolescents and pain through negotiation of conflict and change in the relationship. Both are important.

Attachment allows trusting the relationship even during turbulent times. Adversity is an opportunity for learning. Change is not a straightforward process; setbacks occur and can undermine motivation. Use the opportunities in adversity for growth.

Maintaining relationships is key Focusing on the attachment meaning of issues and problems for your relationship with your child is important. The content is often irrelevant.

CONNECT© is an attachment focused treatment program for parents and caregivers. The above was derived from:

Moretti, MM. An attachment based intervention for parents of teens engaged in antisocial, aggressive and violent behaviour. http://blogs.sfu.ca/research/adolescenthealth/wp-content/uploads/2012/10/Moretti-2012_Attachment-Adolescence-International-Conference1.pdf

Moretti M, Holland R, Moore K, McKay S. An attachment-based parenting program for caregivers of severely conduct-disordered adolescents: Preliminary findings. J. Chld & Yth Cr Wrk (2004), 19, 170-179.