Serving Youth and Families in Crisis

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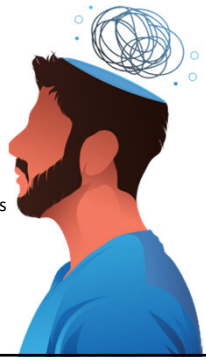
Today's Webinar

- What crisis for youth involves
- The impact of crisis and trauma on youth
- Challenges that youth in crisis present
- Strategies for supporting youth in crisis
- Engaging parents and other adult supports
- Trainings and resources to help



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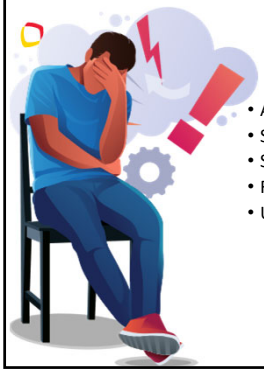

Types of Crisis

- Acute depression, anxiety or other mh events
- Substance use disorders
- Suicidal crisis
- Financial hardship
- Unstable living environment
  - Unsafe home
    - Foster placement
  - Familial homelessness
  - Youth homelessness
  - Runaway status
    - Human trafficking

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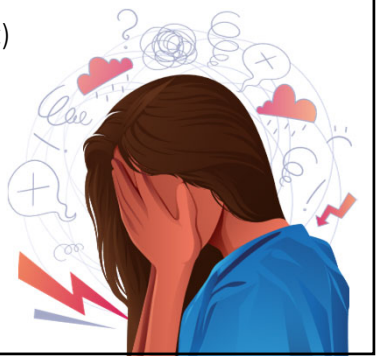
Types of Crisis (cont)

- Abuse/neglect
- Sexual assault
- Law breaking
- Youth pregnancy



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Current Crisis

- Nearly 20% of youth ages 3 – 17 have a mental health, behavioral health or developmental disorder
- Suicidal behavior in high school students increased 40% from 2009 – 2019
- Pediatric and young adult ER visits between 2011 – 2020 remained stable, but percentages due to mental health reasons doubled
  - ER visits for suicidal behavior increased 5x
- YRBSS data shows that all indicators of youth mental health worsened between 2011 and 2021

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Current Crisis (cont)

ABES January – June 2021 (CDC)

- 44% felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)
- 15.3% made a plan about how they would attempt suicide (during the 12 months before the survey)
- 9% attempted suicide (one or more times during the 12 months before the survey)
- 31.1 % reported that their mental health was most of the time or always not good (including stress, anxiety, and depression, during the 30 days before the survey)

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Reasons for Crisis

- Covid (per ABES survey results, 7700 surveys)
  - 29% reported that their parent or other adult in their home lost their job during the COVID-19 pandemic
  - 24% went hungry because there was not enough food in their home during the COVID-19 pandemic
  - 67% reported that schoolwork was more difficult during the COVID-19 pandemic than before it started
  - 55% reported that a parent or other adult in their home swore at them, insulted them, or put them down during the COVID-19 pandemic

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- 11.3% reported that a parent or other adult in their home hit, beat, kicked, or physically hurt them in any way during the COVID-19 pandemic
- 28% reported that they were never or rarely able to spend time with family, friends, or other groups during the COVID-19 pandemic
- Negative impact was higher for mixed ethnicity students, LGBTQIA students

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- Racine, et al (Meta-Analysis of 29 Studies) found that the prevalence of depression and anxiety doubled during Covid

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But youth were struggling before the pandemic

- Mass violence
  - Percentage of students not going to school due to safety fears increased 2011 - 2020
- Natural disasters
- Climate change
- Social media
- Political polarization
- Younger onsets of puberty
- Normative challenges of adolescence
- Lack of sufficient mental health care
  - Not enough providers
  - Cost and access

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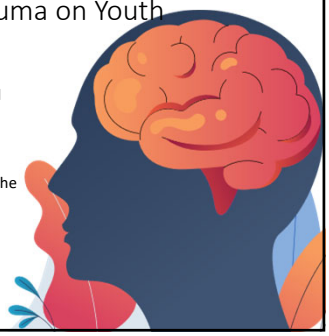
Impact of Crisis and Trauma on Youth

- Adversity is associated with reduced cortical thickness (Colich, et al)
  - In areas associated with social-emotional processing and cognitive processing
- Early trauma can alter neurobiological development
  - Caused by chronic activation of parts of the brain associated with stress response
    - Hippocampus, amygdala



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- Childhood trauma is associated with impairments in components of executive functioning
  - Working memory, inhibitory control, abstract ability, cognitive flexibility
  - Dose response (the more trauma the more pronounced)
- Individuals with ACE are
  - More likely to drop out
  - Have lowered frustration tolerance
  - Can have difficulty attaching

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Challenges of Youth in General

- Youth who have experienced ACE have the aforementioned changes
  - In social-emotional processing, emotional regulation, cognitive flexibility, etc.
- Young people in general can struggle with executive functioning
  - The frontal lobe is not fully developed until mid to late 20's
  - Increased neurotransmitter production (particularly dopamine and serotonin)
    - Make youth more emotional and more responsive to stress
- Event horizons are shorter, making motivation challenging
- Major mental illness often emerges during adolescence

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Challenges of Youth in Crisis

- Youth in a crisis situation have overactive amygdalas (the fear center), while the pre-frontal cortex underperforms
- Excitatory neurochemicals increase (glutamate), along with adrenaline and cortisol
- History of problematic encounters with adults can create dysregulation during crisis

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Intervening with Youth in Crisis

- De-escalation first
  - Initial need of a youth in crisis is for safety
  - Adult response can contribute to calming or escalation
  - Fight-flight-freeze is easy to trigger during crisis
- Separation of crisis and longer term treatment
  - All parties will initially be focused on the crisis situation
- Enlisting parental and other adult support
  - Care of youth ideally need to include family, school and community

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Strategies for De-escalation
From the Crisis Prevention Institute
• Be empathetic and non-judgmental
• Respect Personal Space
• Use non-threatening non-verbals
• Avoid overreacting
• Focus on feelings
• Ignore challenging questions
• Set limits
• Choose wisely what to insist on
• Allow silence
• Allow time for decisions

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Once Acute Crisis is Stabilized:

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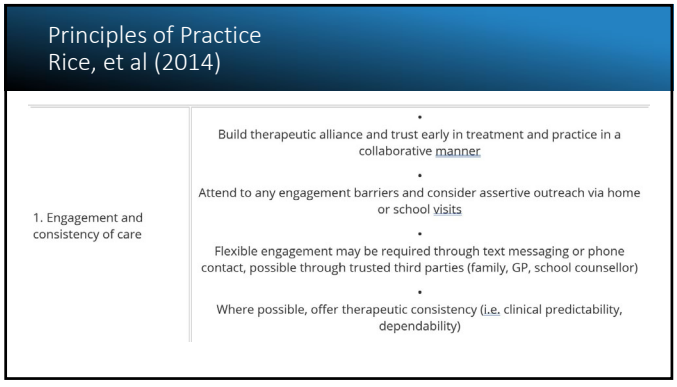
Principles of Practice
Rice, et al (2014)
1. Engagement and consistency of care
• Build therapeutic alliance and trust early in treatment and practice in a collaborative manner
• Attend to any engagement barriers and consider assertive outreach via home or school visits
• Flexible engagement may be required through text messaging or phone contact, possible through trusted third parties (family, GP, school counsellor)
• Where possible, offer therapeutic consistency (i.e. clinical predictability, dependability)

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Principles of Practice
Rice, et al (2014)

2. Ongoing risk assessment and documentation	• Assess and document a clear chronology of suicidal ideation or other risk, including brief formulation of overall risk • Differentiate risk on a continuum, ranging from vague thoughts of death to acute suicidal ideation with plan, access to means, and intent • Consider accessing collateral information from caregivers, friends or others regarding risk • Seek to gain an in-depth appreciation of the young person and include protective factors and reasons for living in assessment and documentation

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Principles of Practice
Rice, et al (2014)

3. Individualised crisis planning	• Collaboratively develop and continuously review an individualised crisis plan • Ensure the young person, caregivers and crisis services have ready access to crisis plan • Restrict access to means of harm, including medication access if necessary

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Principles of Practice
Rice, et al (2014)

4. Activate systems of support	Activate the young person's broader system of support (e.g. family, friends) • Consider integration of family members in therapy sessions to model a safe, contained and calm conversation about the crisis • Provide caregivers with a framework for understanding why suicidal ideation may occur • Where possible, provide caregivers with skills and prompts about how to enquire about suicidal ideation

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Principles of Practice
Rice, et al (2014)

5. Engender hopefulness	• Convey a realistic and hopeful message regarding treatment outcomes • Consider linking the young person to peer support workers to reinforce hope • Promote engagement with meaningful activity • Consider referring to past treatment successes, and/or utilising trained peer support workers who can engender hopefulness by appropriately reflecting on their experiences of recovery

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Principles of Practice
Rice, et al (2014)

6. Develop adaptive coping	• Discuss shared formulation and treatment goals related to crisis • Emphasise the fluctuating and changing nature of suicidal thinking and identif the likelihood of incremental progress • Ensure young person is realistic in their expectations of treatment • Work towards improving the young person's coping repertoire • Work towards developing insight related to adaptive help seeking (i.e. identification of early warning signs) and enhance problem solving skills

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Principles of Practice
Rice, et al (2014)

7. Manage acute risk	• Remain attuned to key signs and symptoms necessitating assertive follow-up • Inform consultant psychiatrist/senior clinicians if risk escalates to acute • Develop and review an acute management plan and engage caregivers, also refer to Principle 3: individualised crisis planning • Refer as appropriate to crisis services • Increase frequency of clinical contact by increasing frequency of appointments regular monitoring, assertive monitoring by an out-of-hours crisis service

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Principles of Practice
Rice, et al (2014)

8. Consultation and supervision	• Access supervision and consultation regardless of level of clinical experience • Work in collaboration and consultation with senior colleagues and where needed, access multidisciplinary support • Higher risk clients may require frequent peer supervision review • Clinicians to be mindful of maintenance of self-care and wellbeing

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Family Engagement: Potential Barriers

- Internal
  - Personal mental health issues
  - Substance use issues
  - Medical problems
  - Limited cognitive abilities
  - Cultural beliefs
  - Past negative experiences with mental health/systems of support

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- External
  - Financial struggles
  - Transportation issues
  - Lack of work flexibility
  - Childcare challenges
  - Family Stressors

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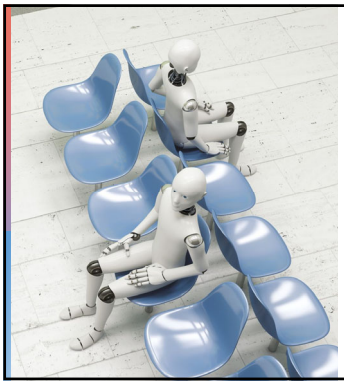

- Interactional
  - Feeling judged
  - Feeling blamed
  - Not feeling listened to
  - Not feeling supported by service systems
  - Being dissatisfied with treatments

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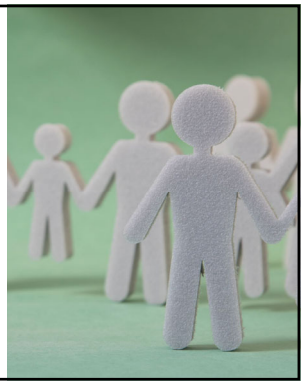
Engaging Families

1. Engage families in a collaborative process
   - Deal with family emotion
     - Families generally feel scared, helpless, frustrated
     - Parental guilt is common
   - Build rapport
     - If service providers appear to be blaming, parents will shut down
     - Engage parents as partners in the solutions, not the causes of the problem



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Engaging Families

2. Assess parent/family abilities, motivation, readiness (Junek, 2018)
3. Identify internal, external, interactional barriers
4. Clarify the treatment process
   - Rational
   - Empirical Support

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Engaging Families

5. Set appropriate expectations for parents/families
   - Parents are not expected to be mental health providers, law enforcement
   - Most important role: healthy and caring parenting
   - "Adolescents are in charge of choices; adults are in charge of responses."(Junek, 2018)
6. Establish and clarify communication for sessions that families are not present at
   - What content of youth sessions will be shared
   - How will parents be notified of risk

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Engaging Families

7. Try to address barriers identified, to maximize parental involvement
   - Putting families in touch with resources for transportation, childcare
   - Acknowledging and addressing negative perceptions of treatment

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Other Support Systems (Schools)

- Youth returning to school after mental health crisis often struggle (Preyde et al, 2018)
  - Socially
  - Academically
  - With ongoing mental health symptoms
- Avoidance of school is common, but caution is advised
  - Homeschool options increase isolation and supervision
  - Avoidance makes anxiety worse
  - Balance goals of not overwhelming students with not increasing avoidance

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- Most schools have plans for reintegration of students after hospitalization
- Successful collaboration with schools is key
  - Get proper and informed release from family and youth to communicate
  - Contact school counselor or administration
  - As in all things, attempt to work as a team (not just as an expert)

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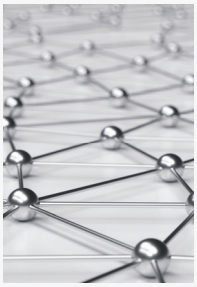
Resources

- Behavioral Health Education Center of Nebraska (BHECN)
  - https://www.unmc.edu/bhecn/
  - A variety of webinars and trainings for providers
  - Supervision and consultation resources
- Mental Health Technology Transfer Center (MHTTC)
  - https://mhttcnetwork.org/
  - A variety of trainings for providers
- National Alliance on Mental Illness (NAMI)
  - https://nami.org
  - Resources for peer and family support



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- American Foundation for Suicide Awareness (AFSP)
  - https://afsp.org
  - Many resources for providers and communities about suicide prevention
  - Specialty trainings
- The Trevor Project
  - www.thetrevorproject.org
  - Resources and trainings to help LGBTQIA youth.

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Extra Community Resources

- QPR Training
- Mental Health First Aid Training

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THANK YOU

Questions?

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