Premier's Anika Foundation Youth Depression Awareness Scholarship

Strengthening the case management thus outcomes of students with mental health needs within our school system

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Depressed young people are susceptible to poor academic progress, social dysfunction, disability, substance abuse, suicidal ideation, attempt and suicide, (NHMRC, 1997).

The above statement was the driving force for me to explore how young people with depression were well managed in the school setting. My practice and study also led me to the understanding that *depression rarely lives on its own.*

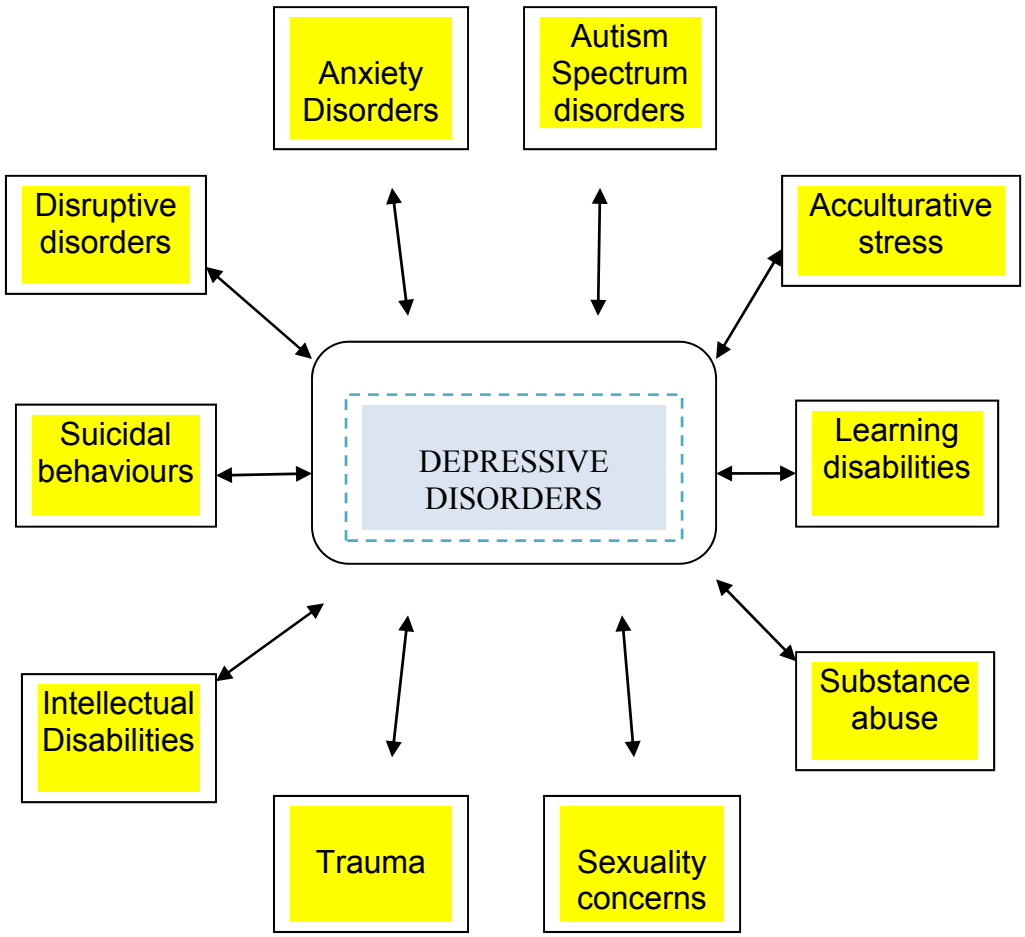

Figure 1: Common presentations comorbid with depressive disorders.

This understanding motivated me to explore best practice in managing students with such high and **diverse** support needs, and in particular I was motivated by the comprehensive document 'A Kit on Effective School Case Management: Strengthening Mental Health Programs for Secondary Students with Mental Health Needs' (de Jong, 2006) as a framework to assist such students. This document was generated through the *MindMatters Plus* Project funded by Commonwealth Department of Health and Aging (DoHA) and managed through the Australian Guidance and Counselling Association (AGCA) and the Australian Principals' Associations Professional Development Council (APAPDC).

Young people with mental health needs are best supported in school settings where there exists connectedness, development of relationships and educational adjustments. Case management is an effective system to allow appropriate educational adjustment for young people with support needs. Effective case management is a **collaborative process** designed to meet the needs of the

young person. It is **student focused** (incorporating their views) and develops, disseminates, monitors and reviews a **plan of action.** Case management yields:

- a coordinated systemic mechanism to develop action plans for students with support needs,
- empowerment of student and other stakeholders to collaboratively participate in problem-solving, and
- clearer processes of accountability, outcome appraisal and contribution to well-being of the young person.

The work of de Jong and his collaborators (see de Jong, 2006), primarily Coosje Griffiths, Area Manager Student Services, Swan District Education Office, was embedded in a school-wide approach to mental health that is best explained by the model following. This model was a portent of one of the more significant findings of my study tour.

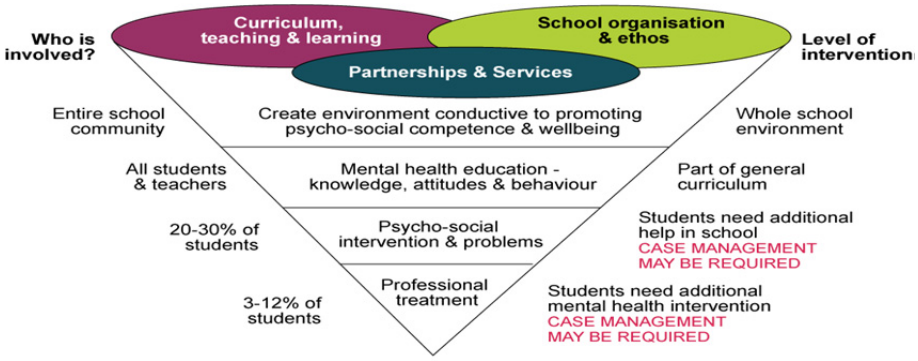

Figure 2: Framework for Comprehensive Whole School Management Mental Health Program (de Jong, 2006)[1].

The AGCA website has provided access to the very comprehensive kit devised by de Jong and team (also provided an equally comprehensive "getting started" professional development package) accessed at: http://mhws.agca.com.au/escm_home.php.

My own anecdotal evidence was that the uptake of this wonderful and remarkably self-explanatory resource was quite limited in New South Wales. The question was why?

Focus of the study

This study was tri-fold in purpose. The initial phase was to explore in a sample of Western Australian schools and in meetings with School Psychologists and other personnel how students with mental health needs were supported through case management. The study hoped to answer the "why?" or "why not?" questions regarding the uptake of systemic case management. This was supplemented by a meeting with Terry de Jong at Edith Cowan University.

The second phase was attendance at the five day National Association of School Psychologists (NASP) conference in Chicago. This allowed access to a wide range of leading psychologists in many fields across school psychology.

[1] The Effective School Case Management Kit was a product of the MindMatters Plus Project funded by the Australian Government Department of Health and Ageing (2006).

The third phase involved Dr Sally Merry's research team at Auckland University. This phase focused on the research process involved in developing and trialling two particular e-interventions in New Zealand.

Significant learning

Phase one: Swan and Cannington District Education Office and school visits

During this phase the amazing commitment of Coosje Griffiths and her Swan District team and John Hesketh of the Cannington District, enabled me to visit up to nine schools, including behavioural centres, an independent primary school, several high schools, Mr Grant Wheatley , manager of the Hospital Schools Services, Hale House (Centre for Inclusive Education) as well as meeting with a variety of consultants including the Team Leader Autism, Learning Difficulties teachers, the Principal Consultant Disabilities/Comorbidity and the Senior Psychologist specialising in Suicide Crisis Support in the Cannington District. The knowledge gained cannot be done justice in this report.

Major points of learning

Strong families regional managers planning meeting.

Strong families is a planning and coordinating process for consenting families who are receiving services from two or more agencies. It was a very valuable experience to attend this meeting as it enabled me to see firsthand (at a regional planning level) the essence of case management in practice.

Effective case management relies heavily on process and understanding thereof by all parties involved. Given the personnel involved in the meeting (and their level of expertise) it became apparent to me that considerable commitment to resources is also a necessary ingredient for successful case management of any description.

This commitment was echoed in conversations with Coosje Griffiths. It was apparent that most schools within the Swan District had come to understand and view management of mental health through the case management model. This was achieved through the training of School Principals, and, through them, schools in effective case management. School Psychologists were also heavily committed to the case management model of mental well-being in schools as a result of receiving training in such process.

Take Home message: If School districts and school principals are committed to case management it is much more likely to be resourced to a level that allows translation into everyday school practice and collaboration with outside agencies.

Cyril Jackson Senior Campus: meeting with Maria Bevacqua - School Psychologist.

Senior college campus incorporates several programs, including:

- an Access program for youth who are disengaged from education,
- ED Support students (IM/IO/IS),
- A mainstream Year 11 and 12,
- Certificated TAFE students,
- e-learning students, and, on a separate site

- 300 intensive English language students, who are refugees and new immigrants.

The school has high support needs and is well resourced. Currently there are 2.6 Psychologists to service the school, 1.6 positions filled by two people for the student services coordinator (this funded by school itself), a campus community coordinator (Personal Development, Health and Physical Education Teacher released for one or two days per week to organise "harmony day", health festivals, lunchtime activities, apply for activities funding, and similar tasks), a school nurse and two Deputy Principals (Intensive English Class and mainstream). These personnel form the student services team. This team meets fortnightly and the student services coordinator is generally the main point of referral. Case management is organised through this substantial team.

School psychologists provide frequent training to staff to increase awareness of mental illness indicators or to outline interventions as required. Relationships are very important for the ethos of the school connectedness for the students and staff. The school's behavioural program is less punitive and more restorative (relationships-based). Restorative justice was a key feature of this school, as well as several others I visited. Key personnel are "Gatekeeper" trained. "Gatekeeper" training is two day training for all school psychologists and key personnel in suicide risk assessment and pathways. Gatekeepers are personnel who are in frequent contact with young people who may be in distress and are in a position to recognise and assist a young person who may be contemplating suicide.

Take home messages:

- Employment of school nurses, (common across the schools)
- Emphasis on relationships throughout the school,
- School campus coordinators to build relationships,
- Use of restorative justice to build relationships,
- Gatekeeper training provided to school psychologists and other key personnel,
- High level of resources directed towards the Student Services team, plus
- Streamlined pathways for case management (echoed across the schools).

Roseworthy Primary School (an Independent Public School- trialling in Western Australia- separate from other DET schools)

This school actively tracks all students on a data base for any educational risk factors and this enables profile building of children which will help initiate case management if required. Teachers are educated in identifying students at risk and following a referral pathway.

The **SAER policy** (Students at Educational Risk) was introduced in 1999. This required specific tracking and case management of students at risk educationally, emotionally and behaviourally. Case management training was provided in the roll-out of this **mandatory** process. Roseworthy has certainly developed the data collection and planning required by the SAER policy. SAER coordinators were appointed to each school; however this funding may be reduced.

Take home message:

- SAER policy and training roll-out are probably the catalyst for the level of case management in Western Australian schools,

- Data collection is imperative, and
- Again, teachers are not heavily involved in case management, but can observe and report triggers for concern as well as acting as conduits for interventions.

Terry de Jong – Edith Cowan University Associate Professor responsible for much of the AGCA (Australian Guidance and Counselling Association) document

This brief lunchtime meeting occurred toward the end of my tour. It was obvious by now that the case management process is not complicated but it does need understanding, training, committed leadership and resourcing. Terry de Jong also mentioned the need for the recognition that *all is not equal for all*. He talked of an ethos of care being essential and that leadership must be immersed in that ethos.

Take home message:

- Ethos of care from the top down, and
- Commitment to the process.

Bernadette Long (Team Leader: Visiting Teachers-Autism): John Hesketh (Area Manager Student Services: Cannington District)

Discussions held with Bernadette Long and John Hesketh allowed me to clarify the barriers to effective case management within schools, identified as:

- No clear processes for referral pathways, data collection etc,
- Executive not involved or aware,
- Teachers resistant to assistance, which they perceive as criticism,
- Lack of a learning support team, whereby the school can become reactive to, for example, funding needs, parental conflict, crisis intervention, or staff discomfort,
- Misconception of the problem (very important to identify the problem),
- Team doesn't recognise the multifaceted nature of the problem and may assume the child is the problem,
- Departments not cooperating, and
- Lack of time for planning.
- Lack of understanding of the process.

Take home message: education, commitment and resources!

Phase Two- National Association of School Psychologists (NASP) Conference

This phase presented me with an overwhelming *potpourri* of knowledge through poster displays; papers and workshops relating to suicide prevention; nonsuicidal self harm; Bipolar Disorder in young people; the BRIEF and executive functioning; prevention and treatment of anxiety; and working with angry boys. The very strong framework that allowed me to make sense of this *potpourri* is the Response –To –Intervention (RTI model), a theme throughout the conference. It should be very apparent that it is reminiscent of the model discussed in Phase One! This model, in its formalised shape, has been utilised in US schools only since 2004-5 yet it is driving the academic, social, behavioural and emotional milieu within the national school system. RTI is an ongoing process, using student performance and other data to guide instructional and

intervention decisions using problem-solving methodology. This is embedded in a three- or four-tiered service delivery model (East & Reder, 2010).

The Core Principles of RTI in relation to instruction or intervention are:

1. Intervene early;
2. Use a multi-tiered model of service delivery;
3. Use problem-solving logic to make data-driven decisions;
4. Use research-based, scientifically validated interventions/instruction to the extent available;
5. Monitor student progress to inform instruction/ intervention;
6. Use data to make decisions;
7. Use assessment for three different purposes: 1) screening; 2) diagnosis; and 3) progress monitoring (National Association of State Directors of Special Education (NASDSE) Inc. (2005).

Whilst the backbone of RTI lies in academic outcome assessment and intervention, the model is very applicable across the behavioural and social-emotional arena and indeed provides a framework. Assessment and intervention practices overlaid on the RTI model are applied over three hierarchical tiers that reflect an increasing level of assessment and intensity of intervention.

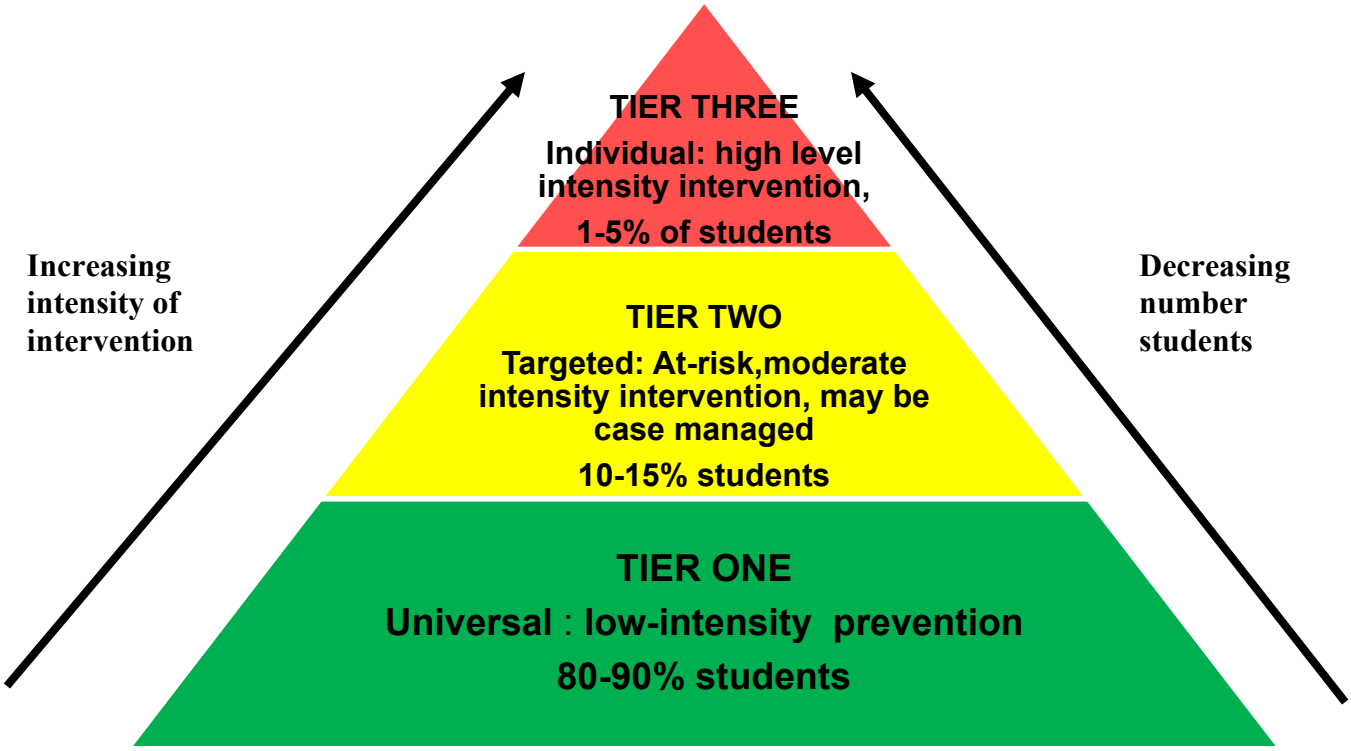

Figure 3: Response to Intervention Model – based on models used across United States *(Hunley & McNamara, 2010: Pro & Thompson, 2010).*

One of the workshops I attended was the Advanced Workshop on Suicide Prevention conducted by Scott Poland, Richard Lieberman and Phillip Lazarus. This workshop provided me with an overwhelming amount of knowledge but I could organise this knowledge via the RTI process.

Areas of note include:

- **The TRUST curriculum** is delivered across grades focusing on self awareness, problem –solving, coping, decision-making, relationship building, stress management and health knowledge.
- **The Life Management Skills Curriculum** is delivered to Year 9 students whereby students are taught to identify signs and behaviours of potential suicide risks in themselves and others and taught how and where to gain adult assistance. The Signs of Suicide (SOS) program was recommended. The premise of **A**cknowledge, **C**are and **T**ell (**ACT**) was designed to equip young people to break the conspiracy of silence and was seen as essential[2]. Gatekeeper training for key staff was seen as paramount as well.
- **Health Connect** is the introduction of a team including a nurse and social/youth workers within some schools.
- **Student Intervention Profiling**, whereby students are referred to the Student Support Team when a change is observed in their usual behaviour patterns in any three of the areas listed below:
    - Academic performance
    - Effort
    - Conduct – including withdrawal
    - Attendance
    - Negativity in teacher comments
    - Disciplinary action
    - Suspension
    - Police activity

Profiling allows students to be case managed at the second tier and as Poland expresses, **surrounded by a circle of care** with the view to preventing escalation into Tier 3- (Imminent risk and crisis intervention).

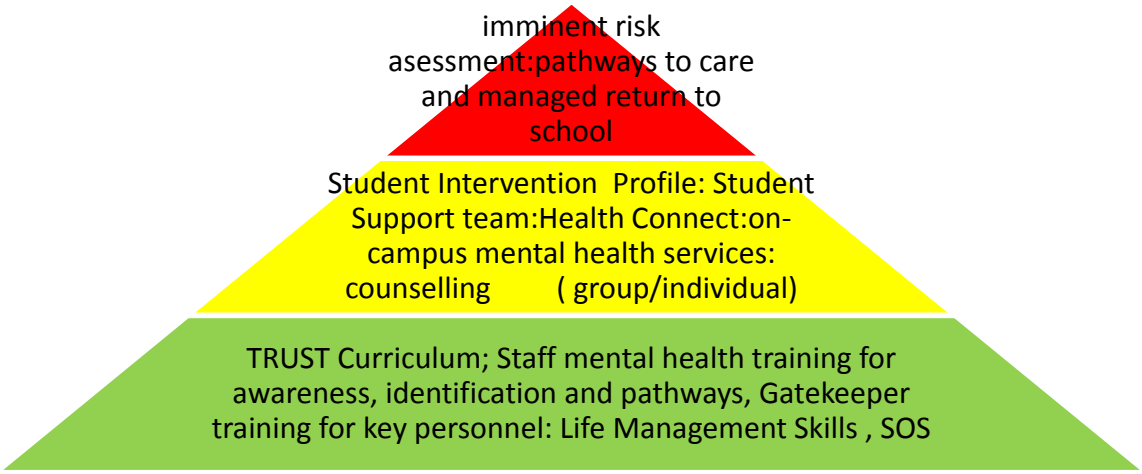

Figure 4: Application of the RTI model to Suicide Prevention within a school.

[2] – This is contraindicated within current New South Wales DET guidelines

Many US school districts have their own CRISIS hotlines (similar to my Western Australian experience), whereby school personnel are required to contact an experienced school district psychologist to outline the case, the steps taken and seek qualified assistance with any planning thereafter. This strategy is not designed to replace the Health response (e.g. CAMHS in New South Wales) but rather to assist the further case management of the student during and after the crisis response (Poland, Lieberman & Lazarus, 2010).

Time prevents further discussion of this outstanding conference; however any learning I received can be utilised in the context of the RTI model. It should be apparent that the tiers on which case management focuses would be possibly tier two and definitely tier three.

After my time in Perth and at NASP conference it also became apparent to me that the apex of the triangle relied on the wider base (lower tiers) and effective case management would *not* be achievable in schools that did not pay sufficient attention to the base of the triangle.

Phase Three: New Zealand: Auckland University and Dr Merry's Research Team.

This was the final phase after several time zone changes. Here I concentrated on looking at two exciting breakthrough research projects utilising computer and mobile phone technology to deliver a targeted Cognitive Behavioural Therapy (CBT) program and universal prevention CBT based program. The computer based CBT program was devised after research indicated a dearth of programs designed to treat depressive disorders in adolescents. There was also little research available for computer based programs (such as *Reachout Central*) or limited efficacy for others, such as O'Kearney's study of "Moodgym" which found that only 40 percent of adolescent males completed less than 50 percent of the program (Stasiak and Fleming, 2009).

Dr Merry's team devised a model that delivered CBT, e-learning and e-entertainment. This e-therapy is in the form of a highly interactive, *avatar*-based interactional, seven module, CBT, 3D fantasy-based game known as "SPARX". The program teaches skills to manage symptoms of depression in a self-directed learning format that can be completed without direct supervision. Young people learn CBT techniques to assist with symptoms of depression (such as dealing with negative thoughts, problem-solving, activity scheduling, anger management and relaxation).

The team is also researching "SPARX Rainbow" which is a form that has been adapted for same-sex attracted young people. This e-therapy is aimed at treating mild to moderate depressive disorders and would fit well into the second or third tier of the triangle. Results are expected in 2011. One motivation cited for the creation of "SPARX" was the need to assist School Counsellors not able to deliver CBT to assist young people in their schools.

The Merry team was also researching the bottom layer of stepped care (Prevention : Universal program) through the mobile phone delivery of three core CBT skills –SPOT, SORT and DO, via twice-daily, 30 second clips, texts, weekly challenges and other engaging tasks. This randomised controlled trial accessed Year 9 students throughout the North Island who demonstrated no symptoms of depression. This program is known as "MEMO". The incentive was derived from a recent evidence-based "quit smoking program" which had demonstrated efficacy.

A comprehensive website detailing the research and updates for both studies can be found at www.sparx.org.nz. I was able to gain an understanding of the research process whilst in Auckland. I am currently studying at Monash University and am required to complete either a minor or major thesis. Dr Merry has expressed some interest in allowing me to research the delivery of "SPARX" within Australia. This would be an exciting proposal.

Conclusion

I have learnt much more than the confines of this report regarding case management of students with mental health needs. I understood that the process of case management is not difficult and the *Mindmatters* website provides an excellent means of establishing that process within a school, including the provision of the necessary proformas. I found that the mandated SAER policy and subsequent roll-out of training was a major catalyst for the uptake of case management within schools such that it is embedded in their language and cultures. To access funding support in Western Australia a level of prior case management is expected. Schools must demonstrate Individualised Educational Plans and Behavioural Management Plans for students prior to funding applications. This also helps embed case management

I also found that the employment of nurses and youth workers and the resources (including teacher) dedicated to the Student Support Services within schools further strengthened this adoption of case management culture. Interestingly the level of student support services in the US was also considerable and Auckland schools were trialling the re-introduction of school nurses!

The commitment of leadership within schools also affected the quality of case management. How this all translates to the New South Wales educational system is not a question I can answer.

As a psychologist employed as a School Counsellor, I was impressed with Gatekeeper Suicide Prevention training delivered to all school psychologists and other Student Services personnel. This two-day training is aimed at workers already engaging with suicidal youth and focuses on imminence of risk assessment, pathways to care and case management skills, amongst other factors. This level of mandated training would be of great benefit to our frontline workers in New South Wales schools.

In Perth I first met the concept of the triangular framework of intervention (albeit upside down) so prevalent through my report findings from Chicago. I have already felt more confident to use this framework in some schools since in order to introduce the case management process and demonstrate where it fits and also to encourage these schools to examine the lower 'tiers' of the triangle. It can be very obvious to a school where there are gaps in the universal and targeted tiers when presented with this framework. Interestingly, many schools in my region are familiar with the triangular concept through the introduction of Positive Behaviour for Learning (PBL). This is encouraging!

In conclusion, when I look back at Figure One (depression and comorbidity), I feel my own ability to assist such young people, as well as my capacity to pass this knowledge on to my peers, have been greatly enhanced. Thank You.

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Useful websites

http://mhws.agca.com.au/escm_home.php This website is the link to the comprehensive Case Management Kit from de Jong and his team. It also includes a foolproof power Point production for introduction to schools.

http://www.safersanerschools.org –This website is a link to restorative practices, increasingly being used in WA schools. Provides a proactive approach for building a school community based on cooperation, mutual understanding, and respect.

http://www.channing-bete.com/prevention-programs/paths - this website is the home page of the Promoting Alternate Thinking Strategies program (K-6). This is a violence-prevention curriculum that promotes social and emotional learning (SEL), character development, and bullying prevention. I attended a part of a training session at the Cannington District Office.

http://www.mentalhealthscreening.org/schools/index.aspx - this is home of the Signs of Suicide universal prevention program delivered to year 09 which has shown evidence-base in reducing suicidal behaviour.

http://jc-schools.net/tutorials/gameboard.htm- this is an excellent gameboard making website used in conjunction with card making website - http://www.avery.com/us/software/jcc

www.sparx.org.nz- website of the Auckland University e-therapy research.

Acknowledgements

I would like to thank Adrian Wignall and the Anika Foundation for the wonderful opportunity that this scholarship has provided me and I hope I can make some small difference to young lives through the findings and application of these findings in our school system. I also recognise the great loss that has generated this possibility.

I would also like to thank Coosje Griffiths, Alison McCarthy, John Hesketh and their teams, Terry de Jong and Dr Merry's team for the care and time they took to share their skills with me.

I have also produced a CD and slide presentation which provides more details of workshops and other learning than can be produced in this report.