

CAMHS and schools – Early action program

Early intervention service for young children with challenging behaviours and emerging conduct disorder – Program description

Program management circular

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 at schools and involves targeted 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

The Policy context

The Victorian Government is committed to improving the health, development, learning and well-being of children and young people living across Victoria. Developing a more systematic approach to the prevention, early intervention and treatment of mental health problems and disorders across all ages is a key part of this commitment. For younger children and their families and carers, evidence-based prevention and early intervention programs, early in life and early in the course of disorder, offer promise of an immediate reduction in distress as well as the opportunity for diversion from life-long problems and associated disadvantage. Individual, familial, social and economic benefits result.

The government's social policy action plan, *A Fairer Victoria*, provides a framework for actioning this commitment. It articulates four priority themes:

- improve access to vital services
- reduce barriers to opportunity
- strengthen assistance for disadvantaged groups and places
- ensure that people get the help they need at critical times in their lives.

A range of policy service development initiatives across Government assist in translating these priorities into action.

Mental health

The provision of additional mental health funding in recent State budgets has enabled the expansion of service developments targeting children with emergent conduct disorder within a supportive policy context.

New Directions for Victoria's Mental Health Services (New Directions 2002) sets out mental health policy directions and identifies a range of initiatives to strengthen service delivery over the next five years. Piloting and evaluating programs for school-aged children who have a conduct disorder, and as such, are at risk of developing mental health and social problems, including offending behaviour, depression and substance abuse (*New Directions for Victoria's Mental Health Services, 2002, p. 30*) was seen as a priority.

The *CAMHS & Schools Project Report (2004)* outlines a project, jointly auspiced by DHS Mental Health Branch and the Department of Education and Training, targeted at developing a more co-ordinated approach between Child and Adolescent Mental Health Services (CAMHS) and Government Schools.

The aim was to improve access to timely treatment of children and young people with mental health problems in the school environment. The project involved state-wide and local consultations that resulted in the development of a collaborative model of practice that could be used by CAMHS and schools. This model provides an ideal framework for delivering programs targeting challenging behaviours and emergent conduct disorders.

The *National Mental Health Plan 2003 to 2008* has been developed to guide the implementation of the National Mental Health Strategy. This Third Plan supports a whole-of-government approach to bring together a range of sectors that impact on the mental health of individuals.

The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000)* has also provided a framework for a coordinated national approach to the promotion of mental health and prevention and early intervention for mental health problems and mental disorders.

Of particular relevance, the Action Plan states outcome indicators for children aged 5 to 11 years that include “decreased incidence, prevalence and burden associated with conduct/disruptive and anxiety/depressive problems”. (*National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 2000, p.29*).

Department of Education and Training

Improving the learning outcomes of every student is the Department of Education and Training’s key objective. This objective is central to the *Blueprint for Government Schools* (Department of Education and Training 2003), which states that all government school students are entitled to an excellent education and a genuine opportunity to succeed, irrespective of the school they attend, where they live or their home background. Priority 1 of the *Blueprint* is recognising and responding to diverse student needs.

The *Blueprint* provides the framework for an effective Victorian government school system – a system with effective teachers, effective leaders and effective schools. “...all government school students are entitled to an excellent education and genuine opportunity to succeed, irrespective of the school they attend, where they live or their home background.”

The overarching objective of creating and sustaining effective schools underpins all *Blueprint* strategies and initiatives. This provides all schools in the government school system with a shared purpose. The *Blueprint* reform agenda is a coherent strategy that provides school leadership teams with a range of tools and frameworks to make their school effective.

With 540,000 students in more than 1600 government schools, the diversity of the student population is recognised and celebrated. The Department is committed to delivering an inclusive education system that ensures all students have access to a quality education to meet their diverse needs. Two vital components of this commitment are the following programs: the **Program for Students with Disabilities** and the **Language Support Program**. Both provide a range of supports and initiatives to assist government school students with additional learning needs, including those students with disabilities.

The Victorian Department of Education & Training’s *Framework for Student Support Services in Victorian Government Schools (1998)* (www.sofweb.vic.edu.au) describes principles, arrangements and resources to enable a strengthening of student welfare and support services. It outlines how a continuum of services can be provided to students and their families within a comprehensive and integrated framework, with an increasing emphasis on preventative approaches and early intervention activities.

Office for Children

In 2005, the Office for Children was established within the Department of Human Services which brought together key policy areas responsible for funding and/or providing services to children and families – Early Years, Child & Family Support Services, Child Protection, Juvenile Justice & Youth Services within one organizational framework. *Protecting children...the next steps*, (www.office-for-children.vic.gov.au) the policy and legislative review conducted by the Office for Children, proposes a greater focus on early intervention with families and strengthens the focus on the needs of children. This thinking has generated from the findings of the *Family Support Innovation Projects* that have been trialled since 2003. These projects include the provision of co-ordinated central intake for family services that builds on strong partnerships and clear referral pathways.

A community-based child protection worker consults to the intake service and enables early intervention for struggling families. It would be important that these services are aware of any CAMHS and Schools Early Action Programs in their region.

Neighbourhood Renewal

Neighbourhood Renewal (www.neighbourhoodrenewal.vic.gov.au) is a Victorian government initiative that brings together the resources and ideas of residents, governments, businesses and community groups to tackle disadvantage in areas with concentrations of public housing. This initiative is being led by the Office for Housing in the Department of Human Services as part of the government's *Growing Victoria Together*. In particular, their goal to build new partnerships across government and communities is relevant to the CAMHS and Schools Early Action Programs and they will be able to provide some supportive infrastructure in disadvantaged communities.

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 per cent 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 per cent), attention problems (6.1 per cent) and aggression (5.2 per cent) are major mental health problems of Australian children (Sawyer, M.G. 2000).

Information collected by the Mental Health Branch in 2001 indicated that 17 per cent 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; or
- Serious violations of rules.

Sanders, M.R. (2000) describes conduct disorder as characterised 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, 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 indicates 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 and depends 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 trialled a pilot early intervention program that produced positive results. He proposed 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 per cent 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 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).
- b. **Family/parenting interventions** - interventions designed to improve parenting skills and family relationships.
A number of well-controlled trials have been conducted evaluating the effectiveness of family 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 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 interventions 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.

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).

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. 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 Programs adopt this multi-level intervention model and encourage the services to form clear protocols for referral, service delivery and consultation.

Service responses

A range of services is 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. Associated with each of the DE&T school networks are student support services that are managed by school principals and supported by DE&T regions. DE&T Regions are responsible to ensure quality assurance, accountability, professional supervision and collegiate support in student support services. Catholic and independent schools are also eligible for this early intervention service.

When children present with co-morbidity of behavioural and emotional symptoms, often within a complex family system, they may be referred to general practitioners or 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.

Service development specifications

The *CAMHS & Schools: Early Action Programs* reflects the Government's commitment 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 operating 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.

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/year. Metropolitan programs have been funded for five eft and rural programs for 3 eft positions. Further program development will depend on funding availability.

Program management

The CAMHS and Schools Early Action 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 however expected 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 school representatives. This program management group could 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 submit brief progress reports half-yearly to the Mental Health Branch, DHS. A detailed report including analysis of outcome measures will be required annually in December and tabled at the following State-wide Advisory Group.

Catchment

The CAMHS and Schools Early Action 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 the 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.

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

Program hours

The EAP 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

The CAMHS and Schools Early Action Programs will have an agreed minimum data set that is directly related to measuring the outcomes specified in the next section *Service outcomes & objectives*.

The agreed upon instruments to be used include: HoNOSCA (Health of a Nation Outcome Scale for Children & Adolescents) and SDQ (Strengths & Difficulties Questionnaire), for measuring behaviour change, a parenting scale such as the Arnold Parenting Scale and the Partnership Analysis Tool for VicHealth.

Service outcomes and objectives

The following outlines the desired service outcomes and objectives for the CAMHS and Schools Early Action Programs. 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 CAMHS and Schools Early Action 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. Programs already involved in providing Early Action 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.

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.

Outcome 3: 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.

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.

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 (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.

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

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 Group that provides guidance and support to the program;
 - ensuring supervision and support to the program team is provided by CAMHS staff; and
 - 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, 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

References

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. (DSM IV) Washington DC, American Psychiatric Association, 1994
2. Commonwealth of Australia (2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*.
3. Commonwealth of Australia *National Mental Health Plan 2003-2008 (2003)*. Department of Health and Aging (available online at www.mentalhealth.gov.au)
4. Commonwealth of Australia *National Mental Health Plan 1992*. Mental Health Branch, Department of Health and Family Services.
5. Dodge, K (2002) *Preventing chronic violence in schools*. United States White House Conference Paper.
6. Durlack, J.A. (1998) Primary prevention programs for children and adolescents are effective, *Journal of Mental Health*, 7, 5: pp463-469.
7. Hill, J. (2002) Biological, Psychological and Social Processes in the Conduct Disorders, *Journal of Child Psychology and Psychiatry* 43: pp. 133-164
8. Sanders, M.R. et al (2000), Early intervention in conduct problems in children in Kosky, R. et al (Eds) *Clinical Approaches To Early Intervention In Child And Adolescent Mental Health*, Australian Early Intervention Network for Mental Health in Young People, Vol 3, Adelaide.
9. Sawyer, M.G., Arney, F., Baghurst, P.A., Clark, J.J., Graetz, B.W., Kosky, R.J., Nurcombe, B., Patton, G.C., Prior, M.R., Raphael, B., Rey, J.M., Whaites, L.C. & Zubrick, S.R. (2001). The mental health of young people in Australia: Key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. *Australian and New Zealand Journal of Psychiatry*, 35, 806-814.
10. The Victorian Department of Education & Training Program for Students with Disabilities Handbook 2006 (also available online at www.sofweb.vic.edu.au/wellbeing/disabil/index.htm)
11. Victorian Government Department of Education & Training. *Framework for Student Support Services in Victorian Government Schools (1998)* (also available online at www.sofweb.vic.edu.au/wellbeing/index.htm)
12. Victorian Government Department of Human Services New Directions for Victoria’s *Mental Health Services: The Next Five Years (2002)* also available online at www.health.vic.gov.au
13. Victorian Government Department of Human Services, Mental Health Branch (2002). *CAMHS & Schools Report (2004)* (also available online at www.health.vic.gov.au)
14. Victorian Department of Premier and Cabinet (2001) *Growing Victoria Together*
15. Zubrick, S.R. et al (2005) *Prevention of Child Behaviour Problems Through universal Implementation of a Group Behavioural Family Intervention*. Prevention Science.

About program management circulars

The information provided in this circular is intended as a guide for development of CASEA programs.

Mental health service management should ensure that policies and procedures are developed in keeping with the principles outlined in this circular.

Further information

For further information please contact contact Amanda Smith via email at: amanda.smith@dhs.vic.gov.au

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