CAMHS and Schools Early Action Program

health

Program Description

Key message

The CAMHS and Schools Early Action (CASEA) program is an early intervention program that aims to prevent the development of severe behavioural disturbance, such as, conduct disorder, in young children. Conduct disorder is a serious behavioural disorder that can impede the social, emotional and educational development of a child.

The CASEA program is based in schools and involves targeting young children, their parents and teachers in learning new ways of relating and dealing with daily challenges.

Purpose

The purpose of this document is to provide a program description to inform the development and delivery of school-based early intervention programs for young children with challenging and difficult behaviours and/or emerging conduct disorder.

Background

Challenging behaviours and conduct disorder

Prevalence

Antisocial behaviours in primary aged children are fairly common and often are developmentally normal. However, when antisocial behaviours significantly interfere with a child's academic, social and/or emotional development the child may be at risk of developing conduct disorder.

In 2000, a national survey examined child and adolescent mental health (Sawyer et al, 2000) and found that 14% or 500,000 children and adolescents in Australia have significant mental health problems, with rates in children the same or higher than rates in adolescents. More specifically it identified that delinquent behaviour (7%), attention problems (6.1%) and aggression (5.2%) are major mental health problems of Australian children (Sawyer, M.G. 2000).

Information collected by the former Mental Health Branch (now the Mental Health, Drugs and Regions Division) in 2001 indicated that 17% of clients attending child and adolescent specialist mental health services (CAMHS) had conduct disorder with approximately half of these also having co-morbid emotional disturbance.

Diagnosis

Three percent of children meet diagnostic criteria for conduct disorder – the most severe behavioural disorder in childhood and adolescence. “The essential feature of conduct disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated” (DSM IV 1994).

There are four main groupings of these behaviours:

- Conduct that is aggressive and threatens or causes harm to others, people or animals
- Conduct that is not aggressive and causes damage or loss to property
- Deceitfulness or theft
- Serious violations of rules.

Sanders, M.R. (2000) characterises conduct disorder by at least three of the following: pervasive and extreme anger, physical aggression, blaming others, destruction of property, lying, stealing, defiance, running away, cruelty to animals and other antisocial acts.

Conduct disorder is a disorder of social and psychological development, caused by interactions between biological, psychological and social factors. These may include socio-economic disadvantage, difficult temperament, early aggression, inconsistent and coercive parenting, attention and learning difficulties and poor problem-solving skills (Sanders, M.R. 2000; Hill, J 2002).

Conduct disorder is a serious problem in young people. It causes significant stress, not only to the young person who is a sufferer, but also to the family/carers, school and peers, and can eventually take its toll on the community. It is a disorder that is often not diagnosed until later childhood/early adolescence but signs of emerging conduct disorder can be identified at an early age. Unfortunately, children at risk of developing conduct disorder are often seen as wayward and naughty rather than as struggling with a disorder that needs identification and intervention.

Early Intervention

Early intervention appears to be an important characteristic of programs known to be most effective in treating conduct disorders (Durlack JA, 1998 pp512-520). Data from well-controlled studies indicate that the optimal management of conduct problems in children needs to be based on an early intervention strategy, which emphasises the role of parent-child interaction factors in the development of conduct disorders. There is growing evidence that suggests added benefits when child-focussed and school-focussed interventions are included (Sanders, M.R. 2000).

Kenneth Dodge, in 2002, delivered a paper entitled ‘Preventing Chronic Violence in Schools’ to a United States White House conference. In it, he raised concern about chronically violent and delinquent adolescents and their cost to society, estimated at US $1.3million per criminal. Longitudinal studies indicate that high-risk children can be identified by the time they complete kindergarten and that chronic violence develops over a lifetime, depending on life experiences. Contributing factors may include harsh parenting styles, a lack of parental supervision, a history of abuse, and social and learning difficulties. Dodge piloted an early intervention program that produced positive results; the implementation of a universal program ‘Fast Track’ that delivered group training for children, parents and teachers with coaching, remedial education and home visits to support the changes. Dodge argued that if such a program cost US$40,000/child to deliver then there would be significant economic benefit if just 3 % of the children were saved from careers of crime.

Zubrick et al (2005) evaluated the effectiveness of a universal group behavioural intervention program (Triple P) in preventing behaviour problems in children. The intervention program was associated with significant reductions in parent-reported levels of dysfunctional parenting and parent-reported levels of child behaviour problems. Positive and significant effects were also observed in parent mental health, marital adjustment, and levels of child rearing conflict.

Evidence based interventions

A number of psychosocial strategies have been adopted in treating children with conduct disorders. AusEinet (Sanders, MR 2000) reviewed the literature to determine the most successful of these interventions. Only selecting treatments on the strength of the available evidence from empirical research examining their efficacy, three main intervention modalities were highlighted:

a. Child-focussed interventions - interventions designed to improve children's capacity to regulate their behaviour.

Several randomised controlled trials of the cognitive-behavioural models of intervention have been conducted which support the dominance of Cognitive Behaviour Therapy (CBT) approaches in producing therapeutic change. Evidence indicates that these approaches reduce behaviour problems, notably aggressive behaviour and increase pro-social behaviour (Sanders, MR 2000).

It is worth noting that while there is increasing evidence to support the use of stimulant medication for children with ADHD who have co-morbid conduct problem behaviour, "…there is no direct controlled evidence that psycho-stimulants confer a therapeutic benefit for children selected with a primary diagnosis of conduct disorder" (Sanders, M.R. 2000 p65).

b. Family/carers and/or Parenting interventions - interventions designed to improve parenting skills and relationships.

A number of well-controlled trials have been conducted, evaluating the effectiveness of family/carers interventions for pre-school and primary aged children who are viewed to be at risk for developing later conduct and emotional problems. Many of these interventions focus on improving parenting and enhancing the child's social and cognitive development. According to the AusEinet findings, in the most successful early intervention programs for conduct problems, parent training forms a central focus for the intervention (Sanders, MR 2000).

c. School-based interventions – interventions designed to improve classroom and playground behaviour at school.

School based interventions have been identified as a key component in the effective treatment of conduct disorders for school-aged children. These include teacher skill development, class wide interventions, curriculum-based interventions, individually tailored interventions, child focussed interventions, environmental interventions and multi-component interventions (see Sander, M.R. 2000 for further details of each component). There is growing evidence attesting to the effectiveness of a broad range of school-based interventions for improving the behaviour and academic achievements of children with conduct disorders. There is also good evidence for the effectiveness of child-focussed interventions (out of class, group-based) that provide social problem solving skills training to high-risk children.

Thus, the treatment of conduct disorder ideally includes interventions delivered at multiple levels, that is, interventions for the student, parents and school community. When this is delivered in an early intervention model it is best located in the early years of school, as this ensures increased accessibility and hopefully, if the program is accepted and normalized within the school curriculum, it will reduce the stigma of severe behavioural problems. The *CAMHS & Schools Early Action Program* (CASEA) adopts this multi-level intervention model and encourages services to form clear protocols for referral, service delivery and consultation.

Service responses

A range of services are already in place to assist in the early identification of conduct disorders. Young children with challenging behaviours can be identified early on by a range of primary care and early years services including general practitioners, maternal and child health nurses and suitably trained child care and pre-school staff. If they have not been detected earlier, problems usually occur upon school entry.

Primary schools are well placed as sites for early identification and intervention. Currently there are approximately 1250 government primary schools in Victoria. These schools are organised regionally into school networks that also incorporate a number of secondary and special schools. When children

present with co-morbidity of behavioural and emotional symptoms, often within a complex family system, they may be referred to general practitioners, paediatricians or specialist Child and Adolescent Mental Health Services (CAMHS) if a more comprehensive assessment is required. An individual management and treatment plan would then be developed to provide the child and their parents with timely and appropriate intervention.

Primary School Nursing

The primary school nursing program provides a confidential health service to children and their families linking them to local services for specialist help or support. School nurses are also able to provide information and advice on issues relating to health and development.

All parents in Victoria are offered the opportunity for their child to have a health and wellbeing assessment on prep entry through the School Entrant Health Questionnaire (SEHQ). The questionnaire provides parents/guardians with the opportunity to raise any concerns they may have about their child's health and development or wellbeing with the school nurse. The SEHQ includes parents' assessment of their child's development through the PEDS and from 2010 includes the Strengths and Difficulties questions. Nurses respond to the parents/guardians concerns, through follow-up and referral if required to an appropriate health professional.

Primary Welfare Officers

The Primary Welfare Officer program provides support to schools where the student population faces educational disadvantage. Primary Welfare Officers coordinate the school's wellbeing team; organise and deliver (frequently alongside classroom teachers) primary prevention and early intervention programs targeting life skills, attendance, engagement and transition from both pre-school to Prep and Year 6 to secondary school; provide early intervention support for groups of at-risk children; and coordinate external program providers and welfare support in the school.

Student Support Services

Student Support Services staff provide services across all Victorian government schools to support children and young people with additional learning or wellbeing needs or at risk of disengagement, and to strengthen the capacity of schools to engage all students in education. Student Support Services staff comprise psychologists, guidance officers, speech pathologists, social workers, visiting teachers, and other related professionals. The work of Student Support Services assists children and young people facing a range of barriers to learning to achieve their educational and developmental potential through the provision of specialised support at an individual, group, school, network and regional level. Catholic and independent schools are also eligible for this early intervention service. DEECD Regions are responsible to ensure quality assurance, accountability, professional supervision and collegiate support in student support services.

School Chaplaincy Program

School chaplains assist a number of Victorian schools and their communities to support the wellbeing of students, including providing guidance about ethics, values, relationships, spirituality and religion, as well as pastoral care and community building.

Service development specifications

The CAMHS & Schools: Early Action Programs (CAESA) reflects the international trend to address problems early to minimise distress and the negative impacts of behavioural problems and disorders on the lives of children and their families. These service developments provide an opportunity for CAMHS to work with their local schools to provide timely and evidence-based interventions for young children, their parents and teachers, that can address current issues with behaviour management, prevent any deterioration of behaviour in vulnerable students and promote health and well-being.

Two three-year pilot projects began operation in 2004. Initial findings are positive. The successes and challenges from these pilots have informed the model of care for the Early Action Programs more broadly. These pilot project teams, now recurrently funded, have developed resources and have extensive experience that is invaluable to the newer programs.

Evaluation findings

The CASEA program began in 2004 with two three-year pilots. Initial evaluations from these pilot projects were positive and the successes and challenges of these pilots have informed the model of care for CAMHS and Schools Early Action Programs more broadly. The program has shown positive results in identifying and intervening in conduct disorders early in primary school aged children.

Established CASEA programs in Bendigo and Austin CAMHS are being evaluated in partnership with the University of Melbourne and Mindful- Centre for Training and Research in Developmental Health. The 3 year evaluation uses a randomised control trial methodology to evaluate the impact of the CASEA program. Schools with a CASEA program and schools on the CASEA program wait list are evaluated at two intervals to measure changes in student behaviour; the schools with a CASEA program being evaluated pre and post CASEA intervention. Preliminary results in 2009 suggested that the CASEA program has had a positive impact on reducing conduct disorders.

Additionally, Eastern Health CAMHS, in partnership with Deakin University and DEECD, undertook a longitudinal study of its CASEA program in 2007-08. The evaluation took place over 23 months to measure the outcomes for children who completed the CASEA program. Longitudinal domains such as overall difficulties, conduct problems, psychosocial impairment and social skills, as reported by parents and teachers, were utilised. Findings from the study indicated significant post-treatment gains made by children in each domain were sustained at follow up. The evaluation provides support for the effectiveness of multi-modal early intervention programs, such as CASEA, for the treatment of childhood conduct disorders.

Aim of the initiative

The aim of this initiative is to reduce the prevalence of conduct disorder in children by delivering sustainable evidence-based interventions in the early years of school and within the school setting.

The target population

The target population for the initiative is young children displaying challenging or difficult behaviours and/or have conduct disorder in Prep to Grade 3 in mainstream primary schools within the CAMHS catchment area. This may include students with disabilities who are integrated into mainstream schooling.

Program resourcing

Since 2004, there has been a gradual roll-out of 2 new programs in most years. Metropolitan programs have been funded for five Effective Full Time (EFT) positions and rural programs for 3 EFT positions. Further program development will depend on funding availability.

Program management

The CASEA program becomes an integral part of the CAMHS service in which it is funded. Appropriate arrangements for the management of the program and clinical supervision and accountability need to be determined but clearly rest with the CAMHS. Clinical accountability should follow the normal arrangements in place for any other like program.

It is expected, however, that the planning and operation of the program, including management of referral processes, would be overseen by a program management group which includes representatives from the program team, the broader CAMHS, regional educational services and primary schools. This program management group may co-opt local Principals onto the group where appropriate, when their school is involved in the program. This shared responsibility between schools and CAMHS is seen as essential for the delivery of a school-based program. This management group could be more broadly advised by a program specific community group or a general CAMHS community advisory group that has representation from other services who may support these families.

Program management groups will present brief progress reports to the State-wide Advisory Group, auspiced by Mental Health, Drugs and Regions Division of the Department of Health. These reports include a listing of the schools involved in CASEA and progress reports around service system collaboration, community reference and management groups, recruitment and staffing, operational and management issues, program development, and program evaluation. A detailed report including analysis of outcome measures and reporting against agreed KPIs will be compiled annually and tabled at the scheduled March State-wide Advisory Group meeting.

Catchment

The CASEA programs are expected over time to engage with all willing primary schools within their CAMHS catchment that are assessed as needing this service. It is preferable for the local program management group to nominate the schools that will be prioritized.

Access to the program

Referrals to CASEA programs will be through the schools involved in the program. Children in the program do not need to be current clients of CAMHS and are not registered with CAMHS once they are participating in the program. If a student requires further CAMHS intervention the program team can initiate a cross program referral for further assessment and intervention as required. This referral should be fast-tracked for a timely appointment as assessment and engagement have already occurred through CASEA.

Schools should be chosen according to their need, willingness to adopt the program and their local community infrastructure, such as, neighbourhood renewal, Child FIRST and support services for minority groups.

Program hours

CASEA programs will operate Monday to Friday within normal office hours. However, some groups or training may need to be run in the evenings to facilitate attendance. Child care provision for parents attending a parent group is highly desirable if possible.

Minimum Data Set

CASEA programs have an agreed minimum data set that is directly related to measuring the outcomes specified in the next section Service outcomes & objectives.

These agreed instruments include: HoNOSCA (Health of a Nation Outcome Scale for Children & Adolescents); SDQ (Strengths & Difficulties Questionnaire), for measuring behaviour change; a parenting scale such as the Alabama Parenting Questionnaire; the Eyberg Child Behaviour Inventory; Satisfaction Questionnaires and a measurement of partnership such as the Partnership Analysis Tool for VicHealth or similar measure.

Targets

A target number of schools is set for each CASEA program. The metropolitan CASEA programs are expected to provide service to ten schools per annum and the rural CASEA programs to six schools. Once programs are established in more remote areas they will be expected to service four schools per annum.

Service outcomes & objectives

The following outlines the desired service outcomes and objectives for the CAMHS and Schools Early Action (CASEA) program. Implementing the program objectives is the means by which the program aims and outcomes will be achieved.

Outcome 1: Primary school aged children will present with less symptoms of severe behaviour disorders such as conduct disorder.

The CASEA program aims to reduce the prevalence of conduct disorder in the primary school aged population by working with students, their parents and schools to better recognize and manage difficult and challenging behaviours in students from Prep to Grade 3. Thus, early and effective intervention will prevent further progression of behavioural problems that may develop into conduct disorder. Research suggests that the multi-level approach may be more effective and that programs that promote social skills and problem solving skill development in young children are likely to be of greatest effect. Existing CASEA programs will be a useful resource for program ideas.

Program Objective 1: A child exhibiting conduct disorder or emergent conduct disorder will be provided with interventions within the school setting in accord with recognised evidence based guidelines.

KPIs and measures:

- *Implementation of evidence based program*
- *Number of children in program(count/school/school term)*
- *Change in behavioural symptom: Pre- and post- Strengths & Difficulties Questionnaire (SDQ-parent and SDQ-Teacher); Eyberg Child Behaviour Inventory (parent completion); and HoNOSCA clinical scale.*

Outcome 2: Parents of primary school aged children whose children present with severe behavioural problems will have improved understanding of conduct disorder and better behaviour management strategies.

Parents are often at a loss as to how to manage their children's difficult behaviour. They also may not realize the impact of their children's behaviour on their parental relationship and how that, in turn, impacts on their responses to children. Parents often have a history of feeling blamed and may feel powerless to make changes. Learning more about their children's challenging behaviours and how to better manage them, in a supportive group with other parents, can help them feel less stigmatized and more accepted by their local school community.

Program Objective 2: Parents will be supported and provided with information about conduct disorder as well as behavioural and other management strategies known to be effective in managing behaviours associated with conduct disorders.

KPIs and measures:

- *Implementation of evidence based program*
- *Number of parents participating in program*
- *Change in parenting practice: Alabama Parenting Questionnaire and Satisfaction Survey (parent completion)*

Outcome 3: The whole school community, including specialist staff, will better understand and be able to respond to the needs of children presenting with symptoms of severe behavioural disturbance such as conduct disorder.

School communities are challenged by students who manifest severe behavioural problems. These behaviours often damage a students' educational learning and their overall development, as well as impacting negatively on their peers. Teachers may have difficulty understanding some of these behaviours which can be challenging to manage within a busy classroom. Children with conduct disorder can experience great distress, as so can their families. School staff working with these children will manage better with specific training about the presentation, needs and management of these children.

Program Objective 3: Provide information, resources and activities about the identification and management of these children in order to enhance the knowledge and skills of staff in identifying and responding to children at risk of or with early signs of conduct disorder.

KPIs and measures:

- *Implement universal school professional development*
- *Satisfaction Survey & reported increased understanding*

Outcome 4: Schools, their support services, and CAMHS will develop stronger partnerships to improving health and well-being outcomes and educational performance by working collaboratively to provide a service for children presenting with severe behavioural problems.

There is a great need for CAMHS and school staff to work closer together to improve the outcomes for these students and their families. The development and delivery of this school-based program will enhance cross-program relationships and create an opportunity to develop collaborative practice principles (refer: CAMHS & Schools Project Report 2004) and protocols to guide practice.

Program Objective 4: Establish joint program management and support structures to oversee the CAMHS & Schools Early Action Program.

KPIs and measures:

- *Clear expression of interest program in place for schools*
- *Mental Health and Education Joint Management Group*
- *Local protocols/program description demonstrates collaboration*

Outcome 5: Access to the appropriate level of support for children in need of assistance is improved by more systematic planning and delivery of responses between student well-being and support services and CAMHS.

Clear protocols and referral pathways are essential for timely and effective intervention and help maintain good professional relationships between services. Referral processes need to be considered for the program participants and for those identified who may need further CAMHS intervention. The referral process can also be supported by consultation and training opportunities.

Program Objective 5: Strengthen planning, protocol and referral pathways between schools, student support services staff and CAMHS for children with conduct disorders.

KPIs and measures:

- *Clear referral pathways and protocols between education and mental health services*
- *Fast track to CAMHS policy for children with complex clinical needs*

Key service features

In summary, each CAMHS will:

Develop appropriate governance and management structures/ processes by:

- establishing a small management group of representatives from CAMHS and education services to oversee the operation of the program
- meeting at least quarterly with a broader CAMHS Community Reference/Advisory Group that provides guidance and support to the program
- ensuring supervision and support to the program team is provided by CAMHS staff
- seeking a commitment from participating primary schools to provide support staff and accommodation for the CAMHS program team.

Deliver an early intervention program that:

- provides an evidence based group therapy program for primary school children with challenging and difficult behaviours, that enhances their social skills and problem solving abilities and helps them better manage their behaviour
- promotes collaborative practice and program sustainability by involving and training school staff and student support services in the direct delivery of the program
- links to further timely and direct therapeutic intervention for those identified as having serious conduct and other disorders including co-morbid disorders such as learning and mental health problems through support from the wider CAMHS service and other relevant health and child and family support agencies.

Provide education and support to:

- parents whose children are at risk of or have an emerging or established conduct disorder or other related disruptive behaviours, about management strategies and skill based approaches through the implementation of an evidence-based parenting group program suitable for these families
- school staff, student support service staff and others as appropriate, so as to further develop skills and knowledge in the early detection and management of conduct disorders and related disruptive behaviours. This should build on local curriculum, welfare and management strategies.

Provide consultation:

- to school staff and student support service staff regarding the management of children with conduct disorders and other related disruptive behaviours.

Develop protocols:

- between schools and CAMHS that include clear referral pathways including a fast-track policy, collaborative practice principles, consultation agreements and training schedules regarding this target group of children and their families.

Evaluate outcomes of the program for children, parents and the school community through the use of valid and reliable measures that monitor:

- Appropriateness of referrals to program
- symptom change in students
- parent understanding of and management of children's behaviour
- school community understanding of conduct disorder and its impact
- schools' responses to the management of children's behaviour
- efficiency of referral process
- effectiveness of collaborative practice between CAMHS and schools
- satisfaction with the program.

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