Early Intervention for Borderline Personality Disorder in Young People

The WOKE Program

Final Evaluation Report

December 2021

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Executive Summary

This report describes the evaluation of the WOKE Program, an early intervention program for young people with characteristics of emerging borderline personality disorder (BPD). The Program was developed by the University of Canberra and implemented from mid-2019 to mid-2021. Over this two-year period, there were four iterations of the Program, funded by Capital Health Network (CHN), ACT's Primary Health Network. This report describes the development of the Program, the evaluation design, and the findings related to implementation and the outcomes and experiences of Program participants.

Background

Personality disorders are serious mental health conditions that cause considerable distress to the individuals affected, their families and friends, and the wider community. One of the most commonly diagnosed personality disorders is BPD. It is most likely to emerge during adolescence and early adulthood. By commencing at this stage of life, it has major disruptive effects on a young person's life trajectory by impacting critical relationships with family and friends and undermining the foundations for vocational attainments. While the evidence for treating BPD is developing, there is need for a greater focus on adolescents and on early intervention before BPD becomes fully established.

Funding

CHN recognised the lack of early intervention programs for young people with emerging BPD in the ACT region and funded the University of Canberra to develop and evaluate an early intervention program for young people aged 15-21 years in the Canberra region. The program developed is called the WOKE Program. The Program was initially funded for 18 months from July 2019 to the end of 2020; it was subsequently extended for 12 months, with the evaluation phase concluding after Program 4 (mid-2021).

Development of the WOKE Program

The Program was based on Dialectical Behaviour Therapy for Adolescents (DBT-A), which has the best evidence for adolescents and provides guidelines for working effectively with parents. This approach was adapted based on clinical experience and the literature to be an early intervention approach for young people who did not have fully diagnosed BPD, although they had related characteristics and early symptoms.

WOKE involves an initial client assessment phase where treatment suitability and feasibility are determined. This is followed by a pretreatment phase where clients and parents are oriented to the different aspects of the Program and make a commitment to participate. Young people then move into a 14-week program, involving a concurrent weekly skills training group and individual therapy. Parents are invited to join their young person by attending the skills training group. Separate parent therapy sessions are provided as needed.

Evaluation aims and methods

There were three key aims to the WOKE Program evaluation:

1. Determine the extent to which the Program was **implemented** as planned.
2. Determine the **effectiveness** of the Program in reducing the symptoms of BPD: specifically, reducing the associated psychological issues of depression and suicidal ideation, and increasing coping skills to deal with BPD symptoms.
3. Understand the **experience** of the WOKE Program for the three key groups involved in the Program: the clients (young people), their family member(s), and the clinicians (interns) delivering the Program.

The design was a single-arm intervention pre-, during-, post- and follow-up design. The mixed design included administrative data to describe implementation; standardised questionnaire measures administered at different timepoints to examine change over time for young people; and interviews to understand participant (young person, family, and clinician) experiences after completion of the Program.

Capital Health Network wishes to acknowledge Australia's Aboriginal people as the Custodians of this land. We pay our respect and recognise their unique cultures and customs and honour their Elders past, present and future.

Implementation

There were four implementation phases of the Program during the evaluation period:

- Program 1: September–December 2019
- Program 2: May–August 2020 (online-only due to COVID)
- Program 3: October–December 2020
- Program 4: March–June 2021

Referrals to the Program came from a range of local mental health service providers. There were 97 referrals where the young person was deemed to be unsuitable for the Program, primarily because they were assessed as being too high risk. Considerable unanticipated effort was then required to assist many of these young people and their families to find alternative treatments.

Overall, 69 young people and 55 parents/family members took part in the four Programs—a total of 124 participants. There was a 97.2% completion rate. The young people were aged from 14-21 years, almost all were female, and most lived with their parents. The number of young people participating fell somewhat short of the original aim, with participation affected by COVID-19.

About half the young people participated with a family member, with all but one being a parent and usually their mother; almost all younger participants had a family member involved.

There were 16 Master of Clinical Psychology students who delivered the Program as part of their second-year practicum placements, under the supervision of the fully qualified clinicians. Another seven Master of Clinical Psychology students contributed to the evaluation through their course-related research projects.

The Program was very cost effective. We estimate that if the costs of the interns are excluded (which are very difficult to cost), each hour of clinical support for Program participants cost $77, and the total cost per participant was $3064.

Effectiveness

Prior to commencement of the Program, the young people were very highly psychologically distressed, severely depressed, and very high on suicidal ideation; had high, although not very or extremely high, levels of borderline symptoms; had high levels of all four types of borderline features (interpersonal chaos, emotional dysregulation, confusion about self, and impulsivity); were very high on most types of difficulties in emotional regulation (emotional regulation, emotional clarity, nonacceptance, and impulse control), which were experienced most of the time, but had somewhat less difficulty with emotional awareness; and were high on ineffective coping skills and low on functional coping skills, although they rarely blamed others as a coping strategy. There was variation, with some young people being very distressed and not coping at all well, and others being much less distressed and coping much better prior to the Program, although all young people were assessed as having a high level of need and suitability for the Program.

The young people in each of the four Programs did not differ significantly from each other on any of the assessment and pre-program measures. The Program groups were, therefore, equivalent at baseline.

Significant change was evident on all measures, comparing those taken prior to commencement of the Program with those taken during and after the Program. Over the course of the Program, young people significantly reduced their symptoms, distress, suicidal ideation, and dysfunctional coping approaches and significantly improved their positive coping strategies.

In order of the strength of the effects, the strongest effect was for improvement in DBT skill use as a way of coping; this change occurred over the course of the Program and was maintained at follow-up. Next was a significant reduction in dysfunctional emotion regulation strategies, followed by reduced depression symptoms and psychological distress, less suicidal ideation, fewer borderline symptoms, and fewer life problems; all these effects were strong. Weaker, but still significant and substantial, effects were evident for less dysfunctional coping and, lastly, less blaming others.

Significant improvements were shown for all measures for Programs 1, 3 and 4. Program 2, however, which was affected by the onset of COVID-19 necessitating the rapid development of an online-only program, showed attenuated effects for several measures. Nevertheless, the trend was still in a positive direction, although some effects did not attain significance.

All effects were either maintained or improved at three-month follow-up.

Program experience

Young people. Interviews with 31 of the young people revealed that most enjoyed the WOKE Program very much. They felt they achieved large gains in their ability to regulate their moods, achieve goals, and have better relationships as of result of the Program and would continue to make progress with the skills they had learnt. Young people generally found the group program daunting to start with, but in the end thought the ability to share and hear from others was one of the most valuable components. The individual therapy sessions enabled them to engage with the skills and group sessions better by being able to personalise their experiences with their therapist. They liked working with the intern psychologists and appreciated the safe and supportive space of the Program. All but one who were interviewed said that they would or already had recommended the Program to other young people. They expressed a strong desire to see the WOKE Program as a permanent mental health service in the ACT, e.g. "please recommend this, and to more people, and get more funding for this, and I really hope it becomes a more known group and avenue. I really hope that it blows up and becomes a very well-funded program because it will change a lot of people's lives".

Family members. All of the 33 parents interviewed were strongly supportive of the Program, and many used superlatives to describe their experience. The clinical staff in particular were singled out for their positive and professional approach. Parents greatly valued that they were included in their young person's treatment, and were welcomed and valued, which was a stark contrast to previous experiences. The group format and ability to share with and learn from other parents and young people was critical, as well as the skills learned and working alongside their young person. The impact of the online-only Program (Program 2), necessitated by COVID-19 restrictions, was noted to be affected by the unfortunate lack of in-person and group communication.

Parents were often surprised at how their young person engaged with the Program and the unexpected outcomes achieved, including significant reductions in self-harm. The Program influenced the transition of their parenting role from parenting a child to parenting an emerging adult, and this improved their relationship with their young person. This change occurred via three main routes: first, changes in parents' understanding and behaviour around power and authority in parenting; second, the development of skills such as negotiation, validation, and radical acceptance; and third, the support found from being around others in a similar position. Many aspects of the Program were challenging, particularly the group work, time commitment and homework practice; all parents noted the high level of commitment required but felt that this effort was definitely worthwhile. Parents saw major changes in their own behaviour and in their young person's ability to regulate their behaviour. The skills they learned generalised and were able to be used with other family members and at work. All parents would or had already referred other families to the Program. Few improvements were suggested, with these mainly being about the need for ongoing connection and support, and timing that fitted better with work and school commitments.

Intern clinicians. All the Master of Clinical Psychology students interviewed had a very positive experience and highly commended the Program, training, and clinical supervision. They were grateful to have such a valuable learning opportunity during their training, and all agreed they had learned unique skills that enabled them to work effectively and confidently with young people at risk as well as with their families. They appreciated learning to work within both group and individual therapy contexts. They also valued being involved in consult and peer support groups, which were new experiences for supporting their practice and learning new skills within a non-judgemental, highly supportive environment. All the interns were eager to refer future clients (if suitable) to the Program. They emphasised that the WOKE Program should become a permanent placement within the Master of Clinical Psychology course, with the majority saying it was the "best placement" they had and that all masters students should get the opportunity to complete a WOKE placement, "It was so rewarding. It was the best experience. It was by far the best placement over my whole degree. And it was just such a positive, massive learning experience".

Impact, challenges and future directions

The WOKE Program has quickly established a valued role in the ACT as an accessible and successful early intervention program for young people with emerging BPD and their families. The strongest advocates for the Program are the young people and their parents who participated in and benefited from the Program, and the intern clinicians who had a highly valued learning experience.

COVID-19 caused unexpected challenges, as it has for all aspects of life. The Clinical Team rapidly developed an online program, which was generally effective, but requires further development to find ways to incorporate the critical group connection and sharing that were reported as one of the most important program components.

The sustainability of the Program is the main issue going forward. Determining funding to keep the Program running is an important goal, as the Program is addressing a major need and service gap in the ACT mental health system. Maintaining the momentum of the Program and retaining clinical staff is essential to sustainability. This includes consolidating the Program as a placement in the Master of Clinical Psychology course, which requires advance planning.

There is also opportunity to expand and extend the Program. This includes developing a graduate group, further developing online options and supports, providing enhanced support to parents, and extending the reach to other vulnerable young people in the community who would benefit from a DBT-type approach (such as young people with alcohol and other drug problems).

The high level of need for effective early intervention programs to improve the mental health of young people in the ACT, particularly young people with BPD characteristics, is widely acknowledged, and the University of Canberra team that developed and evaluated the WOKE Program feel privileged to have been able to contribute to addressing this need.

"THANK YOU FOR GIVING ME THE OPPORTUNITY TO BE PART OF SUCH A GREAT SERVICE TO YOUNG PEOPLE AND THEIR FAMILIES IN CANBERRA AND FOR INVESTING SO MUCH TIME TO UPSKILL US SO THAT WE CAN HELP MORE YOUNG PEOPLE OUTSIDE THE PROGRAM"

(INTERN PSYCHOLOGIST)

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We would like to sincerely thank the young people and their families who participated in the WOKE programs and who generously gave their valuable time to answer questions about their experiences.

Thank you to the Master of Clinical Psychology student interns who helped deliver the programs and also shared their experiences, as well as the student researchers who contributed to the evaluation (see list below).

Special thanks to the Team Leaders who helped develop and implemented the Program, including supervising the clinical psychology student interns—Emily McIntyre and Alexi O'Dea.

Thanks to the clinical psychology students who contributed to the evaluation by focusing their research projects on the Program and helping to collect and analyse some of the data.

Funding and oversight from CHN were greatly appreciated. Without this, the WOKE Program could not have taken place.

The Discipline of Psychology and Faculty of Health at the University of Canberra enabled the Program by incorporating it as a clinical placement in the Master of Clinical Psychology course and through the use of facilities.

We greatly appreciate everyone's time and goodwill to help us develop and implement, understand and improve the WOKE Program.

Clinical Psychology student interns:	Clinical Psychology research students:
Nicole Binks	Candace Bush
Anna Brichacek*	Veronica Ha
Candace Bush	Nicholas Hancock
Rebecca Byrne*	Taylor Malouf
Hon Chung (Tommy) Choi	Jo Maning
Lucy Erickson	Rebecca Norton
Rebecca Greenwood*	Joanna Ogden
Kym Hancock	Emma Parker
Emily Jones	Emma Sinclair
Emily Matenson	Natalie Taylor
Camilla Mead*	Kefu Xie
Jenna McCulloch*	
Penelope Mithen	
Robert Palmer	
Emma Purdy	
Imogen Rizzo	

*undertook a double clinical placement

Purpose of this Report

This project comprised the development and evaluation of an early intervention program for young people, aged 15-21 years, in the ACT with emerging symptoms of borderline personality disorder (BPD). This activity has been supported by funding from CHN through the Australian Government's PHN Program.

The project aimed to develop and deliver a service to address a gap in the ACT health system to provide early intervention for young people with emerging symptoms of BPD.

The project was undertaken by the Psychology Team in the Faculty of Health at the University of Canberra. A Clinical Team developed and delivered the Program and a Research Team undertook the evaluation.

This is the final evaluation report covering all four implementation phases of the Program:

- **Program 1:** September–December 2019
- **Program 2:** May–August 2020 (online-only)
- **Program 3:** October–December 2020
- **Program 4:** March–June 2021

This report briefly describes the development of the WOKE Program, the methodology for the evaluation, and the findings related to the Program's implementation (for Programs 1-4), effectiveness, and the experiences of young people and family participating in the Program and the clinicians delivering it.

Note that Program 5 took place in September-December 2021, supported by additional funding from CHN, but this program is not part of the current evaluation report.

Background

Personality disorders are serious mental health conditions that cause considerable distress to the individuals affected, their families and friends, and the wider community (APA, 2013). One of the most commonly diagnosed personality disorders is borderline personality disorder (BPD). BPD is considered the most serious and most common personality disorder seen among people presenting to mental health services (Lieb et al., 2004). It causes severe psychosocial impairment and is associated with high suicide risk, greater use of mental health resources, and high mortality (Leichsenring et al., 2011). BPD has a lifetime prevalence of 5.9% (Grant et al., 2008). It is complex to treat and, although effective interventions are available, further research and more effective and earlier treatments are urgently needed (Chanen & McCutcheon, 2013).

BPD, like other personality disorders, is characterised by an on-going pattern of behaviour and inner experience that generally becomes evident in adolescence or early adulthood, causing decreasing functioning and increasing distress over time (APA, 2013). Like most mental health disorders, BPD is most likely to emerge during adolescence and early adulthood. By commencing at this stage of life, it has major disruptive effects on a young person's life trajectory by impacting critical relationships with family and friends and undermining the foundations for vocational attainments (Chanen & McCutcheon, 2013).

Clinicians and services can be reluctant to diagnose and provide treatment for younger clients with BPD (Bateman, Gunderson, & Mulder, 2015). This is partly because of a presumption that personality is still forming in adolescence and the stigma associated with the diagnosis that needs to be avoided for young clients (Debast et al., 2017). Despite clinician reluctance to diagnose BPD in those under 18 years of age, it is estimated that 1-3 percent of young people under 18 years would meet the criteria (Østby et al., 2014). Within clinical populations, 33-49 percent of adolescent inpatients are believed to meet criteria for BPD, and 11-22 percent of adolescents being treated as outpatients (Fonagy et al., 2015).

Although BPD often commences in adolescence, the evidence base derives primarily from adult populations. Most of the research on BPD and development of treatments has been undertaken with adult clients (Weiner et al., 2018), and there is limited evidence for younger populations meeting the diagnostic criteria (Chanen et al., 2007). Given the significant emotional, functional and economic impact of this condition, the need for evidence-based early intervention for young people is clear (Byrne et al., 2014).

Once fully established, BPD is difficult to treat effectively; consequently, there is an urgent need for the development of effective interventions to implement earlier in the progression of the disorder (Chanen & McCutcheon, 2013). Adolescents with elevated symptoms of BPD are at increased risk of experiencing a wide range of negative outcomes as adults. These include meeting the criteria for a diagnosis of BPD as adults, developing substance use or mood disorders, and experiencing significant interpersonal problems, distress and having a reduced quality of life (Chanen et al., 2008). Importantly, the functional impairments found in adolescents with BPD can persist for decades (Winograd et al., 2008). There is a compelling case for early intervention for this age group in order to alleviate the young person's symptoms and distress, and improve their longer-term outcomes.

One of the key evidence-based treatments for BPD is Dialectical Behavioural Therapy (DBT). DBT is a form of Cognitive Behavioural Therapy (CBT) originally developed for the treatment of suicidal clients that provides a comprehensive framework for directly targeting the emotional and social skill deficits of people with BPD (Linehan, 1993). DBT represents both a best-practice option for early intervention in BPD as well as a mechanism for ongoing workforce development to provide clinicians with the skills to work with clients with BPD issues. Adaptations of the adult form of therapy have been developed for adolescents (DBT-A), and these are now being further adapted to apply to young people at high risk of development and diagnosis of BPD (Weiner et al., 2018). It is increasingly recognised that it is essential to address the factors that contribute to the development of BPD before they become entrenched and have major negative impacts on a young person's current and future life (Chanen & Kaess, 2012).

> **"IT WAS REALLY FANTASTIC. LIKE, I REALLY ENJOYED IT. I LOOKED FORWARD TO IT EVERY WEEK"**
> (YOUNG PERSON)

Development of the WOKE Program

WOKE Program Clinical Team

The early intervention for BPD characteristics in young people program was developed by the Discipline of Psychology in the Faculty of Health at the University of Canberra, led by Dr Dean Buckmaster, and named the WOKE Program. All aspects of the clinical program were overseen by Dr Dean Buckmaster. Two senior clinical psychologists skilled in DBT—Emily McIntyre and Alexi O'Dea—supervised delivery of the Program as Team Leaders. The Program was delivered by University of Canberra second-year Master of Clinical Psychology and Clinical PhD students as a clinical intern placement. Six-month and 12-month placements in the Program were offered to students. The interns were closely supervised by the clinical psychologist Team Leaders. Master of Clinical Psychology students from the first WOKE Program took on student mentor roles for subsequent programs.

Some of the WOKE team (from left): Camilla Mead, Lucy Erickson, Tommy Choi, Emily Jacobs, Imogen Rizzo, Alexi O'Dea (Clinical Supervisor) and Anna Brichacek.

Program evidence base

To develop the Program, first a review of the literature was undertaken. The Program was based on Dialectical Behaviour Therapy for Adolescents (DBT-A), which has the best evidence for adolescents and provides guidelines for working effectively with parents. This approach was adapted based on clinical experience and the literature to be early intervention for young people who did not have fully diagnosed BPD, although they had related characteristics and early symptoms. The Program has been continuously revised and improved with each implementation in response to formal and informal feedback, current context (ie, COVID-19 restrictions), and preliminary evaluation findings.

Intern training

The Master of Clinical Psychology students were involved in the Program as a second-year intern placement. Their training consisted of three full-day workshops, five three-hour DBT seminars, and seven two-hour Trainee Skills Group sessions. The full-day DBT workshops were provided to students prior to commencement of the Program to build foundational skills in DBT including an emphasis on basic DBT principles and practices. These workshops focussed on the theory and conceptualisation of BPD, and how to undertake the skills sessions, individual sessions, consultation group, and treatment strategies. Five additional three-hour seminars were provided during the Program covering DBT acceptance and change strategies. Topics included case formulation, chain analysis, solution analysis, communication strategies, validation, working with parents, cognitive techniques, informal exposure, and contingency management. The Trainee Skills Group ran throughout delivery of the Program and consisted of developing skills, group teaching competency, and knowledge of the skills in a simulated group environment. The interns were closely supervised by the Team Leaders.

Program description

Briefly, WOKE is a 14-Week DBT-based program adapted for early intervention with young people. The Program involves an initial client assessment phase where treatment suitability and feasibility are determined. This is followed by a pretreatment phase where clients and parents are oriented to the different aspects of the Program and make a commitment to participate in the Program. Clients then move into a 14-week program, involving concurrent weekly skills training group and individual therapy. Parents are invited to join their young person by attending the skills training group. Separate parent therapy sessions are provided as needed. The skills training groups provides training in five skills modules: Mindfulness, Distress Tolerance, Interpersonal Effectiveness, Emotion Regulation, and Walking the Middle Path.

The Walking the Middle Path module provides skills targeted to address problems between client and parent including validation, dialectical approaches to problem solving, and behavioural approaches to promote effective change. Individual client therapy sessions are conducted using DBT individual therapy session structure and treatment strategies. Parent sessions are used to provide parents with additional support for implementing the skills, including coaching and problem-solving barriers to using the skills effectively.

Client referral

Clients were referred into the Program through local mental health services, including headspace Canberra and Queanbeyan, Child and Adolescent Mental Health Services, psychiatrists, local psychology practices, general practices, schools, and other community services.

Program 2 – COVID-19 modifications

The COVID-19 pandemic, and consequent ACT Government and University restrictions, required an online-only program to be rapidly developed early in 2020 for Program 2. Program 2 was initially scheduled to commence in March 2020 but, due to restrictions, had to be delayed and completely redeveloped for online-only participation. This Program comprised the use of weekly pre-recorded skills training modules (developed by the interns) that clients and their family members could view at a time that suited them. There were two weekly telehealth sessions, individually between client and intern therapist, provided over the course of the 14-week online Program. The first telehealth session was used to ensure the client had watched the training video, was oriented to the rationale for the skill, and had enough understanding to start practicing. The second telehealth session was provided later in the week, designed to reinforce progress and problem-solve difficulties with using the skills. No group-based meetings were able to be convened for the online program, as there was insufficient time to develop such a format; consequently, the group-based component was missing—young people and their families undertook the skills training individually by viewing the recorded skills training modules, and young people met via telehealth with their intern therapist.

The intern psychology training program was also adapted to an online learning format. This was provided in an online format and focused on core training in DBT and the key functions of the adapted design including the delivery of telehealth, as well as the original coaching, skills training, and problem-solving approaches. The peer group support was also convened through an online format.

Programs 3 and 4

Programs 3 and 4 returned to in-person delivery using the original Program 1 design. All treatment modes (individual therapy, skills group, and parent sessions) were delivered in-person. In addition, however, the online resources developed for Program 2 were made available as an additional learning resource for participants who were not able to attend a skills group or who required additional support in a particular skill, on an as-need basis.

Evaluation Aims and Methods

Research Team

The evaluation was undertaken by the Research Team comprising University of Canberra staff and students who were not involved in the clinical delivery of the Program. The Research Team was overseen by Professor Debra Rickwood, supported by Dr Clare Watsford. Annaleise Naylor was the research assistant employed by the grant to support the evaluation. Dr Jennifer Ma and Dr Kelly Mazzer undertook clinician interviews. First-year Master of Clinical Psychology students were selected to contribute to the evaluation as their clinical masters' research projects under the supervision of Debra and Clare.

Evaluation aims

There were three key aims to the WOKE Program evaluation:

1. Determine the extent to which the Program was implemented as planned.
2. Determine the effectiveness of the Program in reducing the symptoms of BPD: specifically, reducing the associated psychological issues of depression and suicidal ideation, and increasing coping skills to deal with BPD symptoms (distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness).
3. Understand the experience of the WOKE Program for the three key groups involved in the Program: the clients (young people), their family member(s), and the clinicians (interns) delivering the Program.

Evaluation methods

The research approach was a typical program evaluation design, using mixed methods to examine:

- implementation
- effectiveness, and
- experience.

The design was a single-arm intervention pre-, during-, post- and follow-up design. The mixed design included administrative data to describe implementation; standardised questionnaire measures to examine program effectiveness for young people, which were administered before, during and after the Program; and interviews to understand participant (client, family, and clinician) experiences after completion of the Program.

There was no control group and the research did not comprise an experimental design. Instead of providing experimental scientific evidence, the evaluation determines the effectiveness of the Program in achieving its objectives, with the purpose of providing information to ensure the Program achieved its objectives, including knowing what worked well and what needs to be improved, thereby informing future quality improvement and Program development.

Ethics approval was obtained from the University of Canberra Human Research Ethics Committee (HREC) for the research team to evaluate Program effectiveness. Table 1 provides the HREC approval number for each Program implementation for each evaluation component.

> **"I LEARNT A LOT OF SKILLS AND THEY'VE STAYED WITH ME"**
> (YOUNG PERSON)

Table 1. Ethics approval numbers by Program and research component

Research component	Program 1	Program 2	Program 3	Program 4
Young people questionnaires	2033	4416	4721	6967
Young people interviews	2235	4704	4704 (amendments)	9130
Parent interviews	2235	4704	4704 (amendments)	9130
Clinician interviews	235	4704	4704 (amendments)	9130

Implementation

Program implementation was assessed via documentation of recruitment and referral processes and the number of participants in each Program.

Effectiveness

Program effectiveness was determined by assessing young people on key outcome measures before, during, and after they had completed the Program.

Procedure

At initial assessment for suitability for the WOKE Program, young people were administered the assessment measures by a member of the Clinical Team delivering the WOKE Program. These assessments formed part of the clinical aspect of the Program to ensure participant suitability, but the measures were also used as baseline measures in the evaluation. Participants provided these measures by filling in hard copy questionnaires under clinical supervision. This occurred in-person for all Programs, including Program 2 the online program (as these assessments took place prior to COVID-19 restrictions).

At the first introductory session for the WOKE Program, members of the Research Team were present for part of the session to explain the evaluation research and collect pre-program measures. In this introductory session all the Program participants were together in their respective groups. Questionnaires were administered in hard copy. Participants were provided with private desk space in which to complete the questionnaires. It was explained that the set of questionnaires was long, intrusive, and often repetitive because we were using standardised questionnaires that are validated measures in this field.

Some questionnaires were administered during the Program. These were completed by participants in hard copy during their therapy sessions overseen by the Clinical Team.

The final session of the Program was called graduation. At this time, participants again completed questionnaires in hard copy overseen by the Clinical Team.

For Program 2, the online Program, the questionnaires were undertaken online via Qualtrics, but administered by therapists during participants' telehealth sessions (with the exception of assessment questionnaires which were administered in-person). In first week of the Program, participants were provided with a recording by the Research Team which explained the evaluation research.

At each timepoint, the questionnaires were securely stored, or downloaded, and then entered into the research database.

Three months after graduation, participants were emailed or texted a link to an online follow-up questionnaire, which was completed in the participant's own time online using the Qualtrics platform, from which data were extracted into the research database.

Measures

Client measures were obtained from the WOKE Program participants at five timepoints: 1) assessment; 2) pre-treatment; 3) during program participation; 4) graduation; and 5) 3-month follow-up. Table 2 shows the measures collected at each timepoint. The measures were:

- **Basic demographic information**

Age in years, gender, work/study status, and living situation were collected at assessment.

- **Psychological distress—Kessler 10 Psychological distress Scale (K10) (Kessler et al., 2002)**

The K10 consists of 10 items related to psychological distress experienced over the past four weeks, which are responded to on a 5-point scale from none of the time (1) to all of the time (5). A total score is obtained by summing all the items and can range from 10-50 with higher scores indicating greater distress. Scores of 30 and over indicate very high distress, and scores from 22-29 indicate high distress.

- **Depressive symptoms—Beck Depression Inventory–SF (BDI) (Beck, Rial, & Rickets, 1974)**

The BDI–Short Form consists of 13 items related to the presence and severity of depressive symptoms. Participants respond on a 4-point rating inventory (scored 0-3) based on their feelings over the past two weeks. The total score is the sum of the items and can range from 0-39. This scale is used as a diagnostic guide; scores over 16 indicate severe depression and scores of 8-15 indicate a moderate depression level.

- **BPD symptoms—Borderline Symptoms List–23 (BSL) (Bohus et al., 2009)**

The BSL–23 has 23 items related to BPD symptoms. The 5-point response scale ranges from 0 (not at all) to 4 (very strong) and asks participants to rate how much they have experienced each symptom over the past week. The total scale score is computed by averaging all items (range 0–4). Higher total scores indicate more borderline symptoms. Six grades of symptom severity are defined for mean scores: none or low 0-0.3; mild 0.3-0.7; moderate 0.7-1.7; high 1.7-2.7; very high 2.7-3.5; and extremely high 3.5-4.

- **BPD-related problems—Life Problems Inventory (LPI) (Rathus et al., 2015)**

The LPI is a 60-item self-report instrument developed to assess key BPD features of emotion dysregulation, impulsivity, interpersonal chaos, and confusion about self. Responses to items are on a 5-point scale from 1 (not at all like me) to 5 (extremely like me). The total score is a sum of all items and can range from 60–300. Sub-scale scores are determined by summing the relevant items; each sub-scale has 15 items and can range from 15-75. The sub-scales are confusion about self, emotion dysregulation, impulsivity, and interpersonal chaos. Higher scores indicate more problems with BPD features. A cut-off of 126 and higher on the LPI total score distinguishes those adolescents with features of BPD from normal controls.

- **BPD symptoms—Difficulties in Emotional Regulation Scale–18 (DERS) (Kaufman et al., 2016)**

The DERS–18 is an 18-item self-report measure that evaluates individuals' levels of difficulties in regulating emotions. The questionnaire has 36 items responded to on a 5-point frequency scale: 1 (almost never), 2 (sometimes), 3 (about half the time), 4 (most of the time), 5 (almost always). The measure is summed for a total score (range: 18-90) with higher scores indicating greater problems with emotion regulation. It comprises six sub-scales with six items each, which are non-acceptance of emotional responses, difficulties engaging in goal-directed behaviour, impulse control difficulties, lack of emotional awareness, lack of emotional clarity, and limited access to emotion regulation strategies. Items on the sub-scales are summed to provide total scores that can range from 3-15.

- **Suicidal thoughts—Suicidal Ideation Questionnaire (SIQ) (Reynolds, 1998)**

The SIQ consists of 30 items that assesses frequency of suicidal thoughts over the past month, responded to on a 7-point scale from 0 (I never have this thought) to 6 (almost every day). The total score is the sum of the items and can range from 0-180, with higher scores indicating greater suicidal ideation. Scores at or above 41 indicate potentially significant psychopathology and suicide risk.

- **Coping skills—Dialectical Behavior Therapy Ways of Coping Checklist (WCC) (Neacsiu et al., 2010)**

The WCC consists of 59 items that assess ways participants have coped with stressful events in their lives over the past month. Responses are on a 4-point scale: 0 (never use), 1 (rarely use), 2 (sometimes use), 3 (regularly use). Three sub-scales are computed by averaging the relevant items and the sub-scale scores can range from 0-3: skills use (38 items), where a higher score indicates more use of functional skills; dysfunctional coping (15 items), where a higher score shows more dysfunctional coping; and blame others (6 items), where a higher score indicates more blaming of others.

Table 2. Standardised questionnaire measures administered to young people by timepoint

Assessment	Pre-program	During program	Graduation	Follow-up
K10			K10	K10
BDI			BDI	BDI
BSL			BSL	
LPI		LPI	LPI	
	DERS	DERS		
	SIQ		SIQ	
	WCC	WCC		WCC

Experience

The research approach taken to determine the experience of participants was exploratory and qualitative in nature. Qualitative information was obtained from the three key groups of participants in the Program—the young people, their family member involved in the Program, and the clinicians and intern psychologists delivering the Program.

All Program participants were invited to have an interview, and those who agreed undertook a semi-structured interview. These were conducted in-person for Program 1, via a telehealth platform for Program 2, and via either approach as preferred by the participant for Programs 3 and 4.

The young people and family members were asked questions pertaining to their expectations and experiences of the WOKE Program, as well as their perception of the effectiveness of Program delivery. These interviews were undertaken by members of the Research Team (Research Assistant and Clinical Masters research students).

Interns and clinicians were asked questions about their experience of the Program and associated training, as well as their perceptions of client attitudes and Program improvements. Clinician interviews were conducted by experienced researchers entirely external to the University's Clinical Psychology course and the WOKE Program (Dr Kelly Mazzer or Dr Jennifer Ma). This was important so that the clinicians and intern psychologists were anonymous, and free to express any negative views about the Program without any concerns regarding confidentiality.

"IT WAS A FANTASTIC PROGRAM, REALLY FANTASTIC PROGRAM"

(PARENT)

Findings

Implementation

Administrative data was used to track implementation. Implementation was determined by recording referrals of young people to the Program, the source of referral, and whether they were assessed as suitable or not, the extent the young person participated, and whether they had a family member involved. The number of Master of Clinical Psychology interns was also recorded.

There were four implementation phases of the Program during the evaluation period:

- **Program 1:** September–December 2019
- **Program 2:** May–August 2020
- **Program 3:** October–December 2020
- **Program 4:** March–June 2021

Referrals

Referrals to the Program came from the following sources: private psychologists (16), headspace (10), psychiatrist (10), CAMHS (9), school psychologists (7), general practitioners (6), CatholicCare (4), other community services (4), psychology clinics (3).

Notably, there were 97 referrals where the young person was deemed to be unsuitable for the Program. These young people were generally at too high risk for the Program. Considerable effort was then required to assist many of these young people and their families to find alternative treatments. These young people and their families were particularly looking for DBT treatment programs and approaches. The Clinical Leaders developed a list of private practitioners and other DBT-type programs to refer to. This was an unanticipated requirement of the Program, and took up valuable time that had not originally been factored in. It was felt that for the integrity of the Program it was essential to not just turn young people away, but to ensure that they had an alternative pathway to care.

Participation of young people and their families

The number of participants in each Program by type of participant is provided in Table 3. Overall, 69 young people and 55 parents/family members took part in the four Programs – a total of 124 participants. Importantly, almost all the young people who commenced the Program completed (97.2% completion rate). There were two young people who started the Program but attended only one skills group; a 15-year-old female and a 17-year-old male. There were also five young people who were assessed as eligible to participate in Program 2 but chose not to do so when the Program was delayed due to COVID-19 and was required to be online-only. One of these young people returned to participate in Program 3, but the other four did not return.

Young people

The young people were aged from 14-21 years. Almost all were female (64 female, 1 male, 2 other, 1 rather not say, 1 non-binary). Almost all (n=55, 79.7%) lived with their parents; six lived with friends, five with other family, one with their partner, and one lived alone. None of the participants were Aboriginal or Torres Strait Islander. All but three were born in Australia. For work and study, 16 were at school and not working, 15 were at school and had a casual job, seven were in higher education and not working, 11 were in higher education and had a casual job, nine were working part-time or casual, four were employed full-time, and five were neither employed nor studying.

The number of young people participating fell somewhat short of the original intent of having 12-15 young people per group within each Program. Note that Program 1 comprised two groups, Program 2 had one online group, Program 3 comprised two groups, and Program 4 had one group. There were six groups overall, with potential capacity for 90 young people and their families, so the Program achieved 77% of intended participation. The reasons for not reaching full participation included lower numbers in Program 1, as expected for the first iteration of the Program when it was in its development phase and new to the Canberra community. We expected to increase participation substantially in Program 2 but were thwarted by the advent of COVID-19, and the inability to conduct an in-person program due to ACT Government and University restrictions. Recruitment was halted until an online option was available, and subsequently rapid recruitment was required to enable completion of the Program in time. Uncertainty around in-person contact impacted recruitment into subsequent Programs, as well as lack of certainty of continuation of the Program beyond its first pilot period.

Family

About half the young people participated with a family member (n=33), usually their mother (n=23), although there were eight fathers, one grandfather, and one step-mother. Almost all the younger participants (under 18 years) participated with a family member (91.9%, n=34/37); young adults were less likely to have a family member involved, and 37.5% of those aged over 18 years had a family member participate (n=12/32).

Training of intern clinicians

There were two fully qualified clinical psychologist clinicians, experienced in DBT, involved who fulfilled the roles of Team Leaders, senior clinicians, and intern supervisors. There were 16 Master of Clinical Psychology interns involved in delivering the Program. These people were in their final year placements (placement 3 or 4 out of 4 practicum placements) for their Master of Clinical Psychology course. Half the interns (n=8) undertook one placement in the WOKE Program and half undertook two placements. The clinicians were both females; the interns were 14 females and two males.

The interns were fully supervised by the clinicians and undertook competency-based training as required for the Master of Clinical Psychology course, with additional instruction in DBT. This comprised three initial core DBT workshops, followed by a weekly therapist skills group (TSG) and additional seminars in DBT over the course of the placement. The TSG involved the interns learning and practicing teaching the skills, as well as ongoing instruction in effective skills group facilitation. The additional seminars included more in-depth training in DBT, which was also provided through weekly individual clinical supervision for each intern of between 1-1.5 hours.

Services provided and cost

Over the entire Program, young people received 28 hours of skills group therapy and 14 hours of individual therapy, with an additional four hours of assessment and pre-treatment consultation. Family members could receive up to 28 hours of skills group therapy, as well as 3-5 hours of parent coaching support. The intern clinicians received at least 16 hours of individual supervision and 16 weeks of group supervision.

This amounted to 46 hours of clinical support for each of the 69 young people; 32 hours of clinical support for each of the 55 family members, and 32 hours of clinical supervision for each intern. This was a total of 3174 hours for young people, 1760 family support hours (4934 hours altogether for participants), and 512 hours of clinical supervision for the interns.

The Program funding that was allocated to service delivery (excluding the evaluation research component) was about $380,000. So, if the costs of the interns are excluded, each hour of clinical support for Program participants cost $77, and the total cost per participant was $3064. The Program was entirely free for young people and their family members.

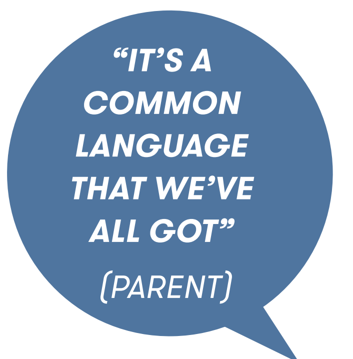
Note, however, that this funding also covered the placement training and clinical supervision costs for the 16 intern psychologists. Clinical Psychologists in Canberra charge about $200 per hour for supervision. Consequently, this cost could have added up to $102,400, demonstrating the considerable value-add of providing the WOKE Program through the University and with the input of the Master of Clinical Psychology students.

Table 3. **Number of participants by Program number, type of participant, and research component**

Participants & research component	Program 1 2019	Program 2 2020	Program 3 2020	Program 4 2021	Total
Young people	N=18	N=17	N=22	N=12	N=69
Assessment questionnaire	n=18	n=17	n=22	n=12	n=69
Pre-program questionnaire	n=17	n=16	n=22	n=12	n=68
During-program questionnaire	n=17	n=17	n=19	n=12	n=66
Graduation questionnaire	n=17	n=17	n=21	n=12	n=68
Follow-up questionnaire	n=6	n=10	n=12	n=6	n=34
Interview	n=5	n=10	n=8	n=9	n=32
Parents/family	N=19	N=7	N=22	N=7	N=55
Interview	n=10	n=5	n=15	n=3	n=33
Clinicians	N= 2 clinicians 6 interns	N= 2 clinicians 6 interns	N= 2 clinicians 8 interns	N= 1 clinician 4 interns	N= 2 clinicians[1] 16 interns[2]
Interview	n= 2 clinicians 5 interns	n= 2 clinicians 4 interns	n= 0 clinicians 2 interns	n= 1 clinician 3 interns	n=[3] 5 clinician interviews 14 intern interviews

Notes:

[1] In total, there were 2 unique clinicians in the Programs; this number does not include Dr Dean Buckmaster.
[2] Some interns undertook a double placement, so the total number of interns is not the sum of interns from all Programs; there were 16 unique interns.
[3] Clinical staff were offered the opportunity for an interview after each Program; the number of interviews does not equal the number of clinicians and interns.



Program modifications (COVID-19)

The COVID-19 pandemic, and consequent ACT Government and University responses, had major ramifications for implementation of the Program. The originally developed Program was an in-person, group-based program with groups of 10-12 young people and their family member attending weekly for a two-hour group session, as well as the young people attending regular (weekly or fortnightly) meetings with their individual therapist. Family members could also have individual therapist sessions if requested.

Due to social distancing guidelines and Faculty of Health Clinic restrictions, the Program could not run as an in-person group program for Program 2. For this Program, intake was also disrupted by the initial impacts of COVID-19 and consequent restrictions. During this period, the WOKE Clinical Team re-designed the Program for online delivery. The re-designed online program, Program 2, commenced on Wednesday the 20th May 2020, later than originally planned (which was March).

Adapting the Program in response to the COVID-19 pandemic resulted in an innovative design comprising an online-only program. Core to this design was the use of weekly pre-recorded skills training modules and telehealth individual sessions. The adapted Program tried to enhance engagement and access by providing clients and parents with online access to the skills for repeated, ongoing review and practice. The individual telehealth sessions supported the clients' learning and application of the skills through coaching and tailoring the skills to their needs. The clinician (intern psychologist) training program also required major adaptation to an online format. It focused on core training in DBT and the key functions of the new design including the delivery of telehealth, coaching, skills training, and problem-solving. The Program design remained based on early intervention framework principles for subthreshold symptoms of BPD, recommendations for the effective adaptation and implementation of DBT, and evidence on the mechanisms of change in DBT—all adapted for online delivery.

Effectiveness

Effectiveness of the Program was determined analysing key standardised measures for change over time. Descriptive statistics for each of the evaluation measures for young people at each timepoint, including the measure's name, the sample size, mean, standard deviation and score range, are presented in Table 4 and Table 5. In Appendix 1, Table 6-Table 9 present this information separately for each of the four Programs.

For the analyses, first analysis of variance (ANOVA) was used to determine whether the young people in each of the four Programs differed significantly from each other. Changes in the quantitative measures over time were then determined using mixed ANOVAs, with repeated measures for timepoint (from assessment/pre-program to during the program, at graduation and at three-month follow-up) and with Program (1-4) as the between-group measure. Significance was set at $p<.001$ unless otherwise specified. When the follow-up measures were included and three timepoints were being analysed, the Program effect was not included because the number of young people in each of the four Programs was not sufficient for analysis. Nevertheless, the response rate for the follow-up measures was high at 49.28%.

Assessment and pre-program

The young people in each of the four Programs did not differ significantly from each other on any of the assessment and pre-program measures. The Program groups were, therefore, equivalent at baseline.

At assessment, young people presented with:

- Very high psychological distress – a score of 30+ indicates very high psychological distress on the K10. The mean score of almost 34 at presentation shows that young people were very distressed emotionally at assessment.
- Severe depression scores – a score of over 16 indicates severe depression on the BDI. The mean score of almost 22 shows that the young people were severely depressed at assessment.
- High levels of borderline symptoms – the mean score of 2.30 for the BSL is in the high symptoms range (1.7-2.7), showing a high level of borderline symptoms at assessment, although not very high or extremely high.
- High levels of borderline personality features - a cut-off of 126 and higher on the LPI total score distinguishes adolescents with features of BPD from normal controls. The mean score of 191.19 shows the WOKE young people were substantially above this cut-off at assessment. They were high on all four types of borderline features – interpersonal chaos, emotional dysregulation, confusion about self, and impulsivity.

At presentation to the Program (immediately pre-program), young people were:

- Very high on difficulties in emotional regulation – the overall mean score of 67.14 shows that on average young people experienced difficulties in emotional regulation between half the time and most of the time at the start of the Program. Young people scored highest on difficulties with goal-directed behaviour, where their mean score (13.47) was close to 'all of the time'. Next were difficulties in emotional regulation (12.40), emotional clarity (11.18), nonacceptance, and impulse control (10.91), which were experienced 'most of the time'. Lack of emotional awareness was the lowest difficulty at presentation, being experienced a bit less than 'half of the time' (8.36).
- Very high on suicidal ideation – the mean score of 82.24 on the SIQ is above the scale cut-off of 41, which indicates potentially significant psychopathology and suicide risk.
- High on ineffective coping skills and low on effective coping skills – the mean WCC dysfunctional coping score of 2.28 showed young people were most likely to use dysfunctional coping approaches, and used these sometimes to regularly; the mean skill score showed they less-than-sometimes used functional coping skills; although their blame others score was quite low, at 1.30, showing that they rarely blamed others as a coping strategy.

Summary

Prior to commencement of the Program, the young people were: very highly psychologically distressed, severely depressed, and very high on suicidal ideation; had high, but not very or extremely high, levels of borderline symptoms; had high levels of all four types of borderline features (interpersonal chaos, emotional dysregulation, confusion about self, and impulsivity); were very high on most types of difficulties in emotional regulation (emotional regulation, emotional clarity, nonacceptance, and impulse control), which were experienced most of the time, but had somewhat less difficulty with emotional awareness; and were high on ineffective coping skills and low on functional coping skills, although they rarely blamed others as a coping strategy. There was variation around the mean scores, with some young people being very distressed and not coping at all well, and others being much less distressed and coping much better prior to the Program, although all young people were assessed as having need and suitability for the Program.

The young people in each of the four Programs did not differ significantly from each other on any of the assessment and pre-program measures. The Program groups were, therefore, equivalent at baseline.

Table 4. Descriptive statistics for young people's scores on evaluation measures by timepoint for all WOKE Programs combined (before commencement of Program)

Timepoint	Measure	n	Mean (SD)	Range [possible range]	Cronbach alpha
Assessment	Psychological Distress - K10	69	33.97 (6.94)	17-47 [10-50]	.89
	Beck Depression Inventory - BDI	69	21.91 (7.09)	5-33 [0-39]	.85
	Borderline Symptoms List - BSL	67	2.30 (0.91)	.22-3.70 [0-4]	.95
	Life Problems Inventory - LPI	67	191.19 (42.05)	71-276 [60-300]	.95
	Confusion about self		54.47 (11.84)	22-75 [15-75]	.88
	Impulsivity scale		40.27 (11.02)	15-67 [15-75]	.81
	Emotional dysregulation		47.63 (12.58)	17-73 [15-75]	.91
	Interpersonal chaos		48.82 (12.90)	17-75 [15-75]	.89
Pre program	Difficulties in Emotional Regulation Scale – DERS	66	67.14 (9.51)	37-85 [18-90]	.82
	Nonacceptance		10.99 (2.89)	4-15 [3-15]	.73
	Goal-directed behaviour		13.478 (1.84)	8-15 [3-15]	.68
	Impulse control		10.91 (3.24)	3-15 [3-15]	.87
	Emotional awareness		8.36 (2.85)	3-15 [3-15]	.78
	Regulation strategies		12.40 (2.14)	6-15 [3-15]	.60
	Emotional clarity		11.18 (2.55)	5-15 [3-15]	.75
	Suicide Ideation Scale - SIQ	64	82.24 (42.62)	5-174 [0-180]	.98
	Ways of Coping Checklist – WCC	67			
	Skill use		1.45 (0.44)	0.53-2.37 [0-3]	.92
	Dysfunctional coping		2.28 (0.43)	0.87-2.93 [0-3]	.81
	Blame others		1.55 (0.69)	0.00-3.00 [0-3]	.82

Notes: Nearly all the measures showed good reliability, as shown by Cronbach alpha statistics of >.80. Some of the DERS measures were lower than this threshold, but still had adequate reliability for research purposes (>.60), particularly given that these scales comprise only three items.

Table 5. Descriptive statistics for young people's scores on evaluation measures by timepoint for all WOKE Programs combined (during and post-Program)

Timepoint	Measure	n	Mean (SD)	Range [possible range]	Cronbach alpha
During program	Ways of Coping Checklist - WCC	64			
	Skill use		1.88 (0.43)	0.87-2.97 [0-3]	93
	Dysfunctional coping		2.01 (0.53)	0.45-3.00 [0-3]	.76
	Blame others		1.30 (0.65)	0.00-2.83 [0-3]	.85
	Life Problems Inventory - LPI	63	170.77 (43.28)	75-283 [60-300]	.96
	Confusion about self		48.64 (13.60)	20-75 [15-75]	.92
	Impulsivity scale		36.66 (11.87)	19-69 [15-75]	.86
	Emotional dysregulation		41.19 (12.81)	16-73 [15-75]	.92
	Interpersonal chaos		43.43 (11.86)	19-72 [15-75]	.88
	Difficulties in Emotional Regulation Scale – DERS	64	53.81 (13.21)	29-84 [18-90]	.91
	Nonacceptance		9.12 (3.18)	3-15 [3-15]	.83
	Goal-directed behaviour		11.43 (3.21)	5-15 [3-15]	.92
	Impulse control		8.18 (3.41)	3-15 [3-15]	.91
	Emotional awareness		7.36 (2.82)	3-14 [3-15]	.78
	Regulation strategies		9.46 (3.05)	2-15 [3-15]	.72
	Emotional clarity		8.55 (3.02)	3-15 [3-15]	.85
Graduation	Psychological Distress - K10	67	27.19 (6.86)	12-43 [10-50]	.89
	Beck Depression Inventory - BDI	67	13.13 (7.47)	0-31 [0-39]	.88
	Borderline Symptoms List - BSL	67	1.56 (0.94)	0.04-3.57 [0-4]	.96
	Suicide Ideation Scale - SIQ	66	53.31 (36.86)	0-157 [0-180]	.99
	Life Problems Inventory - LPI		152.86 (52.50)	71-276 [60-300]	.98
	Confusion about self		43.27 (15.41)	15-71 [15-75]	.95
	Impulsivity scale		33.40 (12.01)	16-67 [15-75]	.88
	Emotional dysregulation		36.21 (14.30)	15-73 [15-75]	.95
	Interpersonal chaos		39.19 (15.18)	15-71 [15-75]	.95

Timepoint	Measure	n	Mean (SD)	Range [possible range]	Cronbach alpha
Follow-up	Psychological Distress - K10	34	26.44 (7.84)	15-45 [10-50]	.92
	Beck Depression Inventory - BDI	32	11.16 (8.70)	0-28 [0-39]	.92
	Ways of Coping Checklist - WCC	32			
	Skill use		1.81 (0.35)	1.18-2.84 [0-3]	.85
	Dysfunctional coping		1.69 (0.70)	0.00-2.73 [0-3]	.95
	Blame others		1.00 (0.58)	0.00-2.17 [0-3]	.81

Notes: Nearly all the measures showed good reliability, as shown by Cronbach alpha statistics of >.80. Some of the DERS measures were lower than this threshold, but still had adequate reliability for research purposes (>.60), particularly given that these scales comprise only three items.

Changes over time

Psychological distress (K10)

Psychological distress was measured at three timepoints, including at follow-up. Distress declined significantly over time from pre-program to graduation, with 45.7% of the variance attributable to timepoint. There was also a significant timepoint by program interaction, explaining 18.1% of the variance, but no significant program effect. Figure 1 shows the nature of the interaction, revealing that young people in Programs 1, 3 and 4 showed a significant decrease in psychological distress, moving from the very high range (clinical cut-off score of 30+) to the high range (score of 22–29); young people in Program 2 (May 2020 online) remained in the very high distress range, although their scores did decrease somewhat.

Figure 1 Psychological distress (K10) by timepoint and Program

There were 34 young people who provided follow-up data for the K10. For these young people, over the three timepoints, the ANOVA showed a significant time effect explaining 33.8% of the variance (see Figure 2). Follow-up tests revealed that the difference between pre-program and graduation was significant, but between graduation and follow-up was not, although there was an overall significant linear trend of declining psychological distress over time.

Figure 2 Psychological distress (K10) by timepoint

Depression (BDI)

Depressive symptoms declined significantly over time, with 50.5% of the variance attributable to change over time. The Program effect and interaction effect were non-significant. Figure 3 shows the dramatic change in depression, from well above the cut-off threshold of a score of 16 to below the clinical criteria cut-off. While the effect for Program 2, the online program, was somewhat attenuated, it was still significant and showed a substantial reduction.

Figure 3 Depression symptoms (BDI) by timepoint and Program

There were 32 young people who provided follow-up data for the BDI. Over the three timepoints, the ANOVA showed a significant time effect explaining 38.9% of the variance (see Figure 4). Follow-up tests revealed that the difference between pre-program and graduation was significant, but between graduation and follow-up was not, although there was an overall significant linear trend of declining depression over time.

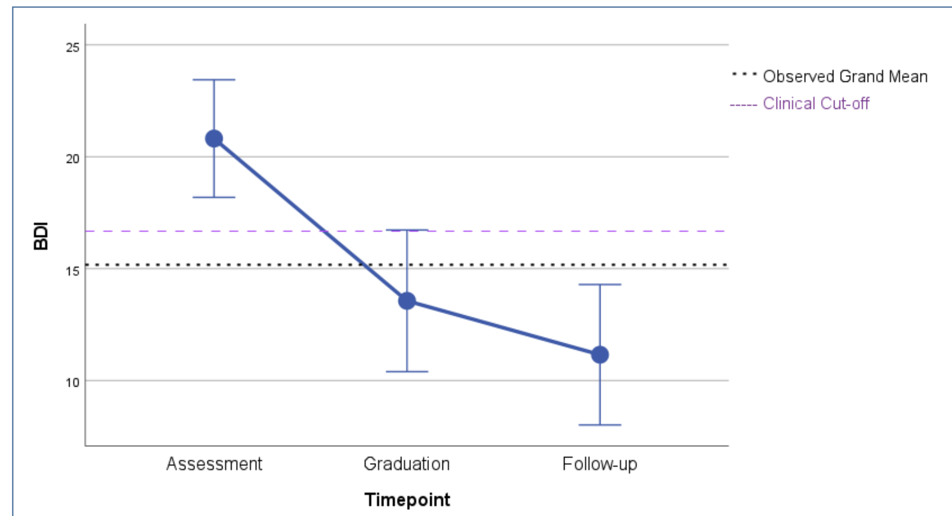


Figure 4 **Depression scores (BDI) by timepoint**

Suicidal ideation (SIQ)

Suicidal ideation declined significantly over time, with 36.4% of the variance attributable to change over time. There was also a significant time by program interaction, explaining 13.7% of the variance, but no significant Program effect. Figure 5 shows the nature of the interaction, revealing that young people in all Programs, except the online Program, showed a significant decrease in suicidal ideation. Young people in Programs 1, 3 and 4 moved from having extremely high suicidal ideation to being much closer to the above the scale cut-off of above 41. Young people in Program 2 did not significantly change over time, although a decreasing trend was evident.

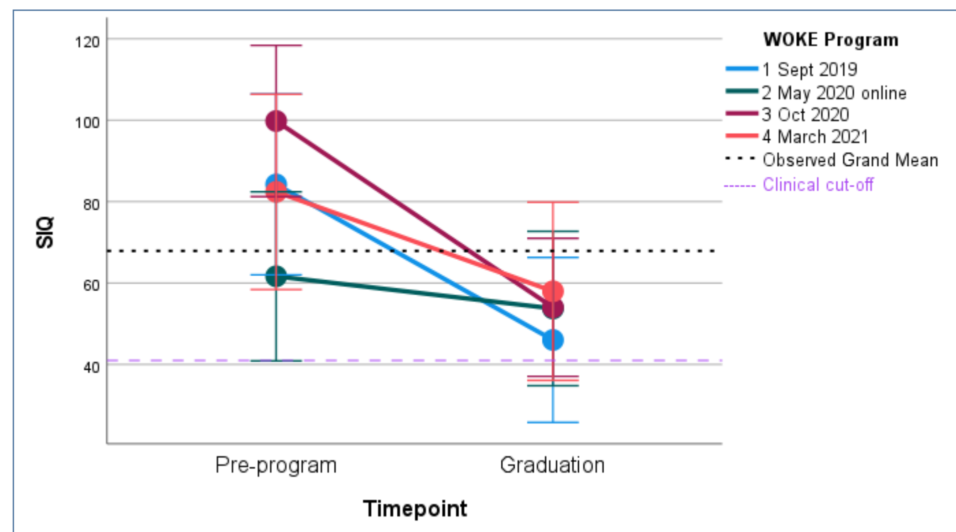


Figure 5 **Suicidal ideation (SIQ) by timepoint and Program**

Borderline symptoms (BSL)

Borderline symptoms declined significantly over time, with 29.7% of the variance attributable to change over time. No other effects were significant (Figure 6).

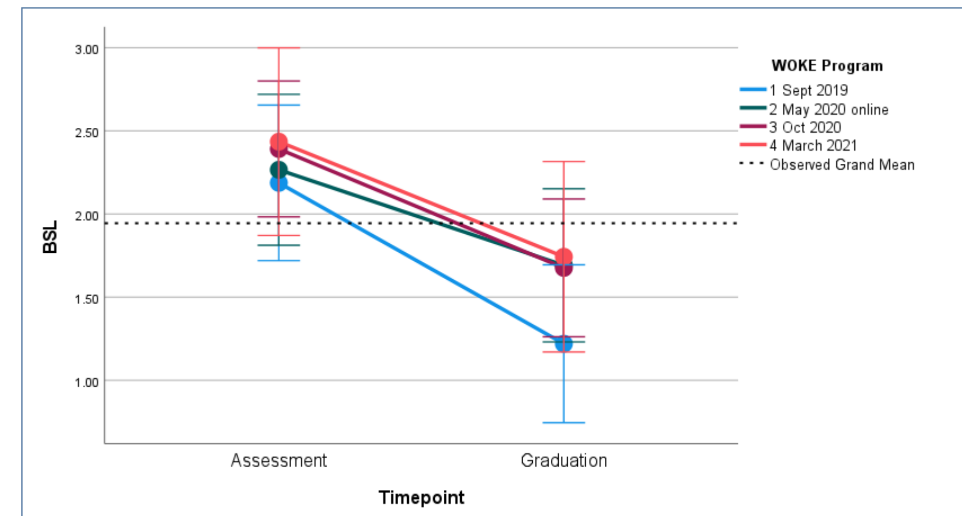


Figure 6 **Borderline symptoms (BSL) by timepoint and Program**

Ways of Coping (WCC)

There were three measures of ways of coping: skill use, dysfunctional coping, and blaming others. These were measured pre-program, during the program, and at follow-up.

Skill use improved significantly from pre-program to during the program, with 59.3% of the variance attributable to time. Other effects were not significant (Figure 7).

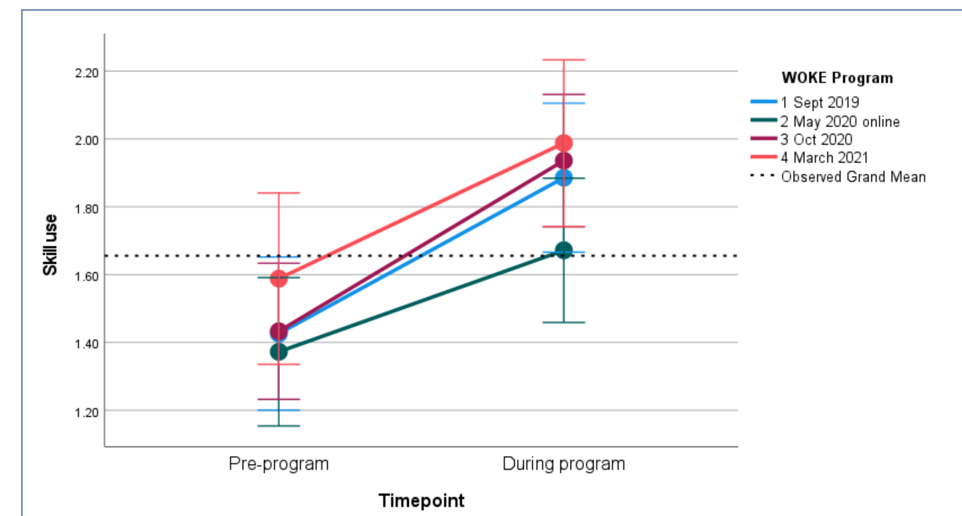


Figure 7 **Skill use (WCC) by timepoint and Program**

Dysfunctional coping significantly declined from pre-program to during the program, with the time effect explaining 17.0% of the variance. The interaction of time and Program just reached significance (p=.043), explaining 12.8% of the variance. Figure 8 shows that young people in Programs 1,3 and 4 started with high dysfunctional coping and this significantly reduced; young people in Program 2 (online) started somewhat lower on dysfunctional coping, and the average level did not change significantly.

Blaming others also significantly declined from pre-program to during the program (p=.010), with the time effect explaining 10.7% of the variance. The interaction of time and Program also attained significance (p=.021), explaining 15.0% of the variance. Again, Figure 9 shows that young people in Programs 1,3 and 4 started with more blaming others and this significantly reduced; young people in Program 2 (online) started somewhat lower on blaming others, and this did not change significantly.

There were 29 young people who provided follow-up data for the WCC. Again, the ANOVAs showed a significant effect of timepoint, and Program was not included in the analysis due to there being too few young people in each Program group.

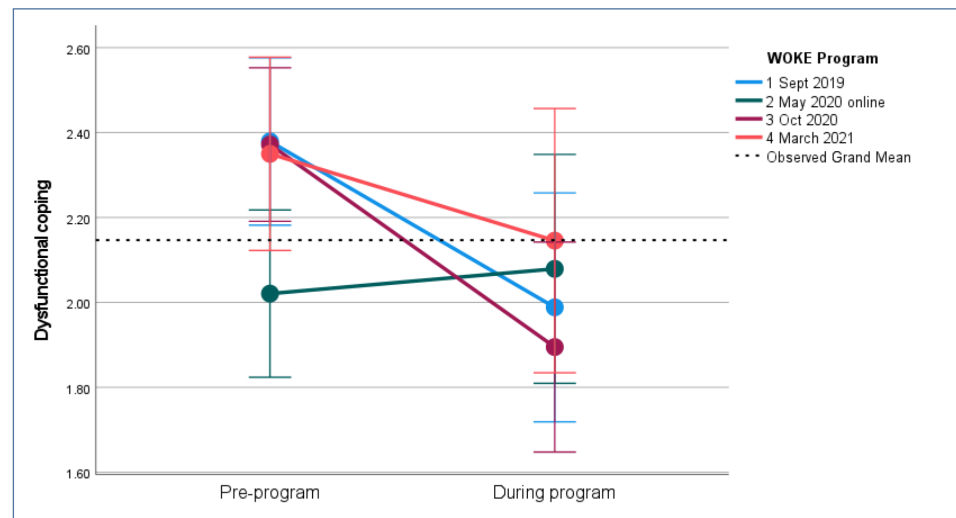


Figure 8 Dysfunctional coping (WCC) by timepoint and Program

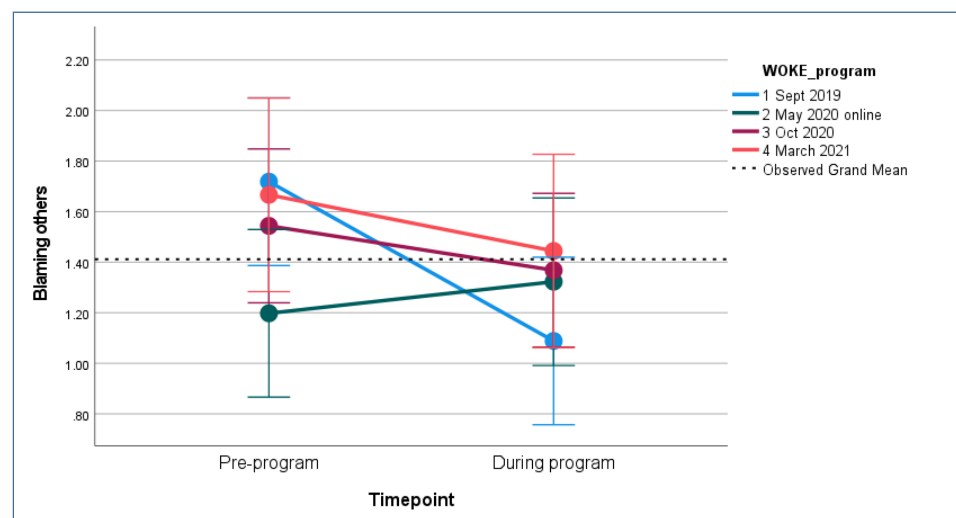


Figure 9 Blaming others (WCC) by timepoint and Program

For skill use, 48.6% of the variance was explained by timepoint, with the difference from pre-program to during the program being significant, but the difference from during the program to follow-up not attaining significance. Overall, there was a significant linear trend of an increase in skill use (see Figure 10).

For dysfunctional coping, 27.1% of the variance was explained by timepoint, with the difference from pre-program to during the program not attaining significance, but the difference from during the program to follow-up being significant. Overall, there was a significant linear trend of a decline in dysfunctional coping (see Figure 11).

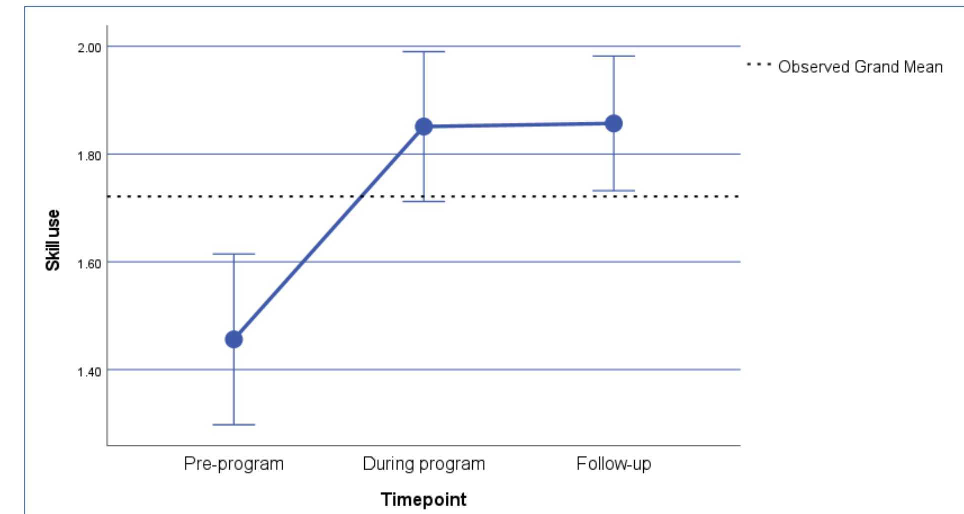


Figure 10 Skill use (WCC) by timepoint

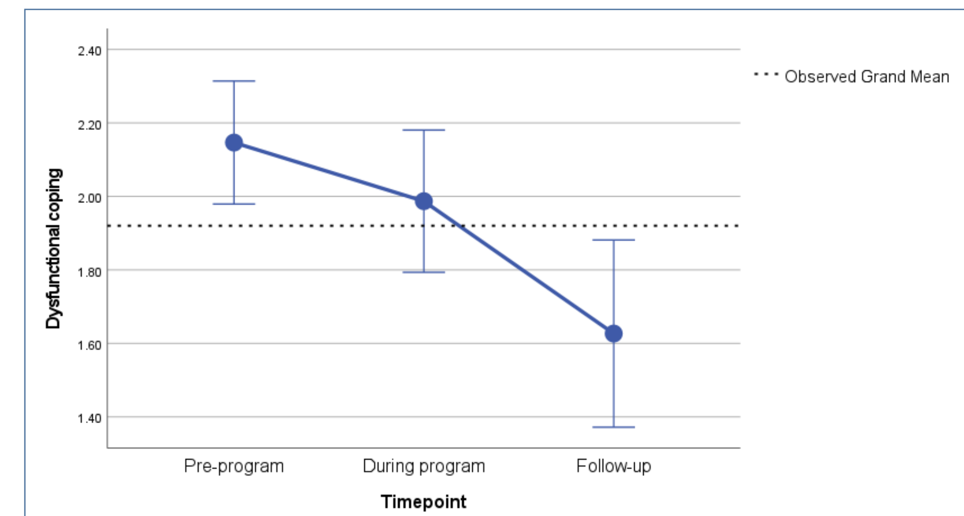


Figure 11 Dysfunctional coping (WCC) by timepoint

For blaming others, 14.1% of the variance was explained by timepoint (p=.014), with the difference from pre-program to during the program not attaining significance, but the difference from during the program to follow-up being significant. Overall, there was a significant linear trend of a decline in blaming others (p=.017) (see Figure 12).

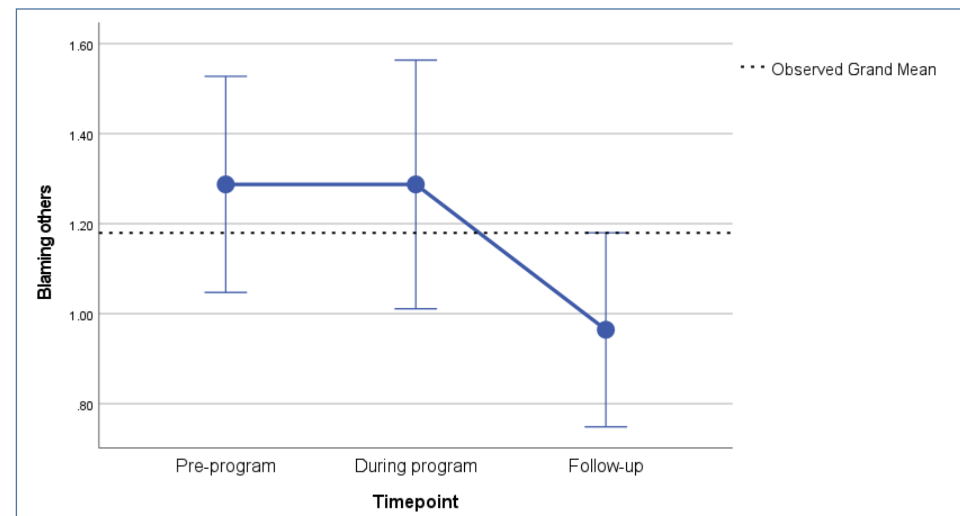


Figure 12 Blaming others (WCC) by timepoint

Difficulties in emotion regulation (DERS)

There were seven measures of difficulties in emotion regulation: a total scale score, and six sub-scale measures of non-acceptance of emotional responses, difficulties engaging in goal-directed behaviour, impulse control difficulties, lack of emotional awareness, lack of emotional clarity, and limited access to emotion regulation strategies. These were measured pre-program and during the program.

The total scale score significantly declined from pre-program to during the program, with the time effect explaining 54.3% of the variance (see Figure 13). The interaction of time and Program was significant (p=.004), explaining 20.6% of the variance. Young people in Programs 1,3 and 4 had significantly reduced their difficulties in emotion regulation from pre-program to during the program; young people in Program 2 (online) started somewhat lower on the DERS, and their scores did not change significantly, although a slight decline was evident.

A similar pattern was evident for each of the sub-scales. In order of the percentage of variance explained by timepoint, the ANOVAs showed a significant reduction in limited access to emotion regulation strategies (52.0%), impulse control difficulties (48.0%), lack of emotional clarity (39.5%), difficulties engaging in goal-directed behaviour (35.0%), non-acceptance of emotional responses (24.8%), and lack of emotional awareness (10.7%, p=.011). The interaction of timepoint and Program attained significance for impulse control difficulties (22.0%, p=.002), lack of emotional clarity (13.9%, p=.033), difficulties engaging in goal-directed behaviour (35.0%), non-acceptance of emotional responses (24.8%), and lack of emotional awareness (14.2%, p=.030). For sub-scales where the interaction was significant, the time effect for Program 2 (the online program) was not significant, while significant change was evident for the other three Programs. For the lack of emotional awareness sub-scale, however, the interaction revealed that the change over time was only significant for Program 3; all three of the other programs showed non-significant change on this dysfunctional emotional regulation skill. The Figures for the sub-scales are provided in Appendix 2.Life problems inventory (LPI)

There were five measures of difficulties in emotion regulation: a total scale score, and four sub-scale measures of confusion about self, emotion dysregulation, impulsivity, and interpersonal chaos. These were measured pre-program and during the program.

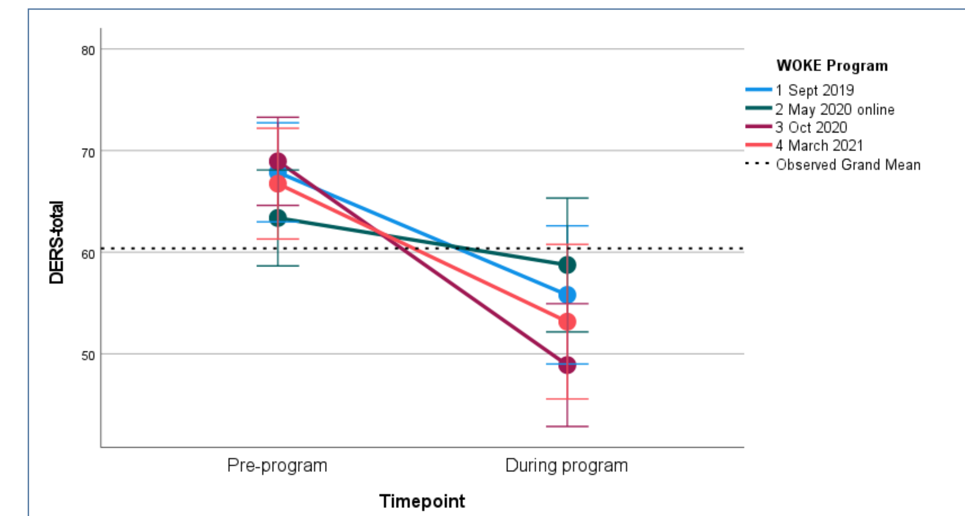


Figure 13 Difficulties in emotion regulation (DERS) by timepoint and Program

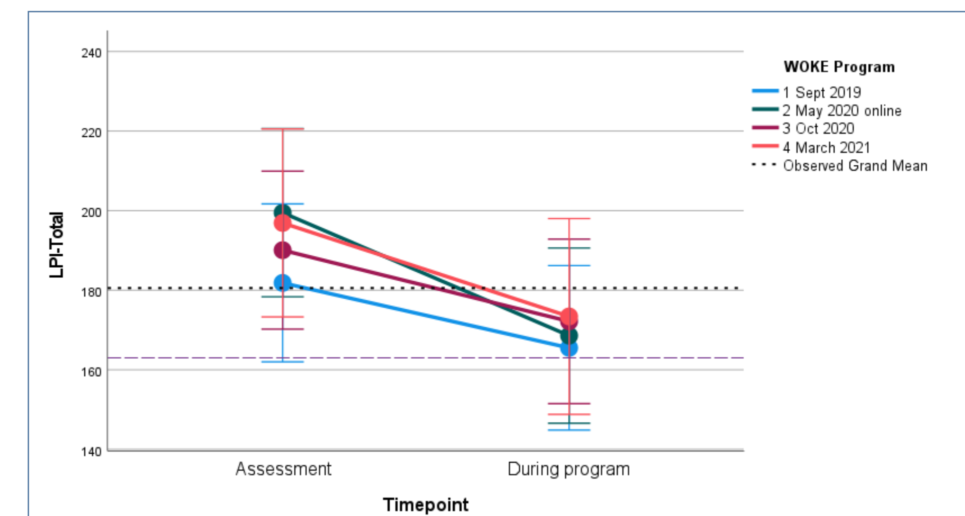


Figure 14 Life problems (LPI) by timepoint and Program

The total scale score significantly declined from pre-program to during the program, with the time effect explaining 26.8% of the variance. No other effects were significant. Figure 14 shows that young people in all Programs started with very high levels of life problems and these reduced substantially to being just above the clinical threshold during the program.

A similar pattern was evident for each of the sub-scales. In order of the percentage of variance explained by timepoint, the ANOVAs showed a significant reduction in confusion about self (19.4%), impulsivity (12.6%, p=.005), emotion dysregulation (18.5%), and interpersonal chaos (19.8%). The Figures are provided in Appendix 3.

Summary

Significant change was evident on all measures, comparing those take prior to commencement of the Program with those taken during and after the Program. Over the course of the Program, young people significantly reduced their symptoms, distress, suicidal ideation, and dysfunctional coping approaches and significantly improved their positive coping strategies.

In order of the strength of the effects, the strongest effect was for improvement in DBT skill use as a way of coping; this change occurred over the course of the Program and was maintained at follow-up. Next was a significant reduction in dysfunctional emotion regulation strategies, followed by reduced depression symptoms and psychological distress, less suicidal ideation, fewer borderline symptoms, and fewer life problems; all these effects were strong. Weaker, but still significant and substantial, effects were evident for less dysfunctional coping and, lastly, less blaming others.

Significant improvements were shown for all measures for Programs 1, 3 and 4. However, Program 2, which was affected by the onset of COVID-19 and necessitated the rapid development of an online-only program, showed attenuated effects for several measures. Nevertheless, the trend was still in a positive direction, although some effects did not attain significance.

All effects were either maintained or improved at three-month follow-up.

Experience

Participants' experiences of the Programs were determined via qualitative analysis of the semi-structured interview data. Interviews were transcribed verbatim and stored in nVivo, which was used to code the information into key themes. The interviews were coded using a data-driven, inductive approach to determine key themes. These were revised as subsequent interviews were coded. Interviews were coded by five members of the research team, and coding was checked by Professor Debra Rickwood or Annaleise Naylor. Key themes and illustrative quotes are presented to understand the experience of young people, their family member, and the interns delivering the Program.

> ***"I AM NOW MUCH HAPPIER THAN I WAS BEFORE"***
>
> *(YOUNG PERSON)*

Young people's experience

A key objective of the WOKE project was to improve the mental health and wellbeing of young people with BPD characteristics. There were 31 interviews conducted with young people who had completed the WOKE Program; a response rate of 44.9%. Of the interviewed participants, 28 were female, two were male, and one identified as non-binary. The mean age was 17.96 years (SD=2.36).

The findings presented here focus on young people's experience of the Program, including noting any differences between the four implementations of the Program, particularly any differences evident for the online-only Program.

Access

Upon finding out about the WOKE Program from their service provider and the referral being sent, young people noted that the WOKE administrators were friendly, informative and replied in a timely manner. Young people also noted that setting up and discussing assessment appointments was an easy and pleasant experience, "the person who runs it, that first phone call. She made me so excited to join the Program. She loved my attitude, I loved hers, which made it really easy for that transition to do something new which is good". This initial experience provided the young people with a good first impression and foundation when commencing the Program.

In terms of access during the Program, young people noted that the building was easy to locate and had great accessibility, "the actual like getting here and everything was really good. And I like sometimes to use a wheelchair and the actual access to the room and everything was really good. Like physically, this building is super accessible. So that part of it was really good". While easy to locate and access via public transport, young people who lived, studied or worked in South Canberra noted that the location was not always convenient and could take some time to travel to and from, "Sometimes because it was like two buses away from my house … I had to spend like an hour on a bus or whatever". Although a short commute was required, most young people noted it was not too long and they could often use the time to freshen up on their skills or discuss the previous session with their family member, "We would drive home together … and like talk about the skills and everything and yeah, it was really good".

The other finding in relation to access was the times available for individual therapy and group sessions. Due to the requirements of the Master of Clinical Psychology placement hours and access to supervision and facilities/services, the WOKE Program primarily ran during business hours. Consequently, group sessions were in the early afternoon, and there was limited availability for early morning or late afternoon individual appointments. As such, young people had to attend sessions during the day, and reported that both they and their family members had to take time off school or work to participate, "I guess mum had to take time off work and I missed out on school". While most young people were able to make this work, some suggested "maybe an afternoon session would be more accessible for people and also for work. Like parents at work".

For the online-only Program, the access issues were not a problem. Online participants noted that the ability to watch the skills video at any time was a great advantage of doing the program online, "Went back and could go at my own pace and do it at the time that suits". Online participants also noted it was easy to take the individual therapy session at convenient times and travel did not have to be factored in, "I definitely liked the fact that I didn't have to go anywhere other than my house to do the activities". Overall, the online participants noted that "it was a lot easier to just kind of like fit in with my daily life".

Expectations

Before commencing the WOKE Program, young people had mixed expectations. Participants who had prior exposure to DBT programs through personal experience or the experience of close friends were aware that DBT involved skills training and working on oneself, "I had a bit of idea, a bit of an idea just how the actual course itself might work". Young people who were new to DBT did not have any concrete idea about how the program would work, although they thought it may offer a "different way of looking at things". In both circumstances, the young people expected "To get a lot better than I was. To see real improvements in my mental health state" as a result of joining and completing the Program. In terms of

what they were wanting from the Program, young people reflected that they were "really looking for some techniques and skills … around how I was feeling and how to deal with those feelings instead of just pushing things aside, actually recognising it, putting a name to it, but not letting that kind of overtake my mind".

Experience of group work

The beginning of the Program was difficult for most young people. Many noted that commencing the skills group was a time of nerves, anxiety and stress, "a little bit obviously worried about the group therapy part because I was worried about, you know, obviously social settings". Many reflected that they were not excited or keen to try group therapy, "I thought I'd hate it and I did at the beginning". However, participants found "everyone was very welcoming, and the instructors were lovely and very chatty, which made it easier for other people to just sort of sit back, especially on the first day, and they could just sort of take the reins". The welcoming environment led to the feeling that "Actually, most of these people are quite lovely and I'm totally safe here. And I'm not going to get a huge amount of judgment, or anything thrown at me or screamed at if I speak up. So that was quite nice". The safe environment created by the facilitators allowed participants to share their experiences and contribute to the group sessions, "once I kind of got to know everyone a little bit more, like I heard them all speak in the group and stuff, I got like a lot more comfortable, I guess talking and stuff in the group".

The group setting and experience was seen as a good way to learn skills. Participants reflected that "the classroom style setting where we all learn out of the presentation, not just like a lecture it was interactive and engaging, in a sense. I learned by doing and being a part of it". Specifically, participants reflected that "I think it works well to have all the content in group and to see other people and also hear how other people had kind of utilised it. I feel like as we got further and further into the program, more and more people felt comfortable sharing like how certain skills had helped them and things like that, which I think was really good. I think it's really nice to kind of hear how other people like applying them in their lives. And sometimes, like people would say something and I'd be like, oh, I should try that. I think that aspect of it was really good". The ability to work with and learn from others was one of the most beneficial aspects of the group Program. This was a factor that some participants in the online-only program, who received pre-recorded videos and did not have a group-based experience, reflected would have been a great addition, "I definitely feel like it would have been a very different experience if it was in person. I feel like some positives would of been being able to interact with other people, like the other people doing the programs".

An interesting consideration was the age range within the groups. Some older participants noted that having younger adolescents involved meant they could not relate or talk freely about current situations, "that's when we get the most destructive behaviours because we have an age where we can buy our own alcohol, we can buy our own smokes and stuff like sex addiction is not something that we can really talk about in a group". Others felt having a mixed age range meant they could see growth and skills working for situations they had gone through, "Well, during group it was really enjoyable. About well, everyone's experiences. I really enjoyed hearing from some of the younger girls in particular, hearing about how they're able to put these things into effect at school and having little things get better for them. Due to my school experience not being that great and just hearing that and like, oh, that's really lovely, that that was there to help you".

Parental involvement

When discussing the involvement of their parents in the Program, most participants enjoyed that experience and reflected that, "I thought that was good because like parents get to communicate with other parents and kids could communicate with kids going through the same thing. It was good to hear about that". Two participants noted that at times they did not necessarily want their parents to be involved all of the time. These young people noted that it can be hard to open up when their parents are around, mainly to protect them, "it's about not wanting them to hear how bad things are for you".

As a way to help ease these apprehensions, some group times were spent in smaller groups. Participants reflected that dedicating specific time to adult-only and young-people-only (or even mixed smaller groups) was a beneficial aspect of the Program, "I liked how they split off into three separate groups sometimes because it just felt a bit easier to, like, communicate. Basically, like tell what you, it's hard to explain, but it's like telling a story without having a whole room of people, waiting for you to move on. It was just bit easier that way".

Participants reflected that it was good to have a family support person there as it provided someone to talk to at home who could offer additional guidance if needed, "I live with mum full time and we're very close. So it was good. She heard things and she learned things, and I think it was really beneficial that she was there as well, because sometimes if I don't remember something, she can go, oh, you can call on this skill. She's sort of another person who I can go to because she's learnt the things as well".

Importantly, some young adults raised whether the most appropriate support person to take part in the Program was their parent. This was a significant factor for some of the older participants, who noted they do not live or spend time with their parents, so parents were not a suitable candidate for the Program. By opening the Program up to participants' other supports, particularly partners, some of the older participants may have been able to experience that connection and guidance in their home environment, "Being able to have my partner there would have made it more of an improvement like for me personally, you know, because she is pretty much my primary carer. She's the one I'm with all the time. I think if she had had a better understanding and had been able to attend and had a better understanding of what I was learning and stuff that would have been really beneficial". However, the participants did note that including a partner would need to be done on a case-by-case basis, "I definitely can understand how, like, you wouldn't want someone who I guess is more like transient in someone's life than a parent to be in the program because like you want them to get the same stuff out of it".

Individual therapy

For their individual therapy, which was one-to-one with an intern psychologist, participants thought it was a beneficial addition to the skills group sessions, "It was different to the group therapy. And I have someone one-on-one to talk to and express myself to". Individual sessions offered young people the ability to speak freely and openly about how they were feeling about the Program and life in general, "I really did like the individual therapy sessions, was a really good way to, like, get out of those feelings that I had that I couldn't share in group or just wasn't right to share in group. But I felt I could really communicate that across to [therapist] who was my individual therapist".

Individual sessions also allowed for an in-depth look at certain aspects going on in that person's life, "looking at specific things that happened during the week and going really in-depth into that and what happened before and doing a little timeline of things really help to understand why this situation happened, why I felt the way I did and stuff". This layer of personalisation also meant skills could be learnt on a more personal level. The young people could seek clarification and ask questions about certain skills, "It was also really good because if there was anything that we'd learned from the previous week that I wasn't sure about or needed clarification or I just didn't quite get it. Can you explain this more so that I could understand it properly". It also allowed the clinicians and the young person to work through the previous week and see where a skill could have been used and how it could have been beneficial, "Figuring out where I could have intervened before things get really bad. So, for next time it was a bit easier and I just could feel like the progress over the 14 weeks or whatever".

Working with intern psychologists

Many young people were not aware that the psychologists they were working with were provisional intern psychologists; they reflected that all of the clinicians were professional and caring, "honestly barely noticed. Yeah. Honestly, if you guys hadn't have told us, I don't think a lot of people would have even registered that they were in training. They acted very professional". Many thought that working with provisional psychologists was actually beneficial, "I'd say better than working with a proper psychologist, to be honest". Participants reflected that working with someone closer in age was a helpful part of the WOKE Program, "I think I liked how some of them, well, they're students, so they're a lot younger than like my psychologist I've seen before"; "One of the students who was younger, who had just like five years ago or something been in high school. So, kind of understood being a teenager nowadays, kind of of a thing. I liked, I liked it".

Young people also reflected that working alongside someone who was also still learning added to their experience, "They were good. It felt like we were learning all together, and it wasn't, it was a very accepting space, I feel, because it wasn't a way above you the way they teach you things. Like obviously they know more than us and are teaching us. But it felt like we were all sort of going through the journey together".

Although the majority of participants had a good experience working with the provisional psychologists, three young people noted that at times the provisional psychologists occasionally were not helpful. One participant reflected that their psychologist got caught up in risk assessments and it kind of derailed the session, "It was like immediately she would think that I'm like going to commit suicide or something, and it just got kind of frustrating, I guess, in a sense". The other two reflected that sometimes the provisional psychologists could not always read the room or the mood and this made sharing tough information more difficult, "She was always really, really happy and like, I don't know how she did it to be honest, always really happy. I just find that a little bit mentally draining … I just didn't feel comfortable totally opening up about some stuff".

Outcomes

Young people all reported that their overall mental health significantly improved, "I am now much happier than I was before"; "it's kind of helped me to find kind of hope, in a sense". The improvement in mental health was related to three key factors: increase in skill awareness and use, improved mood, and improved relationships.

Participants acknowledged that the WOKE Program taught them an array of skills and coping strategies beyond what they already knew, "it's definitely given me more capability and tools and made me sit back and think with things a little bit more". The young people noted that not only have they learnt new skills or ways of applying them, but also that they continued to use the skills after the Program, "I learnt a lot of skills and they've stayed with me". Participants gained a level of mastery and independence over their skills and associated impact on mental wellbeing, "It made me feel good to know that I didn't have to rely on someone, or my mum was the person who had to look after me, I could. I had skills to be able to look after myself where if I was at school, I wouldn't have to call my mum anymore and be like, what do I do? I'm feeling like I want to hurt myself. I know what to do".

Some participants noted that there were times they may revert back to "old" coping styles, "ah, there's definitely still moments where I revert back to bad habits, but there's definitely far more times where I go to my self-sooth or my stop skills or I go outside and garden or read a book or, you know, just incorporate one of the many things I've listed in the books or just other ways I've found to calm myself. But again, it's just about repetition". Use of ongoing resources to prompt them as a reminder was important, particularly the WOKE work book or their family member reminding them was enough to steer them back towards effective coping strategies learnt through the Program, "I'm trying to look over the booklet a bit more and you know, just keep those skills fresh in my mind, like before the school day, I'll just like look through it and see what stands out to me and see what I can use and it's pretty good".

Through the use of skills and better emotional awareness, young people noticed an improvement in their mood and ability to regulate their moods, "definitely more stable moods and I can recognise my emotions, which helps to not push them away. But generally, I just feel a lot happier within myself and I feel in control". Specifically, the young people recalled that their ability to manage and regulate intense emotions has improved, "my crisis moments, I have big ups and downs and it's really helped me control those, so they're not as intense"; "I can actually calm myself down a lot quicker than I used to. Because when I used to get angry, I used to stay angry for like a week and the tiniest things would annoy me. Now the tiniest things don't annoy me".

In terms of their relationships with others, young people also noticed changes, although the magnitude of these varied. When reflecting on their relationships, many young people noted that understanding their own self-value and setting boundaries within relationships was important, "I have learnt my worth and I know the difference between a good friend and a bad friend". Along with establishing personal boundaries, the young people also reflected on their ability to draw on their interpersonal skills to communicate more effectively in tough situations, "I've gotten a lot better communicating what's going on for me and what I need. And also like just taking a step back if we are getting in an argument or we disagree on something or whatever. I don't really understand what's going on. Like just taking a step back and using the interpersonal skills to be, okay, what's going on? And try and speaking fairly and impartially and stuff". Their increased interpersonal skills also assisted the young people to control their actions and reactions to remain calm and in a wise mind during difficult interactions, "like with my parents and stuff like that, I'm able to see their side a bit more instead of just being like, ahh you suck, I'm just going to go".

An important aspect was improvement in their ability to achieve goals and make progress in their lives, "Every single goal that I had set with [therapist], I have pretty much achieved … I had some trouble with substances and I'm completely off the stuff now, which is really good. That's like, just everything. And like, seriously, everything that I set out for myself to do I'm doing, to the best of my ability I'm doing".

"I'M GRATEFUL THAT THIS WAS GIVEN TO ME BECAUSE IT REALLY CHANGED MY LIFE"

(YOUNG PERSON)

As a result of the WOKE Program, participants saw major changes in their behaviours, actions and relationships. Overall, they took a lot away from the Program, "I am a different person. Hundred percent. I can manage them, my emotions so much better. Like ridiculously better. I'm able to control myself now, which is such a big deal because I was really not coping before. I used to be so scared of everything and a terrified, scared, angry girl. And I didn't want to live like that anymore. And I'm grateful that this was given to me because it really changed my life".

Improvements

The majority of participants found the WOKE Program to be very beneficial to their mental health and life in general, "this program is keeping young people alive and like allowing kids to live good lives and not have debilitating mental health issues and to take control of their life. I just can't say how good it's been, and I just valued it so much".

There were, however, three participants for whom the experience was not particularly enjoyable. One participant felt like the Program did not meet their expectations and that they did not learn anything new from it, "I just felt like I spent so much time learning things that I wouldn't find helpful and not enough time actually getting help for my problems that I had like in the moment". This young person was not eager to refer other young people to the Program. The other two participants acknowledged that the WOKE Program was not the best fit for them at the time. Both participants could see value in the Program and felt it would work well for other young people experiencing mental health problems. Both these participants would recommend the WOKE Program to other young people but would consider who they recommended it to.

Other valuable feedback from the young people was about the length of the Program. Some participants felt the Program could have been extended to allow more time for learning and practicing the skills, "If anything, I wish it was longer. I know the students and their school term. But, yeah, I take a while to process, so I'm re-learning it now at home". It was also mentioned that once the Program ends it just ends, and that although support and referrals back to other mental health professionals are discussed and organised, a longer step-down program approach would reduce the "abrupt" ending of the Program.

Summary

Almost all the young people enjoyed the WOKE Program very much. They felt they achieved large gains in their ability to regulate their moods, achieve goals, and have better relationships as a result of the Program and would continue to make progress with the skills they had learnt. Young people generally found the group program daunting to start with, but in the end thought the ability to share and hear from others was one of the most valuable components. The individual therapy sessions enabled them to engage with the skills and group sessions better by being able to personalise their experiences with their therapist. They liked working with the intern psychologists and appreciated the safe and supportive space of the Program. Thirty of the 31 young people who were interviewed said that they would or already had recommended the Program to other young people. They expressed a strong desire to see the WOKE Program as a permanent mental health service in the ACT, "please recommend this, and to more people, and get more funding for this, and I really hope it becomes a more known group and avenue. I really hope that it blows up and becomes a very well-funded program because it will change a lot of people's lives".

Family experiences

A key objective of the WOKE project was to engage family members in the Program to give them the skills to support their young person. There were 33 family members who participated in an interview; a response rate of 60.0% of the 55 family members involved in the Program. The interview participants were mostly mothers (including one step-mother) (n=24) with a mean age of 49.14 years (SD=6.62). There were eight fathers and one grandfather who gave interviews (mean age of 51.56 years, SD=10.90).

How they found out about the program

Family members generally heard about the Program through the mental health workers that their young people were seeing. As the Program progressed, increasingly parents found out about the Program through recommendations from other parents or young people who had undertaken the Program.

Prior experiences of support

Most of the parents reported major challenges finding appropriate support and treatment for their young person prior to accessing the WOKE Program. Some parents had quite extensive experience with other services, which they had generally found unhelpful, "she had experiences with [other service] and with other psychologists. She just got sick of doing risk assessments … She was over it. They really weren't making a difference for her".

Other parents had tried to seek help, but experienced long waiting lists, "we've been on a waitlist for a psychiatrist … since May last year". If they did manage to see someone, they felt they were circulated among professionals without seeing any change in their young person's situation, "like there was nobody who would help us navigate in a way, that's how it felt". Parents were often feeling "a little bit desperate", and that they were "at my wits end". Many parents were very frustrated that there were insufficient resources available in Canberra for young people experiencing BPD-type symptoms, "we've been trying for three years to get onto a program".

Initial expectations and fears

Expectations of the Program were varied; some parents did not know what to expect at all, "I had no idea really", while others had quite a lot of experience with mental health services and were somewhat familiar with DBT and had an idea of what the Program might comprise, although these parents were a minority.

An important aspect of the Program was the initial meeting with the WOKE Clinical Team, who explained the commitment required and Program expectations. This was perceived to be done very well, with "things explained clearly in the beginning", allowing them to go into the Program "with eyes open".

The aspect of most concern regarding the Program was the group sessions, "I was initially apprehensive and I think she was too, apprehensive about the group therapy and about, you know, seeing other people and other parents and having to speak in front of them"; "Lee[1] was very anxious about the first group to start with, didn't really want to do it".

Some parents were also concerned about how whether their young person would open up in group sessions, especially with them present. Many parents commented on their young person being very "closed", "my experience of her is being very closed, you know, not participating, saying no to everything. So she was really, really open and she even did role plays and read things out loud".

All parents expressed a very high level of need for the Program, "I was probably at my wits end". Self-harm was a particular concern, "She was struggling a lot with mental health issues. Big, big emotions … also had been self-harming, and that was escalating". They were all hopeful for some skills to improve family relationships and how they got along with their young person, "have a bit more kindness instead of us all snapping at each other all the time".

1 Pseudonym used.

Access and convenience

Most parents found access at the University of Canberra site very convenient. None had problems with physical access to the Program. Many liked that it was on a University campus, which made it a "pleasant", "easy", "non-stigmatising" place to go.

In contrast, the level of commitment was a challenge to some extent for all parents. Many parents were able to use flexible work arrangements to participate without too much trouble, "I had a really supportive workplace … if I was in my old job I would have found it inaccessible"; "I took a day off work and my husband worked from home"; and felt "lucky" for being able to work flexibly to be able to participate. Some acknowledged that the time commitment from work made the Program inaccessible for some parents, "My partner, he's small business, so it was not a goer for him".

Parents saw it as important to prioritise treatment for their child, acknowledging the commitment involved in attending the Program. This often meant that attendance at the Program was prioritised over work, "we both left work to attend, but we were able to make it work. I mean, kids are a priority". This prioritisation led to work being busier, "leading up to the day and fitting everything in was busy. But we prioritised it as a family", sometimes requiring a "fairly big rearrangement" of the day. Participation in the Program was a substantial commitment for family members.

Program delivery experience

All the parents had a very positive experience of the Program, "I loved it. Absolutely loved it. And it was, you know, in a pretty dark phase of our lives. You know, it was the highlight of the week"; "The overall experience was very positive, extremely positive".

A critical aspect was that parents felt "welcome" and "included for a change". Parents had not experienced this previously, and it was a strong point of contrast with prior help-seeking experiences, "we as parents were also involved and welcomed in it. Whereas before, and I never, not never, with the previous situation we've been in I didn't feel welcomed at all. I think I felt criticised for what we're doing at home or something rather than being helped with. Here it was like, okay, we'll help you to make things better at home as well".

Being able to share openly in a non-judgemental space was highly valued, "there was a trust and just an underlying trust that what we, what we say, what we do, no one is going to be judged for it and we won't talk about it outside the group, so, yeah, I really I felt like I could trust them one hundred and fifty percent".

Hearing other parents and young people's perspectives led parents to feel supported rather than being "alone as a parent". Some found that normalising the feelings they all shared "demonstrates that we're all in it together and we all have these experiences and for the young ones, it's kind of, at least in my head it's a, look your parents feel this kind of thing too". Most parents found sharing openly in the group to be very beneficial, although for a couple of parents this was sometimes seen as over-sharing. Overwhelmingly, however, parents found sharing their common parenting experiences reassuring and supportive and "having other people in the same situation that you can, who would both support you and you could offer support to them … That was probably the absolute best part of it". This led some of the parents to form friendships lasting beyond the end of the Program.

Having their feelings around their difficult parenting journey validated was the first time many parents felt understood and supported. This was reflected in parents feeling "looked for the first time ever in that whole journey. We were looked after properly … And in a really warm, welcoming way. Very professional". This enabled them to feel ready and able to work to learn how to apply the skills to their young person, "We have to understand what she's being taught so that we can help reinforce that at home". Altogether, the Program led parents to feel supported to parent their child and have a safe and secure base from which to parent, "It was brilliant, and it was really, it was very transparent. It was really warm. It was friendly. It was professional. It was it felt like for the first time somebody was holding us as a family. That's how it felt basically. It was for all of us in that way".

Program participants were warned that the Program may be confronting, and some participants found some aspects quite challenging, "it has brought up a lot more emotions than what we thought it would have". Others "had to leave the room once or twice, and just find a corner to have a good cry. I certainly don't think I was the only parent who did that, because, you know, there's a lot of stuff that you're confronted with and dealing with"; "There were times when, you know, the group sessions were a little bit daunting, but that's a kind of get over yourself". Parents recognised this was a difficult process to go through, but that it was worth it as it achieved a good outcome, "a program that's powerful enough to cause a breakdown you need to have and then also provide the tools to deal with it. So that's, for me that's the perfect sort of perfect program". This process built parents' capacity for resilience and increased that capability at the end of the Program, contributing to their wellbeing.

It was evident from many of the interview transcripts that sometimes both parents were involved in the Program to some extent and that this had particular benefits, "I thought it was fantastic. … that kind of surprised me a little bit is what we actually took from it. It changed the way both [father] and I function as parents in terms of the roles we took". Many parents noted the value of having both parents involved, "if it was just one parent going, it probably would have really improved the relationship with that one parent and the other one would probably would have been out in the cold a little bit" and "I kind of wish my husband could have come as well, her stepdad. Because I think he really would have benefited as well".

Most parents found that the homework was a challenge, "The homework was hard, like I'm not going to lie. There were weeks where I was like, I just haven't looked at it. Yeah, try and try and catch up. Do what you can, all those sort of things. But actually, doing the homework was hard"; "it was really hard to practice". It was difficult for parents to fit the homework into their already busy schedules.

At times, the amount of content was overwhelming, "Sometimes it was like I do this skill, this skill, that skill. We have got to get through so many skills today, because we only had a certain amount of time"; "we might have only picked up 10 or 15 percent of what we were taught, but that's probably normal. But what we, what we kind of what resonated with us, is still in use".

Although some parents noted that they already had some of the skills being taught, the Program made them more aware of them, which helped them to engage the skills more often, "good reinforcement of things I knew, but also a reminder of things that I know but don't use enough". Many parents, however, learnt skills that did not have and that were a challenge for them, "the validation skill for example, it's not something that I found very easy to do. Like most people, you just want to fix the problem, like let's, forget about how you're feeling, let's just fix". Other parents noted that they were made more aware of their typical unhelpful approaches, "like 'harden up son and try get on with life, it is what you make it.' But I don't verbalise that anymore and I'm more cognisant of the fact that I have to understand where he's coming from … I think the course … helped me, even if it was only to make me be more self-reflective and stop being a numpty sometimes".

The skills that parents identified as being the most useful included communication, validation, and radical acceptance. The value of the Program regarding communication was around interpersonal effectiveness. Many participants expressed that one of the most useful skills they learnt for parenting was the interpersonal effectiveness skill 'DEAR MAN GIVE FAST', "knowing what the goal is in the interpersonal skills, you know, getting what you want, or is it self-respect, or is it maintaining your relationships, or is it all three". This was the skill many parents said they often referred to with their young person when helping them problem-solve a difficult situation, "she was having trouble with her neighbour, and I said to her 'oh you know what are you going to do' and she said 'oh I will write a DEAR MAN'".

Challenges for online-only Program

Not surprisingly, the parents in the online-only Program missed the group dynamics and in-person connection, and noted this as being needed, although they realised this was not possible under the COVID restrictions, "The whole COVID thing completely screwed it around with it being online … I was sort of looking forward to that, and just being able to talk to other parents and carers, or just hearing what they said in those situations. And it's partly to get that self-reassurance that I did do it right or all those thoughts are normal".

Family members highlighted that although it was more comfortable to watch the videos in their lounge room and at a time of their choosing, the loss of the connection with other people experiencing similar challenges was a negative experience of the course being online. It was thought that having the opportunity to hear from other parents about their challenges might have helped them "feel less alone". Additionally, some family members struggled to see the relevance of the skills to their situation but thought this may have been different if watching in-person with other parents and being able to discuss skills interactively, hearing how they might be applicable for other people. Family members expected that if the course had been able to be in-person, the connections would have been "hugely powerful" in overcoming their isolation and thinking that their own problems were so "big", "unique", and "overwhelming".

Parents in the online Program also noted the impact of the lack of personal connection for their young person, "I think it would have been really useful for her to do the in-person workshop thing, to see other kids in similar sorts of situations. I think that would have been a huge benefit for her. She would never, ever, ever admit that".

As is frequently found to be the case for online programs, motivation was a bigger struggle for participants in the online-only Program, "It was much harder for him to find the motivation to watch the videos and interact with them, because it's so easy to say, I'll do it later"; "When it's online videos it's easier to just let it pass, it's less in your face".

Nevertheless, the online content had value; it was particularly helpful to enable family members to watch the videos at times that suited them, and repeat sections of relevance, even after the end of the course to remind them of the skills.

Special mention of the WOKE Clinical Team

The excellence of the clinical staff and intern psychologists delivering the Program was often specifically commented on by parents:

- "They were just fabulous. They were easy to work with. They were engaging, absolutely passionate. It was wonderful."
- "They were all great, they were really articulate and just managed to explain the concepts very clearly, very well. They had different presentation styles obviously, but they were very engaging, they weren't just standing up lecturing to a room, they were actually engaging the room."
- "I just think they all deserve a medal. I think they're doing a fabulous job, they just put so much into it, so much effort, so much enthusiasm. And they get it right 99 percent of the time, just so impressed with the level of skill and understanding and patience and everything. As I said, I just feel so privileged and blessed to have been able to do the program last year. They deserve a medal."
- "The people running the program did such a great job of creating such a warm and welcoming and safe environment for people to deal with their stuff without judgment, you know, and ah, it's just so nice to be actually in a space like that. Like, that's such a rare thing."
- "All the facilitators of the group therapy were fantastic. Yeah. I honestly can't fault it."

Outcomes for parenting

All parents reported that the Program had positive outcomes for their parenting, "a lot easier to deal with". The Program specifically helped parents to transition to a more appropriate parenting style for an emerging adult, rather than treating their young person as a child. This was especially relevant to not trying to "control" and "fix" all the problems in their young person's life, "I can't fix everything for her. As a mum, I guess we like to do that for our kids because that's what we tend to do when they're … when they become teenagers, they need to start fixing their own problems". Parents reported that learning to validate their young person's emotions was challenging, "you just want to fix the problem, like let's forget about how you're feeling, let's just fix it". They came to realise the costs of a lack of validation, "probably part of her difficulty with expressing how she's feeling is because we just want to fix things for her".

Parents reduced their use of power and authority, and now understood their role as "negotiation". This transition appeared to be connected with a recognition that parenting an emerging adult means no longer having the responsibility to solve problems for their child, but instead having the ability to step back and let the young person make their own choices, "I know that I don't have to solve the problem, she has to solve the problem", and even the recognition that parents may need to step back in order for the young person to step up and take responsibility, "this is her journey. We can be there and love her and support her whenever we can, but we can't do it for her. She has to do it for herself".

The Program changed the relationship that the parents had with their young person, bringing them closer together. From losing confidence in their parental role during their child's transition to adulthood, parents were able to see that their young person still needed them, "she said no, no I want you there. I was like oh, okay, so she wants me there, she needs me there. I thought I was just kind of peripheral". They also learned that setting boundaries assertively allowed you to "stand your ground and build boundaries in your life and they don't have to actually come across as you being rude or nasty". This sense of being able to set boundaries assertively contrasted with setting them aggressively, or not setting them at all, and was recognised as an important step to "feel more confident as a parent".

Developing a common language through learning skills with their young person helped many parents feel empowered to parent an emerging adult. The common language served several different roles: it "opens up our communication a little bit more"; provided a bridge when issues arose as "we're able to use the tools from the program to work through those issues"; and acting as a cipher, "it's like you see these signals now but you know what they're for".

Parents noted that they were now making deliberate or planned choices in how to respond to a situation rather than emotionally reacting in the moment. It had stopped parents from "overreacting to any situation", made them "a lot calmer, a lot more thoughtful in I don't just jump in now", and allows them to "be able to name it instead of just kind of making it up or, you know, reacting or whatever I might normally do". They were also able to approach situations more confidently and intentionally, "when I want to get something out of a conversation with her that I'm thinking before - what do I want to get out of it? How do I approach her? When do I approach her?".

Outcomes for their young person

All parents observed positive outcomes for their young person, "the WOKE Program made such a phenomenal difference for her, even when she was resisting it and didn't want to be there". A particularly significant impact was reduced self-harm which was a really major and very welcome outcome for many parents, "the most obvious kind of level then there was self-harm multiple times a day when they were starting. And it's now very occasional is the most kind of painfully obvious. There was very, very consistent talk of suicide before the program; now very rare".

Some outcomes were noticed by other people. For example, one parent reported "I got an email from her teacher today saying what a different kid she looks like. She's healthier, happier, smiling".

Parents were often very pleasantly surprised by how their young person responded to the Program, "I was really impressed at how much she embraced it. My experience of her is being very closed, not participating, saying no to everything …. now I tell her how impressed we were … she is really chuffed. And that is probably the biggest thing"; "like she didn't want to go, she hated it, she was resisting it. She didn't want to deal with stuff. She didn't want to talk about some things. … So as much as she resisted a large part of the program, it still made a huge difference to her. And in the end, you know, she didn't want it to finish. So, yeah, it's pretty amazing".

Some outcomes for the young person were quite life-changing for the parents and the young people, "I don't feel so worried about leaving them alone in the house together. There was a spell where I was really, really worried that I couldn't not be in the house in case an argument over some absolutely piddly little thing blew up, whereas I don't feel like that anymore"; "You know, they couldn't think about a future at all before. Now we're talking about, OK, what subjects can you pick for college that might be useful for what you then might want to do afterwards? Go to university. What might you want to study? What are you thinking of doing?".

There were some longer-term positives from the group approach also, with a couple of parents noticing, "she's actually in contact with quite a lot of the girls, they all formed like a Snapchat and they all touch base with each other on a regular basis".

Personal growth

Parents generally expressed surprise that they gained so much personally from the Program. This was an "unexpected part", as they assumed their young person would be the only beneficiary, "I thought it was just all about Kelly , but in the end it ended up being about me too". Parents experienced their own personal growth by developing a better understanding of themselves and their emotions. The recognition that their relationship with emotions, as developed during their own childhood, may not be what they need it to be in order to parent their own child was an area of personal growth. Skills of interpersonal effectiveness assisted parents to reflect on and develop their own assertiveness and ability to set boundaries.

Of particular note, parents found the skills useful with their other children. The found that they used the skills more and more often and that it improved their relationship and communication with their other children, and also with other family members: "my other daughter", "one of her older brothers", and "my own mother". Some participants found the skills helpful to use with former partners, "I've used quite a few skills dealing with my ex husband", and one participant shared that he had used a number of skills with his own father in response to "feeling invalidated".

Parents reported that they had applied the skills in other contexts that benefited them, "I didn't realise that it would benefit me, to be honest, when we first started. I thought I was just going there to support Sally[2], maybe learn some things to help her, but it's like I've been saying, like, it's been amazing, like me learning those skills and I can actually apply them anywhere". It was common for parents to mention using the new skills in the workplace, "in a work context. I think more like…something's getting too much…I take a break"; "even with this at school, in my classroom, I used to just do belly breathing and mindfulness colouring and now we do a lot more different things".

2 Pseudonym used.

Would recommend

Every parent responded that they would recommend the Program to others, and many had already done so, "I already have. I've got a friend at school who has some teenagers and is a bit of self-harming amongst all but one of them. Her and her husband have been struggling with accessing services". There was strong advocacy for the Program evident, "the program needs to be well resourced, better advertised, like there are a lot of families out there that need, need this sort of thing and know it's available".

Suggested improvements

Most parents, when first asked, said they had no changes to suggest for the Program. On further reflection, several recommended the need to extend the Program, as it comprised a lot of content and it was challenging to adequately get through it all, "while it's already a big commitment, I do think it's not long enough to get, there's not enough time to go through the depth of material that is there". There was also need for follow-up after the Program, "the only negative for her was they didn't provide really solid plans for follow-up even once this lovely support stopped - like where to from there?". Many parents felt their young person still needed psychological support after the Program, and many did not have this in place. As the Program became more established, potential sources of ongoing support were able to be sourced for parents.

Another suggestion related to the timing of the sessions, where it was recommended that they be scheduled later in the day, at the end of the work day, which would be much less disruptive to work and school commitments, "I was concerned about how much school she was missing, if she was able to catch up with that or that would add extra pressure".

A couple of parents noted, "I was surprised that it was mostly girls, there was only one boy there. And I think it could benefit from having a few more boys, especially for the boy to have others". It was recognised, however, "that it's probably geared towards girls who are expressing their emotions in that way and they're more likely to self-harm and all those sorts of things".

Some parents were unaware at the start about the option for parent sessions, "the one-on-one sessions for us the parents, like I kind of didn't realise that they were there as an option at first, or how they would work or anything like that. So, potentially like front loading those a little bit more".

Overall, however, there were very few changes recommended for the Program, and while parents found some of the aspects challenging, they agreed it was all necessary and that the Program was very well designed, "I actually thought the way it was structured and the way it was delivered was actually very, very good".

Summary

All the parents interviewed were strongly supportive of the Program, and many used superlatives to describe their experience. The clinical staff in particular were singled out for their positive and professional approach. Parents greatly valued that they were included in their young person's treatment, and were welcomed and valued, which was a stark contrast to previous experiences. The group format and ability to share with and learn from other parents and young people was critical, as were the skills learned and working alongside their young person. The impact of the online-only Program (Program 2), necessitated by COVID-19 restrictions, was noted to be affected by the unfortunate lack of in-person and group communication.

Parents were often surprised at how their young person engaged with the Program and the unexpected outcomes achieved, including significant reductions in self-harm. The Program influenced the transition of their parenting role from parenting a child to parenting an emerging adult, and this improved their relationship with their young person. This change occurred via three main routes: first, changes in parents' understanding and behaviour around power and authority in parenting; second, the development of skills such as negotiation, validation, and radical acceptance; and third, the support found from being around others in a similar position. Many aspects of the Program were challenging, particularly the group work, time commitment and homework practice; all parents noted the high level of commitment but felt that this effort was definitely worthwhile. Parents saw major changes in their own behaviour and in their young person's ability to regulate their behaviour. The skills they learned generalised to be able to be used with other family members and at work. All parents would or had already referred other families to the Program. Few improvements were suggested, with these mainly being about the need for ongoing connection and support, and timing that fit better with work and school commitments.

Intern clinicians' experiences

A key objective of the WOKE project was to train and upskill the mental health workforce to be able to work effectively with young people with BPD characteristics. These young people are a client group that many clinicians do not feel confident working with, partly due to their level of risk because of self-harming behaviour, and also the perception that they are difficult to work with. Consequently, the WOKE Program focused on the training and supervision of final year Master of Clinical Psychology students. It was anticipated that by training these students to work with this client group using a DBT approach that the Program would contribute to having graduate clinical psychologists with the confidence and skills to work with such clients when they entered the mental health workforce.

Over the four implementations of the Program, 16 intern psychologists were trained by 2 fully qualified clinical psychologists and Dr Dean Buckmaster. After each Program, the interns and clinicians were invited to take part in an interview. Not all provided an interview after each Program, but only one intern did not provide an interview at all. Overall, there were 19 interviews conducted; 17 of the interviews were with females and two with males. The mean age of the interview participants was 34.84 (SD=7.94): interns 32.29 (SD=7.73) and clinical supervisors 42.00 (SD=1.58). The following results focus predominantly on the intern Master of Clinical Psychology students' experience of their WOKE placement.

Expectations

When first commencing their WOKE placement, students were often apprehensive or concerned about working with young people experiencing symptoms of BPD, "It was a big step up from the population that we'd seen in the Psychology Clinic at the university". There was evidence of stigma or concerns associated with the client population, "I've heard they're the hardest clientele to work with. A lot of psychologists kind of avoid that presentation". Students went into their placement with the expectations that the clientele would be different, difficult, and at times challenging to work with and treat.

Students were excited to work with Dr Dean Buckmaster and the other clinical supervisors involved in the Program. Prior to this placement, students had only received a very brief introduction to the DBT framework through their other clinical studies, and they were keen to learn more, although apprehensive of working with a risky client group.

Ongoing training and support

The WOKE placement provided intensive training prior to and throughout each Program to support students' practice. When reflecting on their training experiences students noted, "there was a lot of knowledge passed on … we really did start from having no knowledge about DBT to sort of being able to run the program. So the training was very comprehensive". Many reflected that the people involved in delivering the Program really made a difference, by making the training environment enjoyable, supportive, and effective. Of special note was the way Dean, Emily and Alexi implemented the DBT framework into their workshops and supervision sessions, "we set out really early on that we would give feedback in a really nonjudgmental way. DBT helps that because it's all about, you know, we're all fallible. We all make mistakes. So, I think there's a bit of an openness there that was quite frank for the students who can only think, oh, I'm going to get in trouble or it's bad to make mistakes".

Students greatly valued the contribution and understanding of their supervisors, "their kind of approach and attitude towards us. But even though we were doing this kind of I guess like more advanced therapy, learning so many new things, being out of our depth, I don't ever think I felt bad because we had such a good attitude of us, our supervisors were like you've got this. Yeah, you can do it. Like you've got our support". Acknowledging they were fallible and still learning, students felt "encouraged to build on skills and challenge ourselves to try different skills and ways of working with clients that we may not have done before". Students' minds were open to new experiences, they were eager to get in and try new things as the Program went on and felt very supported in their learning.

Of significance to the interns was the fact that the WOKE placement offered varying types of supervision and support. The interns referred to three different forms of support in the Program: clinical supervision, consult group, and informal peer support—all of which were valuable and, together, provided a solid training and support base.

Students noted the key role clinical supervisors played in their ongoing skill development. For the duration of the Program each student got "at least 6 sessions of theory, really close supervision weekly and they get to have group supervision essentially weekly, and the clinical supervisors are pretty much on tap for their students". Students acknowledged the critical importance of the clinical supervision and noted that the availability and enthusiasm of their supervisor was something not frequently experienced on other placements, "The support that we got I never felt like I was on my own. I always felt like I was doing it with the support of this incredible team of practitioners who were always there to support me with everything"; "we could go to our supervisors at any time. They all made themselves available and they were there for us. They always would drop things to answer our questions. make sure there was a time". The ongoing supervision and training gave students the time, space, and confidence to ask questions and progress their learning.

Consult group is a crucial part of DBT and provides practitioners a space to discuss clients, issues, and ideas with other clinicians, as well as offer support to each other and boost motivation. Students felt consult group provided essential additional support and learning opportunities; they reported that the consult group "was really, really useful because it kind of helped us form a really cohesive, non-judgemental, supportive group that really carried out throughout the whole WOKE Program". The consult meetings allowed student to "bounce anything off consult. It was brilliant as well. It was really interesting to learn all about everybody else's issues and go aww yeah cool, not alone".

The informal peer supervision and support was also viewed as a beneficial aspect of the WOKE Program. Interns reflected that they "kind of formed a little group which we could chat about stuff and debrief", "when we went back to the group office it's like this warm hug of people that can come and look after you if you need it. If you have a million things going on, because that culture of helping each other and building each other up was deliberate and taught to us we all just helped each other and worked as a real team. And that was deliberately created and we kind of rolled with it, so it made a different work environment to anything I had been a part of before. I think it has added immensely to my training and my skill set".

The combined approach of individual, group, and peer support and supervision meant students had access to an abundance of information and support. The clinical supervisors were accessible at any time of need, particularly if there was something critical to deal with. Beyond time-critical situations, the interns noted the other avenues of support as crucial to their experience of the WOKE Program. Interns "knew that if we had something non-urgent or that might be important to other members of the team it wasn't a long wait for answers. So, if we had an area we felt like something was missing, it sort of only lasted for a week and then we could get all those questions answered so it was really responsive to what we needed as students while we were learning it all". Overall, interns reflected on the idea that "Being part of the team was really quite inspiring and has changed the way I guess I practiced psychology".

Skills and confidence to work with risky clients and families

Emerging from the training and support was the confidence the students felt in their clinical psychology skills to work with this client group and families. Students acknowledged that the WOKE placement was a vital contribution to their professional development. Numerous interns echoed that "these placements have been pivotal in a lot of the skills that I have learned that I do not know that I would have learnt elsewhere. And I am glad that I learnt them early in my career. I think that this would be a good placement because it is exposure to things that you might not get exposure to for years".

The most noteworthy contribution toward the interns' professional development was the identification and management of risk and risky clients. Interns reflected that "Being challenged while you have the support is an important part of the process of studying psychology. And I'm really grateful that I got to have these opportunities to work with this particular client group, which can be really challenging". The WOKE placement provided early exposure and allowed a gradual and supported approach towards risk management, "I think it's just it's really useful as a student to kind of learn that early on, so that you are not just kind of exposed to that when you're out in the professional world and you might not have as much support". The gradual approach provided by the WOKE placement "made me so much more comfortable working with people who are suicidal. It has made me understand and be able to validate those kinds of experiences a lot easier. It's just made me a lot more comfortable in having that conversation with people, and I think that reduces a lot of the stigma in terms of having those clients who are suicidal and self-harming".

This training and exposure affected the way students dealt with risky clients, "if I have got a client that has, you know, that reports self-harm or suicidal thoughts at a certain level, I deal with it in a less restrictive way. That is a better way to try. And I think whereas before I might kind of just go more restricted because I was still understanding risk a little bit, but still understanding, you know, the person's autonomy and you know, the implications of I guess, crisis plans and things like that. Oh, you know, working within a framework of keeping the client safe and stuff. But I think that is probably one of my biggest developments".

The other important aspect was working with families as well as young people, and working in both individual and group contexts, "That's something else that I like about this program, is that you do get to work with more families like the parents are really involved in it".

Overall, all interns left the WOKE placement reflecting that "risk isn't as scary as I first thought. And if you have the right tools and support, then. Yeah, it's a lot more approachable". Students clearly developed the knowledge, skills and confidence to work with this client group that they felt they would not have received otherwise in their clinical training, "I think it (the WOKE Program) has given me so much useful and effective knowledge to then go into the workforce as a new psychologist that I wouldn't have had if I hadn't done the DBT WOKE Program"; "It's just invaluable the skills you learn forever".

Summary

All the students very highly commended the Program, training, and clinical supervision. They were grateful to have such a valuable learning opportunity, and all agreed they had learned unique skills that enabled them to work effectively and confidently with young people at risk and with their families. They appreciated learning to work within both group and individual contexts. They also valued being involved in peer consult and support groups, which was a new experience for supporting their practice and learning new skills within a non-judgemental, highly supportive environment. All the interns were eager to refer future clients (if suitable) to the Program. They emphasised that the WOKE Program should become a permanent placement within the Master of Clinical Psychology course, with the majority saying it was the "best placement" they had and that all masters students should get the opportunity to complete a WOKE placement, "It was so rewarding. It was the best experience. It was by far the best placement over my whole degree. And it was just such a positive, massive learning experience".

Impact, Challenges and Future Directions

Impact

The WOKE Program achieved all of its objectives: it was implemented as planned (albeit with the caveat of the unexpected disruptions due to COVD-19); it attained very positive mental health and coping outcomes for young people; and was a valuable and enjoyable learning experience for young people, their parents, and the intern clinicians, whereby all types of participants learned critical skills.

WOKE has quickly achieved a place in the ACT as an accessible and successful early intervention Program for young people with emerging BPD and their families. With almost no active promotion, and knowledge of the Program occurring mostly through word-of-mouth, the Program has become sought after by service providers and young people and their families. This partly reflects the major service gap this Program fills and the high level of unmet need, as well as the excellent experience of participants in the Program who have recommended it to others.

Notably, service providers have acknowledged the value and benefits of the Program. For example, unsolicited communication from a local psychiatrist included:

> *I am writing to thank you for your invaluable early intervention program and to provide feedback from several clients who have attended over the past year. I have referred several young people to your service with every single client reporting a favourable experience. In some cases, they have gone as far to say it has "been life changing". The feedback I have received has referenced both your group and individual sessions as well as the option of including parents/carers in the process. I hope that any positive feedback you receive will provide further evidence of the ongoing need for this service which I know relies on the provision of ongoing funding. Many thanks again for your endeavor and for the support you have provided to many of my patients.*

The Clinical Team of Dr Dean Buckmaster and Emily McIntyre have established strong connections with mental health service providers and advocates in the ACT region, and awareness of the WOKE Program has grown. A strong referral base has been established, and resources have been developed to find pathways for young people who are not suitable for the Program.

The findings of this evaluation research provide convincing evidence of the positive impact of the Program and its value in terms of cost. Young people improved on all quantitative measures, and these improvements were maintained at three-month follow-up. Young people showed less distress, depression, suicidal ideation, borderline symptoms and dysfunctional coping, and improved positive coping strategies after the Program. The quantitative findings were strongly supported by young people's experiences provided through interviews after completion of the Program. They overwhelmingly found the Program to be a positive, albeit challenging, experience, and one from which they learned new skills that they were able to apply and that helped them to regulate their emotions and improve their relationships with other people. Their family members, mostly parents, reported similar positive impacts. Parents also had a positive Program experience and learned new ways to communicate with and support their young person, with skills generalising to other family members. Some young people and parents reported the Program to be "life changing".

Importantly, the Program trained 16 new clinical psychology graduates who are now confident and skilled in working with young people with borderline symptoms, including self-harm and suicidal ideation, as well as their families. These clinical psychologists enter the workforce with much-needed skills and the positive attitude required to work with this client group. They will be champions for working effectively with this previously neglected and 'too-hard' group of very vulnerable young people and their families.

Challenges and Limitations

The Program and this evaluation must be considered in light of the challenges and limitations. The most significant challenge was the advent of COVID-19, which created major uncertainty and prevented the implementation of Program 2 as originally planned. While the Clinical Team adapted the Program to run online, and did this very successfully, recruitment and assessment into the Program was disrupted and there were fewer clients and family members than expected. COVID-related restrictions also impacted the subsequent programs through uncertainty about scheduling.

The development of an online program and the online resources was an important innovation. The online Program still attained positive outcomes, albeit somewhat attenuated, and was generally well-received by young people and their parents. Participants acknowledged the impact of the lack of in-person communication and learning, and the difficulty maintaining motivation in an entirely online format. Nevertheless, the resources developed out of necessity are a valuable addition to the Program and further exploration of online components is warranted.

An important limitation to the evaluation research was that not all young people and parents participated in the interviews, and not all young people completed the three-month follow-up. It is possible this introduced bias, whereby those who felt more positive about the Program and who were in better mental health contributed to the evaluation results. However, the response rates were actually quite high, with about half the young people providing follow-up data and just under giving interviews and 60% of family members giving an interview.

The research is necessarily limited by its design. There was no control group, and it would be argued that this is likely to be unethical for such interventions, but changes over time in the quantitative measures cannot be attributed to the Program. That these changes were clearly seen to be due to participation in the Program by both young people and their parents, as reported in the interviews, gives considerable confidence in drawing positive conclusions about the impact and experience of the Program.

Future Directions

Sustainability of the Program is the main issue going forward. Determining funding to keep the Program running is an important goal, as the Program addresses a major need and service gap in the ACT mental health system. Maintaining the momentum of the Program and retaining clinical staff is essential to sustainability.

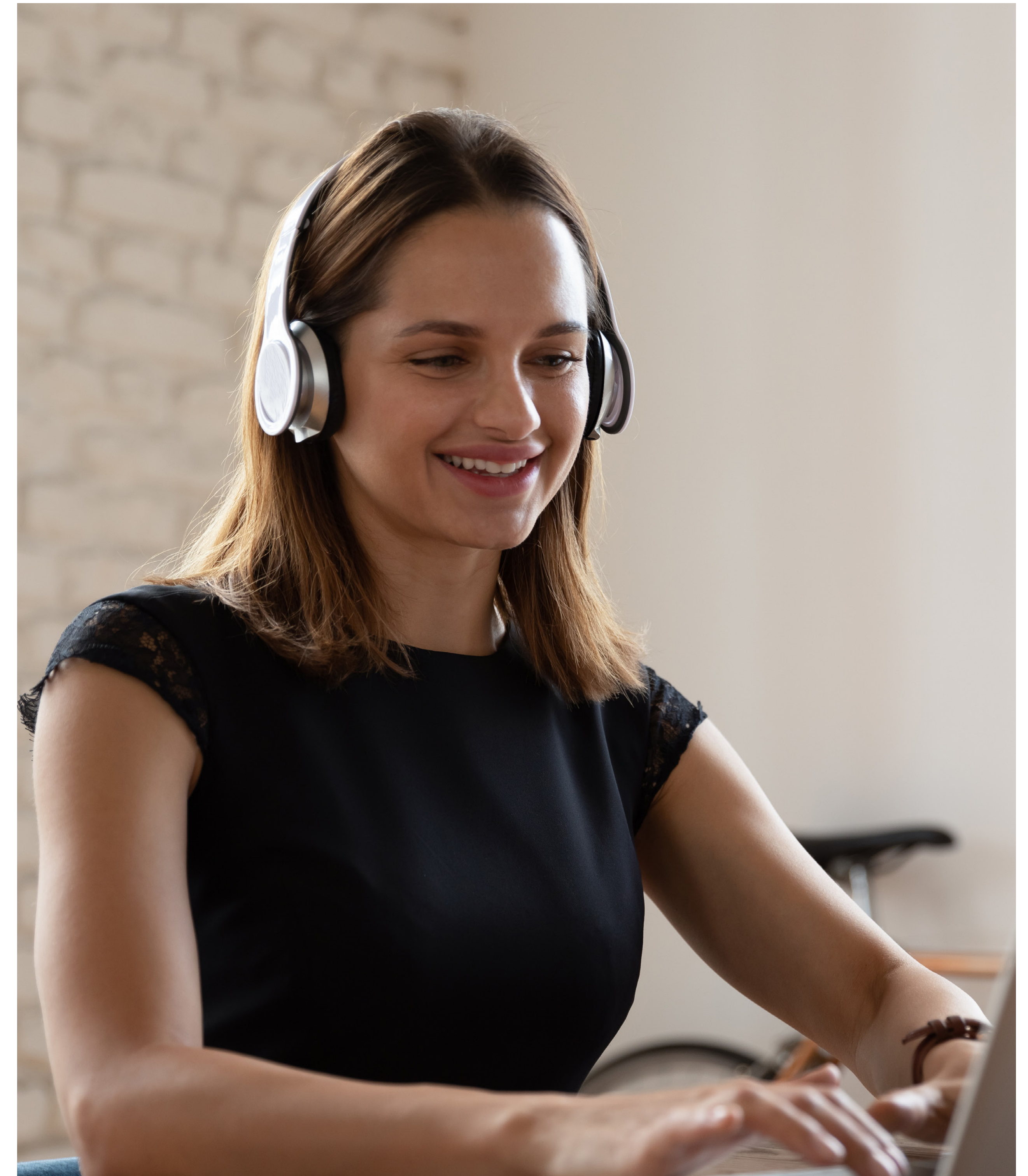
There is a need to consolidate the Program as a placement in the Master of Clinical Psychology course. This requires advanced planning due to the timing of course requirements. The substantial value-add of providing the Program as a placement for clinical psychology students is one of the WOKE Program's major strengths—making the Program very cost-effective and training the future clinical psychology workforce in much-needed skills.

To maximise the positive impact of the Program on the trajectory of clients, establishing a graduate group would enhance longer-term client outcomes. A graduate group is a less frequent group where suitable clients have access to ongoing coaching, practice, and peer support. Currently, the WOKE Team does not have the resources to provide a program for graduating clients, who are vulnerable to losing focus and drifting away from practicing the skills post program. Implementing a graduate group would provide ongoing opportunities for consolidation and further development of the skills, which was noted as important in the interviews by both young people and parents.

In addition to consolidating the current Program and establishing a graduate group, there are other opportunities for the WOKE Program to address service gaps in the ACT mental health system. Using an early intervention approach, opportunities exist to provide services for other vulnerable youth. These include an outreach program, a group-based drug and alcohol program, and further developing aspects of the parent program. Many young people are unable to attend traditional in-person and clinic-based programs due to circumstances beyond their control. An outreach program and further development of online resources and supports could be implemented to increase the reach of the Program for young people who otherwise would not be able to access effective treatment. Another neglected area requiring early intervention is for young people with alcohol and other drug problems. WOKE could be adapted to integrate DBT skills into a program targeting early intervention for these problems. Bolstering parents' skills by providing additional parent sessions would likely improve both parent and young person outcomes.

Further development of the online resources could augment the in-person programs as well as increase reach. Notably, Program 5 (which was not part of this evaluation) was required to go online-only for part of the Program when the ACT went into lockdown in the second half of 2021.

In conclusion, the high level of need for effective early intervention programs to improve the mental health of young people in the ACT, particularly young people at risk of BPD, is widely acknowledged, and the University of Canberra team that developed and evaluated the WOKE Program feel privileged to have been able to contribute to addressing this need.



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Appendix 1 Descriptive statistics for young people's scores on evaluation measures by timepoint for each Program

Table 6. Descriptive statistics for young people's scores on evaluation measures by timepoint for Program 1

Timepoint	Measure	n	Mean (SD)	Range [possible range]
Assessment	Psychological Distress - K10	18	33.39 (7.25)	20-44 [10-50]
	Beck Depression Inventory - BDI	18	20.60 (7.56)	7-33 [0-39]
	Borderline Symptoms List - BSL	17	2.17 (1.09)	0.33-3.70 [0-4]
	Life Problems Inventory - LPI	18	177.62 (42.17)	71-244 [60-300]
	Confusion about self		51.37 (13.29)	22-67 [15-75]
	Impulsivity scale		35.94 (12.87)	15-67 [15-75]
	Emotional dysregulation		45.33 (11.40)	17-61 [15-75]
	Interpersonal chaos		45.02 (12.24)	17-59 [15-75]
Pre program	Difficulties in Emotional Regulation Scale – DERS	16	67.19 (10.72)	45-83 [17-900
	Nonacceptance		10.71 (3.27)	4-15 [3-15]
	Goal-directed behaviour		12.88 (2.12)	9-15 [3-15]
	Impulse control		10.94 (3.51)	5-15 [3-15]
	Emotional awareness		8.58 (3.04)	3-14 [3-15]
	Emotion regulation		11.53 (2.67)	6-15 [3-15]
	Emotional clarity		11.53 (2.90)	6-15 [3-15]
	Suicide Ideation Scale - SIQ	17	81.82 (43.09)	16-144 [0-180]
	Ways of Coping Checklist – WCC	17		
	Skill use		1.38 (.45)	0.53-2.13 [0-3]
	Dysfunctional coping		2.31 (.45)	1.13-2.87 [0-3]
	Blame others		1.69 (.56)	0.00 -2.66 [0-3]
During program	Ways of Coping Checklist - WCC	17		
	Skill use		1.91 (.44)	0.97-2.97 [0-3]
	Dysfunctional coping		1.97 (.58)	0.67-2.80 [0-3]
	Blame others		1.09 (.46)	0.17-2.00 [0-3]
	Life Problems Inventory - LPI	17	165.53 (34.15)	91-236 [60-300]
	Confusion about self		48.18 (12.25)	27-70 [15-75]
	Impulsivity scale		34.00 (11.26)	19-60 [15-75]
	Emotional dysregulation		40.99 (9.80)	20-60 [15-75]
	Interpersonal chaos		42.35 (10.46)	21-65 [15-75]
	Difficulties in Emotional Regulation Scale – DERS	17	55.31 (12.93)	30-80 [18-90]
	Nonacceptance		10.00 (3.50)	3-15 [3-15]

Timepoint	Measure	n	Mean (SD)	Range [possible range]
	Goal-directed behaviour		11.24 (3.25)	6-15 [3-15]
	Impulse control		8.12 (3.85)	3-15 [3-15]
	Emotional awareness		7.81 (2.40)	3-13 [3-15]
	Emotion regulation		9.12 (3.22)	3-14 [3-15]
	Emotional clarity		8.06 (2.93)	3-14 [3-15]
Graduation	Psychological Distress - K10	17	26.18 (5.11)	17-37 [10-50]
	Beck Depression Inventory - BDI	17	11.24 (7.14)	3-31 [0-39]
	Borderline Symptoms List - BSL	17	1.23 (70)	0.22-3.13 [0-4]
	Suicide Ideation Scale - SIQ	17	45.35 (29.23)	11-113 [0-180]
	Life Problems Inventory - LPI	17	131.71 (32.19)	71-182 [60-300]
	Confusion about self		38.94 (11.96)	21-59 [15-75]
	Impulsivity scale		28.12 (7.52)	15-43 [15-75]
	Emotional dysregulation		32.53 (9.55)	17-53 [15-75]
	Interpersonal chaos		32.11 (10.44)	16-56 [15-75]
Follow-up	Psychological Distress - K10	6	28.33 (11.93)	15-45 [10-50]
	Beck Depression Inventory - BDI	6	10.85 (10.19)	0-24 [0-39]
	Ways of Coping Checklist - WCC	6		
	Skill use		1.74 (.31)	1.18-2.11 [0-3]
	Dysfunctional coping		1.76 (.89)	0.47-2.73 [0-3]
	Blame others		1.06 (.78)	0.17-2.00 [0-3]

Table 7. Descriptive statistics for young people's scores on evaluation measures by timepoint for Program 2

Timepoint	Measure	n	Mean (SD)	Range [possible range]
Assessment	Psychological Distress - K10	17	32.24 (8.02)	17-47 [10-50]
	Beck Depression Inventory - BDI	17	21.77 (8.10)	5-32 [0-39]
	Borderline Symptoms List - BSL	17	2.27 (0.83)	0.61-3.65 [0-4]
	Life Problems Inventory - LPI	17	195.96 (39.51)	139-266 [60-300]
	Confusion about self		54.00 (12.47)	33-71 [15-75]
	Impulsivity scale		42.62 (10.07)	27-65 [15-75]
	Emotional dysregulation		47.41 (11.47)	28 - 64 [15-75]
	Interpersonal chaos		50.05 (11.38)	33-69 [15-75]
Pre program	Difficulties in Emotional Regulation Scale – DERS	16	63.38 (10.98)	37-76 [18-90]
	Nonacceptance		10.13 (2.92)	5-15 [3-15]
	Goal-directed behaviour		13.38 (1.78)	10-15 [3-15]
	Impulse control		9.50 (3.78)	3-15 [3-15]
	Emotional awareness		8.50 (2.85)	4-13 [3-15]
	Emotion regulation		12.19 (2.26)	7-15 [3-15]
	Emotional clarity		10.63 (2.33)	7-15 [3-15]
	Suicide Ideation Scale - SIQ	16	61.67 (37.59)	10-139 [0-180]
	Ways of Coping Checklist – WCC	16		
	Skill use		1.37 (0.48)	1-2 [0-3]
	Dysfunctional coping		2.02 (0.53)	1-3 [0-3]
	Blame others		1.20 (0.54)	0-2 [0-3]
During program	Ways of Coping Checklist - WCC	17		
	Skill use		1.72 (0.41)	1-2 [0-3]
	Dysfunctional coping		2.08 (0.39)	1-3 [0-3]
	Blame others		1.34 (0.56)	0-2 [0-3]
	Life Problems Inventory - LPI	16	174.75 (42.50)	113-270 [60-300]
	Confusion about self		50.00 (12.52)	30-66 [15-75]
	Impulsivity scale		37.81 (11.83)	23-64 [15-75]
	Emotional dysregulation		41.38 (12.97)	24-73 [15-75]
	Interpersonal chaos		45.56 (10.15)	33-70 [15-75]
	Difficulties in Emotional Regulation Scale – DERS	17	58.35 (13.50)	34-84 [18-90]
	Nonacceptance		9.41 (3.22)	4-15 [3-15]
	Goal-directed behaviour		12.18 (2.79)	7-15 [3-15]
	Impulse control		9.41 (3.22)	4-15 [3-15]
	Emotional awareness		8.35 (3.16)	3-14 [3-15]
	Emotion regulation		10.59 (2.72)	5-14 [3-15]
	Emotional clarity		9.59 (3.18)	5-15 [3-15]
Graduation	Psychological Distress - K10	17	30.47 (6.23)	15-37 [10-50]
	Beck Depression Inventory - BDI	17	15.65 (6.45)	2-24 [0-39]
	Borderline Symptoms List - BSL	17	1.69 (0.91)	0-3 [0-4]
	Suicide Ideation Scale - SIQ	17	56.76 (36.38)	4-126 [0-180]
	Life Problems Inventory - LPI	17	161.76 (48.77)	81-275 [60-300]
	Confusion about self		45.18 (13.53)	22-67 [15-75]
	Impulsivity scale		35.00 (13.54)	16-65 [15-75]
	Emotional dysregulation		38.59 (3.42)	21-73 [15-75]
	Interpersonal chaos		43.00 (12.50)	17-70 [15-75]
Follow-up	Psychological Distress - K10	10	24.30 (7.45)	15-39 [10-50]
	Beck Depression Inventory - BDI	10	8.86 (7.07)	0-22 [0-39]
	Ways of Coping Checklist - WCC	10		
	Skill use		1.84 (0.25)	1.30-2.16 [0-3]
	Dysfunctional coping		1.72 (0.49)	1.13-2.60 [0-3]
	Blame others		1.09 (0.43)	0.33-1.60 [0-3]

Table 8. Descriptive statistics for young people's scores on evaluation measures by timepoint for Program 3

Timepoint	Measure	n	Mean (SD)	Range [possible range]
Assessment	Psychological Distress - K10	22	36.14 (6.30)	24-47 [10-50]
	Beck Depression Inventory - BDI	22	22.95 (6.23)	11-32 [0-39]
	Borderline Symptoms List - BSL	22	2.37 (0.86)	0.48-3.43 [0-4]
	Life Problems Inventory - LPI		195.92 (43.25)	115–251 [60-300]
	Confusion about self		55.75 (10.94)	37-70 [15-75]
	Impulsivity scale		41.53 (10.66)	24-63 [15-75]
	Emotional dysregulation		51.35 (13.26)	26-70 [15-75]
	Interpersonal chaos		48.25 (13.58)	25-68 [15-75]
Pre program	Difficulties in Emotional Regulation Scale – DERS	22	70.05 (7.06)	53-81 [18-90]
	Nonacceptance		11.82 (2.26)	8-14 [3-15]
	Goal-directed behaviour		14.00 (1.27)	10-15 [3-15]
	Impulse control		11.41 (2.67)	7-15 [3-15]
	Emotional awareness		8.64 (2.79)	4-15 [3-15]
	Emotion regulation		13.09 (1.69)	10-15 [3-15]
	Emotional clarity		11.45 (2.50)	5-15 [3-15]
	Suicide Ideation Scale - SIQ	21	98.11 (42.48)	5-174 [0-180]
	Ways of Coping Checklist – WCC	22		
	Skill use		1.48 (0.42)	0.82-2.18 [0-3]
	Dysfunctional coping		2.41 (0.33)	1.93-2.85 [0-3]
	Blame others		1.65 (0.74)	0-3 [0-3]
During program	Ways of Coping Checklist - WCC	19		
	Skill use		1.94 (0.46)	1.03-2.71 [0-3]
	Dysfunctional coping		1.90 (0.63)	0.40-2.93 [0-3]
	Blame others		1.37 (0.75)	0.00-2.83 [0-3]
	Life Problems Inventory - LPI	18	170.00 (56.30)	75-283 [60-300]
	Confusion about self		46.70 (16.05)	20-75 [15-75]
	Impulsivity scale		37.78 (14.73)	20-69 [15-75]
	Emotional dysregulation		42.74 (16.68)	16-72 [15-75]
	Interpersonal chaos		39.91 (13.35)	19-72 [15-75]
	Difficulties in Emotional Regulation Scale – DERS	19	48.89 (68.00)	29-73 [18-90]
	Nonacceptance		8.11 (3.00)	5-14 [3-15]
	Goal-directed behaviour		10.84 (3.76)	5-14 [3-15]
	Impulse control		7.47 (3.27)	3-14 [3-15]
	Emotional awareness		6.26 (2.73)	3-12 [3-15]
	Emotion regulation		8.84 (3.30)	4-15 [3-15]
	Emotional clarity		7.74 (2.51)	5-14 [3-15]
Graduation	Psychological Distress - K10	21	25.57 (7.78)	12-41 [10-50]
	Beck Depression Inventory - BDI	21	12.48 (7.78)	0-31 [0-39]
	Borderline Symptoms List - BSL	21	1.68 (1.05)	0.13-3.30 [0-4]
	Suicide Ideation Scale - SIQ	20	54.05 (38.78)	0-143 [0-180]
	Life Problems Inventory - LPI	20	156.34 (60.09)	64-260 [60-300]
	Confusion about self		42.72 (16.27)	16-71 [15-75]
	Impulsivity scale		34.61 (12.47)	16-67 [15-75]
	Emotional dysregulation		37.76 (17.58)	15-73 [15-75]
	Interpersonal chaos		38.62 (17.02)	16-71 [15-75]
Follow-up	Psychological Distress - K10	12	24.42 (6.39)	15-36 [10-50]
	Beck Depression Inventory - BDI	10	9.73 (8.99)	0-27 [0-39]
	Ways of Coping Checklist - WCC	10		
	Skill use		1.94 (0.48)	1.21-2.84 [0-3]
	Dysfunctional coping		1.42 (0.91)	0.00-2.67 [0-3]
	Blame others		0.93 (0.71)	0.00-2.17 [0-3]

Table 9. Descriptive statistics for young people's scores on evaluation measures by timepoint for Program 4

Timepoint	Measure	n	Mean (SD)	Range [possible range]
Assessment	Psychological Distress - K10	12	33.33 (5.66)	21-44 [10-50]
	Beck Depression Inventory - BDI	12	22.17 (6.83)	6-33 [0-39]
	Borderline Symptoms List - BSL	12	2.44 (0.89)	0.43-3.30 [0-4]
	Life Problems Inventory - LPI	12	296.92 (43.80)	131-276 [60-300]
	Confusion about self		57.72 (40.32)	41-75 [15-75]
	Impulsivity scale		41.08 (9.33)	25-60 [15-75]
	Emotional dysregulation		44.58 (14.30)	25-73 [15-75]
	Interpersonal chaos		53.83 (14.24)	34-75 [15-75]
Pre program	Difficulties in Emotional Regulation Scale – DERS	12	66.75 (8.99)	53-85 [18-90]
	Nonacceptance		11.00 (3.28)	6-15 [3-15]
	Goal-directed behaviour		13.50 (2.28)	8-15 [3-15]
	Impulse control		11.83 (2.76)	6-15 [3-15]
	Emotional awareness		7.33 (2.84)	3-12 [3-15]
	Emotion regulation		12.67 (1.56)	10-15 [3-15]
	Emotional clarity		10.92 (2.57)	7-15 [3-15]
	Suicide Ideation Scale - SIQ	12	82.42 (41.64)	27-155 [0-180]
	Ways of Coping Checklist – WCC	12		
	Skill use		1.59 (0.40)	0.84-2.37 [0-3]
	Dysfunctional coping		2.35 (0.32)	1.93-2.93 [0-3]
	Blame others		1.67 (0.87)	0.33-3.00 [0-3]
During program	Ways of Coping Checklist - WCC	12		
	Skill use		1.99 (0.40)	1.42-2.68 [0-3]
	Dysfunctional coping		2.15 (0.47)	1.27-3.00 [0-3]
	Blame others		1.44 (0.83)	0.33-1.83 [0-3]
	Life Problems Inventory - LPI	12	173.42 (36.60)	121-233 [60-300]
	Confusion about self		50.17 (13.41)	28-67 [15-75]
	Impulsivity scale		36.89 (7.55)	24-49 [15-75]
	Emotional dysregulation		38.75 (10.25)	16-64 [15-75]
	Interpersonal chaos		47.67 (12.87)	33-72 [15-75]
	Difficulties in Emotional Regulation Scale – DERS	12	53.17 (11.02)	35-74 [18-90]
	Nonacceptance		9.08 (2.87)	5-13 [3-15]
	Goal-directed behaviour		11.58 (2.94)	6-15 [3-15]
	Impulse control		7.67 (3.17)	3-14 [3-15]
	Emotional awareness		7.08 (2.64)	3-12 [3-15]
	Emotion regulation		9.33 (2.74)	5-15 [3-15]
	Emotional clarity		9.00 (3.46)	3-14 [3-15]
Graduation	Psychological Distress - K10	12	26.83 (7.37)	15-43 [10-50]
	Beck Depression Inventory - BDI	12	13.42 (8.60)	1-27 [0-39]
	Borderline Symptoms List - BSL	12	1.66 (1.08)	0.04-3.57 [0-4]
	Suicide Ideation Scale - SIQ	12	58.00 (46.19)	0-157 [0-180]
	Life Problems Inventory - LPI	12	163.83 (64.26)	65-263 [60-300]
	Confusion about self		47.67 (20.31)	15-71 [15-75]
	Impulsivity scale		36.33 (13.26)	19-63 [15-75]
	Emotional dysregulation		35.33 (15.33)	16-64 [15-75]
	Interpersonal chaos		44.50 (18.61)	15-69 [15-75]
Follow-up	Psychological Distress - K10	6	32.17 (3.25)	26-35[10-50]
	Beck Depression Inventory - BDI	6	17.67 (8.04)	5-28 [0-39]
	Ways of Coping Checklist - WCC	6		
	Skill use		1.64 (0.22)	1.39-1.97 [0-3]
	Dysfunctional coping		2.02 (0.27)	1.53-2.33 [0-3]
	Blame others		0.94 (0.40)	0.33-1.50 [0-3]

Appendix 2 Figures for dysfunction in emotion regulation (DERS) sub-scales

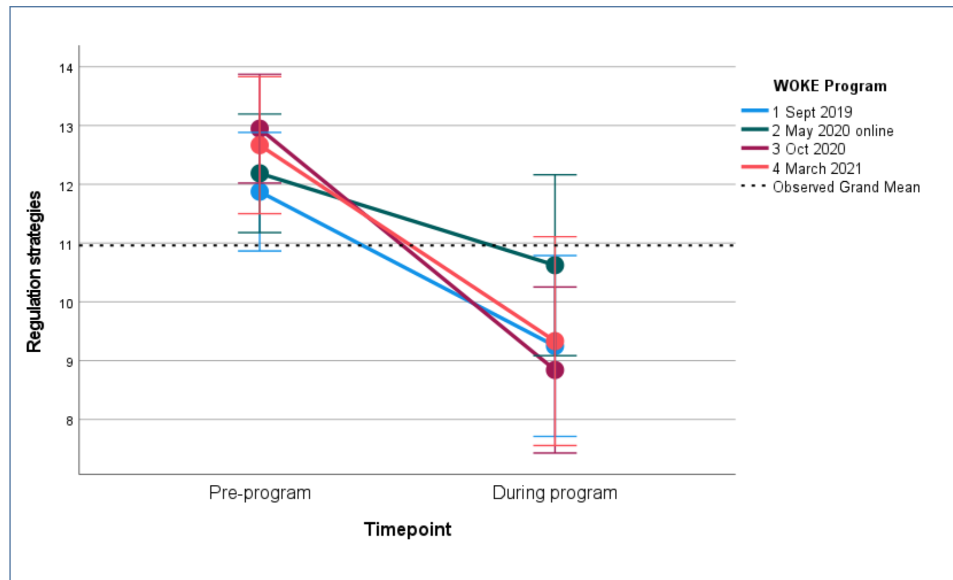

Figure 15 Limited access to emotion regulation strategies by timepoint and Program

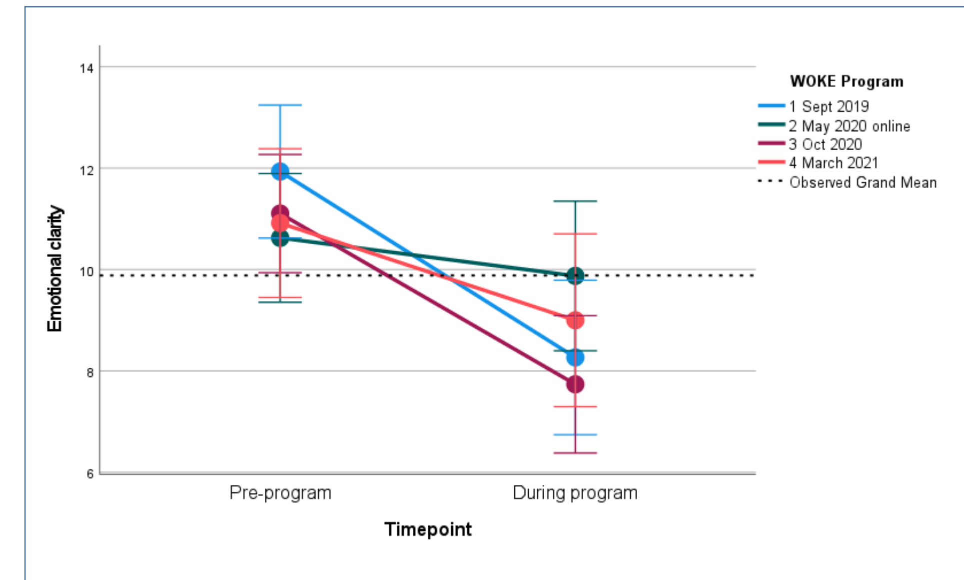

Figure 17 Lack of emotional clarity by timepoint and Program

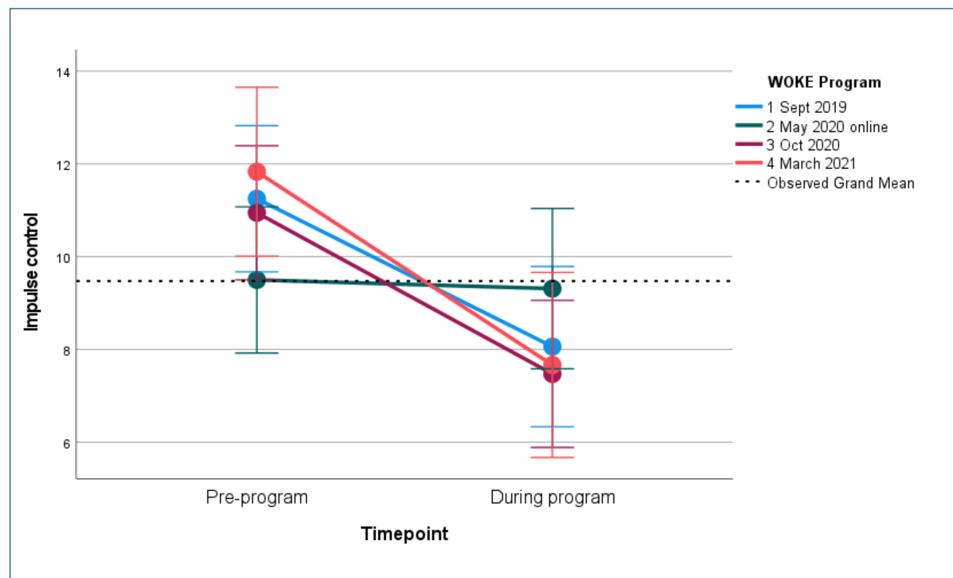

Figure 16 Impulse control difficulties by timepoint and Program

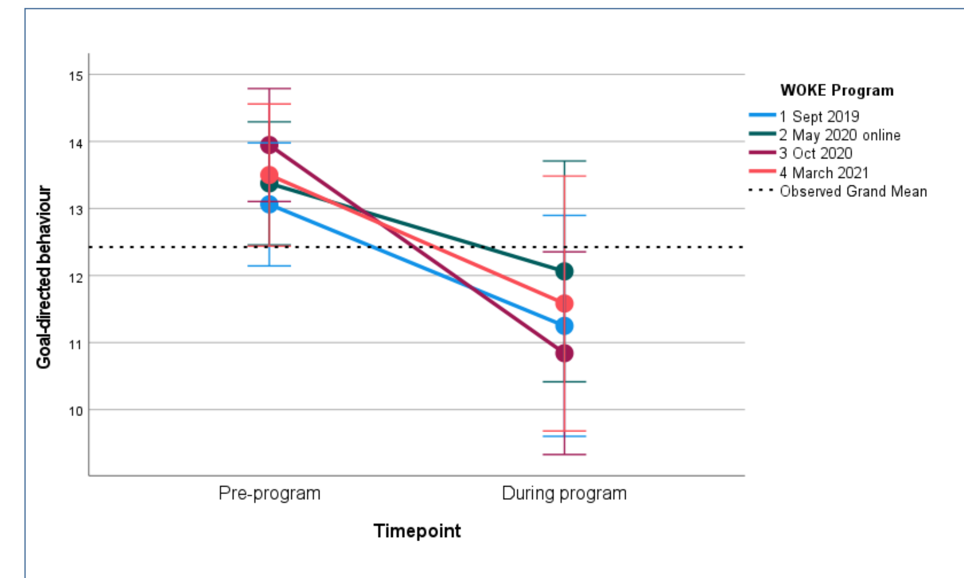

Figure 18 Difficulties engaging in goal-directed behaviour by timepoint and Program

Appendix 3 Figures for life problems inventory (LPI) sub-scales

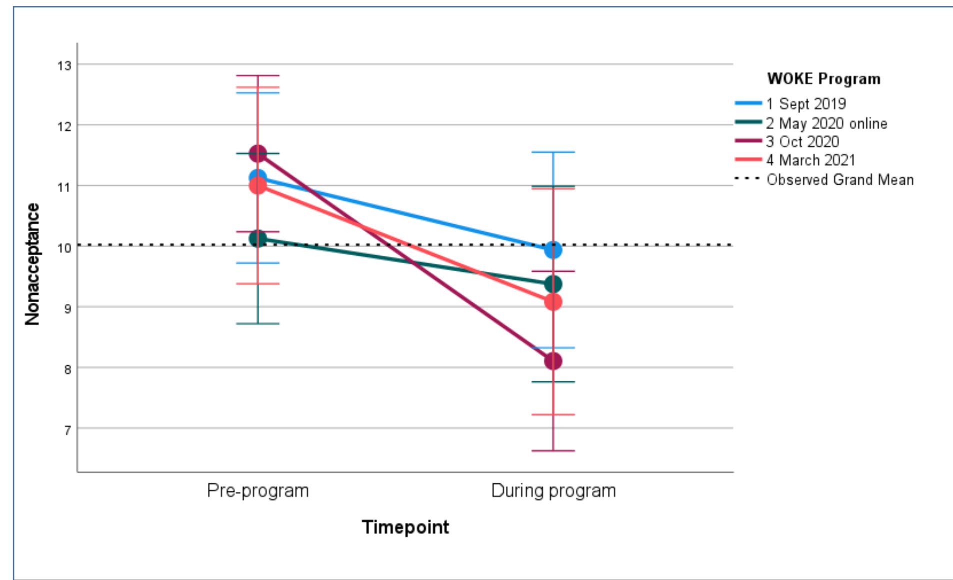

Figure 19 **Nonacceptance of emotional responses by timepoint and Program**

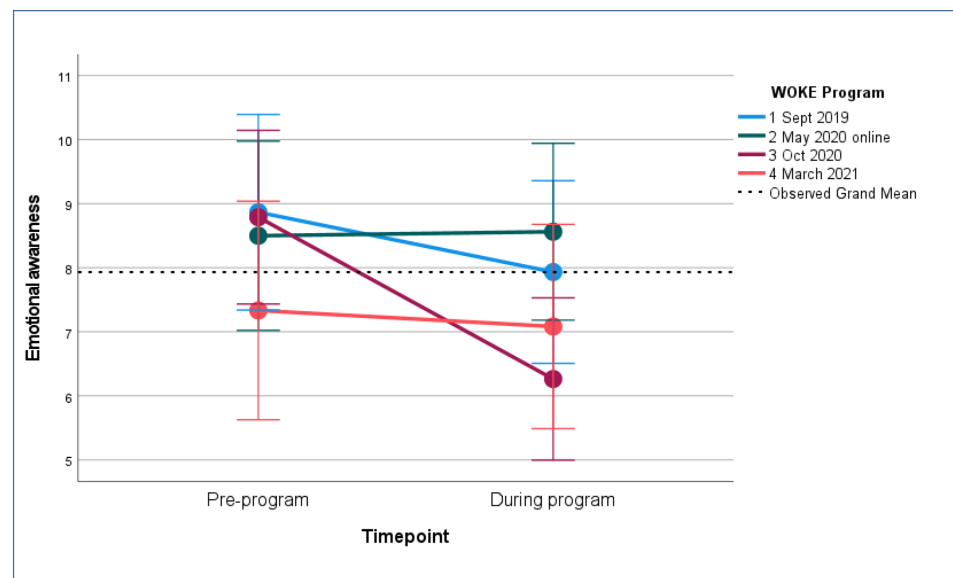

Figure 20 **Lack of emotional awareness by timepoint and Program**

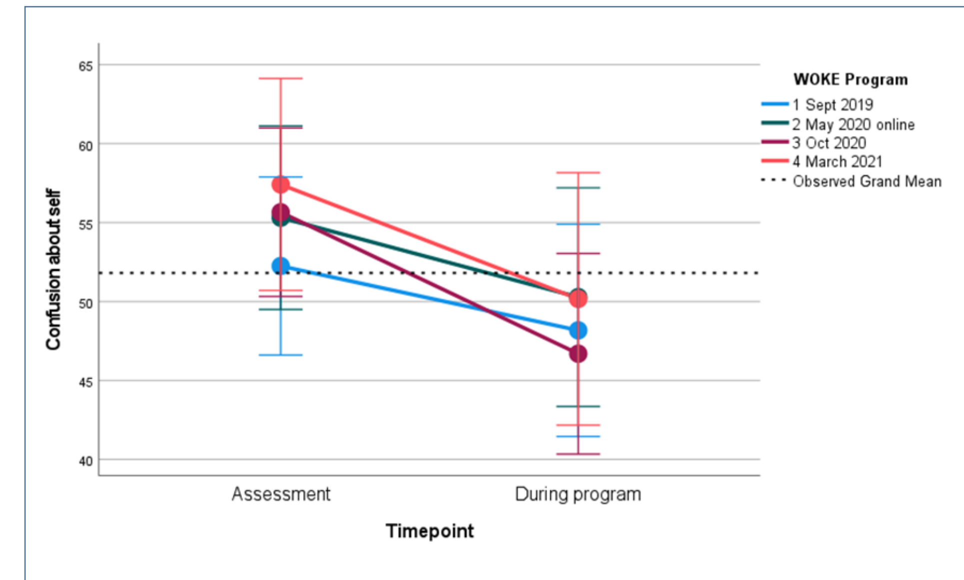

Figure 21 **Confusion about self by timepoint and Program**

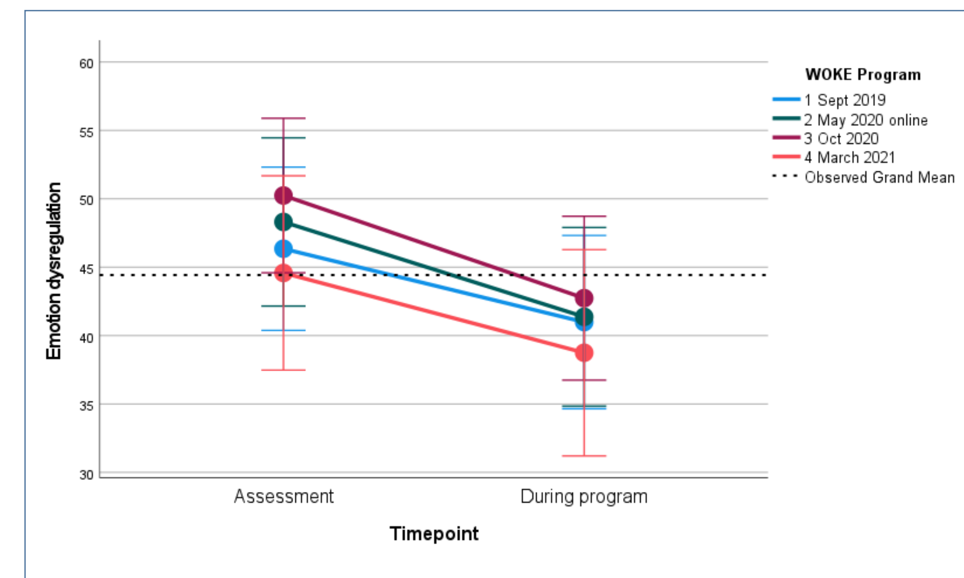

Figure 22 **Emotion dysregulation by timepoint and Program**

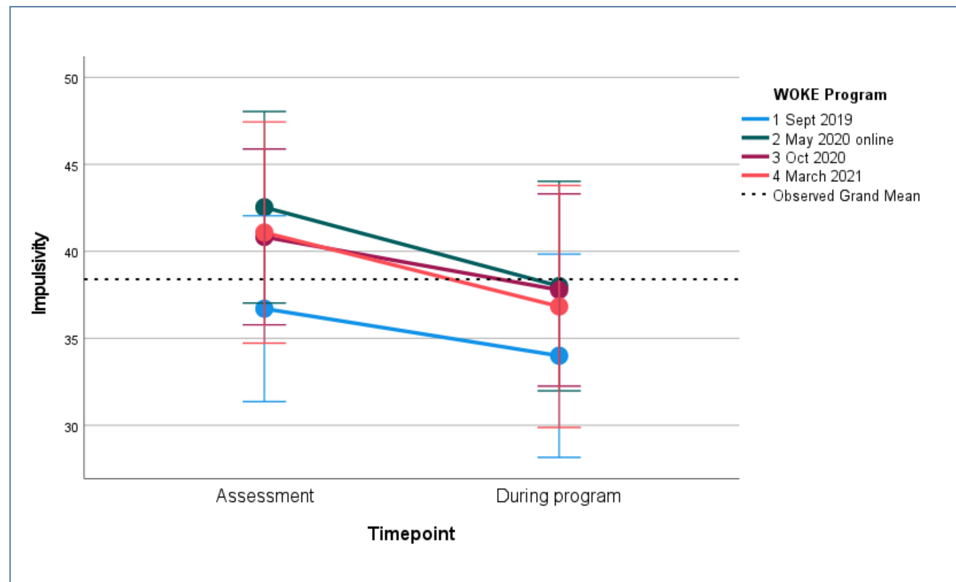

Figure 23 **Impulsivity by timepoint and Program**

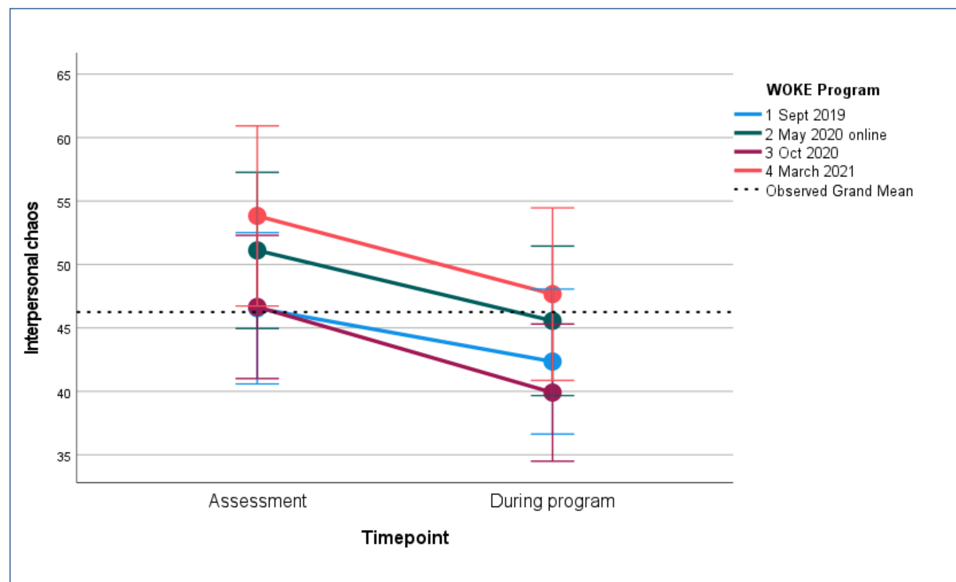

Figure 24 **Interpersonal chaos by timepoint and Program**

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