Emerging Minds.

National Workforce Centre for Child Mental Health

Supporting pre-teens presenting to the emergency department with mental health concerns

SASHA JOHNSTON & CATHRYN HUNTER

Aboriginal and Torres Strait Islander peoples should be aware that this resource may contain images or names of people who have passed away.

Key messages

- The pre-teen years (ages 9–12) are a time of rapid physical, social and neurodevelopmental change and provide a window of opportunity to mitigate potential poor mental health outcomes in adolescence.
- Children who present to a hospital emergency department (ED) with mental health concerns are more likely to attend after hours, be admitted and have a longer ED stay than children presenting with physical health concerns.
- Acute behavioural disturbances and anxiety disorders are common pre-teen ED mental health presentations.
- Sensitive care in the ED (e.g. building rapport, acknowledging pre-teens' concerns and wishes) has the potential to improve pre-teens' mental health trajectories.
- Communicating clearly and consistently with family members throughout their pre-teen's ED care can improve their experiences of help-seeking and the uptake of discharge recommendations.

Disclaimer

The practice recommendations contained in this paper are for information purposes only. This practice paper is not a substitute for your clinical judgement, knowledge and expertise, nor is it medical advice. Pre-teens' individual circumstances may mean that variations from these practice recommendations are appropriate. In all cases, it remains your responsibility to apply clinical common sense and to consult senior staff and relevant policies, procedures and laws in determining the appropriate course of action.

What is this resource about?

This resource offers guidance to assist practitioners in recognising and responding to mental health concerns in pre-teens (9- to 12-year-olds) presenting to EDs. It provides a brief introduction to the challenges and mental health conditions commonly experienced by pre-teens and discusses the nature and prevalence of pre-teen mental health presentations to Australian EDs.

This practice paper draws on data, research and resources about children and young people aged 0–18 years, due to a lack of research specific to the pre-teen years. To ensure accurate representation of the available data and research, we refer to children, pre-teens and young people throughout this resource. Pre-teen data is presented where available, and all practice recommendations are made with pre-teens in mind.

Who is this resource for?

This resource is for all ED staff who work with pre-teens presenting with mental health concerns. The practice recommendations are made with general ED practitioners in mind but may also be useful for those working in tertiary paediatric EDs who are early career practitioners or new to working with pre-teens.

Why is it important to focus on pre-teens?

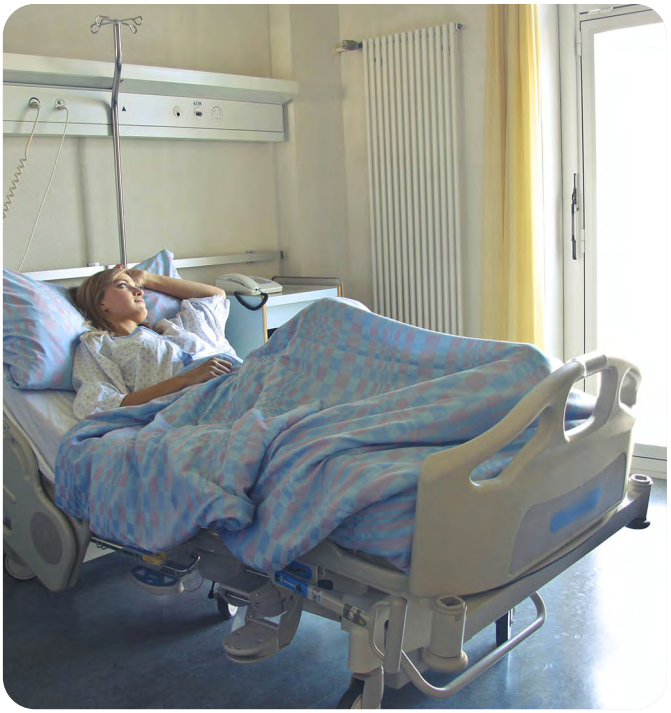
In recent years there has been an increased focus specifically on early childhood and adolescence in policy, research and service provision, while children aged 6–12 years have received comparatively less attention. While the focus on the early and adolescent years is warranted, development continues throughout childhood and key physical, neurodevelopmental and social changes occur during the pre-teen years (The Centre for Adolescent Health, 2018; Wade, Almendingen, & Robinson, 2022).

It is now understood that pre-teen children experience many of the challenges previously thought of as 'teen' issues. These include:

- physical changes, including the onset of puberty (which may include hormonal changes from ages 7–8 years; Klauser et al., 2015)
- the increase of appearance-related issues (e.g. body image and weight concerns; Murphy & Robinson, 2019; Zimmer-Gembeck, Webb, Farrell, & Waters, 2017)
- changing relationships with their peers (e.g. bullying and friendship instability; Bayer et al., 2018; Luthar & Ciciolla, 2016; Rioseco, Warren, & Daraganova, 2020; Robinson, 2020)
- changing family relationships (e.g. increased desire for autonomy and independence; The Centre for Adolescent Health, 2018; Wade et al., 2022)
- the transition from primary to secondary school (e.g. changes to routines, friendships and relationships with teachers; The Centre for Adolescent Health, 2018)
- increased awareness of and potential exposure to adverse events (e.g. climate change; Murphy & Robinson, 2019); and
- increased use of technology with decreased parental monitoring and associated issues (e.g. cyberbullying, body image concerns and online safety; Australian Institute of Family Studies, 2014; Jose & Fu, 2018; Robinson, 2020; Wade et al., 2022).

While most children will not be negatively impacted by these experiences, some may struggle. For example, bullying tends to peak in the pre-teen years and is associated with mental health difficulties (e.g. depression, anxiety, suicidal ideation and eating disorders; Robinson, 2020).

The pre-teen years can also be a challenging time for parents. A study of 2,600 parents in Victoria found increased conflict between parents and children, and parents reported feeling less satisfied with the support provided by their partner, compared to parents of younger and older children (Wade et al., 2022).



The experiences of pre-teen children and their families suggest that the pre-teen years are a critical time for providing support aimed at mitigating poor outcomes. The pre-teen years offer a window of opportunity for early intervention. Recognition of the challenges pre-teen children and their families face, along with the provision of appropriate and timely support, can lead to better health and wellbeing in adolescence and throughout their lives.

Mental health in pre-teens

Alongside significant developmental and social changes, pre-teens may also experience a range of mental health concerns. Many of the issues seen in adolescence can have their onset in the pre-teen period even though diagnosis may not occur for many years (Kessler et al., 2007).

There is limited Australian data available specifically on prevalence and trends in pre-teens' mental health. The available broader age category data tells us that a significant number of pre-teens experience mental health issues, and that a proportion of those have unmet needs for mental health services (Lawrence et al., 2015; Warren, Quinn, & Daraganova, 2020).

Mental health issues often begin in childhood, with an estimated 50% of adult mental illness beginning before age 14 years (Kessler et al., 2007).

Globally the median ages of onset of attention deficit hyperactive disorder (ADHD), autism spectrum disorder, oppositional-defiant disorder, conduct disorder and certain anxiety disorders (e.g. phobias, separation anxiety disorder) are in the pre-teen years (8–13 years; Kessler et al., 2007; Solmi, Radua, & Olivola, 2022).

In Australia, children aged 8–9 years have been found to be more likely to experience hyperactivity than 12- to 13-year-olds; conduct problems have been found to peak at age 6–7 years before decreasing substantially by age 12–13 years; and emotional difficulties increase across the pre-teen years (Rioseco, Warren, & Daraganova, 2020).

It is important to identify and support children with sub-clinical emotional or behavioural concerns as these have been associated with a range of negative outcomes including lower school achievement (The Centre for Adolescent Health, 2018). Further, emotional and behavioural difficulties or mental health difficulties in childhood are associated with continuing difficulties in adolescence (O'Connor, Romanuik, Gray, & Daraganova, 2021).

Mental health difficulties in pre-teens may be less likely to be identified for a number of reasons, such as:

- low mental health literacy (the ability to recognise signs and symptoms of mental health problems) among Australian parents (Rhodes, Measey, O'Hara, & Hiscock, 2018); and
- difficulties accessing mental health services for pre-teens (Lawrence et al., 2015; Warren et al., 2020).

Pre-teens presenting to the ED with mental health concerns

Approximately 2–7% of paediatric presentations to Australian EDs are mental health related (Goldfinch & Kochar, 2022; Hiscock, Neely, Lei, & Freed, 2018; Lim et al., 2021; Say et al., 2021). Around three quarters of children present to general EDs rather than tertiary paediatric EDs (Lim et al., 2021) where access to specialised paediatric mental health services may be limited.

From the limited data available it appears that acute behavioural disturbance and anxiety disorders are two common mental health presentations by pre-teens to Australian EDs (Goldfinch & Kochar, 2022; Hiscock et al., 2018; Say et al., 2021; Tolentino, Symington, Jordan, Kinnear, & Jarvis, 2021). Pre-teens may also present with other conditions such as:

- behavioural and emotional disorders (including conduct disorder, childhood emotional disorder)
- suicidal ideation and deliberate self-harm with or without suicidal intent
- drug overdose or intentional poisoning; and
- mood disorders (including depression).

(Goldfinch & Kochar, 2022; Hiscock et al., 2018; Say et al., 2021; Tolentino et al., 2021).

Acute behavioural disturbance

Acute behavioural disturbance (ABD) appears to be a relatively common ED mental health presentation for pre-teens (Say et al, 2021). ABD is not a mental health diagnosis, but a broad category that covers externalising behaviours such as physical aggression. It includes children with disruptive or aggressive behaviour due to severe autism spectrum disorder or ADHD (Bourke et al., 2021; Say et al., 2021) or anti-social behaviour due to oppositional defiant disorder (Say et al., 2021). ABD presentations, though only making up approximately 12–17% of ED mental health presentations, often require the most resource-intensive support with multiple hospital security staff and others generally involved (Lovett et al., 2022).

A study of a tertiary paediatric ED reported that, in contrast to other presentations, ABD was more likely to: be seen in males under 14 years (83% of presentations); present with police or under a Section 351 (where the child is deemed to be a risk to themselves or others); and require a hospital Code Grey (acute crisis response) or medication for de-escalation (Say et al., 2021). These children are more likely to have longer than average stays, be admitted, and re-present to the ED than children presenting with other mental health concerns (Carison, Babl, Hill, & O'Donnell, 2020).

EDs are busy, highly stimulating environments, that are not necessarily designed to support agitated or highly distressed children (Say et al., 2021). It has been suggested that anticipatory management plans may be helpful in supporting these children (Carison et al., 2020).

As well as being more likely to be in crisis or extreme distress, children presenting to the ED with mental health concerns are more likely than those presenting with physical conditions to:

- present after hours
- be admitted; and
- have a longer than average length of stay in the ED.

(Goldfinch & Kochar, 2022; Hiscock et al., 2018; Say et al., 2021; Tolentino et al., 2021).

The majority of children who present to EDs with mental health concerns have prior mental health diagnoses or past contact with mental health services (Poyraz Fındık, Erdoğdu, Fadıloğlu, & Rodopman Arman, 2022; Say et al., 2021; Tolentino et al., 2021).

Further to this, a significant minority of children may re-present to the ED, with a small number re-presenting multiple times (Qian et al., 2023; Summers et al., 2020). These findings suggest that children may be presenting to the ED with mental health concerns due to a lack of suitable, affordable and available community supports and services (Hiscock et al., 2018).

If children are presenting to EDs because of a lack of available and accessible community mental health services then children who have higher mental health needs or who have experienced trauma or adversity may be even more likely to present (Molloy, Fields, & Trostian, 2020).

Children who are under guardianship or child protection orders, including those who are living in out-of-home care and who have likely experienced serious adversity, are overrepresented in mental health ED presentations and re-presentations (Goldfinch & Kochar, 2022; Say et al., 2021). One study reported that although 1.2% of Victorian children are under a child protection order, these children made up 9.5% of ED mental health presentations and 21.1% of presentations for self-harm (Say et al., 2021).

Aboriginal and Torres Strait Islander children are also overrepresented in mental health presentations to EDs (Goldfinch & Kochar, 2022). As the majority of Aboriginal and Torres Strait Islander children live outside major cities, they are also more likely to be seen in general EDs than tertiary paediatric EDs (Lim et al., 2021).

A window of opportunity

With an estimated 50% of adult mental health conditions beginning before age 14 years (Kessler et al., 2007), pre-teens' attendance at ED with mental health concerns presents a window of opportunity for practitioners to provide supportive mental health care to pre-teens and their families.

Sensitive care in the ED has the potential to alter pre-teens' mental health and wellbeing trajectories for the better by affirming help-seeking and initiating access to appropriate mental health care.

Supporting pre-teens and their families

The following practice recommendations can assist you in providing supportive care to pre-teens and their families. This section covers strategies that may help you to:

- build rapport with pre-teens, including those who are reluctant to engage
- acknowledge pre-teens' concerns and wishes
- respond to challenging behaviour
- engage with pre-teens' family members; and
- effectively plan for pre-teens' discharge.

Note: In developing the following practice recommendations, we spoke to paediatric ED practitioners and parents who have presented to ED with their pre-teen in the past.

Acknowledging challenges

Providing sensitive, supportive care to pre-teens presenting to the ED with mental health concerns is not without its challenges. In making the following practice recommendations, it is acknowledged that ED practitioners often face challenges that are not present in other health care settings, such as:

- acute and life-threatening presentations
- overcrowding and long patient wait times
- lack of prior relationships between patients and practitioners
- brief and single contact between patients and practitioners; and
- presentations due to abuse, family violence and/or neglect.

(Dudley, Ackerman, Brown, & Snow, 2015)

This means that supportive, sensitive care in the ED may look different than in other health care settings. Nonetheless, it is possible to approach children's care in ways that support their wellbeing (Dudley et al., 2015).

Engaging with pre-teens

Keep the potential for past trauma in mind

Adverse experiences, such as being involved in the child protection system, having a chronic illness, or forced migration, can increase children's risk of experiencing mental health problems (National Mental Health Commission, 2021). Pre-teens and their families may have also had traumatic experiences with health care services in the past. There is potential for ED visits to be retraumatising, leading to increased patient stress and discouraging patients from accessing health care (Molloy et al., 2020).

Practicing trauma-informed care is primarily about acknowledging that a person's life experiences will influence what safe and supportive care looks like for them (Menschner & Maul, 2016). The following practice recommendations may assist you in creating a sense of safety for pre-teens and their families.

Note: A complete introduction to trauma-informed care is beyond the scope of this paper. See 'Further resources' at the end of this paper for more comprehensive guides.

Build rapport

Building trust with pre-teens is the first step towards providing supportive mental health care. The following recommendations may assist you in building rapport with pre-teens in the ED. For more general guidance see *Practical strategies for engaging children in a practice setting*.

- Address pre-teens' basic needs – i.e. offer food or drink if appropriate, ask if they are too hot or cold, let them know where the closest bathrooms are, and ask if there's anything you can do to help them feel more comfortable.
- Be transparent about information sharing (Goldstein & Findling, 2006) – e.g. let the pre-teen know that information is shared between hospital staff, or that you've spoken to their family and are aware of why they decided to present at ED.
- Affirm help-seeking – e.g. 'I'm so glad you came in this evening.'
- Acknowledge concerns – e.g. 'I can understand why you're feeling unsure about being here' or 'I know it can be hard talking about how you feel with someone you don't know!' (NSW Kids and Families, 2014).
- Reassure pre-teens that their mental health concerns are not their fault. You might say something like, 'Your body and brain are just letting everyone know that you need some extra support. It's not anyone's fault' or 'Lots of kids feel this way sometimes. With the right support you can start to feel better.'
- Ask pre-teens about their thoughts, feelings, expectations and ideas – children (and their families) are experts in their own lives and may offer information and perspectives that contribute towards better treatment options (Hervatin, 2020a) (see 'A note on shared decision-making' later in this paper for further resources).
- Use age-appropriate language – communicating in an age-appropriate way is important in building rapport with children (Children's Health Queensland Hospital and Health Service, 2022). Pre-teens can be more concrete in their thinking than older adolescents (NSW Kids and Families, 2014). This means that terms like 'depression', 'self-harm', 'suicide' or 'anxiety' may not always be well understood, so:
  - keep explanations short and simple; and
  - use language that describes what you're talking about (see examples in the following table).

Standard medical language	Pre-teen friendly language
Self-harm E.g. 'Are you thinking about self-harming?'	Hurting yourself E.g. 'Do you think about hurting yourself?'
Suicide E.g. 'Are you having thoughts of suicide?	Killing yourself E.g. 'Do you think about killing yourself?'
Anxiety E.g. 'Are you feeling anxious?'	Feeling worried or scared a lot of the time E.g. 'Are you feeling worried or scared a lot of the time?' or be specific about symptoms: 'Is your heart racing/are your hands sweaty or tingly/is it hard to take a full breath?'
Sedative or anti-anxiety medication	Medicine that helps you feel more relaxed

Tailor the physical space

The physical environment of the ED – with its bright lights, constant noise and fast pace – has the potential to exacerbate stress and decrease a patient's ability to cope (Molloy et al., 2020). Where possible:

- provide waiting areas that are quiet, dimly lit and removed from the sights and smells of the ED (Byrne et al., 2021; Dudley et al, 2015). Ideally, this involves creating a dedicated low stimulus waiting space, but can also be achieved by moving pre-teens to quieter areas as required
- consider providing sensory kits that might include items like ear plugs, stress balls, fidget toys, play dough, drawing materials and weighted blankets (Byrne et al., 2021)
- provide age-appropriate activities and waiting areas (Australasian College for Emergency Medicine, 2019); and
- ensure that there is adequate seating available for families.

Acknowledge pre-teens' concerns and wishes

Acting on pre-teens' wishes about their care is not always possible or appropriate. When it's not possible to take children's wishes into account, explaining why you needed to make certain decisions can help them feel informed and respected (Hervatin, 2020). You might say something like:

> 'We needed to [administer medication/procedure/etc] really quickly when you came in, because we were worried that [concern]. We needed to act quickly to keep you safe, so we didn't get to ask you what you thought or how you felt about it. Do you have any questions about it now?'

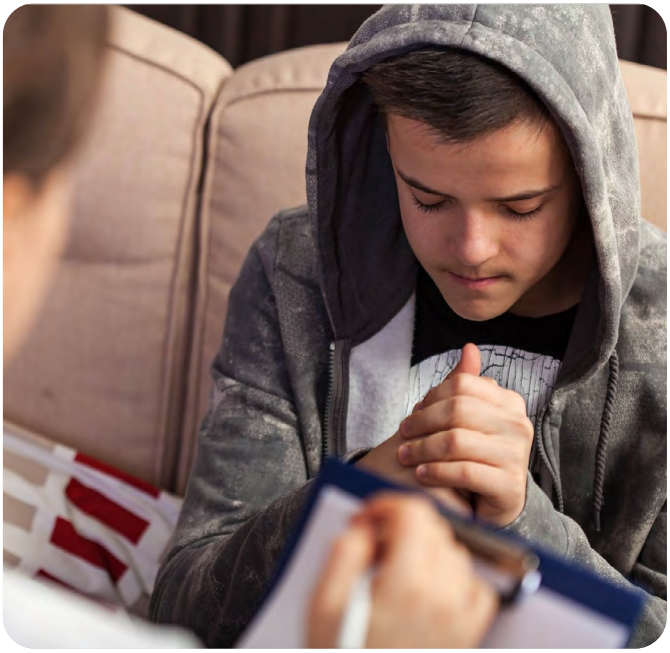
Pre-teens may also be uncomfortable or upset about decisions that they don't agree with. Acknowledging how they feel can help, as it lets them know that their views were heard. You might say something like:

> 'I'm really hearing how upset you are about [decision] – I'm sorry that we weren't able to [carry out pre-teen's wishes].'

See 'A note on shared decision-making' later in this paper for further resources on shared decision-making in children's mental health care.

If you're having difficulty engaging

You may have difficultly engaging children who present to the ED with mental health concerns. This could be because they were brought to the ED against their will (Goldstein & Findling, 2006), or due to their psychological state or negative experiences with healthcare services in the past.



Think outside the box

Pre-teens may feel uncomfortable talking about their mental health. You can support them to share their experiences and views by offering non-verbal communication strategies. You might:

- ask pre-teens to respond using emojis on a family member's electronic device
- offer paper and pens and encourage pre-teens to draw or write their feelings, thoughts or questions
- use communication boards and books that contain pictures or symbols (Hervatin, 2020); and
- use visual resources that depict feelings (Hervatin, 2020). For example, the free-to-download resource from the Australian Childhood Foundation, *Dots with Feelings*, can help children and young people talk about how they feel.

Use reflective listening

Making reflective statements helps young people know that you are listening and have understood their feelings and concerns (NSW Kids and Families, 2014). Asking follow-up questions can help to clarify or prompt for further information. For example, you might say something like:

- 'I'm hearing that you're really angry at your mum for bringing you in. You don't think you need to be here. Is that right?'
- 'So, it sounds like last time you came in, you felt like nobody listened to you. What would it look like if we listened well this time?'
- 'I can hear that you're really dealing with a lot at school...'

Try sentence completion

Offering unfinished sentences can help young people to begin to share their thoughts and experiences (NSW Kids and Families, 2014). Drawing on context, you might ask the pre-teen to complete sentences like:

- 'So, after that happened, you felt…'
- 'And then that's when you decided to…'
- 'And now you're feeling…'

Responding to challenging behaviour

Note: Where verbal de-escalation strategies are insufficient or the pre-teen's behaviour poses a risk to themselves or others, consult senior staff and refer to your hospital's relevant policies and procedures.

When responding to violent or dysregulated behaviour, remember to:

- remain calm – keep your tone of voice and body language relaxed
- ensure safety – remove objects that could be used as weapons and position yourself so that you are always able to access the nearest exit
- introduce yourself and emphasise that you are here to help – e.g. 'I really want to work together to make this better for you' or 'Can you tell me what you need right now?'
- move to a quiet place – if possible, choose somewhere private and dimly lit
- consider the pre-teen's background, circumstances, developmental stage and communication needs
- use reflective listening to acknowledge feelings and concerns (see previous)
- offer distractions such as watching a show on a family member's device, or age-appropriate toys such as stress balls or pencils and paper, where appropriate; and
- avoid responding directly to insults or challenging questions, instead reverting to reflective statements that acknowledge how the pre-teen feels – e.g. 'I can hear that you're really angry at me/Mum/Dad' or 'I can see how much you don't want to be here.'

(The previous section was partially adapted from The Royal Children's Hospital Melbourne's Clinical Practice Guideline *Acute behavioural disturbance: Acute management*. See also their Clinical Practice Guideline on *Autism and developmental disability: Management of distress/agitation*.)

Communicating with families

Effective communication with families can help to reduce the fear and overwhelm families may feel during their child's ED stay (Children's Health Queensland Hospital and Health Service, 2022), and may increase families' satisfaction with the level of care.

- Keep in mind that families of pre-teens with mental health concerns are often facing complex issues. Communicate compassionately and take the time to acknowledge families' efforts, concerns and circumstances.
- Affirm families' help-seeking, where appropriate – e.g. 'You did the right thing by coming in today.'
- Acknowledge families as experts on their child – this can help family members feel listened to and valued:
    - Take the family's concerns seriously – e.g. 'I'm hearing this behaviour is really out of the ordinary for Jake. Can you tell me about anything that's changed for him over the past week?'
    - Draw on family members' knowledge to better support their pre-teen – families who present to the ED with their pre-teens have often been working hard to find solutions. You might ask family members about calming strategies they've used at home, or check in on a pre-teen's sensory sensitivities, likes or dislikes – e.g. 'You know Ella best. Can you tell me a bit about what works for her when she's upset?' or 'What do you think might help Jake cope with [treatment, procedure, etc.]?'
    - Incorporate family members' knowledge during assessments – e.g. 'How will we know if AJ is in pain?' or 'What are some of the ways Ella lets you know that everything's too much?'
- Explain the presenting issue, treatment options, risks and benefits in ways families can understand. This will look different for each family, so ensure you take the time to check for understanding (also known as the 'teach-back' method) by asking questions, e.g. 'To check I've covered everything, can you explain to me what we've agreed to do?' or 'To make sure I haven't missed anything, can you talk me through what you'll do if Jaxon is thinking about suicide?'. You can learn more about the teach-back method and complete courses on the website.
- Invite families to take part in decision-making about their pre-teen's care. Not all families will feel comfortable asking to participate in decision-making or know that participation is an option (Simmons, Rice, Hetrick, Bailey, & Parker, 2015). You might encourage family members to ask questions by saying something like 'Are you wondering if there are any other options?' or 'Is there anything I haven't explained clearly?'

For more information on communicating with families, see the following resources:

- Children's Health Queensland Hospital and Health Service nursing skills factsheet *Family centred care & communication*
- The Raising Children's Network guide, *Effective communication with parents and carers: for professionals*

A note on shared decision-making

Shared decision-making involves practitioners, children and families working together to make decisions about a child's care and treatment (Hervatin, 2020a). Shared decision-making can result in improved mental health outcomes and increased treatment satisfaction for children and their families (Edbrooke-Childs et al., 2016). Partnering with children in their care can also increase the acceptability of procedures and decisions (Grahn, Olsson & Mansson, 2016).

While the benefits of shared decision-making have been considered in making these practice recommendations, a comprehensive guide is beyond the scope of this paper. For further information on shared decision-making in children's mental health care see *Supporting children's participation through shared decision-making in child mental health care* and Orygen evidence summary *Shared decision-making for mental health*.

Keep families 'in the loop'

When asked what would help to improve their experiences in the ED, parents and caregivers of pre-teens with mental health concerns called for practitioners to keep children and families 'in the loop'.

- Avoid separating children and family members wherever possible (Dudley et al., 2015), unless you feel the circumstances warrant speaking to the pre-teen or their family members alone.
- Let pre-teens and their families know what to expect. For example, explaining how long patients might expect to wait, and the reasons for the wait, can help them feel as though you have heard their concerns. You might say something like, 'It will be a bit of a wait. You're in triage category [x], which means that we have to see people who have been in serious accidents or are very sick first. They might enter through different doors, so it can seem like not much is happening, but it's always very busy back there. Someone will be with you as soon as possible.'
- Nominate one staff member involved in their pre-teen's care as a point of contact for the family.
- Acknowledge families' feelings and concerns and offer potential solutions. You might say something like, 'I can hear you're really frustrated that we can't admit Mohammed. I know you're worried about managing his behaviour at home. How about we work together to get a plan in place for when you go home?' (See the 'Planning for discharge' section of this resource for information on safety planning and on-referral.)
- Check in regularly, even if there are no updates – e.g. 'Just letting you know we're still waiting on [x], there's a bit of a backlog at the moment. I'll let you know as soon as we're ready!'
- Ensure an interpreter is available if required.

Set pre-teens and their families up for success

Planning for discharge

The often stressful and busy nature of ED visits can result in overwhelm for families (Curran et al., 2019). Clearly written discharge communications may better support children's health outcomes by increasing families' understanding of discharge instructions and advice (Curran et al., 2019). Ensuring discharge summaries are sent to a family's GP can also help to encourage ongoing care.

Safety planning

Families might feel overwhelmed at the prospect of managing their pre-teen's mental health symptoms at home. Where appropriate, working with pre-teens and their families to create a safety plan can help.

Safety plans generally include:

- warning signs – e.g. staying in bedroom or not seeing friends
- ways to make the environment safe – e.g. removing anything that could be used to self-harm
- distraction or coping strategies, like going for a walk or playing a video game
- things that are important to the young person, or that they are looking forward to, or other reasons to live – e.g. pets, friends, future goals; and
- people and places that can offer support – e.g. Mum, Dad, family, Kids Helpline, GP, ED.

(Kids Helpline, 2022)

You can introduce the idea of safety planning to pre-teens and their parents/caregivers by saying something like, 'It sounds like you're pretty worried about what might happen when you go home. It can help to have a plan so that everyone knows what to do if Rooney starts thinking about hurting himself. I can help you write one out.'

You can write down a safety plan with a pre-teen on paper, on a parent or pre-teen's electronic device, or using an app like the Beyond Now safety planning app.

Download Kids Helpline's Suicide Prevention and Safety Planning poster as a useful reminder of the five main aspects of safety plans.

On-referral

- Supporting pre-teens and their families to access appropriate mental health care is an important part of making the most of the window of opportunity that opens when pre-teens present to the ED with mental health concerns. Appropriate mental health support has the potential to alter pre-teens' mental health trajectories for the better.
- Do not assume that pre-teens or their families have the capacity to follow up on suggestions for ongoing care themselves – take a proactive approach and make referrals to appropriate services wherever possible.
- Where it's not possible to make referrals to mental health services, ensure that families are provided with written copies of the information they need to self-refer.
- Raising Children Network has a useful guide on child and youth mental health services by state.

Further resources

The following resources provide further information that may assist you in providing supportive care to pre-teens with mental health concerns in the ED.

Trauma-informed care

- *In focus: Trauma-informed care* contains an introduction to two key principles in trauma-informed care – curiosity and trust – and provides links to relevant podcasts and online learning courses.
- The clinical practice guide from Orygen *What is trauma-informed care and how is it implemented in youth healthcare settings?* provides an overview of trauma-informed care and several clinical practice points (e.g. information on trauma screening practices), as well as links to further resources.

Suicide and safety planning

- The Kids Helpline guide *Suicide & self-harm: A guide to staying safe* includes safety strategies and information that may be suitable for sharing with family members when children are thinking about suicide.
- *Supporting a child who is thinking of suicide* is another Kids Helpline resource that provides guidance for parents who are supporting a child thinking about suicide.

Working with parents

- The webinar *Sharing information and engaging parents about child mental health* explores how practitioners can share information about children's mental health with parents.
- Orygen's clinical practice guide *Supporting clinicians to work with parents of young people who self-harm* provides information and guidance that may assist in supporting parents when their children have self-harmed.
- The article *In focus: Talking with parents about their children* provides adult-focused professionals with tips on developing skills in hearing and honouring a child's voice in absentia and introduces the PERCS conversation guide.

General mental health information

- The practice paper *Identifying and responding to bullying in the pre-teen years: The role of primary health care practitioners* contains information and practice tips that may be helpful when working with children who are experiencing bullying.
- For assistance in working with parents of pre-teens who are experiencing anxiety see the practice paper *Supporting parents of pre-teen children with mild-moderate anxiety*.
- *Supporting parents who have poor mental health* is a short article that includes tips for recognising and responding to mental health concerns in parents.
- The Raising Children Network website's section on Pre-teens: Mental and physical health contains several articles, including practical strategies for parents and help-seeking information.

References

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