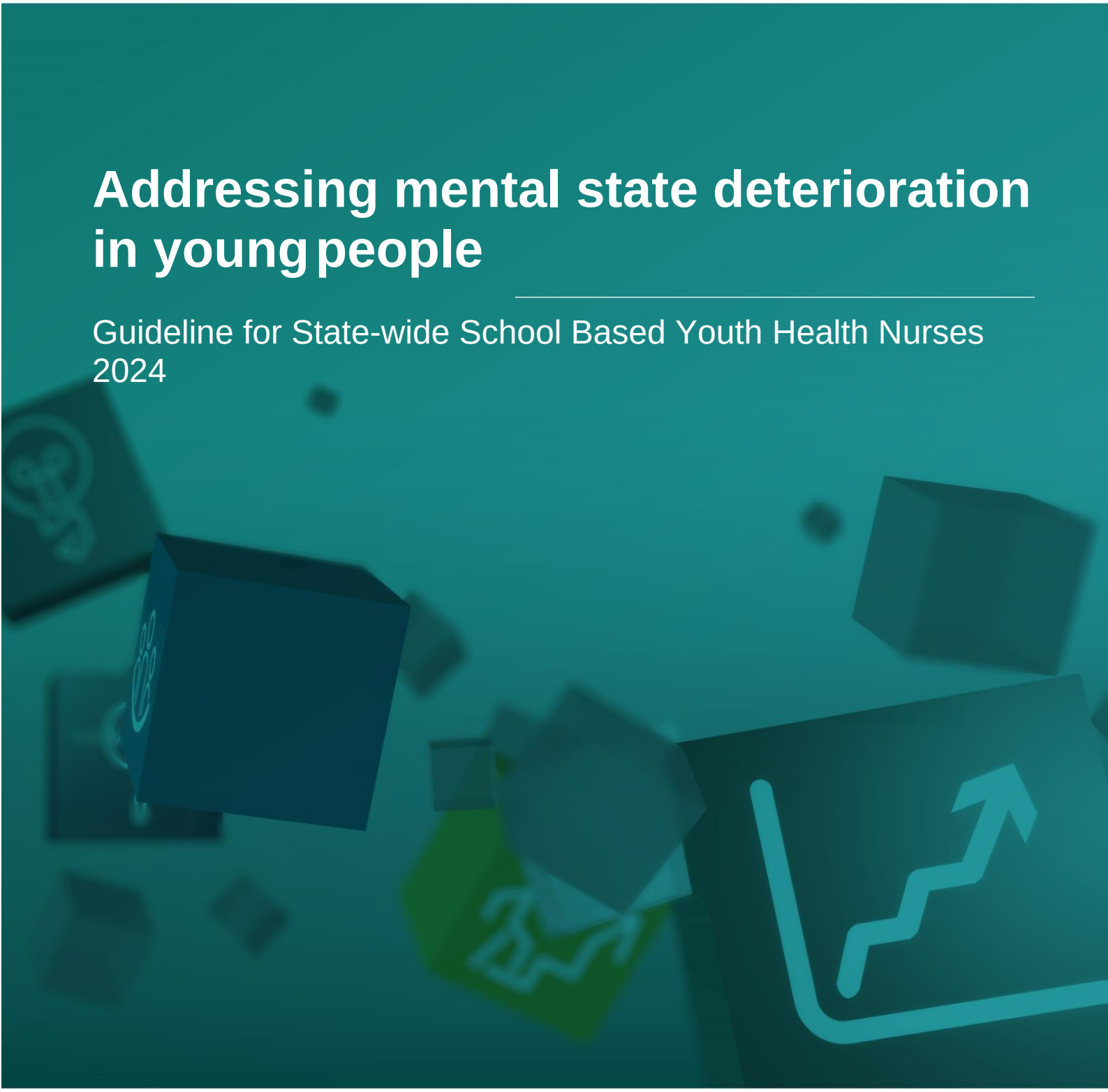
Addressing mental state deterioration in young people

Guideline for State-wide School Based Youth Health Nurses 2024



Addressing Mental State Deterioration in Young People Guideline for State-wide School Based Youth Health Nurses

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For more information contact:
State-wide School Based Youth Health, Child and Youth Community Health Service, Children's Health Queensland, Level 9, 199 Grey Street, South Brisbane

OEmail NMSBYH.State-wide@health.qld.gov.au, phone (07) 3310 7834.

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1.0 Purpose

This Guideline has been developed to support School Based Youth Health Nurses (SBYHNs) and their line managers to provide safe and skilled assessment, early intervention and referral to young people experiencing a deterioration in their mental state.

Deterioration in mental state does not always indicate the presence of mental illness and may indicate a temporary response to psychological distress, physical conditions including delirium, atypical responses to prescribed treatments, or intoxication with licit or illicit substances. A careful and holistic assessment will provide the information required to facilitate the SBYHN to consider and meet the psychoeducation, support, and referral needs of the young person presenting to the service.

2.0 Scope

This guideline is designed to support the practice of all SBYHNs providing service to young people in State Secondary Schools in Queensland.

3.0 Acknowledgement

The development of this guideline has been supported by significant expert input from School Based Youth Health stakeholders, including Children's Health Queensland (CHQ) Child and Youth Mental Health Service (CYMHS) Statewide Ed-LinQ, Forensic CYMHS Aboriginal and Torres Strait Islander Program Coordinator, Aboriginal and Torres Strait Islander Service Integration Coordinator and Consumer Carer Participation Teams, Statewide Child Protection Clinical Partnership, Queensland Children's Gender Service and the School Based Youth Health Nurse Sub Network.

Youth Mental Health First Aid (YMHFA) is the recommended entry level training for SBYHNs, and Youth Mental Health First Aid: A manual for adults assisting young people (Kelly et al., 2017) has been used extensively as a reference throughout this guideline.

4.0 Aboriginal and Torres Strait Islander young people

Mental ill health is a significant health issue for young people with the highest incidence of onset of illness occurring between 12 and 24 years of age. Challenges like housing, employment, and education impact all individuals, yet Aboriginal and Torres Strait Islander communities face unique risk factors that significantly influence their social and emotional wellbeing and the prevalence of mental health issues is higher among Aboriginal and Torres Strait Islander young people compared with their non – Aboriginal peers. The impact of trauma can be transferred through generations, increasing the need for targeted, culturally sensitive mental health intervention.

Significant risk factors that can impact on the social emotional wellbeing of Aboriginal and Torres Strait Islander communities include:

- widespread grief and loss
- impacts of the Stolen Generations and removal of children
- unresolved trauma
- separation from culture and identity issues
- discrimination based on race or culture
- economic and social disadvantage
- physical health problems
- incarceration
- violence
- substance misuse, (Beyond Blue, 2020b).

The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023 identifies nine key strategies that underpin best practice in supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people that include:

- Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural, and spiritual health. Land is central to wellbeing. When the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist. Experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
- Racism, stigma, environmental adversity, and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
- Recognising that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

The Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021 highlights that when young Aboriginal and Torres Strait Islander individuals seek services, they bring unique personal viewpoints and complex family and cultural considerations that differ significantly from other Australians. This necessitates healthcare professionals who are not only skilled in culturally informed clinical practices but also proactive in engaging Aboriginal and Torres Strait Islander health professionals or Liaison Officers. Such collaboration is essential to provide enhanced support to these young people and to assist healthcare providers in devising care plans that are respectful of cultural nuances.

The Queensland Government has recognized the importance of First Nations voices, leadership and lived experience by requiring each HHS to co-develop Health Equity Strategies to deliver health equity, eliminate racial discrimination and institutional discrimination and influence the social, cultural, and economic determinants of health. The Health Equity Strategies are developed in partnership with Aboriginal and Torres Strait Islander organizations, health services, communities, consumers, and Traditional Owners. HHS Aboriginal and Torres Strait Islander Health Equity Strategies are located on

QHEPS.

5.0 Related documents

1. Child and Youth Health Practice Manual. Queensland Child and Youth Clinical Network – Child Health Sub-Network, Children's Health Queensland Hospital and Health Service, 2020.
2. The Role of the School Based Youth Health Nurse Learning Module on the State-wide School Based Youth Health Nurse Professional Development I Learn site.
3. The Role of the School Based Youth Health Nurse Interactive Learning Module on the State-wide School Based Youth Health Nurse Professional Development I Learn site.
4. Suicide Prevention in Health Services Initiative Task Force Action Plan.

6.0 Standards, Guidelines and Key Documents

1. National Action Plan for the Health of Children and Young People: 2020-2030. (Commonwealth of Australia, Department of Health, 2019)
2. Prevention Compassion Care: National Mental Health and Suicide Prevention Plan. (Commonwealth of Australia, Department of Health, 2021)
3. National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state. (Australian Commission on Safety and Quality in Health Care, 2017)
4. National Safety and Quality Health Service Standards, 2nd edition. (Australian Commission on Safety and Quality in Health Care, 2021)
5. National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023. (Commonwealth of Australia, Department of Prime Minister and Cabinet, 2017)
6. National Aboriginal Torres Strait Islander Suicide Prevention Strategy. (Australian Government, 2013)
7. The Department of Health Strategic Plan 2019-2023. (The State of Queensland, Queensland Health, 2020)
8. Student Learning and Wellbeing Framework. (Queensland Government, Department of Education, 2020)
9. Every Life: The Queensland Suicide prevention plan 2019-2029. (Queensland Mental Health Commission, 2019)
10. Children's Health Queensland Strategic Plan 2020-2024. (The State of Queensland, Queensland Health, 2024)
11. Assessment and Treatment of Children and Adolescents with Eating Disorders in Queensland. (Mental Health Alcohol and Other Drugs Branch, 2020)
12. Queensland Child Protection Guide 2.1 The Structured Decision Making System for Child Protection Services. (The State of Queensland, The Department of Child Safety, Youth and Women, 2019)

13. Trans @ School. A guide for schools, educators, and families of trans and gender diverse children and young people. (Queensland Human Rights Commission, 2024)
14. Working with parents: guidance for mental health, alcohol and other drugs services. (Clinical Excellence Queensland, Mental Health Alcohol and Other Drugs Branch, 2021).

7.0 Introduction

Adolescence is a time of rapid change, where young people experience physical, cognitive, social, and emotional changes necessary for the young person to reach their potential in adult life. Half of all people who ever develop a mental illness will have their first episode prior to the age of 18, making adolescence a time of vulnerability.

Mental health problems and adolescent development are interrelated, influencing each other in several ways:

- It can be difficult to distinguish the symptoms of mental health problems from normal adolescent behaviours and moods.
- The changes that occur during adolescence can create additional risk factors for developing mental health problems.
- Mental health problems can interfere with adolescent development.

Deterioration in mental state is defined as a "change is a person's perception, cognitive function or mood which negatively influences their capacity to function as they would typically choose", (Australian Commission on Safety and Quality in Health Care, 2017).

The Youth Survey Report 2023 (McHale et al., 2023) found that a quarter of young people are at risk of serious mental illness, with risk increasing as adolescents age and more prominent among Indigenous young Australians and young women. Furthermore "suicide among young Australians (15-24 years) is at its highest level for ten years and is the leading cause of death for this age group." More recently, the dual impacts of bushfires and Covid-19 in 2020 on the mental health of young people is expected to impact negatively now, and for some time into the future, (AIHW, 2021; Usher et al., 2021).

"Fifty percent of mental ill-health onsets before the age of 15 years, 75% by the age of 24 years, and mental ill health is the leading cause of disability in young people. Left untreated, the trajectory and lifelong impact of mental ill-health are borne by the individual, their families, their communities, and governments. These include: un/underemployment, social exclusion, poor physical health, substance abuse and premature mortality", (Orygen, 2019).

Prompt diagnosis and early intervention in the initial stages of mental illness can have significant and life changing consequences for a person's mental health, particularly for children and young people. Given the serious, long lasting impacts that mental health disorders can have, both on young people themselves and those around them, it is critical that effective mental health interventions and services are in place and that they are relevant and easily accessible for young people (as well as those who care for and support them).

SBYHNs are in a unique position to provide an accessible service, assessment, brief intervention, and referral to young people. The SBYHN role maintains a preventative rather than treatment focus and works to promote positive health outcomes for young people and their families and carers through the delivery of accessible, acceptable, appropriate, and culturally respectful primary health care services in the school setting, (CYHPM, 2020).

8.0 Assessment

SBYHNs offer young people the chance to self-refer to their services or be seen voluntarily after a referral from Department of Education staff, parents, or carers. SBYHN scope of practice involves conducting assessments to explore the presenting issue, identifying the young person's strengths, supports, underlying concerns, risk factors, and significant issues that require intervention, (CYHPM, 2020).

In the context of assessment, a SBYHN must be able to identify, respond and refer appropriately where there is an indication of mental state deterioration, including but not limited to the presence of a risk of significant harm to self or others. The use of the HEEADSSS assessment is a standard SBYHN process, and where risk is identified additional tools may be used to gain further information, e.g., tools that explore the risk of intent to harm self or others or risk of eating disorders. It is outside SBYHN scope of practice to perform a mental state examination, or any complex mental health assessment intended to diagnose.

Stigma, embarrassment, and poor mental health literacy have all been identified as barriers for young people in accessing support for mental health concerns, (Velasco et al., 2020). Additionally, concerns regarding confidentiality; attitudes, communication style and confidence of the health care provider; negative perceptions of health services; developmental characteristics of young people and issues relating to gender, age and culture may all contribute to reluctance to engage with services to seek support, (CYHPM, 2020).

It is essential for young people to feel listened to, respected, safe, to have a sense of autonomy and perceive that their clinician is trustworthy, kind, and caring when seeking help for mental health issues.

To build engagement, it is particularly important to:

- build strong therapeutic relationships
- address confidentiality issues and concerns
- involve caregivers if possible, taking into consideration the young person's age, stage of development, wishes and circumstances, (Orygen, 2017).

Prior to progressing with any consultation and assessment standard SBYHN practice requires the SBYHN will ensure the young person has given consent to referral to the service, is aware of the voluntary nature of the service, and has a sufficient level of maturity and understanding of the presenting health issue to give consent to service, a process described as establishing Gillick competence.

The following issues should be considered in an assessment of capacity to consent to health care:

- the age, attitude and maturity of the child or young person, including their physical and emotional development
- the child or young person's level of intelligence and education
- the child or young person's social circumstances and social history
- the nature of the child or young person's condition
- the complexity of the proposed health care, including the need for follow up or supervision after the health care
- the seriousness of the risks associated with the health care
- the consequences if the child or young person does not have the health care
- where the consequences of receiving the health care include death or permanent disability, that the child or young person understands the permanence of death or disability and the profound nature of the decision he or she is making, (State of Queensland 2023).

A SBYHN has a duty of care to ensure a young person is safe and protected from harm, and this may require sharing information with parents, carers, and other health professionals to reduce risk of harm to a young person or facilitate referral to specialist services. Confirming a young person's understanding of duty of care as it relates to confidentiality prior to their initial and subsequent assessments is an essential component of the process of establishing the informed consent of the young person accessing the SBYHN service.

It is preferable that a young person's parent or carer is involved in their care, however if a young person clearly expresses the wish that information is not shared with their parent or carer, where it is safe to do so, and does not conflict with medico legal and professional obligations, this must be respected. It may be helpful to explore the young person's thinking in relation to their expectation of the outcome of sharing information with a view to finding areas of compromise, an example being the sharing of some critical information relating to a concern, while agreeing to not share other information, where withholding that information does not increase a risk to the young person's safety. Similar considerations are also useful when considering sharing information with a trusted support person within the school, who may be able to offer additional and complimentary support to the young person.

8.1 Building trust and rapport with young people

The development of a therapeutic relationship with a young person is key to a young person feeling comfortable and able to share information in an assessment and participate in decision making around their support and care needs.

Skills and knowledge in the following areas will support the SBYHN's capacity to build rapport with young people:

- Understanding adolescent development issues
- Acquiring effective communication skills
- Understanding relevant medico-legal issues
- Becoming familiar with strategies for working with young people and their families

- Understanding the cultural factors that can influence a young person's sense of themselves and their role in the family and the community
- Understanding different cultural concepts of health. For indigenous people, for example, health is an inseparable part of spiritual, cultural, and social wellbeing, with the wellbeing of the individual, family and community inextricably linked".

The Child and Youth Health Practice Manual (State of Queensland, 2020) and the Providing Safe & Quality Care to Young People practice guide (State of Queensland, 2023) outline approaches for rapport building with young people in the school setting and youth friendly communication.

The Aboriginal and Torres Strait Islander Health Division, Indigenous Health Workers, Indigenous Liaison Officers and the Transcultural Mental Health Centre are additional supports for the SBYHN to build skills and insight into the needs of young people who present for service with diverse cultural influences impacting on their health and wellbeing.

Young LGBTIQ+ people are known to be at increased risk of mental state deterioration and suicide and to have increased obstacles to accessing services. The Queensland Children's Gender Service "LGBTI+ youth mental health practice and suicide prevention training" provides expert education to assist SBYHNs build skills to provide an inclusive and supportive health service, (see 15.0 Skill development and training).

Effective communication skills that support young people to feel welcome, respected and heard are foundational to SBYHN practice. Whilst some SBYHNs enter the service with Child and Youth Mental Health practice backgrounds, and / or post graduate qualifications in child and adolescent health with advanced skills, it is critical that all SBYHNs continue to reflect on how their communication, environment, professional and personal history impact on working with young people and build their skills through reflective practice, professional development, case conference and clinical supervision.

8.2 Psychosocial assessment

It is recommended that every young person who presents to a SBYHN service receives a HEEADSSS adolescent psychosocial assessment. The HEEADSSS assessment elicits information across eight critical domains that reflect the major domains of a young person's life and the risks to their health and psychosocial status. It is a preliminary assessment that will provide indications of a young person's health and wellbeing, risk and protective factors and areas that may require immediate or subsequent intervention. It is critical to deliver the assessment sensitively and prioritise the presenting needs of the young person, and at times it may be that elements of the assessment are not addressed to allow for attention to high priority areas, particularly where the young person is highly distressed or unwell.

It is crucial that a SBYHN builds rapport with a young person during all consultations, and essential that questions that can be of a sensitive nature are introduced skillfully. While the general flow of a HEEADSSS assessment follows a path where more sensitive questions are generally later in the assessment, early domains such as home or eating could hold sensitivity for some young people, and there may be times where presentation indicates the need to move toward questions of a more sensitive nature early in the assessment.

A **HEEADSSS** assessment explores the following domains:

Home
Education/employment
Eating and exercise
Activities, hobbies, and peer relationships
Drug use /cigarettes /alcohol
Sexual activity/sexuality
Suicide /self-harm /depression
Safety and spirituality

A copy of the Statewide Young Person Health Record HEEADSSS Assessment Form can be found in Appendix 1.

A training module and video demonstrating techniques and skills in the context of SBYHN practice have been developed for SBYHNs on delivering an effective HEEADSSS assessment and are located within the iLearn Role of the School Based Youth Health Nurse module. Additional video learning resources for health professionals are also available.

Where there are reported or observed indicators of concern about the deterioration of a young person's mental health, and in particular their risk of self–harm or suicide, a more comprehensive mental health and risk assessment is indicated which encompasses both subjective and objective assessment data to assess their level of risk and the immediacy of intervention.

Examples of these can be found in the Appendices: Young person mental health assessment, (Appendix 2); Young person potential eating disorder assessment tool, (Appendix 3).

8.3 Risk and protective factors

Adolescence is a time of vulnerability for the development of a mental illness and for some young people additional vulnerabilities increase the risk further.

- Aboriginal and Torres Strait Islander young people report higher rates of psychological distress than their non-Aboriginal and Torres Strait Islander peers. Some of the external and internal influences that increase risks to social and emotional wellbeing of young people were identified in Section 4.0 of this guideline. Aboriginal and Torres Strait Islander young people experience higher rates of psychological distress caused directly from the impact of colonisation. Contributing risk factors include the effects of racism, discrimination, historical, political, social, and economic determinants causing intergenerational trauma and profound disadvantage. Culture should be seen as an opportunity to increase protective factors that can contribute to improving social and emotional wellbeing. Connection to culture, family, kinship, community, country, and spirituality are vital parts of mental wellbeing and should never been seen as risk factors. Aboriginal knowledge, spirituality, beliefs, values, and behaviours are the core to strong and positive cultural identity and these domains should not be separated by the system without the risk of further withdrawal from culture.
- Young people who identify as part of the LGBTIQ+ community have higher rates of depression and anxiety, post-traumatic stress disorder, personality disorders, psychosis, eating disorders, self-harm

and attempts to suicide, the risks may peak close to the time they share their sexuality or gender diversity with one or more groups (Queensland Children's Gender Service, 2020). Many LGBTIQ+ young people experience marginalization and discrimination, lack of family support, bullying and isolation, adding to the already existing risks associated with other domains of their life, and impacting on their mental health, engagement in education and employment opportunities.

- Young people who are homeless or at risk of homelessness, are more likely to experience mental health problems because of their homelessness. They are also more likely to be homeless because of a mental health problems or experiences of abuse, neglect and family violence, and experience barriers to accessing services.
- Young people in out-of-home care (and their families) are some of the most vulnerable and disadvantaged members of our community. Children's early attachment to parents and carers and connection to community and culture is of fundamental importance. When this is breached, the child or young person's complex experiences of loss and trauma can have a profound impact on every aspect of development.
- Young people with a disability, communication disorder & language impairment are at an increased risk of developing comorbid mental health difficulties and disorders. Disability defined as; including intellectual, physical, sensory and dual disabilities, neurological impairments and acquired brain injury.
- Young refugees are a highly vulnerable group. They may be settling in Australia without family support after traumatic histories in their home country, and often after transitional placements in other countries. Many will distrust government support and may know little or nothing about what help is available to them.
- Most children of parents with a mental illness stay quite well and may need support only. However, Australian studies show that children living in these families are generally more at risk than the general population. Some are vulnerable and need services, and some are at increased risk of injury and/or abuse, or of developing severe disorders themselves.
- Young people involved in the youth justice system are often vulnerable and more likely to experience mental health problems than the general community. Many have drug and alcohol problems related to their offending.
- Alcohol and other drug use impact significantly on the developing brains of children and adolescents and increase risk of reduced social functioning.

Individual and Family Risk Factors

- Families experiencing caregiving challenges related to children with special needs (for example, disabilities, mental health issues, chronic physical illnesses)
- Children and youth who don't feel close to their parents/caregivers and feel like they can't talk to them about their feelings
- Youth who start dating early or engaging in sexual activity early
- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behaviour
- Families with caregivers who have a limited understanding of children's needs or development
- Families with caregivers who were abused or neglected as children
- Families with young caregivers or single parents

- Families with low income
- Families with adults with low levels of education
- Families experiencing high levels of parenting stress or economic stress
- Families with caregivers who use spanking and other forms of corporal punishment for discipline
- Families with inconsistent discipline and/or low levels of parental monitoring and supervision
- Families that are isolated from and not connected to other people (extended family, friends, neighbours)
- Families with high conflict and negative communication styles
- Families with attitudes accepting of or justifying violence or aggression.

Individual and Family Protective Factors

- Families who create safe, stable, and nurturing relationships, meaning, children have a consistent family life where they are safe, taken care of, and supported
- Children who have positive friendships and peer networks
- Children who do well in school
- Children who have caring adults outside the family who serve as mentors/role models
- Families where caregivers can meet basic needs of food, shelter, and health services for children
- Families where caregivers have college degrees or higher
- Families where caregivers have steady employment
- Families with strong social support networks and positive relationships with the people around them
- Families where caregivers engage in parental monitoring, supervision, and consistent enforcement of rules
- Families where caregivers/adults work through conflicts peacefully
- Families where caregivers help children work through problems
- Families that engage in fun, positive activities together
- Families that encourage the importance of school for children.

(Centers for Disease Control and Prevention [CDC], 2021).

Communities with significant risk factors contribute to the development of individual and family risk, and inversely communities with a number of protective factors, such as having strong partnerships between the community and business, health care, government, and other sectors and where residents feel connected to each other and are involved in the community contribute to increased proportion of residents with individual and family protective factors and hence lower risk of onset of health issues (CDC, 2021).

Many young people present with a complex mix of issues that are impacting on their mental health and wellbeing, some may be acknowledged by the young person as being significant, while others may be present without the young person having recognized their potential impact; some examples being, the potential mix of anxiety, depression, ADHD, autism, language impairment or eating disorders in conjunction with other factors such as family dynamics, cultural pressures, socio-economic factors and health literacy. Additional to the increased risk to mental health these issues may be associated with, they may also be barriers to a young person seeking help and accessing services successfully without sufficient support and consideration in referral and care planning.

Whilst the presence of risk factors may increase the risk of developing a mental health disorder, identifying,

and maximizing protective factors may help to compensate for their presence. A careful exploration of the psychosocial domains of the young person will allow the SBYHN to complete a comprehensive assessment and develop an individualized care plan for the young person, that is strengthened by incorporating strategies to reduce the impact of risk factors and utilises and builds on existing or potential protective factors.

8.4 Deterioration in mental state

Adolescence is a time where many young people experience changes in behaviours, interests, relationships, and tolerance to risk. This can also be influenced by peer group choices and by the young person's maturing cognition and response to growing awareness of factors within family and society. It is essential to consider one's connection to culture when assessing deterioration in mental state. The proximity to culture is crucial for mental wellbeing. When cultural connection is compromised or lost, individuals may experience:

- Increased Stress: Without the support and coping mechanisms provided by cultural connections, stress levels can increase.
- Isolation: Feeling disconnected from one's culture can lead to feelings of isolation and loneliness.
- Identity Confusion: A lack of cultural connection can lead to uncertainty about one's place in the world, affecting self-esteem and self-worth.
- Vulnerability to Mental Illness: These factors can contribute to a higher risk of developing mental health conditions such as depression or anxiety.

A deterioration in mental state can be sudden or gradual, and a young person may present in crisis with mood or thought variation including suicidal thoughts and behaviours, and, or non–suicidal self-injury (NSSI) at an initial or subsequent presentation. The intensity of features varying significantly on different occasions. Table 1 lists indicators and signs of deterioration.

Table 1: Signs of deterioration in mental state

<table>
<tr><th colspan="2">Mental State Deterioration</th></tr>
<tr><td colspan="2">Definition: A change for the worse in a person's mental state, compared with the most recent information available for that person, which may indicate a need for additional care.</td></tr>
<tr><th colspan="2">Assessing Change</th></tr>
<tr><td colspan="2">Identifying and tracking change relies on the availability of individual baseline information to which a person's current mental state can be compared.

Baseline Information ..... Current mental state</td></tr>
<tr><th colspan="2">Signs of Deterioration</th></tr>
<tr><th>Indicators of deterioration</th><th>Clusters of signs of deterioration</th></tr>
<tr><td>Reported change
A person, or someone who knows the person well, reports that her or his mental state is changing for the worse.</td><td>• Self-initiated requests for assistance
• Requests for treatment from healthcare professionals or those close to the person
• Self-reported negative or inflated sense of self
• Self-reported uncontrollable thought processes
• Self-reported negative emotions</td></tr>
<tr><td>Distress
A person, or someone involved in her or his care, shows signs of distress, which are evident through observation and conversation.</td><td>• Uncharacteristic facial expressions
• Physiological/medical deterioration
• Negative themes in conversations
• Apparent distress of self or others</td></tr>
<tr><td>Loss of touch with reality or consequence of behaviours
A person is losing touch with reality or the consequences of her or his behaviour.</td><td>• Indications of experiencing delusions
• Indications of experiencing hallucinations
• Unusual self-presentation
• Unusual ways of behaving
• Appearing confused during conversations</td></tr>
<tr><td>Loss of function
A person is losing her or his ability to think clearly, communicate, or engage in regular activities.</td><td>• Unusual movement patterns
• Loss of skills
• Poor daily self-care
• Reduction in regular activities
• Difficulty participating in conversations
• Unusual speech during conversations
• Seemingly impaired memory
• Apparent difficulty with thinking about things in different ways</td></tr>
<tr><td>Elevated risk to self, others or property
A person's actions indicate an increased risk to self, others, or property.</td><td>• Increases in the use of restrictive practices
• Reduced safety of self
• Reduced safety of others
• Reduced safety of property
• Disengaging from treatment
• Unresponsiveness to treatment</td></tr>
</table>

(Gaskin et al., 2018).

8.5 Responding to deterioration in mental state

The Youth Mental Health First Aid course is recommended training for all SBYHNs. It offers a framework to support young individuals with existing or emerging mental health conditions, ensuring their safety and access to appropriate care. The mnemonic actions are intended to be used flexibly and are not sequential.

Mental Health First Aid Action Plan

Approach the person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give supports and information

Encourage the person to get appropriate professional help

Encourage other supports

(Kelly et al., 2017).

The framework provides a beginning SBYHN with safe parameters for working with young people experiencing mental state deterioration and has the flexibility for experienced SBYHNs to integrate their advanced knowledge into a care plan that meets the needs of the young person and sits within the scope of practice for SBYHNs. Contact Ed-Linq for support with accessing this course Statewide Ed-LinQ Program | Children's Health Queensland.

9.0 Mental health conditions in young people

The role of the SBYHN includes assessment, referral, brief intervention, and support. Whilst diagnosis of mental health illness is not in scope for SBYHNs, knowledge of the indicators for a potential diagnosis will support the SBYHN to identify appropriate care and referral pathways and meet the education and support needs of a young person experiencing changes to their mental health.

Whilst the presence of signs and symptoms is a clear indicator for a potential mental health diagnosis, it is also important to note the progression of signs and symptoms, and the impact the sign/s or symptom/s have on the young person's functioning at home, school and socially. Diagnosis of mental health conditions is determined by mental health professionals. Where a SBYHN identifies a young person with a potential mental health diagnosis, the SBYHN should support the young person to seek an assessment from a mental health professional, wherever possible with the support of a family member, carer or supportive adult.

The Youth Mental Health First Aid; A manual for adults assisting young people 4th edition provides signs and symptoms of common metal health conditions that may be present when the SBYHN is assessing young people in the school setting. These presentations are explored in the following subtopics.

9.1 Depression

If a person has a major depressive disorder; they would have five or more of these symptoms (including at least one of the first two) nearly every day for at least two weeks:

- A depressed or irritable mood
- Loss of enjoyment and interest in activities that used to be enjoyable
- Lack of energy and tiredness
- Feeling worthless or guilty when they are not really at fault
- Thinking about death a lot or suicide
- Difficulty concentrating or making decisions
- Moving more slowly or sometimes becoming agitated and unable to settle
- Having sleeping difficulties or sometimes sleeping too much
- Loss of interest in food or sometimes eating too much. Changes in eating habits may lead to either loss of weight or putting on weight.

These symptoms will cause distress to the person and will interfere with their studies or work and their relationships with family and friends.

The presence of depression may also be an early indicator of bipolar disorder, where it is common for episode/s of depression to precede an episode of mania, which may be exhibited as an elevated mood, over confidence, and increased energy. The young person may be “very talkative, full of ideas, have less need for sleep and take risks they normally would not (Kelly et al., 2017)”.

9.2 Anxiety

Anxiety is a normal reaction to a perceived or real threat, and is experienced by everyone at some time, often described as stress, nervousness, worry or tension. The anxiety response can protect a person from danger and motivate problem solving. In some young people anxiety can escalate and become problematic where it is more severe, longer lasting, and interferes with school, activities and / or relationships.

Manifestations of problematic anxiety impact in several domains:

Thinking - Mind racing or going blank, decreased concentration and memory, indecisiveness, confusion, vivid dreams.

Feeling - Unrealistic or excessive fear and worry (about past and future events), irritability, impatience, anger, feeling on edge, nervousness.

Behaviour - Avoidance of situations, obsessive or compulsive behaviours, distress in social situations, sleep disturbance, increased use of alcohol and other drugs.

Physical -

- Heart: pounding heart, chest pain, rapid heartbeat, blushing
- Breathing: rapid, shallow breathing and shortness of breath
- Nervous system: dizziness, headache, sweating, tingling and numbness
- Gastro-intestinal: choking, dry mouth, stomach pains, nausea, vomiting and diarrhea
- Muscles: aches and pains (especially neck, shoulders and back), restlessness, tremors and shaking.

Young people who experience prolonged or worsening features of anxiety may experience panic attacks, suicidal ideation, and NSSI, and increased risk of developing depression and they require timely and evidence-based intervention to manage the associated risks.

(Kelly et al., 2017).

9.3 Eating disorders

A young person with an eating disorder (anorexia nervosa, bulimia nervosa, binge eating disorder) can be underweight, overweight or fall within a healthy weight range.

The following table lists warning signs that a young person may be at risk of developing or has an eating disorder:

Psychological	Behavioural	Physical
Preoccupation with food, body shape and weight	Dieting/ Evidence of binge eating	Weight loss or weight fluctuation
Extreme body dissatisfaction	Social withdrawal or avoidance of previously enjoyed activities	Sensitivity to the cold or feeling cold most of the time, even in warm temperatures
Distorted body image	Evidence of deliberate vomiting or laxative use	Changes in or loss of menstrual patterns
Sensitivity to comments or criticism about exercise, food, body shape or weight	Excessive, obsessive, or ritualistic exercise patterns	Swelling around the cheek or jaw, calluses on knuckles, or dental discoloration
Heightened anxiety around mealtime	Changes in food preferences	Fainting
Depression, anxiety, or irritability	Rigid patterns around food selection, preparation and eating	
Low self esteem	Avoidance of eating meals	
Rigid 'black and white' thinking, e.g., around food (good or bad)	Lying about food intake, or avoiding questions about eating and weight	
	Behaviours focused on food outside of consuming food	
	Behaviours focused on body shape and weight	
	Development of repetitive or obsessive behaviours related to body shape and weight	

(Kelly et al., 2017)

A young person with an emerging or existing eating disorder may be reluctant to seek help or disclose their thoughts and behaviours; they may feel shame or fear judgement and may deny that they are experiencing any of the above features, even those that are observed.

The presence of disordered eating can lead to medical and psychological crisis, where immediate intervention is warranted. Suicidal ideation and NSSI are both risks associated with eating disorders

A medical emergency is indicated by the presence of any of the following:

- Disordered thinking, delusions, or hallucinations
- Disorientation
- Repeated vomiting
- Repeated fainting
- Collapse or weakness
- Muscle pain or spasm
- Chest pain or shortness of breath
- Blood in faeces, urine, or vomit
- Extreme thinness
- Irregular or low heart rate (> 50 bpm)
- Cold or clammy skin indicating low body temperature or body temperature < 35 degrees Celsius

(Kelly et al., 2017)

9.4 Psychosis

Psychosis is a condition characterized by severe disturbances in thinking, emotion, and behaviour, and can be associated with schizophrenia, psychotic depression, bipolar disorder, schizoaffective disorder, and drug induced psychosis.

Common signs and symptoms seen in young people developing psychosis are:

Changes in emotion and motivation - Depression; anxiety; irritability; suspiciousness; blunted, flat or inappropriate emotion; change in appetite; reduced energy and motivation.

Changes in thinking and perception - Difficulties with concentration or attention; sense of alteration of self, others or outside world (e.g., feeling that self or others have changed or acting differently in some way); odd ideas; unusual perceptual experiences (e.g., reduction or greater intensity of smell, sound or colour).

Changes in behaviours - Sleep disturbances; social isolation or withdrawal; reduced ability to carry out studies or social roles.

A young person experiencing an emerging or evident psychosis may require emergency intervention if they are in a severe psychotic state which may cause them to harm themselves unintentionally, are showing aggressive behaviours (often related to alcohol or other drug use), or have suicidal ideation or behaviours, (Kelly et al., 2017).

Cultural expressions and phenomena can be misinterpreted as signs of psychosis. It's crucial to consider the cultural context, environment, psychosocial factors, emotional wellbeing, and spirituality of the individual, especially when it comes to young people. These aspects deeply influence a person's mental

state and behaviours, and what might be perceived as irregular in one culture could be a usual expression in another. For instance, certain cultural or spiritual experiences may be misinterpreted as hallucinations or delusions, which are common symptoms of psychosis. However, within the cultural framework, these experiences may have significant meaning and acceptance. Therefore, it's important to involve family, clan, original group, LOREMEN, Elders, healers, or an Indigenous Health Worker when assessing such phenomena. They can provide valuable insight into whether these experiences are consistent with cultural practices or if they might indicate a mental health concern, (Jarvis et al., 2020).

10.0 Acute presentation of deterioration in the mental state of a young person

10.1 Suicidal ideation

The leading cause of death for young people in Queensland is suicide, (Queensland Family & Child Commission, 2022).

The Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, (Lawrence et al., 2015) found 7.5 percent of young people aged 12-17 years have considered suicide at some time in the previous 12 months. Note: Aboriginal and Torres Strait Islander young people are 2.6 times more likely to die by suicide compared with their non-Indigenous counterparts, (Australian Institute of Health and Welfare, 2022).

The factors that increase risk of suicide for young people are complex and are often inter-related with marginalization and trauma associated with lived experience. They include the following:

Individual -

- Male gender (identity)
- Experience of trauma (e.g., sexual abuse, adverse childhood experience/s)
- Mental health illness (e.g., anxiety / depression, conduct disorder, schizophrenia, substance abuse disorder)
- LGBTIQ+ sexual orientation
- Previous suicide attempt
- Non suicidal self-injury
- Personality traits (e.g., severe irritability, impulsivity, perfectionistic, borderline personality traits)
- Poor problem-solving skills
- Grief and loss
- Severe insomnia
- Homicidal thoughts

- Recent discharge from a mental health facility or hospital
- Restricted educational achievement
- Use of substances (drug/alcohol)

Family/Social -

- Parent/s with a mental illness
- Parent/s substance using
- Parent death/divorce/separation
- Family history of suicide
- Parent child conflict
- Low socioeconomic status including welfare dependency
- Contagion (e.g., exposure to the suicide of other young people, media reports)
- History of trauma, including personal and intergenerational trauma
- Involvement with Child Safety (Services)
- History of domestic violence

School/community -

- Disengagement from school
- Disciplinary issues and problems
- Bullying
- Contagion / media reports
- Racism
- Dislocation from kinship network
- Negative peer culture

(State of Queensland, 2018)

Risk factors are just one of five key factors relating to suicide that inform assessment of the immediacy and level of risk of a suicide attempt and death by suicide.

The five factors are:

- Risk factors - Factors that are known to increase risk. These relate to individual, family and community.
- Tipping Point - An acute or recent crisis or significant stressor that increases feelings of hopelessness.
- Warning signs - Observable changes and/or communication that signal that a person is considering suicide.
- Future crises - Future triggers or changes that could increase suicide risk.
- Protective - Internal and external supports that are available to reduce risk.

(State of Queensland, 2018)

Irrespective of the presenting issue, it is essential for a SBYHN to include questions specific to ascertaining if a young person has suicide risk factors and/or ideation as part of the standard psychosocial assessment of young people presenting to the service.

Including these questions, using language that is specific and clear, and demonstrates respect, care and a nonjudgmental attitude provides the SBYHN an opportunity to create a safe environment where disclosure of the presence of risk or threats to the young person's safety is possible, including the presence of suicidal ideation or intent.

1. The 'Ask directly' framework (below) gathers information about risk of suicide and is explored in detail in the Queensland Centre for Mental Health Learning QC31; Supporting A Suicidal Young Person training manual, (State of Queensland, 2018). **Show empathy**	'You seem really sad….'. 'It looks like you're having a hard time….'.
2. Normalise	'It is common when young people go through big troubles, that they can have thoughts of suicide'.
3. Ask directly (Clear, direct and matter of fact questions)	'I am wondering if you're having thoughts of ending your life?' 'Have you thought about killing yourself?'
4. Be specific (4P's) **Preoccupying** thoughts How intense are the suicidal thoughts? • Frequency • Duration • Worst times	**Frequency** 'How often do you think of killing yourself?' (e.g. every day, at night time etc.) **Duration** 'How long do these thoughts last?' (minutes/hours) **Worst times** 'When are these thoughts the worst/strongest? (e.g. time of day/situation)
Plan is there a plan? • How • When where • Access to means.	'Do you have a plan to kill yourself?' • How: 'How would you end your life?' • When / Where: 'Have you decided on when to end your life?' • Access to means: 'Do you have access to [means]?'
Past attempts	'Have you tried to kill yourself in the past?' 'How did you try to kill yourself?'
Participating in risky behaviours	'Do you use any substances?' '[If so] do you use them when you are feeling suicidal or feeling really down?'

The QC31, Supporting a Suicidal Young Person Manual, (State of Queensland, 2018) identifies additional underlying beliefs or experiences that may be associated with increased suicide risk:

- a lack of a sense of belonging or connection,
- recent loss and conflict,
- a belief that others would be better off without the young person, or the young person is a burden,
- self-hatred,
- a reduced fear of death or higher pain tolerance, and
- exposure to suicidal behaviour of others.

Whilst young people who "have a specific plan, the means to carry out the plan, a time set for doing it, and an intention to do it" are at highest risk of acting on suicidal thoughts, the lack of a specific plan is not sufficient to ensure safety, (Kelly et al., 2017).

An assessment of suicide risk is a complex assessment and should not be made in isolation, and at a minimum requires a discussion with a clinical line manager, who will assist the SBYHN to make a safe decision about appropriate immediate response, referral and follow up. An emergency response may be required which would include the involvement of a parent or carer, may require information sharing with a Principal or Deputy, and may also involve the Queensland Ambulance Service, where immediate transport to a hospital is necessary and ambulance transport is more appropriate or timely than family/carer facilitated transport.

10.2 Non-suicidal self-injury

Non-suicidal self-injury (NSSI) can occur at any age but is more commonly seen in young people. According to the 2013-14 Australian Child and Adolescent Survey of Mental Health and Wellbeing, 8% of youths aged 12 to 18 had experienced NSSI in the year prior to the survey (2012-2013). Additionally, 5.9% reported engaging in NSSI on four or more occasions during that time frame.

NSSI can take varying forms, including cutting, scratching, deliberately hitting the body on hard surfaces, punching, hitting or slapping self, biting and burning (Kelly et al., 2017). Injuries can range from minor and easily concealed, to a severe injury that requires medical assessment. Physical injuries that would be assessed as requiring a medical assessment or first aid if caused unintentionally should be referred for the same level of care.

Some young people have experienced or fear negative responses to disclosures of NSSI and it is critical that the SBYHN does not reinforce any negative self-perception that a young person may hold regarding their NSSI behaviour. At the same time it is important not to dismiss or minimize behaviour in a way that a young person may perceive that NSSI is a harmless and insignificant behaviour. The risks of NSSI include accidental harmful or fatal injury, increasing tolerance to and incidence of NSSI, and reduced opportunity to build adaptive coping strategies.

Indications that a young person requires an urgent intervention or referral include:

- severe injury that requires medical intervention

- ingestion of medication (non-prescribed or above prescribed dosage)
- injuries becoming more severe
- injuries are interfering with daily life
- injuries to the eye
- injuries to the genitals
- the person expresses a wish to die

(Kelly et al., 2017)

Whilst NSSI is not driven by suicidal ideation, NSSI may exist alongside suicidal ideation, and a careful assessment is warranted to establish all additional risks associated with the young person presenting with self-injury; these may include child protection issues and comorbid mental health issues.

An assessment of NSSI is a complex assessment and should not be made in isolation, and at a minimum requires a discussion with a clinical line manager, who will support the SBYHN to make a safe decision about appropriate immediate response, referral and follow up.

10.3 Panic attacks

Panic attacks are experienced by 'more than one in four people at some time in their lives', more commonly people with an existing anxiety disorder (Kelly et al., 2017).

While there are no ongoing health detriments associated with a panic attack, the experience can be unpleasant and distressing for a young person. During a panic attack several of the following will be present:

- palpitations, pounding heart, or rapid heart rate
- sweating
- trembling or shaking
- shortness of breath, sensation of choking or smothering
- chest pain or discomfort
- abdominal distress or nausea
- dizziness, light headedness, feeling faint or unsteady
- feelings of unreality or being detached from oneself
- fears of losing control or going crazy
- fear of dying
- numbness or tingling
- chills or hot flushes

(Kelly et al., 2017)

Some young people will recognize and identify that they are having a panic attack and will require a private and calm environment and reassurance they are safe and that the symptoms will pass, (Kelly et al., 2017).

Where the young person can identify strategies that they find helpful, (breathing techniques, lying down or sitting in a quiet room) the SBYHN should facilitate or support these. Introducing or searching for strategies during a panic attack is not helpful and may lead to increased distress.

Where a young person is unsure of what is causing symptoms, it is essential that underlying medical issues are considered, and medical assessment is sought where indicated.

A discussion with a clinical line manager, who will support the SBYHN to make a safe decision about appropriate immediate response, referral and follow up is recommended.

10.4 Young people affected by a traumatic event

“A traumatic event is one that causes an individual or group to experience intense feelings of terror, horror, helplessness, or hopelessness, (Kelly et al., 2017)”. Examples of trauma include experience of war, motor vehicle or other accidental injuries, assault (including physical or sexual assault, robbery or domestic and family violence, or witnessing a distressing event. Trauma may also be evident after exposure to terrorist events, mass shootings, warfare and severe weather events, (Kelly et al., 2017).

The impact of trauma does not require proximity to or personal experience of the event and may be caused by single or cumulative exposure to the event.

Mental state deterioration may be evident immediately, or at some later time, and may be evident at a time when there is no immediate threat to the young person present. This is particularly the case where there has been a history of recurring trauma, as in sexual, physical or emotional abuse, or torture, (Kelly et al., 2017).

The presence of trauma events impacts differently on different people; some young people may have heightened vulnerability to impact of further exposure, while some young people may develop coping skills that reduce their risk of further trauma impact and strengthen their resilience.

In a school setting a SBYHN may support the needs of a group or cohort of young people who have been exposed to a traumatic event, such as exposure to an incident of violence enacted on another person or group of persons, a significant injury on a sporting field or in a classroom, or exposure to an acute health deterioration or sudden death of a student, teacher or school community member.

Essential considerations for immediate response:

- Ensure the environment is safe to enter
- Follow school process associated with emergency events, such as lock down procedures
- Encourage young people to follow the instructions of any emergency responders who attend the scene
- Provide appropriate and accurate information to the young person/s, with careful consideration of the needs of the young person/s, the timing and impact of sharing the information, established communication processes in the school, and the role of the SBYHN

- Ensure the immediate safety of the young person/s, which may include moving the young person/s or attending to their immediate needs if a physical injury is present (this may include accompanying or referral to first aid or sick room)
- Where possible, establishing a sense of safety for the young person/s
- Establishing priority needs of young person/s
- Providing privacy to the young person/s where practical
- Establishing rapport and introduction to role of SBYH, when appropriate
- Assessment - where the young person has given consent for service
- Establishing the follow up, referral need of the young person/s.

Young people will have individual responses and needs following exposure to a traumatic event, and some will have their needs met by family/carers and existing support networks. The age and developmental stage of the young person and the presence of any regressive behaviours are an additional consideration that will impact on the decision making on referral.

Referral to psychological support should be encouraged when after four weeks or more following the trauma, the young person:

- Continues to feel very upset or fearful
- Continues to have ongoing intense or distressing feelings
- Withdraws from family or friends
- Is anxious or has nightmares because of, or about the trauma
- Is preoccupied by the trauma
- Is unable to enjoy life because of the trauma
- Experiences post trauma symptoms that interfere with their usual activities.

Younger adolescents may also exhibit temper tantrums, become fearful, crying or avoidant of things that remind them of what happened, or act very differently than before the trauma, in addition to any of the above experiences, (Kelly et al., 2017).

A discussion with a clinical line manager who will support the SBYHN to make a safe decision about the appropriate immediate response, referral and follow up is recommended.

10.5 Severe psychotic states

A severe psychotic state may develop in isolation or as an episode within existing psychotic illness. The severe psychotic state may develop rapidly, or over a period of days, and may be triggered by change, extra stress, life events, and deliberate or accidental missed medication, in a vulnerable young person.

A young person developing or in an acute psychotic state may present with overwhelming delusions and hallucinations, very disorganized thinking, bizarre and disruptive behaviours, causing distress to the young person and placing the young person at extreme risk of harm, (Kelly et al., 2017).

Immediate considerations and care needs:

- Assess any safety risk associated with the young person's symptoms that may impact adversely on the young person, yourself, those around you, or the young person's preferred support person, and respond appropriately. Potential safety risks are not limited to physical safety and the risk of psychological harm and vicarious trauma should be considered. Responses may include seeing the young person in the company of someone they trust, a parent or carer, another school based support person, or seeking an emergency assessment by Queensland Ambulance Service.
- Following careful consideration of personal safety, and if seeing the young person in an office alone, ensure that both the young person and the SBYHN have access to an exit.
- Provide a calm, safe and private space for the young person.
- Communicate clearly, using short, simple sentences, using a neutral tone and manner, introduce yourself and your role and be clear that your intention is to be helpful and to ensure the young person is safe.
- Answer any questions you are able to, and comply with reasonable requests, (seek support in decision making if needed).
- Facilitate the presence of a support person the young person nominates, considering the appropriateness and needs of the support person where they are a peer or another young person.
- A parent or carer will need to be notified of the young person's presentation, the outcome of the SBYHN assessment and recommendations.
- The parent / carer may require brief education or support if the young person has not experienced symptoms associated with a potential psychotic state previously.
- It is essential to determine if the parent / carer has the capacity and willingness to seek immediate assessment for the young person at an appropriate hospital or community mental health setting.
- Continue to monitor the safety needs of the young person and those around them during the assessment, as distorted thinking may impact on the young person's perceptions and thinking in unpredictable ways.

All episodes of care for young people that identify a potential or emerging psychosis require a referral for an emergency assessment and should be discussed with the clinical line manager on the day of the assessment.

11.0 Alcohol and other drug use in young people

The co-occurrence of mental illness and alcohol and other drug (AOD) use in young Australians is common. In some cases, one may pre-empt the other, for example, cannabis use and psychosis, or depression and alcohol use. Once both are present, however, it is difficult to separate the two, and each can interact with aspects of a young person's health and affect the other condition. 'Comorbidity' is the term used to describe cooccurring health issues or disorders (Baker et al., 2016).

Any substance use by a young person should be regarded as potentially problematic, due to the known harmful effects of AOD on the developing brain and the young person's mental health, and the strong

association with risk taking (Kelly et al., 2017).

The risks associated with alcohol and other drug use in young people include physical injuries, the consequences of aggression and antisocial behaviour, sexual risk taking and unplanned sexual activity, becoming a victim of crime, suicide and NSSI. Ongoing AOD use may also impact the normal functioning of the young person in engagement with education, consequences of illegal behaviours, and impact on social and family connection (Kelly et al., 2017). These factors all predispose young people to a risk profile for developing mental health illness, and to the deterioration of preexisting mental health conditions.

The impact of AOD use on young people is often cumulative and presents across a range of psychosocial domains. Whilst young people are aware that the SBYHN offers a confidential service, young people may be reluctant to disclose AOD use, or may not relate its use to the experience that has drawn them to seek a consultation. A skilled introduction and psychosocial assessment will assist the SBYHN to identify AOD use and provide brief intervention, with the goal of improved outcomes long term physical health, social relationships, educational progress, employment and reduced likelihood of legal issues related to AOD use (Kelly et al., 2017).

A young person may require an immediate response where a SBYHN identifies likely alcohol intoxication, poisoning or withdrawal, or drug intoxication (including inhalants), overdose, drug related overheating or dehydration, aggressive behaviours, and suicidal ideation (Kelly et al., 2017). The class of drug used will impact on the presentation of the young person.

Stimulant drugs, such as cocaine and amphetamines, may result in increased confidence and energy, frustration, irritability, and anger, alongside physical symptoms such as increased heart rate, overheating and dehydration. Hallucinogenic class drugs such as magic mushrooms and LSD may cause hallucinations and delusions, which can escalate to fear and paranoia.

Depressant drugs, such as cannabis, tranquilizers and alcohol can cause fatigue, slurred speech, reduced motor skills and slowed reflexes, and with higher levels of intoxication, vomiting, loss of consciousness, depressed respiration, and risk of death. Drugs like cannabis, and MDMA may contain a mix of chemicals that lead to atypical responses, making it difficult to determine what drug/s may have been used (Kelly et al., 2017).

Polydrug use, the use of more than one drug, illicit, licit or prescribed, is known to increase the risk of harm significantly. While it is often hard to predict the effects of one drug due to individual factors, it is even harder to predict the impact of multiple drugs taken in combination. Taking two drugs from the same class, as in stimulants and depressants, or taking drugs from different classes of drug increase the unpredictability and risk associated with AOD use (ADF, 2021). Risks include unintentional overdose, confusion, hyperactivity, fever, sweating, accidents, and injury, vomiting, irregular, slow or rapid respiration and heartbeat, blackouts and memory loss, unconsciousness, coma, and death (ADF, 2021).

As the young person's safety is the primary concern, where there is evidence of a change in mental state or physical capacity that may result in risk to the young person's immediate safety, consideration must be given to the appropriate care needs of the young person, which may require referral for an emergency medical / mental health assessment. Where immediate safety is not at risk, referral to an Alcohol and Drug

service should be discussed with the young person and their family or carer, where that is appropriate.

The SBYHN clinical line manager will support the SBYHN to determine the immediate care and safety needs of the young person.

12.0 Safety

Young people experiencing the impact of mental state deterioration are at risk of harm to themselves more often than they cause risk of harm to others. Disordered thinking and disinhibition related to AOD intoxication may cause a young person to behave erratically, aggressively, and occasionally with violence. Psychosis can cause a young person to be fearful and they may react violently out of a belief that their safety is under threat. The SBYHN should prioritize their own safety, always. Where it is safe to do so the SBYHN may attempt to deescalate the situation.

Helpful strategies include:

- Speak slowly and confidently, with a gentle caring tone
- Avoid responding with a hostile, disciplinary, or challenging manner
- Do not argue
- Do not threaten, this may increase fear or prompt an aggressive response
- Avoid raising your voice or talking quickly
- The young person may overreact to negative language, use positive words such as “stay calm” over negative words “don’t fight”
- Stay calm and present a calm appearance, avoid unnecessary movement
- Do not restrict the young person’s movements
- Be aware that a young person’s behaviours or fear may escalate if you take certain steps e.g., seeking additional support or emergency services (however this may be necessary for the safety of the young person or others)
- Consider taking a break from conversation to allow the young person some time to calm down
- Consider asking the young person to sit if they are standing

(Kelly et al., 2017)

It may be necessary for the SBYHN to leave the space where the young person is talking or acting in a way that leaves the SBYHN feeling unsafe. Where that is the case, the school must be notified, and an emergency plan put into action immediately. This may involve calling Queensland Ambulance Service and/or Queensland Police Service.

The SBYHN should discuss the situation with their clinical line manager at the first opportunity and seek their advice on further processes and follow up, which will include the HHS process for recording a critical event. The safety of the SBYHN is a consideration in the allocation of an appropriate office, and annual safety audits are recommended, or when the school accommodation is changed. It is recommended that all SBYHNs have access to a landline in their room, have a safe exit from their office, and attend

Department of Education training on emergency and lock down procedures. Any deficits in the safe accommodation of the SBYHN should be reported to the Principal or delegate and remedial action agreed as a priority.

SBYHN Line Managers will advise the SBYHN of the Hospital and Health Services (HHS) expected Workplace Health and Safety audit and reporting processes within the local service.

13.0 Referral

Where an initial assessment indicates a young person would benefit from referral for additional assessment and care, wherever possible the young person should be included in discussions and decision making about referral options. Including the young person's parent or carer is advised, particularly when mental health concerns have the potential to impact on the young person's safety. It is critical that the SBYHN is aware of the intake and referral processes for their local services as in some cases service intake policies prohibit accepting referrals without the parent or carer's consent.

Where it is known that a young person is in the care of the Department of Child Safety, Seniors and Disability Services, the SBYHN should consult with the Clinical Nurse Consultant or Clinical Line Manager to determine if it would be helpful, or if obligations exist, to notify the appropriate contact person in the Department of Child Safety. Consultation with the local Child Protection Liaison Officer (CPLO) is recommended to support decision making. The CPLO will make recommendations on whether the information should be shared through a child protection report or through the information sharing pathways as set out in the Child Protection Act - Part 4.

Each SBYHN is required to complete the *Child abuse and neglect capability self-assessment tool* and the self-directed *Child abuse and neglect education module* annually. The module provides an overview of responsibilities, recognition and reporting child protection issues and is a good reference to support decision making. SBYHNs should be aware of and utilise the Child Protection Guide, an online tool to support professionals in deciding where to refer or report concerns about a young person's safety or wellbeing.

The SBYHN must learn about local services as part of the orientation to an allocated school and local community and this will ensure that each young person requiring referral is able to be referred to the service that is best able to meet their needs. The SBYHN clinical line manager will provide support on referral actions based on the level of risk and needs of the young person. Additionally, the Statewide Ed-LinQ Coordinators provide consultation liaison to service providers to facilitate early access to mental health advice, timely assessment and navigating mental health service referral pathways.

The SBYHN should be familiar with the process for referral to:

- The nearest hospital emergency department for urgent assessments
- The nearest Child and Youth Mental Health service
- General Practice
- Headspace

- Community agencies who provide access to mental health workers.

Investigating and providing information such as Medicare card requirement, costs, opening hours and proximity to public transport are also helpful in supporting a successful referral.

Phone and online supports may be useful additional support for young people outside of school and business hours, especially those who may be waiting for an appointment with a specialist service or whose family/carer or school support network is limited.

As with face to face services, the SBYHN should be familiar with the scope of phone and online services before making a young person aware of them, and discuss both the service and how the service may be helpful with the young person, as well as any obstacles that might make the service an unrealistic option for the young person, such as access to data, privacy in the home environment and any safety risk that might arise if contact with the service is detected by others.

Phone and online supports include; Kids Helpline, Headspace, Beyond Blue, Suicide Call Back Service, and Lifeline.

14.0 Professional and clinical practice support

All SBYHNs should access the supports in place in their HHS for professional and clinical practice support when managing complex clients, this provides an opportunity for reflective practice, care review and shared learning.

Care coordination / case review may involve initial liaison with clinical line managers to report and discuss the management of clients with identified complex needs, as well as periodic reviews to provide ongoing collegial support with revisions to care planning. Additional strategies may also be helpful, such as presentation of de-identified information regarding clients with complex care needs at a case conference with medical and/or allied health staff to provide an inter-disciplinary perspective to support case management and referral pathways, (State of Queensland, 2016).

Each HHS will have a process for clinical support, orientation, preceptor and mentoring processes to ensure the SBYHN is aware of the supports available to them, and it is essential that a SBYHN is aware of these and knows how to access each component as part of orientation to their respective HHS SBYHN team.

The local HHS Ed-LinQ Coordinator and the Queensland Children's Gender Service are additional points of contact to review the needs of a young person following a complex presentation or referral pathway.

Provision of Clinical Supervision for SBYHNs is encouraged and where this process is available provides an opportunity for guided reflective practice that enables the nurse to develop increasing therapeutic competence.

Professional and clinical practice support is discussed in more detail in the Role of the School Based Youth

Health Nurse Learning Module, (State of Queensland, 2016).

The SBYHN works with young people with complex needs and at times additional support to manage professional or personal issues causing distress may be helpful. Queensland Health provides free confidential counselling 24 hours a day, 7 days a week through the Employee Assistance Program as an additional support to meet this need.

15.0 Skill development and training

Each HHS will provide orientation and recommendations for the ongoing professional development of SBYHNs. Additionally, the Statewide School-Based Youth Health and Ed-LinQ Suicide Prevention Working Group was established to offer recommendations and support skill development for SBYHNs.

The focus of recommendations aligned with Every life: The Queensland Suicide Prevention Plan 2019-2029, action area 1: to strengthen school based mental health supports, develop school based youth heath nurses' skills, knowledge and ability to work with school personnel to identify and support students at risk of suicide. The group's recommendations include the following:

1. All SBYHNs should complete Youth Mental Health First Aid (YMHFA) training and maintain their accreditation.

   Training is delivered by trained YMHFA instructors, upcoming courses are regularly promoted in the Statewide Ed-LinQ and Local HHS Ed-LinQ newsletters and are also part of the QCMHL course catalogue, and the Mental Health First Aid course calendar.
2. All SBYHNs should complete Queensland Centre for Mental Health course: Supporting a Suicidal Young Person.

   Training is delivered exclusively by QCMHL as an 8hr face to face course (QC31) or via an online classroom (QC37) over 2 four-hour sessions.

Other useful training and resources to supplement the above training include:

- Queensland Children's Gender Service training videos
- Be You – Be You provides professional learning, handbooks, fact sheets, tools and guides, on line events, a programs directory and suicide prevention and response resources.
- Insight - Centre for alcohol and drug training and workforce development
- Dovetail Training – AOD
- Aboriginal and Torres Strait Islander Cultural Practice program in your HHS
- Emerging Minds- Supporting secondary students following a disaster or community trauma
- Orygen Training Resources – Trauma
- Child Protection staff orientation resources

16.0 Suicide prevention and response resources

Be You has developed a suite of prevention and postvention resources which:

- Prepare the school community to be ready should a death by suicide occur;
- Guide the school on how to support a young person at risk of suicide;
- Guide the school response to a death by suicide and the subsequent recovery for the community.

The suite includes a toolkit, fact sheets, resources and information for Aboriginal and Torres Strait Islander families.

The resources and the support of a Be You Consultant are available to all schools. SBYHNs can support the school's capacity to respond to a death by suicide or attempted suicide by confirming the school Principal or Senior Support school staff leaders are aware of the availability of these resources and how to access them. SBYHNs should be aware of how to access the resources and be able to give a brief overview of the content and how the resources can support the school.

17.0 Conclusion

SBYHNs work in partnership with the Department of Education to create inclusive, safe, and supportive environments that support young people to transition to healthy adult lives and achieve educational outcomes. Responding to the mental health literacy, support and referral needs of young people has been a key focus of SBYHN practice from the role's inception in 1998.

Adolescence is a key developmental stage where young people may experience mental state deterioration related to their first episode of mental illness, physical or psychological distress, or substance use. The presence of new and unfamiliar experiences associated with deterioration in mental state can be distressing for the young person and their family or carers.

Early identification, tailored support, education, and referrals reduce the risk and enhance both short-term and long-term outcomes for individuals experiencing mental health deterioration. Additionally, positive encounters with a School-Based Youth Health Nurse during distress can positively shape a young person's willingness to seek health services throughout their life, promoting overall well-being.

To foster these outcomes SBYHNs are required to build competence in engaging with young people, providing a safe environment and skilled assessment to identify potential or existing health concerns, which may include deterioration in mental state.

This guideline provides an outline of key topic areas that will assist the SBYHN to build their communication and assessment skills in the context of deterioration of mental state in young people. It provides an overview of common mental health conditions and clinical responses to acute presentations of mental state deterioration in young people, and addresses safety, referral, and professional and clinical practice support. Additionally, the guideline makes recommendations for skill development and training and suicide prevention and response resources.

Upon employment, it is highly recommended that all School-Based Youth Health Nurses promptly

undertake YMHFA and QCMHL training, as recommended by the Statewide School-Based Youth Health and Ed-LinQ Suicide Prevention Working Group. This training equips SBYHNs with the knowledge and skills necessary to effectively respond to young individuals facing mental state deterioration, self-harm risk, or risk of suicide. These training recommendations expand on and provide a depth of learning experience beyond the scope of the guideline.

Appendices

Appendix 1- Young Person Health Record HEEADSSS Assessment

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0018/2706201/SW1132.pdf

Appendix 2- Young Person Mental Health Assessment

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0026/714086/800065.pdf

Appendix 3- Young Person Potential Eating Disorder Assessment Tool

https://qheps.health.qld.gov.au/__data/assets/pdf_file/0029/714467/800060.pdf

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drug
CYHPM	Child and Youth Health Practice Manual
CYMHS	Child and Youth Mental Health Service
HHS	Hospital and Health Service
MDMA	Methylenedioxymethamphetamine
NSSI	Non–suicidal self injury
QCMHL	Queensland Centre for Mental Health Learning
SBYHN	School Based Youth Health Nurse
YMHFA	Youth Metal Health First Aid

Glossary

Anxiety Disorder	A group of mental disorders marked by excessive feelings of apprehension, worry, nervousness and stress. Includes generalised anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder and various phobias (AIHW, 2021).
Be You	Be You promotes mental health and wellbeing, from the early years to 18, and offers educators and learning communities evidence-based online professional learning, complemented by a range of tools and resources to turn learning into action. Be You is led by Beyond Blue with delivery partners Early Childhood Australia and headspace. Both partners have local teams of trained consultants to provide advice and support to early learning services and schools nationally to help implement a whole-learning community approach growing Australia's most mentally healthy generation.
Bipolar disorder	Bipolar disorder is a chronic (long-term) condition that involves intense mood changes which disrupt everyday life — from extreme highs to extreme lows. It affects 1 in 50 Australians each year, and often develops for the first time during teenage years or early adulthood. Bipolar disorder tends to affect more women than men. It is sometimes referred to as manic depression (Health Direct, 2021).
Blunted	The ability to express emotion is greatly reduced (Australian Government, 2021).
Delerium	Characterised by a disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days), delirium is a serious condition and is associated with increased risk of harm (ACSQHC, 2019).
Depression	A mood disorder with prolonged feelings of being sad, hopeless, low and inadequate, with a loss of interest or pleasure in activities and often with suicidal thoughts or self-blame (AIHW, 2021).
Eating Disorder	An eating disorder is a serious mental health condition that involves an unhealthy preoccupation with eating, exercise or body shape (Health Direct, 2021) .
Drug induced psychosis	Caused by drugs such as alcohol, speed, LSD, marijuana, ecstasy or magic mushrooms. The symptoms last until the effects of the drugs wear off (hours or days) (State Government of Victoria, 2020).
Psychotic depression	Depression can be so intense that it causes psychotic symptoms (State Government of Victoria, 2020).

Psychosis	The word psychosis is used by clinicians to describe beliefs and experiences that are not shared by other people. Beliefs that are seen as unusual or untrue are described as delusions. Hearing voices, seeing visions and perceiving things that cannot be sensed by other people are called hallucinations (NSW Government, 2020).
Schizophrenia	Schizophrenia is a mental illness that causes someone to have an altered experience of reality. It causes psychosis, when people experience delusions and hallucinations. Schizophrenia affects people's thoughts, perceptions and behaviour and interferes with their ability to function at work, school or relate to other people. (Health Direct, 2021) .
Schizoaffective disorder	Schizoaffective disorder is a combination of two mental illnesses – schizophrenia and a mood disorder (State Government of Victoria, 2020).
Suicide	Refers to when a person has ended their own life, Recommended language includes 'died by suicide' and 'suicided'. (Be You, 2021)
Suicidal behaviour	A range of behaviours related to suicide, including thinking about or considering suicide (thoughts), planning for suicide, intending suicide, attempting suicide and suicide itself (Queensland Mental Health Commission, 2019).
Suicidal ideation	Thinking about, considering or planning for suicide. These can range from fleeting thoughts to detailed planning (Queensland Mental Health Commission, 2019).
Suicide prevention	The umbrella term for the collective efforts of governments, community organisations, mental health practitioners, related professionals, individuals, families and communities to enhance safety from suicide-related behaviours and to reduce the incidence of suicide (Queensland Mental Health Commission, 2019).

References

Aguirre Velasco, A., Cruz, I. S. S., Billings, J., et al. (2020). What are the barriers, facilitators, and interventions targeting help-seeking behaviors for common mental health problems in adolescents? A systematic review. BMC Psychiatry, 20, 293. DOI: 10.1186/s12888-020-02659-0

Alcohol and Drug Foundation. (2021). *Polydrug use*. Retrieved from https://adf.org.au/reducing-risk/polydrug-use/

Australian Commission on Safety and Quality in Health Care. (2017). *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*. Retrieved from https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Consensus-Statement-Essential-elements-for-recognising-and-responding-to-deterioration-in-a-person%E2%80%99s-mental-state-July-2017.pdf

Australian Government, Department of Health. (2020). *Suicide prevention*. Retrieved from https://www.health.gov.au/health-topics/mental-health-and-suicide-prevention/about-suicide-prevention

Australian Institute of Health and Welfare. (2021). *Mental health impact of COVID-19*. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19

Australian Government, Department of Health. (2017). *The Fifth National Mental Health and Suicide Prevention Plan*. Retrieved from https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/national-reports/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan

Baker, D., & Kay-Lambkin, F. (2016). *Two at a time: Alcohol and other drug use by young people with a mental illness*. Orygen, The National Centre of Excellence in Youth Mental Health. Retrieved from https://www.orygen.org.au/Policy/Policy-Reports/Alcohol-and-other-drug-use/alcohol_and_other_drug_policy_paper_2016?ext

Beyond Blue. (2020a). *Aboriginal and Torres Strait Islander people: Closing the gap*. Retrieved from https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people/close-the-gap

Beyond Blue. (2020b). *Aboriginal and Torres Strait Islander people: Risk and protective factors*. Retrieved from https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people/risk-factors

Centers for Disease Control and Prevention. (2021). *Risk and protective factors*. U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/violenceprevention/aces/riskprotectivefactors.html

Gaskin, C., & Dagley, G. (2018). *Recognising signs of deterioration in a person's mental state*. Australian Commission on Safety and Quality in Health Care. Retrieved from https://www.safetyandquality.gov.au/sites/default/files/migrated/Recognising-Signs-of-Deterioration-in-a-Persons-Mental-State-Gaskin-Research-Final-Report.pdf

Jarvis, G. E., Iyer, S. N., Andermann, L., & Fung, K. P. (2020). Culture and psychosis in clinical practice. In J. C. Badcock & G. Paulik (Eds.), *A clinical introduction to psychosis: Foundations for clinical psychologists and neuropsychologists* (pp. 85–112). Elsevier Academic Press. https://doi.org/10.1016/B978-0-12-815012-2.00004-3

Kelly, C. M., Kitchener, B. A., & Jorm, A. F. (2017). *Youth mental health first aid: A manual for adults assisting young people* (4th ed.). Mental Health First Aid Australia.

Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., & Zubrick, S. R. (2015). *The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing*. Department of Health. Retrieved from https://www.health.gov.au/sites/default/files/documents/2020/11/the-mental-health-of-children-and-adolescents_0.pdf

McHale, R., Brennan, N., Freeburn, T., Rossetto, A., Richardson, E., Boon, B., & Christie, R. (2023). *Youth Survey Report 2023*. Sydney, NSW: Mission Australia. Retrieved from https://www.missionaustralia.com.au/what-we-do/research-evaluation/youth-survey

NSW Health. (n.d.). HEEADSSS assessment learning video resource. Retrieved from NSW Health

Orygen, The National Centre for Excellence in Youth Mental Health. (2017). *Clinical practice guide: Treating depression in young people - Guidance, resources and tools for assessment and management*. Retrieved from https://www.orygen.org.au/Training/Resources/Depression/Clinical-practice-points/Treating-depression-in-yp

Orygen, The National Centre for Excellence in Youth Mental Health. (2018). *Youth mental health policy briefing: Aboriginal and Torres Strait Islander young people and mental ill-health*. Retrieved from https://www.orygen.org.au/Policy/Policy-Areas/Population-groups/Aboriginal-and-Torres-Strait-Islander-young-people/Orygen-Aboriginal-torres-strait-islander-policy-br

Orygen, The National Centre of Excellence in Youth Mental Health. (2019). *Submission to the Royal Commission into Victoria's Mental Health System*. Retrieved from https://www.orygen.org.au/Policy/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Submission-to-the-Royal-Commission-into-Victoria%e2%80%99s/orygen-submission-royal-commission2019

Queensland Family & Child Commission. (2022). Annual report: Deaths of children and young people, Queensland, 2020-21, Chapter 6. Queensland Government. Retrieved from https://www.qfcc.qld.gov.au/sites/default/files/2022-06/Annual%20Report%20Deaths%20of%20children%20and%20young%20people%202020-21%20Chapter%206.pdf

Queensland Mental Health Commission. (2018). *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*. Retrieved from https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf

Queensland Mental Health Commission. (2019). *Every Life: The Queensland Suicide prevention plan 2019-2029*. Retrieved from https://www.qmhc.qld.gov.au/documents/everylifethequeenslandsuicidepreventionplan2019-2029webpdf

State of Queensland. (2016). *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021*. Queensland Health. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0030/460893/qhatsi-mental-health-strategy.pdf

State of Queensland. (2016). *The Role of the SBYHN Learning Module*. Queensland Health. Retrieved from http://sharepoint.chq.health.qld.gov.au/sites/CYCHS/SBYHNStatewideServices/_layouts/15/start.aspx#/

State of Queensland. (2018). *QC31 Supporting a suicidal young person participant workbook*. Queensland Centre for Mental Health Learning. Queensland Health.

State of Queensland. (2020). *The Child and Youth Health Practice Manual*. Queensland Child and Youth Clinical Network – Child Health Sub-Network, Children's Health Queensland Hospital and Health Service. Retrieved from https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/cy-prac-manual-pt1.pdf

State of Queensland. (2020). *Generation Zero Suicide (GenZs)*. Children's Health Queensland. Queensland Government. Retrieved from https://www.childrens.health.qld.gov.au/chq/our-services/mental-health-services/generation-zero-suicide/

State of Queensland. (2020). *Assessment and Treatment of Children and Adolescents with Eating Disorders in Queensland*. Mental Health Alcohol and Other Drugs Branch. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0040/956569/qh-gdl-961.pdf

State of Queensland. (2023). *Guide to Informed Decision-making in Health Care* (Interim update Version 2.3). Queensland Health. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf

State of Queensland. (2023). *Providing Safe & Quality Care to Young People: A Practice Guide to Adolescent and Young Adult (AYA) Care*. Retrieved from https://www.childrens.health.qld.gov.au/__data/assets/pdf_file/0019/219601/QH-AYA-practice-guide.pdf

State of Victoria. (2020). *Early intervention in mental illness*. Retrieved from https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/early-intervention-in-mental-health

Usher, K., Ranmuthugala, G., Maple, M., Durkin, J., Douglas, L., Coffey, Y., & Bhullar, N. (2021). The 2019–2020 bushfires and COVID-19: The ongoing impact on the mental health of people living in rural and farming communities. *International Journal of Mental Health Nursing*, 30, 3-5. https://doi.org/10.1111/inm.12798

Consultation

Key stakeholders who reviewed this Guideline:

- Director of Nursing, Child and Youth Community Health Services, CHQHHS
- Assistant Director of Nursing, Youth Health, Child and Youth Community Health Services,

CHQHHS

- Nurse Manager, Quality and Safety, Child and Youth Community Health Services, CHQHHS
- State-wide Ed-LinQ Coordinator, Child and Youth Mental Health Services, CHQHHS
- Aboriginal and Torres Strait Islander Service Integration Co-Ordinator, Child and Youth Mental Health Services, CHQHHS
- Program Manager, Child Protection and Forensic Medical Services, Queensland Children's Hospital
- Nurse Navigator, Queensland Children's Gender Service, Queensland Children's Hospital
- Team Leader, Dovetail, Insight Training and Education, Metro North HHS
- Child and Youth Mental Health Service Consumer Carer Participation Team, CHQ HHS
- State-wide School Based Youth Health Nurse Line Managers' Sub-Network
- State-wide School Based Youth Health Nurses Clinical Collaborative Steering Committee
- Clinical Nurse, School Based Youth Health Services, CHQHHS

Document approval details

Document custodian:

Assistant Director of Nursing, Youth Health

Approving body:

Queensland Child and Youth Clinical Network Steering Committee

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	• Standard 1 Clinical governance- Action 1.01 Governance, leadership and culture. • Standard 2 Partnering with consumers- Action 2.05 Healthcare rights and informed consent; Action 2.06-2.07 Sharing decisions and planning care; Action 2.08-2.10 Communication that supports effective partnerships; Action 2.13 Partnerships in healthcare governance planning, design, measurement and evaluation. • Standard 5 Comprehensive care- Action 5.03 Partnering with consumers; Action 5.07 Planning for comprehensive care. • Standard 6 Communication for Safety- Action 6.03 Partnering with consumers; Action 6.09 Communicating critical information; • Standard 8 Recognising and Responding to Acute Deterioration- Action 8.05 Recognising acute deterioration; Action 8.10 Responding to deterioration