Denbighshire Young Persons' Counselling
Service County Hall, Wynnstay Road,
Ruthin, Denbighshire LL15 1YN

Mindfulness and Dialectical Behaviour Therapy: Skills Training for Children, Young People and Families in Schools and Communities

Dan Trevor
Clinical Lead Counsellor/Psychotherapist
Denbighshire Young Persons' Counselling Service

Winston Churchill Memorial Trust Fellow 2017

January 2018

ACKNOWLEDGMENTS

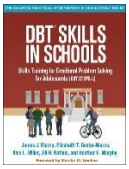
My Fellowship and the learning I have gained from my travels would not have been possible without the generous funding and support of the Winston Churchill Memorial Trust and the generosity of those who gave up their time to share their knowledge, skills and experience with me, before, during and subsequent to my Fellowship travels. In particular I would like to thank:

Friars School, Bangor, NORTH WALES

Gareth Parry and team

DBT STEPS A

(Training attended in Chester UK in July 2017)



Elizabeth T. Dexter-Mazza, Mazza Consulting and Psychological Services Washington

James J. Mazza, Mazza Consulting and Psychological Services Washington

Cork, IRELAND

MENTAL HEALTH PSYCHOLOGY SERVICE
Cork Kerry Community Healthcare

Daniel Flynn, Principal Psychology Manager
Mary Joyce, Research Co-Ordinator
Mareike Weihrauch, Project Research Officer
Mary Atkins, NEPS Psychologist

ACKNOWLEDGMENTS

University of California San Francisco, USA

Dialectical Behavior Therapy (DBT) Program for Adolescents

Auran Piatigorsky
Assistant Clinical Professor
Licensed Clinical Psychologist
Dialectical & Cognitive Behavior Therapy Clinics
Langley Porter Psychiatric Institute

Lincoln High School, Portland, Oregon, USA

Jim Hanson
School Psychologist and initiator of DBT programs for the past decade at Lincoln High School

Missoula, Montana, USA

Montana Association of School Psychologists

Jessica Carranza – 2017-2018 Montana School Psychologist of the Year

University of Alaska, Anchorage

Mike Worrall and students (Hugh Leonard, Jessica McKay)
(National Institutes of Health's Biomedical Learning and Student Training program.

ACKNOWLEDGMENTS

Sashbear Project, Canada

Heather Ryder

Bangor University, North Wales

PRIFYSGOL BANGOR UNIVERSITY

Michaela Swales, Consultant Clinical Psychologist & Reader in Clinical Psychology, Betsi Cadwaladr University Health Board & School of Psychology, Bangor University

Graeme McDonald Ramage, Clinical Psychology PhD Research Student

Denbighshire County Council

Cyngor sir ddinbych denbighshire County Council

Kathryn Nash, Senior Educational Psychologist and Manager of the Denbighshire Independent Young Persons' Counselling Service

CONTENTS

EXECUTIVE SUMMARY
INTRODUCTION

My Churchill Fellowship application was the result of deliberations for myself and colleagues over a period of years on how to find out how other education, therapeutic and mental health professionals were supporting an at risk cohort of young people that we had come to call the 'tier 2½' group (UK CAMHS Mental Health 'tier' structure table: page 8). The young people in this cohort presented with self-harm and/or suicidal behaviours, they had sometimes already used counselling/therapy but did not meet the criteria for an outpatient CAMHS therapeutic intervention at tier 3. I always felt that their situation might be compared to a young person being lost in the wilderness; in that situation they need to learn survival skills first (counselling/therapy might be a part of that later) in order to survive and find their way. I had come to know about Dialectical Behavioural Therapy (DBT) adaptations as skills training for young people through having trained in mindfulness based therapeutic approaches and started researching how DBT skills training could provide our 'tier 2½' group young people with effective emotion regulation, decision making, and problem-solving skills.

Firstly I looked at what was available in the United Kingdom and the main ways young people can seek DBT in the UK through the NHS after a CAMHS mental health assessment at tier 3 (UK) dependent on whether this type of therapy is available are:

- **Through a GP or community mental health team (CMHT)**. Who will have information about the best ways to access DBT in the local area.

- **Through the Improving Access to Psychological Therapies (IAPT).** This is an NHS programme which can provide DBT as a treatment for various mental health problems. However, IAPT is not available in all areas and the waiting lists can be very long.

- **Through the Specialist therapy services** provided by some NHS Trusts (local NHS Trust websites may give details).

For example at tier 4 there are a number of significant differences between the two inpatient units in Wales and as a result, young people in North and South Wales have access to different types of care and support. For example, in North Wales a range of psychological therapies are offered, including DBT. This therapy is not available in the South Wales unit and some young people living in South Wales have been referred to the north to access this therapy.

CAMHS tier structure:

It should be noted that the CAMHS 'tier' structure in the UK is different from and does not align to the tier system in the United States.

Tier One	**Universal services** such as early years services and all primary care agencies including general medical practice, school nursing, health visiting and schools. Tier one services aim to promote mental well-being, recognise when a child or young person may have developmental or mental health problems that this level of service cannot meet, and know what to do when this is the case. Universal services may be provided by a range of agencies.
Tier Two	**More targeted services** such as youth offending teams, primary mental health workers, and school and youth counselling (including social care and education). This includes support for children with less severe mental health problems. Tier two services include mental health professionals working on their own, rather than as part of a multi-disciplinary team (such as CAMHS professionals based in schools). Staff may work with the child or young person directly, or indirectly by supporting professionals working in universal services. In addition, Tier 2 services include school counsellors and voluntary sector youth counselling services. Targeted services include those provided to groups at increased risk of developing mental health problems, such as looked after children's teams. Paediatric services may also be defined as Tier 2 CAMHS because they often take the lead for children with developmental disorders and attention deficit hyperactivity disorder (ADHD).
Tier Three	**Specialist community CAMHS.** These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions, including teams with specific remits, such as ○ CAMHS learning disability teams ○ Community forensic CAMHS ○ Dialectical Behaviour Therapy teams ○ Adolescent substance misuse teams ○ Crisis/home treatment teams preventing admission to hospital ○ Liaison teams providing CAMHS input to children and young people in acute care settings.
Tier Four	**Highly specialist services,** such as day and inpatient services, very specialised outpatient services and, increasingly, services such as crisis/home treatment services which provide an alternative to admission. These are generally services for a small number of children and young people who are deemed to be at greatest risk of rapidly declining mental health, or from serious self-harm, who need a period of intensive input. Tier four services are often provided on a regional or supra-regional basis. There are also a small number of very highly specialised services including medium secure adolescent units, services for those with gender dysphoria and highly specialist obsessive compulsive disorder services. These services are usually commissioned on a national rather than a local basis.

Some individual organisations such as Cardiff based Skills4Living (Action for Children) provide a DBT adapted programme for (16 -24 age group) and has been developed into a new and exciting service funded by the Welsh Government through the Sustainable Social Services Grant and operates as a partnership with another third

sector organisation, Llamau to provide a support service for all Care leavers in Wales.

The Education Policy Institute report in September 2017 outlined the mental health situation in the UK for children and young people (CYP):

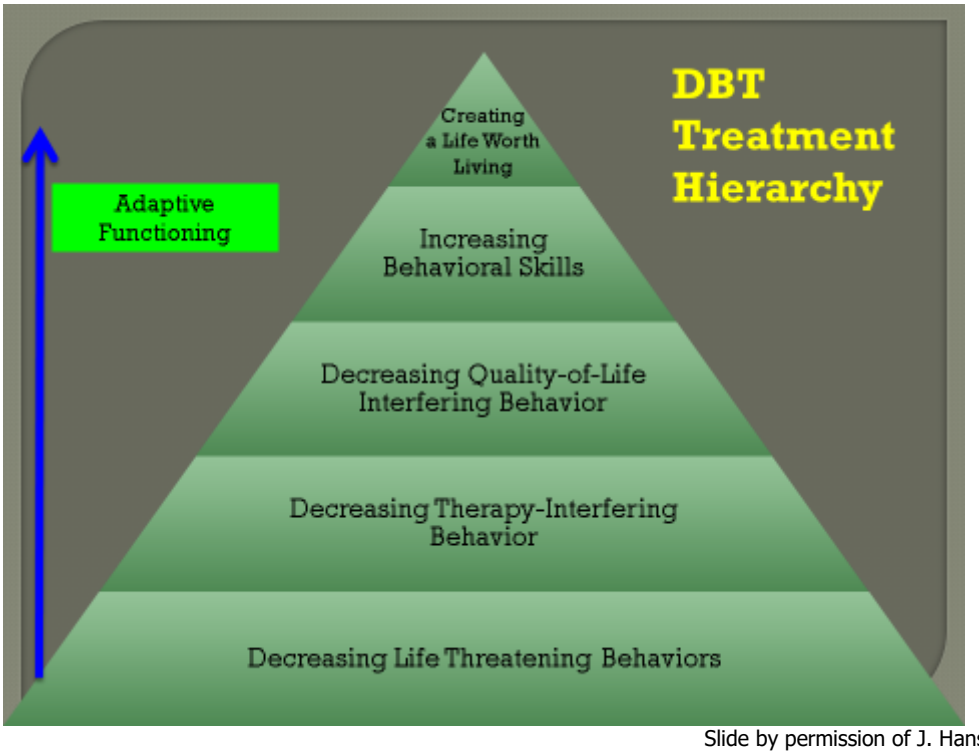
- 26.3% of young people referred to specialist mental health services were not accepted in 2016-17. This figure has barely changed since the previous year, and signifies a substantial increase since 2012-13, when 21.1 per cent of children were turned away.
- The Education Policy Institute estimates that 26.3% of young people currently being treated in the UK represents over 50,000 children.
- There is significant disparity between providers, with some turning away less than 5 per cent of referrals, while others turn away over 50% of young people.

The Welsh Government and Education Committee conducted an inquiry into CAMHS in Wales in 2014. Stakeholders were consulted and the remit of the inquiry included early intervention, access to treatment, regional variations in services and safeguarding issues. The main inquiry findings were that:

- The capacity of Child and Adolescent Mental Health Service provision is insufficient to meet the needs of young people who need a specialist service.
- Complications occur for children and young people who do meet the criteria for CAMHS, these include waiting times, clinic-based services and the use of prescription medication.
- There are no services for those children and young people who do not meet the "medical model" criteria for CAMHS this means that there is a substantial level of unmet need; e.g. at present there is no early intervention psychosis provision in Wales, which is a striking contrast with England.

Widening my area of research to the origins of DBT in the United States I found that it is a comprehensive psychosocial treatment developed for suicidal individuals (Linehan, 1993). That it is the most researched and proven evidence-based treatment for BPD (Borderline Personality Disorder) and that the core concepts of DBT (Mindfulness, Distress Tolerance, Dialectics, Emotion Regulation and Interpersonal Effectiveness) have be critical to people living with emotional regulation disorder, especially in relation to self-harm/ suicide risk.

Adaptations of DBT have been developed for delivery in US schools ranging from a 'universal' model where DBT skills are taught as a timetabled lesson by teachers to more specialised 'selected' and 'indicated' programmes delivered by counsellors/therapists and psychologists. This extends the range of interventions mental health professionals can offer and provides additional skills for some children and young people (CYP).



Slide by permission of J. Hanson

The ultimate goal of DBT is 'to create a life worth living'; this was clearly evidenced in that DBT skill modelling and teaching promotes:

- The practice of being fully aware and present in this one moment. Cognitive and somatic awareness including habitual patterns of thinking and behaviour (Mindfulness)
- How to change emotions that you want to change. Awareness of reactivity and the difference between reacting and responding (Emotion Regulation)
- How to tolerate pain in difficult situations, not change it (Distress Tolerance)
- How to ask for what you want and say no while maintaining self-respect and relationships with others (Interpersonal Effectiveness)
- Understanding polarisation, conflict and rigid thinking (Dialectics) .An additional module developed for families and adolescents - Walking the Middle Path.

This seemed to be an appropriate way for young people in our 'tier 2½' group to acquire and practise skills that engender a sense of individual safety, calming, community efficacy, social connection and positive sense of self which reduce psychological distress and achieve significant reductions in overall emotional distress (Haskell et al., 2014).

Through a process of elimination I considered the adaptation of DBT for adolescents with emotional and behavioural problems by Rathus & Miller (2006) and how it demonstrated increasing evidence for its effectiveness (Swales et al, 2016). This led me in turn to the social- emotional learning programme DBT STEPS – A by Mazza et al (2016) which has Rathus & Miller as co-authors has also been developed from Dialectical Behaviour Therapy (Linehan, 1993) and

the work of Jim Hanson in an established evidenced based programme at Portland High School in Oregon where school based DBT skills training has been shown to reduce suicidal and self-harm behaviours, improve interpersonal effectiveness and help young people with emotion regulation (Mazza & Hanson, 2014a, 2014b; Miller et al, 2014). It was at this point that I felt there was potential to adapt such a programme for our service and I set out on making an application to the Winston Churchill Memorial Trust with the intention of using the Churchill Fellowship to travel to further research and learn how these programmes were implemented and maintained.

METHODOLOGY

Through face to face contact with the developers of a range of DBT adapted programmes for CYP; I visited and spent time with professionals at their places of work, locations and venues where established DBT skills training programmes are undertaken. All the professionals I made contact with were exceptionally generous with their time and were very willing to share their knowledge and experience. This was the beginning of developing professional relationships, gaining a thorough understanding of the programmes and interventions including discussion on how they might be best adapted for Wales and the UK as a whole.

FINDINGS AND CONCLUSIONS

Processing and presenting the practical experience of visiting various adapted DBT programmes for CYP has taken into account best practice in terms of cognisance of individual programme guidance, on robust empirical evidence and the ethical considerations and perspective.

Gaining a clearer understanding of the differences in how mental and behavioural health and education services interact and fall on a continuum that are increasingly provided within a multi-tiered system of supports (MTSS) in the US has been beneficial in widening my perspective on the potential of how young people can benefit.

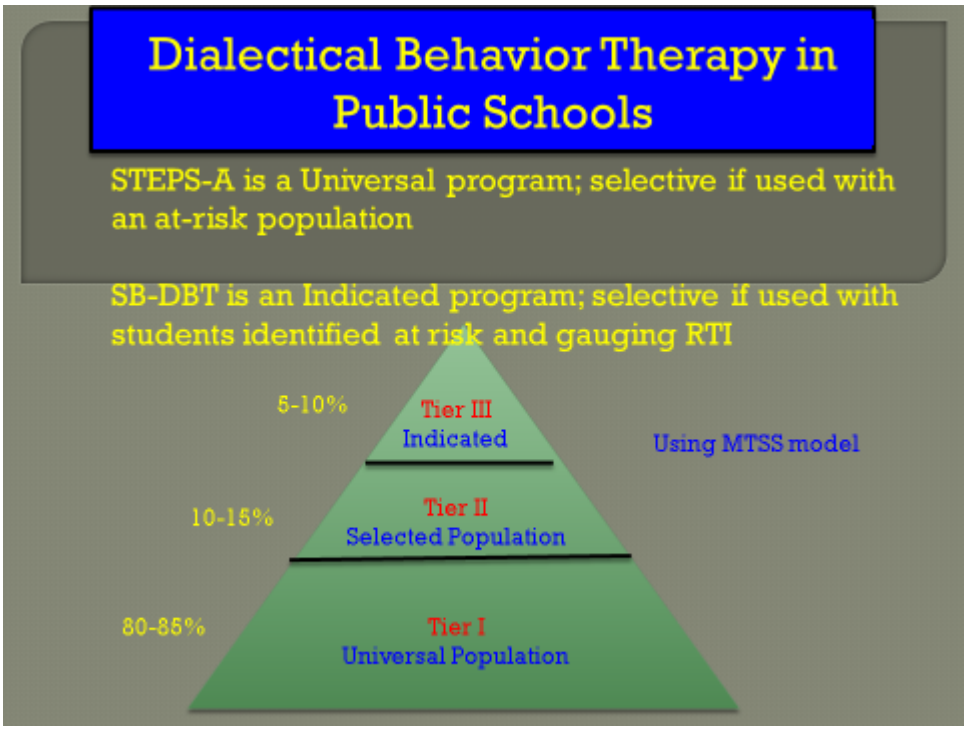
- Tier I: promotion of mental and behavioural wellness and prevention of mental and behavioural health problems (Universal)

- Tier II: direct and indirect services to address emerging mental and behavioural health problems and prevent risky behaviours (Selected)

- Tier III: direct and indirect services to address identified mental and behavioural health problems (Indicated)

It is important to acknowledge that some young people will require more intensive services beyond what a general education setting can provide. At times high risk students may need to be referred onto CAMHS (Child and Adolescent Mental Health Service) for potential outpatient or residential assessment where young people may be able to build on previous knowledge

of skills and language of DBT learned at school. Schools with DBT programmes at Tier 3 may also facilitate a young person's transition from an out-of-school placement back into regular school.



Slide by permission of J. Hanson

A breakdown how DBT STEPS – A is delivered across the tiers:

Tier 1 DBT STEPS – A.
'Universal' level, approx. 8o – 85% of students. Delivered by appropriate school staff (e.g. health teachers) with some mental health background.

Tier 2 DBT STEPS – A.
'Selected' level, approx. 10 – 15% of students more likely to have been identified with mental health concerns and/or to have engaged in at-risk behaviours; receive additional support and intensified services in smaller group settings.

Tier 3 DBT STEPS – A.
'Indicated' level receive school based DBT. In addition to the same strategies as for Tier 2 students in small group setting, may require a second cycle through the programme/slower pace and individual weekly counselling/skill practice.' Immediate' consultation during the school week if a student encounters difficulty. A parent group is facilitated meeting in the evening once or twice per month. Rationale: parents gain insight into the skills being taught, know how to support their children in times a difficulty and meet, support and be supported by other parents. DBT team consultation is the other difference where the team meets at least fortnightly (before or after school) to discuss progress and difficulties, sharing information, collegial supervision and reduce burnout.

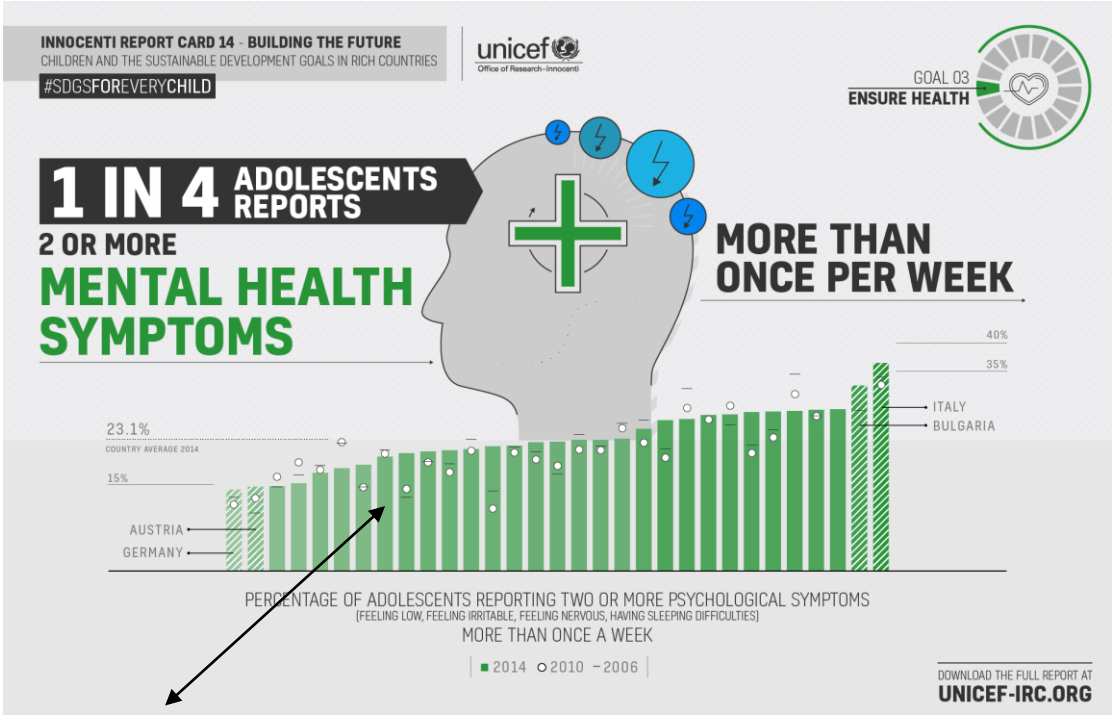
INTRODUCTION

BACKGROUND TO THE PROJECT

Individual Professional Context

My mindfulness practice and training has been a foundation for this Fellowship. I had initially been drawn to mindfulness in terms of adding strategies and techniques for how I work therapeutically with CYP, parents and teachers, but the requirement for a mindfulness daily practice and over time the consequent re-evaluation of my entire therapeutic approach (and everything else!) from a mindfulness perspective resulted in a new radical willingness to be more present in living a more effective life. I discovered DBT through mindfulness which is a core concept of the therapy.

I have been involved in working therapeutically with CYP who have been identified with wellbeing concerns and/or have engaged in at-risk behaviours since 1997. Over the past decade there has been a gradual increase in self-harm emergency admissions to hospital and the number of young people recorder with thoughts of suicide in the UK. Contextually, the Welsh Index of Multiple Deprivation lists a coastal area in the north of Denbighshire (the county where I work) as the 2nd most deprived area in Wales and which includes the category of Childhood Deprivation.



UNITED KINGDOM 19.9%

Summary of adolescent reported psychological symptoms by country (reported from UNICEF Office of Research 2017).

Psychological problems among CYP are multifaceted and widespread. They include anxiety, attention deficit hyperactivity disorder (ADHD) disruptive conduct, eating and mood disorders and other mental health problems. Mental health issues of CYP are gradually gaining the attention they deserve. Evidence demonstrates links between CYP mental health and the experience of being bullied, feeling 'unconnected' to their school environment, feeling excluded and disrespected, low academic achievement, health risk behaviour and – in the most severe cases – leading to self-harm and suicidal behaviour. Childhood mental health conditions levy a substantial cost to society if left untreated.

Working with CYP (especially in recent years) has given me countless opportunities to directly experience the growing need for a clear evidence based intervention for individuals who are potentially at risk of self-harm and/or suicide. This was brought into sharp focus for me in being part of collaboration between Denbighshire Education and the North Wales Betsi Cadwalader Health NHS in the development of a joint Self-Harm Pathway providing a clear pathway guidance on how to respond consistently for young people.

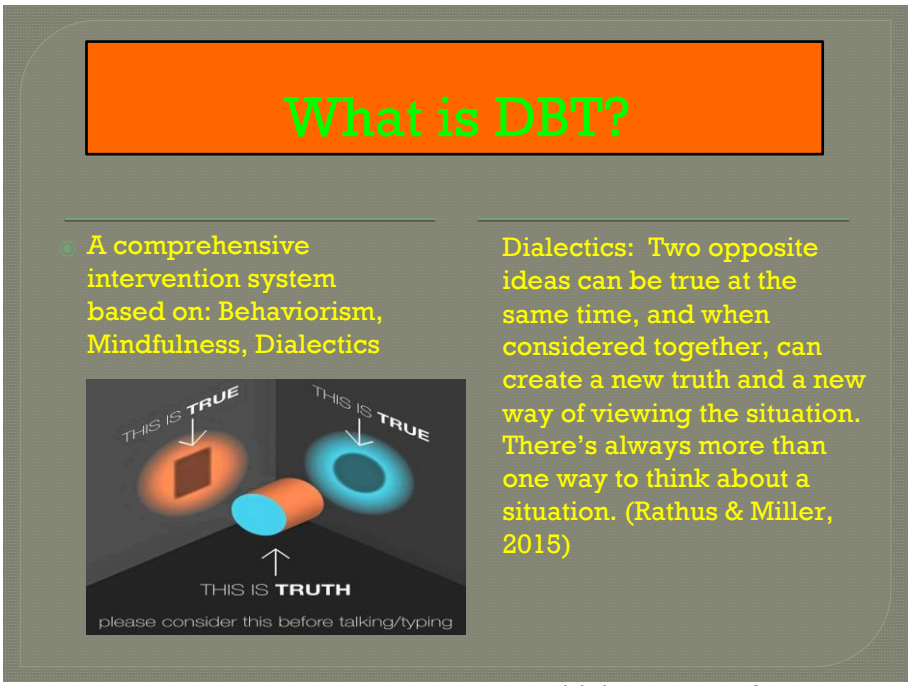
Sometimes some at risk young people find themselves in a situation beyond the support that a general education setting can provide and still seemingly not meeting the criteria for accessing a mental health service assessment. DBT skills will enable such young people to better deal with difficult times.

Academic Context

DBT is an empirically supported treatment for adults with Borderline Personality Disorder who present suicidal and non-suicidal self-injury (e.g. cutting) (Linehan et al., 2006). Emotional and behavioural dysregulation is targeted by DBT; teaching coping skills and using problem solving within a validating environment. DBT has been adapted for adolescents presenting suicidal and self-injurious (Miller, Rathus, & Linehan, 2007). DBT efficacy for adults and adolescents is encouraging for adapting DBT for children with suicidality and/or self-injury. Death rates by suicide for children aged 5 to 14 years of age have doubled over the past 20 years. Approximately 25% of outpatient and 80% of psychiatric inpatient 6 to 12 year old children present suicidal behaviour (Pfeffer et al., 1986), however, there are no established interventions/programmes to help these young people.

The adaptation of DBT for children requires adjustments to accommodate their developmental level. Because DBT is a principle based intervention and not manualised into a specific format, technique or skills set but more importantly by the balance of acceptance and change within a dialectical context. DBT for children needs to adhere to the principles whilst employing child centered resources and activities designed to involve children, sustain attention, and encourage skills acquisition. The DBT skills of mindfulness,

distress tolerance, emotion regulation and interpersonal effectiveness have been adapted from the adult and adolescent guidance (Linehan, 1993). Walking the Middle Path is an additional module was added for families and adolescents. Through understanding the dialectic of acceptance and change the module elucidates that there is more than one way to perceive a situation or resolve a problem. Jim Hanson shared this slide an excellent visual representation of the dialectic paradigm.



Slide by permission of J. Hanson

Aims of the project

The aim of my Fellowship is to research answers for the potential and practicalities of the following questions:

a) What are best evidence based practice models of CYP DBT skills training programmes?

b) What is the best evidence based practice model for adaptation in Wales and the UK?

Methods

There is a substantial and robust body of research evidence demonstrating effectiveness of specific DBT interventions in clinical practice but my interest in adaptations of DBT for children and adolescents required a specific exploration of how programmes have flourished in non-clinical settings and especially in school communities. In this way it was essential for me to experience and gain a sense of the established and successful programmes by visiting relevant centres of excellence.

I felt it was important to meet with the developers and practitioners in person when possible to gain an insight into what challenges they had encountered and the adaptations they had made. Benefiting from the lessons they had learned from having spent, in some cases, years developing and implementing DBT programmes in their specific context. Developing professional relationships facilitated detailed discussion about their experiences, programme adaptations and future plans. Those relationships could also be valuable in developing interventions in the UK.

The generosity of the professionals I visited humbled me in their willingness to make time for me and share their knowledge and experience. Undertaking the research in this way made the additional literature research more meaningful.

FINDINGS

Comparisons: - Society, culture and professional context

To start my Fellowship travels I visited Cork, Ireland in the first week of October 2017. A certain level of stigma exists in Ireland as it does in Wales, Scotland and England in relation to mental health. Ireland's "Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015-2020" is reducing that stigma through education – the more people know about something, the less likely they are to hold negative attitudes. I found Cork to be incredibly friendly, I was made very welcome and I felt very at home there.

I spent time with the DBT STEPS – A pilot project Team Daniel Flynn the Principal Psychology Manager, Dr Mary Joyce (National DBT Project - Project Co-Ordinator), Mareike Weihrauch (Doctoral Clinical Psychology student and Project Research Officer) and Mary Atkins (Educational Psychologist) discussing the DBT STEPS – A pilot project undertaken in eight schools in Cork City and county. The pilot project evaluation report had recently been published. The team were very generous with their time and the depth at which they were willing to explore the evaluation report's recommendations, Daniel Flynn in particular went out of his way to make time for me.

Mental Health Psychology Services, Cork Kerry Community Health Care, Ireland

Young people in the 8 participating Irish schools indicated that participation in mindfulness exercises was the most enjoyable experience of the programme. Some reported it was relaxing and helped to calm their thoughts and stop worrying about things. Other positives included becoming aware of their emotions, understanding their emotions and learning new skills to manage them, participating in group activities together, and the interaction between the students in the class. Examples of feedback from participants included:

"Being able to deal with my emotions and find a solution even in my worst times"

"I liked some of the mindfulness exercises with which you could stop yourself worrying about other things"

"That I learned how to deal and recognise a lot of my emotions"

"I learned a lot of new things on how to deal with certain situations and also how to relax"

Challenges of the programme related to content and delivery. Young people noted that they found the language and wording challenging and at times difficult to understand. They found the material covered to be quite theoretically heavy and thus found it hard to concentrate in the classes. Examples of feedback included:

"The amount of information. There is way too much information for such a short space of time."

Recommendations from participants included simplifying the content and making learning more interactive (teacher/student interaction and including more group activities in order to put the skills learned in class into practice). Some students felt the programme needed to be adapted to make it more relevant to an Irish context. Examples of recommendations from participants included:

"I love the idea of this programme but it needs to be prioritised and cut down. It would be good as an ongoing course – perhaps as 1st to 3rd years, so it could be concentrated on practiced etc..."

"Less terminology. More teamwork/student interaction. Shortened course."
"More interactive activities with students and teachers. And easier language because it makes it seem more complicated than it is and it turns students off."

"I love talking about mental health as someone with an anxiety disorder I feel that everyone would benefit from a class like this. But you're going about it the wrong way ....It needs to be more cooperative between students involved in the class rather than having them sit in a room and wait for the day to be

over. You have to stimulate them, interest them. Most of my class problem with this is that it was boring and controlling. Change this and you have an amazing course that educates people AND listens to others opinion."

This feedback will be important in providing guidance on how the programme needs to be adapted.

The DBT skills training was provided for the school staff by Elizabeth T. Dexter-Mazza and James Mazza, Consulting and Psychological Services Washington, for all teaching staff who delivered the programme and was supported by multi-agency partners in the National Educational Psychology Service and the Health Service Executive (Child and Adolescent Mental Health and Health Promotion) in delivery and evaluation of the programme. The participating schools worked in local multi-disciplinary networks which supported the teachers in understanding and teaching the (Universal model) programme, and also facilitated escalation levels of intervention as required to meet individual student need with support from community health services.

After Ireland I travelled to California and the Pacific North West (Oregon, Washington, Montana, Idaho and Alaska) and Canada (British Columbia) I noticed such great multiplicity every aspect of life. The enormous diversity from the character of San Francisco's colourful city; the amazing Japanese Gardens to Alcatraz to the famously quirky Portland, Oregon for example (both listed in the top 10 most liberal cities in the USA). Portland offers wonderful food and culture from fun-shaped pastries from Voodoo Doughnut in the Old Town, Stumptown Coffee Roasters and Portland Opera, to Powell's, probably the best book shop I have ever been to (which covers a full city block!) to seeing Moose walking in Anchorage Alaska. All life is here and of course the Pacific Northwest is where DBT originates with Marsha Linehan at Washington University. It may be no accident that the West Coast has provided the fertile environment for a therapy that is based on dialectical philosophy, behaviourism and Zen teachings.

In Alaska and British Columbia I experienced extremes of socio-economic differences, weather conditions and the beauty of the natural world. I could see how the standard metaphors commonly in use for describing cultural diversity were all true and sometimes all three being evident in the same place i.e.melting pot: implying that immigrants change to fit the society of their new home; salad bowl: implying that immigrants retain their cultural identity in their new home; kaleidoscope: implying that both the immigrants and society adapt and change.

My Fellowship travels allowed me to see that in some places the professional inter-agency collaborations were seemingly more common and the concept of mental health services being on a continuum stretching from community to specialist services seemed more joined up than the UK, of course this was not

the case everywhere. Guidance and clinical counselling in schools has been a part of school life in the USA for decades by comparison to the Wales National Strategy for counselling in schools which was introduced in Wales in 2007. In this way mental health and wellbeing has been on the 'radar' for education for a long time in American schools and has helped dispel a sometimes short sighted view of the exclusively academic focus of the purpose of school and more broadly education in how children and young people need to be taken care of.

Another apparent difference was around provision of mental health services through private health insurance. In 2013 less than 50 percent of young people with psychiatric conditions received any kind of treatment (Costello et al 2013). Ten percent of young people did not have the required private health care insurance and, when they do have insurance, the extent of mental health services they can access is often limited. Research has identified a number of disparities in accessing mental health services. Young people who are homeless; served by state child welfare and juvenile justice systems; and are LGBTQ are frequently the least likely to be given services.

These comparisons and contrasts were there in the background as I arrived in San Francisco to start my Fellowship in the US. The DBT for Adolescents is a clinical

Langley Porter Psychiatric Institute University of California San Francisco, USA. Dialectical Behavior Therapy (DBT) Program for Adolescents

programme within the Young Adult and Family Centre at the Langley Porter Institute University of California San Francisco. It targets high risk, multi-problem adolescents and specialises in identifying and treating depression and risky behaviours, including self-harm, suicidal ideation and suicide attempts, substance use, binging and purging, risky sexual behaviours, physical fighting, and other forms of risk-taking.

I visited the Langley Porter Psychiatric Institute at UCSF in the second week of October 2017 and Dr Auran Piatigorsky was very generous in sharing his time, knowledge and resources with me enabling me to gain a comprehensive understanding of how the DBT team and programme functions. I wanted to gain an insight into a clinical approach at a clinical setting with the highest

fidelity to the treatment model developed by Marsha Linehan. This is the most stringent certification program for ensuring a clinician is able to deliver adherent DBT, and involves a review of employment history, trainings attended, mindfulness practices and current treatment team status, as well as a written exam, a review by an independent third party of a clinician's written case conceptualization, and a third party review and scoring of three of the clinician's therapy sessions.

Auran had shared an interesting research study by the UCSF team with me on Functions of non-suicidal self-injury in adolescents

- **Affect Regulation** (angry outbursts, emotional instability) more likely to engage in self-harm for **intrapersonal reasons** (e.g. affect regulation, anti-dissociation etc.)
- **Disturbed relatedness Symptoms** (relationship and interpersonal dysfunction) to be more likely to engage in self-harm for **interpersonal reasons** (e.g. autonomy, revenge etc.)

This research extends understanding of the functions that serve to maintain self-harming behaviour in young people seeking treatment for Borderline Personality Disorder (BPD). Findings can enhance the efficacy of interventions aimed at reducing harmful behaviours early in the course of their development.

As well as insights into the logistics of orientation, contracting and scheduling for potential group participants we talked about the concepts of radical genuine-ism or authenticity and self-disclosure and how young people experienced working with therapists as being very different from other interventions they had received. Reinforcement of the suggestions from Ireland for paring down and simplifying the content so that group work is experienced as spacious rather than dense.

I then moved on to Portland, Oregon visiting Jim Hanson, a School Psychologist and forerunner of the initiative for developing DBT programmes in school settings who was the cornerstone of my Fellowship research. Jim provided the warmest of welcomes; he is the coordinator of Lincoln High School's social-emotional learning programs and has been leading

Lincoln High School, Portland, Oregon

the School-Based Dialectical Behavioral Therapy program for over ten years and is the lead author along with Marsha Linehan and University of Washington staff of the upcoming "Implementing DBT in Public Schools" research.

Jim went out of his way to ensure that I had time for discussion by inviting me to accompanying him on a road trip from Oregon via Washington and Idaho states to the School Psychologist Conference in Montana and shared from a wealth of knowledge of direct group delivery experience on the how DBT has been extensively implemented, developed and integrated at Lincoln High at all Tier levels.

While I was in Oregon Jim Hanson shared with me the most recent Oregon Student Wellness Survey report for all schools in Oregon including his school Lincoln High School. This is a survey sponsored by the Oregon Health Authority in collaboration with the Oregon Department of Education and is administered online or on paper to school students. The survey is designed to assess a wide range of information on topics that include gender, race and ethnicity, tribal affiliation, language, school climate, positive youth development, mental and emotional health, problem gambling, substance misuse, drug free communities core measures, height, weight and body mass (BMI) and comparison to past surveys. The survey comprises of 245 multiple choice questions. Here are some examples:

Question 97:

> In the past 30 days, on how many days did you carry a gun as a weapon on school property?

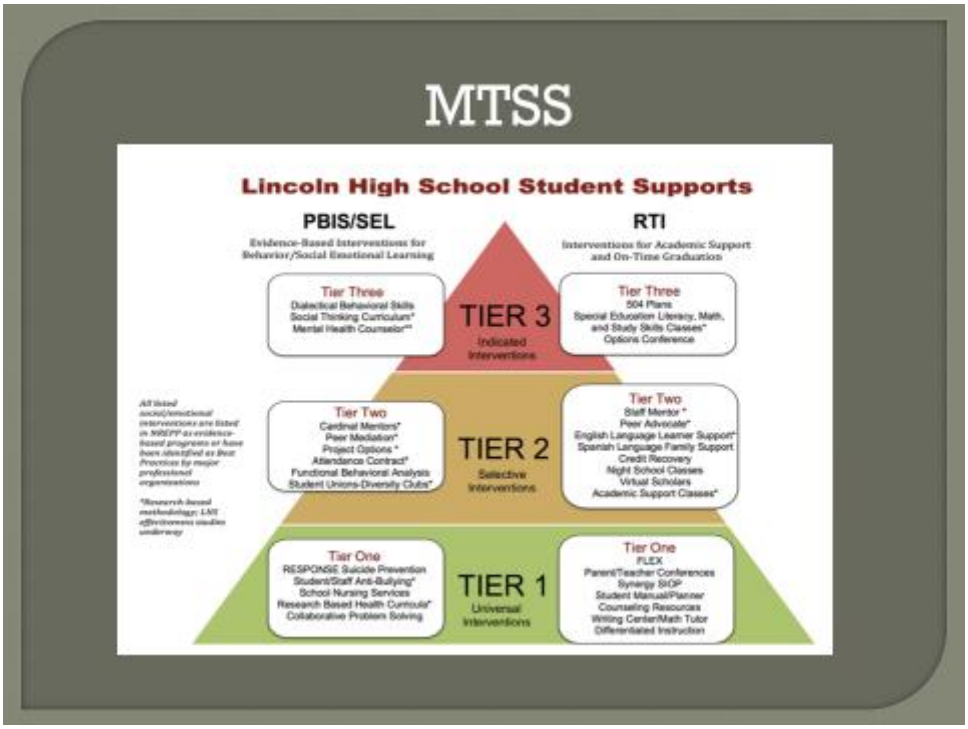
Question 131:

> During the past 12 months did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activity?

Question 133:

> During the past 12 months, how many times did you actually attempt suicide?

This information enables the school to have an insight into whole school trends (and state trends because this survey is undertaken in all Oregon High Schools) such as self-harm and/or suicidal behaviours and informs the individual schools Multi-Tired Supports System about what kinds of interventions might need to be implemented. MTSS addresses academic as well as the social, emotional, and behavioral development of children from early childhood to graduation. DBT is one such intervention that Lincoln High School has available.



Slide by permission of J. Hanson

Additional Research

At the end of my Fellowship I travelled on to Alaska to among other things undertake the 12 hour train journey from Anchorage to Fairbanks in search of the Northern Lights and then onto British Columbia and Vancouver Island (Of the estimated 4000 Mountain Lion's in Canada, 3500 live in BC. Of this, nearly a quarter reside on Vancouver Island - itself only representing 3% of BC's land area). I felt it important to include the fact that DBT skills are identified and valued outside the fertile ground for DBT that is California and the North Pacific Coast and that is why I gave a little time to consider how DBT was being adapted in Alaska and British Columbia, Canada.

Anchorage University were helpful in sign-posting me to the work of Researcher(s): Mike Worrall, and students (Hugh Leonard, Jessica McKay) (National Institutes of Health's Biomedical Learning and Student Training program). Their research has developed in response to Alaska being

consistently classified as having the highest suicide rate in the United States. This rate is nearly twice the national average, with approximately 130 suicides happening in Alaska per annum. Particularly concerning are young people in Alaska who have substantially higher rates of completed suicides than the US average. The national Centre for Disease Control and Prevention 2004 national suicide rates showed 15 to 19 year olds were 8.2 per 100,000. In the Alaska Suicide Follow Back Study, from 2004 – 06 the average annual rate for adolescents was 31.6 per 100,000, over three times the United States rate. In addition there is a significant ethnic disparity in rates of suicide because Alaska Natives account for 39% of suicides but comprise only 16% of the population.

The overarching goal of The Dialectical Behaviour Therapy and Research Program (DBTRP) started in 2015 is developing ways to more effectively disseminate DBT in Alaska, in particular in rural communities. DBT clinical services are provided by Community Mental Health. Current research projects include a pilot project to evaluate and adapt/develop guidelines on the implementation of DBT in the cultural contexts of Alaskan Native peoples (Hugh Leonard). Other research projects in progress include the evaluation of the effectiveness of an online training protocol for training DBT peer supervisors and a theoretical paper on supervision in DBT and other evidence-based treatments.
The Dialectical Behaviour Therapy (DBT) Research Laboratory conducts multiple lines of research aimed at a large goal of dissemination of best Evidenced Based Practices e.g. to adapt DBT to be culturally responsive for Alaska Native communities.

In Canada Heather Rider had generously shared information with me about Sashbear's DBT STEPS – A pilot project over 5 schools.

Sashbear is conducting a pilot research study to measure the impact of a 30 session SEL (Social Emotional Learning) curriculum based on Dialectical Behaviour Therapy (DBT) skills on student's mental health. The curriculum is designed for the range between years 7 and 12. The pilot, funded by the Sashbear Foundation, includes implementation of the DBT based curriculum, general training of staff and specific training of teachers delivering the curriculum to students. Training was delivered by Elizabeth T. Dexter-Mazza and James J. Mazza, Mazza Consulting and Psychological Services Washington June 8-10 2017 with an autumn 2017 implementation.

DBT model adaptations for children and young people

I knew before I travelled in the USA that DBT Skills training programmes in some schools have been established for over a decade and have researched and evaluated the efficacy and impact of programmes.

Jim Hanson very kindly arranged with Jessica Carranza the conference organiser for me to attend the 2017 Montana Association of School Psychologists 'Advancing School Mental Health Support' Conference on systems and supports to implement school based DBT (SB-DBT) with fidelity and how SB-DBT operationalises mental health interventions within a multi-tiered system of support.

The conference provide an opportunity to examine concrete program elements and supports for DBT programs including practitioner training, supervision and student and family orientation protocols. Participants learned the components of the Distillation and Matching model and how it applies to the common elements perspective of evidence-based practices.

In travelling to Montana and attending the conference I realised Montana is at the same stage as the Wales and the rest of the UK in that they are now becoming aware of how DBT Skills training programmes could benefit all school students at a universal level and provide a more specialised intervention for young people with suicidal and self-injurious behaviour's for whom there are currently no evidence-based interventions to address their problems.

DBT-STEPS – A (Skills Training for Emotional Problem Solving for Adolescents) has been developed more recently by Mazza, Dexter-Mazza, Miller, Rathus and Murphy in 2016. It is based on the principles of Dialectical Behavioural Therapy (DBT) (Linehan 1993). The same level of importance is given skills development as in standard DBT with the interwoven modules on mindfulness, dialectics (Middle Path), emotional regulation, distress tolerance and interpersonal effectiveness to promote social and emotional learning. The DBT-STEPS - A programme can be delivered on a whole year or school 'universal' model, 'selected' model or 'indicated' model.

DBT skills training in schools adheres to the three philosophical pillars of the original DBT protocol which are based on dialectics, behavioural science and Zen. It retains an emphasis on biosocial theory of emotional dysregulation (the original protocol states that BPD is a dysfunction of emotional regulation in an invalidating environment). The components of individual psychotherapy, group skills training, phone coaching and a consultation team as the main methods of delivery are adapted so that the individual psychotherapy element becomes more focused on skills practice in general life, in school and in specific situations and instead of phone coaching young people have can access direct support during school hours when they need help in dealing with

difficulty, identifying and describing emotions, stopping avoiding negative emotions, increase positive emotions, manage impulse control, self-soothing and promote interpersonal effectiveness. (Neacsiu, Ward, Ciesielski and Linehan 2012).

Rathus and Miller (2002) demonstrated the malleability of DBT intervention philosophy researching young people who were suicidal. An adjusted version of the original protocol was provided and they discovered significant reductions in suicidal ideation, general psychiatric symptoms and symptoms of borderline personality disorder within the group. This version of DBT has been found to be effective in improving health and quality of life in young people who were suicidal (Swales, Hibbs, Bryning and Hastings 2016).

Many adaptations of DBT for adolescents addressing a wide range of mental health conditions have included; self-injury, unstable affect, deliberate self-harm, bipolar disorder, eating disorders and trichotillomania. Studies have been carried out across a range of inpatient and community settings. Results have been positive and have shown significant improvements in for example: distress tolerance, depression, suicidal ideation, general functioning, anxiety, hospital admissions, violence, binge behaviours, purging and hair pulling (MacPherson, Cheavens and Fristad 2013).

The spectrum of functioning for young people ranges from young people who are managing social situations and their own emotional states allowing them to thrive. At the other end, young people may be severely emotionally dysregulated and encountering numerous difficulties in interacting within their social environment. It has been suggested that DBT skills can be beneficial for young people across this spectrum (Rathus and Miller 2015). Adaptation for CYP will yield significant benefits when used as a preventative intervention in young people, within a school environment. Increasing mindfulness, strengthening emotional regulation, enhancing interpersonal effectiveness, and improving distress tolerance will improve mental health and reduce the risks of developing problematic behaviours to manage stress and distress. It is then expected that this group will be less likely to require more intensive and expensive services in the future.

A Denbighshire STEPS – A pilot programme would be delivered to a 'selected' smaller group of young people who would be existing clients of the School Counselling Service. The 30 session, skills based programme will be delivered over 15 weeks within one double 'lesson' slot or two separate 'lesson' slots each week. This initiative will increase the skills and capacity of the school counsellors to work with this group of young people.

This adaptation of the DBT-STEPS -A programme builds on ongoing research into the efficacy of DBT-STEPS - A when delivered by school teachers as a universal intervention. This DBT-STEPS - A programme will be delivered by school counsellors to an indicated group of young people who are at increased risk of developing mental health problems.

Other important information obtained during the trip:

Lessons learned and other insights that came out of visiting programmes in Cork, Southern Ireland, California and Oregon in the USA:

- Established DBT STEPS – A programmes consider themselves as part of 'Seamless mental health services available in a continuum stretching from the community at large to primary care and specialist mental health services' (Flynn et al, CAMHS, Cork, HSE South. 2017).

- 'Health, mental health and education affect individuals, society, and the economy. We must work together whenever possible to coordinated effective supports. Schools are a perfect setting for this collaboration. At Lincoln we embrace the WSCC model – Whole School, Whole Community, Whole Child' (Lincoln High School, Portland, Oregon).

- Multi-agency funding fostered the ability of education, health and community services to train and work together to develop and enhance a mental health programme for young people which channels extra support for 'at risk' adolescents as necessary

- Incorporating more multi-media and opportunities for interactive learning, and consider double lesson duration sessions in order to have sufficient time for module content. Changing the order of presentation of the modules to a new sequence of: mindfulness then emotion regulation followed by interpersonal effectiveness and finally distress tolerance skills.

- Student feedback offered useful suggestions of how programmes could be refined

- The need for schools to incorporate DBT Skills training in the class timetable to ensure that students have the opportunity to cover the full content of the programme over the course of the academic year and therefore maximising its potential benefit.

- Allowing time and resources for staff training and avail of supervision consultation on a regular ongoing basis.

- The importance of buy-in by stakeholders and facilities made available so that partner agencies (Educational Psychology, CAMHS and Health Promotion staff) co-facilitate the programme and enhance the student's experience of the programme.

- Consideration needs to be given for how to best engage parents in understanding and supporting their child's mental health and wellbeing (Miller et al., 2007). This might require further evaluation where

information is gathered from parents about their needs and also for the development of the materials to be delivered.

CONCLUSIONS

The nature of evidence

My Fellowship was partly motivated by the knowledge that Suicide is a leading cause of death for young people and until the emergence of an adapted DBT protocol for this group there has been no evidence-based intervention to address their problems.

As a result of undertaking research at part of my Churchill Fellowship I have found there is substantial evidence supporting the efficacy of DBT. The first randomised controlled trial (RCT) of DBT was published in 1991, in which Dr. Marsha Linehan and her colleagues found that DBT resulted in significant improvements for chronically suicidal and self-injuring women with borderline personality disorder, a clinical population that had previously been viewed as untreatable (Linehan et al., 1991). In the time since this milestone study, DBT has been expansively researched for a wide range of mental health conditions receiving treatment in diverse practice settings throughout the world.

The adaptation of DBT skill training programmes for adolescents in non-clinical settings have only been 'recently' established in some schools and the longest standing examples now have been operating for 10 years. There is a growing body of evidence for DBT adaptations for CYP.

I have come to realise that Rathus and Miller's (2002) work has influenced all the programmes I looked at on my Fellowship travels and specifically refer to the in vivo nature of DBT by describing it as an 'outpatient' model (by comparison to 'hospital' based clinical settings for high risk adolescents). This is particularly significant for its potential efficacy with any at risk cohort but maybe more so with CYP who are naturally curious and social creatures and curiosity drives development. A young person is able to contact their counsellor to provide in-the-moment support. The objective is to support clients on how to use their DBT skills to effectively cope with difficult situations that arise in their everyday lives. Clients can contact their individual therapist between sessions to receive support at the times when they need help the most. It will be important to consider how this can be adapted for a school situation.

That DBT is a principle-driven, rather than a protocol-driven approach. This is important in that it facilitates a capacity to 'stay with' the young person's situation and experience, where principles help to understand the situation and determine which techniques would be helpful.

Jim Hanson's research from the work undertaken at Lincoln High School (Portland, OR) is centre stage in looking back over my Fellowship and it speaks for itself:

- Suicide was the leading cause of death before DBT Skills Training programme started in 2007

- About 20 parent meetings per year for self-harm, suicide ideation or attempt (record year high was 45 meetings) before DBT skills training programme started in 2007

- High stress and anxiety (Oregon Healthy Teens Survey - Yr11students)

  2008 13% of students reported considering suicide

  2012 8.4% of students reported considering suicide. The DBT programme had been delivered at the school for 4 years

- Before DBT: one to two suicides per year, since the DBT skills training programme there have been no suicides

- Before DBT: two to three placements into Portland Public School's day treatment classroom per year, since DBT skills training programme there has been one placement

Answering the original questions posed by the aims of the Fellowship:

a. What are best evidence based practice models of CYP DBT skills training programmes?

The statements from Cork in Ireland: 'Seamless mental health services available in a continuum stretching from the community at large to primary care and specialist mental health services' and from Portland, Oregon USA: 'Health, mental health, and education affect individuals, society, and the economy. We must work together whenever possible to coordinated effective supports. Schools are a perfect setting for this collaboration. At Lincoln we embrace the WSCC model – Whole School, Whole Community, Whole Child.

These project examples in addition to the UCSF Langley Porter programme evidenced best practice based on a continuum model within a multi-tiered system of supports promoting mental health and wellbeing.

b. What is the best evidence based practice model for adaptation in Wales and the UK?

Lincoln High School's programme evidenced a best practice model for our pilot project, however, any school starting a DBT skills training programme in the UK will probably need to start on a smaller scale than Lincoln High School's current comprehensive programme which includes all 3 tiers across the whole school ('Universal' (Tier I), 'Selected' (Tier II) and 'Indicated' (Tier III).

The best practice model is the 'Indicated' level (Tier III) which would provide a DBT skills training programme of direct and indirect services to address identified mental and behavioural problems for young people.

RECOMENDATIONS

Recommendation 1:

- Dissemination of the Fellowship findings could be achieved through an academic article. Consideration needs to be given to which publication/s.

- Promoting the a DBT skills training pilot project in Denbighshire Schools (the main planned outcome of the Fellowship) in which Kathryn Nash (Senior Educational Psychologist and Manager of the DIYPCS will facilitate implementation) could be summarised in a 'poster' and exhibited as part of Bangor University School of Education's exhibition by CIEREI (Collaborative Institute for Education Research, Evidence and Impact) in North Wales which will be opened by the Welsh Governments Minister for Education Kirsty Williams AM in late February 2018 (Poster on page 30).

- Presentation could be delivered at an appropriate conference; an invitation has been received to present the Fellowship findings at the 'Child's World - New Shoes New Direction' International Conference: 11-13th July 2018 at Aberystwyth University. A conference devised to frame new concepts in collaborative practice in childhood studies against social, legislative and organisational changes within an international strategic dimension.

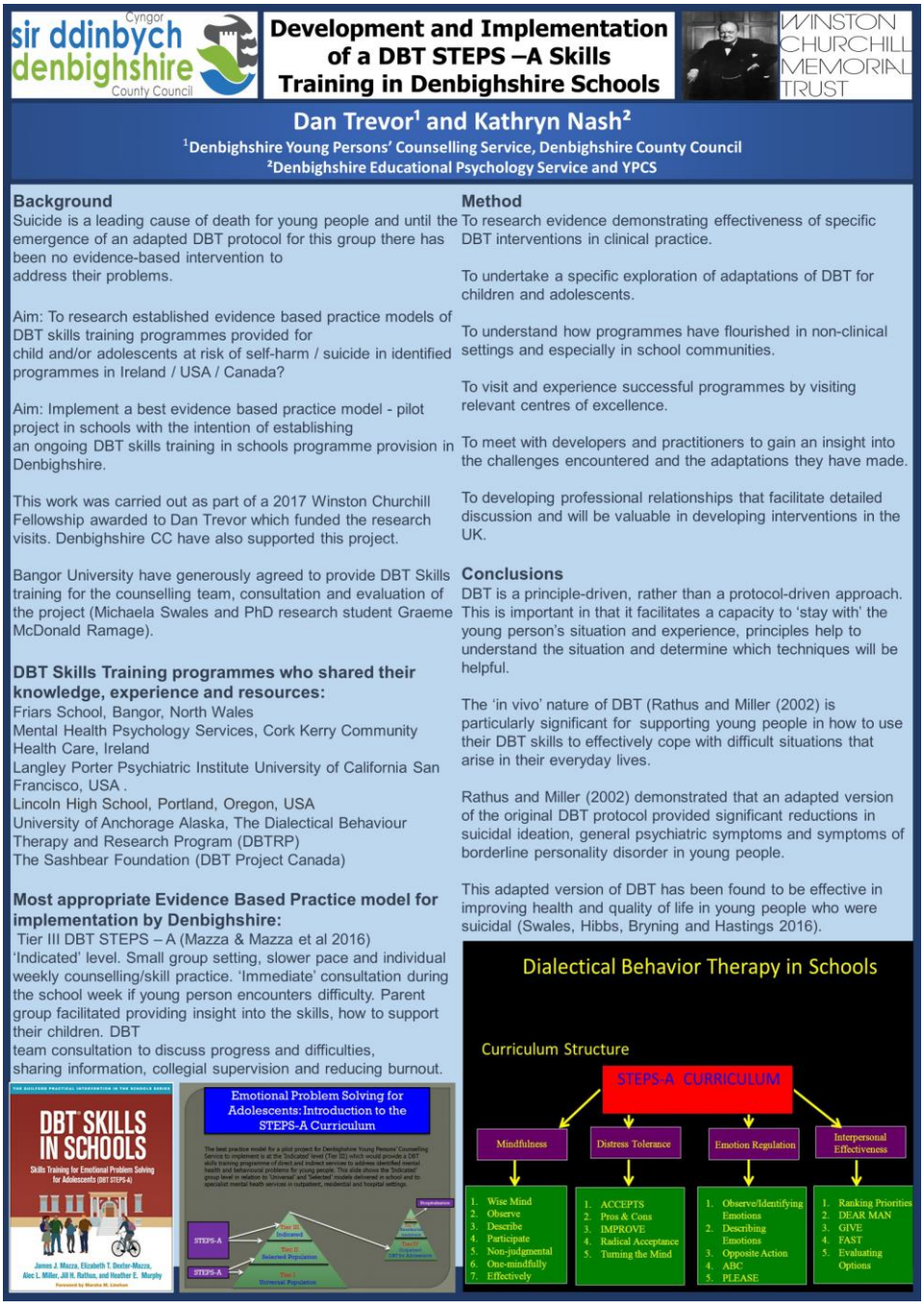
Recommendation 2:

A DBT Skills training pilot project could be planned, organised, funded and implemented by the Denbighshire Young Person's Counselling Service to deliver an 'indicated' level DBT Skills training programme at selected schools in Denbighshire. Bangor University's offer to provide training for counselling staff and on-going consultation for the duration of the project could be accepted (Michaela Swales Consultant Clinical Psychologist – International DBT Trainer)

Recommendation 3:

An offer by Bangor University (Graeme McDonald Ramage currently a clinical psychology PhD research student) to base part of a doctoral research dissertation on the evaluation of outcomes could be accepted for the potential Denbighshire DBT skills training pilot for young people.

Poster for Bangor University School of Education CIEREI (Collaborative Institute for Education Research, Evidence and Impact) exhibition:



Cyngor sir ddinbych denbighshire County Council

Development and Implementation of a DBT STEPS –A Skills Training in Denbighshire Schools

WINSTON CHURCHILL MEMORIAL TRUST

Dan Trevor[1] and Kathryn Nash[2]

[1]Denbighshire Young Persons' Counselling Service, Denbighshire County Council
[2]Denbighshire Educational Psychology Service and YPCS

Background

Suicide is a leading cause of death for young people and until the emergence of an adapted DBT protocol for this group there has been no evidence-based intervention to address their problems.

Aim: To research established evidence based practice models of DBT skills training programmes provided for child and/or adolescents at risk of self-harm / suicide in identified programmes in Ireland / USA / Canada?

Aim: Implement a best evidence based practice model - pilot project in schools with the intention of establishing an ongoing DBT skills training in schools programme provision in Denbighshire.

This work was carried out as part of a 2017 Winston Churchill Fellowship awarded to Dan Trevor which funded the research visits. Denbighshire CC have also supported this project.

Bangor University have generously agreed to provide DBT Skills training for the counselling team, consultation and evaluation of the project (Michaela Swales and PhD research student Graeme McDonald Ramage).

DBT Skills Training programmes who shared their knowledge, experience and resources:

Friars School, Bangor, North Wales
Mental Health Psychology Services, Cork Kerry Community Health Care, Ireland
Langley Porter Psychiatric Institute University of California San Francisco, USA .
Lincoln High School, Portland, Oregon, USA
University of Anchorage Alaska, The Dialectical Behaviour Therapy and Research Program (DBTRP)
The Sashbear Foundation (DBT Project Canada)

Most appropriate Evidence Based Practice model for implementation by Denbighshire:

Tier III DBT STEPS – A (Mazza & Mazza et al 2016) 'Indicated' level. Small group setting, slower pace and individual weekly counselling/skill practice. 'Immediate' consultation during the school week if young person encounters difficulty. Parent group facilitated providing insight into the skills, how to support their children. DBT team consultation to discuss progress and difficulties, sharing information, collegial supervision and reducing burnout.

Method

To research evidence demonstrating effectiveness of specific DBT interventions in clinical practice.

To undertake a specific exploration of adaptations of DBT for children and adolescents.

To understand how programmes have flourished in non-clinical settings and especially in school communities.

To visit and experience successful programmes by visiting relevant centres of excellence.

To meet with developers and practitioners to gain an insight into the challenges encountered and the adaptations they have made.

To developing professional relationships that facilitate detailed discussion and will be valuable in developing interventions in the UK.

Conclusions

DBT is a principle-driven, rather than a protocol-driven approach. This is important in that it facilitates a capacity to 'stay with' the young person's situation and experience, principles help to understand the situation and determine which techniques will be helpful.

The 'in vivo' nature of DBT (Rathus and Miller (2002) is particularly significant for supporting young people in how to use their DBT skills to effectively cope with difficult situations that arise in their everyday lives.

Rathus and Miller (2002) demonstrated that an adapted version of the original DBT protocol provided significant reductions in suicidal ideation, general psychiatric symptoms and symptoms of borderline personality disorder in young people.

This adapted version of DBT has been found to be effective in improving health and quality of life in young people who were suicidal (Swales, Hibbs, Bryning and Hastings 2016).

References

CQC (2016) Brief guide: waiting times for community child and adolescent mental health services. Care Quality Commission. Available at: https://www.cqc.org.uk/sites/default/files/20170121_briefguide-camhs-waitingtimes.pdf, December 2016

Children's Commissioner. (2016) Children's Commissioner's report Lightning Review: Access to Child and Adolescent Mental Health Services. Available at: https://www.cqc.org.uk/sites/default/files/20170121_briefguide-camhs-waitingtimes.pdf

Costello, E. J., He, J. P., Sampson, N. A., Kessler, R. C., & Merikangas, K. R. (2013). Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey–Adolescent. *Psychiatric Services, 65* (3), 459.

Frith, E. (2017) Access and waiting times in children and young people's mental health services. Education Policy Institute (EPI). https://epi.org.uk/report/mental-health-access-waiting-times/

Flynn, D., Joyce, M., Weihrauch, M., Corcoran, P., Galleger, E., O'Sullivan, C., Hurley, P. (2017). Dialectical Behaviour Therapy – Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS –A): Pilot Implementation in an Irish Context. Cork HSE South.

Hanson, J. (2016) "School-Based DBT: Merging Mental Health and Behavioral Supports for High School Students at Tiers II & III: Dialectical Behavioral Therapy in the Public Schools" (June 6, 2016). *Georgia Association for Positive Behavior Support Conference.* Paper 78.

Haskell, I., Daly, B.P., Hildenbrand, A., Nichols, E., Mazza, J.J. and Dexter-Mazza, E.T. (2014) Skills training for emotional problem solving for adolescent (STEPS – A); Implementation and programme evaluation. Paper presented at the annual conference on Advancing Mental Health, Pittsburgh, and P. A.

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., Heard, H.L. (1991). Cognitive-behavioral treatment of chronically Para suicidal borderline patients. Arch Gen Psychiatry. 1991 Dec; 48 (12):1060-4.

Linehan, M.M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

Linehan, M.M., Comtois, K.A., Murray. A.M., Brown. M.Z., Gallop. R.J., Heard, H.L., Korslund, K.E., Tutek, D.A., Reynolds, S.K., Lindenboim, N., (2006). Two-year randomized controlled trial and follow-up of dialectical behavior

therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry. 63(7):757-66.

MacPherson, H.A., Cheavens, J.S. and Fristad, M.A. (2013). Dialectical behavior therapy for adolescents: theory, treatment adaptations, and empirical outcomes - Clinical child and family …, 2013 - Springer

Mazza, J.J., Dexter-Mazza, E.T., Murphy, H.E., Miller, A.L. and Rathus, J.H. (2016) Skills Training for Emotional Problem Solving for Adolescents (STEPS – A): Implementation DBT Skills training in schools. Guilford Press.

Mazza, J.J., & Hanson J.B. (2014a, February). Dialectical Behaviour Therapy (DBT) in Public Schools. Paper presented at the annual conference of the National Association of School Psychologists, Washington, DC.

Mazza, J.J., & Hanson J.B. (2014b, October). Multi-tiered approach to dialectical behaviour therapy (DBT) in schools. Paper presented at the annual conference of the Washington State Association of School Psychologists, Stamina, and DC.

Miller, A.L., Rathus, J.H., Linehan, M.M., (2007). Dialectical Behavior Therapy with suicidal adolescents. New York: Guilford Press

Neacsiu, A. D., Ward-Ciesielsk, E. F. and Linehan (2012) Emerging approaches to counseling intervention: Dialectical behavior therapy. The Counseling - journals.sagepub.com

Pfeffer, C.R., Plutchik, R., Mizruchi, M.S., Lipkins, R. (1986) Suicidal behavior in child psychiatric inpatients and outpatients and in non-patients. American Journal of Psychiatry; 143:733–738.

Rathus, J. H., and Miller, A.L. 2002). Dialectical Behaviour Therapy adapted for suicidal adolescents. Suicide and life-threatening behaviour, 32 (2), 146-157.

Sadeh N., Londahl-Shaller, E.A., Piatigorsky, A., Fordwood, S., Stuart, B.K., McNiel, D.E., Klonsky, E.D., Ozer, E.M., Yaeger, A.M.. Functions of non-suicidal self-injury in adolescents and young adults with Borderline Personality Disorder symptoms. Psychiatry Res. 2014 May 15; 216(2):217-22. Doi: 10.1016/j.psychres.2014.02.018. E pub 2014 Feb 19.

Swales, M., Hibbs, R. A. B., Bryning, L., Hastings. R. P. (2016) Health related quality of life for young people receiving dialectical behaviour therapy (DBT): a routine outcome-monitoring pilot. Springer Plus **5**:1.