Orygen
The National Centre of Excellence in Youth Mental Health

Clinical practice in youth mental health

# Addressing barriers to engagement

## Working with challenging behaviour

### Introduction

There is no universal definition of challenging behaviour, this is partly because whether or not a behaviour is seen to be 'challenging' is subjective. Whether a person perceives a young person's behaviour to be challenging depends on many factors. These may include their social and cultural background,[1] role (e.g. a clinician, teacher), previous exposure to the behaviour, relationship with the young person, confidence in their ability to respond in an appropriate way, available support (e.g. clinical management), and the context in which the behaviour presents (e.g. a classroom, an inpatient unit). It is also important to consider whether or not a behaviour is developmentally appropriate.

This clinical practice point focuses on engaging young people (aged 12-25 years) who are presenting with challenging behaviour. It is designed to support clinicians to:

- Appreciate the importance of responding appropriately to challenging behaviour;
- Better understand factors that may contribute to challenging behaviour;
- Reflect on their personal responses to challenging behaviour and how they manage these;
- Identify and address potential barriers to engagement associated with different types of challenging behaviour; and
- Access additional resources and professional development to further develop their skills in engaging, assessing and treating young people exhibiting challenging behaviour.

A basic level of knowledge on the principles of engagement in young people, and barriers to engagement is assumed (see Box 1). **Please note, risk assessment and management are not the focus of this resource. Clinicians are strongly encouraged to seek continued professional development in this area and to act in accordance with their duty of care and their organisation's risk management policies.**

For the purpose of this clinical practice point, challenging behaviour refers to behaviour that clinicians working in youth mental health settings typically experience as challenging, namely:[2]

- Reluctant or resistant behaviour – this may range from limited engagement in conversation with the clinician to refusing to speak;
- Self-harm and threats to self-harm;
- Hostile, aggressive or threatening behaviour – this may range from mild signs of agitation to verbal or physical aggression directed toward the clinician and/or others;
- Chaotic or disorganized behaviour – for example, a person's behaviour may be bizarre and/or their flow of thought and speech difficult to follow; and
- Intoxication.

**Box 1. Core principles of engagement with young people: A refresher**

**Clinical practice in early psychosis: Working with clinical complexity and challenges in engagement** provides a review of barriers to engagement (many of which are not specific to early psychosis; available on Orygen's website orygen.org.au).

**Working Together (2nd Edition): Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Chapter 22)** provides a review of the core principles of care for young Aboriginal and Torres Strait Islander young people (available at telethonkids.org.au).

**Clinical practice in early psychosis: Working with cultural diversity** provides an overview of engagement principles with Culturally and Linguistically Diverse young people (many of which are not specific to early psychosis; available at orygen.org.au).

## Why is it important for clinicians to respond appropriately to young people exhibiting challenging behaviour?

Clinicians will frequently encounter young people exhibiting challenging behaviour, and often a young person will present with more than one type of challenging behaviour. This behaviour may be evident at the point of referral, first contact and/or at any point during the course of their contact with the young person. A clinician's failure to respond appropriately is likely to damage engagement and the therapeutic alliance which may result in a range of poor clinical outcomes, [3-5] particularly as young people are typically harder to engage in treatment than other age-groups.[6] Challenging behaviour can elicit strong emotional reactions within a young person's support system. Others around them (e.g. family, friends, teachers) may feel overwhelmed and/or struggle to separate the challenging behaviour from the young person themselves (i.e. they see the young person rather than their behaviour as the problem). A clinician's ability to provide some containment to the young person's support system can be an important crisis intervention. Challenging behaviour can also elicit strong emotional responses from clinicians. The ability to engage in reflective practice (both in the moment and following contact) is critical to avoiding burnout and achieving positive clinical outcomes. Clinicians should also be mindful that challenging behaviour might reflect underlying risk that needs to be appropriately assessed and managed.

## Understanding factors that may contribute to challenging behaviour in young people

In order to respond empathically to a young person exhibiting challenging behaviour, one must first be able to reflect on why the behaviour may be occurring.

Young people can be more prone to exhibiting challenging behaviour due to their stage of development.[2, 7] Healthy development in adolescence and young adulthood is characterised by increased novelty-seeking, risk-taking and peer-directed social behaviour.[8] These drives place an increased demand on executive functioning and self-regulation of emotions and behaviours. However, a young person's neural and cognitive development may not have 'caught up' enough to meet these demands. This 'mismatch' may manifest in young people exhibiting behavioural problems, lacking foresight into the potential consequences of their actions, having difficulty expressing themselves, and/or seeing things from someone else's perspective.[2, 7]

**A clinician's failure to respond appropriately is likely to damage engagement and the therapeutic alliance which may result in a range of poor clinical outcomes, particularly as young people are typically harder to engage in treatment than other age-groups.**

Negative interpersonal experiences and trauma can also contribute to challenging behaviour. A young person may have experienced mistreatment and/or abandonment by authority figures in the past. They may have negative prior experiences of services, clinicians and/or treatments. They may be struggling with a perception that others expect them to have more insight and understanding into their ill health than they do. All of these experiences can contribute to ambivalence about engaging in treatment, hostility toward you as the clinician, and utilising unhealthy coping strategies including self-harm and substance abuse.

**Challenging behaviour is likely to manifest if they do not believe that engaging with you will support them to meet their immediate needs, or if they think that you are there to serve the needs of others rather than to support them.**

Affective, cognitive and behavioural disturbance related to symptoms of mental ill health, related stressors, and/or the side effects of psychotropic medication can all contribute to challenging behaviour. These may include hyper-arousal, paranoia, extreme fatigue, difficulty concentrating, thought disorder, an avoidant coping style, hopelessness about their situation, poor insight, and/or ambivalence about change.[2, 3, 9] Adverse side-effects from psychotropic medication can also contribute to challenging behaviour (e.g. cognitive difficulties, increased agitation) and/or exacerbate ambivalence about engagement.[10]

A young person may have significant unmet needs such as feeling unsafe in their living situation, experiencing poverty or homelessness. Challenging behaviour is likely to manifest if they do not believe that engaging with you will support them to meet their immediate needs, or if they think that you are there to serve the needs of others rather than to support them.[2] The latter is particularly relevant to young people who feel coerced into engaging with mental health services.[2]

It is important to be sensitive to additional barriers to care faced by young people who are: lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI), experiencing homelessness, have comorbid substance use issues, living in rural or remote communities, culturally and linguistically diverse and/or Aboriginal or Torres Strait Islanders.[11] Failure to do so may result in their behaviour being misinterpreted as hostile, reluctant or resistant when in fact the service may be failing to recognise and/or to meet their needs.

TIP

Engagement is a dynamic and ongoing process that requires continued attention. Potential ruptures to the therapeutic relationship should be addressed when they occur.

## What are the core principles of engagement when a young person presents with challenging behaviour?

- The young person has probably received punitive and negative responses in response to their behaviour in the past. Adopt a non-blaming stance and try to understand their perspective.[2]
- Don't take the behaviour personally. Rather acknowledge (to yourself, the young person, and others involved in their care), that while a certain behaviour may be inappropriate or unhelpful, they are probably coping the best way they can in their current circumstances with the coping strategies and resources available to them.[2]
- Reassure them that you are here to support them and that you would like to work with them to try to figure out how you can best do that at this stage.
- Always work from a recovery-oriented approach and explore their strengths.[5] Try to empower the young person while taking into consideration their capacity, your duty of care and the responsibilities of family/carers.[12] Consider implementing shared-decision making (see *Clinical practice in youth mental health: Shared decision making* at orygen.org.au).[5, 13]
- Check-in with them regularly to ensure your understanding of things is 'on track'.
- Ask if there are practical things that you might be able to help with e.g. Centrelink, transport to appointments.[5, 9]
- Transference and counter-transference issues are important to consider regardless of your therapeutic orientation.[14-16] However, do not to be too quick to attribute your reactions, or those of the young person to counter-transference/transference.[17]
- Involvement of family and peer-support workers may enhance engagement if the young person is open to their involvement.[2, 5, 18]
- Always try to conduct a comprehensive risk assessment and implement risk management protocols as indicated.[2]
- Practice self-care, utilise supervision, senior clinical staff and a team-based approach to avoid burnout.

TIP

Be mindful that while assessment of risk, acuity of symptoms and adherence to medication is necessary; an over-emphasis on these aspects of care can hamper engagement.[9]

## Additional engagement considerations in the context of resistant or reluctant behaviour

- Acknowledge and normalise that they seem to be finding the interaction difficult.
- Try to explore why this may be the case. Some guesswork may be required.[2] For example, "I wonder if you might feel like you were forced to come here today?" If you suspect that their symptoms are making it difficult for them to engage and adapt your approach accordingly.
- Consider possible cognitive, language and cultural barriers (e.g. mental health problems may not conceptualised in the 'Western' way in their culture).
- Gently ask if there is anything that might make it a bit easier for them to communicate with you. Provide suggestions (e.g. "Sometimes people find it helpful to bring a support person into the room, to write or draw instead of talking, or to talk about something other than what's going wrong").
- Try to address any practical barriers to engagement that you suspect/can identify (e.g. Do they need an interpreter? Would they prefer a clinician of a different gender? Do they need appointments later in the day due to sleep disturbance?).
- If you suspect that the young person feels coerced by others to be there, empathise with how that must feel. It may be useful to ask the young person what might help in terms of 'getting them off your back.' Reassure them that their attendance is voluntary if this is the case. If their attendance is mandatory encourage them to use your time as a space to focus on their needs.

TIP

Reflect on what your expectations of the young person are and whether they are realistic in the context of their current situation. In some cases turning up to a session might be all they are capable of at that time.[9]

## Engagement considerations in the context of self-harming behaviour and/or threats to self-harm

- Maintain an open and curious approach to explore what function the self-harm is serving (e.g. emotional regulation, a way to communicate distress, an attempt to suicide) for *this* young person at *this* time.[2, 19]
- If self-harm is being used as a coping strategy, reassure them that you understand this and that you are not trying to 'take it away' or asking them to 'give it up' immediately. Rather, you would like to work with them to develop/re-engage with other coping mechanisms that may be more adaptive.[19]
- Balance their desire for autonomy and confidentiality with your duty of care.[12]
- Remember that self-harming behaviour alone is not indicative of any particular diagnosis.[19]

### Box 2. Helpful resources on self-harm and suicidal risk in young people

Beyondblue Adolescent and Young Adult Clinical Guidelines – see section C2 (available at beyondblue.org.au).

What to do? A guide to crisis intervention and risk management in early psychosis (available at orygen.org.au).

Mythbuster – Self-harm: Sorting fact from fiction (available at orygen.org.au).

## Engagement considerations in the context of aggressive behaviour

- Protect yourself and others from harm. Respond in a calm manner avoiding provocation or confrontation. Respect personal space and keep a safe distance.
- Be concise and clear while respectful . Allow time for them to hear and understand what is being said and to respond. Repeat information if you need to.
- Agree as much as possible, or 'agree to disagree' where you need to.
- Differentiate between the underlying emotion (e.g. anger, anxiety, panic) and the aggressive behaviour.
- Try to assist them to de-escalate (e.g. help them to articulate what they are upset about, use grounding techniques, and/or try to establish what it is that they want).
- Give choices and be clear what consequences may occur if escalation occurs.
- Try to assess whether or not they are intoxicated.

Content adapted from [2]

TIP

Validate the underlying emotion while setting limits in a non-threatening manner, clearly stating what behaviour is acceptable and what is not.

### Box 3. Resources on anger, aggression and risk of violence in young people

Clinical practice in youth mental health: Assessing and managing the risk of violence in early psychosis

Evidence Summary: Understanding and assessing anger-related difficulties in young people

Mythbuster: Moving from common myths to a better understanding of anger in young people

Please note: All the above resources are available on Orygen's website orygen.org.au

## Engagement considerations when a young person presents to a session/ service intoxicated

A young person may present to a clinician in an intoxicated state. Assessment is difficult as substance use can exacerbate or mask mental health symptoms and increase risk to self and others. Engagement is very important as a comorbid substance use disorder is associated with increased risk of disengaging from care.[5, 6]

- Ensure you are familiar with your organisation's policy on responding to intoxication and the symptoms of intoxication with different classes of substances.
- Remain calm and gentle in your approach – introduce yourself, your role and remind them of where they are.[20]
- Approach their substance use problem as a health issue rather than a moral issue, [21] maintain a non-judgemental approach but avoid collusion.[22]
- Always assess mental state and risk. Try to establish which substances they have taken (through direct questioning, mental state exam and collateral information). Remember that substance use may increase risk of self-harm, suicide and aggression.[22] Remember to assess for risk of vulnerability as well as harm to self and/or others.[22]
- Be mindful of your duty of care and consider the need to breach confidentiality if there is significant risk and/or the client is a minor. Assess whether there is need to seek urgent medical care due to risks associated with overdose, withdrawal, intoxication or psychostimulant toxicity.[22] Acute behavioural disturbance secondary to methamphetamine intoxication or toxicity requires urgent sedation.[23]
- If the risk is low and the young person is known to you, it is usually best to re-schedule.[2] Write down any important information as the person is likely to have difficulty recalling what you spoke about.[2]
- Be mindful that young people often see substance use as part of the solution, not the problem. Overlooking this will increase risk of disengagement.[22]

TIP

It is important to try to assess what substances a young person has used to better anticipate their behaviour and to assess and manage their risk appropriately.

### Box 4. Resources related to substance use in young people

**Evidence Summary: Effectiveness of motivational interviewing for young people engaging in problematic substance use** (available on Orygen's website orygen.org.au).

**Queensland Health Dual Diagnosis Clinical Guidelines** - comprehensive risk management guidelines and content specific to dual diagnosis in young people (see Chapter 10; available at dovetail.org.au along with a range of resources specific to substance use and young people).

## Engagement considerations in the context of disorganised/chaotic behaviour

Chaotic/disorganised behaviour may be longstanding (possibly reflecting cognitive deficits, behavioural problems or immaturity) or of recent onset (possibly reflecting a recent-onset mental health disorder or intoxication).[2]

- Be clear and concise in your communication, avoid jargon and write things down.
- Obtain written consent to gather collateral information.
- Conduct a mental state examination and risk assessment.
- Be consistent and practical in your approach. Check if there are practical issues you can support them with.

Content adapted from [9]

## What if a young person doesn't engage despite your best efforts?

- Don't force the issue – this may be counterproductive.
- Wherever possible, leave the door open for them to re-engage.
- Consider onward referral to a service that can provide assertive outreach.
- Carefully consider the risks and benefits of continuing assertive engagement and treatment versus discharging the young person. A team-based approach to decision-making is recommended.
- If there are ongoing risk concerns, a service may decide to continue to monitor the young person via their family/carers, and/or other services for a period of time.

Content adapted from [9]

### Box 5. Access related professional development resources

Free webinars on a number of related clinical topics in youth mental health are available at orygen.org.au.

A helpful clinically-oriented open-access article (available at mja.com.au) – **Tips and techniques for engaging and managing the reluctant, resistant or hostile young person.**

Use of the **DSM-5 Cultural Formulation Interview** may enhance engagement through provision of culturally competent care (see dsm5.org).

## References


1. Xeniditis K, Russell A and Murphy D. Management of people with challenging behaviour. *Advances in Psychiatric Treatment*. 2001; 7: 109-16.
2. McCutcheon LK, Chanen AM, Fraser RJ, Drew L and Brewer W. Tips and techniques for engaging and managing the reluctant, resistant or hostile young person. *Medical Journal of Australia*. 2007; 187: S64-7.
3. O'Brien A, Fahmy R and Singh SP. Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*. 2009; 44: 558-68.
4. Martin DJ, Garske JP and Davis MK. Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*. 2000; 68: 438-50.
5. Dixon LB, Holoshitz Y and Nossel I. Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry*. 2016; 15: 13-20.
6. Aljumah K and Hassali M. Impact of pharmacist intervention on adherence and measurable patient outcomes among depressed patients: a randomised controlled study. *BMC Psychiatry*. 2015; 15:219.
7. Steinberg L. Cognitive and affective development in adolescence. *Trends in Cognitive Sciences*. 2005; 9: 69-74.
8. Spear LP. The adolescent brain and age-related behavioral manifestations. *Neuroscience & Biobehavioral Reviews*. 2000; 24: 417-63.
9. Orygen - The National Centre of Excellence in Youth Mental Health. *Clinical Practice in Early Psychosis: Working with Clinical Complexity and Challenges in Engagement*. 2016.
10. Priebe S, Watts J, Chase M and Matanov A. Processes of disengagement and engagement in assertive outreach patients: Qualitative study. *The British Journal of Psychiatry*. 2005; 187: 438-43.
11. Brown A, Rice SM, Rickwood DJ and Parker AG. Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. *Asia-Pacific Psychiatry*. 2015.
12. National Institute for Health and Care Excellence. Borderline personality disorder: recognition and management. Clinical Guideline (CG78). Manchester, 2009.
13. Orygen - The National Centre of Excellence in Youth Mental Health. *Clinical Practice in Youth Mental Health: Shared Decision Making*. 2016.
14. Cartwright C, Rhodes P, King R and Shires A. Experiences of countertransference: Reports of clinical psychology students. *Australian Psychologist*. 2014; 49: 232-40.
15. Cartwright C. Transference, countertransference, and reflective practice in cognitive therapy. *Clinical Psychologist*. 2011; 15: 112-20.
16. Hayes JA, Gelso CJ and Hummel AM. Managing countertransference. *Psychotherapy*. 2011; 48: 88–97.
17. King R and O'Brien T. Transference and countertransference: Opportunities and risks as two technical constructs migrate beyond their psychoanalytic homeland. *Psychotherapy in Australia*. 2011; 17: 12.
18. Lucksted A, Essock SM, Stevenson J, et al. Client views of engagement in the RAISE Connection Program for early psychosis recovery. *Psychiatric Services*. 2015; 66: 699-704.
19. Orygen - The National Centre for Youth Mental Health. *Mythbuster - Self-harm: Sorting Fact from Fiction*. Melbourne. 2015.
20. Drug and Alcohol Office. *A Counsellor's Guide to Working with Alcohol and Drug Users - 2nd Edition*. Western Australia. 2007.
21. New South Wales Health. *NSW Clinical Guidelines For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings. Sydney*. 2009.
22. State of Queensland (Queensland Health). *Queensland Health Dual Diagnosis Clinical Guidelines: Co-occuring mental health and alcohol and other drug problems*. Brisbane. 2010.
23. Commonwealth of Australia. *Management of Patients with Psychostimulant Toxicity: Guidelines for Emergency Departments*. 2006.


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