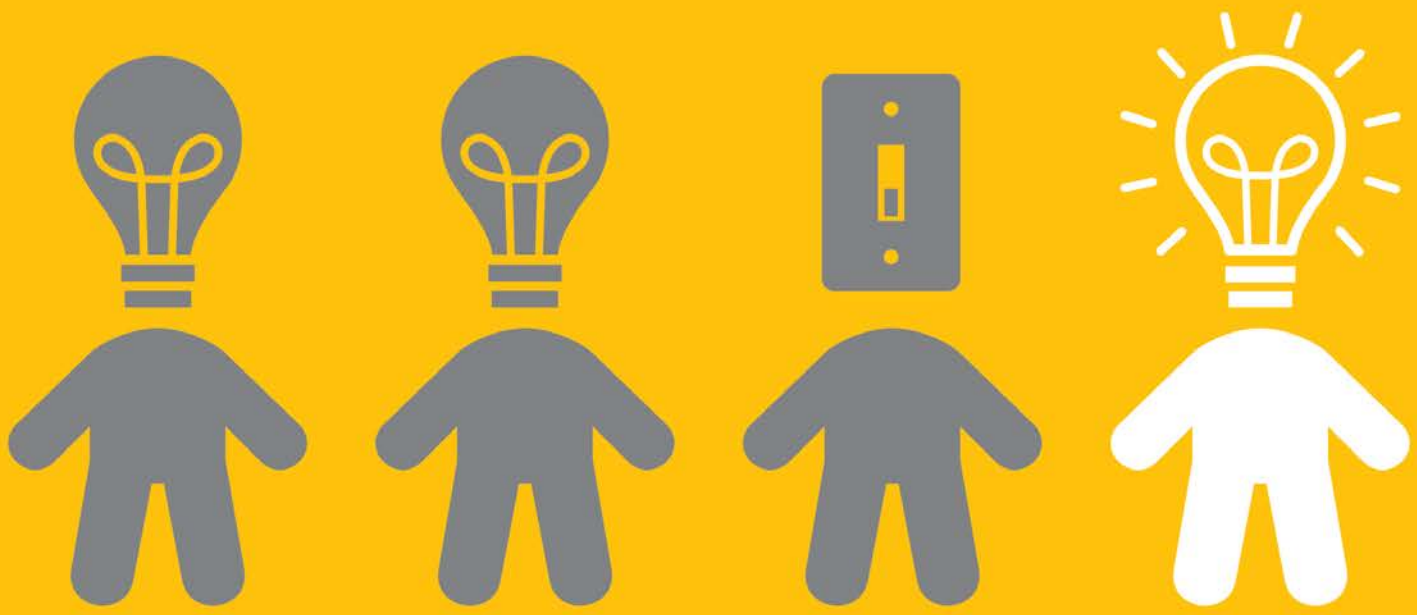
Adolescent Intervention

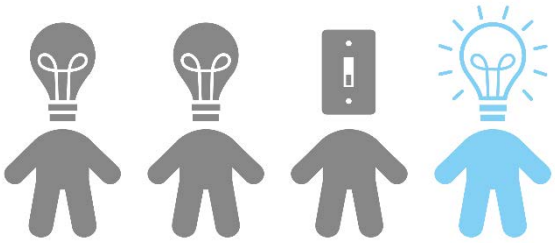
Guide for Clinicians



Intervention for working with young people with complex mental health issues, including personality disorder, trauma history, self-harm and suicidal behaviour and difficulties with affect, identity and relationships

PROJECT AIR
A PERSONALITY DISORDERS STRATEGY

SCHOOLS, TEACHERS & STUDENTS



Project Air Schools

This intervention was developed with the support of the NSW Ministry of Health and the New South Wales Department of Education.

The Project Air Strategy for Personality Disorders acknowledges a steering committee who provided expert review and oversight of this guide: Pauline Kotselas (Co-Chair), Department of Education (DoE), Danielle Thomas (Co-Chair), NSW School-Link, (MH-Children and Young People), Tanya Lancaster (DoE), Erin Pilon (DoE), Marc Reynolds (MH-Children and Young People), Cathie Matthews (MH-Children and Young People), Mahlie Jewell (Consumer representative), Tamaryne Dickens (CAMHS), Jane Schmid (DoE), Anna Sidis (CAMHS), Yolisha Singh (CAMHS), David Bunder (ISLHD School Link Coordinator).

The Project Air Strategy for Personality Disorders also acknowledge the local advisory group of experienced clinicians who provided peer review of this guide: Karina Rovere (CAYMHS), Esther Creagh (CAYMHS), Jane Whittingham (DoE), Jane Schmid (DoE).

Project Air Strategy (2018) Adolescent Intervention: Guide for Clinicians. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

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ISBN:

978-1-74128-287-0 (paperback)

978-1-74128-266-3 (ebook)

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SECTION 1

1.1 Orientation

The guide is divided into seven sections. Section 1 provides an introduction to the guide. It includes a 'Preface' (1.2) which identifies earlier work undertaken in Project Air Strategy for Schools, and defines key terms used in the text. 'Introduction' (1.3) explains that the aim of the guide is to outline an intervention for clinicians working with young people with complex mental health issues in schools and in community mental health. 'Key principles for working with young people' (1.4) outlines the principles for working with young people and identifies common ingredients in the psychotherapy of personality disorder which are at the core of this guide and its development.

Section 2 is divided into four sub-sections. 'Introduction to the case studies' (2.1) introduces clinicians to two young people – Kai and Britney – who are facing a range of challenges. The case studies portray symptoms commonly reported by young people with complex mental health issues, in particular, heightened emotional sensitivity and interpersonal difficulties. These case studies will be referred to throughout the guide to provide examples of how aspects of the intervention may be used with a young person. The sub-section 'Working with complexity' (2.2) provides information about the biopsychosocial model, which describes the complex interactions between biological, psychological and social factors in the development and maintenance of psychological disorders. This section also includes information about the role of temperament, attachment, environment, trauma and genetics. The sub-section 'Relational approach to case formulation' (2.3) outlines the theoretical model underpinning this intervention. 'Reflective practice and self-care' (2.4) outlines some of the emotions that clinicians may experience in working with young people with complex mental health issues, and highlights the importance of reflective practice for noticing and managing clinician responses. A structured method to understanding relationship themes is outlined in order to understand the young person's relational themes, how these relationship themes present in therapy, and how the clinician's reactions may affect the way they work with the young person. This section also emphasises the importance of engaging in regular self-care.

Section 3 outlines a flexible intervention for a young person experiencing complex mental health issues. 'Intervention' (3.1) is divided into four sub-sections and provides an overview of the different points at which the intervention might be used depending on factors such as the presentation of the young person, previous treatment and the context in which the intervention is being delivered. The sub-section 'Engaging the young person' (3.2) considers issues involved in building trust and engaging the young person, confidentiality and factors to consider in connecting with hard to reach young people. The 'Assessment' sub-section (3.3) outlines a flexible approach to assessment, and identifies a number of broad and targeted measures. 'Assessing and Managing risk' (3.4) outlines key points in regard to assessing and managing young people at risk of suicide. This section is designed to complement professional development in suicide risk assessment and safety planning. Psychotherapy (3.5) presents different clinical skills, techniques and activities that can be applied in the provision of psychological treatment to young people experiencing complex mental health. It is structured to reflect key principles underlying the guide, including the relational model of care, the balance between supportive and expressive techniques and the "curious stance" to stimulate self-understanding and self-control in young people.

Section 4 explores recent research regarding self-harm in young people, including: biopsychosocial risk factors for self-harm; understanding the context of self-harm in schools; issues regarding social contagion; and, clinical assessment and responses to self-harm. The section also provides insight into the relationship between internet use and self-harm in young people.

Section 5 is divided into two sub-sections. 'Collaboration in and with the school' (5.1) identifies factors that support collaboration between families, community mental health services and schools, considered essential for the coordination of support for young people with complex mental health. This section also emphasises the importance of prioritising the education of the young person, and factors that can support this goal. 'Working with families' (5.2) highlights the importance of being sensitive to family context and how this may be a perpetuating or protective factor in the young person's life. This section also emphasises the importance of involving a parent/carer or significant family members in the young person's life, where possible. Strategies for working with families are included.

Section 6 outlines the key elements in conducting a complex care review, including aims and key principles as well as the steps involved. Section 7 is divided into three sub-sections. 'Additional resources' (7.1), provides templates for clinical tools and fact sheets referred to in the guide. 'Further resources' (7.2), provides links to

useful websites and information related to working with young people with complex mental health issues. Many of these resources are referred to in the guide. And finally, ‘References’ (7.3) lists the journal articles and reports referred to in the guide.

Associated resources and materials

Each section of the guide links to associated resources and materials. These resources have been designed with the awareness that psychologists, psychiatrists, counsellors, education and health staff, may utilise them with young people and their parents/carers. Templates of these resources can be found in the ‘Additional resources’ (7.1) section. Links to other resources referred to the guide can be found in the ‘Further resources’ (7.2) section.

Project Air Strategy resources can be found online at: www.projectairstrategy.org

1.2 Preface

The aim of this guide is to support clinicians to implement effective evidence based practices to respond to complex mental health presentations in young people in both school and community mental health settings.

This guide builds on previous work undertaken in Project Air Strategy for Schools, which included the development of a guide for teachers titled 'Working with young people with complex mental health issues' and the professional development of education staff to help schools to effectively identify, respond, support and refer students with severe and complex mental health concerns (particularly personality disorder), and manage challenging behaviours common in this population (particularly self-harm). The guide for teachers can be accessed at: https://projectairstrategy.org/content/groups/public/@web/@ihmri/documents/doc/uow225736.pdf

Project Air Strategy for Schools also developed a collaborative training project between the NSW Department of Education, NSW Ministry of Health and the Project Air Strategy for Personality Disorders based at the University of Wollongong. The training package includes presentation slides, a guide for working with young people with complex mental health needs, fact sheets, a training film, and web-based resources.

The course will assist teachers to develop strategies to successfully support and engage students who are experiencing mental health problems and challenging behaviours. The participants explore reasonable adjustments that teachers can use to support students within the classroom. The course is composed of two modules each of two hours duration covering the following:
Module 1. Identifying, understanding and responding to young people with complex mental health issues (2 hour in-service workshop to be delivered in schools)
Objectives covered allow participants to develop:

- An understanding of young people with complex mental health issues
- An understanding of the different roles of teachers, welfare team, school counselling staff and health workers in supporting intervention and treatment
- An awareness of young people with emerging personality disorder
- Strategies to support a young person

Module 2. Identifying, understanding and responding to young people with complex mental health issues: Focus on self-harm and risky behaviours (2 hour in-service workshop to be delivered in schools)
Objectives covered allow participants to develop:

- Further understanding of complex mental health issues
- An understanding of the different roles of teachers, welfare team, school counselling staff and health workers in supporting intervention and treatment
- An understanding of self-harm and how to respond
- An understanding of social contagion in the school setting
- An understanding of other risks including suicide and how to respond
- Further skills to support a young person and their family/carers
- The role of self-care and teacher wellbeing

Definitions

Young Person

This term is used to describe children and young people between the ages of 11 and 18 years. This term is used throughout this guide to indicate a client.

Clinician

The term "clinician" in this guide refers to school counselling service staff and community mental health clinicians who are involved in the treatment of young people with complex mental health presentations.

Education Staff

The term “education staff” is used throughout this guide to refer to any member of staff within a school or education system who engages in regular interaction with students. This includes teachers, support staff, school counsellors/school psychologists, senior psychologists, school deputies and principals.

School Counselling Service Staff

The term “school counselling service staff” is used throughout this guide to refer to school counsellors, school psychologists, Senior Psychologists, Education and District Guidance Officers.

Parent/Carer

The term parent/carer is used throughout this guide to refer to the young person’s parents or legal guardians.

Complex Mental Health

The term complex mental health encompasses a combination of needs and factors as contributing to ‘complexity’. These are likely to:

- Significantly impact on functioning
- Impact across settings (home, school, community)
- Include challenging behaviours that place the young person or others at risk
- Require a targeted response from a range of services
- Long duration: not due to a specific single event, but part of a longer history of difficulties (> 12 months)

Personality Disorder

Personality disorder is a mental health disorder recognised by the International Classification of Diseases (ICD), and the Diagnostic and Statistical Guide for Mental Disorders (DSM). Personality disorder refers to personality traits that are maladaptive, pervasive in a number of contexts over an extended duration of time and cause significant distress and impairment. For young people, the diagnosis may be termed ‘emerging personality disorder’. This term may be applied if a young person does not meet full diagnostic criteria but is presenting with some personality disorder symptoms.

Community Mental Health Services

Community mental health services provide a range of community based services for adolescents and their families with a range of difficulties that are seriously impacting on their mental health and emotional wellbeing. Some services are delivered from hospital in inpatient settings.

Self-harm

Self-harm involves deliberately harming oneself physically via cutting, burning, hitting, scratching or overdosing on prescribed or illicit drugs.

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1.3 Introduction

Project Air is a Personality Disorders Strategy that aims to enhance treatment options for people with personality disorder and their families and carers. Project Air Strategy for Schools provides a comprehensive set of resources which have been developed to assist schools to better recognise and respond to young people with complex mental health problems.

This intervention is designed to assist clinicians working with young people with complex mental health issues, including personality disorder, trauma history, self-harm, suicidal behaviour and difficulties with affect, identity and relationships.

The aim of this guide is to assist clinicians such as community mental health practitioners and school counsellors, by outlining a clinical intervention for young people with complex mental health presentations. It is anticipated that users of this guide will have varying degrees of experience in working with young people with complex mental health issues, ranging from newly appointed clinicians through to highly experienced clinicians. It is also anticipated that clinicians working in community mental health services may be entirely focused on working with this population of young people, while for other clinicians, for example school counsellors, it may be a part of their work.

A personality disorder emerges when an individual's personality traits become maladaptive and cause significant impairment in their life, often differing from social norms and expectations [1]. People with personality disorder may describe problems in controlling their emotions, feeling different from others and not knowing who they are as people, suffering from intense relationship anxieties and concerns, and sometimes can also report problems with feeling impulsive, angry, and spaced out. Associated problems can include self-harm, substance misuse or reckless behaviours. Its onset typically occurs during adolescence or young adulthood, yet the disorder is often overlooked in young people. This is despite personality disorder in adolescence being recognised as a legitimate diagnosis [2, 3]. Personality disorder in young people is unlike the usual struggles of adolescence in that it is characterised by severe dysfunction and impairment, including heightened emotional sensitivity and interpersonal difficulties. Furthermore, research suggests that stigma and lack of information about this disorder is evident within the community, resulting in a need for appropriate knowledge, skills and resources for working effectively with adolescent personality disorder [4].

Research identifies that there is considerable flexibility and malleability in personality disorder symptoms in adolescence, with evidence suggesting that these features are highly responsive to intervention [5]. Moreover, there is evidence for the effectiveness of brief interventions and their place in mental health settings. Recently published research indicates that brief interventions were equally as effective at reducing mental health symptoms in young people as treatment as usual [6].

This guide therefore presents a brief intervention that can act as the first step in the young person's treatment journey, in line with Project Air Strategy's relational step-down model of care [7].

Although personality disorders are a common complex mental health issue, this guide has not been designed exclusively for this presentation. Many young people will not be diagnosed with the disorder, may be presenting with emerging symptoms, or may be experiencing other issues such as self-harm, suicidal behaviour, interpersonal difficulties and trauma symptoms. We refer to complex mental health as a broad term to encompass the variety of these presentations.

Important considerations

In working with young people, a number of important principles apply:

- The legal framework underlying work with children and adolescents, including health, school and government policies and requirements
- As young people mature, it is important to balance the autonomy of the young person with the legal responsibilities
- Consider, respect, and be sensitive to culturally diverse backgrounds
- Consider, respect and be sensitive to gender and sexuality issues

1.4 Key principles for working with young people

The Project Air Strategy for Personality Disorders [8] key principles for working with young people with complex mental health issues such as personality disorder are listed below:

Key Principles for Working with Young People with Complex Mental Health Issues

- Be **compassionate**
- **Listen** and **validate** the young person's current experience
- Take the young person's experience **seriously**
- Maintain a **non-judgemental** approach
- Remain **calm, respectful** and **caring**
- Engage in **open communication**
- Be **clear, consistent** and **reliable**
- Convey **encouragement** and **hope**
- Monitor your own **internal reactions**
- Do not misattribute **extreme distress** or impairment as "normal" adolescent difficulties
- Create a **welcoming** and **understanding** environment that encourages open discussion about mental health among young people and adults
- **Work collaboratively** with the young person, parents, guardians, schools and health professionals
- Be aware and supportive of **diversity** in identity and background, including the Aboriginal and Torres Strait Islander, culturally and linguistically diverse (CALD), and the LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual and others) community
- Prioritise the **education** of the young person, including school attendance and completion of school work
- Support and make **reasonable adjustments** to assist a young person's return to school after a mental health emergency
- Reinforce the young person's **strengths** and resilience while implementing trauma-informed care where appropriate

This information is also available in a factsheet: '*Key principles for working with young people with complex mental health issues'* which can be found at www.projectairstrategy.org.

Five common ingredients of effective treatment in the psychotherapy of personality disorder have also been identified [9]. These principles are at the core of this guide and informed its development. They are as follows:

1. **Structured (manual directed) approaches to prototypic borderline personality disorder problems:** this guide has been developed to provide structure to the clinicians' work. Although aspects of the intervention can be used flexibly, the guide highlights the importance of consistency for the young person.
2. **Young person is encouraged to assume control of themselves (i.e. sense of agency):** this guide has been designed to promote the young person's sense of agency in the treatment they are being provided, for example, ensuring open communication with the young person and tailoring the intervention to their needs.
3. **Clinicians help connections of feelings to events and actions:** this manual provides skills and strategies to assist the young person to understand events and their reactions. It also provides information on how events can trigger difficult feelings that can be understood.
4. **Clinicians are active, responsive, and validating:** this guide promotes the clinician playing an active role in therapy, for example, fostering an awareness of their reactions to the young person and how this can be useful for therapy.
5. **Clinicians discuss cases, including personal reactions, with others:** this manual promotes reflective practice, peer consultation and collaboration as core components of effective treatment.

The 'AIR' in Project Air Strategy is an acronym for **Affect, Identity and Relationships**. These represent the core symptoms of personality disorders.

- **Affect:** high emotional sensitivity, increased response to emotional stimuli, slow return to baseline, intense episodic dysphoria, irritability, and inappropriate anger that is hard to control, dissociation or impulsive and self-destructive feelings
- **Identity:** changing sense of self, difficulty identifying and persisting with life goals, unstable identity and feelings of emptiness, self-criticism and suicidal ideation
- **Relationships:** attachment insecurity and worries about being abandoned, problematic peer relationships, tendency to idealise or devalue others, intense worries or paranoid fears about others

SECTION 2

2.1 Introduction to the case studies

In this guide there are two training case studies: Kai and Britney.

These case studies may remind you of specific clients, students, or young people. However, they are not real cases; they have been developed to highlight common symptoms and issues often seen in this population. They have also been developed to highlight the individual differences among young people. Young people may have similar symptoms, the same diagnosis, or be of similar age, but differ in how they experience the world.

The case studies will be referred to throughout the guide to provide tangible examples of how parts of the intervention may be used with a young person.

Case Study 1: Kai

Kai is an 11 year old male student (in Year 6) attending primary school in a remote town. Kai lives in out-of-home care with foster carers, after being removed from his biological parents at 5 years of age due to sexual abuse and neglect. Kai has been with his current foster parents for 2 months, after two previous foster placements were discontinued due to difficulties managing his behaviour. This is Kai's sixth school since kindergarten. The focus of the current referral is to develop a transition to high school plan for Kai.

Interview with class teacher
Kai's teacher reports that he has daily anger outbursts, and has thrown chairs and tables on many occasions. The teacher responds by evacuating other children from the room, and staying with Kai until he calms down. This can take up to one hour, during which time the classroom has been "turned upside down". When the teacher tries to talk to Kai about his behaviour he says he can't remember what happened, even a short time after the incident.

As a result of Kai's unpredictable behaviour other students are wary of him and he has not made friends. Kai has difficulty engaging in tasks and will often roam around the room, distracting other students. When the teacher attempts to redirect Kai he sometimes appears not to understand what is being said to him and will stare blankly. At other times Kai appears to comprehend but does not follow instructions.

Kai is well below stage outcomes for literacy and numeracy. Kai is eligible for two mornings of additional support for literacy and numeracy, but refuses to work with the Student Learning Support Officer (SLSO) in the classroom. A risk management and behaviour support plan has been developed in consultation with the Learning and Support Team and Kai's foster parents; however, current strategies to support Kai have not been effective. The teacher is also concerned about the daily disruptions to other children's learning.

Family situation
Kai lives in foster care with Jan and Stephen, who have two adult biological children. Kai has three younger siblings who live with Kai's mother and stepfather, and an older brother who lives in a separate foster care placement. Kai has supervised visits once a month with his family. Jan reports that Kai's behavior is difficult to manage at home, particularly when he returns from family visits. Kai has frequent "meltdowns" during which he has broken windows and "trashed the house". Kai says that he hates Jan and Stephen and talks about running away. Jan has tried to involve Kai in afterschool activities based on his interests, however this has not been successful as Kai refuses to follow instructions and is aggressive towards other children. Kai wets the bed most nights. Jan has noticed that money and mobile phones have gone missing from the house, even though they give Kai pocket money and he has his own phone. Although very positive initially, Jan and Stephen are now not sure they will be able to continue to foster Kai.

Previous assessment
Kai was referred to the community mental health service due to significant behaviour difficulties when he first came into foster care, however as there were no identified mental health issues he was only seen briefly and then referred on. Kai was assessed by a paediatrician when he was 8 years of age and diagnosed with Attention Deficit Hyperactive Disorder and Oppositional Defiant Disorder.

Kai is currently on an extensive waiting list for a paediatric review. The school counsellor who visits the school one day a month is undertaking cognitive and behaviour assessment with Kai. At present there are no other health services involved in Kai's care

Case Study 2: Britney

Britney is a 16 year old female in Year 11 returning to school after a recent inpatient admission following a suicide attempt. While in hospital Britney was diagnosed with borderline personality disorder and upon discharge was referred to the local community mental health service for ongoing support. In the months before her suicide attempt, Britney moved out of the family home into supported medium term accommodation with child protection services involvement. Since Britney's admission, the School-Link Coordinator has been pulling together the various professionals to support effective collaboration for Britney.

Family situation
Prior to moving into supported accommodation Britney lived with her mother Wendy and 8 year old brother Damien. Earlier in her childhood, Britney witnessed frequent and severe family violence perpetrated by her father against her mother which continued until her parents separated when she was 12 years of age. Britney has not had contact with her father since the separation. Britney's mother also has a diagnosis of borderline personality disorder, and longstanding challenges with alcohol and substance misuse. She struggles with feelings of guilt about the violence witnessed by her children and her sense that she failed to protect them and didn't leave the relationship sooner. For this reason she sometimes is very demanding to know how Britney is feeling, where she is and who she is with, and sometimes repeatedly asks her or phones or texts her to "check in". Her mother has been doing this is in a way that shows care and concern but to Britney it feels like some of her autonomy and capacity to make her own choices are being challenged. This is confusing for Britney as at other times in the past, her mother has been withdrawn and emotionally unavailable. Over the years there have been numerous reports of neglect to the child protection agency.

School situation
In the past school had always been a safe place for Britney. She found that it provided a way to escape from the intensity of her family situation. She has been a competent student with a particular interest and talent in visual art. Her year advisor reported that since commencing year 11, Britney has had difficulty concentrating in class and handing in assignments. Britney has been offered additional tutorial support to complete assessment tasks, as she is currently not meeting requirements for completion of the preliminary course. Her art teacher recently reported concerns about disturbing drawings that Britney made in class, which included images of self-harm. More recently Britney started seeking out her year advisor in a distressed state, and reporting to the first aid officers in the front office to have minor wounds dressed.

Peer relationships
Increasingly Britney has found relationships with her peers challenging. She can be quite combative and angry, and struggles with "black and white" thinking, which often results in her getting into conflicts with her peers on social media in particular. She has had a few close friends over the years of high school but generally is perceived as an "outsider" and has found it difficult to fit in with a group. Her close friendships are often turbulent wih her alternating between periods of being very close and then abruptly cutting off communication and withdrawing.

Return to school meeting
The return to school meeting was attended by Britney, her community mental health clinician, the youth worker from the accommodation service, deputy principal, year advisor and school counsellor. Britney agreed to return to school the following Monday on a part day exemption plan, to be increased to full time over the following four weeks. Britney's community mental health clinician said that he was having weekly appointments with Britney. Britney gave permission for her safety plan to be shared with the school counsellor. The deputy principal said he would incorporate the strategies discussed into a draft risk management plan, to be reviewed at the end of the first week of Britney attending school or before if needed

2.2 Working with complexity

This section of the guide provides information about the biopsychosocial model, temperament, attachment and the role of environment, trauma and genetics. Experienced clinicians already familiar with the concepts in this section may like to refer to the suggested reading in section 7.2 to extend their understanding.

Objectives:

1. Further develop an understanding of the biopsychosocial model in the development and maintenance of psychological disorders, including the role of temperament and attachment style
2. Consolidate understanding of the influence of environment, genetic factors and traumatic experiences on the development of complex mental health issues

The biopsychosocial model

The biopsychosocial model describes the complex interactions between biological, psychological, and social or environmental factors in the development and maintenance of psychological disorders. In working with young people facing complex mental health issues, **vulnerability to these problems is determined by the complex interaction between genetic factors (inherited characteristics) and environmental experiences** [10].

Risk factors and supportive and enriching factors in the young person's environment all play a role. These environmental experiences influence genetic expression of traits and may contribute to emotional and behavioural dysregulation. This, in turn, can lead to the possible emergence of psychopathology, including personality disorder symptoms, as shown in the diagram below.

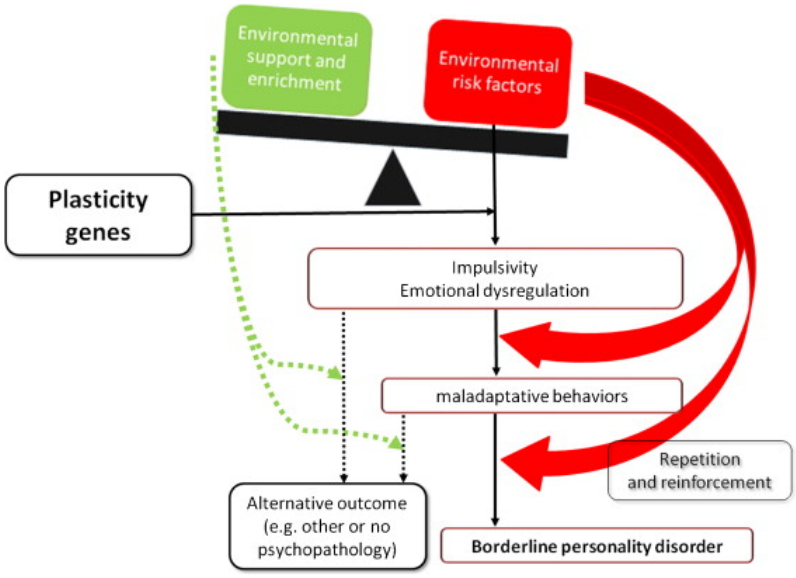


Figure reproduced from Amad, Ramoz [10] to display how the interaction of positive and negative environmental experiences may influence genetic expression and resulting pathways to the development of borderline personality disorder.

Temperament

Temperament refers to individual differences in the way that infants respond to their environment and their capacity to be soothed in the face of distress. It is partly determined by genetic factors and may play a role in the development of complex mental health issues [11].

Some infants can be understood as being more interpersonally hypersensitive [12] and thus possessing a "thinner skin" than others. They may become emotionally dysregulated more easily and it may be more difficult

for caregivers to soothe them. **It is important to keep in mind that temperament can be a vulnerability factor in the development of mental health difficulties, yet it can also increase resilience**. Further information regarding how an understanding of temperament can inform psychotherapy with young people facing complex mental health issues is provided in the psychotherapy section of this guide (3.5).

Attachment

Temperament has important links to the concept of attachment, which refers to **the quality of the emotional bond that develops between an infant and their primary caregiver/s**. Generally speaking, "good enough" parenting results in the establishment of a "secure" attachment between infant and caregiver [13-15]. Secure attachment implies that the infant has enough experiences of their caregiver reliably responding to them during times of distress. Through these repeated experiences, the infant learns that their caregiver is reliable and available to meet their needs. The caregiver can function as a "secure base" through which the infant can safely explore their world as their independence develops, and then be soothed by the caregiver after this period of separation.

Sometimes there are difficulties in the formation of secure attachment. A number of factors relate to this including infant temperament, caregiver mental health issues, child protection issues and other external sources of family stress that may influence the capacity of caregivers to reliably respond to infant distress. In this case, the infant can develop an insecure attachment style, which is characterised by difficulties in using caregivers as a secure base to explore the environment and being soothed once reunited with the caregiver [13]. Importantly, **infant attachment style influences relationship stability in adulthood, and insecure attachment styles can increase vulnerability for the development of psychological disorders** [16]. Understanding attachment style and promoting secure attachment for young people with complex mental health issues is therefore very important [17], and will be discussed in further detail in the psychotherapy section of this guide (3.5).

Environment, trauma and genetics

While it is common for young people experiencing complex mental health issues to have experienced traumatic events during their lives, it is important to remember that not all young people will have experienced trauma [18]. In some cases, young people facing complex mental health issues may have experienced stable early lives without any significant traumatic events (e.g., abuse, neglect, accident, etc.). Genetic factors are influenced in complex ways through both positive and negative environmental experiences. For this reason, **young people may be vulnerable to the development of complex mental health issues even in the absence of specific traumatic events**. At the same time, a high percentage of young people experiencing complex mental health issues do report previous traumatic experiences. Therefore, **the guidelines and intervention presented in this guide are consistent with trauma-informed models of care.**

Thinking about complexity

Let's apply some of this information to Case Study 1: Kai.

Understanding the development of Kai's problems using the biopsychosocial model

- Some of Kai's problems include high levels of emotion dysregulation and impulsivity, and difficulties in regulating his behaviour and connecting with his peers
- We can identify a number of environmental risk factors in his development (e.g., sexual abuse, neglect, frequent disruptions in attachment relationships, multiple school changes)
- Using the framework of the biopsychosocial model, we understand that these negative environmental experiences, in combination with Kai's inherited characteristics (genetic factors), have increased the likelihood of emotional and behavioural dysregulation, and consequent emergence of complex mental health problems

- We may also wish to gather further information regarding environmental support and enrichment factors for Kai – to understand possible protective factors in his development

Kai's temperament and attachment style, and the role of trauma

- We don't have a lot of information regarding Kai's temperament as an infant but one of his main problems at present appears to be his propensity to become highly emotionally dysregulated – we may wonder about the history of these problems and whether his temperament as an infant created greater sensitivity and difficulties to be soothed during distress
- What emerges very clearly in the narrative about Kai is the role of complex trauma and frequent disruptions in key attachment relationships from an early age – there is strong evidence to suggest that these experiences have resulted in Kai developing an insecure attachment style

2.3 Relational approach to formulation

This section provides information about the relational model of care. The relational model provides a framework for formulation and as such, is a foundational component of the intervention.

Objectives:

1. Develop an understanding of the Relational Model of Care
2. Enhance awareness of the five relational domains that reflect both the young person's relationship with themselves (intrapersonal), as well as how they relate to range of other people in their lives (interpersonal)
3. Translate the model into practice
4. Further develop understanding of the Core Conflictual Relationship Theme as a framework that can be used to clarify relationship themes in the young person's life

The Relational Model of Care

The theoretical background for the brief intervention described in this guide is based on the Project Air Strategy relational model of care [7]. This relational model proposes an integrative approach in supporting young people with complex mental health concerns. It is a broad approach that not only uses cognitive and behavioural understandings of the young person, but also expands this to consider more dynamic conceptualisations of the functions of these behaviours within other relationships and the broader social community. The reactions of others to the young person are also an important source of data in helping to understand the difficulties being addressed. Sources of trauma and their effect on attitudes and expectations form an important window into understanding the internal world of the young person.

Relationships in the lives of young people with complex mental health issues are viewed as a potential source of problems, but can also act as the key to addressing these problems and helping the young person understand their motives and actions. This focus can help young people to develop healthier and more satisfying relationships in their lives.

The relational model recognises that mental health symptoms can be understood as stemming from problematic and dysfunctional relationship patterns that have developed over time. It can be helpful to consider that the young person may have faced difficulties during their development that lead them to rely on ways of expressing and getting their needs met that may appear extreme, maladaptive, and/or unhelpful, but may have been the only viable way to do this in the context of their difficulties. These may be associated for example with attachment insecurities, problems arising when trust is violated, or as a result of chronic invalidating responses from others.

When working with young people with complex mental health issues, it can be helpful to think of the following types of relationships in the life of the young person:

a. Relationship to self

b. Relationship with clinician

c. Relationship with family

d. Relationship with peers

e. Relationship with school and community

These five relational domains reflects both the young person's **relationship with themselves (intrapersonal)** and **how they relate to the range of other people in their lives (interpersonal)**.**Translating the model into practice**

One way to think about the relational model of care is that it is like a lens that can provide alternative perspectives of a young person's problems. The intervention presented in this guide provides specific guidance and strategies for psychotherapy focused on these five key relationships.

Before exploring strategies to support the use of this model, we acknowledge that it can be difficult to think in this way, specifically when working with young people who may display maladaptive behaviours such as self-harm and/or threats to hurt themselves or others. In this situation, it is common for clinicians to feel a range of emotions, including significant anxiety regarding how best to manage the complexities of the situation. While these responses can be necessary and functional, sometimes this may lead to a focus on the immediate behaviour, without the corresponding understanding of its context and what the young person may be trying to communicate.

The young person's relationship with themselves

Adolescence is a time when young people are undergoing significant physical changes in their bodies, moving toward greater independence, and experiencing more freedom and responsibility as they navigate the passage from childhood to becoming a young adult. It is a time of forming a sense of identity, through identification with peer groups, but also individuation. Experimentation, impulsivity, and sensation-seeking behaviours are often part of the picture and can be understood in the context of developmental neurobiology, which documents the dramatic changes in structure and function of the brain during this important time of neurodevelopment [19].

Young people with complex mental health issues may be particularly challenged in understanding who they are and where they want to go in life. They may have difficulties with self-image and self-esteem, struggle with feelings of guilt and shame, and also find it hard to tolerate the anxiety that often accompanies the new experiences of adolescence. In particular, **young people with complex mental health issues may find it hard to express these challenges in words and may resort to actions and maladaptive behaviours, as a way to voice these feelings.**

The relational approach highlights the importance of helping the young person connect with themselves and build upon their strengths to assist them in developing a secure sense of who they are. Specific strategies and guidance are provided in the psychotherapy section of this guide (3.5).

The young person's relationship with clinician

The clinicians who work closely with the young person play a particularly important role in promoting wellbeing. It is through these relationships that the young person may begin to develop trust and feel supported in working toward achieving their goals. It is also the case, however, that these relationships may be challenging. One of the reasons for this relates to attachment style. Young people with insecure attachment styles may find it hard to develop a relationship of trust with their clinician. One of the challenges in working with young people more generally concerns engaging the young person and building rapport, but this becomes more challenging in the case of young people with an insecure attachment style.

In thinking about the young person's relationship challenges, the Core Conflictual Relationship Theme (CCRT) [20] is a framework that supports the relational model thinking underpinning this intervention [21]. The CCRT approach can help to clarify relationship themes in the life of the young person. This method focuses on looking at the relationship narratives of the young person to identify common themes across different relationships. These themes will become evident in the relationship narratives the young person discusses with their clinician.

The CCRT method involves identifying three core components of relationship narratives i) the young person's wish, hope or desired outcome during an interpersonal interaction (wish); ii) the perceived response of others to this wish (response of other); and iii) the corresponding response by the young person to these wish-response of other sequences (response of self). **The focus of psychological therapy is thus on both "the self" (how the young person experiences their emotions, thoughts and behaviours), and also on "the other" (how they understand others' reactions, motives, and behaviours towards them).** These discussions are grounded in identifying what is important to the young person (the wishes, goals or values). **Through repeated discussions**

of different interpersonal interactions and relationship narratives of the young person, it becomes possible to identify themes and patterns (similar to schemas) across different relationships.

The CCRTs identified through the young person's relationship narratives are also likely to play out in the relationship between young person and clinician. It is helpful for clinicians to be aware of this in order to help the young person gain greater insight into maladaptive relationship patterns and how they can be altered to enable more satisfying relationships. More on the CCRT method is described in the 'Reflective practice and self-care' section of this guide (2.4). It is important to recognise that at times the problem might not be in either the young person or their social environment - but might be the interaction between these two and thus the intervention might need to be targeted to relationship understanding and change.

The young person's relationship with family

Fostering a healthy and supportive relationship between the young person and their family and/or carers can be very important for strengthening and promoting wellbeing in the context of complex mental health issues. This is because **the young person's family and carers often play a foundational role in supporting the young person and consolidating the important therapeutic work taking place within the clinical context.**

As young people move towards greater independence, they may behave in ways to distance themselves from their family and caregivers in order to experiment and find a unique sense of who they are. This can lead to conflict and challenges in communication between the young person and their family or caregivers. Stresses and challenges in the young person's family and caregivers may also impact on the young person.

Another important aspect to consider in the young person's relationship with their family is the role of attachment. The attachment style of both the young person and their family members may influence communication styles and the ways that the young person is able to express and have their needs met, particularly during times of distress. Attachment in the family environment is considered in more detail in the psychotherapy section of this guide (3.5).

The young person's relationships with peers

During adolescence, there is a focus on young people forming significant relationships with individuals and peer groups in order to feel a sense of belonging that extends beyond family ties. This process can be difficult and may be particularly challenging for young people experiencing complex mental health issues.

For these reasons, **it is important to support young people in connecting with peers in a healthy way and feeling a sense of belonging and acceptance**. The relational model and CCRT method can be used to better understand difficulties that young people may face in peer relationships. These and other recommendations are discussed in more detail in the psychotherapy section of this guide (3.5).

The young person's relationship with the school and community

When working through the relational model lens, although there is a focus on the young person's relationship with themselves and other people who are close to them, it is also important to consider their relationships more broadly. Systemic issues affecting a school community may contribute to the challenges a young person is facing, or they may ameliorate these difficulties. Interventions aimed at facilitating communication and safe and effective transactions between key groups within the environment of the young person may be highly therapeutic.

Helping the young person to feel a sense of belonging and connection within their school and community is an important aspect of promoting self-esteem, resilience and wellbeing. Promoting these benefits may need a focus beyond the young person and onto the positive and negative interpersonal environment factors holding and supporting, or exposing and threatening the work. Other benefits of increasing connection to the school and wider community include increasing the chance for connection with peers and providing routine and structure in the young person's life. As mental health professionals within schools, school

counselling service staff are in a unique position to support young people to develop these connections. School counselling service staff may also act as important facilitators of information and support of young people being managed by community mental health clinicians. Further recommendations are provided in the Psychotherapy section (3.5) of this guide.

Seeing through the relational model lens

The following provides an example of relational model thinking using Case Study 2: Britney.

Britney's relationship with her self

- We may want to ask Britney to describe herself as a person, to identify her likes and dislikes, her attitudes and feelings towards herself, and her goals, for example – at present there is not a lot of information to help us understand the quality of her relationship with herself.
- Britney has a history of self-harm and a recent suicide attempt – young people sometimes resort to actions to express difficult feelings that they struggle to put into words – and asking questions to understand the meaning of this behaviour and how it may relate to her thoughts and feelings about herself may be helpful (though gently and over the course of building a trusting relationship). She may be communicating to herself and others through these behaviours.

Britney's relationship with her clinician

- There are a number of past and present clinicians involved including her youth worker from the accommodation service, a clinician at the community mental health service and the school psychologist.
- Britney expressed to the school psychologist that she thought counselling was a "waste of time" – we may wonder about this communication and how she perceives her relationship with the school psychologist. It is worth considering if these views about counselling reflect an external locus of control i.e. lack of agency in recognising she needs to move beyond looking at others for solutions ("waste of time") and seek to find solutions in herself (in collaboration with a counsellor).
- Britney also requested a morning check-in with her year advisor as part of her care plan, and her support team also includes the deputy principal and art teacher, suggesting that these are other relationships of importance to her.
- As there are many key people involved in Britney's care it will be important to ensure clear communication between all involved. This is also a strong protective factor for Britney. There are lots of opportunities for her to receive support and to form close therapeutic relationships.
- Through these relationships and over time, there will be the opportunity to explore Britney's perceptions of herself (i.e., how she experiences her emotions, thoughts and behaviours), and also "the other" (how she understands others' reactions, motives, and behaviours towards her). This represents a key task of psychological therapy.

Britney's family and peer relationships

- It's noted that Britney has recently moved to supported accommodation after previously living with her mother, Wendy, and younger brother. We also know that historically Britney witnessed frequent and severe family violence perpetrated by her father against her mother, the separation of her parents when she was 12, with no further contact with her father since then.
- We may want to gather further information about Britney's relationships with her family (e.g., their capacity to support her, communication styles). This kind of information will be particularly helpful in relation to understanding her living situation, plans for the future, and contact with her family.
- At present we have some information regarding the challenges and sensitivity Britney experiences in her peer relationships. There exists the chance to further explore her understanding of these relationships, capacity to reflect on her own perspective and the perspectives of others, conflict management, and helping her to better meet her relational needs.
- It will also be important to consider the role of Britney's attachment style in her relationships with family and peers (and also the key clinicians involved, as above) – from the information provided we may hypothesise that Britney experiences attachment difficulties in the context of repeated exposure to traumatic events during her upbringing.

Britney's wider relationships to the school and community

- As noted above, there are a number of key clinicians involved in Britney's care – ensuring clear communication between all involved will be highly important and therapeutic in supporting her.
- Searching for ways to increase Britney's engagement with the school and wider community may provide a chance for her to feel a greater sense of connection to herself and others, and provide routine and structure in her life (e.g. she has a strong interest in art – how could this interest be used to promote her engagement at school and in the broader community?).

Understanding relationships by studying the sequence of events, thoughts, feelings and behaviours, and seeing these in relation to the 4 P's model of conceptualisation

It is useful to break down specific events in the young person's life by undertaking a "chain analysis" to understand how the different components of the relational model interact i.e. the relationship between the self, others and the community.

The 4 P's can also assist to understand the relationship between presenting problems, history and other information to strengthen the general picture of the young person. It includes:

- Predisposing factors: background factors that make the young person susceptible to presenting with the given problems
- Precipitating factors: recent stressors that have caused the young person to present with the problems/symptoms now
- Perpetuating factors: maintaining factors
- Prognostic factors: risk and protective factors

Basic formulation applied to case study Kai

Presenting Problems:

- Interpersonal: difficulty making friends, difficulties in relationships with foster parents, biological parents, siblings
- Emotional: anger outbursts, throws objects and furniture, difficulty soothing, hypervigilant
- Behavioural: unsettled in classroom, roams around room, distracts others, wets bed, hoarding money/phones, aggressive towards other children
- Cognitive/Academic**:** low literacy and numeracy, difficulty engaging in tasks, easily distracted
- Dissociative: can't remember, stares blankly, appears not to understand

Predisposing Factors:

- Traumatic history of sexual abuse and neglect
- Removed from biological parents at age 5
- Separated from siblings
- Difficulties with attachment – manifests as aggressive/erratic behaviour
- ADHD/ODD diagnoses
- Multiple foster care placements
- Frequent school moves

Precipitating Factors:

- Recent change in schools, as well as approaching the transition to high school
- Recent change in care, with possible breakdown in current placement
- Lack of positive interactions with others across settings

Perpetuating Factors:

- Self-concept – how does Kai see himself and his world? What are his strengths and interests? Is there anyone he trusts or feels safe with?
- Difficulty relating to current foster carers
- Frequent school changes
- Difficulties with emotional regulation, hypervigilance

Prognostic Factors:

Risk

- Difficulty making friends
- Unstable care – possible breakdown in current placement
- Learning difficulties

Protective

- Siblings – potential for relationship
- Student Learning Support Officer time could be directed towards supporting social skills through games and play
- Structured school environment can provide opportunities for development of interpersonal skills

Interventions:

- The relational model points to areas to intervene at intrapersonal and interpersonal targets
- Interpersonal and intrapersonal relationship focus through individual sessions with Kai and separate sessions with foster parents, support for teacher
- Explore opportunities for additional support outside of school, liaise with child protection agency and community mental health
- Classroom observations to identify triggers/signs that distress is escalating
- Consult with teacher and work with Kai to implement classroom strategies to develop emotional regulation e.g. behavioural monitoring, sensory box of activities, quiet space for “time in”.
- Redirect Student Learning Support Officer time toward structured activities which would involve Kai interacting with one or two peers
- Build relationship with a supportive adult at school (not classroom teacher)
- Cognitive assessment, consult with teacher and Learning and Support Team re adjustments to improve access to curriculum
- Paediatric assessment and review of medication
- Liaise with high school and education support services to plan for transition and access available support

2.4 Reflective practice and self-care

This section outlines some of the emotional responses that clinicians may experience in working with young people with complex mental health issues. It also reinforces the importance of engaging in self-care and reflective practice.

Objectives:

1. Be aware of emotional responses that clinicians may feel in working with young people facing complex mental health problems
2. Understand the importance of actively engaging in reflective practice
3. Understand how to apply the Core Conflictual Relationship Theme method

Resources:

- Worksheet: Understanding relationship themes

In working with young people facing complex mental health problems, it is common for clinicians to experience emotional responses. These responses may include:

- Feeling uncomfortable and confused
- Feeling powerless, anxious and worried by the situation
- Feeling frustrated or angry
- An intense like or dislike for a young person
- Wishing the young person would move to another school or service
- Feeling pulled to the rescue of the young person and becoming emotionally invested in the young person's wellbeing
- Feeling incompetent and overwhelmed by the young person's presenting complexities
- Doing more than usual (e.g. disclosing personal information or giving out private mobile numbers)
- Doing less than usual (e.g. finding it hard to engage or avoiding dealing with the person)
- Difficulty providing a consistent response due to the "push-pull" nature of the young person's relational style.

It is important to notice and be aware of these kinds of reactions. A young person experiencing complex difficulties can induce a wide range of complimentary or opposing feelings in clinicians, young people, teachers and others that can happen quickly and outside immediate awareness. Debriefing and seeking support from colleagues to obtain a more balanced perspective on these dynamics, as well as engaging in self-care and self-reflection, can help to manage these feelings that commonly arise in working with young people who face complex mental health issues.

Reflective practice

A key method for noticing and appropriately managing emotional responses to young people facing complex mental health issues is to actively engage in reflective practice. Consistently engaging in reflective practice is also a key skill in using the relational model of care to inform treatment.

Reflective practice broadly refers to processes through which clinicians locate and challenge assumptions and biases in order to increase awareness and professional competence [22]. Through structured approaches designed to enhance reflective thinking, clinicians can work most effectively with young people experiencing complex mental health concerns. Although many clinicians face busy professional lives and schedules, setting aside time to engage in structured reflective practice is crucial in working with this population.

Structured approaches to engaging in reflective practice have been documented [23]. These approaches recommend that the clinician choose a troubling or difficult interaction with the client (i.e., young person) and/or

significant other (e.g., caregiver of the client). The next step requires taking time to reflect on questions regarding this interaction, including the following [reproduced from 23]:

- Describe the interaction
- What were my thoughts, assumptions, and expectations about the interaction?
- What was the emotion of the interaction? Similar or different from my usual experience with this young person?
- To what degree do I understand this reaction as similar to the young person's interactions in other relationships?
- What did I want or hope to happen?
- What assumptions, models, or theories do I now use to understand what is going on?
- What past professional or personal experiences may have affected my understanding?
- How else may I describe and interpret this interaction in the session?
- How might I test out alternatives?
- How will the young person's responses inform what I do next?

These questions serve as examples of many of the important areas to think about [23], however there is no correct or incorrect way to use them. **It is recommended that clinicians experiment to find their own way to engage in reflective practice.** For example, some people may benefit from taking time to write about their responses, whereas others may find it helpful to engage in a discussion with a colleague.

Engaging in reflective practice also complements use of the CCRT method in working with young people experiencing complex mental health issues. In the case that a young person presents in crisis or has a chronic risk of hurting themselves, it may be hard to focus on using the CCRT method, due to high levels of distress and risk of harm to the young person. **The balance between ensuring that appropriate risk assessment and management is conducted and engaging in psychotherapy with young people experiencing complex mental health issues can be challenging. This underscores the importance of engaging in reflective practice during this kind of work.**

Understanding core conflictual relationship themes

The following '*Understanding Relationship Themes Worksheet*' provides a structured method to reflect on a **young person's behaviour and its underlying communication**. It also aims to promote understanding of the clinician's response during the interaction. This information can be helpful to understand other relationships in the young person's life, as well as future interactions you may have with the young person.

An example of the worksheet follows and presents how it may be applied to a fictional scenario involving the case study of Britney. It is important to keep in mind there is no right or wrong answer, nor is there necessarily a definitive solution. **The purpose of the worksheet is to facilitate reflective practice** – particularly, understanding **the young person's relationship themes, how these relationship themes may present in therapy, and how your own reactions may affect the way you work with the young person.**

This worksheet may be quite challenging to complete at first, particularly if you have only worked with the young person for a short period of time. If you are having trouble identifying how the young person may be feeling (i.e., their wish), it may be easier to first reflect predominantly on your own reactions (e.g., you may be experiencing something similar to those reactions listed previously). Consider what these reactions might indicate to you about the young person or your own values and beliefs.

A blank version of this worksheet can be found in section 7.1.

Describe a recent incident or behaviour:
E.g. Britney attended the past two sessions saying that everything was 'fine' and counselling was a 'waste of time'. She then came to your office crying on Friday 2:30pm saying 'no one cared about her', 'I hate everything'.

What do you think the young person wanted? (I.e. what was their 'wish'?)
E.g. Britney wanted comfort and to be understood (came to your office crying and feeling uncared for)

How did the young person expect people to respond to them? (I.e. what was their 'response of other'?)
E.g. She expects people not to care ('no one cares')

What is their usual response? (i.e. their 'response of self' to this wish-response-other sequence)
E.g. Britney responds by angrily rejecting her feelings and projecting her feelings onto others (pretending things are fine and being angry at others for wasting her time; hating everything - i.e. the uncomfortable, unpleasant feelings of being vulnerable)

What are some of the feelings and thoughts that come up for you in reflecting on this situation?
E.g. Feeling irritated that her neediness has come up late on a Friday when you are tired at the end of the week. Feeling hopeless and you are reluctant to help her now, since she rejected your offer of help earlier.

What might this behaviour and your response tell you about the young person's relationships with other people, for example, their family or peers?
E.g. Britney may have a history of pushing people away and acting as though everything is fine, but then reach out for care in ways that are challenging, such as crying and self-harming. Her friends may therefore react in a similar way to you – feeling annoyed, wanting to help, but then feeling pushed away, before being asked to help again 'when it suits her'.

What will I remember if something similar happens in the future? What have I learnt that I can apply to future situations?
E.g. Britney has a history of being separated from her family (does not talk to her father, parents are not together, and she currently lives in supported housing). This may make it more difficult for Britney to open up to people, in fear that she will be abandoned. Having clear boundaries and expectations with Britney, whilst also being compassionate and supportive, will allow Britney to experience having her wishes met in a way that feels genuine and safe. Her experiencing others' reactions in a genuine way will also help her to internalise what others might be experiencing.

Self-care

Given the reactions that clinicians may experience when working with young people with complex mental health issues, it is important to engage in regular self-care. Self-care is highly personal; what may work for one person may be quite different compared to the next. Some evidence-based suggestions are presented below:

- Supervision: individual and/or group supervision is vital, particularly for exploring any emotional reactions you may have in working with young people presenting with complex mental health issues. Supervision helps to ensure that these normal reactions are used appropriately and effectively to guide your work with the young person.
- Mindfulness: engaging in regular mindfulness activities (e.g. breathing exercises, meditation, and grounding).
- Boundaries: maintaining boundaries can be difficult. You may find yourself thinking about a particular client when you aren't at work. Some people use methods such as listening to music on the way home or wearing a clothing item (e.g. a scarf), and then leaving it at work as a physical lifting of the day's work.
- Physical wellbeing: looking after yourself (e.g. eating well, sleep hygiene, regular exercise).

My self-care

What self-care strategy can I do today?

What self-care strategy can I implement longer-term?

SECTION 3

3.1 The Intervention

Overview

This section outlines a flexible intervention for a young person experiencing complex mental health issues, such as personality disorder, self-harm, or suicidal ideation. It is divided into the following sections:

3.2 Engaging the young person

3.3 Assessment

3.4 Assessing and managing risk

3.5 Psychotherapy

The content in these sections may be thought of as broad phases of the intervention that don't need to be followed in a prescriptive manner. For example:

- You may have already completed a thorough assessment and formulation, and may therefore decide to draw upon skills and techniques from the intervention section, tailored to the young person's needs.
- A young person may present to you in crisis and the goal of the intervention may just be working in the early phases of engagement, assessment and care planning.
- Or you may have the opportunity to complete all phases of the intervention with the young person.

While this guide outlines an intervention for clinicians in both school and health settings, it is acknowledged that there are many differences in the way clinicians work depending on setting, location, resources and focus. For example, some community mental health services may focus on crisis intervention and refer to other services for psychotherapy. The intervention is designed to be flexible to accommodate some of these differences.

Aspects of the intervention may already be a part of your current practice and understanding, for example, initial assessment and formulation, or perhaps you have used some of these skills previously. This guide has been designed to complement the quality practice that clinicians in schools and community mental health are already doing, and its flexible approach allows you to adapt the intervention to your current practice and the young person's needs.

We also understand that, depending on your setting for providing clinical services, you may only have several sessions with a young person, or not have the caseload or time to see a young person more regularly. This flexible approach allows you to tailor the intervention to the context you are working in and provides key information and skills to assist you. Critical to the approach is developing an understanding of the relational patterns active in the situation to help yourself, teachers, families and the young person better understand and respond in ways that are more effective, and enriching for the young person and their future.

3.2 Engaging the young person

Objectives:

1. Focus on building trust and engaging the young person
2. Develop a shared understanding of confidentiality and its limits
3. Further develop understanding of factors to consider in engaging hard to reach young people

Resources:

- Fact Sheet for Health and Education Staff: Exchanging information and working together to keep young people safe

The importance of engaging the young person

Establishing a relationship with a young person is of vital importance for this particular clinical population, as they may have a history of invalidating experiences, insecure or inconsistent relationships. They may therefore 'test' to see if you will be the same – *will you leave like the last clinician that couldn't handle me? Will you break my trust?* Keeping in mind the reflective practice skills and relational model information mentioned earlier in this guide will assist you in this work and help you to remain engaged, empathic and supportive towards the young person. For further information on developing the therapeutic alliance and engaging young people see the following webinar produced by Orygen: www.orygen.org.au/Education-Training/Resources-Training/Webinars/The-Therapeutic-Alliance.

This section of the guide will outline tips to build trust, explaining confidentiality and exchange of information to the young person, and how to engage hard to reach young people. This information will already be familiar to clinicians, it is included to highlight the importance of engagement with this particular clinical population.

Building trust

Young people meeting with a clinician for the first time may feel uncomfortable and unsure of what to expect. A clear discussion is required at the outset of the therapeutic relationship to establish well defined expectations for both clinician and young person. These clear expectations provide a safe and predictable therapeutic environment.

The following steps will help to build rapport and set the frame for treatment:

- Provide an outline of what is going to happen during the session
- Create an empathetic stance by acknowledging the effort that the young person has made to attend the session, as well as discomfort that they may feel at times during the session
- Discuss confidentiality and its limits (see confidentiality section that follows)
- Explain practicalities such as the time, location, duration of sessions, follow up appointments
- If you are working in the school setting discuss with the young person how they would like to be contacted about appointments, for example if they would like to make regular appointments in advance or be contacted by the clinician through other channels e.g. office messenger
- If you are conducting an assessment which may involve asking the young person questions that are of a sensitive nature, then let the young person know that they can choose not to answer questions
- Ask open ended questions to encourage the active involvement of the young person in the session
- Check for feedback during the session, including that you have understood the young person's main concerns and goals in coming to see you

It important that the young person comes away with the sense that the clinician cares about what they are experiencing. Directly engaging with the young person on their present concerns and difficulties so that they feel heard and understood is more likely to lead to the young person returning for further therapy. This stance will also help to strengthen the young person's self-efficacy and trust in mental health services.

Adopting an approach that values the inherent strengths in young people, as well as those strengths that can be nurtured and developed, promotes a sense of partnership as well as optimism that things can change. A

strengths approach focuses on what is going well, rather than problems and deficits. This stance promotes the value of looking to our strengths and the strengths of those around us to face challenges and difficult times.

It is often the case that when young people meet with a clinician they will share things that are of a deeply personal nature that may not have been shared with other adults. Connecting with a young person through humour can be a way to help them feel more at ease to talk about difficult thoughts, feelings, relationships, or things that have happened to them. This can help to strengthen the therapeutic alliance by increasing engagement. Finding humour in difficult situations is also a way to gain perspective and may help the young person to create more space for reflection. Humour can also be used to promote change, for example by making an exaggerated suggestion the clinician may be able to encourage the young person to think differently about ways of viewing a problem or difficulty that they are facing.

It is important that the clinician understands the developmental needs of the young person, as well as the issues they may be experiencing. Young people are in the process of establishing their identity and gaining autonomy from parents, teachers and other adults. Adopting a respectful stance and encouraging the young person's autonomy will help to build effective collaboration between the clinician and the young person.

Confidentiality

Clinicians will be aware that confidentiality refers to the professional obligation of psychologists not to disclose to others information obtained in the context of providing a psychological service. Australian Psychological Society Ethical guidelines for working with young people state that "confidentiality is an essential part of providing client psychological services to young people" [24, p.185]. This principle applies to the work of clinicians in schools and community mental health settings who are registered psychologists.

Confidentiality is a major concern of young people with complex mental health issues. Concerns around information being shared with parents, teachers or friends can deter young people from seeking help [25]. For this reason it is important to talk with the young person about confidentiality and its limits at the outset of the therapeutic relationship and as often as necessary after that to clarify the young person's understanding and expectations.

While it is important to respect and maintain confidentiality, on occasion it may be necessary to disclose confidential information. These circumstances include:

- The young person is at serious risk of harming themselves,
- At serious risk of harming someone else,
- At risk of or committing a serious criminal offence, or
- They are being seriously threatened or harmed by someone else

Where disclosure is not essential, the young person, or a person with legal authority to act on their behalf (e.g., parent/carer), should be invited to give informed consent before any information is exchanged or disclosed to others. It is important to clarify with the young person and their parent/carer what information will be shared, its intended use and to whom it will go.

More detailed information about the ethical, legal and policy context to confidentiality for psychologists working in schools and health settings can be found in section 7.2.

Exchange of information between schools and health services

On occasions, it may be helpful to exchange information with other agencies or services about a young person as part of the assessment process or to engage other services in the young person's care.

Child protection legislation in NSW allows for the exchange of information to promote the safety, welfare or wellbeing of a young person without their consent, and takes precedence over the protection of confidentiality. Guidance as to the circumstances under which information can be exchanged under Chapter 16A of the legislation is provided in the Fact Sheet for Health and Education Staff: Exchanging information and working together to keep young people safe found at

https://beta.dec.nsw.gov.au/__data/assets/pdf_file/0009/588519/Exchange-info-Health-Education-FACTSHEET_Nov17_FINAL.pdf. This fact sheet is also included in section 7.1.

Tips on discussing confidentiality with the young person

- Ask the young person for their understanding of confidentiality
- Explain that you will maintain and respect confidentiality wherever possible, but that there are limits to guaranteeing confidentiality
- Outline some of the specific serious circumstances where disclosure of confidential information may be necessary
- Invite the young person to give informed consent where disclosure to others is not essential
- Decide with the young person what issues will be discussed with parents and school, and the extent to which parents will be involved in treatment
- Encourage the young person to share important information with their family, where appropriate
- Where it is essential to disclose information to others, where possible consult with the young person with regard to the way in which the information is to be passed on and to whom
- Where possible consult with the young person as to the timing of any disclosure

Hard to reach young people

There is evidence that that young people who experience marginalisation are at increased risk of developing mental health problems and may face barriers in accessing services [26, 27]. This may include but is not limited to: young people who are culturally and linguistically diverse, Aboriginal and Torres Strait Islanders, same sex attracted and/or gender diverse, or young people who live in rural or remote areas. Young males are also less likely to access services, despite being recognised as a high risk group for psychological difficulties.

Aboriginal and Torres Strait Islander young people [28-30]

- Experience serious mental health difficulties at a higher rate compared to non-Aboriginal young people
- Experience stigma and feelings of shame associated with help seeking, particularly regarding mental health
- Are more likely to access informal help seeking involving family, friends or other community members than formal services and professionals
- Grief and loss have a significant impact on the social and emotional wellbeing of Aboriginal children and young people, both related to past history of loss and trauma, as well as current and ongoing losses
- Experience historical and ongoing racism and discrimination which impact on their access to services
- Are more likely to live in a rural or remote area than non-Aboriginal youth and may therefore face barriers to accessing services due to geographic location
- May have concerns around the authorities intervening in their family as a result of seeking help from a health professional

Culturally and Linguistically Diverse (CALD) young people [31-33]

- Face significant cultural and linguistic barriers in accessing mental health services
- May be vulnerable to depression and psychological disturbance due to stressors related to the migration and settlement process
- Refugee young people may have directly or indirectly experienced torture and trauma, loss and separation from family and friends, disrupted education, long periods languishing in immigration detention and uncertainty related to their visa status. These experiences make them vulnerable to developing PTSD, depression and other psychological disorders
- May experience identity confusion as a result of being caught between cultures – the values of their parents' and a desire to fit in with mainstream youth culture. They may also experience role reversals as a result of being placed in positions where they are required to interpret for their parents or other family members

- May come from cultural backgrounds where there are strong taboos against talking about family issues outside of the family. As a result they may be less likely to seek mental health treatment and more likely to present in crisis

Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex and Asexual (LGBTQIA+) [27, 34, 35]

- Experience higher rates of depression and mood disorders, and have a higher prevalence of suicidal thoughts, plans and attempts
- May experience social and or family exclusion and use the internet to find safety, express their identity and increase their sense of belonging
- Are very likely to experience heterosexism and homophobia at school and in the community which impacts on young people's feelings of safety and is related to higher rates of substance use, self-harm and suicide attempts

Rural and remote young people [36]

- Do not have ready access to age appropriate mental health services and support
- Barriers such as stigma, concerns around confidentiality, lack of anonymity and logistic difficulties including cost and availability of transport can prevent rural and remote young people from accessing mental health services
- The incidence of mental health problems in young people is more pronounced in rural areas

Young males [37]

- Are nearly three times as likely to die by suicide as young Australian females
- Use mental health services at a proportionally lower rate than young females, and do not access traditional help-seeking pathways
- Traditional ideas around masculinity, including being "tough" and self-reliant, act as a barrier to young males accessing services and expressing emotions
- Young males are more likely to present with externalising behaviours (anger, substance use, risk taking) which do not align with diagnostic criteria for mood and other mental health disorders, and therefore their symptoms can be missed
- Services, including schools, need to recognise that a young man's behaviour may be a symptom of mental health difficulties, and develop initiatives to reach young men including the use of peer support networks and technology

While there are groups of young people who may be hard to reach and who may be at increased risk of complex mental health issues, all young people have unique and diverse experiences that may lead to significant distress and mental health issues. If individual differences are not acknowledged they can lead to a number of negative consequences for the young person, including diminished trust, perception of a lack of understanding and empathy, and feeling that others are imposing their values and beliefs.

Some principles for engaging and working with diverse and hard to reach groups include:

Hard to reach young people may be reluctant to engage with formal services or may not live within reach of services. Providing access to technology based services can help to address some of these barriers. Increasingly online interventions are emerging as an important setting in which to deliver mental health support to young people [38, 39]. Technology based interventions include: telephone counselling services e.g. Kids Helpline, Lifeline, SANE helpline; online services e.g. Youth Beyond Blue, Reachout.com, eheadspace; as well as evidence based online interventions e.g. moodgym.

Be aware and supportive of diversity in identity and background, including Aboriginal and Torres Strait Islander, culturally and linguistically diverse (CALD), and the LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual) community.

Assist young people to link to support groups and peer networks. For example, when working with young people from LGBTQIA+ community, it can be helpful to share information about specialist support and advocacy

services (see Further Resources section). In many areas, Headspace run social groups for young people who identify as same sex attracted, gender diverse or questioning, as well as running support groups for parents. Clinicians can also consult with specialist services to increase their understanding of the issues that their client may be experiencing. For young people who live in rural or remote areas, accessing these services can be difficult. Assisting young people to connect with online and telephone supports can be helpful e.g. Reachout,com, QLife, eheadspace.

Recognise that externalising behaviours (anger, substance use, risk taking), may indicate the presence of mental health difficulties. This needs to be taken into consideration across health and school contexts, as these behaviours may preclude a young person from being eligible for a service, or being met with a discipline response by staff in the school, which is unlikely to address the underlying issues and may serve to further alienate the young person if appropriate help is not provided.

If a young person is returning to school following a suspension for aggressive behaviour or possession of illegal substances, wellbeing issues need to be considered as part of the resolution of the suspension, and the young person given the opportunity to speak to the school counsellor or external support services. If the young person is reluctant to engage with these services then consider alternative support such as mentoring with a trusted adult at school or in the community.

Clinicians can strengthen their competence in understanding the concerns of Aboriginal and Torres Strait Islander young people through accessing training on cultural behaviours and appropriate communication strategies.

Clinicians need to take time to familiarise themselves with the refugee, migration and settlement experiences of young people who live in the community in which they are working. This may involve attending cross cultural training as well as accessing training provided by specialist services such as the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) http://www.startts.org.au/.

When working with people from culturally and linguistically diverse backgrounds who do not speak English well, learn how to access and use interpreters to enhance your skills. This is particularly important when working with the families of young people who are experiencing complex mental health issues.

3.3 Assessment

This section outlines a flexible approach to assessment, and identifies a number of broad and targeted measures that may be helpful.

Objectives:

1. Further develop skills in adopting a flexible approach to assessment, as well as core components of assessment
2. Enhanced awareness of broad and targeted measures
3. Further understand the value of collaboration between health and education in assessing and supporting young people

Resources:

- Clinical Assessment – Initial Interview
- McLean Indicators of Concern

While many young people with complex mental health issues will have had previous contact with health services, for others seeing the school counsellor or attending an appointment at a community mental health service may be the first time they have accessed a mental health service. This has important implications for the assessment process. Best practice indicates the need for comprehensive psychosocial assessment to guide case formulation and treatment planning [9]. However, in instances where there are extensive health records and assessment information already available, obtaining further clinical information may be perceived as invasive and lead to the young person deciding not to return for support. In these instances, a briefer assessment involving checking against existing clinical information may be more useful, as well as checking of more recent risk and mood.

Some community mental health services, following an initial assessment interview, may provide information about the most appropriate service to support the young person with psychotherapy.

If a young person is presenting in crisis, then focusing in the initial sessions on listening directly to the young person's situation and forming a risk assessment and safety plan will be the priority. It may then be possible to obtain more comprehensive clinical information prior to further intervention.

Core components of assessment

This section outlines the core components of assessment. It is important to keep in mind that assessment and history taking are not linear processes. The clinician does not need to complete assessment before intervention, as further assessment and history will emerge during the course of working with the young person. Therefore, time may be best spent directly engaging with the young person on their present concerns and difficulties so that they feel heard and understood, strengthening their self-efficacy and trust in mental health services.

Clinical interview with a young person

Where a young person presents for the first time and is not in crisis, conducting a clinical interview that covers areas relevant to their mental health and psychosocial functioning is an important part of understanding the young person in front of you and formulating a treatment plan. It can also be used as an opportunity to jointly uncover strengths and identify goals for therapy.

There are a variety of clinical assessment tools that clinicians may use depending on the service they work in, and the young person’s presentation. For a more comprehensive psychosocial interview, a widely used assessment tool such as the HEADSSS assessment interview (an acronym that stands for home, education/employment, activities and peer relationships, drug and alcohol, sexuality, suicide/depressions and safety) may be used [40]. See section 7.2 for a link to headspace Psychosocial Assessment for young people.

Alternatively, if a briefer assessment is preferred, a simple initial interview format may be followed. In section 7.1 we have provided a clinical assessment initial interview tool that outlines the key headings that are recommended

to address in the initial assessment, for example, the presenting concerns, completing a genogram, and conducting a risk assessment.

Document Review

Health and school records can be reviewed as part of the assessment process. These records include but are not limited to paediatric or psychiatric reports, medical records, student counselling files and pupil record cards, cognitive and behavioural assessment reports, reports from allied health practitioners (e.g., speech pathologists and occupational therapists), academic and standardised assessment reports and school enrolment and attendance records. These records and reports contain vital information about the young person's developmental history, social and environmental factors that may be relevant to the young person's presentation, early emotional and behaviour difficulties, history of trauma including abuse and or neglect as well as pre-existing mental health conditions.

Observation

Depending on the young person's age, observing the young person in the classroom and/or playground, as well as clinical observations during assessment can help the clinician to understand the young person's strengths and difficulties. For example, in the case of Kai, spending time in the classroom may enable the clinician to identify triggers and signs that distress is escalating, as well as patterns of child-teacher or peer interactions. This information can assist in case formulation and treatment planning.

Interviews with parent and teacher

A semi structured interview with the parent/carer to obtain background information as well as current concerns is an important part of the assessment process. It can also provide an opportunity for the parent/carer to voice their concerns and needs, and to discuss referral to other services.

As part of understanding the young person's developmental history, asking questions around childhood temperament can help to identify vulnerability and resiliency factors. As discussed in section 2.2, the young person's temperament as an infant plays a significant role in the development of complex mental health issues. Asking the parent/carer questions about what the young person was like as an infant may assist the clinician in understanding the origins of difficulties with emotion regulation and relationships. This information can also be used with the young person to understand how their temperament and experience as a child may have influenced their development and who they are as a person.

An interview with the teacher or year advisor can also inform the assessment process. The teacher can provide important information about the young person's behaviour in the classroom, interactions with peers, interactions with teachers and academic progress, which helps to inform the clinician's understanding of the young person. It may also help to identify changes in the learning environment to better cater for the needs of the young person.

Liaison between health and education

Many young people with complex mental health issues will have previous or current involvement with community mental health services. With the consent of the young person and their parent/carer, close collaboration between clinicians in health services and clinicians in schools in assessing and supporting young people can result in improved care. One particular way in which collaboration can be enhanced is through sharing of safety/care plan information.

The School Link Coordinator in your Local Health District can provide information and support to facilitate communication between schools and health services. For more information go to:

http://www.health.nsw.gov.au/mentalhealth/programs/mh/Publications/nsw-school-link-strat-actionplan-2014-2017.pdf

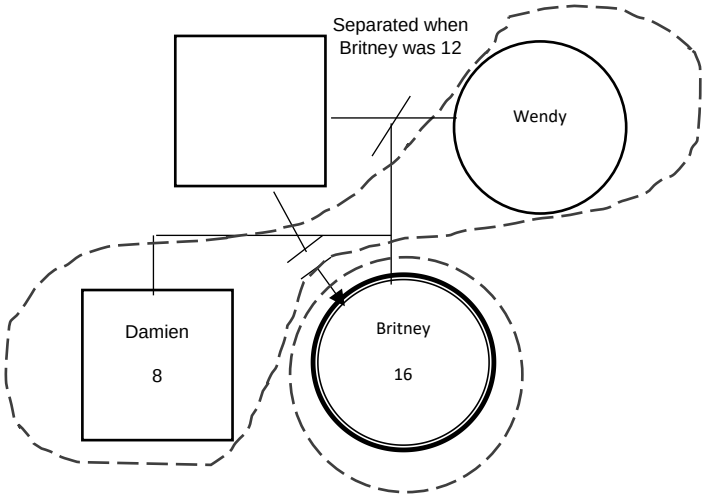
Completing a genogram

Completing a genogram during the initial assessment with a young person will allow for a clear understanding of who is in the young person's immediate family. This is also a non-confrontational way to start getting the young person to open up and decrease their anxiety at the start of therapy. Ask the young person: "Who is in your family?" and draw the genogram keeping it an interactive process with the young person. Include their immediate family, extended family, and anyone else they consider important in their life. Ask the young person about their pets and include this information if relevant.

Once the genogram is completed, ask several follow-up questions: "Who do you live with?", "Who are you closest to?", "Who do people say you are most similar to?", and "How would you describe your family?" You can also ask for short descriptions of family members "How would you describe mum in three words?" The genogram also provides opportunity to document any family mental health issues e.g. "Do you know if anyone in the family experiences mental health issues?". The genogram will provide a starting point for understanding the broader familial context when working with the young person and how this may be perpetuating the young person's issues or acting as protective factors.

An activity that may be useful following this exercise is the 'circles of closeness' activity in section 3.5.

Example genogram for case study Britney: the below genogram shows that Britney, her brother Damien (8 years old), her Mother, Wendy (age unknown), and her father (name and age unknown). The genogram shows that Britney's parents separated when she was 12 years old. The arrow between Britney and her father represents that they are cut off from one another, as we know from the case study that she has not spoken to her father since her parents separated. The dashed lines around Wendy and Damien represent that the two of them live together, whilst the separate dashed lines around Britney represent that she lives elsewhere in supported accommodation.



For information on how to draw a genogram, we have provided an information sheet in section 7.1 which was developed by McGoldrick, Gerson [41].

Completing a timeline

Completing a timeline during the initial assessment with the young person is an engaging way to sequence important events in the young person's life, and to identify stressful life events that may be contributing to their current difficulties. Ask the young person "tell me about some of the important events that have happened in your life?" and draw the timeline keeping it an interactive process with the young person. The timeline can be based on chronological age, or may use dates to indicate positions along the line. The young person can rate the impact of the event on a scale: 1-10. Once the timeline is completed, ask follow up questions to identify the consequences of events on relationships in the young person's life.

Measures

Broad based measures that can be completed by the young person, their parent/carer and or teacher can provide a useful overview of the young person's difficulties, and identify problem areas where more targeted measures may be indicated.

Broad

- Strengths and Difficulties Questionnaire (SDQ)
- Achenbach System of Empirically Based Assessment (Achenbach)
- Behavior Assessment System for Children, Third Edition (BASC-3)
- Conners Comprehensive Behavior Rating Scales (Conners CBRS)

Targeted

McLean Indicators of Concern [42]

This tool is a screening measure for BPD and a copy can be found in section 7.1. This tool has been included to aid clinicians in recognition of young people who require more thorough mental health evaluation for BPD. Each endorsed item is worth one point on a scale that ranges from 0-10. If a young person endorses seven or more items on the McLean Indicators of Concern then referral for further assessment is recommended. If a young person meets three or more items they may still benefit from indicated prevention and early intervention.

Emerging Cross Cutting Measures

The American Psychiatric Association (APA) is offering a number of emerging measures for further research and clinical evaluation that are relevant to the assessment of young people. The following measures can be found in the Additional Resources section.

- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure— Child Age 11–17
- The Personality Inventory for DSM-5—Brief Form (PID-5-BF) — Child Age 11–17

The DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Child Age 11–17 is a self-rated measure completed by the young person that assesses domains that are important across different psychiatric diagnoses. The aim is to assist clinicians to identify additional areas that may have an impact on the young person's treatment. The domains included are somatic symptoms, sleep problems, inattention, depression, anger, irritability, mania, anxiety, psychosis, repetitive thoughts and behaviours, substance use, and suicide ideation. See additional resources section for the measure and scoring instructions.

The Personality Inventory for DSM-5—Brief Form (PID-5-BF) — Child Age 11–17 is a self-rated personality trait assessment scale for young people. It assesses five domains including negative affect, detachment, antagonism, disinhibition, and psychoticism. The testing of this resource to date in the field has been well received by clinicians who have found it useful to understand each personality domain and overall personality dysfunction.

3.4 Assessing and managing risk

This section outlines key points in regard to assessing and managing young people at risk of suicide. It is anticipated that clinicians using this guide will have completed professional development in suicide risk assessment and safety planning.

Objectives:

1. Consolidate understanding of the skills involved in engaging the young person and obtaining a thorough understanding of the causes of distress and their capacity to cope
2. Enhance awareness of risk assessment frameworks
3. Understand the importance of individualised safety and care planning to assist the young person to reduce their level of risk and frequency of crisis
4. Understand importance of planning for a student's return to school following a mental health event

Resources:

- Black Dog Safety Plan
- Project Air Strategy Guidelines on Working with People in Crisis and Conducting a Risk Assessment
- Project Air Care Plan
- Project Air Support and Safety Plan for School

Care and Safety Plans

This section refers to three different care and safety plans that are included as examples in Section 7.1:

- Black Dog Safety Plan
- Project Air Care Plan
- Project Air Support and Safety Plan for School

These sample plans are designed to be developed collaboratively with the young person and key supports in the young person's life. They each have a different focus as outlined below:

Black Dog Safety Plan

The Safety Plan is a collaborative working document negotiated with the young person, the primary clinician and key supports when suicide risk is high. It may take several sessions to fully develop, and requires ongoing review and modification. For further information about individualised safety planning see Youth in Distress: Managing suicidality and self-harm [43].

Project Air Care Plan

The purpose of developing a Care Plan is to provide an individualised plan to assist the young person to reduce their level of risk and frequency of crisis. Unlike a Safety Plan it is not designed specifically to address risk of suicide. The Care Plan is developed jointly by the clinician and the young person, and formally identifies short and long-term goals, triggering situations, helpful strategies and skills to use in times of crisis, strategies and skills that have not been helpful, places to call in the event of an emergency and the people involved in their care.

Project Air Support and Safety Plan for School

The Support and Safety Plan for School is designed for the school context to support the young person where the young person is returning to school following a mental health event that involved a period of absence e.g. hospitalisation. This plan can be completed by the young person, their parent/carer and a school executive member. It should be simple, young person-centred, made in consultation with relevant staff members, and reviewed over time.

Risk Assessment and Safety Planning

When a young person presents in distress it is important to engage with the young person and obtain a thorough understanding of the causes for their distress and their capacity to cope. **It is important to enquire about the three key domains they function in: school, home and peer relationships.**

When a young person's presentation suggests that suicide risk is high, specific questioning around suicidal ideation and behaviour is crucial to assessing safety.

There are a number of risk assessment frameworks which are recommended (APS, Orygen) when working with young people who may be engaging in self-harm and or suicidal behaviour. A link to one of these frameworks is included in section 7.2:

- Framework for Suicide Risk Assessment and Management for NSW Health Staff

Distinguishing between acute and chronic risk

Acute risk refers to the very real risk of a person dying by suicide. Characteristics of acute risk may include:

- The person has a clear plan for suicide
- The means by which the person intends to die is potentially lethal
- The person has access to the means, or can readily gain access to the means, to enact the plan
- There is nothing to suggest hope of rescue
- The person expresses feelings of hopelessness regarding the future
- Delusions may be present, causing the person to believe they must die
- Comorbid depression and/or substance misuse is present

Chronic risk behaviour tends to be less harmful and the person does not wish to die. These behaviours are usually recurring responses to interpersonal stress, particularly to a sense of rejection and abandonment, and act as a means of communicating emotional distress. However, accidental death remains a risk. Ambivalence about dying may also form part of the pattern, for example, the person may have a suicide plan which they do not intend to immediately act upon but serves to mentally give them a way out and thereby allow them to continue to live.

Responding to a crisis situation

During a crisis situation young people are generally at their worst – symptoms are at their most extreme and risk-taking, self-harm or suicidality may be evident. It is important to find a balance between attending to the incident and its ramifications and understanding the nature of the person's behaviour. Remember this might be an emergency where the best response is to ring an ambulance or the police to attend to the young person's immediate risk and get emergency care. However, if the young person is not at acute risk, calling an ambulance or asking a carer to take a young person to the emergency department may be an overreaction that causes significant distress to the young person.

Responding to acute risk

If the person is deemed to be at acute risk, the following steps are recommended:

- Contact emergency services (e.g., ambulance) and remain with the young person until they have arrived and care is being provided
- Identify the person's psychosocial support system and contact their parent/carer, and if appropriate, their mental health professional and discuss the treatment plan and crisis intervention
- In the school context, alert senior staff including the principal and the senior psychologist

Responding to chronic risk

If the risk is assessed as chronic, the following steps are recommended;

- Where available, consideration should be given to linking the young person to external support in the community dependent on the level of acuity e.g. the GP, community mental health.
- Where possible, ensure continuity of care – it is preferable for the person to consult with the same clinician each time
- Establish a risk profile over time. All information regarding the person's risk should be forwarded to the primary treating clinician or team
- The person should be encouraged to clearly communicate their needs verbally.

Safety Planning

Negotiating a safety plan with a young person who is experiencing suicidal thoughts or feelings to reduce their level of suicide risk is recommended. A safety plan is an individualised, collaborative, working document. Black Dog Institute advises that a Safety Plan works best when [43]:

- The young person is willing to develop the plan
- The young person is willing to involve others
- Based on a strong therapeutic relationship
- Evolving, clinically useful document
- Facilitates communication between support people

There are a number of different safety plans which are recommended by Black Dog Institute and Beyond Blue:

- Black Dog Safety Plan (included in section 7.1)
- SANE Staying Alive (see section 7.2)
- BeyondNow suicide safety plan app (see section 7.2)

While these tools for assessing and managing risk are available, they should not be used in isolation. It is important to remember that suicide risk assessment is one part of an overall assessment of the young person in distress. It is important that clinicians working with young people with complex mental health issues work collaboratively with the young person and others involved in their care to develop a coordinated approach. It is also important that clinicians access training to develop the skills and confidence to assess and manage risk. Also see Project Air Strategy Guidelines on Working with People in Crisis and Conducting a Risk Assessment in the Treatment Guidelines for Working with People with Personality Disorders available to download from www.projectairstrategy.org.

Care Planning

As described above, the purpose of developing a Care Plan is to provide an individualised plan to assist the young person to reduce their level of risk and frequency of crisis.

A collaborative Care Plan helps to:

- Manage and reduce the young person's level of risk
- Increase the young person's level of safety
- Provide a structured goal-oriented plan that helps to contain anxiety of the young person and those involved in their care and education
- Seek agreement on how to most effectively reduce distress for this particular young person
- Clarify what has been done in the past that has not helped to reduce the young person's level of distress or has made it worse
- Engage the young person in their own treatment process and encourage self-responsibility
- Support the young person and school staff to navigate their way through a crisis
- Support decision making
- Improve communication between professionals supporting the young person and clearly articulate roles

Introduce the Care Plan with the young person as follows:

“The purpose of the Care Plan is for us to work together to set goals, explore strategies for when you are feeling distressed, and to think about some key people in your life that you feel comfortable going to for support. This may help you feel more supported in your life and help you stay on track with your work or study. This is not a legal document, but will help us work together to ensure that we have planned for your wellbeing."

The first section of the Care Plan involves discussing goals with the young person. This can be a helpful way for you to both stay on track. These goals can be short or long term, and socially, psychologically or academically orientated. For example: “I want to pass my next assignment” or “I want to see the counsellor each fortnight” or "I want to get on better with my sister" or "I want to understand my cultural roots".

The second section of the Care Plan allows young people to think about their coping strategies. The two of you will work together to explore the young person’s triggers, strategies they can use when these triggers occur, and strategies they have used in the past that didn’t work or made the situation worse.

The final section of the Care Plan is a space for young people to record important details about their support people. For example, the person’s name, contact details, role and whether they are suitable to contact in a time of crisis.

Once the Care Plan is completed, provide the original document to the young person, make a copy for your own records, and, where consent has been provided, make copies for distribution to other relevant individuals or organisations (e.g. other health professionals involved in the young person’s care, parent or caregiver).

Completing the Care Plan will support the young person’s ongoing wellbeing. It is important to review this plan over time in order to effectively monitor the young person’s progress.

A sample Care Plan for case example Britney is included below. A template is included in section 7.1.

My Care Plan

Name: Britney **Clinician Name*:** Jane

My main therapeutic goals and problems I am working on

(1) In the short term finish my English assessment task by next Friday

(2) In the long term go to uni

My crisis survival strategies

Warning signs that trigger me to feel unsafe, distressed or in crisis wanting to isolate myself, getting stressed and agitated, wanting to cut, thinking about all the people in my life who have left me

Things I can do when I feel unsafe, distressed or in crisis that won't harm me talk to one of the workers at the refuge, take a hot shower, draw in my art book

Things I have tried before that did not work or made the situation worse numb the pain by getting really drunk

Places and people I can contact in a crisis:

Lifeline: 13 11 14 **Emergency: 000** **Kids Helpline: 1800 551 800** **Mental Health Line: 1800 011 511**

Local Service:

My support people (e.g. *partner, family members, friends, psychologist, psychiatrist, teacher, school counsellor, social worker, case worker, GP*)

Name	Contact Details	Role in My Care	OK to Contact?
Julie	0426 562 381	refuge worker	yes
Miss Delaney		year advisor	yes
Mrs Hoang		deputy	yes
Jane		school psychologist	yes
David	4328 5087	CAMHS psychologist	yes

Signature: Britney **Clinician's Signature: Jane**

Date: 23 March **Date of next review: 6 April**

Copies must go to the people that can help to keep me safe. These people are (please specify): Jane (school psychologist), Miss Delaney (year advisor), Mrs Hoang (deputy principal), David (CAMHS clinician), Julie (Refuge)

*Write and/or review in partnership with young person and a health care professional, for example School Counsellor/School Psychologist, CAMHS clinician or GP.

Care Plan available to download from www.projectairstrategy.org

"Make it your own": Helping the young person to personalise their care plan

Encourage the young person to get creative and make a care plan that is personally relevant to them. This could be achieved in lots of different ways – here are some suggested ideas that will help you to encourage the young person to "make it their own":

- Draw or decorate with meaningful pictures or images
- Use colours
- Include favourite quotes
- Include messages or images related to goals.

The young person can be encouraged to update their care plan over time. This can be a collaborative and ongoing process. It can help the young person to feel a sense of agency and engagement in working towards their goals and creating a meaningful life.

Support and Safety Plan for School

The Support and Safety Plan for School is designed for the school context to support a young person who may be returning to school after a period of absence due to a mental health event e.g. hospitalisation. This plan can be completed by the young person, their parent/carer and a school executive member. The plan includes:

- The student's name and staff consulted
- The student's actions, plans and goals
- A list of people that the student can talk to at school
- An agreed time for regular contact to address any issues with the plan
- A plan for a flexible timetable e.g. reasonable adjustments

The Support and Safety Plan for School is included in section 7.1.

3.5 Psychotherapy

This section outlines different clinical skills, techniques or activities that can be applied in the provision of psychological treatment to young people experiencing complex mental health issues. All clinicians have their preferred psychotherapy methods, interventions and techniques; this section may provide new ideas that can be incorporated into practice.

Objectives:

1. Further develop understanding of clinical skills, techniques and activities that can be used to help the young person strengthen their relationship to self and relationships with others
2. Appreciate the balance between supportive versus expressive techniques
3. Further focus on developing a "curious stance" to promote the young person's sense of agency and stimulate the young person's ability to mentalise – develop self-understanding and self-control [44]
4. Enhance understanding of the importance of "setting the frame" before starting psychotherapy, including practical arrangements of the therapy contract as well as the importance of setting goals
5. Further understand factors that influence the clinician and young person's relationship including attachment style and rupture and repair in the therapeutic relationship
6. Enhance understanding of the importance of preparing to finish psychotherapy
7. Factors to consider in extending the intervention

Resources:

See the Project Air Treatment Tools Fact Sheets (available online at www.projectairstrategy.org) for a range of structured mindfulness activities including:

- Project Air Five Things Fact Sheet
- Project Air Fact Sheet: Dropping Anchor
- Project Air Fact Sheet Making and using a Sensory Box

Overview

This section is structured to reflect key principles underlying the guide. This includes **the relational model** of care [7], the balance between **supportive techniques (such as bolstering self-esteem)** and **expressive techniques (such as helping the person change behaviours or thoughts)**, and **"the curious stance".**

The process of assessment and formulation informs the focus of the intervention delivered to the young person. Using the information gathered during these initial stages will assist the clinician in drawing from the range of therapeutic techniques. This allows for a tailored approach that is driven by the needs and goals of the young person. Specific information about factors to consider in commencing and finishing a psychotherapy contract is provided under the following headings:

- Setting the frame
- Preparing to finish psychotherapy

The relational model

The relational model of care is the primary theoretical basis of this intervention and provides a way of thinking that clinicians can apply within this brief intervention, and also for longer-term work where indicated. Importantly, adopting this framework allows for flexible application of the intervention, which is crucial in therapeutic work with young people experiencing complex mental health problems. In this section, we provide a range of clinical skills, techniques and activities that can be used to help the young person strengthen their relationship to self and relationships with others. These are presented under the headings:

- Interventions to strengthen the young person's relationship to self
- The clinician and young person's relationship

- The young person's relationship with family and peers
- The young person's relationship with school and community

Supportive versus expressive techniques

During the intervention process, it is helpful for the clinician to hold in mind the balance between supportive vs. expressive techniques. **Supportive techniques are "acceptance" based and include validation, empathy, and reflection to bolster the young person's current functioning. Alternatively, expressive techniques are those that are "change" based to help them think and do things differently that support healthier goals and relationships.** Supportive techniques strengthen the young person in their current situation. In this regard, supportive techniques are about the clinician demonstrating a sense of understanding, validation and compassion. It is these techniques that generally build a strong sense of rapport between clinician and the young person. Expressive techniques are about promoting the young person to make positive, but often difficult, changes in their life. In this sense, these techniques can be experienced as challenging as they encourage the young person to think differently, make different choices, and engage in different behaviours.

Supportive vs. expressive techniques

What do supportive and expressive techniques actually look like? Here are some examples:

Supportive techniques:

- Convey your support for the young person's wish to achieve their goals, a hopeful (but realistic) attitude towards the young person achieving them, and recognition when the young person has taken steps towards achieving those goals
- Show understanding and acceptance of the young person
- Find things to like about the young person
- Show respect for the young person
- Use the word "we" to encourage a strong bond in working therapeutically with the young person
- Refer to previous topics and experiences shared with the young person to show that you hold them in mind

Expressive techniques:

- Be curious – ask the young person to talk about what they're thinking and feeling
- Encourage new behaviours and thoughts that are more positive and helpful for the person
- Gently challenge the young person to explain situations where their words and/or behaviours might not match up – but do this with a sense of curiosity and wonder rather than "trying to catch them out"
- Talk about the young person's relationships and explore what they think another person is thinking and feeling, and why they are acting in a certain way
- Talk about the relationship between you and the young person and how they are perceiving you (n.b., this is a highly expressive technique and, as with all expressive techniques, needs to be applied with consideration of timing and striking the right supportive vs. expressive balance – more on this below)

All types of psychotherapy, regardless of modality, tend to be a mixture of supportive and expressive techniques. The relational model allows you to choose any technique from any modality of therapy as long as you understand its relationship to the goals of treatment and how it supports positive change. As a clinician, it is helpful to consider how to achieve an optimal balance of supportive and expressive techniques. If we were to use expressive techniques at the outset of treatment, without using enough supportive techniques to establish rapport with the young person, this may lead to a rupture the therapeutic relationship. A useful analogy to think of is ensuring you have "money in the bank". In other words, it is important to utilise supportive techniques to build a relationship with the young person ("saving money") before using expressive techniques to challenge them to make changes in their life ("spending money"). This is particularly true for young people experiencing complex issues, as the notion of feeling supported and perceiving the clinician as a reliable and trustworthy person is vital during the therapy process - "saving money" builds trust and acceptance between the client and therapist.

Another consideration with regard to balancing supportive vs. expressive techniques concerns the wider context of the young person's life at the time of therapy. When young people are experiencing crises or other forms of instability in their lives, it can be most helpful to focus on supportive techniques that allow them to maintain equilibrium. This is because making significant changes is challenging and they may not be in a stable enough place to face change. Therefore considering the timing of these interventions in the context of the young person's life is important.

The curious stance

One of the most helpful expressive techniques in psychotherapy is in adopting something known as "the curious stance". This concept aligns somewhat with therapeutic neutrality or the 'not-knowing' technique. **It puts the young person as the "expert" of their thoughts and experience, and the clinician as the "wondering student".** The focus in sessions is thus on discovery through conversation and other activities in therapy - to help build a stronger and healthier and more coherent narrative of the young person's life story, their personality and preferences, and thus give them confidence and strength to think and do healthier things in the present and future.

By adopting the curious stance, the clinician promotes the young person's sense of agency - their capacity to be able to understand themselves and thus influence and direct the course of their life and decision making with greater confidence and skill. **It is important to remember that the 'curious stance' is an expressive technique aimed at helping the young person change.** As such, the young person can find this difficult because it is encouraging them to think and act in new ways that can challenging. For example, young people might never have had to explain themselves or their behaviours to anyone in the past, thus can respond "I don't know" to simple questions.

This difficulty in articulating personal history and narrating the internal world of thoughts and feelings has been studied extensively in science, and is known as 'alexithymia' [45]. These problems can be particularly evident in describing early childhood memories of early relationships, such as in using the Adult Attachment Interview [46]. The goal is to stimulate the young person to be able to mentalise, and thus better understand themselves and understand the minds of others [17]. **We want the young person to become an expert at understanding themselves, and skilled at understanding the thoughts, intentions and behaviours of others. This is also known as *interpersonal mastery* [44].**

In essence, adopting the curious stance is about the clinician being curious about what is going on in the mind of the young person. This means asking lots of questions to understand the thoughts and emotions that influence the young person's actions. Through asking questions to understand the mind of the young person, the clinician helps to stimulate the young person to feel greater curiosity about their own mind. It is in this way that young people may begin to better understand themselves and their actions. It is about adopting a "not-knowing" stance and actively asking the young person to articulate their thoughts, feelings, and motives for behaviours. Through this process, it becomes possible for the young person to better understand themselves and, as a result, have more satisfying relationships with others.

Asking questions to stimulate curiosity

Here are some example questions to stimulate curiosity in the young person about their own mind. But keep in mind that there are no correct or incorrect questions to ask – what is most important is the attitude as a clinician that you adopt. It's about being completely curious about what is going on for the young person and why they act the way they do – there are many ways apart from the below examples to ask about this:

- "What did you notice happening for you when X happened?"
- "What were you thinking when X happened?"
- "What were you feeling when X happened?"
- "Has there been another time in your life when you felt or thought similar to this?"
- "What do you think was different this time compared to last time?"
- "What was happening for you before you did X?"

Similarly, there are many ways to stimulate curiosity in the young person about the minds of others, for example:

- "Why do you think X did Y?"
- "What do you think X was thinking/feeling when they did Y?"
- "Why do you think X said that?"

It is important to ask questions that help the young person understand more about their own minds but also the minds of others. This helps them to better understand their own actions but also the actions of others. **When asking young people to reflect in this way, they may respond by saying "I don't know" or show other forms of reluctance to engage in this kind of discussion. Engaging in this kind of thinking can be difficult. It is vital, however, to sensitively persist in asking questions to increase the young person's understanding of self and other. When the resistance from the young person becomes too high, it is time to revert back to using supportive techniques.** A typical therapy session can begin and end with supportive techniques, but the middle "working" part of the session can involve a variety of activities that stimulate the young person to express and understand themselves and others, and using a curious stance can be an effective and efficient way to help the young person do that difficult work.

Setting the frame

Before commencing psychotherapy, it is important that both clinician and young person have a clear sense of the "frame" of therapy. In part, this refers to the development of a shared understanding regarding the practical arrangements of the therapy "contract". It is recommended that clinician and young person have a clear discussion regarding:

- The length of the therapy contract (e.g., 3 sessions, 6 sessions, 6 months, 1 year)
- Setting a regular day and time to meet (where possible)
- Where therapy will take place (recommended to use the same room if possible)
- How often therapy sessions will occur (e.g., weekly, fortnightly)
- How long therapy sessions will run for (e.g., 50 minutes)
- The young person's goals
- What will happen if the clinician or the young person has to cancel a session (e.g., "If I have to cancel I will let you know in this way and we will reschedule")

The important principle here is that both the young person and clinician have a clear understanding of what therapy will involve. This serves to create a sense of safety and consistency, and helps to create a relationship of trust between clinician and young person.

The importance of goals

In addition to negotiating the practical arrangements of therapy, another key aspect of setting the frame of longer-term psychotherapy concerns collaboratively setting and working towards the young person's goals. The SMART framework is ideal for this purpose. A reminder about the SMART framework is to set goals that are:

***S**pecific*

***M**easurable*

***A**ttainable / Achievable*

***R**elevant*

***T**imely*

However, it can often be the case that young people with complex mental health concerns may find it hard to set clear goals. When this is the case, it can be helpful to consider that anything the young person identifies that they want more or less of in their lives, however general (e.g., "to worry less"), can be adopted as a treatment goal.

The important thing to consider as a clinician is that goals provide the roadmap during therapy that helps to illuminate the focus of therapy. Setting goals has the additional benefit of thus serving to mark when progress has been made toward achieving goals. Goal attainment provides clues that treatment is working. **Working with the young person to set goals also helps to encourage a sense of agency and motivation for them to engage in therapy.**

Setting the frame for a brief intervention

Sometimes a young person may only attend one session with a clinician. This may be for a variety of reasons, for example, the young person feels their needs have been met and they do not want further intervention. Or the young person may decide that therapy is not for them at this point in time. Or the clinician is not able to provide further sessions and may refer the young person to another service for therapy. Whatever the case, even in a single session intervention, it is still important to attend to setting the frame, and addressing issues such as termination.

It is important that both the young person and the clinician have a clear understanding of what therapy will involve. This will help to create a sense of safety, and to develop a relationship of trust, which underpins the therapy relationship. In addition, establishing the limits to what you can provide can help to address expectations and prepare the young person for a positive ending to the session. This is more likely to increase the chances of the young person returning for further therapy, even at a later date, as well as strengthening the young person's self-efficacy.

What might a single session look like?

1. Set the frame – discuss confidentiality and its limits, length of session, flag termination/options for extending the intervention, goals. Explain to the young person:
   We have the next 50 minutes together to jointly work on identifying some ways to manage the difficulties you have been experiencing and to set some goals. At the end of the session today we can talk about options for further support depending on what you want. How does that sound to you?
2. Briefly discuss key relationship domains – home, school and peer relationships – with genogram. Identify support network.
3. If person is in distress or crisis, ask if they are having thoughts around self-harm or suicide - if yes, focus on risk assessment and building engagement.
4. If no, or if low risk, then identify goal/s - e.g. *What are you hoping will be different as a result of coming to see me today? What would you like to achieve by coming to this appointment today?*
5. Discuss what sorts of things the person has tried to reduce their distress/cope: *What have you tried?*
6. Discuss *What works/ What doesn't work?*
7. Brief work around identifying values/strengths.
8. Feedback about what appears to be going well – focus on strengths – as well as areas jointly identified that may need further work. Encourage young person to try something new following the session – this could be as simple as looking at an app, going for a walk, trialling mindfulness, looking at a resource that has been recommended.
9. Brief discussion to ascertain willingness for further sessions with clinician: e.g. *Given what you've told me today, I think there are some more things we can talk about to help make things a bit easier for you at home/school. Do you think you would be interested in returning for another appointment?*
   Where the young person expresses interest in continuing, set the frame for further sessions and ask them to consider their values and goals before next session:
   "I'm really glad that you found today helpful. Over the next week I'd like you to have a think about what kinds of things you'd like to achieve for yourself in the future and your goals in life. That way we can make sure you're doing things each day which will help lead you in the direction you want to go".
10. Termination - where the client is not continuing, encourage them to think about their future goals and values and to act in ways that are consistent with these. Provide the young person with some self-help information e.g., help line cards, online resources. You might say something like: *"I think it's really great that you came here today and decided to talk about your problems. And even though you're not coming back (for now), it can still be helpful to have a think about what kinds of things you'd like to achieve for yourself in the future, and keep that in mind as you go about your life."*

Some further things to consider.

- The above steps broadly follow the outline provided in a Care Plan. It may be useful to use the Care Plan to guide your discussion, and to provide the young person with the plan to take away with them, either as a paper copy or as a screenshot on their phone.
- If the young person is distressed during the session, focusing on a grounding techniques such as helping the young person connect to the physical world through their senses and mindfulness exercises can be helpful. See the fact sheets in Section 7.1.

Interventions to strengthen the young person's relationship to self

It is often the case that young people experiencing complex mental health problems face significant challenges in knowing who they are as a person and where they want to go in life. These problems are further exacerbated by the developmental stage of adolescence, in which a key task is consolidating independence and direction in life, as well as a sense of belonging. For these reasons, **a key task of psychotherapy with the young person concerns helping them to articulate their internal world; who they are as a person, and what is important to them.**

There are a range of structured activities, resources and tools to assist the clinician during this process. A number of examples are presented below. More generally speaking, however, it can be helpful for clinicians to adopt a therapeutic stance that emphasises the following:

Conversations that help the young person identify what is important for them

During discussions or sessions with the young person, focus on helping them to feel a sense of agency in their life and discuss their preferences, strengths, likes and dislikes, choices, and what they have learnt about themselves from previous experiences, for example. What is helpful is for the clinician to adopt a "curious" stance; that is, asking questions to learn more about the young person not only helps with the clinician's understanding of who the young person is, but also helps the young person to become curious and begin to engage in the process of discovering more about who they are and what they want in life.

Activities that can strengthen the young person's sense of self

While the curious stance and asking questions to help the young person discover more about who they are can be helpful, another way to support this process involves helping the young person to engage in activities, both in and outside of therapy that can strengthen their sense of self. For example, utilising activities from art or play therapy modalities may be helpful in the session (more on this below). Story-telling and narrative approaches can help the person understand who they are and where they have come from. Helping the young person to engage in extracurricular activities can be helpful to strengthen sense of self and boost self-esteem. For example, young people may be encouraged to pursue activities in sport, art, music, dancing, academics, public and community service, buddying, guiding others and leadership, working, or volunteering.

Helping the young person feel a sense of belonging

During the stage of adolescence, it is also important for young people to feel a sense of belonging within peer groups and the wider community. It can be helpful for clinicians to encourage these connections. This could be achieved through discussions of cultural history, family history, and promoting engagement with groups (e.g., school, teams, church, or clubs).

Skills to get through distressing situations

Another area of intervention to consider in helping the young person connect with themselves is teaching and practising skills to help them stay safe during distressing situations or crises. Dialectical Behaviour Therapy includes a range of skills that are of relevance; in particular mindfulness and distress tolerance skills (e.g., engaging in alternative behaviours, generating alternative thoughts and emotions). The purpose of these skills is to help the young person feel more in control of their emotions and reactions during times of distress [47]. For examples of specific skills used, refer to the DBT Regulator workbook [47]. This resource is available for download at https://www.projectairstrategy.org/guidelines/index.html. There is an accompanying DBT group

therapy manual for facilitators to provide extra guidance in delivering these interventions (available at https://www.projectairstrategy.org/guidelines/index.html).

Grounding techniques

When a young person is finding it hard to concentrate, dissociating or detaching themselves from others, grounding exercises can be a useful skill to connect to the present moment. Grounding is also important for a young person prior to concluding a session.

Mindfulness exercises can be a good strategy for connecting to the here-and-now. See the Project Air Treatment Tools Fact Sheets (available online at www.projectairstrategy.org) for a range of structured mindfulness activities.

Another strategy is to help the young person to connect to the physical world through their senses. Asking the young person to tell you what they can see in the room, the colour and shapes, focusing their attention on sounds outside the room and then inside the room, noticing their feet on the ground, their back against the chair, identifying something they can smell or taste (refer to the Project Air Five Things fact sheet).

Metaphors can be useful to combine with these techniques, and provide an externalising frame so that the person is separated from the problem. For example, using the metaphor of being "caught up in an emotional storm" and needing to "drop anchor" to ground oneself can be a helpful way of describing the process of connecting to the present moment and calming oneself. This can be a particularly helpful technique when a young person is highly distressed or agitated (refer to the Fact sheet Dropping Anchor).

Sensory box

Encourage the young person to create and use a sensory box (Fact Sheet Making and using a sensory box are included in Additional Resources Section). Preparing a box in advance will be helpful for moments where the young person experiences heightened emotions or difficult thoughts. Including items that stimulates the five senses can help to soothe, distract, and help the young person stay in the present moment. Examples of items they may wish to place in the sensory box include:

- Sight: Photos of friends, family or pets, pictures of places you have visited or would like to visit, affirmation cards, crystals or rocks with interesting colours, coloured papers and textas, paints with water
- Sound: Music player and headphones, flute, a bell, ukulele, rattle or drum
- Smell: Perfume, essential oils, candles, herbs such as lavender or rosemary, smelly textas, popping corn
- Taste: Herbal teas, favourite sweets or snacks, peppermints, lozenges, citrus, jellies or liquorice
- Touch: Soft toys, scarf, stress ball, slime, kinetic sand, playdough, drift wood, shells or skipping stones from a beach or creek

Explain to the young person:

> *Sometimes when we are feeling distress, heightened emotions or having difficult thoughts, it can be helpful to bring our awareness to our five senses. One way we can do this is by preparing a sensory box, full of things that you enjoy, that will help you get through a difficult moment. How does that sound?*
>
> *[Discuss any concerns the young person has and answer any questions.]*
>
> *[Help the young person develop a list of things they can put in their sensory box. Provide examples that are listed here. It is important to make sure that the items included are things that the young person enjoys, and will not cause them further harm.]*

When explaining how to use the sensory box:

> *Some people find self-soothing hard and may avoid being nice to themselves. Give yourself permission to do something nice for yourself – everyone needs this. If you engage in self-soothing and notice harsh, judgmental thoughts or difficult emotions arise, gently notice and acknowledge them, and then return to trying to stay mindfully connected to the experience of being immersed in the box and the activities that appeal to you.*
>
> *When engaging with the sensory box, enjoy the experience and become absorbed in doing something you enjoy. Mindfully engage with each of the items in your sensory box, and describe what you see, hear, smell, taste or feel. Remember that it is normal for your attention to wander, and when you notice*

this happening gently turn your attention back to what you are doing. You may also notice yourself making judgements. This is a common and almost automatic response. If this occurs just notice that a judgement has been made and bring your attention back to what you are doing.

Best future self exercise

This exercise helps the young person be in to touch with their values and what is important to them. Values act as a compass point, guiding us in the direction we would like to move towards.

Ask the young person: "what would your best future self look like?" Encourage the young person to imagine what this is like, perhaps have them write it down or encourage them to draw something that represents this for them. For example, what would they be doing, how would they be feeling.

Note: Adolescence is defined as a time where young people are discovering who they are and who they would like to be. Complex mental health issues such as personality disorder exacerbate this experience, meaning this activity may be particularly difficult for them to think ahead to the future or consider who they are as a person. Similarly, if the young person is experiencing self-harm and suicidal behaviours, it may be best to focus on the here-and-now, rather than future-based activities such as this one, as doing so may be distressing.

Strength and values cards

Therapy cards are an example of an activity that can be used with young people to identify strengths and/or values, to boost self-esteem, and to strengthen sense of self. There are many ways to use these cards. The following provides one example.

Ask the young person to spread the cards out on a flat surface – floor or table works well. Ask the young person to select strengths that come easily to them. Potential questions include:

- Who sees these strengths in you?
- Are there any strengths here that others don't see?
- Have you always had these strengths or have they developed over time?
- Tell me about a time when you have used these strengths to cope with a challenge you were facing.
- Can you think of how you could use these strengths to cope with a current challenge?

Ask the young person to select cards that show values they would like to develop. Possible questions include:

- Do you know anyone who has these values?
- How do they use them?
- Could they be a role model for you in developing these values?

Select cards that show strengths that you find challenging. Example questions include:

- Can you explain what is difficult about this for you?
- Can you think of a time when you used this strength, even a little bit?
- Is there anyone in your circle of family and friends who could help you to develop these strengths?

At the end of the activity the young person can take a photo of their top strengths or list them on a card to keep in their wallet, as a reminder.

Art and play therapy ideas

Using art and play to engage young people may be particularly beneficial in cases when young people find it difficult to engage in therapy or experience problems expressing themselves verbally, which can be related to complex mental health issues, particularly when early relational trauma has occurred [48, 49]. **Art and other creative therapies can help young people express complex feelings and thoughts that may be currently too difficult to put into words.**

Tree of Life

Tree of Life is an example of a strength-based approach that can help the young person to identify with a sense of place - cultural history, family history, sense of belonging. Originally developed as an approach for working with children in southern Africa impacted by HIV/AIDS, Tree of Life has been used in Australia as both an art and a drama technique for working with refugee young people and other vulnerable groups to "find hidden stories of strength and skills" [50].

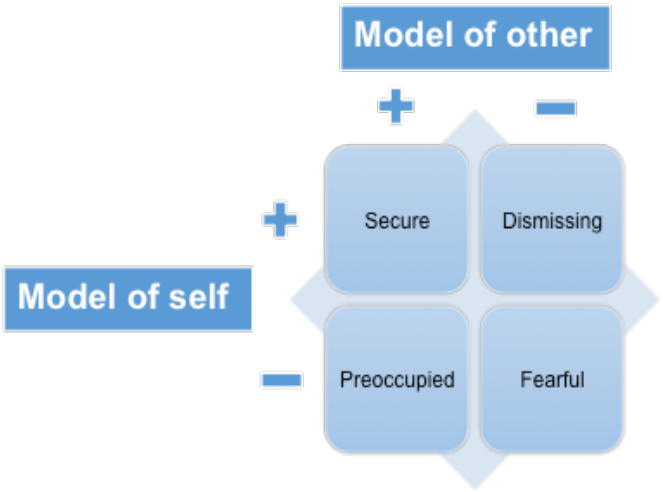
The approach involves the young person drawing their own 'tree of life' and speaking about their 'roots' (where they come from), their skills and knowledge, their hopes and dreams, the special people in their lives, the 'storms' that affect their lives, as well as ways of responding to these storms. For further information about the Tree of Life and how to deliver this approach individually and in groups see: https://dulwichcentre.com.au/the-tree-of-life/

The clinician and young person's relationship

The young person's relationship with their clinician is extremely important as it provides opportunity to foster a relationship of trust and reliability through which important therapeutic work is achieved, and also the chance to see how relationship problems in the life of the young person may manifest and be worked through in the therapeutic relationship.

Understanding attachment style

Considering the role of early temperament and attachment style in the life of the young person is another way that can help the clinician understand strengths and difficulties in the young person's relationships, both with the clinician and with others.



The table above provides a summary of the main types of attachment styles [51], with respect to dominant view of self and other. Attachment style can be classified into one of these four primary categories:

Secure	Positive view of self and other; belief that attachment figures are available and responsive to needs.
Preoccupied	Negative view of self/positive view of other; belief that attachment figures are inconsistent in responding to needs; associated with anxiety, hypervigilance, and fluctuating between wanting to increase proximity with attachment figure and pushing away.
Dismissing	Positive view of self/negative view of other; discounting of need for close relationship with attachment figure; associated with attempts to increase distance from attachment figure, avoiding interdependence, and striving for self-reliance.
Fearful	Negative view of self/negative view of other; fear of attachment figures; associated with confusion about whether to approach or avoid attachment figures.

Becoming familiar with the different types of attachment styles above can help the clinician to understand patterns of behaviour exhibited in the young person's relationships with others, including in the relationship with their clinician. This can be particularly helpful if the young person exhibits a style of relating that is challenging for their clinician to work with. Understanding that the young person's relational difficulties may be related to their early experiences and attachment style, which may have had aspects of survival value in the past, can help clinicians to maintain compassion when faced with challenging behaviours and high levels of distress. Research has shown how fearful and preoccupied attachment patterns require longer and more patience to change over time [52].

Rupture and repair

Ruptures in psychotherapy are defined as “an emotional disconnection between client and therapist that creates a negative shift in the quality of the therapeutic alliance” [53, p. 273]. Ruptures can occur at any time, but particularly when the client's negative or insecure attachment system has been activated. Ruptures are also more likely during expressive change based phases of therapy. **It is important for the clinician to repair any ruptures by behaviour such as acknowledging the difficulties the client is experiencing, apologising for any misunderstandings, addressing any conflicts, and finally using more supportive techniques to help regain trust and assist in regulating emotions.**

The young person’s relationship with family and peers

In line with the relational model, it is important for clinicians to also focus on ways to equip the young person to develop and maintain healthy relationships with family and peers. As highlighted previously this can serve to increase sense of belonging and connection. Significantly, family members play an extremely important role in supporting the young person, including supporting the work of psychotherapy.

Helping the young person understand their social world

Activities such as the “circles of closeness” (which follows) can help the young person gain a better understanding of who is (present) or who has been (past) important in their lives.

Understanding temperament/attachment style

Promoting strategies to enhance attachment security in the family environment is also important. In the assessment of family relationships, it can be helpful to use genograms to understand key family relationships in the life of the young person (described in more detail in the assessment section). Furthermore, the CCRT method can also be helpful in gathering more information regarding patterns of communication in the relationships between the young person and his or her family members.

Interpersonal effectiveness skills

There are a range of DBT-informed interpersonal skills that may be helpful when working with young people experiencing complex mental health issues. These may focus on assertiveness, communication styles, or resolving difficulties with peers.

Examples include:

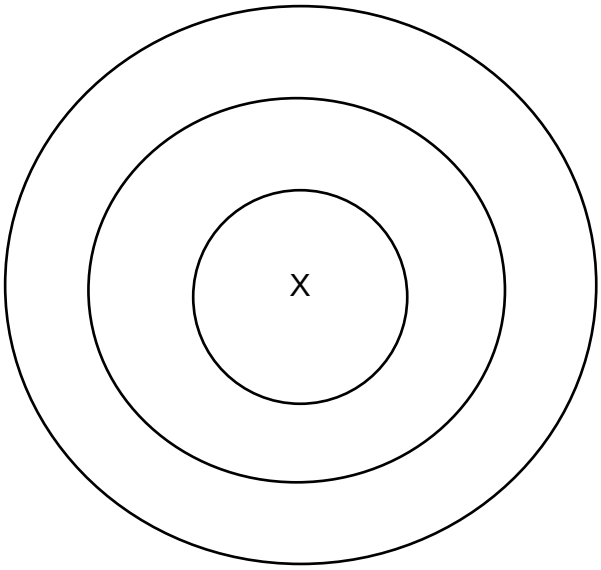
- Moving away from “either-or” thinking, and accepting that there may be different points of view
- Identifying goals for interpersonal effectiveness (e.g. “What specific results do I want from this interaction? How do I want the other person to feel about me after this interaction? How do I want to feel about myself after the interaction is over?”)
- Identifying and addressing factors that might interfere with the young person’s interpersonal effectiveness (e.g., lack of skills, environmental factors)
- Challenging myths about interpersonal effectiveness (e.g. “I can’t stand it when I don’t get my needs met”, and replacing with alternate statements “I can stand it when I don’t get my needs met”)
- Identifying the difference between low intensity and high intensity interpersonal situations, to better understand a situation that can be accepted for what it is or one that needs to be changed through assertively asking for what the person wants/needs

For further interpersonal effectiveness skills and strategies see the DBT Regulator skills workbook which is available to download https://www.projectairstrategy.org/guidelines/index.html

Circles of Closeness

This activity is an engaging way of exploring the young person’s significant relationships (current and past), and to obtain a picture of the young person’s interpersonal functioning. It can also provide the clinician with insights into the young person’s attachment style.

Ask the young person to draw concentric circles on a large sheet of paper, with their name or initials in the centre of the smallest circle:



Explain the following:
The inner circle represents those closest to the young person
The middle circle represents those who are an important part of the young person's world but not closest to them
The third circle represents people in the young person's life

Questions:
'Who are the important people in your life?'
Discuss each relationship, invite the young person to mark on the circle the initials of the person

Further types of questions:
Facts and opinions – e.g. '*what do you value about this relationship?'*
Events – e.g. '*can you tell me about a situation where you felt this person understood you?'*
Feelings – e.g. '*what difference did this make to how you felt?'*

For younger children, this can also be done by having them choose toys to represent themselves and key family members, and placing the toys next to each other in order of who they are closest to.

The young person's relationship with school and community

As described in section 2.3, during psychological treatment with the young person it is important to consider their relationships more broadly, including their wider relationship to the school and community. One important aspect concerns ensuring effective communication between all clinicians and other key groups involved in the young person's care. This is discussed in greater detail in section 5.1. Ensuring a whole-of-school approach in the care of the young person provides an effective foundation to support psychological treatment.

Promoting the young person's involvement in activities at school (both routine and extracurricular) serves to foster a sense of belonging and connection with their school, teachers, and peers. Wherever possible it is recommended that the school endeavour to make reasonable adjustments to help young people with complex mental health issues engage in school activities, in line with the Disability Standards for Education and Disability Discrimination Act.

As discussed above in the "activities that can strengthen the young person's sense of self" and "helping the young person feel a sense of belonging" sections, during psychological treatment it is recommended that

clinicians discuss how the young person may become engaged in community activities and groups. Promoting this kind of engagement serves to increase the young person's self-esteem and chance for connection with peers, as well as provide new opportunities and greater routine and structure in the young person's life.

Preparing to finish psychotherapy

From the very beginning of psychotherapy it is important to plan towards achieving a positive ending (i.e., termination). This is especially important when working with young people who present with complex mental health issues that may include difficulties with secure attachment and trust, as well as fears of abandonment. This is partly why it is important to establish a clear therapeutic frame from the outset of treatment, which includes a termination date. The goal with young people with attachment insecurities and fears is to allow them to experience a "good" ending of a relationship. **The goal is to allow them to experience all the feelings that are brought up, but also to internalise how to both survive the ending but also continue to be able to hold on to the positive parts of the therapy.** This allows the young person to continue to grow even when the sessions have finished. This can take some skill to achieve and the best way to do that is to actively work towards the ending and discuss it often with the young person, being open to hearing their experience and worries. It is advisable to inform the young person frequently regarding the number of therapy sessions remaining, particularly when nearing the end of the therapy contract.

Another way to effectively prepare for the end of therapy is to set aside a number of final sessions to reflect on the process of therapy (e.g., 1-6 sessions). During these sessions, a number of areas can be explored, for example:

- How has the young person made progress in working towards their goals
- How has the life of the young person changed over this time
- What skills has the young person learnt during therapy
- How can the young person continue to support themselves now that therapy is finishing
- What has been positive about attending therapy
- What have been the challenges or difficulties during therapy
- What does the young person want in the future

Asking questions such as these examples helps the young person to reflect on their time in psychotherapy, and consolidate and internalise the important work of therapy. A further reason that effective therapy termination is so important, is that it instils hope for the young person and provides a positive experience of therapy, should the need for further psychotherapy arise in the future.

Extending the intervention

In working with young people with complex mental health issues, in certain circumstances it may be beneficial to consider extending this brief intervention to a longer format (e.g., young people that require ongoing treatment and can best access this through the school setting or local community mental health centre). This intervention is specifically designed to allow flexible delivery. The following information provides some guidelines on factors to consider in extending the intervention.

When planning to extend this psychotherapy intervention, it is important to consider a number of factors. These are largely concerned with the questions of a) "Will the young person benefit from longer-term psychotherapy?" and b) "Does the school or community health and family situation have the capacity/resources to provide this?" **During the planning stages, it is strongly recommended that the decision to extend the intervention be collaboratively made, ensuring clear communication between the agencies involved.**

In extending the psychotherapy intervention provided in the first instance, it is recommended that a new therapy contract is discussed. This helps to ensure that both clinician and young person have a clear sense of the practical arrangements of therapy. As mentioned at the start of the psychotherapy section of the guide, this will involve a shared discussion regarding:

- The length of the therapy contract (e.g., 3 sessions, 6 sessions, 6 months, 1 year)

- Setting a regular day and time to meet (where possible)
- Where therapy will take place (recommended to use the same room if possible)
- How often therapy sessions will occur (e.g., weekly, fortnightly)
- How long therapy sessions will run for (e.g., 50 minutes)
- The young person's goals
- What will happen if the clinician or the young person has to cancel a session (e.g., "If I have to cancel I will let you know in this way and we will reschedule)

This promotes safety and consistency for the young person and also helps to provide a clear focus of psychotherapy. It could be the case that the young person wishes to continue working on similar areas or pursuing similar goals as discussed in the initial intervention. Another possibility, however, is that the young person wishes to set new goals or begin to work on different areas as the psychotherapy intervention continues. In either case, it is helpful to have a clear sense of the direction of the therapy, particularly as it helps the young person to feel a sense of agency and ownership of the therapy.

The section on "preparing to finish psychotherapy" above provides guidance on factors to consider in concluding psychotherapy treatment. Just as these are applied in the brief intervention presented in this guide, it is equally important to include a focus on creating a positive ending to therapy in the case of more extended treatment.

SECTION 4

4.1 Self-harm – social contagion and online considerations

Objectives:

1. Further develop an understanding of self-harm, its prevalence and functions in young people
2. Consolidate understanding of biopsychosocial risk factors for self-harm
3. Enhance understanding of the context of self-harm in schools, and social contagion issues
4. Further develop awareness of clinical assessment and responses to self-harm
5. Enhance understanding of key elements of psychological support for young people who self-harm
6. Further develop insight into relationship between internet use and self-harm in young people

Self-harm is a leading public health issue facing Australian adolescents. Over the last decade normalisation of self-harm behaviours through the media, music, videos, and magazines has occurred [54]. The challenges of responding to this issue are apparent in all areas of the schooling and health systems. Schools can struggle to identify and respond and teachers can be overwhelmed and confronted by the behaviours. In the health system, from general practice doctors to emergency departments in hospitals, all practitioners are seeing an increase of young people presenting with self-harm injuries.

The cost of self-harm treatment in hospital for children aged 16 and under, in Australia over a 10 year period has recently been estimated at $64 million AUD [55]. Utilising linked data the author's study of self-harm hospitalisations sheds light on the presentations of young people less than 17 years of age. A very small proportion (n=124, 0.7%) was aged 6-10 years and predominately male (75.6%), whereas in the 11-16 year age group (n= 18,099, 99.3%) the majority were female (82.0%) [55]. A higher proportion of children hospitalised were from urban areas (71.8% vs. 27.5% rural) and from areas with socio-economic disadvantage [55].

Relevant clinical considerations from [55] study include:

- Half (50.3%) of the children aged 11-16 also had a chronic health condition
- Poisoning was the most common method of self-harm for children aged 11-16 (82.3%)
- Majority of poisonings are with over the counter non-opioid analgesics
- More than half of all self-harm incidents requiring hospitalisation occurred at home; 59.7% of 6-10 year olds and 54.8% of 11-16 year olds
- School was the place of occurrence for 8.1% of children ages 6-10 years and 5.7% of 11-16 year olds
- Children aged 6-10 were more likely to have a moderate or serious injury (52.5% compared with 38% of 11-16 year olds)
- Hospitalisations for self-harm are increasing for males, although females aged 11-16 are hospitalised at 5:1 the rate of males

The increasing number of young women engaging in self-harm has also been documented internationally. Population based research in the United Kingdom has identified that the rates of young women aged between 13 and 16 years engaging in self-harm have increased by 68% in the period 2011-14 [56].

Why do young people engage in self-harm

There are a range of theories about why young people engage in self-harm and it is likely that no one theory will encompass every individual that self-harms. Some self-harm behaviour is one-off and experimental (Edmondson et al., 2016), while other self-harm behaviours continue in negative cycles. Overall, the evidence suggests the function of self-harm is largely affect regulation [57], but it is likely that self-harm serves several functions concurrently [58]. Self-reports from young people offer a range of reasons such as attempting to control, escape from, or avoid difficult and overwhelming feelings and emotional pain, expressing anger, feeling 'something' (e.g., if feeling numb or dissociated), self-punishment, or communicating a need for help [59, 60]. Edmondson, Brennan, & House's (2016) recent systematic review into self-reported reasons found that self-harm may be used to invoke positive experiences (i.e., providing non-sexual gratification; being used to define oneself) [59].

A review of how young people understand the function of their own self-harm suggests four themes: release; to control difficult feelings; to represent unaccepted feelings and to connect with others. These findings suggest that self-harm does function as an affect-regulation mechanism, and that it also takes place in a context of relational experiences [59]. There are also some indications that young people may engage in self-harm to facilitate acceptance into a peer group [9] and also as part of their self-identity construction [59].

There have been a number of studies that suggest self-harm behaviour releases endorphins that provide temporary relief, but the self-harm act can lead to negative feelings of shame and embarrassment, which in turn leads to further self-harm. Young people in psychological distress are more likely than other groups of young people to continue to self-harm (Rasmussen et al., 2016), so identifying and addressing the needs of this group is important. Young people engaging in dysfunctional coping strategies like self-harm may have difficulties in finding a more appropriate or effective behavioural response. Similarly, for some young people, self-harm functions as an appetitive behaviour that is self-reinforcing.

Self-harm is associated with increased risk of suicide [61] and is potentially the strongest predictor of future suicide attempts [62], although a young person may self-harm without suicidal intent or suicide without ever engaging in self-harming behaviours. However, unintentional death may occur as a result of self-harm**.** Furthermore young people often shift between methods and utilise drug and alcohol that place them at increased risk for suicide [63]. Other behaviours may also be understood as being punitive in that they may reflect an underlying low self-concept and high self-critical psychology. These can include behaviours such as undereating or overeating as a form of punishment, choosing unsafe relationships and situations, and so on.

Furthermore, the developmental challenges during adolescence are likely to contribute to self-harm including separation, autonomy and identity formation [59].

Biopsychosocial risk factors

Family

There are a range of family factors that are particularly important risk factors for self-harm, including poor parent-child relationships, hostility and perceived low levels of parental caring and communication [64]. Parental mental health, drug and alcohol misuse as well as childhood maltreatment are further important risk factors [64]. Research suggests that the severity of self-harm may be related to child maltreatment [65, 66]. There is strong evidence that childhood abuse and neglect affects interpersonal functioning and mental health symptoms. Self-harm "may function to distract from severe trauma-related emotional distress or to reduce post traumatic numbing and dissociation" [62, p. 6]. For children who live in out of home care the combination of family factors as well as the challenges of living in care, results in increased risk factors for self-harm [64].

Stressful life events

Key stressful life events are also triggers for self-harm behaviours as well as suicidal ideation. These events include conflict, loss, rejection, breakup of relationships, disciplinary issues and legal issues [64]. The stressors that result in a child engaging is self-harm differ depending on their age. Younger children tend to cite family stressors, whereas older adolescents focus on peer related stress [64].

Mental health issues

For some young people who self-harm, the behaviour is associated with current mental health issues. Kids Helpline data revealed the most common risk factors for young people wanting assistance for self-harm were emotional distress, followed by diagnosed mental and physical health concerns [67]. Young people with emerging borderline personality disorder features are particularly more likely to engage in self-harm behaviours [61], as are young people with anxiety and depression [68].

School

There are a number of school factors that may act as risk factors for self-harm behaviours for children and young people. Social stressors in the school context, for example being a victim of bullying or intense conflict with peers, increases risk of self-harm [69-71]. Academic pressures, particularly related to performance, have also been identified as increasing the risk of self-harm [71].

Role of the school

Self-harm can sometimes be invisible within the school setting, with only the most severe acts detected [9]. However, there is a strong recognition of the role schools play in preventing and responding to student self-harm. Prevention strategies through whole of school well-being frameworks aim to build the coping skills and resilience of children and young people to cope with stressful life events. Increasing the capacity of students from the start of their schooling is essential to develop capacity to respond to demands in an adaptive, rather than maladaptive way. Encouragement of help-seeking can be supported by having time available that staff can allocate to individual students to detect or receive disclosures [71]. A supportive person in the school could also link the student to treatment responses in the school setting. Other protective factors that have been identified include promoting a sense of belonging and connectedness to school [72]. Having access to a proactive support person at school and assertive responses to bullying were important in reducing student distress and possible self-harm [73].

Social contagion issues

There are suggestions that hearing about self-harm from others, both friends and non-friends as well as through media and the internet may predispose young people to believe that self-harm can be an effective way to respond to distress. There is less evidence for the contagion effect of self-harm when compared with strong evidence base for the contagion of suicidal behaviours, but it is emerging as an explanation in understanding the increasing prevalence rates. Social learning is theorised as a potential model for contagion of self-harm, when young people learn behaviours from their peers perceived to be influential [54].The extent to which these influences continue to affect health and behaviour when under stress is debated, but social ties are likely to influence maladaptive coping strategies like self-harm [54]. For young people with low internal resources to respond to their own or others distress, difficulties with problem solving and communication, or lacking a support system may be more likely to be influenced by peers engaging in self-harm [54].

Clinical assessment and responses

We do know that psychological and psychosocial interventions are effective in reducing repetitive self-harm along with assertive outreach [64]. There is a demonstrated evidence base for dialectical behaviour therapy (DBT), cognitive-behavioural therapy (CBT), and mentalization-based therapy (MBT) in reducing self-harm behaviours [74, 75]. Furthermore, brief interventions can also be effective [64] and could be feasible within the school environment. Often there is a perception that self-harm should be referred to outside psychiatric services, but there are several issues including high thresholds, long waiting lists and difficulties in accessing the service in a timely manner [76], that may require clinicians in the school setting to offer psychological services to the young person. The following sections outline some additional considerations to be given to students who engage in self-harm.

Assessment of self-harm

There are five important areas to assess in relation to adolescent self-harm:

1. Consideration of childhood maltreatment

The assessment of childhood maltreatment is important to assess in self-harm presentations, however, this assessment must take place in a way that is trauma informed care [62]. Examining child wellbeing reports and family history may offer some indications regarding child maltreatment. Consultation with the senior psychologists or other health professionals will be important to inform your actions.

2. Assessment of key stressful life events

Key stressful life events are also indicated as triggers for self-harm behaviours as well as suicidal ideation.

3. Exploring of the function of self-harm for the young person

It is important to seek to understand the meaning of self-harm for the young person. As noted earlier, there are a range of different functions that will require different behavioural strategies in order to be addressed appropriately. Therefore exploring with the young person the underlying reasons for the purpose and consequences of their self-harm behaviour is key to intervening effectively.

Questions that explore the function of self-harm

Do you ever have thoughts of harming yourself?
Have you ever deliberately done something to hurt yourself?
Have you ever harmed yourself as a way of coping?
When do you self-harm?
How do you feel before and after you self-harm?
Do you feel better after you self-harm? How long does this feeling last?

These questions may be difficult for a young person to answer. It is important to be sensitive when asking these questions. Validate that self-harm is a common way for young people to cope in the short-term, but that it can be harmful in the long-term. Getting an understanding of the function of their self-harm behaviour will assist in helping the young person to find other ways to cope.

4. Suicidal ideation

As self-harm is a risk factor for suicide, an assessment of risk should be undertaken. See section 3.4 ‘Assessing and managing risk’.

5. Online considerations

Online access to self-harm sites can provide both risks and benefits [77]. Therefore clinicians working with young people should assess the links between type of online forums accessed and self-harm behaviours. At intake several questions should be asked to understand more, for example: *How often do you visit the Internet to get or share health information and have you made friends over the Internet?* See the following section regarding online considerations for further information.

6. Mental health assessment

Impaired mental health is associated with self-harm behaviours so an assessment of mental health is required. See the assessment section 3.3.

Key elements of psychological support

Timeliness: Timeliness of the interventions is important as the research suggests many repetitions of self-harm occur within 1-4 weeks of the index event, so commencing treatment within that time is important.

Involvement of support: The involvement of family or mobilisation of other sources of support for the young person has been shown to be useful during the therapeutic process and to be valuable in reducing both suicidal ideation and self-harm behaviours [78].

Setting realistic goals: It is important to be realistic in goals of treatment; a reduction in the number of self-harm behaviours is more likely to be a realistic goal than immediate cessation [64].

Motivation to change behaviours: Motivational interviewing has been suggested as a valuable tool for clinicians working with young people who self-harm, promoting behaviour change [78]. It can be an effective prelude to an intervention, may support initial engagement, and dropout rates [79].

Maintenance of sobriety and harm minimisation: A important goal for the young person is not engaging in the use of substances [78]. Self-harm is often an impulsive act and drug and alcohol consumption is likely to increase the risk of impulsive acts and repeated acts of self-harm [61]. A young person should be linked to external Drug and Alcohol Services to support harm minimisation.

Enhance and sustain positive affect: Brent, McMakin [78]. Self-harm may often be accompanied by negative feelings towards the self (e.g., self-critical attitudes) or other negative affective states. Working with young people to engage in activities over time that enhance and sustain positive affect and increase self-esteem is an important part of effectively managing self-harm.

Addressing sleep difficulties early: Promoting sleep hygiene is important for young people engaging in self-harm. A sleep fact sheet can be found at https://www.headspace.org.au/assets/Factsheets/HSP225-Sleep-Fact-Sheet-DP3.pdf [78].

Skill development*:* Self-harm is likely to indicate difficulties in affect regulation, but also difficulties in a young person's ability to express themselves, communicate with others and to represent and share their life experiences [59]. Getting young people to understand and tolerate their needs and feelings and develop ways to express these adaptively is important [59]. Problem solving approaches that are developed and rehearsed with the young person can support them when faced with future interpersonal crises [61].

Addressing other factors*:* The stressors associated with a chronic health conditions or disability may well be overlooked despite being indicated as associated with self-harm behaviours. Self-harm can also be part of a cluster of mental and behavioural difficulties including alcohol consumption, substance misuse and anti-social behaviour [80]. When self-harm is co-occurring with alcohol and substance misuse and/or violence other specific treatment for these conditions is required that addresses these key individual risk factors [61, 80].

Online considerations

For young people today, online activity is commonplace for socialising, information seeking and entertainment. Online forums can be an important medium to share life and self-harm experiences anonymously for young people who engage in self-harm [77]. For clinicians working with young people it is increasingly important to assess online as well as real world activity. Table 1 provides some clinical considerations related to self-harm that are important to explore with the young person.

Table 1 clinical consideration for online self-harm activity

Self-harm variables	Online Self-harm activity
Frequency	Frequency of time online
Urges	Type of website used
Attitudes	Nature of content accessed
Number of methods	Whether content is posted or read

Adapted from [77]

Whitlock, Lader [81] suggest that a **number of questions are asked by clinicians at different points** during the therapeutic intervention as shown in Table 2.

Table 2 Clinician questions related to young person's Internet use

Intake general questions	• How often do you visit the Internet to get or share health information? • Have you made friends online?
Probing questions once relationship is established	• Have you ever visited a website to find out or to talk about self-harm?
If yes, subsequent questions probe the involvement in self-harm website, regularity and frequency of visits and degree of involvement with online friends and perceived function of involvement	• Are there places you regularly go to find out about or to talk about self-harm? • How often do you visit this/these sites? • What type of site(s) do you visit? • What do you like to do most while there? • Do you like to post messages or videos or do you like to just see what is happening? • Can you tell me the names of the sites you like the best?
If the young person is using these sites regularly, this may suggest they are using these to meet some of their needs	• How close do you consider your online friends to be? • Have you ever met with friends you made online? • How comfortable do you feel hearing stories from others who self-injure? • Have you shared your own story? How did this feel? • What do you like most about having friends that you only really know online? • How honest are you when you share information on the Web? (Do you minimize or tend to embellish?) • Do you tend to remain anonymous, or do you share your name and contact information?
Questions about online confidantes is important as they may be influential	• Do you have online friends with whom you talk about self-injury? • Do you ever take their advice? • Can you provide examples of advice you got from an online friend that you used?

Adapted from [81] pp. 1140-1141.

Social support through online self-harm forums [77] is primarily driven by a validation and acceptance motive. Therefore addressing social isolation for young people may be valuable [77]. Revisiting Internet use over time is worthwhile and further exploring the role of internet use regarding therapy is also indicated if the young person frequently uses the internet [81]. A further consideration is that if young people are already accessing online forums related to self-harm, the health information available on many of those sites is poor, therefore provision of 'reliable online resources' promoting recovery is important [77]. Suitable resources can be found on the Reachout.com, headspace and SANE websites at: https://au.reachout.com/, https://headspace.org.au/, https://www.sane.org/get-help.

SECTION 5

5.1 Collaboration in and with the school

Objectives:

1. Further understand factors that support or hinder collaboration with schools, including parent and young person concerns regarding confidentiality, and mental health awareness of education staff
2. Enhance awareness of strategies that promote collaboration with schools
3. Further understand the importance of prioritising the education of the young person including school attendance and completion of school work
4. Understand the goal of keeping the young person in the school, and factors that support or work against this goal

The importance of a team approach

Supporting young people with complex mental health issues requires a team approach involving key supports within their family, the school community and health professionals. For this approach to work effectively there needs to be shared understanding around the best strategies to support the young person's wellbeing and to keep them safe. This requires regular communication between members of the team.

For schools to provide support and to make adjustments to curriculum it is necessary that they are provided with enough information about the mental health of the young person. In most instances, this involves a parent/carer making contact with the school, connecting with an appropriate member of staff, and having a conversation around the needs of their child. However, school staff also make direct contact with a parent/carer in relation to concerns about a young person. In instances where a young person is accessing mental health services in the community, and where the parent/carer and young person have given permission to share information, then it may be the health professional who makes contact with the school to share information.

It is good practice to follow up initial contact with a meeting at school involving the parent/carer, young person, mental health clinician and key members of staff e.g. school counsellor, year advisor, deputy principal, to put together a plan to support the young person at school.

Strategies to address barriers to collaboration

There are a number of barriers that inhibit collaboration in and with the school. Parents/carers and young people are understandably concerned about the privacy and confidentiality of information concerning their own or their child's mental health. They may have concerns about how this information will be used, and who it will be passed onto. Another reason cited for not sharing information with the school is the concern that it will leave the young person vulnerable to stigmatisation and other negative consequences that may actually worsen their mental health [82, 83].

In addition there are occasions where information is provided to the school by a parent/carer or health professional, but is not passed on to relevant staff involved in supporting the young person. This can lead to teachers and other staff feeling inadequately supported to meet the needs of students in their class who may be presenting with behaviours of concern e.g. self-harm or aggressive behaviour.

There are also breakdowns that occur in communication between mental health services, professionals and schools that hinder good practice in supporting young people with complex mental health problems. In some instances a young person may return to school the day after presenting at the Emergency Department or following a hospital admission with no communication having occurred between the family or the health service with the school. It may be left to the young person to communicate what has happened with a member of staff e.g. school counsellor or year advisor, and this may not occur until sometime after the young person has returned.

The following strategies can help to address parent/carer concerns and promote collaboration between schools and health:

- When a young person, parent/carer or health professional shares information with the school about the mental health of a young person, it is important that the staff member checks what information can be shared and with whom. There needs to be a balance between providing enough information to teachers of the student to keep the young person safe, while ensuring that the young person's rights to privacy and confidentiality are maintained.

- The school to identify a key contact person for the parent/carer/health professional to communicate with, who will then pass on agreed information to other members of the support team at school. This might be the year advisor, deputy principal, school counsellor or head teacher welfare. It can be helpful for the young person to have input into deciding who the contact person will be, based on their relationships with staff.

- Closer collaboration between schools and health services can help to strengthen relationships between clinicians working across different settings, resulting in more integrated mental health care for young people [84]. Facilitative factors that promote collaboration include regular network meetings attended by both school counselling service staff and community mental health clinicians; dedicating time and resources for complex case reviews attended by school counselling service staff, community mental health clinicians and other relevant agencies; and, joint training opportunities which allow for clinicians across school and health settings to develop mutual understanding as well as opportunities for networking and future collaboration.

- In instances where there are safety concerns about the welfare or wellbeing of a young person, it may be necessary for health and education staff to exchange information under Chapter 16A of the Children and Young Person (Care and Protection) Act 1998. For guidance as to the circumstances under which information can be exchanged under Chapter 16A is provided in the Fact Sheet for Health and Education Staff: Exchanging information and working together to keep young people safe and well are provided in the Additional Resources section. The local School Link Coordinator may be contacted to assist the school in following up further information.

- Planning for the students return to school when there has been a period of absence e.g. hospitalisation, is important to ensure that the young person feels supported and welcome when they return, and can also help to allay staff anxiety around safety concerns. Writing and regularly reviewing the Support and Safety Plan for School (included in section 7.1) in partnership with the young person and family/carers can support this process.

Prioritising the education of the young person

A key principle for working with young people with complex mental health difficulties is to prioritise the education of the young person, including school attendance and completion of school work. School offers opportunities for vulnerable young people to engage with peers and supportive adults as well as to engage in age appropriate social activities and learning which are protective for mental health. Evidence suggests that positive school experiences can support recovery for young people with complex mental health issues and improve academic outcomes [85].

There are a variety of factors that work against the goal of keeping the young person in the school. Education staff may be concerned about their ability to keep a young person safe at school, especially where there are concerns around self-harm, suicide or risk of harm to others. These fears may be particularly heightened where there has been the death of a student or staff member by suicide in the school or local community. Staff may also have concerns around the impact of a student's behaviour on the mental health and wellbeing of other students/peers. In many instances the young person themselves may be ambivalent about school, resulting in frequent absences, late arrivals and truancy.

An important strategy to support the goal of keeping the young person in the school is to distinguish between acute and chronic risk. When a young person is deemed to be at acute risk of suicide, it is essential that an ambulance or the police are called to attend to the young person's immediate risk and get emergency care. Follow up includes contacting the young person's parent/carer, communicating with external health professionals involved in the young person's care and following mandatory reporting guidelines.

While this response can be lifesaving when a young person is at acute risk, responding to chronic risk *may* require a different approach. Chronic risk behaviours tend to be less harmful and the person does not have a clear intent to die. The young person may still be engaging in risky, unsafe behaviour, however these behaviours are usually a recurring response to interpersonal stress, particularly to a sense of rejection and abandonment, and act as a means of communicating emotional distress. Even so, accidental death remains a risk. In addition, a young person who is at chronic risk may also have episodes of acute risk. For this reason it is essential that a risk assessment is conducted every time the young person presents in crisis. Further guidance regarding how to respond to chronic risk is provided in section 3.4 assessing and managing risk.

Schools can better meet the needs of young people with complex mental health issues by having a well-defined approach to risk assessment and care planning. Having clearly identified members of the school's wellbeing team e.g. year advisor or deputy principal, as the first point of contact where a teacher is concerned about a young person's safety is an important step. School counsellors are trained to conduct risk assessments, and can work with the young person to develop a collaborative, individualised safety plan to manage risk in consultation with the family, key school staff and external health professionals where appropriate. Where available, consideration should also be given to linking the young person to external support in the community dependent on the level of acuity e.g. the GP, community mental health. Follow up with the young person after a crisis, and developing a care plan as a strategy for reducing the young person's level of distress and crisis is crucial to ensure ongoing monitoring and support. The steps involved in care planning are outlined in this guide.

In instances where a young person is having regular appointments with a community mental health clinician, regular communication will be essential to communicate respective roles. For example, the role of the school counsellor may be to provide support and advice to staff to address concerns around the young person's safety, rather than engaging in direct work with the young person. This may involve communicating with teachers of the student to provide advice around strategies to support the young person in the classroom, making recommendations regarding adjustments to curriculum or learning support, and providing psychoeducation to staff around mental health issues such as self-harm. It is important that the young person has a support team at school to provide day to day support and ongoing monitoring.

Increasing staff awareness of complex mental health issues can also help to address the goal of keeping the young person in the school. Symptoms of mental health difficulties can sometimes be overlooked as behaviour problems [82]. Increased mental health awareness can result in a more compassionate response to the young person, and may also lead to a more proactive management of problems such as bullying. Project Air Strategy for Schools has developed a set of resources to assist schools to better recognise and respond to young people with complex mental health problems which can be found at: https://www.projectairstrategy.org/UOW225734.html

It is also important to offer support to the peers and friends of a young person with complex mental health issues. Providing young people with tips and information about how to help a friend, awareness of mental health issues, and coping skills is an important strategy for promoting resiliency and a supportive culture within the school. This may involve offering one to one support for peers, targeted interventions for vulnerable groups e.g. Resourceful Adolescent Program, and whole school or whole year initiatives e.g. R U OK day, Youth Aware of Mental Health, Teen Mental Health First Aid. Links to these programs can be found in section 7.2.

5.2 Working with families

Objectives:

1. Enhance awareness of family context as a potential perpetuating or protective factor in young person/s life
2. Further understand the importance of involving parent/carer or significant family members where possible
3. Enhance awareness of strategies for working with families
4. Further understand the principles of "good enough" communication with young person and their family

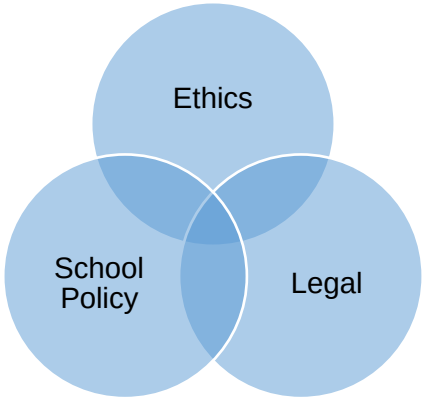
When working with a young person it is important to consider the broader family context and how it may be impacting their academic life, peer and family relationships and their mental health. This is particularly true for psychotherapy, where the clinician may see a young person weekly, fortnightly, monthly, or intermittently, while the remainder of the young person's time will either be spent in school or at home. A lot of change is made outside of the therapy room, so it is important for the clinician to understand the context in which they are trying to intervene. **This will aid the intervention by providing an understanding of what factors the clinician can assist the young person to change, and what factors the clinician may need to support them to accept.**

This is in line with Project Air Strategy's relational model (2.3), where the clinician needs to consider the young person's relationship with themselves (e.g. how they see themselves and their role within their family) and their relationships with others (e.g. how do they get along with other members of the family). Similarly, how this may impact their relationship with yourself as the clinician and other members of the school.

The intervention in this guide emphasises the involvement of a parent/carer or significant family members in the young person's life. The level of involvement will vary for each young person. For example, this may involve having a family member directly included in sessions, having telephone contact, or not having them involved at all. Some factors to consider when deciding on the level of involvement include:

- The young person may request for their sessions to remain private and for their parent/carer to not be involved, particularly in a school context
- Involving parent/carer or other family members may place the young person at risk
- Involving parent/carer or other family members may rupture the therapeutic alliance
- The young person's age i.e. the young person may not have capacity to provide informed consent
- The young person may have other support people that they perceive as family, for example, a parent of another peer, aunt or grandparent that they would like involved
- The young person might be under care of the state (parental responsibility to the minister)

This decision will also depend on the ethical obligations of the profession (for example, registered psychologists need to follow the APS Code of Ethics), legal, and school policy. This generally refers to issues such as confidentiality, mandatory reporting, informed consent, and consent to release and/or obtain information, and ensuring that all factors are considered in your decision-making.



Regardless of whether family is directly involved or not, it is vital to consider the young person's family context and how this may be a perpetuating or protective factor in the young person's life.

It is also worth noting that many young people experiencing complex mental health issues may have a parent or close family member who experiences similar issues, due to rates of intergenerational transmission particularly for personality disorder. It is important to keep this in mind when communicating with family members. Below are a list of tips for working with families.

Tips for working with families

Be clear in communication: Try to be unambiguous, neutral and clear in your communication. If your communication is misread, the person may respond with anger, humiliation or insecurity. Reflect on what you said (or did not say) and how you said it – it may help you communicate more effectively in the future.

Allow the other person time to speak: If the person feels interrupted they may perceive this as rejection or aggression and may respond negatively in return. Providing the person with opportunities to talk will help the person express themselves verbally.

Be aware of your non-verbal communication: This will ensure that you are giving a clear overall picture of your intended message. For example: tone of voice, pace, and facial expression. It is helpful to keep your tone of voice and facial expression neutral.

Maintain boundaries and have a clear role definition: It is important to clearly outline your role and the level of communication you will be having with the young person's family. For example, outlining what level of information will be shared, when and how it will be shared. Aim to provide what is reasonable even though you may feel pulled into providing more help and assistance than what is usual.

Open communication with the young person: If you have a conversation with a family member, it is best to be open with the young person about this. You may find out ancillary information from a family member that could impact your work with the young person e.g. if a family member discloses information that the young person has not directly told you, this may affect the questions you ask or the way you formulate their presenting concerns. An appropriate response may be: "I prefer that X is involved in these conversations and is aware of any conversations we may be having about them."

Young person-centred: Always consider the young person's perspective and promote their sense of agency about what they would like to do with their information. If you do need to release information due to risk concerns, ensure that this is done in a respectful manner.

Display compassion, respect, a non-judgemental attitude, and validation of feelings at all times

"Good enough" communication: Remember that you are not always going to get it right and the conversation won't run perfectly every time.

“Good enough” communication

Talking to a young person and their family members may be challenging at times and not always run as smoothly as hoped. Below are 5 ways to be “good enough” in your communication:

1. **Constancy:** become a steady and stable support in the young person’s life
2. **Attunement:** actively listen and attend to the young person’s and their family’s needs, wishes and desires
3. **Empathy:** aim to understand the young person’s and their family’s experience. It is also important not to judge parents based on your own experiences or beliefs about parenting
4. **Continuity:** offer stability and connection
5. **Don’t be a ‘reaction’:** think about your response, rather than being reactive

SECTION 6

6.1 Conducting a complex care review – key elements

This section outlines key elements in conducting a complex care review. Complex care reviews provide an opportunity to bring together individuals who are involved in the young person's care or can provide expert advice.

Objectives:

1. Further understand the aims and key principles of a complex care review
2. Highlight steps involved in conducting a complex care review

The aim of the complex care review

- Improve outcomes and trajectory for the individual young person
- Develop consensus about significant factors for the individual young person
- Improve knowledge and awareness of complex mental health issues
- Strengthen skills in supporting young people with complex mental health issues
- Develop shared understanding and opportunities for collaborative care between education, health and other relevant agencies
- Contribute to staff development and young person outcomes through active collaborative participation
- Improve staff confidence in working with young people with complex mental health issues

Key principles

***Relational continuity*:** a consistent core group of clinicians/school staff provides young people with a sense of predictability and coherence [86].

Seeing the whole picture and making connections: making space to consider the interplay between complex issues can facilitate the examination of compounding issues, transitions and vulnerabilities [87]. Ensure assessments draw on family history and consider social, cultural and biological factors [87].

***Liaison function*:** discussions about individuals results in both better care for the young person and forms the basis for developing an ongoing liaison relationship between stakeholders [88]. This liaison function also supports information sharing between agencies and reduces the over reliance of one agency perspectives [89].

***Purposeful processes*:** the gathering of information, conducting of the review and following up are undertaken with purpose to achieve better outcomes and safeguarding the young person [89].

Share information about self-harm, suicide and child protection concerns: information about risk needs to be shared in a way that is understood by other agencies who may be from different professional backgrounds. Ways to identify and respond to any changes in risk should be discussed [87].

Steps to undertaking a complex care review

1. ***Agreement of which young person to be reviewed by key stakeholders***

Considerations: Why the young person would benefit from a complex care review.
The purpose of the meeting should then be determined and shared. Develop key questions that the review needs to address.

2. ***Consent obtained from student and parent/caregiver***

Considerations: Age of young person and who holds parental responsibility. Seek the young person's views on what is important to them to inform the review. At the initial stages of the complex care review, the participation of the young person and carer in the meeting is not recommended. It may, however, be appropriate to consider the involvement of the young person and their carer at a later stage.

3. Nomination of spokesperson- key clinician

Considerations: Each complex care review requires work prior to, and during, the meeting. Often there are pre-phone calls, sometimes assessment and reading of care summaries and other preparation work. Nomination of a spokesperson (such as a school counsellor/school psychologist) to provide an overview of the young person's situation is recommended.

4. Determining who should be involved in the complex care review

Considerations: The team involved in the education and clinical care for the young person, other agencies involved as appropriate (i.e. child protection agency, supported accommodation services, local Aboriginal agency, Headspace etc.), past or future schools if appropriate, specialists from Department of Education (i.e. networked specialist facilitator, leader psychology practice, senior psychologist education for the school) and school-link coordinator from the area. Ideally the group should not be too large.

5. Nomination of facilitator of the review

Considerations: This person is responsible for convening and facilitating the meeting and ensuring the meeting discussions and outcomes are recorded. This should be different from the spokesperson and someone who feels confident in managing different perspectives.

6. Arrange meeting and distribute care review summary

Considerations: Face to face meetings may cause a delay in them occurring but are generally preferable to facilitate effective collaboration. The care review summary should be prepared by someone who has access to information about the young person. Where possible a written summary should be sent 7 days prior to the participants who will be attending the meeting.

7. Conduct meeting

The usual structure for a complex care review meeting is:

- Introductions (5 mins)
- Verbal presentation by spokesperson of the young person's situation (10 mins)
- Discussion of the young person, question and answer session (40 mins)
- Open discussion and workshop of core principles (20 mins)
- Close and document outcomes (5 mins)

Please note that the duration and structure of the review can be varied depending on need.

The spokesperson and facilitator will then develop and provide a brief summary of the meeting with agreed outcomes for the support team. A suggested summary framework is as follows:

- Brief background to presenting issues
- Young person's strengths
- Agreed outcomes including, but not limited to, therapeutic engagement, staff responses, communication, roles
- Planning for further meetings

Preparing for a complex care review for Kai

The school counsellor, in consultation with the principal, class teacher, foster carers and child protection caseworker decided to undertake a complex care review. The purpose of the review is to gather information to support transition planning for Kai, plan for comprehensive mental health assessment, and identify further supports that can be put in place to achieve better outcomes for Kai. At this stage, there are no health services involved in Kai's care. He is on a waiting list for a paediatric review through the outreach clinic provided by the Local Health District.

The child protection case worker gave consent for the review, in consultation with Kai's foster carers. The school counsellor agreed to be the spokesperson for the review, and in agreement with the senior psychologist, arranged to conduct some of the work involved in preparing for the review from their base school.

The main focus in preparing for the review involved gathering information from Kai's current and previous school (e.g. risk management forms, behaviour support plans, attendance data), reviewing the previous paediatric report, meeting with Kai's foster carers to gather information, and conducting a teleconference with the child protection caseworker to obtain further background information regarding Kai's family and his experience since coming into care.

In addition to the teacher and principal from the school, the school counsellor and the child protection case worker it was decided that the network centre specialist facilitator from Department of Education, as well as the school-link coordinator for the Local Health District would be invited to attend the complex care review.

The principal agreed to convene and facilitate the meeting. The school counsellor took responsibility for preparing and distributing the care review summary a week prior to the meeting. The meeting took place at the primary school, with several participants taking part via teleconference.

SECTION 7

7.1 Additional Resources

Index:

Schools, Teachers & Students

Understanding Relationship Themes Worksheet

This worksheet provides provides a structured method to reflect on a young person's behaviour and its underlying communication. It also aims to promote understanding of your own response during the interaction and what this information may reveal about young person's other relationships and your own future interactions with them.

Describe a recent incident or behaviour:
What do you think the young person wanted? (I.e. what was their 'wish'?)
How did the young person expect people to respond to them? (I.e. what was their 'response of other'?)
What is their usual response? (i.e. their 'response of self' to this wish-response-other sequence)

Schools, Teachers & Students

What are some of the feelings and thoughts that come up for you in reflecting on this situation?
What might this behaviour and your response tell you about the young person's relationships with other people, for example, their family or peers?
What will I remember if something similar happens in the future? What have I learnt that I can apply to future situations?

NSW GOVERNMENT

November 2017

Fact Sheet for Health and Education Staff: Exchanging information and working together to keep young people safe and well

This fact sheet outlines key principles as to how Health and Education staff can work together to keep young people safe and well.

1. Working with young people, their families, carers and communities

Staff working within Health and Education are accountable for matters related to child protection, privacy and confidentiality as determined by a range of employment obligations, professional standards and legislation. The standards and obligations are contained within codes of conduct and ethical standards, legislation specific to privacy and confidentiality and child protection, and Agency policies and procedures.

It is best practice when routinely working with young people in assessment and care planning, to seek a comprehensive understanding of the young person and their care needs by seeking information from a range of significant parties and other service providers.

In this context it is best practice to discuss the limits of confidentiality with the young person. This should include when and what kind of information could be shared with different parties, recognising that these parties may change over time. Parties may routinely include their parents, carers, school and other agencies involved with the young person This discussion should be documented in the 'care plan' for health workers and the 'education plan' for school staff.

Best practice is to gain consent wherever possible to share information. The type of information to be shared should be a collaborative decision with the young person and their family/carers.

Only relevant information is exchanged and this is on a 'need to know' basis. Information should be disclosed only to the appropriate person at the school, hospital or health service; you do not have to provide the 'whole file'.

The current Child Protection Legislation in NSW allows for exchange of information to promote the safety, welfare or wellbeing of a young person without their consent. In fact, Chapter 16A takes precedence over the protection of confidentiality or an individual's privacy because the safety, welfare and wellbeing of children and young people are considered paramount.

The sections below outline the current Child Protection Legislation and provide guidance as to when and how information can be exchanged under Chapter 16A.

2. Child Protection Legislation

The **Children and Young Persons (Care and Protection) Act 1998** (the Act) establishes the legal framework for child wellbeing, child protection and out- of-home care services in NSW. The overriding principle of the Act is that the safety, welfare and wellbeing of children or young people is paramount (section 9).

The consequences for children and young people when agencies fail to work together can be very serious.

The Act recognises that all agencies that have responsibilities relating to the safety, welfare or well- being of children and young persons should be able to provide and receive information that promotes the safety, welfare or well-being of children or young persons, (section 245A).

- **Chapter 16A** of the Act enables exchange of information between agencies that have responsibilities relating to the safety, welfare or well-being of children or young people including the Department of Education and NSW Health (health services and hospitals). For other organisations covered by the Act, see **Section 248 (6)**.
- **Chapter 16A** allows for information to be shared with or without consent (See Section 6. What about privacy?).

3. When can information be exchanged under Chapter 16A?

Information relating to the safety, welfare or wellbeing of a child or young person may be provided upon request or it can be proactively shared between agencies if it will assist to:

- make a decision, assessment or plan (e.g. care plan or planning for a student's learning and support; and/or
- provide any service; and/or
- manage a risk to a child or young person that might arise in either agency's capacity as a service provider.

Requests for exchange of information need to be clear about the purpose, and how they will assist in supporting the young person and their family.

The circumstances under which a request for sharing of information may be declined are stipulated in the Act, and include if the organisation believes the sharing of information would prejudice a criminal investigation, endanger a person's life, or is not in the public interest.

Should it be considered that in the event that one of these criteria apply to a specific request:

- **In Health,** the matter should be escalated through local clinical governance processes for a final decision and communication of the decision with the agency that has made the request.
- **In Education,** the matter should be escalated through the relevant reporting line (for example a Principal should consult with the Director PSNSW before declining a request), and advice sought from the Department's Child Wellbeing Unit.

4. What kind of information can I exchange?

The information exchanged is on a 'need to know' basis. Disclose the relevant information to the appropriate person at the school, hospital or health service; you do not have to provide the 'whole file'.

Education

A school could provide a health service/hospital with information about: attendance; a student's learning difficulties or disabilities; incidents involving the student (such as bullying); concerns about the student's wellbeing or behaviour (such as self-harm); or concerns about the student's parents/carers (such as concerns about the family's current capacity to provide care and support to the young person).

A school could also provide relevant information about the family's living arrangements or other agencies that are known to be working with the student.

NSW Health (health services and hospitals)

A Health service/hospital could provide a school with any information that will assist the young person to remain safe and well while at school. This may include information about the young person's current mental state that could impact on their behavior and school functioning (e.g. mood, cognitive functioning), psychosocial stressors (e.g. family or relationship stressors), and current risks (e.g. suicidal ideation and self-harm behaviours).

A Health service/hospital could also advise a school of triggers to distress and current school-based stressors such as bullying, relationship difficulties, or issues managing academic demands. In collaborative care planning the Health service/hospital could also provide advice or recommendations to assist the school in helping the young person manage their distress.

A Health service/hospital could also provide information about the outcome of relevant assessments, mental health support plans, and engagement with other services. Other relevant information could include concerns about the student's parents/carers (such as concerns about the family's current capacity to provide care and support to the young person).

5. How is information exchanged and kept secure?

Before exchanging information under Chapter 16A

Consider:

- if appropriate, and risk is not imminent, can you obtain consent first?
- what information is useful and relevant to exchange?
- is there an established pathway for exchange?
- who in the school or Health service is the best person to be able to act on the information? (e.g. information about bullying may be referred to the Principal to decide who is best placed to deal with the alleged behaviour, whereas imminent risk of significant harm may need to be communicated with the school counsellor, or in their absence the school Principal)
- **In Health**, consultation with peers, service manager, and clinical supervisor
- **In Education**, consultation with the line supervisor or seeking expert advice (e.g. from Legal Services)
- contacting your local Child Wellbeing Unit as an additional resource for advice.

In addition to completing or complying with a request under Chapter 16A, document in the clinical file **(for Health)** or the relevant student file **(for Education)** the reason for your decision with relevant detail indicating that you have considered the above issues.

Exchanging information under Chapter 16A

Written exchange is preferred and standard forms, letters, e-mails and other forms of electronic communication can be used. Links to standard letters can be found in the **Interagency Guidelines**.

In addition to completion of the formal request, explain and document any advice to the other agency about sensitivities in the information and how these might be managed. Any actions agreed by both agencies should also be noted in the young person's file.

Where the use of Chapter 16A facilitates collaborative care planning by verbal means, for example, at multi- agency case conferences, then the information exchanged under Chapter 16A should still be documented.

Storage

Agencies sharing personal information are still expected to protect the confidentiality of the information, for example, by storing it securely.

6. What about privacy?

It is good practice to seek consent to exchange information when possible, but not always necessary. Chapter 16A overrides the protection of confidentiality or of an individual's privacy because the safety, welfare and wellbeing of children and young people is considered paramount.

Chapter 16A allows information to be exchanged despite other laws that prohibit or restrict the disclosure of personal information, such as the *Privacy and Personal Information Protection Act 1998, the Health Records and Information Privacy Act 2002* and the Commonwealth *Privacy Act 1988*.

Some circumstances in which you would **not** seek consent include but are not restricted to:

- where you believe it is likely to further jeopardise a child or young person's safety, welfare or wellbeing;
- where you believe it would place you or another person at risk of harm; or
- where you are unable to contact a parent/carer and the matter is urgent.

Where you intend to share information in relation to parents or family circumstances, carefully consider the type of information that it is relevant and necessary to share. For example, it may not be necessary nor relevant to share the parent's psychiatric diagnosis without their consent, however it may be necessary and relevant to share concerns in relation to the impact of the parent's illness on their capacity to provide care for their child.

7. Can I be prosecuted or disciplined for disclosing information?

The Act stated that, if a person acts in good faith when providing any information in accordance with Chapter 16A, he or she:

- is not liable to any civil or criminal action, or any disciplinary action, for providing the information; and
- cannot be held to have breached any code of professional etiquette or ethics or departed from any accepted standards of professional conduct.

8. Where can I find further Information?

Generally:

- **Exchanging information under 16A**
- **Providing and requesting information under 16A**
- **Responding to requests under 16A**
- **Keep Them Safe: A shared approach to child wellbeing' fact sheets**
- **Mandatory Reporter Guide**
- **Ethical guidelines for working with young people** (Australian Psychological Society. Note member access required).
- **Psychologists in NSW Schools Client Information Sharing (Relating to the NSW Keep Them Safe Legislation)** (Australian Psychological Society).

Health

- **Child Wellbeing and Child Protection Policies and Procedures for NSW Health**
- NSW Health Child Wellbeing Unit – Phone 1300 480 420 (Mon-Fri: 8.30am to 5.00pm)
- **Privacy Manual for Health Information**
- **Working with child clients** (Australian Association of Social Workers)
- **NSW Child and Adolescent Mental Health Services (CAMHS) Competency Framework**

Education

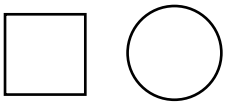
- **Protecting and Supporting Children and Young People Policy**
- **Legal Issues Bulletin 51 – School Counsellors, Confidentiality and the Law**
- *NSW Education Child Wellbeing Unit* Phone 9269 9400 (Mon-Fri: 8.30am to 5.00pm)

SHPN (MHCYP) 160464

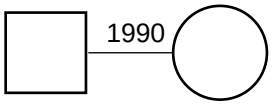
Genograms

Key symbols

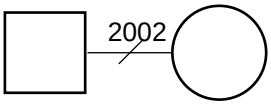
Male Female



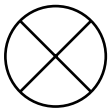
Married/defacto (year married above line)



Separation/divorce (date separated above line)

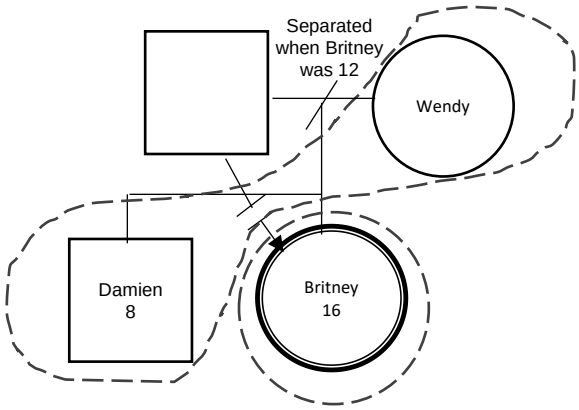


Death (year of death above symbol)



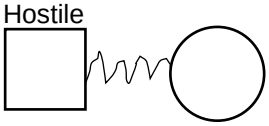
Key points

- Age is placed in the middle of the symbol, while the birth year is placed above
- The key young person (e.g. your client), has a bold outline e.g. Britney in the below example
- A household is shown by circling members living together
- Children and siblings are drawn below parents/carers
- Make a note of any mental health issues or abuse
- More symbols can be found online or at the reference on the bottom of this page

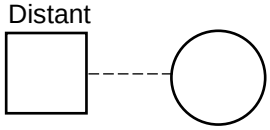


Interactional patterns between people

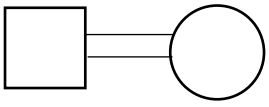
Hostile



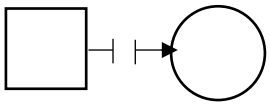
Distant



Close



Cut-off



Adapted from McGoldrick, Gerson, and Petry, S. S. *Genograms: Assessment and Intervention*. (2008). W.W. Norton & Company

Schools, Teachers & Students

Clinical Assessment – Initial Interview

Key Components

- Confidentiality, limits to confidentiality, and consent
- Building rapport and trust with the young person
- Risk assessment: suicide, self-harm, drugs/alcohol, abuse, harm to others

Presenting Issue(s)

What is the presenting issue(s)?

Family Dynamics

Genogram: immediate family and extended; "how close are you to X"; "who lives with you?"

Family mental health history: *"Is there a history of mental illness in the family?"*

Schools, Teachers & Students

Timeline

Draw a timeline with the young person: Positive and negative significant life events – can focus on last 12 months, or start in childhood and continue to present. Identify stressful life events, especially those related to relationships, which coincided with onset of symptoms

Schools, Teachers & Students

Risk Assessment Notes

Current and past thoughts of suicide
Current and past suicide attempts
Do they have a plan? Access to means?
Is the risk imminent?

Current and past self-harm behaviour

Drug and alcohol use

Risk of harm to others
Experience of abuse – past, current

Schools, Teachers & Students

History of Presenting Issues (including past/current treatment and medications)

How long has this been occurring?

Have you previously sought help?

What helped/didn't help?

Diagnoses

Any past diagnoses?

Potential differential diagnoses?

Support Network

School, work, friends, family

Schools, Teachers & Students

Strengths/Interests

Treatment Goals

Priorities

What are the priorities? (*Consider resources available e.g. number of sessions, external services*)

McLean Indicators of Concern

Name:

This tool screens the key criteria for Borderline Personality Disorder (BPD). This form is designed to aid in your formulation of the young person's concerns and subsequent intervention. If you use this tool and include any confidential information, please ensure that it is filed or shredded appropriately.

Item	Yes	No
In your experience, do you perceive that the young person's relationships have been troubled by a lot of arguments or repeated breakups?		
Have you ever been concerned that the young person has deliberately hurt his/herself physically (e.g. punched, cut, burned his/herself), or attempted suicide?		
Do you perceive the young person to have at least two problems with impulsivity (e.g. eating, binges, spending sprees, substance misuse, verbal outbursts)?		
Do you experience the young person to be extremely moody?		
Do you perceive the young person to feel angry a lot of the time, or experience the young person in an angry or sarcastic manner?		
Do you perceive the young person to be often distrustful of other people?		
In your experience, does the young person present as frequently feeling "unreal" or as if things around them are unreal?		
Do you perceive or experience the young person as feeling empty?		
Do you perceive the young person to feel that he/she has no idea of who he/she is or that he/she has no identity?		
In your experience, do you perceive the young person to make desperate efforts to avoid feeling or being abandoned (e.g. repeatedly calling someone to reassure him/her that the person still cared, begged the person not to leave him/her, clung to another person physically)?		

Reference: Zanarini, M.C., et al., A screening measure for BPD: The McLean screening instrument for borderline personality disorder (MSI-BPD). Journal of Personality Disorders, 2003, 17(6): p. 568-573.

Safety Plan

Emergency Numbers:

Lifeline 13 11 14

Kids Helpline 1800 55 1800

Suicide Call back 1300 659 467

eheadspace 1800 650 890

beyondblue Support Service.... 1300 224 363

Support People:

1. .....

2. .....

3. .....

4. .....

5. .....

Appointments Scheduled				
Provider	Date	Time	Date	Time

Medications		
Medication	Dose	When to take

Limit Substances	
Substance	Strategies

Limiting means

In the next 24 hours	
Time	Action

Triggers
1.
2.
3.
4.
5.

Warning Signs
1.
2.
3.
4.
5.

Helpful Strategies	

Reasons to Live
1.
2.
3.
4.
5.

My Care Plan

Name: **Clinician Name*:**

My main therapeutic goals and problems I am working on

(1) In the short term

(2) In the long term

My strategies

Warning signs that trigger me to feel unsafe, distressed or in crisis

Things I can do when I feel unsafe, distressed or in crisis that won't harm me

Things I have tried before that did not work or made the situation worse

Places and people I can contact in a crisis:

Lifeline: 13 11 14 **Emergency: 000** **Kids Helpline: 1800 551 800** **Mental Health Line: 1800 011 511**

Local Service:

My support people *(e.g. parents, siblings, friends, psychologist, teacher, school counsellor, GP, relatives)*

Name	Contact Details	Role in My Care	OK to Contact?

Signature: **Clinician's Signature:**

Date: **Date of next review:**

Copies must go to the people that can help to keep me safe. These people are (please specify):

***Write and/or review in partnership with young person and a health care professional, for example School Counsellor/School Psychologist, CAMHS clinician or GP.**

www.projectairstrategy.org

_____'s Support and Safety Plan for School

www.projectairstrategy.org

Student name: **Staff Consulted*:**

This plan can support you to identify strategies you would like to put in place when returning to school after a complex mental health concern.

Student health and wellbeing is a priority for learning. As a school we will assess your needs to ensure you feel safe. This plan will help us do this together.

Actions, plan and goals to assist my health and wellbeing at school:

People I can talk to at school to assist me:

The school will provide regular contact and communication to check on my health and wellbeing.

Agreed contact (e.g. twice a day, daily, weekly):

Contact method:

A flexible timetable may be needed for a period of time as outlined below.

Signature: **Date:**

Date of next review:

Copy for the: Student / School / Parent/ Other (please specify):

***Write and or review in partnership with the young person and their family/carers. This plan should be formed in collaboration with a school executive member and other education staff depending on the context of school.**

Self Help

Five Things

When experiencing strong emotions and thoughts, we can sometimes get caught up in them and lose track of our surroundings. This exercise uses our five senses to help us center and ground ourselves, and can help us to be more aware of our surroundings. Using our five senses can help us to be in touch with the present moment in a non-judgmental way to get through a difficult moment.

Instructions:

When you notice yourself being caught up in strong emotions and thoughts, pause for a moment:

- Look around your surroundings and *name five things that you can see…*
  Notice the details of things around you, such as the colour, shape, texture, height, or width of an item.

- Listen to the sounds that are around you, and *name four things that you can hear…*
  You might hear the sound of air conditioning, birds, wind, or your own stomach. Depending on where you are you might have to listen very carefully.

- Now turn your attention to things that are in contact with your body and *name three things that you can touch or feel…*
  These could be the feeling of your body sitting in a chair, the feeling of the clothes you are wearing, the weight of your hair on your back, or the grass under your feet.

- Now turn your attention to the smells in your environment, *and name two things that you can smell…*
  You might notice the smell of flowers, trees, food, candles or simply fresh air.

- Now focus on things that you can taste, and *name one thing that you can taste…*
  This could be the toothpaste from brushing your teeth or food or drink that you just had.

As you notice each sense, try to describe what you notice with as much detail as possible, as this will assist to focus attention on the activity. Remember that it is normal for your attention to wander, and when you notice this happening gently turn your attention back to the exercise. You may also notice yourself making judgements (e.g., becoming irritated by a noise). This is a common and almost automatic response. If this occurs just notice that a judgement has been made, and bring your attention back to what you are observing (e.g., “I heard a loud noise”). Try to foster a sense of curiosity towards the present moment.

Self Help

Dropping Anchor

Sometimes during distressing or crisis situations we may feel that we're caught in an emotional "storm" – tossed around by the waves and wind (i.e., distressing thoughts and emotions) and unable to see and think clearly.

Grounding is a mindfulness technique that helps us bring our attention to the present moment. When we feel overwhelmed by our feelings and thoughts, we may often lose track of our surroundings. Mindfulness helps us to reconnect to the present moment. It's about taking a moment to pause and check-in with ourselves. Though it can be very difficult to engage in mindfulness during times of distress or crisis, it is a helpful skill to practice and our capacity to use this technique will increase.

You can think of this practice as similar to a boat dropping anchor during a storm. Though dropping anchor won't necessarily make the storm pass, it does provide safety for the boat until conditions are calmer. Practicing this skill over time can help us feel greater stability and improve our ability to handle stressful situations.

Here are the instructions:

When you notice yourself getting overwhelmed by your emotions and thoughts, *'drop an anchor'* by:

1. *Pausing for a moment* to re-orient yourself with your surroundings
2. Take slow *deep breaths*, noticing how your chest rises and falls with each breath
3. Firmly *plant your feet* into the ground, feeling the muscles in your legs tense up
4. *Stand or sit up straight*, feeling the muscles in your back contract
5. Then look around you and describe *three things that you can see*
6. Listen to the sounds that might be present and describe *three things that you can hear*
7. *Repeat* the exercise until you feel more calm or grounded

Remember that it is normal for your attention to wander, and when you notice this happening gently turn your attention back to the exercise. You might find that practicing this exercise doesn't make all of the distressing thoughts and feelings go away. That's perfectly ok – see if you can just create a little bit of space between yourself and your distress. You may also notice yourself making judgements. This is a common and almost automatic response. If this occurs simply notice that a judgement has been made and gently bring your attention back to whatever it is that you are observing.

Self Help

Making and Using a Sensory Box

Our five senses (sight, sound, smell, taste and touch) play a major role in helping us understand, communicate and react to our environment. When experiencing strong emotions or during times of crisis, we may become overwhelmed. Stimulating our five senses can help us to soothe ourselves and may help us stay present in the moment.

Sensory boxes are designed to be available when you experience heightened emotions or difficult thoughts, so preparing a box in advance may be helpful. Examples of items you may wish to place in the sensory box include;

- **Sight:** Photos of friends, family or pets, pictures of places you have visited or would like to visit, affirmation cards, crystals or rocks with interesting colours, coloured papers and pens, paints with water
- **Sound:** Music player and headphones, flute, a bell, ukulele, rattle or drum
- **Smell:** Perfume, essential oils, candles, herbs such as lavender or rosemary, popping corn
- **Taste:** Herbal teas, favourite sweets or snacks, peppermints, lozenges, citrus, jellies or licorice
- **Touch:** Soft toys, scarf, stress ball, slime, bubble wrap, kinetic sand, playdough, drift wood, shells or stones from a beach or creek

When engaging with the sensory box, enjoy the experience and become absorbed in doing something you enjoy. Mindfully engage with each of the items in your sensory box, and describe internally what you see, hear, smell, taste or feel. Some people find self-soothing hard and may avoid being nice to themselves. If you engage in self-soothing and notice harsh, judgmental thoughts or difficult emotions arise, gently acknowledge them, and then return to trying to stay mindfully connected to the experience of being immersed in the box and the activities that appeal to you. Remember that it is normal for your attention to wander, and when you notice this happening gently turn your attention back to what you are doing.

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			

Instructions to Clinicians

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a self-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the child's treatment and prognosis. In addition, the measure may be used to track changes in the child's symptom presentation over time.

This child-rated version of the measure consists of 25 questions that assess 12 psychiatric domains, including depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use. Each item asks the child, age 11–17, to rate how much (or how often) he or she has been bothered by the specific symptom during the past 2 weeks. The measure was found to be clinically useful and had good test-retest reliability in the DSM-5 Field Trials conducted in pediatric clinical samples across the United States.

Scoring and Interpretation

Nineteen of the 25 items on the measure are each rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The suicidal ideation, suicide attempt, and substance abuse items are each rated on a "Yes or No" scale. The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. Table 1 (below) outlines threshold scores that may be used to guide further inquiry for the domains. With the exception of inattention and psychosis, a rating of mild (i.e., 2) or greater on any item within a domain that is scored on the 5-point scale may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment for that domain is needed. The DSM-5 Level 2 Cross-Cutting Symptom measures listed in Table 1 may be used as a resource to provide more detailed information on the symptoms associated with some of the Level 1 domains.

Frequency of Use

To track change in the child's symptom presentation over time, it is recommended that the measure be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the child that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Table 1: DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17: domains, thresholds for further inquiry, and associated Level 2 measures

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Child Age 11–17 (Patient Health Questionnaire Somatic Symptom Severity [PHQ-15])
II.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance—Child Age 11-17 (PROMIS—Sleep Disturbance—Short Form)[1]
III.	Inattention	Slight or greater	None
IV.	Depression	Mild or greater	LEVEL 2—Depression—Child Age 11–17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)
V.	Anger	Mild or greater	LEVEL 2—Anger—Child Age 11–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)
VI.	Irritability	Mild or greater	LEVEL 2—Irritability—Child Age 11–17 (Affective Reactivity Index [ARI])
VII.	Mania	Mild or greater	LEVEL 2—Mania—Child Age 11–17 (Altman Self-Rating Mania Scale [ASRM])
VIII.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Child Age 11–17 (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)
IX.	Psychosis	Slight or greater	None
X.	Repetitive Thoughts & Behaviors	Mild or greater	LEVEL 2—Repetitive Thoughts and Behaviors—Child 11–17 (adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)
XI.	Substance Use	Yes/ Don't Know	LEVEL 2—Substance Use—Child Age 11–17 (adapted from the NIDA-modified ASSIST)
XII.	Suicidal Ideation/ Suicide Attempts	Yes/ Don't Know	None

[1]Not validated for children by the PROMIS group but found to have acceptable test-retest reliability with child informants in the DSM-5 Field Trial.

The Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: This is a list of things different people might say about themselves. We are interested in how you would describe yourself. There are no right or wrong answers. So you can describe yourself as honestly as possible, we will keep your responses confidential. We'd like you to take your time and read each statement carefully, selecting the response that best describes you.						**Clinician Use**
		Very False or Often False	**Sometimes or Somewhat False**	**Sometimes or Somewhat True**	**Very True or Often True**	**Item score**
1	People would describe me as reckless.	0	1	2	3	
2	I feel like I act totally on impulse.	0	1	2	3	
3	Even though I know better, I can't stop making rash decisions.	0	1	2	3	
4	I often feel like nothing I do really matters.	0	1	2	3	
5	Others see me as irresponsible.	0	1	2	3	
6	I'm not good at planning ahead.	0	1	2	3	
7	My thoughts often don't make sense to others.	0	1	2	3	
8	I worry about almost everything.	0	1	2	3	
9	I get emotional easily, often for very little reason.	0	1	2	3	
10	I fear being alone in life more than anything else.	0	1	2	3	
11	I get stuck on one way of doing things, even when it's clear it won't work.	0	1	2	3	
12	I have seen things that weren't really there.	0	1	2	3	
13	I steer clear of romantic relationships.	0	1	2	3	
14	I'm not interested in making friends.	0	1	2	3	
15	I get irritated easily by all sorts of things.	0	1	2	3	
16	I don't like to get too close to people.	0	1	2	3	
17	It's no big deal if I hurt other peoples' feelings.	0	1	2	3	
18	I rarely get enthusiastic about anything.	0	1	2	3	
19	I crave attention.	0	1	2	3	
20	I often have to deal with people who are less important than me.	0	1	2	3	
21	I often have thoughts that make sense to me but that other people say are strange.	0	1	2	3	
22	I use people to get what I want.	0	1	2	3	
23	I often "zone out" and then suddenly come to and realize that a lot of time has passed.	0	1	2	3	
24	Things around me often feel unreal, or more real than usual.	0	1	2	3	
25	It is easy for me to take advantage of others.	0	1	2	3	
					Total/Partial Raw Score:	
					Prorated Total Score: (if 1-6 items left unanswered)	
					Average Total Score:	

Krueger RF, Derringer J, Markon KE, Watson D, Skodol AE.

Personality Trait Domain Scoring

FOR CLINICIAN USE ONLY	Personality Trait Domain	PID-5 BF items	Total/Partial Raw Domain Score	Prorated Domain Score	Average Domain Score
	Negative Affect	8, 9, 10, 11, 15			
	Detachment	4, 13, 14, 16, 18			
	Antagonism	17, 19, 20, 22, 25			
	Disinhibition	1, 2, 3, 5, 6			
	Psychoticism	7, 12, 21, 23, 24			

Instructions to Clinicians

This Personality Inventory for DSM-5—Brief Form (PID-5-BF)—Child Age 11–17 is a 25-item self-rated personality trait assessment scale for children ages 11–17. It assesses 5 personality trait domains including negative affect, detachment, antagonism, disinhibition, and psychoticism, with each trait domain consisting of 5 items. The measure is completed by the child prior to a visit with the clinician. Each item on the PID-5-BF asks the child to rate how well the item describes him or her generally.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (i.e., 0=very false or often false; 1=sometimes or somewhat false; 2=sometimes or somewhat true; 3=very true or often true). The overall measure has a range of scores from 0 to 75, with higher scores indicating greater overall personality dysfunction. Each trait domain ranges in score from 0 to 15, with higher scores indicating greater dysfunction in the specific personality trait domain. The clinician is asked to review the score on each item on the measure during the clinical interview and indicate the raw score for each item in the section provided for "Clinician Use." The raw scores on the 25 items should be summed to obtain a total raw score. The scores on the items within each trait domain should be summed and entered in the appropriate raw domain score box. In addition, the clinician is asked to calculate and use **average scores for each domain and for the overall measure. The average scores** reduce the overall score as well as the scores for each domain to a 4-point scale, which allows the clinician to think of the child's personality dysfunction relative to observed norms.[1] The **average domain score** is calculated by dividing the raw domain score by the number of items in the domain (e.g., if all the items within the "negative affect " domain are rated as being "sometimes or somewhat true" then the average domain score would be 10/5 = 2, indicating moderate negative affect). The **average total score** is calculated by dividing the raw overall score by the total number of items in the measure (i.e., 25). The average domain and overall personality dysfunction scores were found to be reliable, easy to use, and clinically useful to the clinicians in the DSM-5 Field Trials.

Note: If 7 or more items are left unanswered on the measure (i.e., more than 25% of the total items are missing) the total score should not be calculated. Similarly, if 2 or more items are left unanswered on any one domain, the domain score should not be calculated. Therefore, the child should be encouraged to complete all of the items on the measure. However, if 7 or more of the total items on the measure are left unanswered but 4 or 5 items for some of the domains are completed, the raw or average domain scores may be used for those domains. If for the overall measure 1 to 6 items are left unanswered, or for any domain only one item is left unanswered, you may prorate the total raw score or domain score by first summing the scores of items that were answered to get a **partial raw score**. Next, multiply the partial raw score by the total number of items on the measure (i.e., 25) or in the domain (i.e., 5). Finally, divide the value by the number of items that were actually answered to obtain the prorated total or domain raw score.

$$\text{Prorated Score} = \frac{\text{(Partial Raw Score x number of items on the PID-5 BF)}}{\text{Number of items that were actually answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track change in the severity of the child's personality dysfunction over time, it is recommended that the measure be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child receiving care that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

[1]Krueger RF, Derringer J, Markon KE, Watson D, Skodol AE. (2013). *The Personality Inventory for DSM-5 Brief Form (PID-5-BF).* Manuscript in preparation.

7.2 Further Resources

This section provides links to further resources and reading for additional Information.

Project Air Strategy for Personality Disorders http://www.projectairstrategy.org

- Project Air Strategy for Personality Disorders offers a comprehensive set of resources online including factsheets, videos and treatment guidelines

Working with complexity - suggested further reading

Amad, A., Ramoz, N., Thomas, P., Jardri, R., Gorwood, P. (2014). Genetics of borderline personality disorder: Systematic review and proposal of an integrative model. *Neuroscience and Biobehavioral Reviews, 40*, 6-19.

Bartholomew, K. & Horowitz, L.M. (1991). Attachment styles among young adults: a test of a four category model. *Journal of Personality and Social Psychology, 61*(2), 226-244.

Jiménez, J.P., Botto, A., Herrera, L., Leighton, C., Rossi, J.L., Quevedo, Y., Silva, J.R., Martínez, F., Assar, R., Salazar, L.A., Ortiz, M., Ríos, U., Barros, P., Jaramillo, K., Luyten, P. (2018). Psychotherapy and genetic neuroscience: An emerging dialog. *Frontiers in Genetics, 9,* 257.

Leichsenring, F., Leibing, E., Kruse, J., New, A.S., Leweke, F. (2011). Borderline personality disorder. *Lancet 377,* 74-84.

Winsper, C. (2018). The aetiology of borderline personality disorder (BPD): contemporary theories and putative mechanisms. *Current Opinion in Psychology, 21*, 105-110.

Privacy and Confidentiality

- **Legal Issues Bulletin 51: School Counsellors, confidentiality and the law https://education.nsw.gov.au/about-us/rights-and-accountability/media/documents/public-legal-issues-bulletins/LIB-51-School-Counsellors,-Confidentiality-and-The-Law.pdf**
- Ethical guidelines for working with young people (Australian Psychological Society. Note member access only)
- Consent to medical treatment: the mature minor https://www.racgp.org.au/afp/2011/march/consent-to-medical-treatment-the-mature-minor/

Sexuality and Gender diversity

Support and information:

- Twenty10 http://www.twenty10.org.au/
- The Gender Centre https://gendercentre.org.au/
- ACON https://www.acon.org.au/
- Legal Issues Bulletin 55: Transgender students in schools – legal rights and responsibilities: http://www.dec.nsw.gov.au/about-us/information-access/legal-issues-bulletins
- QLife https://qlife.org.au/

Migrant and Refugee services and support

- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) http://www.startts.org.au/
- Multicultural Youth Affairs Network NSW http://www.myan.org.au/nsw/
- NSW Settlement Partnership https://nsp.ssi.org.au/

Exchange of information between Education and Health

- Exchanging information related to child protection and wellbeing https://www.facs.nsw.gov.au/providers/children-families/interagency-guidelines/exchanging-information

Child Protection

- Mandatory Reporter Guide https://reporter.childstory.nsw.gov.au/s/

Online and Telephone supports

- **Kids Helpline** phone counselling and webchat 1800 55 1800, https://kidshelpline.com.au
- **Lifeline** Crisis support and suicide prevention 13 11 14
- **SANE helpline** information, guidance, and referrals to manage mental health concerns 1800 187 263
- **Youth Beyond Blue** Information, resources and support for young people dealing with depression and/or anxiety https://www.youthbeyondblue.com/
- **Reachout.com** Online mental health organisation that provides support to young people and their parents https://au.reachout.com
- **eheadspace** Online and telephone counselling for young people https://www.eheadspace.org.au/
- **moodgym** Online self-help for depression and anxiety https://moodgym.com.au

Assessment

- Headspace Psychosocial Assessment for Young People https://headspace.org.au/assets/Uploads/headspace-psychosocial-assessment.pdf

Risk Assessment and Safety Plans

- Framework for Suicide Risk Assessment and Management for NSW Health Staff http://www.health.nsw.gov.au/mentalhealth/programs/mh/Publications/framework-suicide-risk-assess.pdf
- SANE “Staying Alive” safety planning cards info@sane.org
- Beyond Now suicide safety planning app https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

Mental Health Awareness and Resiliency Programs

- Resourceful Adolescent Program http://www.rap.qut.edu.au/

- RU OK Day https://www.ruok.org.au/
- Teen Mental Health First Aid https://mhfa.com.au/cms/teen-mhfa-course-information

7.3 References

1. American Psychiatric Association, *Diagnostic and statistical manual of mental disorders: DSM-5*. 5th ed. 2013, Arlington, VA: American Psychiatric Association.
2. Chanen, A.M. and K.W. Thompson, *Preventive Strategies for Borderline Personality Disorder in Adolescents.* Current Treatment Options in Psychiatry, 2014. **1**(4): p. 358-368.
3. National Health and Medical Research Council, *Clinical practice guideline for the management of borderline personality disorder*. 2012, NHMRC: Melbourne.
4. Chanen, A.M. and L. McCutcheon, *Prevention and early intervention for borderline personality disorder: current status and recent evidence.* Br J Psychiatry Suppl, 2013. **54**: p. s24-9.
5. Chanen, A.M., M. Jovev, and H.J. Jackson, *Adaptive functioning and psychiatric symptoms in adolescents with borderline personality disorder.* J Clin Psychiatry, 2007. **68**(2): p. 297-306.
6. Wagner, G.A., et al., *Effectiveness of brief intervention and case management for children and adolescents with mental health difficulties.* Children and Youth Services Review, 2017. **79**: p. 362-367.
7. Grenyer, B.F.S., *An integrative relational step-down model of care: The Project Air Strategy for personality disorders.* The ACPARIAN, 2014. **9**: p. 8-13.
8. Project Air Strategy for Personality Disorders, *Treatment guidelines for personality disorders.* 2015, NSW Health and Illawarra Health and Medical Research Institute.
9. Bateman, A.W., J. Gunderson, and R. Mulder, *Treatment of personality disorder.* The Lancet, 2015. **385**(9969): p. 735-743.
10. Amad, A., et al., *Genetics of borderline personality disorder: Systematic review and proposal of an integrative model.* Neuroscience & Biobehavioral Reviews, 2014. **40**: p. 6-19.
11. Ensink, K., et al., *A developmental psychopathology and neurobiological model of borderline personality disorder in adolescence.* Journal of Infant, Child & Adolescent Psychotherapy, 2015. **14**(1): p. 46-69.
12. Gunderson, J.G., *Disturbed relationships as a phenotype for borderline personality disorder.* The American Journal of Psychiatry, 2007. **164**(11): p. 1637-1640.
13. Bretherton, I., *The origins of attachment theory: John Bowlby and Mary Ainsworth.* Developmental Psychology, 1992. **28**: p. 759-775.
14. Fonagy, P., & Target, M., *Attachment and reflective function: Their role in self-organisation.* Development and Psychopathology, 1997. **9**(4): p. 677-700.
15. Winnicott, D.W., *The theory of the parent-infant relationship.* Int J Psychoanal, 1960. **41**: p. 585-95.
16. Mikulincer, M. and P.R. Shaver, *An attachment perspective on psychopathology.* World Psychiatry, 2012. **11**(1): p. 11-15.
17. Fonagy, P., P. Luyten, and L. Strathearn, *Borderline personality disorder, mentalization, and the neurobiology of attachment.* Infant Ment Health J, 2011. **32**(1): p. 47-69.
18. Lewis, K.L. and B.F.S. Grenyer, *Borderline personality disorder or complex posttraumatic stress disorder: An update on the controversy.* Harvard Review of Psychiatry, 2009. **17**(5): p. 322-328.
19. Sturman, D.A. and B. Moghaddam, *The neurobiology of adolescence: changes in brain architecture, functional dynamics, and behavioral tendencies.* Neurosci Biobehav Rev, 2011. **35**(8): p. 1704-12.
20. Luborsky, L., *A guide to the CCRT method*, in *Understanding transference: The Core Conflictual Relationship Theme method*, L. Luborsky and P. Crits-Christoph, Editors. 1998, American Psychological Association: Washington, DC. p. 15-42.
21. Grenyer, B.F.S., *The clinician's dilemma: Core conflictual relationship themes in personality disorders.* ACPARIAN, 2012. **4**: p. 25-27.
22. Schön, D.A., *Educating the Reflective Practitioner*. Jossey-Bass Higher Education Series. 1987, San Francisco: Jossey-Bass.
23. Cooper, L.D. and A.T. Wieckowski, *A structured approach to reflective practice training in a clinical practicum.* Training and Education in Professional Psychology, 2017. **11**(4): p. 252-259.
24. Australian Psychological Society, *Ethical Guidelines: Complementing the APS Code of Ethics*. 11 ed. 2012, Melbourne, Victoria: Australian Psychological Society.
25. Gibson, K., et al., *What Young People Want: A Qualitative Study of Adolescents' Priorities for Engagement Across Psychological Services.* Journal of Child and Family Studies, 2016. **25**(4): p. 1057-1065.
26. Blanchard, M., et al., *Rethinking the Digital Divide: Findings from a Study of Marginalised Young People's Information Communication Technology (ICT) Use.* Youth Studies Australia, 2008(4): p. 35.
27. Stephens-Reicher, J., et al., *Reaching the hard-to-reach: how information communication technologies can reach young people at greater risk of mental health difficulties.* Australas Psychiatry, 2011. **19 Suppl 1**: p. S58-61.
28. Price, M. and J. Dalgleish, *Help-seeking among Indigenous Australian adolescents.* Youth Studies Australia, 2013. **32**(1): p. 10-18.
29. Bullot, A., et al., *Mission Australia's 2017 Youth Survey Report*. 2017.
30. Wynne-Jones, M., et al., *Aboriginal grief and loss: A review of the literature.* Australian Indigenous Health Bulletin, 2016. **16**(3): p. 10.

31. Fazel, M., et al., *Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors.* The Lancet, 2012. **379**(9812): p. 266-282.
32. Murray, K.E., G.R. Davidson, and R.D. Schweitzer, *Psychological Wellbeing of Refugees Resettling in Australia: A literature review prepared for The Australian Psychological Society.* Australian Psychologist, 2008.
33. Gopalkrishnan, N. and H. Babacan, *Cultural diversity and mental health.* Australasian Psychiatry, 2015. **23**(6 Suppl): p. 6-8.
34. Mustanski, B.S., R. Garofalo, and E.M. Emerson, *Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths.* American Journal of Public Health, 2010. **100**(12): p. 2426-32.
35. Rosenstreich, G., J. Comfort, and P. Martin, *Primary health care and equity: the case of lesbian, gay, bisexual, trans and intersex Australians.* Aust J Prim Health, 2011. **17**(4): p. 302-8.
36. Hodges, C.A., M.S. O'Brien, and P.D. McGorry, *headspace: National Youth Mental Health Foundation: Making headway with rural young people and their mental health.* Australian Journal of Rural Health, 2007. **15**(2): p. 77-80.
37. Baker, D. and S. Rice, *Keeping it real: Reimagining mental health care for all young men*. 2017, Orygen, the National Centre of Excellence in Youth Mental Health: Melbourne.
38. Burns, J. and E. Birrell, *Enhancing early engagement with mental health services by young people.* Psychology Research and Behavior Management, 2014. **7**: p. 303-312.
39. Collin, P.J., et al., *ReachOut.com: The role of an online service for promoting help-seeking in young people.* Advances in Mental Health, 2011(1): p. 39.
40. Goldenring, J.M. and D.S. Rosen, *Getting into adolescent heads: an essential update.* Contemporary Pediatrics, 2004. **21**(1): p. 64-74.
41. McGoldrick, M., R. Gerson, and S.S. Petry, *Genograms: Assessment and Intervention*. 2008: W.W. Norton & Company.
42. Zanarini, M.C., et al., *A screening measure for BPD: the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD).* J Pers Disord, 2003. **17**(6): p. 568-73.
43. Black Dog Institute, *Youth in distress: Managing suicidality and self harm particpant workbook*. 2018: Randwick NSW.
44. Grenyer, B.F.S., *Mastering relationship conflicts: Discoveries in theory, research and practice.* 2002, Washington DC: American Psychological Association.
45. New, A.S., et al., *Empathy and alexithymia in borderline personality disorder: Clinical and laboratory measures.* Journal of Personality Disorders, 2012. **26**(5): p. 660-675.
46. Carter, P.E. and B.F.S. Grenyer, *The effect of trauma on expressive language impairment in borderline personality disorder.* Personality and Mental Health, 2012. **6**(3): p. 183-195.
47. Mission Australia and Foundation for Alcohol Research and Education (FARE). *Regulator: A Dialectical Behaviour Therapy Skills Workbook*. n.d.; Available for download at: https://www.projectairstrategy.org/guidelines/index.html
48. Gwinner, K., *Arts, therapy, and health: Three stakeholder viewpoints related to young people's mental health and wellbeing in Australia.* The Arts in Psychotherapy, 2016. **50**: p. 9-16.
49. Gantt, L. and L.W. Tinnin, *Support for a neurobiological view of trauma with implications for art therapy.* The Arts in Psychotherapy, 2009. **36**: p. 148-153.
50. Ncube, N. and D. Denborough, *Finding hidden stories of strength and skills: using the Tree of Life with Aboriginal and Torres Strait Islander children*. 2009, Dulwich Centre Foundation: Adelaide.
51. Bartholomew, K. and L.M. Horowitz, *Attachment styles among young adults: a test of a four category model.* Journal of Personality and Social Psychology, 1991. **61**(2): p. 226-244.
52. Reis, S. and B.F.S. Grenyer, *Fearful attachment, working alliance and treatment response for individuals with major depression.* Clinical Psychology & Psychotherapy, 2004. **11**(6): p. 414-424.
53. Daly, A.M., et al., *Rupture resolution in cognitive analytic therapy for adolescents with borderline personality disorder.* Psychol Psychother, 2010. **83**(Pt 3): p. 273-88.
54. Wester, K.L., C.W. Morris, and B. Williams, *Nonsuicidal Self-Injury in the Schools: A Tiered Prevention Approach for Reducing Social Contagion.* Professional School Counseling, 2018. **21**(1): p. 142-151.
55. Mitchell, R.J., et al., *Intentional self-harm and assault hospitalisations and treatment cost of children in Australia over a 10-year period.* Australian and New Zealand Journal of Public Health, 2018.
56. Beardslee, W.R., et al., *Preventive interventions for children of parents with depression: international perspectives.* Medical Journal of Australia, 2012. **1**(Suppl 1): p. 23-27.
57. Klonsky, E.D., *The functions of deliberate self-injury: A review of the evidence.* Clin Psychol Rev, 2007. **27**(2): p. 226-239.
58. Rasmussen, S., et al., *Why do adolescents self-harm? An investigation of motives in a community sample.* Crisis, 2016. **37**: p. 176-183.
59. Stänicke, L.I., H. Haavind, and S.E. Gullestad, *How Do Young People Understand Their Own Self-Harm? A Meta-synthesis of Adolescents' Subjective Experience of Self-Harm.* Adolescent Research Review, 2018. **3**(2): p. 173-191.
60. Chapman, A.L., K.L. Gratz, and M.Z. Brown, *Solving the puzzle of deliberate self-harm: The experiential avoidance model.* Behav Res Ther, 2006. **44**(3): p. 371-394.

61. Hawton, K., K.E.A. Saunders, and R.C. O'Connor, *Self-harm and suicide in adolescents.* The Lancet, 2012. **379**(9834): p. 2373-2382.
62. Schmaal, L. and S. Bendall, *Childhood maltreatment and non-suicidal self-injury: clinical implications.* Lancet Psychiatry, 2018. **5**(1): p. 5-6.
63. Hawton, K. and A. James, *Suicide and deliberate self harm in young people.* BMJ, 2005. **330**(7496): p. 891-4.
64. Carter, G.L., et al., *Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm.* Aust N Z J Psychiatry, 2016. **50**(10): p. 939-1000.
65. Holmqvist, R., *Staff feelings and patient diagnosis.* Canadian Journal of Psychiatry, 2000. **45**(4): p. 349-356.
66. Hu, N., et al., *The impact of child maltreatment on the risk of deliberate self-harm among adolescents: A population-wide cohort study using linked administrative records.* Child Abuse & Neglect, 2017. **67**: p. 322-337.
67. National Children's Commissioner, *Children's Rights Report 2014*, Australian Human Rights Commission, Editor. 2014, Australian Human Rights Commission,: Sydney.
68. Hiran, T., et al., *The management of young people who self-harm by New Zealand Infant, Child and Adolescent Mental Health Services: cutting-edge or cutting corners?* Australasian Psychiatry, 2018: p. 1039856217748248.
69. Claes, L., et al., *Bullying and victimization, depressive mood, and non-suicidal self-injury in adolescents: The moderating role of parental support.* Journal of Child and Family Studies, 2015. **24**(11): p. 3363-3371.
70. Fisher, H.L., et al., *Bullying victimisation and risk of self harm in early adolescence: longitudinal cohort study.* BMJ (Clinical Research Ed.), 2012. **344**: p. e2683-e2683.
71. Evans, R. and C. Hurrell, *The role of schools in children and young people's self-harm and suicide: systematic review and meta-ethnography of qualitative research.* BMC Public Health, 2016. **16**(1): p. 1-16.
72. Klemera, E., et al., *Self-harm in adolescence: protective health assets in the family, school and community.* Int J Public Health, 2016: p. 1-8.
73. Fortune, S., J. Sinclair, and K. Hawton, *Adolescents' views on preventing self-harm: a large community study.* Soc Psychiatry Psychiatr Edpidemiol., 2008. **43**.
74. Ougrin, D., et al., *Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis.* J Am Acad Child Adolesc Psychiatry, 2015. **54**(2): p. 97-107 e2.
75. Rossouw, T.I. and P. Fonagy, *Mentalization-based treatment for self-harm in adolescents: a randomized controlled trial.* J Am Acad Child Adolesc Psychiatry, 2012. **51**(12): p. 1304-1313 e3.
76. Morgan, S., et al., *Parents of young people with self-harm or suicidal behaviour who seek help—a psychosocial profile.* Child Adolesc Psychiatry Ment Health., 2013. **7**.
77. Lewis, S.P. and Y. Seko, *A Double-Edged Sword: A Review of Benefits and Risks of Online Nonsuicidal Self-Injury Activities.* Journal Of Clinical Psychology, 2016. **72**(3): p. 249-262.
78. Brent, D.A., et al., *Protecting adolescents from self-harm: a critical review of intervention studies.* Journal of the American Academy of Child & Adolescent Psychiatry, 2013. **52**(12): p. 1260-1271.
79. Marker, I. and P.J. Norton, *The efficacy of incorporating motivational interviewing to cognitive behavior therapy for anxiety disorders: A review and meta-analysis.* Clinical Psychology Review, 2018. **In press**.
80. Borschmann, R., et al., *20-year outcomes in adolescents who self-harm: a population-based cohort study.* The Lancet Child & Adolescent Health, 2017. **1**(3): p. 195-202.
81. Whitlock, J., W. Lader, and K. Conterio, *The internet and self-injury: what psychotherapists should know.* J Clin Psychol, 2007. **63**(11): p. 1135-43.
82. Hart, T. and M. O'Reilly, *'The challenges of sharing information when a young person is experiencing severe emotional difficulties': Implications for schools and camhs.* Child and Adolescent Mental Health, 2017.
83. Bowers, H., et al., *Stigma in school-based mental health: perceptions of young people and service providers.* Child & Adolescent Mental Health, 2013. **18**(3): p. 165-170.
84. Cooper, M., Y. Evans, and J. Pybis, *Interagency collaboration in children and young people's mental health: A systematic review of outcomes, facilitating factors and inhibiting factors.* Child: Care, Health and Development, 2016. **42**(3): p. 325-342.
85. Greig, A., et al., *Guest Editorial: The Changing Context for Mental Health and Wellbeing in Schools.* Educational & Child Psychology, 2016. **33**(2): p. 6-11.
86. Haggerty, J.L., et al., *Continuity of care: a multidisciplinary review.* BMJ, 2003. **327**(7425): p. 1219-1221.
87. National Society for the Prevention of Cruelty to Children. *CAMHS: Learning from case reviews: Summary of risk factors and learning for improved practice for child and adolescent mental health service*. 2017.
88. Byng, R., et al., *Exposing the key functions of a complex intervention for shared care in mental health: case study of a process evaluation.* BMC Health Services Research, 2008. **8**(1): p. 274.
89. National Society for the Prevention of Cruelty to Children and Social Care Insitute for Excellence *Practice issues from serious case reviews*, in *Learning into practice: improving the quality and use of serious case reviews*. n.d.