DRAFT

PURCHASING GUIDANCE

For the

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES (ATAPS) PROGRAM –

CHILD MENTAL HEALTH SERVICE (CMHS) COMPONENT

April 2012

Prepared based on a report from the Australian Psychological Society in conjunction with the Child Mental Health Services Working Group and funded by the Australian Government Department of Health and Ageing

Table of Contents

Introduction

The *Access to Allied Psychological Services* (ATAPS) Program funds the provision of short term mental health services for people with mental disorders through fund-holding arrangements administered by Divisions of General Practice and operational Medicare Locals. The fund-holding arrangements will transition to all Medicare Locals during 2011-12 as they are established and demonstrate capacity to provide mental health services.

Children who have, or are at risk of, developing a mental, childhood behavioural or emotional disorder can receive treatment through Tier 2 of the ATAPS Program, known as the ATAPS Child Mental Health Service (CMHS).

Purpose of the Purchasing Guidance

This purchasing guidance has been developed to inform Medicare Locals on the delivery of ATAPS CMHS using best practice evidence based treatment approaches. Moreover, the aim of this purchasing guidance is to describe and promote a consistent, evidence based approach to psychological interventions for clinicians working with children with, or at risk of developing, mental disorders (WARMD[1]), and their families under ATAPS CMHS. It is important to note that this purchasing guidance is NOT intended for use as a training manual, but has been developed out of recommendations for "best practice" for allied health professionals working with children WARMD under ATAPS CMHS.

This purchasing guidance has been developed based on the final draft purchasing guidance the Australian Psychological Society (APS) prepared in consultation with a working group formed to oversee and inform the development of this project in 2011. This working group included representatives from the APS, the Department of Health and Ageing, Australian General Practice Network (AGPN), Australian Association of Social Workers (AASW), Australian College of Mental Health Nurses (ACMHN), Occupational Therapy Australia (OT Australia), and Royal Australian College of General Practitioners (RACGP). Other

[1] For the remainder of this document "children with or at risk of developing a mental disorder" is referred to with the acronym "WARMD". Eligibility for the ATAPS CMHS for children assessed as 'at risk' is defined as Part 1: The ATAPS CMHS Target Group and Eligibility Criteria and the ATAPS CMHS Operational Guidelines.

mental health experts were also consulted, including an expert paediatrician and a representative of the Australian and New Zealand College of Psychiatrists (RANZCP).

The *ATAPS Operational Guidelines* do not provide specific information on psychological service strategies and ATAPS workforce requirements pertaining to infants and children under 12 years of age. As such, this purchasing guidance complements the *ATAPS Operational Guidelines* and the *ATAPS CMHS Operational Guidelines*, and should be considered simultaneously.

The APS via the working group as mentioned earlier, has made recommendations to the Department on the operation of the ATAPS CMHS, including future training and resource development needs. The Department will consider these recommendations separately, particularly the development and implementation of national ATAPS CMHS training planned for the second half of 2012.

The Department may revise this document as appropriate in the future.

Document Structure

1: Background

This Section of the Purchasing Guidance provides background to service delivery for children with mental, childhood behavioural or emotional disorders and their families, and includes a summary of relevant literature findings. It is important to note that the information presented below represents a brief summary of some of the key issues and findings relevant to working with children. It includes: the purpose of ATAPS; background about the ATAPS CMHS component; information pertaining to the target group; the population health model; principles underpinning child and family service delivery; and, provides a summary of relevant epidemiology findings, social context, service context and the current policy context within Australia.

2: Early Intervention and Assessment

This Section of the Purchasing Guidance provides advice around the assessment of children WARMD and their families.

3: Service Delivery

This Section outlines the findings from a review of best practice in psychological interventions for children WARMD, and a discussion around referral pathways, examples of complex and less complex cases, and the requirements for an ATAPS Child Treatment Plan (also known as a *GP Mental Health Treatment Plan*).

4: Workforce Issues

This Section outlines the essential core skills and competencies and the desirable skills and competencies required by the ATAPS workforce, information on up-skilling, responsibilities around professional development and the new national on-line training to be implemented by the Department of Health and Ageing.

1. Background

1.1 ATAPS Program

The ATAPS Program is an Australian Government program that provides access to effective, low cost treatment for people with a mental illness who may not otherwise be able to access services. ATAPS funds the provision of short term mental health services for people with mental disorders through fund-holding arrangements administered by Divisions of General Practice (Divisions) and established Medicare Locals. The fund-holding arrangements will transition to Medicare Locals during 2011-12 as they demonstrate capacity to provide mental health services.

Medicare Locals across Australia will receive funding from the Department to provide these services through a variety of service delivery models including direct employment, subcontracting and vouchers. Individuals accessing ATAPS are to receive care delivered by suitably qualified allied health professionals.

ATAPS has shown promising results since its inception in 2003, with more than 273,000 client referrals and the provision of over 1.1 million mental health services (as at December 2011). In 2010, a thorough review of the initiative was completed with the following four key areas of improvement identified:

- Better addressing service gaps;
- Increasing efficiency;
- Encouraging innovation; and
- Improving quality.

One of the key recommendations to come out of the review was that supporting infrastructure should be refreshed and refocussed, in order to improve the quality of ATAPS services and further promote evidence-based best practice interventions for consumers.

As a result of additional Government funding announced in 2010 and 2011; and, in order to address the review of ATAPS recommendations – the Department has funded the ATAPS Service Purchasing Guidance, Clinical Governance and Support Project. The aim of this project is to ensure that ATAPS services are of consistently high quality, appropriate, and that allied health providers are suitably supported and equipped with appropriate knowledge and skills.

Additional funding has been provided through the ATAPS initiative to expand its capacity to support particular population groups; including the current focus of this purchasing guidance, children (aged under 12 years) with behavioural and emotional disorders and their families. It has been recognised that certain groups have specific and diverse needs to those of the general population, and that it is essential that Medicare Locals have the necessary information and guidance to provide high quality services to these populations in order to meet those needs[2].

1.2 Expansion of ATAPS - The Child Mental Health Service (CMHS) component

ATAPS funding was significantly increased in the 2011-12 Federal Budget with an additional $205.9 million to be provided over five years to increase the capacity to provide services to an additional 184,000 people in hard to reach groups - around 50,000 children and their families; 18,000 Indigenous Australians; and around 116,000 people from other hard to reach groups or locations, with a particular focus on low socioeconomic areas. Funding to improve access to

[2] Funding for ATAPS will be transitioning to Medicare Locals during 2011-2012.

psychological services for children under the ATAPS Program has been allocated through the following two measures:

- 2010 *Taking Action to Tackle Suicide* (TATS) – Additional Services for Children with Mental Health or Developmental Issues (2010 Election Commitment) - $34.1 million over 5 years; and
- The *Delivering National Mental Health Reform* package announced as part of the 2011-12 Budget (Expansion of ATAPS – Improving Access for Children) - $69.9 million over 5 years.

These Commonwealth measures include funding to develop linkages and support networks between mental health service providers and community workers, including school counsellors. As part of the ATAPS Program expansion for children, funding has been made available for the development and provision of education and training resources for allied health professionals involved in delivering services to children and their families. In addition, these new purchasing guidance for Medicare Locals, and clinical support for allied health providers to assist with the treatment of complex children's needs were to be developed. It is anticipated these enhancements will improve the quality of ATAPS child mental health services and increase the capacity of service providers to deliver appropriate services.

It should be noted that due to the CMHS component being a new component of ATAPS there is minimal information (e.g. operational guidelines) that have been developed to date specifically related to the delivery of ATAPS CMHS. This purchasing guidance is intended to inform Medicare Locals, and as previously stated, will be refined over time to incorporate changes in the ATAPS Program, and better meet the information needs of Medicare Locals.

1.3 Overview of CMHS Parameters

1.3.1 ATAPS CMHS Target Group and Eligibility Criteria

For the purposes of this purchasing guidance the *target group* is defined as: children aged less than 12 years who have, or are at risk of developing a mental, childhood behavioural or emotional disorder (and have been referred to within this document as children WARMD).

The *eligibility criteria* for services under the ATAPS Tier 2 Child Mental Health Service include:

- a child assessed as having definite or substantial signs and symptoms of an emerging mental disorder (including conduct disorder), where this causes "significant dysfunction in everyday life"; and

- a child at risk of developing a mental disorder, where the child shows any number of signs or symptoms (social-emotional-behavioural) of developing a mental disorder and/or where the child's developmental pathway is considered to be disrupted by their mental health condition (i.e., not limited to disruptive disorders). Signs of disruption to functioning in any number of settings are included. That is, one setting was considered sufficient to warrant the child's eligibility to receive services under ATAPS CMHS (e.g., home or school).

1.3.2 Eligible disorders and contextual factors

The full list of ATAPS CMHS ICD-10 disorders and contextual factors applicable under the ATAPS CMHS (i.e., CMHS target group referred to within this paper) can be found at Table 1. Referrals under ATAPS CMHS should include where possible a good developmental assessment by a referring practitioner in order to avoid inappropriate referrals.

The following ICD-10 disorders have been added to the general list of disorders outlined in the ATAPS Operational Guidelines (see Appendix 1), specifically for the CMHS target group:

1. Separation Anxiety Disorder of Childhood (F 93.0);
2. Attachment Disorders of Infancy or Early Childhood (F94.1 and F94.2);
3. Feeding Disorder of Infancy and Childhood (F98.2);
4. Encopresis (F98.1);
5. Social anxiety disorder of childhood (F93.2);
6. Obsessive compulsive disorder (F42);

7. Post traumatic stress disorder (F43.1);
8. Elective Mutism (ICD-10 F94.0) [also referred to as Selective Mutism in the DSM-IV TR];
9. Tic disorders (F95);
10. Gender identity disorder of childhood (F64.2) [included under Sexual Disorders in Table 1];
11. Emotional disorders with onset specific to childhood (F93);
12. Children that have experienced problems related to negative life events in childhood (Z61); including removal from home in childhood (Z61.1) and problems related to alleged sexual abuse (Z61.4, Z61.5 and Z61.6);
13. Problems related to upbringing (Z62); and
14. Problems related to primary support group, including family circumstances (Z63); for example, stressful life events affecting family and household (including mental disorders within the family) (Z63.8).

Childhood behavioural disorders

For the purposes of the CMHS component of ATAPS, *'childhood behavioural disorders*' (one category of disorders listed on Table 1) are included as mental disorders and incorporate the Attention-Deficit and Disruptive Behaviour Disorders {as defined in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)}. Relevant components of the DSM-IV-TR Attention-Deficit and Disruptive Behaviour Disorders include: Conduct Disorder; Attention/Hyperactivity Disorder (ADHD); Oppositional Defiant Disorder; and Disruptive Behaviour Disorder, not otherwise specified (NOS).

In relation to common childhood problems (e.g., feeding, sleeping, and toileting difficulties), these referrals should only be made to an ATAPS CMHS clinician following a comprehensive physical assessment. That is, when the referring practitioner considers the child's symptoms to have underlying psychological/social/contextual factors that need to be addressed via a psychological intervention.

In cases where children (e.g., children with behavioural/toileting/feeding difficulties) can competently be treated by GP's, paediatricians, maternal and child health nurses, and/or mental health nurses etc. (and where these services are available), the child should not be referred to ATAPS CMHS as a first option. However, an exception may arise when families live in remote areas and do not have access to a range of primary care services.

ATAPS disorders not included for ATAPS CMHS

The following disorders from the ATAPS Operational Guidelines (Appendix 1), are not included under the CMHS component of ATAPS:

1. Bipolar Disorder; and
2. Chronic and Acute Psychotic Disorders.

The exclusion of these disorders was based on the literature which suggests that it would be extremely rare for children to be diagnosed with a psychotic disorder or bipolar disorder before the age of 12 years (Tiffin, 2007: Lewinsohn, Klein & Seeley, 1995, as cited in Young & Fristad, 2007). In addition, children presenting with features of a psychotic disorder were considered to be best serviced in a specialist mental health setting rather than in a primary care setting.

Children with these disorders would typically need more intensive support than could be offered via ATAPS CMHS.

Table 1: List of disorders and contextual factors (ICD-10) for treatment under ATAPS CMHS

1	Attachment disorders
2	Depressive disorders
3	Adjustment disorder
4	Anxiety disorders – including: (a) Generalised Anxiety Disorder (includes overanxious disorder of childhood) (b) Separation Anxiety Disorder (c) Social Anxiety Disorder /Social Phobias (d) Phobic disorders /Specific Phobias (e) Obsessive Compulsive Disorder (f) Post traumatic Stress Disorder (g) Panic disorder*
5	Elective Mutism (or Selective Mutism)
6	Sleep disorders
7	Somatoform disorder
8	Neurasthenia (Chronic Fatigue Syndrome)
9	Feeding disorders[3]
10	Eating disorders
11	Encopresis[4]
12	Enuresis[5]
13	Bereavement disorders
14	Childhood behavioural disorders – limited to: (a) Conduct Disorder (b) Attention - Deficit / Hyperactivity Disorder (ADHD) (c) Oppositional Defiant Disorder (d) Disruptive Behaviour Disorder, not otherwise specified (NOS)
15	Tic disorders (e.g. Tourette's syndrome)
16	Substance use disorders (e.g. glue sniffing, alcohol and drugs)
17	Dissociative (conversion) disorder*
18	Sexual disorders – including but not limited to Gender Identity Disorder of Childhood
19	Emotional disorders with onset specific to childhood (F93)
20	Mental disorder, NOS
21	Contextual factors- including but not limited to: (a) Problems related to upbringing (Z62) (b) Problems related to negative life events in childhood (Z61) (c) Other problems related to primary support group, including family circumstances (Z63)

Note: Although prevalence rates for some disorders listed in Table 1 are less commonly observed in childhood (marked *), they have been retained under ATAPS CMHS in order to be inclusive and for ATAPS CMHS to benefit children at risk of developing disorders – in line with an early intervention approach to mental health service delivery.

[3] In cases where children (e.g., with behavioural/toileting/feeding difficulties) can competently be treated by GP's, paediatricians, maternal and child health nurses, and/or mental health nurses etc. (and where these services are available), the child should not be referred to ATAPS CMHS as a first option. However, an exception may arise when families live in remote areas and do not have access to a range of primary care services.

[4] As above

[5] As above

1.3.3 Treatment Considerations under ATAPS CMHS

- Some therapeutic approaches can involve working with parents in order to address the child's mental health needs. For instance, parent skills training with *parents only* in sessions (i.e., addressing the parenting relationship in order to support the child) are an appropriate intervention under ATAPS CMHS (see Table 4).

- Working with children WARMD and their families, requires more flexible approaches than working with adults.

- It is inappropriate for clinicians to be providing services to parents in front of children at times.

- Clinicians under ATAPS CMHS will also be guided by the developmental age of the child, when considering the therapeutic modality of choice.

- The number of sessions under ATAPS CMHS should take the form of up to 6 + 6 + 6, with the latter 6 sessions being applicable for "exceptional circumstances". (In the case of children, referral for up to an additional 6 sessions under exceptional circumstances eligibility could be extended to include specific clinical situations where ceasing treatment would lead to a detrimental outcome for the child (determined on a case by case basis)).

- Treatment under ATAPS CMHS must use evidenced based interventions (as specified in Table 2).

- Treatment may involve evidence based parenting interventions (i.e., only as specified in Table 2), if determined to be the best clinical and ethical means of addressing the child's needs in light of assessment findings and evidenced based practice. Parents can be present at all sessions with the child where clinically appropriate. Clinicians can determine how many sessions to provide to parents without the child being present, however they should ensure that there is maximum capacity for treatment of children within the total allowable

number of sessions. The child receiving treatment must always be the focus of services and support. It is a requirement of ATAPS CMHS for the child to attend for regular review and monitoring by the clinician during treatment (e.g. estimated as every third session).

The following *caveats in relation to service provision under ATAPS* CMHS apply:

- Where the service (or intervention) is available in the community and matches the needs of the client(s), clients should not be referred to ATAPS CMHS as an initial option.

- ATAPS CMHS does not fund services (or programs) already funded elsewhere; for instance Triple P parenting programs, and under these circumstances referrers need to refer families directly to Triple P (or relevant parenting programs) where appropriate.

- Treatment under ATAPS CMHS must be focused around the child's mental health needs, and should not include treatment of parents' mental disorders and/or relationship counselling addressing the couple relationship.

Table 2: Summary of evidence-based child and family interventions

	CBT		Behavioural interventions		Parenting/family-based interventions (inc. Psycho-education)		MBCT		Play Therapy		Family Therapy	
ADHD[a]			✓		✓	Behavioural-based			×			
Attachment Disorders					✓							
Anxiety Disorders	✓		✓	Social effectiveness training (social phobia only)			×	Suitable for children 9+	×			
Bereavement**	No level 1 or 2 evidence											
CD/ODD	✓	Suitable for children aged 8+	✓	e.g. social skills and problem-solving skills	✓	Parent-child interaction therapy, parent/teacher training			×			
Eating Disorders**					✓						×	
Elective Mutism**	✓		✓									
Encopresis[a]			✓		✓						×	Narrative approach
Enuresis	✓	Urine alarm interventions, CBT for older children	✓									
Depressive Disorders	✓	Suitable for children aged 8+	✓				×	Suitable for children 9+	×			
Feeding Disorders			✓		✓	Behavioural-based						
Gender Identity Disorder**	No level 1 or 2 evidence											
Neurasthenia (Chronic fatigue syndrome)**	✓	Suitable for older children										
PTSD	✓	Trauma-focused			×	Child and family-focused CBT (CFF-CBT)			×			
Sleep Disorders	✓	Suitable for older children	✓		✓	Behavioural-based						
Somatoform Disorders (pain)	✓		✓		✓							
Tic Disorders[a] (e.g. Tourette's syndrome)	×		✓	e.g. habit reversal training								

PTSD = Post-Traumatic Stress Disorder; ADHD = Attention-Deficit Hyperactivity Disorder; CD = Conduct Disorder; ODD = Oppositional Defiant Disorder; MBCT = Mindfulness-Based Cognitive Therapy

[a] May involve the use of medical interventions as evidence-based practice (e.g. medication, nutritional management) used in conjunction with psychological interventions

** The research is limited in this area with children under the age of 12. Controlled studies are warranted. See full literature review

✓ There is level 1 or 2 evidence to support the use of this intervention for this mental disorder

× There is emerging evidence for this intervention however no level 1 or 2 studies have been undertaken to date.

Note: Evidence listed above is based on level 1 and 2 evidence only (i.e. RCTs, systematic reviews, meta-analyses)

Note: Interventions such as CBT and MBCT should be developmentally appropriate and modified for use with younger children

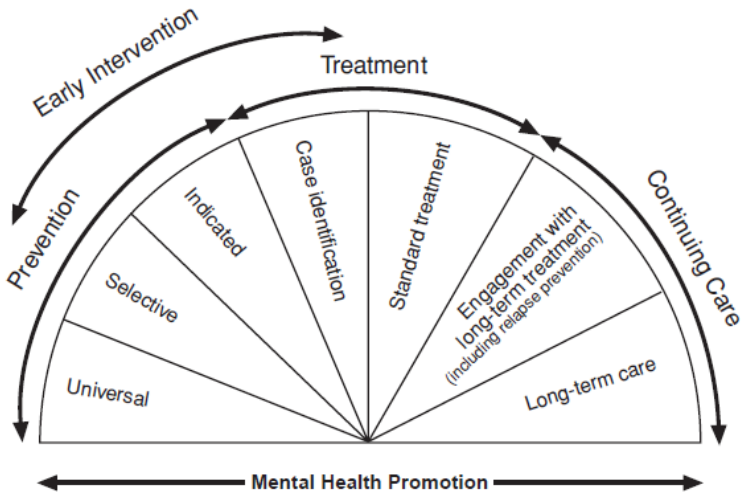
Note: Low prevalence mental disorders (e.g. substance use disorders, conversion disorder) were excluded from the literature review due to there being limited available scientific best-practice evidence with children under 12 years.

1.4 Policy and Service Provision Context

1.4.1 Population health and the public health model of service delivery in Australia

When attempting to meet the mental health needs of children and young people, interventions from a diverse spectrum of approaches are required; including taking into account prevention and early intervention, treatment, and the long-term care needs of the child (Commonwealth Department of Health and Aged Care, 2000; see Figure 1 for a pictorial representation). In Australia, the public health model is adapted across many disciplines, and aims to prevent problems occurring in the first instance by targeting policies and interventions at known risk factors in order to reduce the later emergence of the target problem.

Figure 1: The mental health intervention spectrum for mental disorders



Source: Adapted from Mrazek and Haggerty (1994) p.23.

Preventative interventions can be described as primary, secondary or tertiary interventions. *Prevention* is defined as 'interventions that occur before the initial onset of a disorder' to prevent the development of disorder (Mrazek & Haggerty 1994; cited by Commonwealth Department of Health and Aged Care, 2000*). Primary* or universal interventions are targeted at the entire population or community and provide support and education before problems occur. *Secondary* interventions are those that target specific "at risk" individuals or groups and aim to both provide early intervention and attempt to prevent the subsequent escalation of the issue. *Tertiary* interventions include the treatment

strategies that are used once primary and secondary intervention has failed. *Indicated prevention* interventions are aimed at population groups and individuals at high risk of the onset of a disorder, who have the early signs and symptoms foreshadowing mental health difficulties and mental disorders but who do not meet the diagnostic criteria for diagnosis of a disorder. Examples of indicated prevention interventions include parenting programs for parents of children who display aggression and noncompliance. Whereas *early intervention* refers to interventions targeting children showing early signs/symptoms of a mental health difficulty or mental disorder; or interventions for children experiencing the first episode of a mental disorder. Early intervention encompasses the 'indicated prevention', 'case identification' and 'early treatment' sectors of the model presented in Figure 1.

The specific interventions that are best utilised with children should be based on the best available evidence in the literature (i.e. the interventions which have demonstrated statistically[6] significant benefits to the sample of participants) (Commonwealth Department of Health and Aged Care, 2000). It is likely that the selected evidence-based interventions will span the full range of interventions in the spectrum (Figure 1) in order to adequately impact on the mental health problems they address, however the availability of interventions will determine the range of interventions used (Commonwealth Department of Health and Aged Care, 2000).

A successful mental health system will take into account the importance of not only effective treatment strategies for mental health issues once they are already apparent in the child, but the more cost-effective components of mental health *promotion* and *prevention*. Mental health promotion aims to maximise the mental health and wellbeing among populations and individuals, whereas prevention may be directed at whole populations, high risk groups or at individuals who have been identified as being at risk. Prevention is likely to have its greatest impact in young children because of the considerable potential to reduce long-term, as well as short-term issues (Commonwealth Department of Health and Aged Care, 2000).

[6] Clinical benefits of interventions can also be considered.

1.4.2 Principles underpinning child and family service delivery

It is considered of great importance that service delivery under ATAPS CMHS is based on principles and standards which underpin good clinical practice. The following documents contain principles and practice standards which are considered by the mental health experts preparing this guidance document to underpin good clinical practice for clinicians working with children WARMD and families. These include:

- The principles outlined in The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) position paper (2011).
  See http://www.aicafmha.net.au/resources/index.html

- The importance of *family centered principles* - considered to be crucial for positive outcomes for children and families.

  The Royal Children's Hospital Melbourne, Centre for Community Child Health has a number of recommended references on family centered practice.

- See reference list at
  http://www.rch.org.au/emplibrary/ccch/EY_Ref_mod2.pdf#xml=http://www.rch.org.au/cgi-bin/texis/webinator/search/pdfhi.txt?query=family+centred+practice&pr=rchmelb_ext&prox=page&rorder=500&rprox=500&rdfreq=500&rwfreq=500&rlead=500&rdepth=0&sufs=0&order=r&cq=&id=4eb7be5e102

- The standards outlined in The Royal Australasian College of Physicians' ''Standards for the care of children and adolescents in health services".
  See http://www.racp.edu.au/page/child-adol

- National standards for mental health services 2010
  http://www.health.gov.au/internet/publications/publishing.nsf/Content/m ental-pubs-n-servst10-toc~mental-pubs-n-servst10-pri

- Protocols for the delivery of social and emotional well being and mental health services in Indigenous Communities.

See http://www.uq.edu.au/nghepu/documents/protocols.pdf

Also see:

- The Royal Australian and New Zealand College of Psychiatrists: Report from the Faculty of Child and Adolescent Psychiatry. *Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand,* 2010. http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/peips_report.pdf

In summary, the main issues covered in these documents include:

- the importance of ATAPS CMHS clinicians working within a developmental framework in order to meet the unique needs of children WARMD and families;
- family centered principles guiding clinical practice;
- delivering high quality clinical services that are evidenced-based;
- working within settings that are appropriate for the developmental needs of child clients; and
- being mindful of the need to work in a culturally sensitive manner with children and families from CALD/Indigenous communities. Thus, it is essential that principles underpinning high professional standards and family centered practice (as discussed in these documents) are kept in mind by Medicare Locals in their planning of service delivery under ATAPS CMHS.

It is essential that principles underpinning high professional standards and family-centered practice are kept in mind by Medicare Locals in their planning of service delivery under ATAPS CMHS

1.4.3 Ethical Issues in working with children

- Clinicians need to familiarise themselves with *ethical issues* which are specific to working with children and families, a vulnerable client group. For instance, issues pertaining to the client-therapist relationship, consent to assessment and treatment, and to the release of information to third parties.

- Clinicians should refer to the ethical principles of their professional association for guidance around these issues.

Also see:
Early Childhood Australia's Code of Ethics. This Code of Ethics provides a framework for reflection about the ethical responsibilities of early childhood professionals –for professionals working with children birth to eight years. http://www.earlychildhoodaustralia.org.au/pdf/code_of_ethics/code_of_ethics_%20brochure_screenweb_2010.pdf

1.4.4 Epidemiology

Prevalence rates for mental disorders across the childhood period are cause for significant concern. Moreover, the average age of onset for many common mental disorders appears to be during childhood and adolescence, and many disorders diagnosed in adulthood have their origins in childhood (Kessler et al., 2005; Newman et al., 1996). For instance, for autism and attachment disorders, typical age of onset is birth to 3 years. For attention deficit hyperactivity disorder, the typical age of onset is before 7 years (but the typical age of diagnosis is age 7-9 years). For onset of conduct disorders it is 9-14 years and the average age of onset is 7-14 years for some types of anxiety disorders (e.g., phobias and separation anxiety) (Kessler et al, 2007). Across disorder type, earlier age of onset is associated with an increased severity of impairment, and a greater likelihood of multiple diagnoses (Newman et al., 1996).

Internationally, epidemiological studies consistently show throughout the world that between 10-20 percent of children and young people in urban settings suffer from a diagnosable mental health problem**.** In the National Survey of Mental Health and Wellbeing, 1 in 7 Australian children and adolescents (aged 4-

17 years) were found to be experiencing a mental health difficulty; a prevalence estimate of 14% (Sawyer et al, 2000). Findings from the survey indicated that the most common disorders were ADHD (11%), followed by Depression (3.7%) and Conduct Disorder (3.0%; Sawyer et al, 2000). However, it should be noted that prevalence estimates in the study may be an underestimation of actual prevalence as anxiety disorders were omitted from this study (Raphael, 2000).

In Australia, further studies comparable to Sawyer et al's (2000) National Survey of Children's Mental Health and Wellbeing have not been conducted which prevents analysis of whether prevalence is rising or falling in Australia. However, internationally there is evidence of a significant rise in mental disorders in young people (Rutter & Smith, 1995; Collishaw et al., 2010; Achenbach et al., 2003). In addition, Zubrick, Silburn, Vimpani and Williams (2000) highlighted a concerning trend whereby mental disorders appear to be affecting children and young people at earlier periods. For instance, emerging data reveals that mental health problems in infants can be reliably identified, and the prevalence of disorders in this age group in Northern Europe is between 16-18% (Skovgaard et al., 2000; as cited in RANZCP, 2010); and in the US, the prevalence of socio-emotional and behavioural difficulties in a representative sample of one and two year olds is 11.6 % (Briggs-Gowan et al, 2001; as cited in RANZCP, 2010).

Of further concern is that epidemiological studies have reported high rates of comorbidity in children with community samples indicating as many as 68% of children have comorbid disorders and these rates are considered to possibly be higher among clinical samples (Bird, Gould, & Staghezza-Jaramillo, 1994, as cited in Riosa, McArthur, & ` le Preyde, 2011).

In addition, Sawyer et al.'s report (2000) identified that the services that were most frequently used by children and adolescents were family doctors, paediatricians and counselling in schools. Furthermore, a 2007 - 08 survey of general practitioner activity was conducted in Australia (BEACH survey) and findings indicated that the most common mental health problems managed by general practitioners for children (aged birth to 14 years) were behavioural symptoms/complaints (27%), ADHD (18%), sleep disturbance (14%) and depression/anxiety (13%) (AIHW, 2009).

Indeed, mental disorders have been reported to have caused the highest burden of disease among children in 2003 (AIHW, 2009). These findings of increased prevalence, earlier presentation of symptoms and the long term consequences in terms of burden of disease- at both an individual and population level- has led many researchers to be concerned about the wellbeing of Australia's children (RANZCP, 2010).

1.4.5 Social Context

There are a number of social issues that are reported within the literature to be relevant to children with mental disorders and their families. These include factors relating to children's school context (e.g. peer relationships, bullying, academic achievement); their family context (e.g. parenting style, family disharmony, parents' mental health issues, parents' employment status) and also their community context (e.g. social isolation) (Bond et al., 2001; Huntsman, 2008; Raphael, 2000).

Within the literature there is substantial evidence that the incidence of mental disorders is reported to be higher for children from disadvantaged backgrounds; for instance, children living in poverty (Samaan, 2000) and those residing in out of home care (Raphael, 2000). Furthermore, children of parents with a mental disorder are also reported to show a higher rate of behavioral, developmental and emotional problems than those in the general population (Beardslee et al., 1998, as cited in Huntsman, 2008).

Ethnicity and cultural factors are also reported to be factors influencing children's mental health outcomes (Raphael, 2000). For instance, Aboriginal and Torres Strait Islander children are reported to experience significant social adversity and poor health outcomes. Findings from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey indicate that Aboriginal and Torres Strait Islander children aged 4-14 years were significantly more likely to have a mental health condition compared with non-Indigenous children (13% compared to 8%) (Sawyer et al., 2000).

Findings also demonstrate that cumulative risks factor such as poverty, maternal depression and ethnic minority have been associated with poorer health (including mental health) outcomes for children. Indeed, recent studies have shown higher rates of mental disorders in children when multiple risk factors

occur together (Wille, et al., 2008; as cited in KidsMatter Primary, 2011). This includes the detrimental effects of poverty and disadvantage on individuals, families and communities such as poor and unequal living conditions, conflict and violence that are societal and community level risk factors to mental health (VicHealth, 2009).

1.4.6 Service Context

Despite the large number of people who experience a mental disorder each year (approximately one in five), Australian data provides evidence that only one quarter of children experiencing mental health difficulties seek assistance from a health service (Department of Health and Ageing, 2006). While an increasing number of children are accessing the Better Access services, substantial percentage of those who have mental health difficulties have not been diagnosed, or are not receiving treatment for their condition, based on findings from studies. This suggests a large unmet need for mental health services and that many families are either not receiving any assistance, or are relying on informal sources of support, such as family and unpaid carers. It also suggests the existence of potential barriers that may be making it more difficult for children and families to be accessing and using mental health services.

1.4.7 Service Structure

Traditionally mental health services for children have been criticised for being fragmented, lacking in coordination (impacting upon families' ability to access and navigate their way around services), and not being able to meet the growing service demands (e.g. McGorry, 2007). Furthermore, there has also been criticism amongst the mental health sector pertaining to the lack of funding and priority given to children WARMD, with a lack of emphasis on prevention and early intervention (e.g. The Children's Mental Health Coalition, 2010).

Clearly with a capped program allocation, it would not be possible for ATAPS to meet the needs of all infants and children with a diagnosed mental illness, nor should there be a need to do so, given the availability of the Better Access to Psychiatrists, Psychologists and General Practitioners, through the Medicare Benefits Schedule (Better Access) Initiative. Consistent with the policy decisions and announcements of Government, ATAPS is a complimentary program to Better Access that can be effective at targeting particularly hard to reach and

disadvantaged groups. As such, Medicare Locals will need to prioritise access to services for children being managed by their GP or paediatrician in the primary care setting.

The following section summarises the different types of mental health services and initiatives available for children and families in Australia at the time of releasing this purchasing guidance. Also refer to Table 3, which outlines services for children and families in Australia.

Table 3: Services and Initiatives for Children and Families in Australia (as at December 2011)

Service Type	Prevention	Early Intervention	Treatment	Professional Support Services
CALD and Indigenous services and Initiatives	**Indigenous Initiatives and Services** e.g. National Indigenous Child and Family Resource Centre; National Aboriginal Community Controlled Health Organisation (NACCHO); SNAICC			
				Indigenous Government resources http://www.aifs.gov.au/afrc/links/indigenous.html
	Strong Fathers Strong Families Program			
	Indigenous early childhood development			
				CALD online resources http://www.aifs.gov.au/afrc/links/caldfamilies.html#a5; http://www.beyondblue.org.au/index.aspx?link_id=102 e.g. Family mental health support services (see http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-multi-fact)
				Indigenous resources http://www.healthinfonet.ecu.edu.au/; http://www.beyondblue.org.au/index.aspx?link_id=4.1411 http://www.cyh.com/SubContent.aspx?p=147
Child Welfare Services			**Child Welfare Early Intervention Initiatives** e.g. Child First (Vic); Child Protection Services; Brighter Futures (NSW); Take Two (Vic)	

Service Type	Prevention	Early Intervention	Treatment	Professional Support Services
Children and Family centres	Dept. of Disability, Housing and Community Services (ACT); Dept. of Education and Children's Services (SA).			
Community Health			**Community health services/centres** e.g. psychology/social work/speech pathology	
Community supports		**Community services** e.g. Uniting Care Connections; Anglicare; Relationships Australia		
Crisis support services			**Helplines** e.g. Kidshelpline, Parentline, Lifeline	
Disability services			**Disability services** e.g. Specialist Children's Services and Intellectual Disability Services (Vic government services)	
			Parenting support for parents with special need children e.g. Noah's Ark (Vic)	
			Autism-specific services e.g. specialist autism assessment teams via public mental health; Autism early intervention centres e.g. Irabina (Vic)	
			Government-funded initiatives e.g. autism assessment via government-funded schemes; Early Days online workshops etc.	

Service Type	Prevention	Early Intervention	Treatment	Professional Support Services
Health		**Public Hospital services** e.g. Community & Liaison, Psychology Departments; Psychiatry services; Outpatient allied health services; Hospital Emergency services; Public Paediatric Services (e.g. outpatient clinics); Specialist clinics		
Justice			**Services provided via Justice Departments** e.g. Children's court clinic (Vic); Family Court Supports e.g. family mediation	
Mental health			**Public Mental Health Services** – mental health assessment and treatment services for children and youth; Outpatient and Inpatient services (e.g. CYMHS and ELMHS in Vic)	
			Drug and alcohol services	
Perinatal support services	**Maternal and child health** **Hospital outpatient clinics** e.g. Mercy Women's Clinic (Vic) **Universal home visits** e.g. maternal and child health nurses (Vic)			
		Sustained home visits for targeted groups, e.g. Enhanced maternal and child health in Victoria, Best Beginnings (WA)		
	Perinatal services e.g. PIRI (Vic), Early parenting centres e.g. QEC (Vic)			
	National initiatives e.g. Beyondblue national perinatal program			
Private services			**Private services** e.g. Services funded under government schemes Better Access, ATAPS.	
			Private services e.g., child psychiatrists/paediatricians/GPs, psychology and allied health in private practice; services provided by private hospitals and clinics	

Service Type	Prevention	Early Intervention	Treatment	Professional Support Services
Private (cont)		**Mental Health Nurse Incentive Program (MHNIP)** (Government funding available for coordinated clinical care for those with severe mental illness)		
Research funded services	e.g. Murdoch Children's Research Institute (MCRI), Centre for Community Health resources (CCCH), Parent Infant Research Institute (PIRI)			
School / Early Childhood supports		**Prevention, promotion, early intervention mental health initiatives** e.g. KidsMatter; Launching into learning (Tas)		
		School / early childhood based supports: School Psychologists/counsellors; and Preschool field officers.		
				Hunter Institute Response Ability
Services for special need groups		**ADHD services / supports** e.g. ADHD support groups (Every Day with ADHD)		
	Eating disorder supports e.g. Butterfly Foundation; National Eating Disorder Collaboration			
	Sexual abuse services and supports e.g. Gatehouse centre (Vic); Australian Childhood Foundation; National Sex Violence Resource Centre			
	Trauma loss and grief-network and online resources			
University services			**University based clinics**	

Service Type	Prevention	Early Intervention	Treatment	Professional Support Services
Other initiatives and peak bodies	e.g. FACSIA (good beginnings parenting program); ARAFMI; COPMI; Carers Australia; ARACY; Niftey; AEDI; beyondblue; National Drug and Alcohol Research Centre			
				Supervision services e.g. private psychologists. See APS website http://www.psychology.org.au/
				Victorian Transcultural Psychiatry Unit
				Interpreter services for children with special needs, such as children with communication impairments, e.g. Translating and Interpreting Service (TIS), Doctors Priority Line.
				Website resources for professionals e.g. APS website; South Australian Website for Child and Youth Health - CYH (SA) http://www.cyh.com/SubDefault.aspx?p=98; CCCH website at RCH
	Parenting resources e.g. Raising Children Network			

Adapted from Cother, E., & McGill, K. (2010). Hunter Institute of Mental Health - 2009/10 Update to the Early Childhood and Parenting Services Scoping Study, Final Report http://www.himh.org.au/client_images/982726.pdf

Direct Treatment

Direct treatment for children and families with mental health concerns are mainly provided through public, community, research programs and private sectors within Australia. These included the following at the time of releasing this purchasing guidance:

1. *Public services* including:

- Specialist child and youth mental health services. For instance, Child and Youth Mental Health Services (CYMHS) and Early in Life Mental Health Services (formerly CAMHS) provide direct services for children and young people who have mental disorders with severe symptoms, usually in the community; and

- Public hospitals.

2. C*ommunity based services* such as:
   Anglicare, Relationships Australia, Community Health Services, University Clinics, Early Parenting Centres; and supports accessed via Early Childhood Services and Schools.

3. *Research based services*: This includes services offered through funded research projects (often offered via university programs/clinics and research organisations).

4. *Private sector and fund holding arrangements*: Allied health professionals (e.g. psychologists, social workers, occupational therapists and mental health nurses), GP's, paediatricians, and child psychiatrists. Many of these services are funded (or partly funded) through government funded initiatives (described below).

Commonwealth Government Schemes:

There are a number of Commonwealth Government schemes under which allied health professionals are eligible to provide services to children and families under Medicare and through other fund holding arrangements. These include:

- *The Better Access to Mental Health Care initiative* introduced new mental health Medicare items on 1 November 2006 (known as Better Access to Psychiatrists, Psychologists and GPs through Medicare Benefits Schedule initiative). These items enable people with diagnosed mental disorders to access services from a range of mental health service providers, including psychologists and appropriately trained occupational therapists and social workers.

- *The helping children with autism initiative*- Medicare items have been available from 1 July 2008 for the diagnosis and early intervention treatment of children with autism or any other pervasive developmental disorder (PDD). The Medicare items cover two specific types of services - assessment services and treatment services.

- *Better Start for Children with a Disability Initiative*- from 1 July 2011 new Medicare funded services have been available for the assessment and treatment of children with a disability. This program is available to children diagnosed with sight and hearing impairments, cerebral palsy, Down syndrome and Fragile X syndrome. Medicare items are available for services provided by eligible allied health professionals, as well as optometrists and orthoptists. The Medicare items cover two specific types of services - assessment services and treatment services (taken from The APS website; http://www.psychology.org.au/medicare/).

- *Allied Health Individual Services for patients with a chronic medical condition and complex care needs under Medicare*- A number of Medicare rebates are available for services, per patient each calendar year. Services can be provided by a number of professionals, as listed on the following website link: http://www.health.gov.au/internet/main/publishing.nsf/Content/Chronic+Disease+Allied+Health+Individual+Services

- *Mental Health Nurse Incentive Program*. Under this program, funding is provided for organisations to engage mental health nurses to assist in the provision of coordinated clinical care for people with severe and persistent mental illness. Information regarding the program, including patient eligibility

criteria is at: www.medicareaustralia.gov.au/provider/incentives/mental-health.jsp

- *Access to Allied Psychological Services (ATAPS)* – as discussed earlier, this funding enables General Practitioners (GPs), paediatricians or psychiatrists to refer consumers to allied health professionals who deliver focused psychological strategies services; ATAPS complements allied health services funded through Medicare.

The CMHS is a component of ATAPS

Promotion, early intervention and prevention activities:

These activities are being offered through a number of government funded initiatives, including the *KidsMatter* suite of activities. These include:

- The *KidsMatter Primary* initiative which aims to promote mental health, prevent mental illness and initiate early intervention where necessary among primary school students in the school setting.

- The *KidsMatter Transition to School Parent* initiative which aims to support children and parents during the transition from preschool to primary school through an evidence-based approach that promotes positive parenting behaviours and practice and improves the knowledge of parents relating to the issues children face when transitioning to school.

- Under the KidsMatter Early Childhood initiative, work is continuing to expand the *KidsMatter* concept into early childhood settings such as preschools and long day care. A specific initiative addressing the needs of Aboriginal and Torres Strait Islander children is also under development.

Recommended websites:

- See http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/early-intervention-1 for more information about government services and initiatives.

- See www.kidsmatter.com.au for more information about KidsMatter

1.4.8 Service Barriers

There are a number of issues that may act as barriers for children WARMD, their families, and referrers in being able to access services. These include:

1. *Access and Affordability Issues*

- Few children WARMD receive professional help. Parents report practical issues to explain why children do not receive professional help including being unable to afford help; not knowing where to get help; seeking help but not receiving it; and having to wait too long before help was available (Sawyer et al., 2000).

2. *Service issues*

- Families of children WARMD often experience long waiting lists for public services (e.g., Child and Youth Mental Health Services) and there is a reported shortage of public mental health facilities for children in Australia (McGorry, 2007).

3. *Consumer Issues*

- Families and referrers (e.g. schools) may be reluctant to refer children to mental health professionals for support due to the perceived stigma of diagnosing and/or treating children WARMD. For example, Sawyer et al. (2000) reported that 6% of parents reported that the stigma of getting help kept them from getting help for their children with symptoms of mental health difficulties.

- Schools and early childhood services often struggle to identify and access referral pathways for children and families (e.g. due to waiting lists or due to children not meeting criteria for services).

1.4.9 Policy Context

See Appendix 2 for a list of key policies relevant to mental health service delivery under ATAPS CMHS.

The policies listed in the appendix are those considered by the Australian Government to be key to directing the work of the Australian Government in its contribution to mental health reform activities in Australia. They can also be viewed by going to: http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/policies-lp-1

2. Early Intervention and Assessment

Part 2 of this purchasing guidance provides information pertaining to: early intervention approaches; and assessment of children under ATAPS CMHS

2.1 Early Intervention – children at risk of developing mental disorders

There is strong evidence for the benefits of early intervention approaches for the treatment of childhood mental disorders and the long-standing and devastating consequences that can occur when treatment does not occur. The prevention and early intervention of mental disorders in childhood is critically important, both to improve children's mental health, and to help prevent the onset of mental disorders in adolescence and adult life. The evidence-base to support prevention and early intervention strategies for child mental health continues to expand and strengthen, and indicates the potential of such strategies to be both beneficial and cost-effective (RANZCP, 2010). In addition, there is considerable evidence showing that the onset of many adult psychological problems has origins in childhood, often with childhood behavioural and emotional problems (Bayer et al., 2009). Left untreated about 50% of children are reported to grow out of behavioural problems. Whereas, for the remaining 50% the long term sequelae can include school dropout, family breakdown, depression, substance abuse and employment difficulty (Bayer et al, 2009).

> Parenting style has been shown to be the single most important environmental factor to influence a young child's behaviour; hence, most preventive programs try to optimise parenting styles (Bayer et al., 2009).

Children's mental disorders are in part inherited and in part due to the environment. Preventive interventions have focused primarily on optimising the environment, with a view to managing or preventing the child's problem.

Furthermore, studies that have reviewed the evidence pertaining to preventative interventions have shown that for preschool children (2-5 years), family support and parenting programs continue to be the most effective method of preventing the onset of emotional and behavioural problems which predispose to mental illness in later childhood. Whilst for school age children (5-12 years), school-based in addition to family and individual child intervention becomes more relevant to prevention and early intervention of mental disorders, and in detecting and controlling behavioural and emotional problems. However, it is important to still involve and support families in school-based programs or initiatives. Additionally, parenting programs can continue to offer effective methods of intervention for school aged children (RANZCP, 2010).

There is therefore substantial evidence to support the importance of providing effective prevention and early intervention efforts for children at risk of mental disorders. Parenting interventions have been the main intervention approach and there have been reported positive outcomes, including reductions in children's emotional and behavioural difficulties (Webster-Stratton, 1998; Sanders et al, 2008). A number of authors have reported challenges in engagement as a factor for consideration when implementing parenting programs (e.g., Moran et al., 2004). Practitioners implementing parenting interventions need to consider barriers to engagement (including cultural factors, child care, transport, location, time of parenting group) and ways of best supporting parents to access services (Moran et al; 2004).

Parenting interventions

Allied health professionals delivering ATAPS CMHS are to use evidenced based parenting interventions. However, practitioners do need to consider their clients' context (e.g., information obtained from assessment findings) and try to match their clients' needs with evidenced based interventions which take into account any relevant contextual factors (e.g., applicability of interventions for CALD and Indigenous populations).

The implementation of preventative interventions (e.g., CBT based parenting interventions) for anxiety disorders in preschool aged children is recommended as a strategy to prevent onset of anxiety disorders and prevent their emergence in children (Rapee et al., 2010).

Children at risk of depressive disorders should be a target for evidenced based preventative interventions, given the prevalence of depressive disorders and the evidence base for preventative interventions (Beardslee et al., 2003). Moreover, preventative interventions with a sound evidence base should be used by clinicians working with children where a parent has a mental disorder; for instance, family focused interventions (Beardslee et al., 2003; Beardslee et al., 2007).

Recommended resources**:**

- See the KidsMatter Primary programs guide (component 3) for a review of specific parenting programs. http://www.kidsmatter.edu.au/primary/content/uploads/2011/09/Component-3-specific-01.09.11.pdf

- See the KidsMatter Early Childhood programs guide for a review of specific parenting programs. http://www.kidsmatter.edu.au/ec/resources/programs-guide/

- See the *Children of Parents with a Mental Illness (COPMI)* website for information and resources. Go to http://www.copmi.net.au/

See references:

- Bayer, J., Hiscock, H., et al. (2009). Systematic review of preventive interventions for children's mental health: what would work in Australian contexts? *Australian and New Zealand Journal of Psychiatry*, 43, 695-710.

- Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children

at risk: Evidence of parental and child change. *Paedatrics*, *112* (2), 119 - 131.

- Bearsdlee, W. R., Gladstone, T.R.G., Wright, E.J., & Forbes, P. (2007). Long-term effects from a randomized trial of two public health preventative interventions for parental depression. *Journal of Family Psychology*, *21* (4), 703-713.

- Rapee, R. M., Kennedy, S. J., Ingram. M., Edwards, S.L., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry, 167* (12), 1518-1524.

- The Royal Australian and New Zealand College of Psychiatrists: Report from the Faculty of Child and Adolescent Psychiatry. *Prevention and early intervention of mental illness in infants, children and adolescents:* Planning strategies for Australia and New Zealand, 2010.

2.2 Assessment

The approach to assessment of children WARMD and families will vary depending on the allied health professional's role, the setting and their professional relationship with the family. A comprehensive assessment always includes consideration of strengths and vulnerabilities that the parents and children bring to their current circumstances, a developmental focus (including the relational context), and attention to bi-psycho-social factors that help or hinder the child and family at this time of rapid developmental change (Mares, Newman & Warren, 2011).

During the assessment a range of information needs to be gathered from a number of sources, determined at least in part by the setting in which the child and family are being seen and the purpose of the assessment. Direct sources of information should include: clinical history (including early developmental milestones), observations of child and family members and their interactions, tests, and other sources (e.g. information from early childhood services or schools). Other information that informs the assessment may include past agency involvement and interventions. Where possible the clinician should consider assessing a child alone, as well as in session(s) with their

family/parents (or carers) in order to understand the relationship context of the child's presenting symptoms. Information should also be collected from key informants across multiple settings; for example, home and early childhood service/school (Egger, 2009).

There are a number of assessment tools that can be used to support the assessment of children WARMD and their families (see Appendix 3, for examples of commonly used assessment tools). For instance, questionnaires can be given to older children, parents and the school (with parental consent) in order to gain information about the child across contexts and compare perspectives of key informants. Clinicians need to ensure that they use appropriate standardised assessment tools (e.g. taking into account the age of the child); and for these tools to be used in accordance with standardised administration procedures. Training in the interpretation of test findings is important, as findings need to be interpreted within the context of a comprehensive assessment, taking the bi-psycho-social context into account.

The information outlined in Table 4 is a summary of the main steps used in conducting comprehensive mental health assessments with children and families. It is important to emphasise that a family centred approach requires the input of the client in a shared journey with the clinician around understanding assessment findings and treatment planning.

Assessment of children WARMD and families can be broken down into the following key steps, as described in Table 4.

Table 4: Overview of mental health assessment process

Assessment of child	Including clinical interview (pending on age), observations of play, drawings, using assessment tools, gathering past assessment information (e.g. professional reports).
Assessment of parents	Including clinical interview (e.g., discuss the current problem, individual parent's histories, child's early developmental and medical history), and observations of parents' interactions with child.
Assessment of family	Including family history, genogram (family tree), identify family's resources, determine the role the child plays within the family, relationship with siblings, and observe family dynamics.
Assessment of child in other relevant social contexts	(with parental permission) – including: early childhood service/school context (may include observations, history and administering questionnaires to staff).
Formulation	Clinician formulates the case (integrates assessment information), taking into account assessment information from all relevant contexts and informants.
Feedback to client(s), Treatment Recommendations and Plan	Feedback formulation, diagnosis (if appropriate) and set treatment plan with goals (developed in consultation with clients).

Assessment Recommendations:

1. **Assessment of children WARMD and families should be conducted in *up to three sessions* under ATAPS CMHS**

   In most cases two assessment sessions dedicated to the assessment component were thought to be sufficient and appropriate due to the limited amount of sessions available under ATAPS (although it is acknowledged that clinicians will need to condense the assessment process outlined in Table 4).

   - However, a third session is available to clinicians if they determine this to be clinically necessary, based on the presenting problem and complexity of the case.

   - These sessions should include the opportunity for a separate parent session, child session and where possible family assessment session.

> *Assessment under ATAPS CMHS should involve the child, family and school/child care setting*

2. **Importance of a comprehensive assessment**

   - The importance of a comprehensive assessment when working with children WARMD and families is stressed. In fact, a thorough assessment is considered to be an intervention in itself, and to often lead to more efficient treatment outcomes. Furthermore, it is considered imperative that *assessment under ATAPS CMHS should involve the child, family and school/early childhood service.*

3. **Cognitive / developmental assessment**

- It was noted that at times it can be quite difficult to differentiate emotional problems versus developmental delays (e.g. cognitive delays, language delays, motor delays) when assessing children WARMD.

- In cases where clinicians identify that a cognitive/developmental assessment is indicated, *one* session can be used to administer a standardised assessment tool (e.g. Wechsler Intelligence Scale for Children) providing the clinician is competent to administer this tool. Alternatively, ATAPS CMHS clinicians have the option of referring children out for developmental/cognitive assessment (with parental consent) to a suitably qualified professional (e.g. school psychologist or private practitioner) as deemed necessary.

- Children with developmental/learning issues should **not** be referred to ATAPS CMHS if there are no emotional/behavioural difficulties (i.e., signs of a mental disorder).

3. Service Delivery

This Section of the Purchasing Guidance provides information pertaining to a review of the literature pertaining to treatment of children WARMD and families (evidenced based practice), referral pathways and the use of interpreters.

3.1 Literature Review – Evidence-Based Psychotherapies for Children's Mental Disorders

3.1.1 NHMRC Guidelines for Evaluating Evidence

The National Health and Medical Research Council (NHMRC) have published a clear and accessible guide for evaluating evidence and developing clinical practice guidelines. The NHMRC guide informs public health policy in Australia and has therefore been adopted as protocol for evidence reports by the Australian Psychological Society. The evidence on which a treatment recommendation is based is graded by the NHMRC according to the criteria of level, quality, relevance and strength.

The 'level' and 'quality' of evidence refers to the study design and methods used to eliminate bias. NHMRC has developed a rating scale used to designate the level of evidence of clinical studies, which is reproduced below.

3.1.2 Designation of levels of evidence

Level	Evidence source
I	Systematic review of all relevant randomised controlled trials
II	At least one properly designed randomised controlled trial
III-1	Well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
III-2	Comparative studies with concurrent controls and allocation not randomised (cohort studies) or interrupted time series with a control group
III-3	Comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group
IV	Case series, either post-test or pre-test and post-test

Source: NHMRC, 1999

The 'relevance' of evidence refers to the extent to which the findings from a study can be applied to other clinical settings and different groups of people. This should also include consideration of relevant outcomes from the consumer's perspective, such as improved quality of life. Finally, the 'strength' of evidence relates to the size of the treatment effect seen in clinical studies. Strong treatment effects are less likely (than weak effects) to be the result of bias in research studies and are more likely to be clinically important.

3.1.3 Using Evidence to Make Recommendations for Treatment

According to the NHMRC, evidence is necessary but not sufficient in making recommendations for treatment. Assessing the evidence according to the criteria of level, quality, relevance and strength, and then turning it into clinically useful recommendations depends on the judgment and experience of the expert clinicians whose task it is to develop treatment guidelines.

There is debate as to what defines 'evidence-based' practice. Some clinicians believe that only psychological interventions that have demonstrated treatment

efficacy by the 'gold standard' of clinical trials – Randomised Controlled Trials (RCTs) – should be endorsed. Others contend that psychological research evidence should be gathered from broader methodologies and that, for instance, the psychotherapeutic experience cannot be captured in RCTs. In addition, although RCTs are identified as providing the strongest evidence, a range of other methodologies for investigating the efficacy of interventions have been adopted. Further, the importance of therapist and client variables as contributors to treatment outcomes should be acknowledged.

A criticism of the use of the RCT as a necessary measure of the success of an intervention has been that in the real world the treatment setting is never as controlled as in RCT conditions. This has led to the debate between studies of treatment efficacy (controlled studies) and studies of treatment effectiveness (studies in the naturalistic setting). It can be argued that both are important and that effectiveness studies complement RCTs by demonstrating efficacy in actual treatment settings and identifying factors in the real life setting that impact on treatment efficacy. The NHMRC states that in order to provide quality health outcomes, clients' preferences and values, clinicians' experience and the availability of resources also need to be considered in addition to research evidence. A Policy Statement on Evidence-Based Practice in Psychology by the American Psychological Association (APA) explicitly enshrines the role of clinical expertise and client values – alongside the application of best available research evidence – in its definition of evidence-based practice. "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences". All of these factors together are central to achieving positive treatment outcomes.

3.1.4 Using Evidence-based Psychological Interventions in Practice

Using evidence-based psychological interventions in practice requires a complex combination of relational and technical skills, with an imperative to attend to both clinical and research sources of evidence to identify treatment efficacy. This requires the use of empirical principles and systematic observation to accurately assess mental disorders and develop a diagnostic formulation, select a treatment strategy and to collaboratively set goals of treatment with consideration of the

client's unique presentation and within the limits of available resources. The choice of treatment strategies requires knowledge of interventions and the research supporting their effectiveness, in addition to skills to address different psycho-socio-cultural circumstances in any given individual situation. For comprehensive evidence-based health care, the scientific method remains the best tool for systematic observation and for identifying which interventions are effective for whom under what circumstances.

3.1.5 Evidence-Based Interventions

The evidence supports a number of evidence-based interventions for young children in the treatment of diagnosable mental disorders, as well as general behavioural and emotional difficulties. The use of interventions with younger children tends to be more multi-modal than with use with adolescents and adults (e.g. the use of group and parent-child interventions are used frequently).

The research literature was reviewed for articles that were published within the last 10 years (2002 - 2011); however where there may have been gaps in the literature or where a specific intervention was reviewed, some older articles were considered. Where possible, this review draws upon the findings of the child and adolescent component of the *2010 APS Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review* publication, however it builds on this by including a more thorough review of infant and young children's mental health.

Due to the short time-lines for which this review has taken place, articles which are considered the most rigorous in terms of their level, quality, relevance and strength (as per the NHMRC criteria i.e. systematic reviews, meta-analyses, randomised controlled trials) were given priority in the current review and are considered the strongest evidence in order to make evidence-based recommendations on best practice.

3.1.6 Clinical Interventions:

Prior to a discussion of the evidence base for a number of childhood disorders, a brief comment about different treatment interventions (in alphabetical order) and relevant considerations follows.

Art Therapy

Art therapy is an intervention method that traditionally has drawn from psychoanalytic theory for its framework and procedures. A breadth of current art therapies, informed by a variety of theoretical paradigms, share a common procedure that uses creative art as a method for promoting expression and healing. When working with children, pencil drawing, colouring, painting, and clay are the most common media (Eaton, Doherty, & Widrick, 2007).

The current literature reviewed shows that there is emerging evidence for Art Therapy (especially for treatment of behavioural disorders in younger children and procedural anxiety), **but *there does not appear to be enough evidence to be recommending this therapeutic intervention as a best practice treatment at this time under ATAPS CMHS*.**

References:

Leblanc, M. & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counselling Psychology Quarterly*, 14(2), 149–163.

Bratton, S. C., Ray, D., Rhine, T., & Jones, J. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376–390.

Phillips, R. D. (2010). How firm is our foundation? Current play therapy research. *International Journal of Play Therapy, 19*(1), 13–25.

Meta-analyses: Highlights the need for the data to be comparable and the problem of weak studies which may contaminate the whole data set. http://www.experiment-resources.com/meta-analysis.html

Attachment Interventions

This review has found evidence for the use of family behavioural interventions and treatments based on attachment theory, for the treatment of attachment disorders (Carr, 2009; Cassidy et al., 2011; Toth, 2006). However, *it is recommended that clinicians refer to reviews of individual programs, due to the*

variability of interventions (or treatment programs) used for the treatment of attachment difficulties[7].

There is evidence for the efficacy of such treatments that improve infant outcomes on mothers with post-natal depression (Van Doesum KTM et al, 2008).

In addition, treating attachment disorders requires a considerable skill level on the part of the clinician, and often requires additional training in infant or child and family mental health and the use of specific interventions. In light of workforce issues (see workforce issues section), it is unlikely that many ATAPS CMHS clinicians will have the expertise needed to service this client group.

Behaviour Therapy

Behaviour therapy is based on the theory that behaviour is learned and therefore can be changed. Examples of behavioural techniques include exposure, activity scheduling, relaxation, and behaviour modification. Behavioural interventions are commonly used when treating children WARMD and families, and have a strong evidence base; as shown in the current review for a range of childhood mental disorders.

Behavioural interventions when treating younger children WARMD requires clinicians to work with parents and families (e.g. parent skills training and family based behavioural interventions). For clinicians with appropriate training and skills these interventions are considered to be relatively simple to administer and user friendly for families.

This review demonstrates that behavioural interventions (including family behavioural interventions) have a strong evidence base across a number of childhood disorders (e.g., Beidel et al., 2000; Verdeli, et al., 2006).

Cognitive Behaviour Therapy (CBT)

CBT is a focused approach based on the premise that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions. The therapist helps individuals identify unhelpful thoughts,

[7] Reviewing specific programs is not the focus of this document as outlined at 'Attachment Disorders' and 'Program Reviews' in this document.

emotions and behaviours. Therapeutic interventions, such as cognitive restructuring and self-instructional training are aimed at replacing dysfunctional thoughts with more helpful cognitions, which leads to an alleviation of problem thoughts, emotions and behaviour (APS, 2010).

The current review shows that CBT *has a strong evidence base for the treatment of a number of disorders which occur in childhood* (e.g., O'Kearney et al., 2010); and has also been adapted for the treatment of PTSD (trauma focused CBT) with a demonstrated evidence base (e.g., Kowalik et al., 2011). CBT used with children is usually modified and includes use of pictures, cartoons and diagrams to engage children and take into account their developmental needs. Positively, a number of CBT interventions for children have been manualised (e.g., Barrett's Friends for Life Program-reference; Barrett, 2004a; 2004b) making its delivery quite easy for clinicians with the appropriate training and skills.

The developmental level of the child needs to be taken into account when considering CBT as a treatment of choice with children (i.e., child only interventions). In general, CBT (child only) is recommended for use with children eight years plus and requires children to have well developed language and reasoning skills for its effective use. To date there is limited evidence for the efficacy of CBT in younger children (Minde et al., 2010). However, where there is a demonstrated evidence base for the use of CBT with younger children (e.g., CBT adapted for preschoolers), then under these circumstances this modified treatment approach is recommended for use under ATAPS CMHS providing it is considered to be the best fit for the child and family and their presenting concerns (e.g., Scheeringa et al., 2011). It should be noted that modified CBT for younger children, typically involves the parents/family (parent-child format) in the child's treatment (e.g., Scheeringa et al., 2011; Rapee et al., 2010).

Note: family/parent based CBT is also referred to below under family therapy interventions.

Family Therapy

Family therapy may be defined as any psychotherapeutic endeavour that explicitly focuses on altering interactions between or among family members and

seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family. There are several family-oriented treatment traditions including psycho-educational, behavioural, object relations (psychodynamic), systemic, structural, post-Milan, solution-focused, and narrative therapies (Henken et al., 2009).

The current literature review demonstrated a strong evidence base for behavioural and CBT based family interventions used for the treatment of a number of childhood disorders (e.g., PTSD; Scheeringa et al, 2011). Family therapy has also been found to have a demonstrated evidence base for the treatment of anorexia in older children (12 years plus) as reported in The APS's 2010 literature review. In addition, there is an emerging evidence base for the treatment of encopresis using a narrative approach (Michael White's ''Sneaky Poo'') and other disorders (e.g. depression and bereavement), but more research is required (Carr, 2009).

See references:

Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy, 31*, 3-45.

Evidenced–based Psychological Interventions: A literature review (Third Edition). The Australian Psychological Society, 2010.

See http://www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf

Mindfulness Based Cognitive Therapy:

Mindfulness-based cognitive therapy (MBCT) is a treatment that emphasises mindfulness meditation as the primary therapeutic technique. MBCT was developed to interrupt patterns of ruminative cognitive-affective processing that can lead to depressive relapse. In MBCT, the emphasis is on changing the relationship to thoughts, rather than challenging them. Decentred thoughts are viewed as mental events that pass transiently through one's consciousness (APS, 2010).

MBCT used with children is a relatively new psychological treatment with an emerging evidence base. This review has shown promising results (e.g. *level I and II evidence for MBCT for the treatment of anxiety disorders*), but at this stage further research is warranted prior to considering this treatment as a 'best practice treatment' for children with or at risk of mental disorders.

See references:

Burke, C.A. (2010). Mindfulness-Based Approaches with Children and Adolescents: A Preliminary Review of Current Research in an Emergent Field. *Journal of Child and Family Studies,* 19, 133-144.

Thompson, M and Gauntlet-Gilbert, J. (2008). Mindfulness with Children and Adolescents: Effective Clinical Application. *Clinical Child Psychology and Psychiatry*, 13 (3), 395-407.

Parent-Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) is an evidenced based treatment developed by Sheila Eyberg for children ages 2–7 years and their caregivers. Based on Baumrind's (1966) developmental theory of parenting, PCIT draws from both attachment and social learning principles to teach authoritative parenting –a combination of nurturance, good communication and firm control. PCIT is divided into two stages, relationship development (child-directed interaction) and discipline training (parent-directed interaction), and there are three distinct assessment periods (pre-treatment, mid-treatment, post-treatment).

The current literature review has found a strong evidence base for PCIT as a treatment of childhood behavioural disorders, as discussed in the following section. However, PCIT requires a considerable skill level in order to deliver this intervention. Despite its sound evidence base, it is thought unlikely that too many allied health professionals working under ATAPS CMHS will have the knowledge and skills required to be able to implement this treatment (see workforce issues section).

See reference:

See Chapter 12. Zisser, A and Eyberg, S.M. Parent–Child Interaction Therapy and the Treatment of Disruptive Behaviour Disorders. In Weisz, J.R and Kazdin, A.E. (2010). *Evidence-Based Psychotherapies for Children and Adolescents*. (2nd ed.) The Guildford Press: New York.

Play therapy

In play therapy, play is viewed as the vehicle for communication between the child and the therapist on the assumption that children will use play materials to directly or symbolically act out feelings, thoughts, and experiences that they are not able to meaningfully express through words (Bratton, Ray & Rhine, 2005). The key assumption of play therapy is that play is a primary means through which children experience and "make-meaning" of the world around them and that careful attention and guidance by skilled play therapists to the play of children can bring about some type of therapeutic effect. These ideas promote the notion that the experience of play, in itself, is a curative, healing, and transformative process (Urquiza, 2010).

The current literature reviewed shows that there is emerging evidence for Play Therapy (especially for treatment of behavioural disorders in younger children and procedural anxiety), **but *there does not appear to be enough evidence to be recommending this therapeutic intervention as a best practice treatment at this time under ATAPS CMHS*** (refer list of references under 'Art Therapy' above).

Literature review: Review of the Treatment of Childhood Mental Disorders

A number of disorders which occur during childhood have been reviewed as part of the current literature review - these findings are discussed below (in alphabetical order).

Anxiety Disorders

Anxiety disorders are among the most common forms of mental health disturbance in childhood, with a point prevalence of 5–10% (Cartwright-Hatoon, McNicol & Doubleday, 2006). Much of the research into childhood anxiety

disorders tends to group various anxiety disorders together under one study, and report the findings of the intervention's effectiveness on the anxiety disorders as a group, rather than on specific conditions. Where possible, the literature reviewed the evidence-base for the most commonly observed anxiety disorders in young children. The highest prevalence anxiety disorders occurring in childhood are Separation Anxiety Disorder, social phobia/social anxiety disorder, Obsessive Compulsive Disorder (OCD), Generalised Anxiety Disorder (GAD), and Post Traumatic Stress Disorder (PTSD) (reviewed individually within this section).

The evidence supports the following interventions for treating childhood anxiety disorders:

- Developmentally modified CBT, including intervention delivered in individual, group, parent-child format and family based CBT (for 8 years plus). The main components of intervention may have included:
    - Developing coping plans
    - Cognitive self-control
    - Relaxation
    - Self-evaluation and reward (contingency management)
    - Modelling
- Exposure-based approaches, including:
    - Systematic desensitisation
    - Gradual exposure (in vivo or imaginary)
    - Reinforced exposure
- Social Effectiveness Training (i.e., type of behavioural intervention) -*for the treatment of social phobia only.*

It should be noted that the treatment of young anxious children with CBT has received little scientific study. Thus, while there is good evidence for the efficacy of CBT in children aged 8 years and older (Kendall et al., 2004), there is presently only one empirically validated psychosocial treatment outcome study for anxious preschool and early school aged children (Monga et al., 2009, as cited in Minde, Roy, Bezonsky, & Hashemi, 2010).

Attachment Disorders

There is a lack of consensus about the precise meaning of the term "attachment disorder", although there is general agreement that such disorders only arise following early adverse care-giving experiences. The most widely researched attachment disorder in the literature is Reactive Attachment Disorder (RAD). The prevalence of RAD is relatively rare; however it appears to be more common among samples of maltreated children, with estimates of up to 35% in this group (infant mental health).

There has also been considerable controversy around the "attachment therapy" interventions; however, there is some consensus surrounding the generally accepted interventions. The evidence supports the following interventions for treating the child and family with attachment problems[8]:

- Family-based behavioural interventions (brief, highly focused)
- Parent-Child Interaction Therapy
- Interventions based on attachment theory; involving the parent alone, with the child, or in group format have some promising findings, but further research is warranted before considering these as best practice treatment.*
- Infant-led Psychodynamic Psychotherapeutic Interventions (eg *Watch, Wait and Wonder* program), have promising findings, however further research is warranted.

Attention-Deficit Hyperactivity Disorder (ADHD)

ADHD or Hyperkinetic Disorder typically presents itself during childhood, and is characterised by a persistent pattern of inattention and/or hyperactivity, as well as forgetfulness, poor impulse control or impulsivity, and distractibility. It affects approximately 5.1% of children aged 2-5 years (Egger & Angold, 2006); however, there is considerable variance in reported prevalence rates, with estimates ranging from 0.3 – 6.5% in preschool-aged children (McDonnell, 2003).

[8] ***Note of Caution:*** Due to the variability of interventions used for the treatment of attachment difficulties, it is advisable for clinicians to refer to the evidence base for individual programs/interventions. For example, *Circle of Security* has promising findings, but further research is warranted. Whilst other programs have an emerging evidence base (e.g. *Baby Hugs and Pairs* are two Australian programs with sound theoretical underpinnings and promising findings), but there is not enough evidence to be considering them as a "best practice treatment" at this stage.

The evidence supports the following interventions for treating childhood ADHD:

- *Behavioural Based Parent-Training Interventions*, both group and individual-based (e.g., *The Incredible Years and Triple P* programs which have a well established evidence base[9]);
- Other b*ehavioural interventions*, including:
    - Operant treatment (reinforcement contingencies)
    - Modelling
- *Systemic interventions (behaviourally based)* comprising sessions with families, school staff, and the child, however they are best offered as elements of multi-modal programs *involving stimulant medication;*

- *Stimulant Medication (*with and without psychosocial treatments), but depends on age of child and severity of symptoms.

The large body of research suggests that for clinical samples of preschoolers with ADHD and their families, the most efficacious programs for the treatment of ADHD may be individually delivered, developmentally appropriate, and multimodal in nature.

In addition, there is insufficient evidence to recommend CBT as a treatment for ADHD (i.e., to directly target ADHD symptoms) based on our literature review findings.

Bereavement

Experiencing loss and bereavement in childhood is a painful and sometimes traumatic experience that can be associated with grief symptoms, overall negative affect, and later depression or anxiety. Research indicates that up 5% of children and adolescents will experience a crucial loss before the age of 15 years (Shneiderman, Winders, Tallett, & Feldman, 1994). While many children are resilient, experiencing bereavement during early childhood can have both immediate and long-term effects on a child's mental health and ability to function in family and school life.

[9] It should be noted that individual programs mentioned herewith (e.g., *Triple P and The Incredible Years programs*) are not funded under ATAPS – these programs have been cited within this document as examples of programs with a strong evidence base.

Additionally, children of different ages may respond differently to bereavement and require different interventions (Stack, 2003; Pfeffer et al., 2002). Stack (2003) studied bereavement in the paediatric intensive care setting and noted that children's grief responses vary depending on factors such as age, maturity and previous exposure to the death of a loved one. Children aged less than 5 years were typically unable to grasp the permanency of death; however, children aged around 11 years tended to respond in a more adult-like (modelled) manner.

Despite the abundance of therapeutic literature on how to help bereaved children, *there remains a lack of empirical evidence for the treatment of childhood bereavement*. In fact, previous meta-analyses on treating childhood bereavement have shown small and largely non-significant effect sizes on different types of grief interventions (Currier, Holland, & Neimeyer, 2007).

Conduct-Related Problems (Conduct Disorder and Oppositional Defiant Disorder)

Conduct Disorder refers to a persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. Conduct Disorder (CD) is one of the more severe types of what is commonly known as Disruptive Behaviour Disorders, often referred to as challenging behaviours and is a common reason for referral. The other two disruptive behavioural disorders are Oppositional Defiant Disorder (ODD) and Attention-Deficit Hyperactivity Disorder (ADHD). ODD describes a milder pattern of negative, hostile, defiant and disobedient behaviour. Both CD and ODD are more common in boys than girls. The prevalence of ODD is about 10% for children under 12 years, and about 3 - 7% in children for CD (Robins, 1991).

The evidence supports the following interventions for treating Conduct Disorder and Oppositional Defiant Disorder:

- *Behavioural Family Interventions* and/or Behavioural Parent and Teacher Training (such as The Incredible Years Parent, and the Triple P Parenting Program)

- *Behavioural interventions*, such as:
    - Operant treatment (reinforcement contingencies)
    - Social skills training (modified for younger children e.g. use of puppets)
    - Problem-solving skills training (cognitive-behavioural intervention for children 8 years plus)
- *Cognitive Behaviour Therapy* for older children (typically 8 years plus) for instance, anger control training; and
- *Parent-Child Interaction Therapy* (PCIT).

Depressive Disorders

Depression is one of the most common internalising problems in young people. The prevalence rate for young children is often difficult to quantify as there is little epidemiology data on infant and preschool depression (infant mental health). However, key findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being suggest that the rate of Depressive Disorder among children aged 4 – 17 years old is around 3% (Sawyer et al., 2001).

The best support for depressive disorders in children is CBT particularly in group format (child-only or child-plus-parent).

The evidence supports the following interventions for treating childhood depression:

- *CBT* for older children (typically for 8 years plus) - provided through the modalities of child group only, and child group plus parent components, which may involve some of the following interventions:
    - Behavioural activation
    - Cognitive restructuring
    - Problem solving
    - Affect regulation
    - Communication skills/conflict resolution
    - Self control training

- Pleasant activity scheduling
- *Behavioural interventions*, such as modelling and relaxation

Eating Disorders of Childhood

While the onset of eating disorders such as Anorexia Nervosa (AN) and Bulimia Nervosa (BN) occurs typically during early adolescence (Lewinsohn, Striegel-Moore & Seeley, 2000), disturbances in eating (other than of feeding during infancy) do occur in childhood. Anorexia nervosa can arise from the age of around 8 years, whilst full bulimia nervosa appears very rare in those under 12 years (Bryant-Waugh, 2000 as cited in Gowers & Bryant-Waugh, 2004; NICE, 2004). However, the literature on eating disorders, particularly during childhood, is scarce. Younger children may be more likely to present with atypical eating disorders and disturbances, rather than meeting the full criteria for an eating disorder (Gowers & Bryant-Waugh, 2004; NICE 2004).

As noted, published Australian data on early-onset eating disorders (EOEDs) in children younger than 14 years is scarce, and for the research that does exist on EOEDs, children comprise only a small proportion of the sample and tend to focus exclusively on anorexia nervosa. One Australian population survey found that for children aged 5–13 years, the annual national incidence for EOEDs requiring hospitalisation to be 1.1 per 100 000 children, and the total annual national incidence to be 1.4 per 100 000 children (Madden, Morris, Zurynski, Kohn & Elliot, 2009).

The limited evidence supports the following intervention for treating the young child with an eating disorder:

- Family-based behavioural (weight management) interventions (obesity/binge-eating)[10]

[10] *Family-based behavioural interventions* are often considered the first line of treatment for paediatric obesity. The goal of family-based behavioural interventions is either to: (1) induce weight loss; or (2) prevent excess weight gain and normalise growth by slowing the trajectory of weight gain relative to height. When determining whether to target weight loss or weight gain prevention, it is necessary to consider the child's severity of obesity and age. Weight gain prevention is recommended for very young children and youth who are overweight, not obese, and is accomplished through achieving a stable energy balance. Weight loss is indicated for older children and adolescents, especially for

- The most efficacious lifestyle treatment approaches for paediatric eating- and weight-related problems focus on four primary components: dietary modification, changes in energy expenditure, behaviour change techniques, and parental involvement at all levels of change

➢ Note: the current review found that *there is insufficient evidence to support any other psychosocial interventions with children under the age of 12 years with eating disorders*[11].

Elective Mutism (also known as Selective Mutism)

Elective mutism is a disorder of social functioning that most commonly presents in early childhood. The ICD-10 describes elective mutism as a condition characterised by a marked, emotionally determined selectivity in speaking, such that the child demonstrates his or her language competence in some situations but fails to speak in other less familiar situations (WHO, 1992). Typically, the child may speak at home or with close friends however, becomes mute around strangers or at school. The condition is commonly associated with personality features such as social anxiety, withdrawal, shyness, sensitivity, or resistance. It is a rare disorder with estimated prevalence rates of less than 1% of the general population (Stone, Kratochwill, Sladezcek & Serlin, 2002).

It has been suggested that clinicians are likely to produce stronger treatment effects for children with elective mutism if: (a) they can deliver treatment relatively soon after the onset of the disorder, and (b) at an early age (Stone et al., 2002).

A number of different psychotherapeutic approaches for the treatment of elective mutism have been reported in the literature, however for the most part, mostly case reports for the efficacy of these therapies have been published (Sharkey & McNicholas, 2008).

---

those above the 95th BMI percentile, and is achieved through inducing a negative energy balance. Family-based behavioural interventions seek to attain either of these goals by promoting small, successive changes in children's dietary and physical activity behaviours through the use of behaviour- change strategies and familial support (Wilfley, Vannucci, & White, 2010).

[11] There is evidence for the use of family therapy and self help treatments (primarily CBT based) in the treatment of children older than 12 years, but not for children less than 12 years (see the APS 2010 literature review for further details).

A best-evidence synthesis recommends the following interventions for treating the child suffering from elective mutism:

- *Behavioural interventions*, such as:
    - Positive reinforcement
    - Contingency management
    - Shaping
    - Stimulus fading
    - Social skills training
    - Self-modelling
    - Combined behavioural approach (e.g., modelling with positive reinforcement)
- *Cognitive-behavioural approaches* may also be effective.

➢ It is important to note that *there is insufficient evidence (mostly single case studies) for the treatment of elective mutism in children* and further research is warranted.

Encopresis

Encopresis, otherwise known as "soiling", is the term used to describe the repeated expulsion of faeces, whether involuntary or intentional, in inappropriate places in a child who has usually already been toilet trained. It differs from term *faecal incontinence* which is used to describe organic (physiological) soiling conditions.

Encopresis affects about 1.5 – 7.5% of children under the age of 12 and is a clinical problem that makes considerable demands on primary care and paediatric services (McGrath, Mellon & Murphy, 2000).

In conjunction with nutritional and medical management, the evidence supports the following behavioural interventions for the treatment of encopresis*:*

- *Behavioural interventions,* used together with laxative therapy, including:
    - Toilet re-training
    - Scheduled sitting times

    - Incentive scheme/reinforcement
    - Recording bowel activity/sticker charts
    - Dietary advice/education
- *Behavioural family therapy* (as part of a multi-modal program) involving psycho-education coupled with a reward program (parents reinforce appropriate daily toileting routines)

In addition, there is some evidence for Michael White's narrative family therapy approach which externalises the soiling problem (called "Sneaky poo"), but the current review did not find any level I or II evidence.

Enuresis

Nocturnal enuresis, or bedwetting, is a fairly common condition observed in children (and sometimes adolescents and adults) and is defined as the involuntary passing of urine while asleep after an age at which bladder control would normally be anticipated (i.e. beyond the age of about 5 years). It affects about 20% of 5-year old children (Feehan, McGee, Stanton & Silva, 1990).

The evidence supports the following interventions for treating the child with enuresis:

- Urine alarm interventions
- Simple behavioural interventions, including:
    - Retention control training
    - Reward systems, such as star charts
    - Lifting child to toilet
- Complex behavioural interventions (e.g. dry-bed training)
- Cognitive behaviour therapy (for older children, typically 8 years plus)

Reference:

See The Royal Children's Hospital bedwetting fact sheet. Go to:
http://www.rch.org.au/kidsinfo/factsheets.cfm?doc_id=3716

Feeding Disorders

Feeding disorders are one of the more relatively common problems occurring in infancy and early childhood, with estimates ranging from 25% - 40% in infants and young children developing normally, and up to 80% in children with developmental problems. Problems commonly reported by parents include food refusal, self-feeding difficulties, swallowing problems, and frequent vomiting. Severe feeding disorders may also be associated with failure to thrive (Zeanah, 2009).

The particular intervention (or combination of interventions) used depends on the outcome of the assessment and which factors are impacting on the child's feeding problems.

The evidence supports the following interventions for treating the child with feeding problems:

- *Behavioural interventions*, including:
    - Differential attention/reinforcement (attending to appropriate behaviour and ignoring inappropriate behaviours)
    - Extinction-based procedures, such as non-removal of the spoon (NRS) and physical guidance (PG) (effective for total food refusal that has not responded to differential attention)
    - Positive reinforcement of independent and desired feeding behaviours (effective for total food refusal that has not responded to differential attention)
- *Family-based behavioural interventions* (i.e. comprising parents prompting, shaping and reinforcing appropriate feeding behaviour and ignoring inappropriate behaviours).

Gender Identity Disorder (GID)

Gender identity disorders can manifest themselves in varying degrees of severity from early childhood onward, however the prevalence estimates for children and adolescents is below 1%. Children with GID express a desire to belong to the

opposite sex, or insist that they actually do belong to it. They may display characteristic behaviours of the opposite sex, preferring playmates of the opposite sex as well as the clothing and games that typically pertain to it. They reject anything regarded as belonging to their biological sex (Korte, et al. 2008). There has been little empirical research undertaken to date on childhood gender identity disorder, with evidence suggesting that psychotherapeutic techniques may not be particularly effective with children (Zucker, 2008). There is evidence to suggest that hormonal and surgical interventions may be the most effective way to resolve gender dysphoria for some adolescent patients (e.g. Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005). However, *for children it is difficult to draw any conclusions on best-practice*, due to the fact that not even one RCT has been carried out to date on this population (Zucker, 2008).

Neurasthenia (Chronic Fatigue Syndrome)

The ICD-10 Disorder "Neurasthenia" (Chronic Fatigue Syndrome) has been found to occur in about 2% of children and adolescents (Garralda and Chalder, 2005). The current literature review found limited research evidence for treatments with young children (i.e., few studies looking specifically at young children with chronic fatigue). However, there is evidence which supports the use of CBT with older children with Neurasthenia.

See Reference:

Evidenced–based Psychological Interventions: A literature review (Third Edition). The Australian Psychological Society, 2010. See: http://www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf

Post Traumatic Stress Disorder (PTSD)

More than a quarter of children will experience a significant traumatic event before reaching adulthood (Costello, Erkanli, Fairbank & Angold, 2002), including child abuse, domestic violence, natural disasters, war, the unexpected death of significant others and other frightening experiences. Varying lifetime trauma rates for children and adolescents have been reported in the literature ranging

from 9.2% (Breslau, Davis, Andreski & Peterson, 1991) to as high as 40% (Boney-McCoy & Finklehor, 1996). However, many more trauma-exposed children may not meet the full diagnostic criteria of PTSD, but will experience comparable functional impairments to those that do.

The evidence supports the following intervention for treating childhood PTSD and trauma experiences:

- CBT, particularly Trauma-Focused CBT (TF-CBT), in individual, group and parent-child format.

Sleep Disorders

During infancy, the most frequent complaints that parents have regarding their babies' sleeping behaviours fall into one of two categories: excessive night waking, which affects as many as 15-20% of children under the age of 3 years, and settling difficulties at bedtime (delaying or resisting bedtime), which are typically seen in 5-10% of children aged 2 years and above (Mindell, 1993). The most commonly reported overall prevalence rate of any type of sleep problem in the infant-toddler population is around 25% (Zeanah, 2009).

Behavioural interventions are considered the mainstay of treatment of bedtime struggles and night waking in early childhood. Unmodified extinction and parent education/prevention are the two behavioural interventions that appear to have the strongest empirical support.

The evidence supports the following interventions for treating the child with sleep problems:

- *Behavioural interventions* (for behavioural insomnia), including:
    - Extinction interventions (especially unmodified extinction)
    - Appropriate sleep hygiene
    - Maintaining a consistent sleep-wake schedule (scheduled awakenings)
    - Consistent bedtime routine and helping children fall asleep independently

    - Bedtime fading and response cost
- *Family-based behavioural programs/parent education programs*
- *Behavioural and Cognitive Interventions (for insomnia) for older children (older than 8 years)*, including:
    - Stimulus control (designed to associate the bed with sleep only and develop consistent sleep-wake cycle)
    - Sleep restriction (time in bed should be equal to the child's average total sleep time)
    - Relaxation (progressive muscle relaxation, imagery, meditation)
    - Cognitive restructuring

Somatoform Disorder

Somatoform disorders are mental disorders that are characterised by the repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms have no physical basis. If any physical disorders are present, they do not explain the nature and extent of the symptoms or the distress and preoccupation of the patient (ICD-10). There are a number of different types of somatoform disorders, including Conversion disorder, Somatisation disorder, Hypochondriasis, Body dysmorphic disorder, and Pain disorder. For the purpose of this literature review and due to time constraints, only evidence pertaining to Pain Disorder will be presented here.

Chronic pain is a relatively common phenomenon and affects about 15–30% of children and adolescents (Palermo, Eccleston, Lewandowski, Williams, & Morley, 2010; Eccleston, Palermo, Williams, Lewandowski, & Morley, 2009). Many children with chronic pain experience significant pain-related disability such as limited social and physical activities and recurrent school nonattendance. The most common location for pain is in the head, abdomen, and limbs (Perquin et al., 2000), and girls more commonly report instances of chronic and recurrent pain than boys.

The evidence supports the following interventions for treating the child suffering from pain disorders:

- *Behavioural strategies*, including:
    - Relaxation
    - Biofeedback
    - Behavioural management programs (e.g. teaching parents operant strategies to reinforce adaptive behaviours such as school attendance)
- *CBT* (for older children, typically 8 years plus)

Tic Disorders

Tic disorders are a relatively common developmental disorder among children. About 10% of children have tics (motor and/or vocal) during childhood with the majority of cases disappearing once the child reaches adolescence (Verdellen, van de Griendt, Hartmann & Murphy, 2011). Approximately 1-2% of school-age children and adolescents develop Tourette 's syndrome (Robertson, 2008), a type of tic disorder characterised by multiple motor and vocal tics. Comorbid conditions are common amongst tic disorder patients, with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD) and Pervasive Developmental Disorder (PDD) common in this population.

Whilst there is evidence for the use of behavioural interventions for the treatment of tic disorders in children and adolescents, when symptoms are severe, fail to respond to behavioural interventions, and interfere with social, family, or academic functioning, medications are often recommended (Jensen, Buitelaar, Pandina, Binder & Haas, 2007).

The evidence supports the following behavioural interventions for the treatment of tic disorders:

- Behavioural interventions, particularly:
    - Habit reversal training
    - Exposure with response prevention
- Other behavioural interventions as adjunctive treatments, including:
    - Contingency management
    - Function based interventions
    - Relaxation training (e.g. progressive muscle relaxation)

Disorders that more commonly occur in youth and adults

In relation to low prevalence mental disorders that more commonly occur in older adolescents and adults (e.g. conversion disorder), it should be noted that they were not the focus of the current review due to the limited empirical literature with children under 12 years and therefore lack an evidence-base. However, it is recommended that readers refer to the APS's 2010 literature review.

See reference:

Evidenced–based Psychological Interventions: A literature review (Third Edition). The Australian Psychological Society, 2010. See http://www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf

Program Reviews

This review has been kept at a broad level and generally does not cover reviews of individual programs (unless used as an example of a type of intervention). However, readers are referred to the KidsMatter program guides for reviews of specific programs (see below).

KidsMatter Program Guides

- In addition to the current literature review, The Australian Psychological Society has reviewed mental health and wellbeing programs, as part of their work on the KidsMatter Primary and KidsMatter Early Childhood initiatives and developed Programs Guides which are recommended to readers as a useful resource.

- To view the KidsMatter Primary programs guide go to: http://www.kidsmatter.edu.au/primary/programs-guide/

- To view the Kidsmatter Early Childhood programs guide go to: http://222.kidsmatter.edu.au/ec/resources/programs-guide/

Additional reference:

Wise, S, da Silva, L., Webster, E., and Sanson, A. (2005). The Efficacy of Early Childhood Interventions. Australian Institute of Family Studies. Commonwealth of Australia http://www.aifs.gov.au/institute/pubs/resreport14/aifsreport14.pdf

3.2 Clinical Practice Guidelines

There is a lack of clinical practice guidelines that have been published to date, relevant to children (birth to twelve years) WARMD; this is an area greatly lacking and needing further development.

- *See Appendix 3 for a list of relevant clinical practice guidelines.*

3.3 Treatment Recommendations: Evidenced-based best practice with children under ATAPS

Based on a review of the literature and clinical practice guidelines, the following treatments[12] are considered to have a strong evidence base and are therefore recommended for use under ATAPS CMHS. The following treatments are also considered to be appropriate for use within a short-term treatment context, in line with the requirement of the ATAPS CMHS component of service delivery.

3.3.1 Treatments being recommended for funding under ATAPS CMHS

- Behavioural Interventions
- Parenting/Family-based interventions[13]
- Cognitive Behavioural Therapy Interventions

[12] The term *treatment* and *intervention* are used synonymously herewith.
[13] See Table 2 and literature review for specific interventions being recommended herewith.

A summary of the findings of the current literature review are presented in Table 2.

3.3.2 Treatments Considerations ATAPS CMHS

Principles:

- A strengths focused family centred approach needs to be the premise of ATAPS CMHS clinical work.

A multi-disciplinary perspective:

- CMHS clinicians need to have a multidisciplinary perspective in their clinical work with children and families (e.g., linking into multi-disciplinary peer supervision groups and webinars).

- In addition, there may be occasions where a *multi-disciplinary care coordination meeting* may be required to plan treatment and to review it, such as when a group of multi-disciplinary professionals are providing treatment to ATAPS CMHS clients.

Developmental level of child:

- Age of child and developmental abilities/weaknesses (e.g. language skills) need to be considered. For instance, clinicians will need to consider the appropriateness of using CBT (i.e., child only format), when working with children with language delays and intellectual disabilities.

Family:

- Assessment information and goals identified by the child/family and their preferences around treatment will need to be taken into account.

- Parents' level of functioning and capacity to be involved in treatment (e.g. appropriateness for behavioural parent interventions, need for interpreters etc.) must be considered.

- Family functioning and any relevant issues (e.g. separations and access arrangements, restraining orders) that may impact upon parent's involvement need to be considered.

Evidenced based practice:

- Use of evidence based interventions for the specific mental disorder being treated (as discussed earlier) or prevented was highlighted as a priority for ATAPS CMHS clinicians.

- The evidence base for working with children with co-morbid conditions is limited and this was acknowledged as a major issue given the reported high prevalence rates of children with co-morbid conditions (as discussed earlier; see epidemiology section). Therefore, a high level of clinical skills will be required by clinicians given the complexity of cases that are likely to present under ATAPS CMHS; these considerations need to influence workforce recruitment and the training needs of the ATAPS workforce (discussed later).

- Clinicians need to be aware of pharmacological interventions when working with children (e.g. ADHD). Medication is often used alongside psychological interventions and clinicians will need to familiarise themselves with relevant guidelines and evidence.

- Clinicians would benefit from familiarising themselves with the literature and evidence around providing psychological support to children and families with medical and neurological conditions (e.g., diabetes and epilepsy) and the psychological issues that may arise for children and families when adjusting to these conditions.

3.3.3 Guidelines and supports for clinicians

- It is recommended Medicare Locals develop guidelines for the following issues:

- *Managing risk* (e.g. managing aggressive clients) with least restrictive interventions.

- *Forensic and legal issues*; for instance, covering topics such as mandatory reporting of abuse (differences across States and Territories were highlighted).

- *Safety Issues*. For instance, there may be a level of risk for some clients in which it may not be safe for them to be seen in certain environments (e.g., in cases where parents have restraining orders in place).

- In addition, the need for clinicians to have supports in place to manage challenging client situations (e.g. crises) was also identified as an important consideration for service planning.

3.3.4 Use of interpreter services under ATAPS CMHS

The ATAPS Operational Guidelines outline costs that can be met by funding paid to Medicare Locals which includes the use of interpreters under "service" costs.

In relation to clients requiring interpreters:

- Medicare Locals also need to be aware of the other services available in the community to assist with the CALD/Indigenous/hearing impaired/special needs clients - to complement ATAPS treatments.
- Medicare Locals are required to establish linkages and relationships within the local area to use different services to complement ATAPS.

3.4 Referral Pathways and ATAPS Child Treatment Plans

3.4.1 Referral Pathways

The following professionals can refer children for ATAPS CMHS:

Referral: **GPs, psychiatrists, and paediatricians.**

Provisional Referral (refer to current ATAPS Operational Guidelines):

- Allied health professionals who are eligible to provide services under ATAPS (appropriately trained occupational therapists, social workers, psychologists, mental health nurses and Aboriginal and Torres Strait Islander health workers);
- School psychologists/counsellors or Deputy Principals/Principals
- Referrals from schools and early childhood services need to be made via senior staff members (e.g. Directors or Principals/Deputy Principals), where the school or early childhood service does not have a qualified psychologist or counsellor (in consultation with the parents); and
- Directors of early childhood services.

Referrals: GP, psychiatrists, and paediatricians

Provisional Referrals (refer above):

- Eligible occupational therapists, social workers, psychologists, mental health nurses and Aboriginal and Torres Strait Islander health workers
- School psychologists/counsellors or Deputy Principals/Principals
- Directors of early childhood services

Figure 2 depicts the various referral pathways in which a child may receive mental health services (not including exceptional circumstances).

Other provisional referral arrangements apply for the different ATAPS Program target groups, which can be found in the following ATAPS Operational Guidelines:

- ATAPS Aboriginal and Torres Strait Islander People Mental Health Service;
- ATAPS Aboriginal and Torres Strait Islander Suicide Prevention Service; and
- ATAPS Suicide Prevention Service.

3.4.2 ATAPS Child Treatment Plans

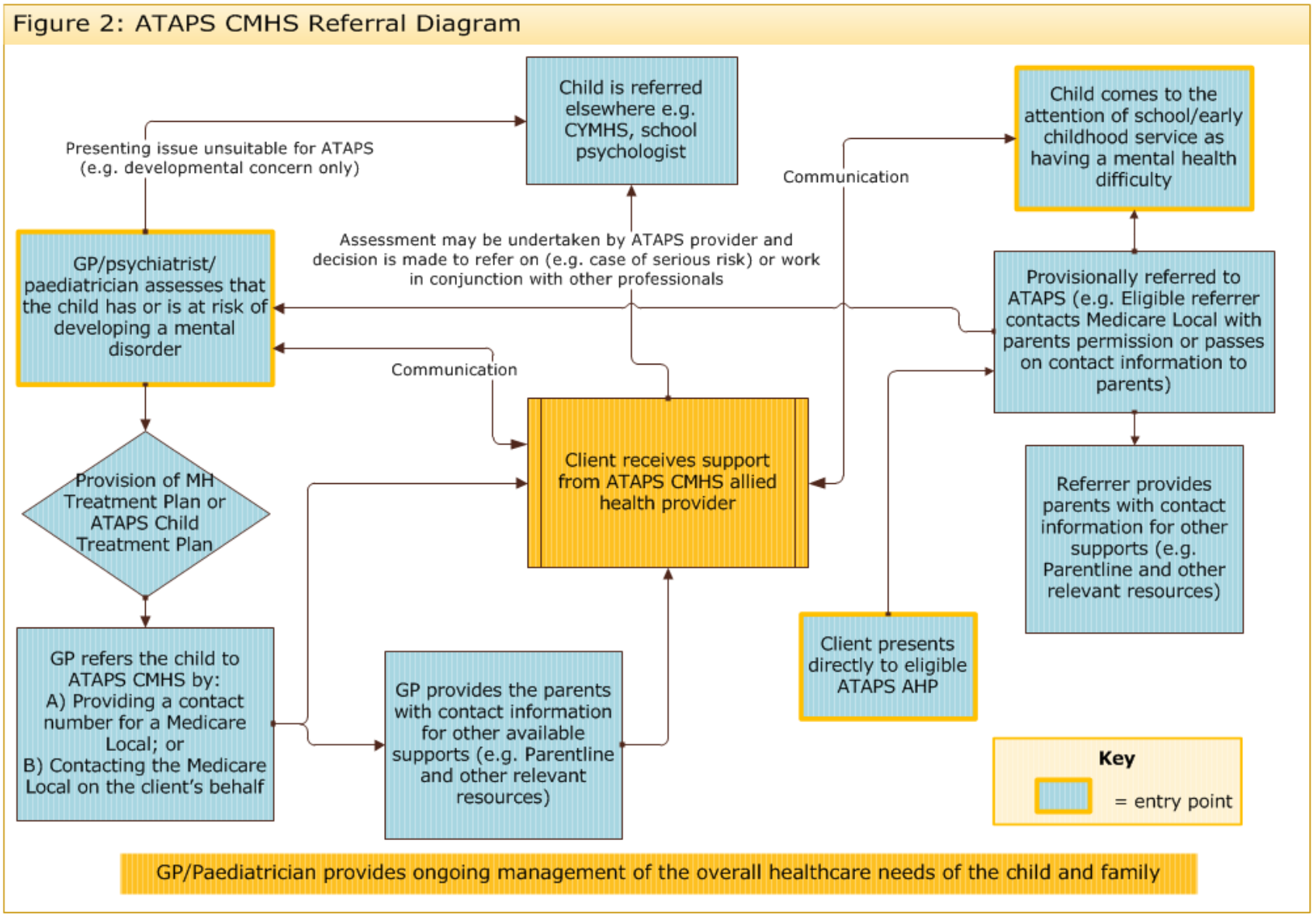
For the purposes of the ATAPS CMHS, professionals should use the term ATAPS Child Treatment Plan (otherwise known as "GP Mental Health Treatment Plan"), in light of issues around labelling/stigmatising young children that may hinder families from becoming engaged with ATAPS CMHS.

The GP, psychiatrist or paediatrician who is referring a client to ATAPS must undertake an assessment and prepare an ATAPS Child Treatment Plan. Where a provisional referral is made (refer above), the allied health professionals are required to work with the Medicare Local and GP to link the client in with the GP, and have an ATAPS Child Treatment Plan developed.

ATAPS Child Treatment Plans (otherwise known as "GP Mental Health Treatment Plans"), are required for all children referred to ATAPS CMHS.

As outlined in the ATAPS Operational Guidelines there are exceptions for the development of ATAPS Mental Health Treatment Plans. There may be difficulties in meeting the requirement where there is difficulty accessing GPs, with providing treatment to homeless people, or in some Aboriginal and Torres Strait Islander communities. Medicare Locals encountering difficulties in meeting the requirement of a treatment plan should endeavour to have a Mental Health Treatment Plan prepared as soon as possible, and if this is occurring regularly should approach the Department.

Figure 2: ATAPS CMHS Referral Diagram



Referring children under ATAPS CMHS:

The workforce issues and the limited capacity for Medicare Locals to recruit sufficient suitable allied health staff under ATAPS CMHS (especially in rural and remote regions) is acknowledged. However, it is imperative that referrals of children under ATAPS CMHS need to be made to mental health professionals with the qualifications and skills necessary to competently service this population, in line with good clinical practice. Therefore, the following recommendations are made to support Medicare Locals with their considerations around intake/referrals under ATAPS CMHS.

It is recommended that Medicare Locals provide referrers with an intake guide and service map, to support referrers in locating appropriate ATAPS clinicians and other service options in their local area. This will help ensure a consistent and effective intake processes. The development of an intake guide will be an important resource to support the implementation of this area of work. The guide would include information on the referral decision making process. Case scenarios could be developed to clarify types of cases considered to be appropriate to be referred to various professionals, and include a section with templates relevant to intake.

1. *For ATAPS CMHS allied health staff without specialist child and family mental health training it is recommend that they could treat the following types of cases*:

    - *Less complex presentations* e.g. children with social-emotional-behavioural problems that do not appear to meet criteria for a mental disorder can be referred to a suitably qualified allied health professional eligible to deliver ATAPS CMHS, providing they have the skills and expertise to enable them to work therapeutically with children WARMD and families using evidenced based treatments, and following completion of the mandatory training[14].

[14] See workforce section for discussion on professional development needs of the ATAPS CMHS workforce, essential core skills and proposed online training for all staff prior to working with children WARMD and their families; and the need for clinical supervision and support.

- Examples of less complex presentations suitable for treatment under ATAPS CMHS by staff without specialist child and family mental health skills are illustrated in Table 5 below.

Table 5: Examples of less complex cases

Examples of less complex cases include children presenting with:
Anxiety symptoms (e.g. avoidance of social situations, phobias, separation anxiety)
Mood symptoms (e.g., feeling sad, teary, agitated) - providing no serious risks[15] are indicated
Concerns about eating/body image -providing no serious risks are indicated
Somatic complaints (e.g. headaches) in the absence of physical causes
Moderate behavioural problems

2. *For ATAPS CMHS allied health staff <u>with</u> specialist training in child and family mental health, the following types of cases are recommended as being suitable for referral under ATAPS CMHS[16]:*

- More complex clinical presentations (See Table 6 for examples) should only be referred to skilled clinicians that are experienced in working with children and families with complex mental health difficulties (e.g. clinical child psychologists, and other allied health staff with an extensive background and training in working in the children's mental health field).

[15] "Serious risks" refers to children presenting with signs or symptoms which suggest that they could be at considerable risk of harm to self or others e.g. previous unsuccessful suicide attempt; self harming behaviours (e.g. glue sniffing) etc.
[16] ATAPS CMHS allied health staff <u>with</u> specialist training in child and family mental health can also be referred less complex cases as per Table 5.

- Where these professionals are not available under ATAPS CMHS, referrers need to refer clients to other services or professionals (e.g. mental health services) as determined to be clinically appropriate. Recommendation 1 (above) will help with this process.

Table 6: Examples of more complex cases

Examples of *complex cases* include children presenting with:
Symptoms of considerable concern (e.g. extreme aggression, suicidal ideation, persistent low mood)
Symptoms or signs of self-harm/harm to others (e.g. threats of harm to peers, binge drinking, suicidal ideation)
Long-standing issues (e.g. long history of behavioural issues reported to be exacerbating in intensity and frequency)

3. For more complex cases consideration about ATAPS clinicians (e.g., clinical psychologists) working in conjunction with other professionals (e.g., child psychiatrists and paediatricians) is recommended; needing to be determined on a case by case basis and dependent on availability of clinicians and parental consent.

4. Working with infant mental disorders (e.g. Attachment Disorders) requires specialist skills and should only be undertaken by clinicians qualified and experienced to work with infants with mental disorders and families.

5. Whilst difficult to determine at the point of referral, where possible referrers should try to refer children to mental health professionals that are best suited to treat the referral problem.

6. If the ATAPS CMHS clinician assesses a case and then feels they are not best able to meet the needs of the child and family, the case should be referred to a more appropriate clinician/agency for treatment (in line with good clinical practice).

7. Similarly, if an ATAPS CMHS clinician attempts a particular intervention and does not appear to be making gains, it is recommended that the case needs to be referred to a more appropriate clinician or agency (in line with good clinical practice).

4: Workforce issues

4.1 Skills and Competencies required by ATAPS CMHS workforce

It is recommended that Medicare Locals recruit psychologists and other eligible allied health clinicians with as many of the skills and competencies as possible outlined under 'Essential Core Skills' and 'Desirable Enhanced Skills' below. In addition to the core essential skills listed below, it is expected that all allied health professionals working under ATAPS CMHS have ***full registration with their relevant professional body and adhere to the professional ethics of their professional association.***

Allied health professionals to be employed to deliver mental health services as outlined in the ATAPS Operational Guidelines, includes appropriately trained:

- occupational therapists;
- social workers;
- mental health nurses;
- psychologists; and
- Aboriginal and Torres Strait Islander health workers.

It is expected that all Medicare Locals will continue to ensure ATAPS child mental health services are delivered by fully qualified allied health professionals, who are only practicing within their area of competence.

The Department of Health and Ageing will progressively implement a range of training modules for ATAPS clinicians delivering CMH services from the second half of 2012. The training will enable professionals to enhance their area of competence, and up-skill to meet some (not all) of the essential core skills identified below. The online training to up-skill the allied health providers is not intended to replace the required qualifications for each profession and/or clinical experience to be able to practice. All allied health professionals delivering CMHS must undertake the on-line training to help meet the essential core skills within 12 months of commencing to deliver CMHS.

The identification of the skills required by the ATAPS CMHS workforce has been compiled following a review of the literature and compilation of best practice treatments for children under ATAPS CMHS[17] .

4.1.1 Essential Core Skills and Knowledge

The following are considered to be *essential core skills and knowledge (i.e., mandatory)* deemed necessary for allied health professionals working under the ATAPS CMHS component to be able to deliver services:

1. Relevant qualifications as per the requirement of the profession and experience in working clinically with children (birth to 12 years), parents and families'
2. Extensive child development knowledge (as demonstrated via training at post graduate level for the relevant profession demonstrating competency in this area and/or via continued professional development up-skilling training);
3. Knowledge of childhood mental disorders and "best practice" in terms of their treatment(s);
4. Skills and competence at completing bi-psycho-social assessments of children (birth to 12 years) experiencing or at risk of developing mental disorders and their families; knowledge, skills and experience in the delivery of a range of treatments relevant to working with children (birth to 12 years) with or at risk of mental disorders and their families (particularly behavioural and CBT interventions); training and skills in the delivery of evidenced based parenting interventions and behavioural family based interventions;
5. Training and experience in working with families – including knowledge of systems theory; family centred practice; and an understanding of family dynamics/problems and their impact on children; knowledge of ethical and professional issues when working with children and families.

[17] These skills were compiled based on reviewing job descriptions for similar allied health roles (i.e., working with children WARMD), and reviewing the skills taught in post graduate mental health training courses (e.g. psychology masters programs); as well as the clinical wisdom and experience of the expert working group.

4.1.2 Additional Skills and Knowledge (highly desirable)

It is also considered to be highly desirable for allied health professionals delivering ATAPS CMHS to have the following additional skills and competencies. In determining staffing selection criteria it is recommended that the Medicare Locals consider applicants that meet as many of the following criteria as possible:

1. Experience in working within a private practice setting with children with mental health difficulties and/or past experience working in a child mental health setting (e.g. CYMHS) or schools;
2. Experience working with relevant community agencies (e.g. child care centres and schools);
3. Culturally sensitive practice – including experience working with clients from CALD and Indigenous communities, and working with interpreters; experience working with children with special needs (e.g. disabilities, medical and neurological conditions);
4. Crisis assessment skills;
5. Group treatment experience (e.g., CBT groups with children);
6. Experience engaging in clinical supervision relevant to children's mental health.

4.2 Ongoing Clinical Support and Professional Development

Medicare Locals should prioritise the recruitment of ATAPS CMHS staff who meet as many criteria as possible; particularly meeting the criteria outlined in the "essential core skills'' section (above). Where there are "gaps'' identified in relation to the above criteria, it is recommended that Medicare Locals provide support to clinicians by linking them up with appropriate professional development opportunities including: training (e.g. webinars), professional supervision and resources to ensure clinicians delivering services under ATAPS CMHS are adequately equipped to work competently with children WARMD and their families.

The skills defined above are considered to define the range of training needs of the ATAPS CMHS workforce, in terms of skilling up ATAPS CMHS allied health staff.

4.3 Recruitment of Allied Health Professionals

The following workforce issues should be considered as part of the Medicare Locals' service planning, and recruitment and retention plans.

Based on the statistics reviewed around workforce numbers, there are only a small percentage of mental health professionals that work privately with children with mental disorders and families in Australia (Mathews, Stokes, Crea, & Grenyer, 2010; Stokes, Mathews, Grenyer, & Crea, 2010; AASW Data Mining Survey Report, 2010). Moreover, there are few psychologists who specialise in the paediatric mental health field, and even fewer clinical child psychologists (e.g., survey findings presented in Grenyer et al., 2010). Similarly, there are also considered to be few allied health staff with skills and background which may make them appropriate to work under ATAPS CMHS, particularly relative to what is anticipated to be the demand for these workers.

In addition, working with infants with or at risk of developing mental disorders (part of the target population) is considered to be a highly specialised field, and there are few clinicians with the skills required to assess and treat infants with or at risk of developing mental disorders and their families.

Furthermore, there are a broad range of disorders on the ATAPS CMHS list (Table 1). Consequently, it may be difficult to find suitable professionals with the skills and expertise which cover the full range of childhood disorders particularly those disorders that are quite rare in childhood (e.g. conversion disorder) and/or disorders that require more specialised skills to treat (e.g. attachment disorders).

4.4 Professional and ethical considerations

There are professional and ethical considerations when working therapeutically with children (a highly vulnerable client group). Caution is recommended around

the risks associated with subjecting children to incompetent or unsuitable mental health care with potentially damaging consequences to their ongoing mental health and emphasise the need for high recruitment standards being maintained.

Medicare locals may experience difficulties in relation to the recruitment and referral of suitable staff under ATAPS CMHS, but the *importance of maintaining a high standard of care* in line with good clinical practice for children and families (see principles section) is emphasised. In addition, it would be advisable for strict guidelines around professional practice be put in place by Medicare Locals to ensure that staff are only practicing within their area of competence.

Therefore, in light of anticipated workforce issues the *need to skill up the ATAPS workforce (where required),* as per the plans proposed within this purchasing guidance will be essential (refer Part 4).

4.5 Professional development and responsibility

Professional development is the systematic and formal advancement of knowledge, skills and theory to meet current practices. Professional development is detailed and specific learning to improve the quality and consistency of clinical practice. It is an integral part of developing as a clinician which is designed to increase levels of expertise, understanding and clinical practice. Ongoing professional development is essential in order for clinicians to continue to practice in the area of children's mental health and use the most current evidence based practices to inform assessment and treatment. Continuing education programs, mental health professional networks, individual and peer supervision sessions, workshops and webinars are a major source of information for clinicians and are considered to be necessary in order to ensure the clinical work undertaken under ATAPS CMHS is based on current clinical evidence.

The purpose of supervision is to assist the practitioner to learn from his or her experience and progress in expertise, as well as to ensure the delivery of quality services to their clients. It also serves to enhance the professional functioning of the supervisee and to reflect on their clinical work with clients within a "safe space".

A combination of skills, knowledge and experience make up competency in the specialised area of children's mental health. In order to maintain and progress these skills, clinical involvement in *individual supervision and/or multi-disciplinary peer supervision is highly recommended to consolidate learning*.

Therefore, in addition to undertaking professional learning opportunities (e.g. webinars and professional reading) it is important for clinicians to have opportunities to implement their new learning and reflect on this in their supervision - to assist clinicians to integrate new skills into their every day clinical practice with ATAPS CMHS clients[18].

The Department contracted the Australian Psychological Society (APS) to consult a range of child mental health experts on the development of this Purchasing Guidance. Recommendations on the training needs of ATAPS Program allied health professionals providing services to children under 12 years of age was also provided to the Department as part of this process. The Department will develop and implement training and professional development in the second half of 2012 for the ATAPS CMHS workforce.

It is essential to prioritise 'skilling up' staff to ensure that all ATAPS CMHS staff meets the basic core skills

The proposed training will support the implementation of ATAPS CMHS and aims to be flexible; for instance, utilising technological mediums (e.g. webinars) that enable broad dissemination across urban, rural and remote regions of Australia. It is noted that staff will have a diverse range of training needs (i.e., gaps across many of the skills listed in the above section). Thus, training materials produced will need to encompass the full range of training needs of the ATAPS CMHS workforce and be pitched at a level which meets a minimum level of competence (as per 4.1.1) in order to be most effective in skilling up the workforce.

[18] ATAPS service funding allows funding for supervision.

5: Bibliography

Achenbach, T. M., Dumenci, L., & Rescorla, L. A. (2003). Are American children's problems still getting worse? A 23-year comparison. *Journal of Abnormal Child Psychology*, 31, 1-11.

ADHD: The NICE guideline on diagnosis and management of ADHD in children, young people and adults. National Clinical Practice Guideline Number 72. The British Psychological Society and the Royal College of Psychiatrists, 2009.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.

Australian Association of Social Workers (2010). *Data Mining Survey Report*. Unpublished manuscript.

Australian Bureau of Statistics (2007). National Survey of Mental Health and Wellbeing: Summary of Results. ABS Cat No. 4326.0. Canberra: ABS.

Australian Institute of Health and Welfare (2003). Australia's young people 2003: Their health and wellbeing. Canberra: AIHW.

Australian Institute of Health and Welfare (2009). A picture of Australia's children 2009. Cat. no. PHE 112. Canberra: AIHW.

Australian Psychological Society. (2007). Better access to mental health initiative: Orientation manual for clinical psychologists, psychologists, social workers and occupational therapists.

Australian Psychological Society (2010). Evidenced–based Psychological Interventions: A literature review (Third Edition). See http://www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf

Barrett, P. (2004a). FRIENDS for Life: Group leaders' manual for children. Bowen Hills, Queensland, Australia: Australian Academic Press.

Barrett, P. (2004b). FRIENDS for Life: Workbook for children (4th ed.). Bowen Hills, Queensland, Australia: Australian Academic Press.

Bassilios B, Fletcher J, Pirkis J, King K, Kohn F, Blashki G, et al. (2009) Evaluating the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program: Fourteenth Interim Evaluation Report – Ongoing gains in improving access to mental health care in Australia. Melbourne: Centre for Health Policy, Programs and Economics, The University of Melbourne.

Beardslee, W. R., Gladstone, T. R. G., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Paedatrics*, *112* (2), 119 - 131.

Bearsdlee,W.R., Gladstone, T.R.G., Wright, E.J., & Forbes, P. (2007). Long-term effects from a randomized trial of two public health preventative interventions for parental depression. *Journal of Family Psychology*, *21* (4), 703-713.

Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology, 68*(6), 1072 -1080.

Bond, L., Carlin, J., Thomas, L., Rubin, K., & Patton, G. (2001). Does bullying cause emotional problems? A prospective study of young teenagers. *British Medical Journal*, 323, 480-484.

Boney-McCoy, S., & Finklehor, D. (1996). Is youth victimisation related to trauma symptoms and depression after controlling for prior symptoms and

family relationships? A longitudinal prospective study. *Journal of Consulting and Clinical Psychology, 64*(6), 1406-1416.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005).The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36* (4), 376–390.

Brazzelli, M., & Griffiths, P. (2006). Behavioural and cognitive interventions with or without other treatments for the management of faecal incontinence in children. *Cochrane database of systematic reviews* (Online) (2), pp. CD002240.

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48*(3), 216-222.

Carr, A. (2009). Bipolar disorder in young people: Description, assessment and evidence-based treatment. *Developmental Neurorehabilitation, 12*(6), 427-441.

Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy, 31*, 3-45.

Cartwright-Hatoon, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review, 26*, 817–33.

Cassidy, J., Woodhouse, S. S., Shreman, L. J., Stupica, B., & Lejuez, C. W. (2011). Enhancing infant attachment security: An examination of treatment efficacy and differential susceptibility. *Development and Psychopathology, 23*, 131-148.

Cohan, S. L., Chavira, D. A., & Stein, M. B. (2006). Practitioner review: Psychosocial interventions for children with selective mutism: A critical evaluation of the literature from 1990–2005. *Journal of Child Psychology and Psychiatry, 47*(11), 1085–1097.

Cohen, J. A., Bukstein, O., Walter, H., Benson, R. S., Chrisman, A., & Farchione, T. R. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(4), 414–430.

Commonwealth Department of Health and Aged Care (2000). P*romotion, Prevention and Early Intervention for Mental Health—A Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescents. *Journal of Traumatic Events, 15*(2), 99-112.

Cote, S. M., Bolvin, M., Xuecheng, L., Nagin, D. S., Zoccolillo, M., & Tremblay, R. E. (2009). Depression and anxiety symptoms: Onset, developmental course and risk factors during childhood. *Journal of Child Psychology and Psychiatry, 50*(10), 1201-1208.

Currier, J. M., Holland, J. M., & Neimeyer, R. A., (2007). The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology, 36*, (2), 253–259.

David-Ferdon, C. & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal Of Clinical Child and Adolescent Psychology, 37*(1), 62 -104.

de Graaf et al (2008). Effectiveness of the Triple P Parenting Program on parenting: A meta-analysis. *Family Relations, 57*, 553-566.

Di Ceglie, D., Sturge, C., & Sutton, A. (1998). *Gender identity disorders in children and adolescents: Guidance for management*. Royal College of Psychiatrists, London. http://www.rcpsych.ac.uk/files/pdfversion/cr63.pdf

Eaton, L. G., Doherty, K. L., & Widrick, R. M. (2007). A review of research and methods used to establish art therapy as an effective treatment method for traumatized children. *The Arts in Psychotherapy, 34*, 256–262.

Eccleston, C., Palermo, T. M., Williams, A. C. D. C., Lewandowski, A., & Morley, S. (2009). Psychological therapies for the management of chronic and recurrent pain in children and adolescents. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD003968. DOI: 10.1002/14651858.CD003968.pub2.

Egger, H. L. (2009). Psychiatric assessment of young children. *Child Adolescent Psychiatric Clinic North America, 18*, 559-580.

Egger, H. L., & Angold, A. (2006). Common emotional and behavioural disorders in preschool children: Presentation, nosology, and epidemiology. *The Journal of Child Psychology and Psychiatry*, 47, 313-337.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology, 37,* 215-237.

Fabiano, G. A., et al. (2009) A meta-analysis of behavioral treatments for attention-deficit/hyperactivity disorder. *Clinical Psychology Review, 29*(2), 129 -140.

Feehan, M., McGee, R., Stanton, W., & Silva, P. A. (1990). A 6-year follow-up of childhood enuresis: prevalence in adolescence and consequences for mental health. *Journal of Paediatrics and Child Health, 26*, 75-79.

Findlay, S., Pinzon, J., Taddeo, D., & Katzman, D. K. (2010). Family-based treatment of children and adolescents with anorexia nervosa: Guidelines for the community physician. *Paediatrics & Child Health, 15*(1), 31-35.

Fishman, L., Rappaport, L., Schonwald, A., & Nurko, S. (2003). Trends in referral to a single encopresis clinic over 20 years. *Pediatrics, 111,* 604-607.

Fristad, M. A. (2006). Psychoeducational treatment for school-aged children with bipolar disorder. *Development and Psychopathology, 18,* 1289-1306.

Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Archives of General Psychiatry, 66*(9), 1013 -1021.

Garralda, M. E., & Chalder, T. (2005). Practitioner review: Chronic fatigue syndrome in childhood. *Journal of Child Psychology and Psychiatry, 46*(11), 1143–1151.

Glazener, C. M. A., Evans, J. H. C., & Peto, R. E. (2005). Alarm interventions for nocturnal enuresis in children. *Cochrane database of systematic reviews*, Issue 2.

Goenjian, A. K., Karayan, I., Pynoos, R. S., Minassian, D., Najarian, M. D., Steinberg, A. M., et al. (1997). Outcome of psychotherapy among early adolescents after trauma. *American Journal of Psychiatry, 154*, 536–542.

Grenyer, B. F. S., Mathews, R., Stokes, D., & Crea, K. (2010). The Australian psychology workforce 2: A national profile of psychologists' education, training, specialist qualifications and continuous professional development. *Australian Psychologist, 45*(3), 168-177.

Henken, T., Huibers, M. J., Churchill, R., Restifo, K. K., & Roelofs, J. J. Family therapy for depression. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD006728. DOI: 10.1002/14651858.CD006728.

Herman, K. C., Borden, L. A., Webster-Stratton, C., & Reinke, W. M. (2011). The impact of the Incredible Years Parent, Child and Teacher Training

Programs on children's co-occuring internalizing symptoms. *School Psychology Quarterly, 26*(3), 189-201.

Huntsman, L. (2008). Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families. Literature review. NSW Department of Community Services.

Infancy to young adulthood: A mental health policy for Western Australia (2011). http://www.health.wa.gov.au/documents/Infancy_to_Young_Adulthood.pdf

Ghosh, I. C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse and Neglect, 35*(7), 504-13.

Jaegermann, N., & Klein, P. S. (2010). Enhancing mothers' interactions with toddlers who have sensory processing disorders . *Infant Mental Health Journal*, *31*(3), 291–311.

Janca, A., Ustun, T. B., van Drimmelen, J., Dittmann, V., & Isaac, M. (1994). ICD-10 Symptom Checklist for Mental Disorders, Version 1.1. Geneva, Division of Mental Health, World Health Organization.

Jensen, P. S., Buitelaar, J., Pandina, G. J., Binder, C., & Haas, M. (2007). Management of psychiatric disorders in children and adolescents with atypical antipsychotics: A systematic review of published clinical trials. *European Journal of Child and Adolescent Psychiatry, 16*, 104–120.

Katzman D, Golden N, Neumark-Sztainer D, et al. (2000). From prevention to prognosis: Clinical research update on adolescent eating disorders. *Pediatric Research,* 47, 709-712.

Kelly, C. (1996). Chronic constipation and soiling in children: A review of the psychological and family literature. *Child Psychology and Psychiatry Review, 1,* 59–66.

Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact of substance use and depression at 7.4-year follow-up. *Journal of Consulting and Clinical Psychology, 62*, 276–287.

Kerwin, M. E. (1999). Empirically supported treatments in paediatric psychology: Severe feeding problems. *Journal of Pediatric Psychology, 24(*3), 193-216.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age of onset distributions of DSM-IV disorders and the national comorbidity survey replication. *Archives General Psychiatry*, *62*, 593-602.

KidsMatter Australian Primary Schools Mental Health Initiative http://www.kidsmatter.edu.au/primary/kidsmatter-overview/

KidsMatter Australian Primary Schools Mental Health Initiative (2011).*Component 3. Working with parents and carers. Literature review.* Unpublished manuscript.

KidsMatter Australian Primary Schools Mental Health Initiative (2011).*Component 4. Helping children experiencing mental health difficulties literature review.* Unpublished manuscript.

KidsMatter Australian Early Childhood Mental Health Initiative http://www.kidsmatter.edu.au/ec/

Koegl, C. J., Farrington, D. P., Augimeri, L. K., & Day, D. M. (2008). Evaluation of a targeted cognitive-behavioral program for children with conduct problems - The SNAP under 12 outreach project: Service intensity, age

and gender effects on short- and long-term outcomes. *Journal of Clinical Child Psychology and Psychiatry, 13*(3), 419 -434.

Korte, A., et al. (2008). Gender identity disorders in childhood and adolescence: Currently debated concepts and treatment strategies. *Deutsches Aerzteblatt International, 105*(48), 834-41.

Kowalik, J., Weller, J., Venter, J., & Drachman, D. (2011). Cognitive behavioral therapy for the treatment of pediatric posttraumatic stress disorder: A review and meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry, 42*(3), 405.

LaForett, et al. (2008). Psychosocial treatment for preschool-aged children with ADHD. *Developmental Disabilities Research Reviews, 14*, 300-310.

Larson, K., Russ., S. A., Crall, J. J., & Halfon, N. (2008). Influence of multiple social risks on children's health. *Paediatrics, 121*(2), 337-344.

Lewinsohn, P. M., Striegel-Moore, R. H., & Seeley, J. R. (2000). Epidemiology and natural course of eating disorders in young women from adolescence to young adulthood. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 1284-1292.

Lock, J., & Fitzpatrick, K. K. (2007*).* Evidence-based treatments for children and adolescents with eating disorders: Family therapy and family-facilitated cognitive-behavioral therapy. *Journal of Contemporary Psychotherapy, 37*, 145-155.

Lock, J., & Fitzpatrick, K. K. (2009*).* Advances in psychotherapy for children and adolescents with eating disorders. *American Journal of Psychotherapy, 63*(4), 287-303.

Lock, J., Le Grange, D., Forsberg, S., & Hewell, K. (2006). Is family therapy useful for treating children with anorexia nervosa? Results of a case

series. *American Journal of Child and Adolescent Psychiatry, 45*(11), 1323–1328.

Madden, S., Morris, A., Zurynski, Y. A., Kohn, M., & Elliot, E. J. (2009). Burden of eating disorders in 5–13-year-old children in Australia. *The Medical Journal of Australia, 190*, 410–414.

Mares, S., Newman, L., & Warren, B. (2005). *Clinical skills in Infant Mental Health. The first three years* (2nd ed.) ACER Press: Australia.

Mathew, J. L. (2010). Evidence-based management of nocturnal enuresis: An overview of systematic reviews. *Indian Pediatrics, 47*(9), 777-780.

Mathews, R., Stokes, D., Crea, K., & Grenyer, B. F. S. (2010). The Australian psychology workforce 1: A national profile of psychologists in practice. *Australian Psychologist, 45*(3), 154–167.

McDonnell, M. A. (2003). Prevalence of psychopathology in preschool-aged children. *Journal of Child and Adolescent Psychiatric Nursing*, *16*, 141-152.

McGory, P. D. (2007). Service models for the future. The specialist youth mental health model: Strengthening the weakest link in the public mental health system. *The Medical Journal of Australia, 187*(7), S53-S56.

McGrath, M. L., Mellon, M. W., Murphy, L. (2000). Empirically supported treatments in pediatric psychology: Constipation and encopresis. *Journal of Pediatric Psychology, 25*(4), 225-254.

Melfsen, S. et al., (2011). Cognitive behavioral therapy of socially phobic children focusing on cognition: a randomised wait-list control study. *Child and Adolescent Psychiatry and Mental Health, 5*(1), 5.

Mellon, M. W. & McGrath, M. L. (2000). Empirically supported treatments in pediatric psychology: Nocturnal enuresis. *Journal of Pediatric Psychology, 25*(4), 193-214.

Mendenhall, A. N., Fristad, M. A., & Early, T. J. (2009). Factors influencing service utilization and mood symptom severity in children with mood disorders: Effects of multifamily psychoeducation groups (MFPGs). *Journal of Consulting and Clinical Psychology, 77*(3), 463 -473.

Meyer-Bahlburg, H. F. L. (2008). Treatment guidelines for children with disorders of sex development. *Neuropsychiatrie de l'Enfance et de l'Adolescence, 56,* 345-349.

Milgrom, J., Ericksen, J., McCarthy, R., & Gemmill, A.W. (2006). Stressful impact of depression on early mother-infant relations. *Stress and Health, 22,* 229–238.

Mindell, J. A., Kuhn, B., Lewin, D, S., Meltzer, L. J., & Sadeh, A. (2006). Behavioral treatment of bedtime problems and night wakings in infants and young children. *Sleep, 19(*10), 1263-1276.

Mindell, J. A., & Meltzer, L. J. (2008). Behavioural sleep disorders in children and adolescents. *Academy of Medicine Singapore, 37*(8), 722-728.

Minde, K., Roy, J., Bezonsky, R., & Hashemi, A. (2010). The effectiveness of CBT in 3-7 year old anxious children: Preliminary data. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*(2), 109-115.

Mindell, J. A. (1993). Sleep disorders in children. *Health Psychology, 12*, 151-162.

Moran, P., Ghate, D., & van der Merwe, A. (2004). *What works in parenting support? A review of the international evidence.* Nottingham, UK: Department for Education and Skills.

National Mental Health Reform - Ministerial Statement. http://budget.australia.gov.au/2011-12/content/download/ms_health.pdf

National Public Health Partnership (2005).*Healthy Children - Strengthening Promotion and Prevention across Australia. National Public Health Strategic Framework for children 2005-2008.* NPHP: Melbourne (VIC).

Newman, D. L., Moffitt, T. E., Caspi, A., Magdol, L., Silva, P. A., & Stanton, W. R. (1996). Psychiatric disorder in a birth cohort of young adults: Prevalence, comorbidity, clinical significance, and new case incidence from ages 11 to 21. *Journal of Consulting and Clinical Psychology*, *64* (3), 552-562.

NICE (2004). *Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (NICE guideline).* Clinical guideline 9. National Institute for Health and Clinical Excellence. http://guidance.nice.org.uk/nicemedia/live/10932/29220/29220.pdf

O'Kearney, R. T., Anstey, K., von Sanden, C., & Hunt, A. (2010). Behavioural and cognitive behavioural therapy for obsessive compulsive disorder in children and adolescents. *The Cochrane Library*, Issue 1.

Operational Guidelines for the Access to Allied Psychological Services Component http://www.gpv.org.au/files/downloadable_files/Programs/Mental%20Health/Better%20Outcomes/ATAPS%20Guidelines%20to%20June%202011.pdf

Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, February 2010 http://www.health.gov.au/internet/main/publishing.nsf/content/8573A6A3FAB3595BCA257700000D8E78/$File/review.pdf

Palermo, T. M., Eccleston, C., Lewandowski, A. S., Williams, A. C. C., & Morley, S. (2010). Randomized controlled trials of psychological therapies for management of chronic pain in children and adolescents: An updated meta-analytic review. *Pain, 148,* 387–397.

Pavuluri, M. N., Graczyk, P. A., Henry, D. B., Carbray, J. A., Heidenreich, J., & Miklowitz, D. J. (2004). Child- and family-focused cognitive-behavioural therapy for paediatric bipolar disorder: Development and preliminary results. *Journal of the American Academy of Child & Adolescent Psychiatry,* 43(5), 528 -537.

Perquin, C. W., Hazebroek-Kampscheur, A. A. J. M., Hunfeld, J. A. M., Bohnene, A. M., van Suijlekom-Smit, L. W. A., Passchier, .J, et al. (2000). Pain in children and adolescents: a common experience. *Pain, 87*, 51–8.

Pfeffer, C. R., Jiang, H., Kakuma, T., Hwang, J., & Metsch, M. (2002). Group intervention for children bereaved by the suicide of a relative. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 505–513.

Pretorius, G., & Pfeifer, N. (2010). Group art therapy with sexually abused girls. *South African Journal of Psychology*, *40*(1), 63-73.

Ramchandani, P., & Wiggs, L. (2000). A systematic review of treatment of settling problems and night waking in young children. *British Medical Journal, 320,* 209-213.

Rapee, R. M., Kennedy, S. J., Ingram. M., Edwards, S.L., & Sweeney, L. (2010). Altering the trajectory of anxiety in at-risk young children. *American Journal of Psychiatry, 167* (12), 1518-1524.

Raphael, B. (2000). Promoting the mental health and wellbeing of children and young people. Discussion paper: Key principles and directions. Canberra, Department of Health and Aged Care, National Mental Health Working Group.

Riosa, P. B., McArthur, B. A., & ` le Preyde, M. (2011). Effectiveness of psychosocial intervention for children and adolescents with comorbid problems: A systematic review. *Child and Adolescent Mental Health*, *16*(4), 177-185.

Robertson, M. M. (2008). The prevalence and epidemiology of Gilles de la Tourette syndrome. Part 1: The epidemiological and prevalence studies. Journal of Psychosomatic Research, 65 (5), 461–472.

Robins L. N. (1991). Conduct disorder. *Journal of Child Psychology and Psychiatry, 32*(1), 193-212.

Rosner, R., Kruse, J., & Hagla, M. (2010). Meta-analysis of interventions for bereaved children and adolescents. *Death Studies, 34,* 99–136.

Ruth A. B. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, *10*(2), 125-143.

Rutter, M., Kim-Cohen, J., & Maughan, B. (2006). Continuities and discontinuities in psychopathology between childhood and adult life. *Journal of Child Psychology & Psychiatry*, *47* (3-4), 276-295.

Samaan, R. A. (2000). The influences of race, ethnicity, and poverty on the mental health of children. *Journal of Health Care for the Poor and Underserved, 11*(1), 100-110.

Sanders, M. R., Ralph, A., Sofronoff, K., Gardiner, P., Thompson, R., Dwyer, S. et al. (2008). Every family: A population approach to reducing behavioural and emotional problems in children making the transition to school. *Journal of Primary Prevention, 29*(3), 197-222.

Sawyer, M. G., Arney, F. M., Baghurst, P. A., Clark, J. J., Graetz, B. W., Kosky, R. J., et al. (2000). The mental health of young people in Australia. Canberra, Australia: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

Sawyer, M. G., Arney, F. M., et al (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.

Sharkey, L., & McNicholas, F. (2008). More than 100 years of silence', elective mutism: A review of the literature. *European Child & Adolescent Psychiatry, 17*(5), 255-263.

Sharp, W. G. (2010). Pediatric feeding disorders: A quantitative synthesis of treatment outcomes. *Clinical Child and Family Psychology Review, 13*(4), 348 -365.

Siegenthaler, E. Munder, T. and Egger, M. (2012). Effect of Preventative Interventions in Mentally Ill Parents on the *Mental Health of the Offspring: Systematic Review and Meta-Analysis*. Journal American Academy of Child and Adolescent Psychiatry 51: 8-17.

Silver, E., Williams, A., Worthington, F., and Phillips, N. (1998). Family therapy and soiling: An audit of externalizing and other approaches *Journal of Family Therapy,* 20, 413–422.

Silverman, W. K., Ortiz, C. D., et al. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 56 -183.

Silverman, W., Pina, A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 105-130.

Smith, J.C., Cumming, A., Xeros-Constantinides, S. (2010). A decade of parent and infant relationship support group therapy programs. *International Journal of Group Psychotherapy*; 60 (1); 59-88.

Smith, Y. L. S., van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35,* 89–99.

Sprenger, L., Gerhards, F., Goldbeck, L. (2011). Effects of psychological treatment on recurrent abdominal pain in children: A meta-analysis. *Clinical Psychology Review, 31,* 1192–1197.

Stack, C. (2003). Bereavement in paediatric intensive care. *Paediatric Anaesthesia*, *13*, 651–654.

Stokes, D., Mathews, R., Grenyer, B. F. S., & Crea, K. (2010). The Australian psychology workforce 3: A national profile of psychologists in salaried employment or in independent private practice. *Australian Psychologist, 45*(3), 178-188.

Stone, B. P., Kratochwill, T. R., Sladezcek, I., & Serlin, R. C. (2002). Treatment of selective mutism: A best-evidence synthesis. *School Psychology Quarterly, 17*(2), 168 -190.

The Children's Mental Health Coalition, Our Children Our Future (2010) http://www.aaimhi.org/viewStory/Policies+and+Submissions

The Royal Australian and New Zealand College of Psychiatrists: Report from the Faculty of child and Adolescent Psychiatry. Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, 2010. http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/peips_report.pdf

Thomas, R., & Zimmer-Gembeck, M. J. (2011) Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment. *Child Development, 82*(1), 177 -192.

Tiffin, P.A. (2007) Managing psychotic illness in young people: A practical overview.

Child and Adolescent Mental Health, 12 (4), 173–186.

Toth, S. L. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology, 74(*6), 1006 -1016.

Trowell, J. Joffe, I., et al. (2007) Childhood depression: A place for psychotherapy - An outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child & Adolescent Psychiatry, 16*(3), 157 -167.

Urquiza, A. J. (2010). The future of play therapy: Elevating credibility through play therapy research. *International Journal of Play Therapy*, *19*(1), 4–12.

Van der Oord, S., Prins, P. J. M., Oosterlaan, J., & Emmelkamp, P. M. G. (2008). Efficacy of methylphenidate, psychosocial treatments and their combination in school-aged children with ADHD: A meta-analysis. *Clinical Psychology Review,* 28, 783–800.

Van Doesum, KTM, Riksen-Walraven, JM., Hosman, CMH. And Hoefnagels, (2008). CA. *Randomized Controlled Trial of a Home-Visiting Intervention Aimed at Preventing Relationship Problems in Depressed Mothers and Their Infants*. Child Development, 79, 547-561.

Verdellen, C., van de Griendt, J., Hartmann, A., & Murphy, T. (2011). European clinical guidelines for Tourette Syndrome and other tic disorders. Part III: Behavioural and psychosocial interventions. *European Journal of Child and Adolescent Psychiatry, 20*, 197-207.

Verdeli, H. V. Mufson, L., Lee, L., & Keith, J. A. (2006). Review of evidence-based psychotherapies for pediatric mood and anxiety disorders. *Current Psychiatry Reviews, 3*, 395 -421.

VicHealth strategy and business plan 2009-2013 http://www.vichealth.vic.gov.au/~/media/About%20Us/Vichealth%20Strategic%20Priorities/Attachments/Strategic_Framework_web.ashx

Watson, H. J., & Rees, C. S. (2008). Meta-analysis of randomized, controlled treatment trials for pediatric obsessive-compulsive disorder. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 49(5), 489 -498.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology, 66*(5), 715-730.

Weisz, J. R., Hawley, K. M., & Doss, A. J. (2004). Empirically tested psychotherapies for youth internalizing and externalizing problems and disorders. *Child & Adolescent Psychiatric Clinic of North America, 13*, 729-815.

Weisz, J. R., & Kazdin, A. E. (2010). *Evidence-Based Psychotherapies for Children and Adolescents*. (2nd ed.) The Guildford Press: New York.

Wildes, J. E., Marcus, M. D., Kalarchian, M. A., Levine, M. D., Houck, P. R., & Cheng, Y. (2010). Self-reported binge eating in severe pediatric obesity: Impact on weight change in a randomized controlled trial of family-based treatment. *International Journal of Obesity, 34,* 1143–1148.

Wilfley, D. E., Tibbs, T. L., Van Buren, D. J., Reach, K. P., Walker, M. S., & Epstein, L. H. (2007). Lifestyle interventions in the treatment of childhood overweight: A meta-analytic review of randomized controlled trials. *Health Psychology, 26*, 521–532.

Wilfley, D. E., Vannucci, A., White, E. K. (2010). Early intervention of eating- and weight-related problems. *Journal of Clinical Psychology in Medical Settings, 17*(4), 285 -300.

World Health Organization (1992). *International classification of diseases*, 10th ed., World Health Organization.

Young, S., & Amarasinghe, J. M. (2010). Practitioner Review: Non-pharmacological treatments for ADHD: A lifespan approach. *Journal of Child Psychology and Psychiatry,* 51(2), 116–133.

Zeanah, C. H. (2009). *Handbook of Infant Mental Health* (3rd ed.) The Guilford Press: New York.

Zubrick, S. R., Silburn, S. R., Burton, P., & Blair, E. (2000). Mental health disorders in children and adolescents: Scope, cause and prevention. *Royal Australian and New Zealand Journal of Psychiatry*, *34*, 570-578.

Zucker, K. J. (2008). Children with gender identity disorder: Is there a best practice? *Neuropsychiatrie de l'Enfance et de l'Adolescence, 56*, 358-364.

6. Appendices

Appendix 1: Disorders listed in the ATAPS Operational Guidelines - Definition of Mental Illness for the Better Outcomes in Mental Health Care Program (as at November 2011)

1. Alcohol use disorders	12. Drug use disorders
2. Chronic psychotic disorders	13. Acute psychotic disorders
3. Bipolar disorder	14. Depression
4. Phobic disorders	15. Panic disorder
5. Generalised anxiety	16. Mixed anxiety and depression
6. Adjustment disorder	17. Dissociative (conversion) disorder
7. Unexplained somatic complaints	18. Neurasthenia
8. Eating disorders	19. Sleep problems
9. Sexual disorders	20. Hyperkinetic (attention deficit) disorder
10. Childhood behavioural disorders – limited to: (a) Conduct Disorder; (b) Attention - Deficit / Hyperactivity Disorder (ADHD); (c) Oppositional Defiant Disorder; (d) Disruptive Behaviour Disorder, not otherwise specified (NOS);	21. Enuresis
11. Bereavement disorders	22. Mental disorder, NOS

Appendix 2: Policy Context

National Mental Health Strategy

The National Mental Health Strategy is a commitment by the Australian and State and Territory Governments to improve the lives of people with a mental illness. It includes the:

- National Mental Health Policy (2008)
  The National Mental Health Policy is a joint statement by the Health Ministers of the Commonwealth, States and Territories of Australia. It was revised and endorsed by Health Ministers again in December 2008, to provide a strategic vision for further whole-of-government mental health reform in Australia.
- Fourth National Mental Health Plan (PDF 1589 KB)
- Mental Health statement of rights and responsibilities
- National Health Reform Agreement
  http://www.coag.gov.au/docs/national_health_reform_agreement.pdf

  COAG has agreed, out-of-session in August 2011, the National Health Reform Agreement which will deliver major reforms to the organisation, funding and delivery of health and aged care. The Agreement sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system. The reforms will achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future through increased Commonwealth funding. This new agreement gives effect to the commitment made by COAG on 13 February 2011, and in doing so, supersedes the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform. Under the National Health Reform Agreement, the Commonwealth is providing an extra $16.4 billion, through to 2019-20, for public hospitals.

National Health Care Agreement, 2011 - http://www.coag.gov.au/docs/national_healthcare_agreement_2011.pdf
On 20 December 2007, the Council of Australian Governments (COAG) agreed to a reform agenda that will boost productivity, workforce participation and geographic mobility, and support wider objectives of better services for the community, social inclusion, closing the gap on Indigenous disadvantage and environmental sustainability. This National Healthcare Agreement affirms the agreement of all governments that Australia's health system should: (a) be shaped around the health needs of individual patients, their families and communities; (b) focus on the prevention of disease and injury and the maintenance of health, not simply the treatment of illness; (c) support an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the continuum of care; and (d) provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

- Council of Australian Governments (COAG) National Action Plan on Mental Health (2006 - 2011)
  The COAG National Action Plan on Mental Health 2006-2011 was developed between governments to provide further impetus to mental health reform and complements the National Mental Health Strategy. The COAG National Action Plan emphasised the importance of governments working together, and the need for more integrated and coordinated care. It also committed governments to a significant injection of new funds into mental health.
- National Suicide Prevention Strategy
- Towards Better Mental Health for the Veteran Community
  A blueprint for the planning and delivery of mental health services to the veteran community. Go to http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/policies-lp-1 for links to specific policies mentioned above.

Additional documents:

Health Budget 2011-2012, Delivering National Mental Health Reform
http://www.health.gov.au/internet/budget/publishing.nsf/Content/37F7E9CFA7BBD3C3CA25788A002EC0DF/$File/hmedia02.pdf

Budget Strategy and Outlook, Budget Paper No. 1. 2011-12
http://cache.treasury.gov.au/budget/2011-12/content/download/bp1.pdf?v=2

National Mental Health Report 2010
http://www.health.gov.au/internet/main/publishing.nsf/Content/8C20A89EAC527C40CA2577EE000F6E01/$File/report10v3.pdf

National Mental Health Reform 2011-12

http://www.health.gov.au/internet/publications/publishing.nsf/Content/nmhr11-12~nmhr11-12-priorities~children

Appendix 3: Assessment tools

Commonly used mental health screening/assessment tools	
1	*The Strengths and Difficulties Questionnaire* (SDQ); author: Goodman (1997)
2	*Health of the Nation Outcome Scales for Children and Adolescents* (HoNOSCA); authors: University of Manchester, Department of Health, and The Royal College of Psychiatrists (1998)
3	*Behavioral Assessment System for Children*, Second Edition *(BASC-2);* authors: C. R. Reynolds & R. W. Kamphaus (2004)
4	*Child Behaviour Checklist (CBCL); author: T. M Achenbach (2001)*
5	*Spence Children's Anxiety Scales* (SCAS); author: S. Spence (1998)
6	*Revised Children's Manifest Anxiety Scales: Second Edition (RCMAS-2);* authors: C. R. Reynolds & B. O. Richmond (2008)
7	*Children's Depression Inventory* (CDI); author: Kovacs (1992)
8	*Infant-Toddler Social and Emotional Assessment* (ITSEA); authors: A. Carter & M. Briggs-Gowan (2006)
9	*Brief Infant-Toddler Social and Emotional Assessment* (BITSEA); authors: M. Briggs-Gowan & A. Carter (2006)
10	*Conners Rating Scales-Revised (CRS-R)*; author: C. K. Conners (1997)

Note: This table shows examples of commonly used assessment/screening tools with children. There are many other assessment tools not mentioned above and this table is provided as an example of some assessment tools to consider. However, clinicians need to consider the best tools that suit their client's circumstances (on a case by case basis); based on clinical judgement.

Appendix 4: Clinical Practice Guidelines

Clinical Practice Guidelines:

http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

ADHD

NHMRC Australian Draft Guidelines on Attention Deficit Hyperactivity Disorder (2009)

http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ch54_draft_guidelines.pdf

National Institute for Health and Clinical Excellence (NICE) (2008). Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults, http://guidance.nice.org.uk/CG72

Eating Disorders

Royal Australian and New Zealand College of Psychiatrists (2003). Australian and New Zealand clinical practice guidelines for the treatment of Anorexia

http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Australian_Versions/AUS_Anorexia_nervosa.pdf

Depression

Royal Australian and New Zealand College of Psychiatrists (2004). Australian andNew Zealand clinical practice guidelines for the treatment of depression. Australian and New Zealand Journal of Psychiatry, 38, 389–407. http://www.shdivgp.com.au/images/stories/documents/mental%20health/depression_clinican_full.pdf

Anxiety Disorders

Royal Australian and New Zealand College of Psychiatrists (2003). Australian and New Zealand clinical practice guidelines for the treatment of panic disorder and agoraphobia. Australian and New Zealand Journal of Psychiatry, 37, 641–656.

http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Clinician/CPG_Clinician%20Full_Panic_Disorder_Agoraphobia.pdf

Antidepressant Medication

Clinical Guidance on the use of Antidepressant Medications in Children and Adolescents (MARCH 2005) The Royal Australian and New Zealand College of Psychiatrists http://www.ranzcp.org/images/stories/ranzcp attachments/Resources/College_Statements/Practice_Guidelines/Clinical_Guidance_on_the_use_of_Antidepressant_medications_in_Children_and_Adolescents.pdf

Gender Identity Disorder

Di Ceglie, D., Sturge, C., & Sutton, A. (1998). *Gender identity disorders in children and adolescents: Guidance for management*. Royal College of Psychiatrists, London. http://www.rcpsych.ac.uk/files/pdfversion/cr63.pdf

7. Glossary

Behavioural activation: a type of behaviour therapy for treating depression. It focuses on activity scheduling to encourage clients to approach activities that they are avoiding and on analysing the function of cognitive processes (e.g. rumination) that serve as a form of avoidance. Clients are therefore refocused on their goals and valued directions in life.

Biofeedback: a treatment technique in which people are trained to improve their health by controlling certain bodily processes that normally happen involuntarily, such as heart rate, blood pressure, muscle tension, and skin temperature.

Child: a young person aged less than 12 years of age.

The Circle of Security Intervention: a group-based, parent education and psychotherapy intervention designed to shift patterns of attachment–care giving interactions in high-risk caregiver–child dyads to a more appropriate developmental pathway. It is based on attachment theory and procedures, current research on early relationships, and object relations theory.

Cognitive restructuring: a technique used in cognitive therapy which refers to the process of learning to refute cognitive distortions or fundamental "faulty thinking," with the goal of replacing one's irrational, counter-factual beliefs with more accurate beneficial ones.

Comorbidity: the co-occurrence of two or more mental disorders or conditions.

Early intervention: interventions that target children showing early signs/symptoms of a mental health difficulty or mental disorder, or interventions for children experiencing the first episode of a mental disorder.

Failure to thrive: refers to children whose current weight or rate of weight gain is significantly lower than that of other children of similar age and gender.

Failure to thrive may be the result of medical problems or factors in the environment, such as abuse or neglect.

Formulation: an integrative statement that provides an etiological understanding of factors contributing to the presentation of the client at the time of assessment. Factors that are considered in formulating a case are sometimes referred to as the four P's and include: predisposing, precipitating, perpetuating and protective factors.

The HUGS (Happiness, Understanding, Giving & Sharing) Program: a specialised three-session parent-infant intervention which aims to foster re-establishment of joyful parent–infant interactions by strengthening parental skills in sensitive responsivity to infants through play, understanding infant cues and separating parental issues from infant needs. Whilst the major therapeutic target of intervention is the mother's interchange with her infant, her cognitions, attitudes and beliefs (including the influence of family of origin) are also challenged.

The Incredible Years programs: a series of training packages for parents, teachers, and children to help promote children's use of appropriate conflict management skills, and to strengthen social skills, emotional regulation and academic success, in order to increase self-esteem and reduce behavioural problems (e.g. aggression).

Mental disorder: (also referred to as a mental health disorder) describes a clinically recognisable set of symptoms or behaviours associated in most cases with distress and interfere with personal functioning (Raphael, 2000). Set criteria for mental disorders are outlined in diagnostic manuals (Diagnostic and Statistical Manual – IV and International Classification of Disease – 10).

Mental health difficulties: (in relation to children) refers to a wide range of cognitive, emotional and behavioural difficulties that may cause concern or distress. They are relatively common, and may include symptoms which do not meet the threshold for a diagnosis, but nevertheless can cause distress and disruption to functioning. Mental health difficulties also encompass mental disorders, which are more severe and/or persistent mental health conditions.

Multi-Family Psychoeducation Groups (MFPG): a multi-family intervention aimed at treating children aged 8 -12yrs with mood disorders combining elements of psychoeducation, family systems, and CBT techniques to target mood disorder symptoms and the impairment they cause. It aims to help parents and children learn about mood disorders and their treatment; gain support from other families with similar difficulties and from professionals who understand the disorders; and build skills in areas such as symptom management and communication.

Non-removal of the spoon: a form of escape extinction to treat feeding problems in which an adult holds the spoon in front of a child's mouth until he or she takes a bite of food. Upon acceptance, positive reinforcement is provided (e.g. descriptive praise, tangible items).

The Pairs (Parent and Infant Relationship Support) program: a short-term community group therapy program for high-risk infants and their parents. The program aims to increase positive parent-infant interaction and secure attachment, to decrease maternal postnatal depression, and to foster optimal infant development.

Parent: can have responsibility for a child, and in the context of this document, persons having responsibility for a child may in some circumstances include guardians or persons having custodial responsibilities for the child.

Physical guidance: another form of escape extinction for feeding problems in which an adult physically guides the spoon into a child's mouth and physically assists him or her in opening the mouth. Acceptance of the spoon results in positive reinforcement.

Primary intervention: interventions that are targeted at the entire population or community and provide support and education before problems occur.

Secondary intervention: interventions that target specific “at risk” individuals or groups and aim to both provide early intervention and attempt to prevent the subsequent escalation of the issue.

Self-regulation: the capacity to control the nature and the intensity of one's responses, by regulating levels of arousal, attention, affect, and action.

Sensory processing: the ability to receive sensory information from the environment and the body and to respond appropriately.

Sensory-processing disorders: refers to children with both sensory-processing and self-regulation difficulties. At this stage sensory processing disorders have not been included in a diagnostic manual (Diagnostic and Statistical Manual – IV and International Classification of Disease – 10).

Significant dysfunction in everyday life: refers to a child's inability to undertake successfully the activities associated with daily life and general life independence relevant to their developmental level and needs. For example, in the case of a child their mental health condition would be interfering with their ability to develop age appropriate skills (e.g. play, relate to carers, socialise with peers and/or learn) across school, family and/or peer settings.

Sleep hygiene: a term used to describe good sleep habits, or things that can be done to ensure good quality sleep (e.g. going to bed at the same time each night, getting regular exercise).

Social Effectiveness Training: a small group behavioural treatment program designed to improve the social competence of children between the ages of 8 and 12 who suffer from social phobia.

Tertiary intervention: includes the treatment strategies that are used once primary and secondary intervention has failed (interventions that occur after the fact).

Trauma-focused CBT (TF-CBT)**:** addresses problems specifically associated with significantly traumatic events that children experience or witness. The aim is to help children overcome traumatic avoidance, shame, sadness and trauma-specific problems. TF-CBT is a model incorporating CBT, attachment, family,

humanistic and psychodynamic therapy principles, as well as research findings about the physiology of childhood trauma.

The Triple P – Positive Parenting Program: a multilevel, evidence-based parenting and family support strategy designed to prevent behavioural, emotional and developmental problems in children (or halt their progression and reduce their severity) and provide support for parents and families. It aims to help parents develop a safe, nurturing environment and promote positive, caring relationships with their children, and to develop effective, non-violent strategies for promoting children's development and dealing with common childhood behaviour problems and developmental issues.

Urine alarm interventions: an intervention used to treat enuresis which consists of some kind of alarm activated by urination. Urine alarms were initially bed-based, with the child sleeping on a pad or mat containing an electrical circuit. Urine, coming into contact with this would complete the circuit causing a bell to ring. The alarm is intended to change the meaning of the sensation of having a full bladder from a signal to urinate to a signal to inhibit urination and waken.

The Wait, Watch and Wonder (WWW) program: a child-led psychotherapeutic approach that specifically and directly uses the infant's spontaneous activity in a free play format to enhance maternal sensitivity and responsiveness, the child's sense of self and self-efficacy, emotion regulation, and the child-parent attachment relationship.